Comprehensive Crisis Services

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Definitions

Refer to Appendix A and the Telehealth Supplement for definition of terms used in this Appendix. The following definitions are specific to comprehensive crisis and transition services.

“Assessment” means the same as defined in DBHDS Crisis Services regulation 12VAC35-105-1850. Assessments shall be completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S.

“Behavioral health crisis” is an acute psychological or emotional change which results in a marked increase in personal distress, requires a rapid response, and exceeds the abilities and the resources of the individual and those involved to effectively resolve.

“Crisis call center” means the same as defined in § 37.2-311.1 of the Code of Virginia.

“DBHDS crisis data platform engagement” means utilization of Virginia’s Crisis Data Platform for the reporting of outcomes and basic information pertaining to a behavioral health crisis.

“Mobile Crisis Response Episode” means all service components delivered in response to a single precipitating behavioral health crisis event and, effective 1/1/2027, shall not exceed four hours (16 units) within the 24 consecutive hours from the time of admission. The time of admission is defined as the time in which the Mobile Crisis Response staff person acknowledges they have started the assessment in the DBHDS crisis data platform. All contacts with the individual arising from the same precipitating event, regardless of the number of times the team physically departs from and returns to the individual’s location, constitute a single episode, require a single registration, and are payable as a single episode. A new episode requires a new and distinct precipitating behavioral health crisis event. Continued or unresolved symptoms from the prior episode do not, standing alone, constitute a new precipitating event.

“Psychiatric evaluation” means an assessment, based on present problems and symptoms, of an individual’s biological, mental, and social functioning, for the purposes of diagnosis and treatment including an assessment of the need for prescription medication and ongoing care.

“Telemedicine assisted assessment” means the in-person service delivery encounter by a QMHP or CSAC with synchronous audio and visual support from a remote LMHP, LMHP-R, LMHP-RP or LMHP-S to: obtain information from the individual or collateral contacts, as appropriate, about the individual's mental health status; provide assessment and early intervention; and, develop an immediate plan to maintain safety in order to prevent the need for a higher level of care. The assessment includes documented recent history of the severity, intensity, and duration of symptoms and surrounding psychosocial stressors.

"Therapeutic group home (TGH)" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents. TGH providers shall meet all requirements in DBHDS Regulations for Children's Residential Facilities (12VAC 35-46).

The following mean the same as they are defined in the Telehealth Services Supplement to this manual:

- Telehealth
- Telemedicine

Prescreening Assessments

Prescreening assessments are conducted through Community Services Boards (CSBs) emergency services pursuant to section §37.2-800 et. seq. and section §16.1-335 et seq. of the Code of Virginia. Additional information on prescreening assessment is located in the Emergency Custody and Temporary Detention Orders Supplement to this manual.

Diagnosis Requirements

These crisis and transition services are applicable to individuals who meet criteria for any diagnosis across the domains of mental health, substance-related and addictive disorder and neurocognitive or neurodevelopmental disorders within the most recently published version of the Diagnostic and Statistical Manual of Mental Disorder (DSM). Mobile Crisis Response is the exception, as it is available to any individual experiencing a *behavioral health crisis* who meets medical necessity criteria for that service.

Department of Behavioral Health and Developmental Services (DBHDS)

DBHDS licensed providers are required to follow DBHDS licensing requirements in addition to DMAS requirements outlined in this manual. Providers of these services should note updates to DBHDS regulations effective 7/17/2024. Information on this update is available here: https://townhall.virginia.gov/L/viewstage.cfm?stageid=10344 and also on the DBHDS Office of Licensing webpage: https://dbhds.virginia.gov/clinical-and-quality-management/office-of-licensing/

Assessment Requirements

1. Assessments shall be completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S.
2. The provider shall actively involve the individual and individual's authorized representative, if applicable, and shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.
3. The provider shall make reasonable attempts to obtain previous assessments or history relevant to the crisis and shall use the individual's previous assessments or other relevant history within the course of treatment.

4. The provider shall complete a crisis assessment detailed enough to (i) determine whether the individual qualifies for admission and (ii) initiate a safety plan or crisis ISP for those individuals who are admitted to the service. At a minimum, the assessment shall include:
    a. Diagnosis, including current and past substance use or dependence and risk for intoxication or substance withdrawal, and co-occurring mental illness or developmental disability;
    b. Risk of harm;
    c. Cognitive functional status, including the individual's ability to protect from self-harm and provide for the individual's basic human needs;
    d. Precipitating issues, including recent stressors or events;
    e. Presenting needs, including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs. The assessor shall record:
        i. Any physical reaction to the presenting crisis. Examples include issues with sleep, appetite, or daily activities;
        ii. The individual's housing arrangements and living situation if mentioned by the individual; and
        iii. Any trauma, such as sexual abuse, physical abuse, or natural disaster, if appropriate, including if a trauma is related to the current crisis or mentioned by the individual
    f. Additional current medical issues and symptoms;
    g. Current medications, including recent changes to medications;
    h. Barriers that will impact the individual's ability to seek treatment or continue to participate in services, including the individual's mood, ability, and willingness to engage in treatment, and access to transportation;
    i. The individual's recovery environment and circle of support; and
    j. Communication modality and language preference

    In addition to the above, providers of RCSU and community stabilization shall also include, at a minimum, the following:
    k. Relevant treatment history and health history, to include
        i. Past prescribed medications
        ii. Psychiatric hospitalizations
        iii. Other treatments
        iv. Allergies, including allergies to food and medications
        v. Recent physical complaints and medical conditions
        vi. Nutritional needs
        vii. Chronic conditions
        viii. Communicable diseases
        ix. Restrictions on physical activities
        x. Restrictive protocols or special supervision requirements

xi. Preferred interventions in the event behaviors or symptoms become a danger to self or others
xii. All known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and a history of trauma
xiii. Past serious illnesses, serious injuries, and hospitalizations
xiv. Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household
xv. Other interventions and outcomes, including interventions and outcomes that were unsuccessful

l. The individual's housing arrangements or living situation
m. Trauma, such as sexual abuse, physical abuse, or natural disaster
n. Current or previous involvement in systems, such as legal, adult protective services, or child protective services
o. If applicable to the individual's crisis, the assessment shall also include:
    i. The individual's social, behavioral, developmental, and family history and supports
    ii. Employment, vocational, and educational background
    iii. Cultural and heritage considerations
    iv. Financial stressors

Safety Plans and Crisis Individualized Services Plans (Crisis ISP)

1. The development of the safety plan and crisis ISP is a collaborative process but shall be, at a minimum, reviewed and signed off by a LMHP, LMHP-R, LMHP-RP or LMHP-S. All crisis providers are required to create and implement safety plans. RCSU and community stabilization providers are also required to create and implement crisis ISPs.
2. The safety plan and crisis ISP shall be developed based on the crisis assessment with the participation and informed choice of the individual receiving services and applicable authorized representatives.
3. The provider shall use signed and dated progress notes to document the provider's efforts toward the implementation of the goals and objectives contained within the safety plan or crisis ISP
4. In order to document agreement, both the safety plan and the crisis ISP shall be signed and dated at a minimum by the person responsible for implementing the safety plan or crisis ISP and the individual receiving services or the individual's authorized representative, if appropriate. Refer to DBHDS crisis services regulations (12VAC35-105-1860 – 12VAC35-105-1870) for additional information on ensuring and documenting the individual's participation and informed choice.

<u>Additional Safety Plan Requirements</u>

Providers shall implement a person-centered safety plan immediately after admission that shall continue in effect until discharge from the provider's service. The safety plan shall be based on the individual's immediate service, health, and safety needs identified in the crisis assessment and be an ongoing activity. Completion of a crisis education and prevention plan (CEPP) as defined in 12VAC35-105-20 meets this requirement.

The safety plan shall include, at a minimum:

1. Warning signs that a crisis may be developing, such as thoughts, images, mood, situation, and behavior or stressors that may trigger the individual;
2. Internal coping strategies and things the individual can do without contacting another person, such as relaxation techniques or physical activities;
3. People and social settings that the individual may turn to for distraction or support;
4. People the individual may ask for help;
5. Professionals or agencies the individual can contact during a crisis; and
6. Strategies the individual can use to make their environment safe.

