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## Definitions

"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's behavioral health status. It includes documented history of the severity, intensity, and duration of mental behavioral health care problems and issues.

“Behavioral health crisis” means at risk of onset or worsening of behavioral health symptoms (thoughts, behaviors, or emotions) in which an individual is at risk of hurting themselves or others and/or the symptoms prevent the individual from being able to care for themselves or function effectively in the community.

“Certified Preadmission Screening Clinician” means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by DBHDS.

“Collateral contact” means face-to-face or telephonic exchange between the behavioral health provider of an individual and the individual’s authorized representative and others engaged in the individual’s wellness for the purpose of care coordination. The following is a list of typical collateral contacts: family members, teachers, principals, primary care clinicians, guidance counselors, day care provider staff, previous therapists, attorneys or other staff from the courts, state agencies, social service agencies, outreach programs, after-school programs, community centers, and behavioral health providers at another level of care such as inpatient providers.

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

"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.

“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.

“Health literacy counseling” means patient counseling on mental health, and, as appropriate, substance use disorder, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.

"Individual, family, or group therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and

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evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate behavioral health disorders and associated distresses that interfere with behavioral health.

“Peer recovery support services” means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual.

“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.

“Skills Restoration” means facilitating improved communication, problem solving, coping skills, and stress management through modeling, coaching and cueing to increase the individual's continued adjustment to and management of mental illness.

“Telemedicine assisted assessment” means the in-person service delivery encounter by a QMHP-A, QMHP-C, 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.

The following mean the same as they are defined in Chapter 2 of this manual:

- Certified substance abuse counseling assistant (CSAC-A)
- Certified substance abuse counselor (CSAC)
- CSAC supervisee
- Licensed Mental Health Professional (LMHP)
- LMHP-resident (LMHP-R)
- LMHP-resident in psychology (LMHP-RP)
- LMHP-supervisee in social work (LMHP-S)
- Registered Peer Recovery Specialist (PRS)
- Qualified Mental Health Professional-adult (QMHP-A)
- QMHP-child (QMHP-C)
- QMHP-eligible (QMHP-E)

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The following mean the same as they are defined in Chapter 4 of this manual:

- Care Coordination
- Individual
- Individual Service Plan (ISP)
- Psychoeducation
- Treatment Planning

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

- Telehealth
- Telemedicine

### Diagnosis Requirements

These crisis 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.

### Mobile Crisis Response

Mobile Crisis Response Level of Care Guidelines	
Service Definition	<p>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.</p> <p>Mobile Crisis Response is designed to support individuals in the following manner:</p> <ul style="list-style-type: none"> <li>• Provide rapid response to individuals experiencing a behavioral health crisis</li> </ul>
Critical Features & Service Components	

