MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2022
Policy Number: *450*	**Subject:** Crisis Receiving and Stabilization Program

Definition

Crisis Receiving and Crisis Stabilization Programs are designated services for members experiencing a behavioral health crisis related to a mental health disorder and/or a combination of mental health and substance use disorder (co-occurring). The Crisis Receiving and Crisis Stabilization Programs are designed to provide triage, crisis risk assessment, evaluation, and intervention to members whose crisis response needs are deemed to be urgent or emergent.

Community-based crisis programs are designated as either:

(1) Tier I: Crisis Receiving Program;

(2) Tier II: Crisis Stabilization Program; or

(3) Tier III: Crisis Receiving and Stabilization Program.

A program delivering both Crisis Receiving and Stabilization must follow the appropriate requirements below for Tier I and/or Tier II, depending on which level of service is being provided.

Provider Requirements

Tiers I, II, and III Crisis Receiving and Stabilization Programs are required to:

(a) operate 24 hours a day, seven days a week, 365 days a year;

(b) be provided by a licensed mental health center;

(c) have 24-hour awake direct care staff; and

(d) have a 24-hour on call licensed clinical mental health professional.

Tier I: Crisis Receiving Program

Crisis Receiving Program means a community-based outpatient program that provides evaluation, observation, intervention, and referral for members experiencing a crisis due to behavioral health (i.e., mental health or a co-occurring mental health and substance use disorder.
Crisis Receiving is a short-term urgent or emergent treatment for crisis intervention and stabilization of no more than 23 hours and 59 minutes from the time the member is admitted to the program. Members receiving this service must be evaluated, then stabilized and/or referred to the most appropriate level of care. A Crisis Receiving Center is an alternative, but not a replacement, to a community hospital Emergency Department (ED); as such, it operates 24 hours a day, seven days a week, 365 days a year (24/7/365) and offers walk-in and first responder drop off options.

Medical Necessity Criteria – Tier I, Crisis Receiving Program

(1) Any mental health diagnosis from the current version of the DSM or ICD as the primary diagnosis;

(2) The presenting clinical problem requires a safe, contained environment wherein observation and assessment can be conducted to determine the next steps in the member's care; and

(3) Level of impairment assessment indicates that the symptoms may stabilize within a 23 hour and 59-minute period at which time a less restrictive level of care may be appropriate.

Service Requirements – Tier I, Crisis Receiving Program

(1) Crisis Receiving Program must be billed as a bundled service and includes the following:

(a) clinical assessment;

(b) crisis stabilization services;

(c) when indicated, psychotropic medications administered and monitoring behavior during the crisis stabilization period;

(d) screening for suicide risk and violence risk and when clinically indicated completes comprehensive suicide risk and/or violence risk assessments and planning;

(d) observation of symptoms and behaviors;

(e) care management services, including referral and coordinated transportation to additional, facility-based, psychiatric, or behavioral health care when indicated;

(f) support or training for self-management of psychiatric symptoms; and

(g) inclusion of family or natural supports, with consent, as available.

(2) Crisis Receiving staff will attempt to follow up with 100% of members discharged into the community via phone within 72 hours of discharge.

(3) It is required that each member receiving the Crisis Receiving Program receive every service listed above that is identified as medically necessary and documented in the member's the member's individualized treatment plan and in the member's file.

Utilization Management – Tier I: Crisis Receiving Program

(1) Prior authorization is not required. Admission to Crisis Receiving Program requires documentation in the member's file that the individual meets the medical necessity criteria.

(2) Continued stay reviews are required if a member accesses the Crisis Receiving Program more than four times in a 30-day period.

Tier II: Crisis Stabilization Program

Crisis Stabilization Program is short-term, 24-hours or more, of supervised residential treatment in a community-based facility of fewer than 16 beds for adults with a mental health and/or mental health and substance use (co-occurring) disorders. It is an emergency treatment for crisis intervention and stabilization that offers a treatment option as an alternative to Acute Inpatient Hospitalization. The service includes medically monitored residential services to provide psychiatric stabilization on a short-term basis and is designed to reduce disability and restore members to previous functional levels by promptly intervening and stabilizing when crisis situations occur. The focus is recovery, preventing continued exacerbation of symptoms, and decreasing risk of, or need for, higher levels of care, including hospitalization.