The safety plan may also include:

1. A description of how to support the individual when pre-crisis or behaviors are observed;
2. Specific instructions for the systems supporting the individual during a pre-crisis behavior;
3. A description of how to support the individual when crisis behaviors are observed; and
4. Specific instructions for the systems supporting the individual during crisis.

In the event an individual receiving services requires medication management or seclusion (as allowed in the service per 12VAC35-115-110), the need shall be clearly documented in an attachment to the individual's safety plan.

Additional Crisis Individualized Service Plan (ISP) Requirements

Providers of RCSU and Community Stabilization shall implement a crisis ISP as soon as possible after admission but no later than 48 hours after admission and prior to discharge from the provider's crisis service. The crisis ISP shall be based on the individual's immediate service, health, and safety needs identified in the crisis assessment. The crisis ISP shall include:

1. Relevant and attainable goals, measurable objectives to inform treatment, and specific strategies for addressing each need documented within the individual's crisis assessment;
2. Services, supports, and frequency of services required to accomplish the goals, including relevant psychological, mental health, substance use, behavioral, medical, rehabilitation, training, and nursing needs and supports;
3. Any use of seclusion if allowed in the service per 12VAC35-115-110;
4. The role of the individual and others in implementing the crisis ISP;

5. Identification of employees or contractors responsible for the coordination and integration of services, including employees of other agencies;
6. A behavioral support or treatment plan, if applicable; and
7. Projected discharge plan and estimated length of stay within the service.

Mobile Crisis Response

Mobile Crisis Response Level of Care Guidelines	
Service Definition Critical Features & Service Components	Mobile Crisis Response services are available 24 hours a day, seven days a week, to provide for rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real-time to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to i) de-escalate the behavioral health crisis and prevent harm to the individual or others; ii) assist in the prevention of an individual's acute exacerbation of symptoms; iii) development of an immediate plan to maintain safety; and iv) coordination of care and linking to appropriate treatment services to meet the needs of the individual. Mobile Crisis Response is designed to support individuals in the following manner: • Provide rapid response and assessment by a LMHP, LMHP-R, LMHP-RP or LMHP-S to individuals experiencing a behavioral health crisis • Meet the individual in an environment where they are comfortable to facilitate service engagement, stabilization and resolution of the crisis when possible; ○ Services provided in community locations where the individual lives, works, participates in services or socializes. Locations include but are not limited to schools, homes, places of employment or education, or community settings. • Provide appropriate care/support/supervision in order to maintain safety for the individual and others, while avoiding unnecessary law enforcement involvement, emergency room utilization, and/or avoidable hospitalization; • Prevent further exacerbation of symptoms that would put the individual at risk of an out of home placement or disruption in current living environment. • Refer and link to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care;

	• Coordinate with behavioral health providers providing services to the individual throughout the delivery of the service.
	
	Critical features of Mobile Crisis Response include:
	• Recovery-oriented, trauma-informed, developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;
	• An approach to the individual in crisis that is sensitive to their cultural identity and demonstrates humility and respect for their lived experiences and preferences in participating in care;
	• Assessment
	• Crisis Intervention: De-escalation including on-site interventions of presenting emotional or behavioral symptoms and safety/crisis planning
	• Care Coordination
	  ○ Engaging peer/natural and family support;
	  ○ Linkage and referral to ongoing services, supports and resources as appropriate in coordination with law enforcement, emergency responders, and DBHDS Certified Preadmission Screening Clinicians.
	
	Covered service components of Mobile Crisis Response include:
	• Assessment, including telemedicine assisted assessment
	• Care Coordination
	• Crisis Intervention
	• Health Literacy Counseling
	• Individual and Family Therapy
	• Peer Recovery Support Services
	• Treatment Planning

Required Activities	In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to Mobile Crisis Response: **DBHDS Crisis Data Platform Engagement:** The provider shall engage with the DBHDS crisis data platform as required by DBHDS. **Assessment:** At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall conduct an assessment to determine the individual’s appropriateness for the service. This assessment shall be done in-person, through telemedicine or through a telemedicine assisted assessment. See the Assessment Requirements section for details. For consecutive registration requests, an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall, at a minimum, review and update

	the assessment to include evidence and clinical justification for the additional units requested. **Care Coordination:** 1. Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). 2. Active transitioning from Mobile Crisis Response to an appropriate level of care shall be required; which includes care coordination and communication with the individual's MCO or FFS service authorization contractor, service providers and other collateral contacts. **Crisis Intervention:** A safety plan is required. See the Safety Plan and Crisis ISP section for additional information. **Additional Service Requirements:** 1. Services shall be provided in-person with the exception of the assessment and care coordination activities. 2. Services shall be available to the individual 24 hours per day, seven days per week, in their home, workplace, or other setting that is convenient and appropriate for the individual. 3. Service delivery shall be individualized.
Mobile Crisis Response Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	This service is available to any individual who meets the below criteria, regardless of diagnosis. Individuals shall meet **all** of the following criteria: 1. The individual shall be experiencing an active behavioral health crisis; **and** 2. Urgent intervention is necessary to stabilize or prevent escalation of the individual's behavioral health crisis; **and** 3. The individual or collateral contact reports at least **one** of the following: a. suicidal/assaultive/destructive ideas, threats, plans or actions; **or** b. an acute or increasing loss of control over thoughts, behavior and/or affect that could result in harm to self or others; **or** c. functional impairment or escalation in mood/thought/behavior that is disruptive to home, school, or the community or impacting the individual's

	ability to function in these settings; **or** d. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; **and** 4. Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community.
Continued Stay Criteria Diagnosis, Symptoms, and Functional Impairment	Not available for this level of care. If additional units are needed, providers should conduct necessary call center engagement in accordance with DBHDS guidelines and submit a new registration form with the managed care organization (MCO) or fee-for-service (FFS) service authorization contractor. Individuals shall meet admission criteria.
Discharge Criteria	The individual shall be discharged when the individual no longer meets admission criteria and/or an appropriate aftercare treatment plan has been established and the individual has been linked or transferred to appropriate community, residential or in-patient behavioral health services.
Exclusions and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: 1. Effective 1/1/2027, services are limited to 4 hours (16 units) within the 24 consecutive hours from the time of admission for a precipitating behavioral health crisis event. Service limits for youth below age 21 may be exceeded based on medical necessity under EPSDT. 2. Temporary housing shall not be conditioned upon an individual receiving any crisis service, and housing (including temporary housing) is not a reimbursable component of this service. a. While loss or lack of housing may contribute to a behavioral health crisis, the solution to the housing need shall be addressed through non-Medicaid funding or services related to housing. Housing crises shall be addressed through appropriate housing resources. Virginia's emergency housing response system is managed by sixteen Continuum of Care (CoC) entities. Providers of Mobile Crisis Response are expected to have relationships with the CoCs in any geographic area where they provide services.

	b. Mobile Crisis Response shall assess whether a behavioral health crisis triggered by the stressor of a housing problem exists, or if the episode is a housing crisis. For behavioral health crises triggered by the stressor of a housing problem, the provider shall use interventions and a plan directed explicitly at the behavioral health needs and symptoms. Individuals experiencing housing crisis shall be referred and connected to the CoC process in their geographical area. 3. Providers are prohibited from using Medicaid reimbursement to cover housing costs for an individual and any funds used for this purpose will be retracted. 4. Mobile Crisis Response shall not be provided to individuals receiving inpatient hospital services. 5. Services may not be provided in groups where one staff person or a team of staff provides services to two or more individuals at the same time. 6. Mobile Crisis Response shall not be used in place of an ongoing behavioral health service. Repeated Mobile Crisis Response episodes delivered without documented care coordination and linkage to an appropriate ongoing level of care do not constitute medically necessary crisis intervention and are not reimbursable. 7. Mobile Crisis Response shall not be provided or billed pursuant to a standing arrangement, recurring schedule, or provider-initiated outreach in the absence of an individual's active behavioral health crisis. Provider-generated demand for Mobile Crisis Response is considered abuse of the service and is not reimbursable. Members shall be informed by providers of the appropriate services that occur on a recurring schedule (e.g., ongoing rehabilitative services, outpatient services) and actively engaged or referred to those services. Providers who are identified as generating demand for Mobile Crisis Response instead of providing active intervention to engage individuals in the appropriate longer term rehabilitative service will be referred for review for Medicaid Fraud, Waste, and/or Abuse and reported to DBHDS and mobile crisis hubs for MOU and licensing reviews. 8. A provider shall not condition, or appear to condition, an individual's access to any other service delivered by that provider or by an affiliated entity upon the individual's receipt of

	Mobile Crisis Response. An individual who approaches a provider for services shall not be required to receive Mobile Crisis Response services prior to receiving another behavioral health service. 9. Providers who are dispatched to an individual experiencing a behavioral health crisis shall not require that the individual receive 4 hours of mobile crisis response prior to transitioning to an appropriate level of care.
Mobile Crisis Response Provider Participation Requirements	
DBHDS Licensing	Providers shall be licensed by the Department of Behavioral Health and Developmental Services. Provider's DBHDS license shall be active and in good standing (conditional, annual or triennial). Mobile Crisis Response providers shall be licensed by DBHDS as a provider of: 1. Outpatient Service/Crisis Stabilization (07-006) or 2. DD Outpatient Service/Crisis Stabilization – REACH (07-007) Mobile Crisis Response providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS training for this service as required by DBHDS.
Regional Crisis Hub Memorandum of Understanding /Contracts	Prior to DMAS enrollment Mobile Crisis Response providers shall: 1. Have an active Memorandum of Understanding (MOU) or contract with at least one regional crisis hub. This requirement does not apply to CSBs that act as the regional crisis hub. All MOUs/contracts shall be kept up to date with the DMAS Online Provider Enrollment System.
DMAS Provider Enrollment	Prior to rendering Mobile Crisis Response or claiming reimbursement, providers are required to be enrolled with DMAS with the following: 1. Provider type: 156 or 456 2. Provider specialty: Mobile Crisis Response (920) 3. Taxonomy: 251S00000X 4. Providers shall submit with their DMAS enrollment application all of the following: a. Appropriate 07-006 and/or 07-007 DBHDS License b. All Regional Crisis Hub MOUs/Contracts that are applicable

<table>
<tr>
<td>Staff Requirements</td>
<td>Mobile Crisis Response providers shall meet <u>at least one</u> of the below team staffing composition requirements (#1-5). (See Mobile Crisis Response Billing Requirements below)
<table>
<tr><th>#</th><th>Team Composition (s)</th></tr>
<tr><td>1</td><td>1 Licensed[x]</td></tr>
<tr><td>2</td><td>1 QMHP/CSAC[x] <u>and</u> 1 PRS or
1 QMHP/CSAC[x] <u>and</u> 1 CSAC-A</td></tr>
<tr><td>3</td><td>1 Licensed[x] <u>and</u> at least one of the following: PRS or CSAC-A</td></tr>
<tr><td>4</td><td>2 QMHPs (team may include one QMHP-T) or
2 CSACs[x] or
1 QMHP <u>and</u> 1 CSAC[x]

Team compositions cannot consist of 2 QMHP-Ts</td></tr>
<tr><td>5</td><td>1 Licensed[x] <u>and</u> at least one of the following: Licensed[x], QMHP, QMHP-T or CSAC[x]</td></tr>
</table>
[x] Includes those in their regulatory board approved residency/supervisee/trainee status in accordance with DHP regulations.

The dispatched team shall meet DBHDS licensing regulations for teams (12VAC35-105-1840):
a. If a single staff member is dispatched, that staff member shall be a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
b. QMHPs, QMHP-Ts, CSACs and PRSs shall not provide services without another qualified staff member physically present in-person.
c. A QMHP-T shall not provide services without a QMHP, LMHP, LMHP-R, LMHP-RP or LMHP-S also physically present in-person.
d. In instances where the assessment is completed through a telemedicine-assisted assessment, two qualified staff members shall be present in-person except when the in-person staff is a LMHP, LMHP-R, LMHP-RP or LMHP-S.

• Assessments shall be conducted by a LMHP, LMHP-S, LMHP-R, LMHP-RP.
• Care Coordination shall be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP, QMHP-T, CSAC*, CSAC-Supervisee*, or CSAC-A*.</td>
</tr>
</table>

	• Crisis Intervention shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*. • Health Literacy Counseling shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC* or CSAC-Supervisee*. • Individual and Family Therapy shall be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S. • Peer Recovery Support Services shall be provided by a Registered Peer Recovery Specialist. • Treatment Planning shall be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP, QMHP-T, CSAC*, CSAC-Supervisee*. **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and §54.1-3507.2* Supervisors of Registered Peer Recovery Specialists shall complete the DBHDS Peer Recovery Specialist Supervisor Training available through the DBHDS Office of Recovery Services. All Mobile Crisis Response staff shall be in possession of a working communication device in order to provide care coordination, engage natural/family supports and link the individual to needed follow-up services.
Mobile Crisis Response Service Authorization and Utilization Review	
Service Authorization	1. Providers shall submit a registration to the individual's MCO or FFS service authorization contractor within one business day of admission. 2. A Mobile Crisis Response episode consists of all service components delivered in response to a single precipitating behavioral health crisis event and, effective 1/1/2027, shall not exceed four hours (16 units) within the 24 consecutive hours from the time of admission. a. The time of admission is defined as the time in which the Mobile Crisis Response staff person acknowledges they have started the assessment in the DBHDS crisis data platform. b. All contacts with the individual arising from the same precipitating event, regardless of the number of times the team physically departs from and returns to the individual's

	location, constitute a single episode, require a single registration, and are payable as a single episode. c. A new episode requires a new and distinct precipitating behavioral health crisis event. d. Continued or unresolved symptoms from the prior episode do not, standing alone, constitute a new precipitating event; e. For individuals aged 21 and older, the four-hour limit is a hard cap and shall not be exceeded within that period. f. For individuals under the age of 21, the four-hour limit may be exceeded based upon documented medical necessity and subject to prepayment review. 3. The registration form shall be submitted with the required and accurate DBHDS crisis data platform reference number from the mobile crisis response dispatch. 4. The provider shall enter the correct service-specific provider NPI into the DBHDS crisis data platform. 5. The provider shall enter the correct Medicaid number for the individual into the DBHDS crisis data platform. 6. Overlapping/concurrent registrations/billing with two or more Mobile Crisis Response teams are subject to prepayment review. 7. For individuals with frequent utilization of mobile crisis response, the MCOs may conduct prepayment review to determine medical necessity for the service. a. If subsequent mobile crisis response dispatches are deemed not medically necessary, the MCO may reimburse only for time necessary to complete the assessment. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs' processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. Information on the FFS service authorization contractor's processes is located at Acentra Health/DMAS Reference Info | MES (virginia.gov).
Documentation and Utilization Review	Refer to Chapters IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services. The individual's clinical record shall reflect either resolution of the crisis which marks the end of the current episode or the discharge

	plan to an appropriate service to manage the ongoing symptoms associated with the crisis.

Mobile Crisis Response Billing Requirements

Units billed shall reflect the treatment needs of the individual and shall be based on the individual meeting medical necessity criteria.