Medical Necessity Criteria

Any mental health diagnosis from the current version of the DSM or ICD as the primary diagnosis AND at least one of the following:

(1) Dangerousness to self as evidenced by behaviors that may include, but not be limited to any of the following:

(a) self-injurious behavior or threats of same with continued risk without ongoing supervision;

(b) current suicidal ideation with expressed intentions and/or past history of carrying out such behavior with some expressed inability or aversion to doing so, or an inability to contract for safety;

(c) self-destructive behavior or ideation that cannot be adequately managed and/or treated at a lower level of care without risk to the member's safety or clinical well-being; or

(d) history of serious self-destructive or impulsive, parasuicidal behavior with current verbalizing of intent to engage in such behavior, with the risk, as judged by a licensed clinical mental health professional, being significantly above the member's baseline level of functioning.

(2) Dangerous to others, as evidenced by behaviors that may include expressed intent to harm others, current threats to harm others with expressed intentions of carrying out such behavior, with some expressed inability or aversion to doing so.

(3) Grave disability as exhibited by ideas or behaviors, as evidenced by behaviors that may include:

(a) mental status deterioration sufficient to render the member unable to reasonably provide for his/her own safety and well-being;

(b) an acute exacerbation of symptoms sufficient to render the member unable to reasonably provide for his/her own safety and well-being;

(c) deterioration in the member's functioning in the community sufficient to render the member unable to reasonably provide for his/her own safety and well-being;

(d) an inability of the member to cooperate with treatment combined with symptoms or behaviors sufficient to render the member unable to reasonably provide for his/her own safety and well-being; or

(e) a licensed clinical mental health professional's inability to adequately assess and diagnose a member, as a result of the unusually complicated nature of a member's clinical presentation, with behaviors or symptoms sufficient to render the member unable to reasonably provide for his/her own safety and well-being, but not sufficient to require the intensity of inpatient treatment.

Service Requirements

(1) Crisis Stabilization Program must be billed as a bundled service and includes the following:

(a) screening for suicide risk and violence risk and, when clinically indicated, completes comprehensive suicide risk and/or violence risk assessments and planning;

(b) observation of symptoms and behaviors;

(c) ongoing safety, crisis, and clinical assessment;

(d) when indicated, initiate, or continue medication management including administering and monitoring psychotropic medications during the crisis stabilization period;

(e) support or training for self-management of psychiatric symptoms;

(f) care management services, including disposition and discharge planning and coordination to the least restrictive and most appropriate level of care.

(2) Crisis Stabilization staff will attempt to follow up with 100% of members discharged into the community via phone within 72 hours of discharge.

(3) It is required that each member receiving the Crisis Stabilization Program receive every service listed above that is identified as medically necessary and documented in the member's the member's individualized treatment plan and in the member's file.

Utilization Management

(1) Prior authorization is not required. Admission to Crisis Stabilization Program requires documentation in the member's file of a current mental health DSM or ICD diagnosis, as the primary diagnosis.

(2) Continued stay reviews are required for more than three days in the Crisis Stabilization Program, and will be required every three days thereafter, and may be submitted via Auto-Authorization (Policy 206/206a).

(3) The crisis stabilization facility must show the following:

(a) any mental health diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis;

(b) active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria; and

(c) a lower level of care is inadequate to meet the member's treatment or safety needs.

(4) In addition to (3) above, either (a), (b), or (c) below:

(a) there is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the crisis stabilization setting;

(b) there is a high likelihood of either risk to the member's safety, clinical well-being, or further significant acute deterioration in the member's condition without continued care and lower levels of care are inadequate to meet these needs; or

(c) the appearance of new impairments meeting admission guidelines.

(5) The provider must document in the file of the member that the member meets the medical necessity criteria.