1. One unit of service equals 15 minutes.
2. To bill any team composition (#1 - #5), the team member(s) shall be physically present in-person for the duration of the unit(s) billed as evidenced by, at a minimum:
    a. documentation of in-person team member(s) and
    b. the signature of the team member(s) on progress notes.
3. Unlicensed staff working physically alone without their teammate in team compositions #2-5 do not meet the staff qualifications required to receive Medicaid reimbursement.
4. Mobile Crisis Response teams shall be engaged and actively delivering one of the service components with the eligible individual, family member or collateral contact during the time billed in order to qualify for reimbursement.
5. Services shall not be provided beyond the 24 consecutive hours from the time of admission indicated on the registration form.
6. Providers conducting an assessment through telemedicine or a telemedicine assisted assessment shall follow the requirements for the provision of telemedicine described in the “Telehealth Services Supplement” including the use of the GT modifier for units billed for assessments completed through telemedicine or a telemedicine assisted assessment. Mobile Crisis Response services are not eligible for originating site fee reimbursement. MCO contracted providers shall consult with the contracted MCOs for their specific policies and requirements for telehealth.

Procedure Code	Unit	Description	Notes	Provider Qualifications
H2011 and modifier (s) as appropriate	Per 15 minutes	Mobile Crisis Response		Service components shall be provided by a qualified provider (see Provider qualification and staff requirements section)

Team Composition(s) #	Modifier	Modifier Meaning
1	HO	1 Licensed[x]

Team Composition(s) #	Modifier	Modifier Meaning
2	HT, HM	1 QMHP /CSAC[x] **and** 1 PRS **or** 1 QMHP /CSAC[x] **and** 1 CSAC-A
3	HT, HO	1 Licensed[x] **and** at least one of the following: PRS **or** CSAC-A
4	HT, HN	2 QMHPs (can include one QMHP-T, shall not consist of 2 QMHP-Ts) **or** 2 CSACs[x] **or** 1 QMHP **and** 1 CSAC[x]
5	HT	1 Licensed[x] **and** at least one of the following: Licensed[x], QMHP, QMHP-T or CSAC[x]

[x] Includes those in their regulatory board approved residency/supervisee status in accordance with DHP regulations.

23-Hour Crisis Stabilization

23-Hour Crisis Stabilization Level of Care Guidelines	

Service Definition
 	
Critical Features & Service Components
	23-Hour Crisis Stabilization provides short-term assessment, observation and crisis intervention services for individuals experiencing a behavioral health crisis who require a safe environment for initial assessment and intervention. 23-Hour Crisis Stabilization services are provided for a period of up to 23 hours and may co-locate with RCSUs as part of a continuum of crisis care.
	
	23-Hour Crisis Stabilization is appropriate for individuals who have urgent behavioral health needs including but not limited to significant emotional dysregulation, disordered thought processes, substance use and intoxication resulting in behavioral crisis and environmentally de-stabilizing events that require multi-disciplinary crisis intervention and observation to stabilize the immediate crisis and determine the next appropriate step in the plan of care.
	
	The goals of this service include but are not limited to:
	• Opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full 23 hours of service to determine the best resources available for the individual to prevent unnecessary hospitalization.
	• **Assessment:**
	  ○ Psychiatric evaluation
	  ○ Further diagnostic testing (drug screens, lab tests and monitoring for emergent medical needs),
	  ○ Level of care determination
	• **Care Coordination:**

	○ Screening and referral for appropriate behavioral health services and community resources. • **Crisis Intervention:** ○ Improvement of acute symptoms, ○ Resolution of acute intoxication, ○ Safety planning • **Health Literacy Counseling:** ○ Provision of medication and monitoring of response ○ Targeted education concerning diagnosis and treatments Covered Service Components of 23-Hour Crisis Stabilization include: • Assessment • Care Coordination • Crisis Intervention • Health Literacy Counseling • Individual and Family Therapy • Peer Recovery Support Services • Skills Restoration • Treatment Planning
Required Activities	In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to 23-Hour Crisis Stabilization: **Assessment:** • At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall conduct an assessment for determining medical necessity criteria and the individual's appropriateness for the service. See the Assessment Requirements section for details. • A psychiatric evaluation shall be completed at admission by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist. ○ The 23-Hour Crisis Stabilization provider may use a psychiatric evaluation completed within 24 hours prior to admission by a psychiatrist or nurse practitioner to meet this requirement. Documentation that the 23-Hour Crisis Stabilization psychiatrist, nurse practitioner or physician assistant has reviewed and updated (as clinically necessary) the evaluation at admission shall be in the clinical record. **Nursing:** 23-Hour Crisis Stabilization providers shall have 24 hour in-person nursing. A nursing assessment meeting the requirements

	of 12VAC35-105-1890 shall be completed at the time of admission. Nursing can be shared among co-located programs. **Care Coordination:** • Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). • Coordination of withdrawal management services with a medical provider is required as necessary. • Appropriate transition to the next level of care shall be required. Documentation shall include a demonstration of active transitioning from 23-hour crisis stabilization to an appropriate level of care which includes coordination with the individual's MCO or FFS service authorization contractor, service providers and other collateral contacts. • The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served; • The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers. **Crisis Intervention:** A safety plan is required. See the Safety Plan and Crisis ISP section for additional information. **The following components shall be available to individuals in the treatment program and provided in accordance with the individual's assessed needs:** • Individualized treatment planning; • Individual and family therapy • Nursing on-site 24/7; • Skills restoration and health literacy counseling; • Assessment and evaluation as well as additional clinically indicated psychiatric and medical consultation services; • Medical, psychological, psychiatric, laboratory, and toxicology services available on-site or by consult or referral; • Crisis intervention and safety planning support available 24/7; • Peer recovery support services, offered as an optional supplement for individuals; • Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to ensure continuity of care.

	Additional service requirements: • At a minimum, required components of 23-Hour Crisis Stabilization include: assessment (psychiatric, nursing and LMHP), crisis intervention, and care coordination. Providers shall have the capacity to provide any of the above components for up to 23 hours based on the individual's needs. • Services shall be provided in-person with the exception of the psychiatric evaluation and care coordination. • Service delivery shall be individualized. Group delivery of service components is not appropriate for this service. • Services shall be accessible 24 hours a day, 7 days a week.
23-Hour Crisis Stabilization Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	**All of the following criteria shall be met (1-5)*:** 1. The individual shall be experiencing an active behavioral health crisis; **and** 2. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates with the Diagnostic and Statistical Manual; **and** 3. The individual or collateral contact reports at least **one** of the following: a. suicidal/assaultive/destructive ideas, threats, plans or actions; **or** b. an acute or increasing loss of control over thoughts, behavior and/or affect that could result in harm to self or others; **or** c. functional impairment or escalation in mood/thought/behavior that is disruptive to home, school, or the community or impacting the individual's ability to function in these settings; **or** d. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; **or** e. Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment **and** 4. There is evidence of at least **one** of the following: a. Indication that the symptoms will adequately resolve or stabilize within a 23 hour period at which time a less restrictive level of care will be appropriate **or**

	b. The presenting clinical problem requires a safe, contained environment wherein observation and assessment can be conducted to determine next steps in the individual's care **and** **5.** Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community.
Continued Stay Criteria Diagnosis, Symptoms, and Functional Impairment	There is no continued stay for this service, the service is a total maximum of 23 hours per episode.
Discharge Criteria	Regardless of the individual's clinical status, the service requires that individuals be discharged within 23 hours. The point at which that discharge occurs within that time frame may depend on: • Whether the individual no longer meets admission criteria or meets criteria for a less or more intensive level of care; • Determination and availability of the service or natural supports to which the individual is to be discharged into the care of.
Exclusion Criteria and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following exclusion criteria and service limitations apply: 1. The individual is not appropriate for this service if there is a presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care. 2. Temporary housing shall not be conditioned upon an individual receiving any crisis service and housing (including temporary housing) is not a reimbursable component of this service. If an individual meets admission criteria for this service and housing is an assessed need, this should be noted as a need on the registration to support coordination of resources for the individual. While loss or lack of housing may contribute to a behavioral health crisis, the solution to the housing need shall be addressed through non-Medicaid funding or services related to housing. 23-hour Crisis Stabilization should address the behavioral health crisis triggered by the stressor of a housing problem using interventions and a plan directed explicitly at the behavioral health needs and symptoms. Providers are prohibited from using Medicaid reimbursement to cover housing costs for an

	individual and any funds used for this purpose will be retracted. 3. Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010. 4. 23-hour crisis stabilization providers are not authorized by DBHDS Office of Licensing to provide Temporary Detention Order (TDO) services. Individuals placed under a TDO after admission to 23-hour crisis stabilization may remain at the provider's location until transportation to the next accepting facility is arranged. Additional 23-hour crisis stabilization per diems are not billable to DMAS during this time. 5. A provider shall not condition, or appear to condition, an individual's access to any other service delivered by that provider or by an affiliated entity upon the individual's receipt of 23-hour crisis stabilization. An individual who approaches a provider for services shall not be required to receive 23-hour crisis stabilization services prior to receiving another behavioral health service.
23-Hour Crisis Stabilization Provider Participation Requirements	
Provider Qualifications	23-Hour Crisis Stabilization service providers shall be appropriately licensed by DBHDS as a MH Center-Based Crisis Receiving Center for adults (02-040) or Children and Adolescents (02-041) and enrolled with DMAS (see Chapter II). This service shall be provided in a licensed location that meets DBHDS crisis services physical site requirements within the Licensing Regulations. The licensed location shall be identified on the provider's DBHDS license. Services may not be provided in other locations outside of a DBHDS licensed site. 23-Hour Crisis Stabilization providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	These programs shall be supervised by a LMHP who is acting within the scope of their professional license and applicable State law. A licensed psychiatrist or nurse practitioner (who is acting within the scope of their professional license and applicable State law) shall be available to the program 24/7 either in-person or via telemedicine to provide assessment, treatment recommendations and consultation. A nurse practitioner or physician assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist.

	Service components shall be provided by the following: • Assessments shall be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP • Care Coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*. • Crisis Intervention shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*. • Health Literacy Counseling shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management. • Individual and Family Therapy shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. • Nursing services shall be provided by either a RN or a LPN who is present on the unit. The LPN shall work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70. • Peer Recovery Support Services shall be provided by a Registered Peer Recovery Specialist. • Skills Restoration shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T or a residential aide under the supervision of at least a QMHP. • Treatment Planning shall be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP, QMHP-T, CSAC* or CSAC Supervisee* **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2* Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine. Supervisors of Registered Peer Recovery Specialists shall complete the DBHDS Peer Recovery Specialist Supervisor Training available through the DBHDS Office of Recovery Services.

23-Hour Crisis Stabilization Service Authorization and Utilization Review	
Service Authorization	Providers shall submit a registration for one 23-hour episode/one unit to the individual's MCO or FFS service authorization contractor within one business day of admission. Consecutive registrations from the same or different provider are not permitted. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. Information on the FFS service authorization contractor's processes are located at Acentra Health/DMAS Reference Info | MES (virginia.gov).
Documentation and Utilization Review	The individual's clinical record shall reflect either resolution of the crisis which marks the end of the current episode or the discharge plan to an appropriate service to manage the ongoing symptoms associated with the crisis. Refer to Chapters IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services.
23-Hour Crisis Stabilization Billing Requirements	
1. One unit of service equals 23.00 hours and is reimbursed as a per diem. 2. The billing date is the day of admission and per diems cannot be billed on two consecutive calendar days. 3. Psychiatric evaluation may be provided through telemedicine. Providers shall follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement", including the use of telemedicine modifiers. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.	

Billing Code	Modifier	Unit	Description	Notes	(See Provider qualification and staff requirements section)
S9485		Per Diem	23-Hour Crisis Stabilization		Service components shall be provided by a qualified provider
S9485	32	Per Diem	23-Hour Crisis Stabilization – Emergency Custody Order	Billing modifier used if the individual is under an ECO	Service components shall be provided by a qualified provider

Billing Code	Modifier	Unit	Description	Notes	(See Provider qualification and staff requirements section)
				during admission	
90791, 90792	n/a	n/a	Psychiatric Diagnostic Evaluation	Providers should bill CPT codes appropriate for the activity and professional conducting the assessment when an assessment is completed but the individual does not enter the service.	Qualified providers

Residential Crisis Stabilization Unit (RCSU)

Residential Crisis Stabilization Unit (RCSU) Level of Care Guidelines	
Service Definition Critical Features & Service Components	RCSUs provide short-term, 24/7, residential psychiatric and substance related assessment and brief intervention services. The service supports the following individuals: • Individuals experiencing changes in behavior noted by impairment or decompensation in functioning that may result in the need of a higher level of care. • Individuals stepping down from a higher level of care that need continued monitoring, stabilization and mobilization of resources. • Individuals who need a safe environment for assessment, stabilization, and prevention of further escalation or decompensation. RCSUs may also provide medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis; see provider qualifications and billing guidance for further details.

	The goals of RCSU services are as follows but are not limited to 1) stabilize the individual in a community-based setting and support the individual and natural support system; 2) Reduction of acute symptoms; and 3) Identification and mobilization of available resources including support networks. This service occurs in a non-hospital, community-based crisis stabilization residential unit with no more than 16 beds. RCSUs may co-locate with 23-Hour Crisis Stabilization. Critical Features/Covered Service Components of RCSUs include: • Assessment (medical, psychiatric evaluation, nursing assessment, etc.) • Care Coordination • Crisis Intervention • Health Literacy Counseling • Individual, Group and/or Family Therapy • Peer Recovery Support Services • Skills Restoration • Treatment Planning
Required Activities	In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to RCSUs: **Assessment:** • At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall conduct an assessment for determining medical necessity criteria and the individual’s appropriateness for the service. The assessment should be completed as soon as possible after admission but no later than 24 hours after admission. See the Assessment Requirements section for details. • A psychiatric evaluation by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist is required. • At a minimum, a brief psychiatric intake assessment completed by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist shall be completed within four hours of admission to ensure that there are no medical or psychiatric needs that warrant immediate referral to a higher level of care. This brief psychiatric intake assessment can be completed in person, via telehealth or RCSU staff telephonic consultation with the psychiatrist, nurse practitioner or physician assistant, to

identify and address any potential immediate medical or psychiatric needs.

- A comprehensive psychiatric evaluation shall be completed within 24 hours of admission.

- The RCSU provider may use a psychiatric evaluation completed within 24 hours prior to admission by a psychiatrist or nurse practitioner to meet this requirement. Documentation that the RCSU psychiatrist, nurse practitioner or physician assistant has reviewed and updated (as clinically necessary) the evaluation within four hours of admission, shall be in the clinical record.

Nursing: RCSU providers shall have 24 hour in-person nursing. A nursing assessment meeting the requirements of 12VAC35-105-1890 shall be completed at the time of admission. Nursing can be shared among co-located programs.

Care Coordination:

- Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
- Appropriate transition to the next level of care shall be required. Documentation shall include a demonstration of active transitioning from RCSU to an appropriate level of care which includes care coordination and communication with the individual's MCO or FFS service authorization contractor, service providers and other collateral contacts.
- The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.
- Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports.
- The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;

Crisis Intervention: A safety plan is required. See the Safety Plan and Crisis ISP section for additional information.

	Treatment Planning: A crisis ISP is required. See the Safety Plan and Crisis ISP section for additional information. **The following components shall be available to individuals in the treatment program and provided in accordance with the individual's ISP.** • Individualized treatment planning; • Individual, group and family therapies; • Nursing in-person 24/7; • Skills restoration and health literacy counseling; • Assessment and evaluation as well as additional clinically indicated psychiatric and medical consultation services shall be available; • Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral; • Crisis intervention and safety planning support available 24/7; • Peer recovery support services, offered as an optional supplement for individuals; • Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to ensure continuity of care. **Additional Service Requirements**: • To bill the per diem on days other than the day of admission, providers shall provide daily individual, group or family therapy unless the LMHP, LMHP-R, LMHP-RP or LMHP-S documents the reason why therapy is not clinically appropriate. In addition, providers shall, at a minimum, provide at least two of the following daily: o Crisis Intervention o Health Literacy Counseling o Peer Recovery Support Services o Psychiatric Evaluation o Skills Restoration • Services shall be individualized and provided in-person with the exceptions of the psychiatric evaluation, individual, group and family therapy and care coordination.
Residential Crisis Stabilization Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and	Individuals shall meet **all** of the following criteria (1-5)*: 1. **One** of the following shall be present: a. The individual shall be experiencing a behavioral health crisis **or**

Functional Impairment	b. The individual is stepping down from a higher level of care after a recent behavioral health crisis and needs continued stabilization prior to returning to the community **and** 2. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates with the Diagnostic and Statistical Manual; **and** 3. **One** of the following shall be present: a. Substantial changes in behavior noted by significant impairment or decompensation in functioning related to a behavioral health crisis; **or** b. Actual or potential danger to self or others as evidenced by: 1. Suicidal thoughts or behaviors and/or recent self-injurious behavior with suicidal intent; **or** 2. Hopelessness and helplessness likely to lead to self-injury **or** 3. Threatening harm to others or homicidal ideation; **or** 4. Command hallucinations or delusions; **or** 5. Acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation; **or** c. Significant loss of impulse control that threatens the safety of the individual and/or others; **or** d. Significant inability to maintain basic care for oneself and to keep oneself safe in the community in an age appropriate manner that is not associated with Dementia; **or** e. Intoxication that causes significant emotional, behavioral, medical, or thought process disturbance that interfere with judgment so as to seriously endanger the individual if not monitored and evaluated; **or** f. Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment; **or** g. Individual does not have the ability and/or the resources to support maintenance of safety and/or stability in the community until longer term services are available/accessible or mobilized; **and** 4. The presenting clinical problem requires a safe, contained environment wherein assessment, evaluation and treatment can be conducted to determine next steps in the individual's care; **and** 5. Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to

	function in at least one of the following life domains: family, living situation, school, social, work, or community. **The medical necessity for individuals admitted under a TDO issued pursuant to section §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia is established and DMAS or its contractor cannot limit or deny services specified in a TDO (see the Temporary Detention Order Supplement to the Psychiatric Services Manual for additional details).*
Continued Stay Criteria Diagnosis, Symptoms, and Functional Impairment	**All** of the following criteria shall be met (1-8): 1. The individual continues to meet admission criteria 2. Another less restrictive level of care would not be adequate to meet the individual's safety needs 3. Treatment is still necessary to reduce symptoms and improve functioning so that the individual may participate in a less restrictive level of care 4. There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care 5. The individual's progress is monitored regularly and the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals 6. Psychiatric medication monitoring is occurring as clinically indicated. 7. Individual/family/guardian/caregiver/natural support is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway 8. Coordination of care and active discharge planning are ongoing, with goal of transitioning the individual to a less intensive level of care
Discharge Criteria	Any **one** of the following criteria shall be met: 1. The individual no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is available; **or** 2. The individual is not making progress toward goals, nor is there expectation of any progress and a different level of care is being recommended by the supervising LMHP; **or** 3. Functional status is restored as indicated by one or both of the following: a. no essential function is significantly impaired; and/or

	b. an essential function is impaired, but impairment is manageable at an available lower level of care
Exclusion Criteria and Service Limitations	The individual is not appropriate for this service if there is a presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care. In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: 1. RCSUs may not be billed concurrently with any other behavioral health service except when a service overlap with other community behavioral health services is needed as part of a safe discharge plan. Documented justification of the time needed for discharge planning and care coordination to other services is required. Overlap durations will vary depending on the documented needs of the individual and the intensity of the services but may not exceed 48 hours unless approved by the MCO or FFS service authorization contractor. 2. Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010. 3. A provider shall not condition, or appear to condition, an individual's access to any other service delivered by that provider or by an affiliated entity upon the individual's receipt of RCSU. An individual who approaches a provider for services shall not be required to receive RCSU stabilization services prior to receiving another behavioral health service.
Residential Crisis Stabilization Unit Provider Participation Requirements	
Provider Qualifications	RCSU service providers shall be licensed by DBHDS as a provider of MH Residential Crisis Stabilization for Adults (01-019) or Children and Adolescents (01-020), REACH Group Home Service Adult (01-004) or Children and Adolescents (01-041) and be enrolled with DMAS (see Chapter II). If RCSUs choose to provide ASAM 3.7 (medically monitored intensive inpatient) services, they shall also be licensed by DBHDS for ASAM 3.7 services. If RCSUs provide services to an individual under a TDO, the provider shall have a stipulation on their DBHDS license authorizing the provider to serve individuals who are under a TDO in accordance with 12VAC35-105-580.

	This service shall be provided in a DBHDS licensed location that meets the crisis services physical site requirements within DBHDS Licensing Regulations. The licensed location shall be identified on the provider's DBHDS license. Services may not be provided in other locations outside of the licensed site. RCSU providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	A LMHP (who is acting within the scope of their professional license and applicable State law) shall supervise this program. A licensed psychiatrist or nurse practitioner (who is acting within the scope of their professional license and applicable State law) shall be available to the program 24/7 either in-person or via telemedicine to provide assessment, treatment recommendations and consultation meeting the licensing standards for residential crisis stabilization and medically monitored withdrawal services at ASAM level 3.7. A nurse practitioner or physician assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist. Service components shall be provided by the following: • Assessments shall be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. • Care Coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP, QMHP-T, CSAC*, CSAC Supervisee*, or CSAC-A*. • Crisis Intervention shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*. • Health Literacy Counseling shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management. • Individual, Group, and Family Therapy shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. • Nursing services shall be provided by either a RN or a LPN who is present on the unit. The LPN shall work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70. • Peer Recovery Support Services shall be provided by a Registered Peer Recovery Specialist.

	• Skills Restoration shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T or a residential aide under the supervision of at least a QMHP. • Treatment Planning shall be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP, QMHP-T, CSAC* or CSAC Supervisee* **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2* Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine. Supervisors of Registered Peer Recovery Specialists shall complete the DBHDS Peer Recovery Specialist Supervisor Training available through the DBHDS Office of Recovery Services.
Residential Crisis Stabilization Service Authorization and Utilization Review	
Service Authorization	Providers shall submit a registration to the individual's MCO or FFS service authorization contractor within one business day of admission. The registration permits five calendar days/five units of service. Units billed shall reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria. If additional activities beyond five calendar days/five units are clinically required, the provider shall submit an authorization request to the FFS service authorization contractor or MCO through a continued stay service authorization request submitted no earlier than 48 hours before the requested start date of the continued stay and no later than the requested start date accompanied by the following items: 1. An initial assessment that meets the Assessment Requirements section. 2. A current addendum to the initial assessment, (can be in a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; **and** 3. Nursing Assessment; **and**

	4. Psychiatric Evaluation; **and** 5. Crisis ISP; **and** 6. Safety plan; **and** 7. Documentation of care coordination. Service authorization requests may require the submission of documentation of referrals to post-discharge services at the appropriate level of care based on the assessed needs of the individual. If a provider is licensed for both RCSU and for the provision of ASAM 3.7-WM, and an individual is admitted to the RCSU for withdrawal management services, the provider should bill for the Addiction and Recovery Treatment Services until withdrawal management is no longer needed. At that time, they may submit a registration for RCSU services. Consecutive registrations from the same or different provider are not allowed. A service authorization is required if additional service is required beyond the five calendar days/five units. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. Information on the FFS service authorization contractor's processes is located at Acentra Health/DMAS Reference Info | MES (virginia.gov).
Documentation and Utilization Review	Refer to Chapter IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services.

Residential Crisis Stabilization Billing Requirements

1. One unit of service equals one calendar day and is reimbursed as a per diem. The day of admission is billable regardless of the time of admission.
2. Day of discharge is billable if the minimum required activities to bill the RCSU per diem are met.
3. Individuals who meet criteria for RCSU may transition from ASAM Level 3.7 to RCSU services.
4. The individual should be directly admitted to a level of care that is appropriate to meet their treatment needs. Individuals likely to need greater than 23 hours of stabilization should be directly admitted to RCSU versus admitting to 23 hour Crisis Stabilization.
5. Psychiatric evaluations and individual, group and family therapy may be provided through telemedicine. Providers shall follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use

telemedicine modifiers. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	**Modifier**	**Unit**	**Description**	**Notes**	**Provider Qualifications** (see Provider qualification and staff requirements section)
H2018		Per Diem			Service components shall be provided by a qualified provider
H2018	32	Per Diem	RCSU – Emergency Custody Order	Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service.	Service components shall be provided by a qualified provider
H2018	HK	Per Diem	RCSU – TDO	Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service.	Service components shall be provided by a qualified provider
90791, 90792	n/a	n/a	Psychiatric Diagnostic Evaluation	Providers should bill CPT codes appropriate for the activity and professional conducting the	Qualified provider

				assessment when an assessment is completed but the individual does not enter the service.	

TRANSITION SERVICE

Community Stabilization

Please also refer to the DMAS Bulletin available at this link: https://vamedicaid.dmas.virginia.gov/bulletin/community-stabilization-coverage-change-and-mobile-crisis-response-policy-change

Community Stabilization Level of Care Guidelines	
Service Definition Critical Features & Service Components	Community Stabilization services are available 24 hours a day, seven days a week, to provide for short-term assessment, crisis intervention, and care coordination to individuals who have recently experienced a behavioral health crisis. Community Stabilization is a bridge service that supports an individual as they are making a transition between certain levels of care when there is a gap in availability of services. Services may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Services involve advocacy and networking to provide linkages and referrals to appropriate community-based services and assisting the individual and their natural support system in accessing other benefits or assistance programs for which they may be eligible. Community Stabilization is a non-center, community-based service. Services are provided in community locations where the individual lives, works, participates in services or socializes. The goal is to stabilize the individual within their community and support the individual and natural support system during the following: 1) between an initial Mobile Crisis Response and entry in to an established follow-up service at the appropriate level of care if the appropriate level of care is identified but not immediately available for access 2) as a transitional step-down from a higher level of care if the next level of care is identified but not immediately available or 3) as a diversion from a higher level of care. Critical Features of Community Stabilization include:

	• Recovery-oriented, trauma-informed, culturally congruent and developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;
	• **Assessment**;
	• **Care Coordination:**
	  ○ Linkage and referral to ongoing services, supports and resources, as appropriate and least restrictive level of care;
	  ○ Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use;
	  ○ Engaging peer/natural and family support to strengthen the individual's participation and engagement;
	• **Crisis Intervention:**
	  ○ Brief Therapeutic Interventions;
	  ○ Crisis education, safety, prevention planning, and support;
	  ○ Interventions to integrate natural supports in the de-escalation and stabilization of the crisis;
	• **Skills Restoration:**
	  ○ Skill Building;
	  ○ Psychoeducation
	
	Covered Services components of Community Stabilization include:
	• Assessment
	• Care Coordination
	• Crisis Intervention
	• Health Literacy Counseling
	• Individual and Family Therapy
	• Peer Recovery Support Services
	• Skills Restoration
	• Treatment Planning

Required Activities	In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to Community Stabilization: **DBHDS Crisis Data Platform Engagement:** The provider shall engage with the DBHDS crisis data platform as required by DBHDS. **Assessment:** At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall conduct an assessment in-person to determine the individual's appropriateness for the service. See the Assessment Requirements section for details. **Care Coordination:**

	• Community Stabilization services shall link/transition the individual to follow-up services and other needed resources to stabilize the individual within their community. • Active transitioning from Community Stabilization to an appropriate level of care shall be required; which includes care coordination and communication with the individual's MCO or FFS service authorization contractor, service providers and other collateral contacts. • Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). **Crisis Intervention:** A safety plan is required. See the Safety Plan and Crisis ISP section for additional information. **Treatment Planning:** • A crisis ISP is required. See the Safety Plan and Crisis ISP section for additional information. • Discharge planning and transition to an appropriate level of care shall begin at admission. **Additional Service Requirements:** • Services shall be provided in-person with the exception of care coordination activities. • Services shall be available to the individual participating in the service 24 hours per day, seven days per week, in their home, workplace, or other setting that is convenient and appropriate for the individual. • Service delivery shall be individualized. Group delivery of service components is not appropriate for this service.
Community Stabilization Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Individuals shall meet the following criteria: 1. Documentation indicates evidence that the individual currently meets criteria for a primary International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates to a Diagnostic and Statistical Manual diagnosis; **and** 2. The individual is at risk of repeat admissions to crisis services, emergency departments, or psychiatric inpatient services or dangerous decompensation in functioning and additional support is required to prevent inpatient admission; **and**

	Prior to admission, the individual shall meet either #3 or #4: 3. The individual is currently residing in a Therapeutic Group Home or ASAM 3.1; **or** 4. The individual is transitioning from one of the following services and the necessary service is not immediately available: i. 23-Hour Crisis Stabilization ii. Acute Psychiatric Inpatient Services iii. ASAM levels 3.1 – 4.0 iv. CSB Emergency Services v. Hospital Emergency Department vi. Mobile Crisis Response vii. Partial Hospitalization Program (Mental Health or ARTS) viii. Psychiatric Residential Treatment Facility (Mental Health or ARTS) ix. RCSU x. Short-term detention or incarceration xi. Therapeutic Group Home **and** If the individual meets criteria #4, then the following additional criteria shall be met: 5. Without immediate access to the identified community-based service, there is evidence that the individual would be at risk for a higher level of care during the transition to the next service; **and** 6. Clinically appropriate behavioral health service referral(s) has been identified and a plan for the timeline of transition from Community Stabilization to that provider has been established. If the timeline for transition exceeds 2 weeks, the Community Stabilization provider should initiate referrals to additional follow-up service providers.
Continued Stay Criteria Diagnosis, Symptoms,	**All** of the following criteria shall be met: 1. The individual continues to meet admission criteria;

and Functional Impairment	2. Treatment is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan; 3. Safety plan includes support system involvement unless contraindicated; 4. There is documented, active discharge planning starting at admission; 5. There is documented active care coordination with other service providers. If care coordination is not successful, the reasons are documented, and efforts to coordinate care continue. If the timeline for this transition exceeds 2 weeks, the Community Stabilization provider has documented communications with additional, specific service providers to support alternative service options or potentially faster access to the recommended service type.
Discharge Criteria	Once an individual meets criteria for discharge, services are no longer eligible for reimbursement. **At least one** of the following discharge criteria is met: 1. The individual no longer meets admission criteria; 2. A safe discharge plan has been established and an appropriate level of care has been initiated; 3. An effective safety plan has not been established and the individual requires a higher level of care; 4. The individual and/or support system is not engaged in treatment. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues; 5. The individual's physical condition necessitates transfer to an acute, inpatient medical facility.
Exclusions and Service Limitations	Individuals who meet any of the following criteria are not eligible to receive Community Stabilization Services (with exception for transitions, see billing requirements section): 1. The individual is receiving behavioral health services (MHS and ARTS) more intensive than standard outpatient psychotherapy/psychiatric services for mental health and substance use disorders or targeted case management service, unless approved by the individual's MCO or FFS service authorization contractor; 2. The individual is receiving inpatient or specific residential treatment services including psychiatric residential treatment facility (PRTF) or ASAM levels 3.3 – 4.0, unless for the purposes

	of service transition or approved by the individual's MCO or FFS service authorization contractor; 3. The individual's psychiatric condition is of such severity that it cannot be safely treated in this level of care; 4. The individual's acute medical condition is such that it requires treatment in an acute medical setting. In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: 1. Temporary housing shall not be conditioned upon an individual receiving any crisis service and housing (including temporary housing) is not a reimbursable component of this service. a. While loss or lack of housing may contribute to a behavioral health crisis, the solution to the housing need shall be addressed through non-Medicaid funding or services related to housing. b. Community Stabilization shall address the behavioral health crisis triggered by the stressor of a housing problem using interventions and a plan directed explicitly at the behavioral health needs and symptoms. 2. Providers are prohibited from using Medicaid reimbursement to cover housing costs for an individual and any funds used for this purpose will be retracted. 3. Services may not be provided in groups where one staff person or a team of staff provides services to two or more individuals at the same time. 4. A provider shall not condition, or appear to condition, an individual's access to any other service delivered by that provider or by an affiliated entity upon the individual's receipt of Community Stabilization. An individual who approaches a provider for services shall not be required to receive Community Stabilization services prior to receiving another behavioral health service.
Community Stabilization Provider Participation Requirements	
Provider Qualifications	Community Stabilization service providers are required to be: • Licensed by DBHDS as a provider of Outpatient Service/Crisis Stabilization (07-006) or DD Outpatient Service/Crisis Stabilization – REACH (07-007) • Enrolled as a provider with DMAS (see Chapter II). • Credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care. Temporary exceptions to network requirements may be allowed in

<table>
<tr><td></td><td>accordance with post-stabilization guidelines established in 42 CFR 422.113 and until a transition of services to an in-network provider has been initiated by the individual's MCO.

Community Stabilization providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual.

Community Stabilization Teams shall have an active Memorandum of Understanding (MOU) or contract with the regional crisis hub. This MOU or contract shall be kept up to date with the DMAS Online Provider Enrollment System.</td></tr>
<tr><td>Staff Requirements</td><td>Community Stabilization service providers may offer delivery of the service through different staffing complements depending on what activities are being delivered and what staffing is required to provide such activities. (See Community Stabilization Billing Requirements below)

<table>
<tr><th>#</th><th>Staffing/Team Composition (s)</th></tr>
<tr><td>1</td><td>1 QMHP-A or QMHP-C or 1 CSAC[x]</td></tr>
<tr><td>2</td><td>1 Licensed[x]</td></tr>
<tr><td>3</td><td>1 Licensed[x] <u>and</u> 1 PRS or
1 Licensed[x] <u>and</u> 1 CSAC-A</td></tr>
<tr><td>4</td><td>1 Licensed[x] <u>and</u> 1 QMHP-E or QMHP-C or QMHP-A or
1 Licensed[x] <u>and</u> 1 CSAC[x]</td></tr>
</table>
[x] Includes those in their regulatory board approved residency/supervisee status.

• Assessments shall be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP.
• Care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*.
• Treatment Planning shall be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-T, CSAC* or CSAC Supervisee*.
• Crisis Intervention shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*.
• Health literacy counseling shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC*, or CSAC Supervisee*.</td></tr>
</table>

	• Individual and family therapy shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. • Skills Restoration shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-T. • Peer recovery support services shall be provided by a Registered Peer Recovery Specialist. Supervisors of Registered Peer Recovery Specialists shall complete the DBHDS Peer Recovery Specialist Supervisor Training available through the DBHDS Office of Recovery Services. All Community Stabilization staff shall be in possession of a working communication device in order to provide care coordination, engage natural/family supports and link the individual to needed follow-up services. *CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2
Community Stabilization Service Authorization and Utilization Review	
Service Authorization	Community Stabilization requires a service authorization and service providers delivering Community Stabilization shall meet all the service requirements listed in this section. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Service authorization requests shall include, at a minimum: 1. A complete service authorization request form. The service authorization form shall be submitted with the required DBHDS crisis data platform reference number. The provider is responsible for ensuring that the correct service-specific provider NPI and individual's Medicaid number is entered into the DBHDS crisis data platform. 2. Documented referral from discharging provider, if applicable. The referral shall, at a minimum, include the name of the individual, the name and credentials of the referring provider, the reason for the referral, anticipated length of service needed and the name of the community stabilization provider submitting the authorization.

	3. The safety plan developed by the referring provider if referred from Mobile Crisis Response, 23-Hour Crisis Stabilization or RCSU, 4. If an individual meets admission criteria for this service and housing is an assessed need, this should be noted as a need on the service authorization request submitted to support coordination of resources for the individual. Service units are authorized based on medical necessity with a unit equaling fifteen minutes. If additional services are clinically required, the provider shall submit an authorization request to the FFS service authorization contractor or MCO through a continued stay service authorization request submitted no earlier than 48 hours before the requested start date of the continued stay and no later than the requested start date accompanied by the following items: 1. complete service authorization request form. The service authorization form shall be submitted with the required DBHDS crisis data platform reference number. 2. initial assessment; **and** 3. current addendum to the initial assessment (can be in a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; 4. safety plan; **and** 5. Crisis ISP; **and** 6. Documentation of care coordination activities. Service authorization requests may require the submission of documentation of referrals to post-discharge services at the appropriate level of care based on the assessed needs of the individual; **and** 7. Any housing needs shall be noted on the service authorization request form for the purposes of care coordination. The information provided for service authorization shall be corroborated and in the provider's clinical record. An approved

	service authorization is required for any units of Community Stabilization to be reimbursed. Units billed shall reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria. The referring provider shall determine what other services the individual is receiving prior to referring to Community Stabilization. It is the responsibility of both the referring provider and the Community Stabilization provider to determine if the individual has another community behavioral health provider. Providers should contact the MCO/FFS service authorization contractor or collateral contacts prior to initiating Community Stabilization services. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. Information on the FFS service authorization contractor's processes is located at Acentra Health/DMAS Reference Info | MES (virginia.gov).
Documentation and Utilization Review	Refer to Chapters IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services.

Community Stabilization Billing Requirements

1. One unit of service equals fifteen minutes.
2. The staff who deliver the activities for each contact determine the billing code modifier and the reimbursement rate associated with that unit of service.
3. Two- person Team Billing (team composition #3 and #4)
   a. Team billing is based on the assessed treatment needs of the individual as documented in the assessment and ISP.
   b. When two staff members provide services as a team, providers shall bill for team compositions #3 or #4 as appropriate based on the credentials of the staff providing the service.
   c. To bill for a team Medicaid rate for team compositions #3 - #4, both team members shall be present for the duration of the unit billed as evidenced by, at a minimum, both team member signatures on progress notes.
   The exception to this rule is when a team member separates from their teammate and the individual participating in the service in order to conduct care coordination activities. Documentation shall still indicate that both team members were providing a covered service for units billed.
   d. Staff working physically alone without their teammate in team compositions #3-4 are not allowed to bill the team Medicaid reimbursement rate. If only one

member of the team is required based on the individual's treatment needs, the provider may bill for staff compositions #1 or #2 depending on the credentials of the staff member providing the service.

4. Community Stabilization staff shall be engaged and actively delivering services to the eligible individual, family member or collateral contact during the time billed.
5. Teams that consist of two LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss (any combination) may bill using the HT modifier even if one of the team members is not registered with DHP as a QMHP.
6. A service overlap of Community Stabilization with other behavioral health services is allowed with documented justification of time needed to transition to or from Community Stabilization to other services as part of a safe discharge plan. Overlap durations will vary depending on the documented needs of the individual and the intensity of the services but may not exceed 48 hours unless approved by the MCO or FFS service authorization contractor.

Billing Code	**Unit**	**Description**	**Notes**	**Provider Qualifications** (see Provider qualification and staff requirements section)
S9482 with appropriate modifier	Per 15 minutes	Community Stabilization		Service components shall be provided by a qualified provider
90791, 90792	n/a	Psychiatric Diagnostic Evaluation	Providers should bill CPT codes appropriate for the activity and professional conducting the assessment when an assessment is completed but the individual does not	Qualified provider

			enter the service.	

Staff/Team Composition #	Modifier	Modifier Meaning
1	HN	1 QMHP-A or QMHP-C or 1 CSAC[x]
2	HO	1 Licensed[x]
3	HT, HM	1 Licensed[x] **and** 1 Peer **or** 1 Licensed[x] **and** 1 CSAC-A
4	HT	1 Licensed[x] **and** 1 QMHP-T or QMHP-C or QMHP-A **or** 1 Licensed[x] **and** 1 CSAC[x]

[x] Includes those in their regulatory board approved residency/supervisee status.