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	<ul style="list-style-type: none"> <li>• Meet the individual in an environment where they are comfortable to facilitate service engagement, stabilization and resolution of the crisis when possible; <ul style="list-style-type: none"> <li>○ 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.</li> </ul> </li> <li>• 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;</li> <li>• Prevent further exacerbation of symptoms that would put the individual at risk of an out of home placement or disruption in current living environment.</li> <li>• Refer and link to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care (including pre-admission screening in appropriate cases conducted by a DBHDS Certified Preadmission Screening Clinician);</li> <li>• Coordinate with behavioral health providers providing services to the individual throughout the delivery of the service.</li> </ul> <p>Critical features of Mobile Crisis Response include:</p> <ul style="list-style-type: none"> <li>• Recovery-oriented, trauma-informed, developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;</li> <li>• 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;</li> <li>• <b>Assessment</b> and screening of behavioral health crisis needs, including screening for suicidal or homicidal risk; <ul style="list-style-type: none"> <li>○ When necessary and in any location where the individual may be located, a DBHDS Certified Preadmission Screening Clinician may complete a Preadmission Screening within this service;</li> </ul> </li> <li>• <b>Crisis Intervention:</b> De-escalation and resolution of the crisis, including on-site interventions for immediate de-escalation of presenting emotional or behavioral symptoms; <ul style="list-style-type: none"> <li>○ Brief therapeutic and skill building interventions;</li> <li>○ Safety/crisis planning</li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>● <b>Care Coordination:</b> <ul style="list-style-type: none"> <li>○ Engaging peer/natural and family support;</li> <li>○ Engagement with the DBHDS crisis data platform;</li> <li>○ Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care including community stabilization;</li> <li>○ Coordination and collaborate effectively and successfully with law enforcement, emergency responders, and DBHDS Certified Preadmission Screening Clinicians.</li> </ul> </li> </ul> <p>Covered service components of Mobile Crisis Response include:</p> <ul style="list-style-type: none"> <li>● Assessment, including telemedicine assisted assessment</li> <li>● Care Coordination</li> <li>● Crisis Intervention</li> <li>● Health Literacy Counseling</li> <li>● Individual and Family Therapy</li> <li>● Peer Recovery Support Services</li> <li>● Pre-admission screening</li> <li>● Treatment Planning</li> </ul>
Required Activities	<p>In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to Mobile Crisis Response:</p> <ul style="list-style-type: none"> <li>● The provider must engage with the DBHDS crisis data platform as required by DBHDS.</li> </ul> <p><b>Assessment:</b></p> <ul style="list-style-type: none"> <li>● At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment to determine the individual’s appropriateness for the service. This assessment must be done in-person, through telemedicine or through a telemedicine assisted assessment. At a minimum, the assessment must include the following elements: risk of harm; functional status; medical, addictive and psychiatric co-morbidity; recovery environment; treatment and recovery history; and, the individual’s ability and willingness to engage. The assessment requirement can also be met by one of the following: <ul style="list-style-type: none"> <li>○ A Comprehensive Needs Assessment (see Chapter IV for requirements).</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>○ Preadmission screening: If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment</li> <li>○ A DBHDS approved assessment for crisis services if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.</li> </ul> <p><b>Care Coordination:</b></p> <ul style="list-style-type: none"> <li>● Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).</li> <li>● 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 contractor, service providers and other collateral contacts.</li> </ul> <p><b>Crisis Intervention:</b></p> <ul style="list-style-type: none"> <li>● Development of a plan to maintain safety in order to prevent the need for a higher level of care; <b>or</b></li> <li>● Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; <b>or</b></li> <li>● If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.</li> <li>● Services must be provided in-person with the exception of the assessment and care coordination activities.</li> <li>● Telehealth is permissible for prescreening activities pursuant to section §37.2-800 et. seq. and section §16.1-335 et seq. of the Code of Virginia that and are billed using modifiers HK and 32.</li> <li>● Services must 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.</li> </ul>
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	<ul style="list-style-type: none"> <li>• Service delivery must be individualized. Group delivery of service components is not appropriate for this service.</li> </ul>
<b>Mobile Crisis Response Medical Necessity Criteria</b>	
Admission Criteria	This service is available to any individual meeting the below criteria, regardless of diagnosis.
Diagnosis, Symptoms, and Functional Impairment	<p>Individuals must meet <b>all</b> of the following criteria:</p> <ol style="list-style-type: none"> <li>1. The individual must be experiencing an active behavioral health crisis; <b>and</b></li> <li>2. Urgent intervention is necessary to stabilize or prevent escalation of the individual’s behavioral health crisis; <b>and</b></li> <li>3. The individual or collateral contact reports at least <b>one</b> of the following: <ol style="list-style-type: none"> <li>a. suicidal/assaultive/destructive ideas, threats, plans or actions; <b>or</b></li> <li>b. an acute or increasing loss of control over thoughts, behavior and/or affect that could result in harm to self or others; <b>or</b></li> <li>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; <b>or</b></li> <li>d. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; <b>and</b></li> </ol> </li> <li>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.</li> </ol>
Continued Stay Criteria	Not available for this level of care. If additional units are needed, providers should submit a new registration form with the Managed Care Organization (MCO) or Fee-For-Service (FFS) Contractor and any necessary call center engagement in accordance with DBHDS guidelines. Individuals must meet admission criteria.
Diagnosis, Symptoms, and Functional Impairment	
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.

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Exclusions and Service Limitations	<p>In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV, the following service limitations apply:</p> <ol style="list-style-type: none"> <li>1. Mobile Crisis Response may only be provided to individuals receiving inpatient hospital services for the explicit purpose of pre-admission screening by a DBHDS Certified Preadmission Screening Clinician.</li> <li>2. 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.</li> </ol>
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**Mobile Crisis Response Provider Participation Requirements**

Provider Qualifications	<p>Mobile Crisis Response providers must be licensed by DBHDS as a provider of Outpatient Crisis Stabilization services and be enrolled as a provider with DMAS (see Chapter II).</p> <p>Mobile Crisis Response providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.</p> <p>Mobile Crisis Response providers must have an active, DBHDS approved Memorandum of Understanding with the regional crisis hubs via DBHDS by July 31, 2022.</p>
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Staff Requirements	<p>Mobile Crisis Response providers must meet <b>at least one</b> of the below team staffing composition requirements (#1-5). (See Mobile Crisis Response Billing Requirements below)</p>
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#	Team Composition (s)
1	1 Licensed <sup>x</sup>
2	1 QMHP-A/QMHP-C/CSAC <sup>x</sup> <b>and</b> 1 PRS <b>or</b> 1 QMHP-A/QMHP-C/CSAC <sup>x</sup> <b>and</b> 1 CSAC-A
3	1 Licensed <sup>x</sup> <b>and</b> 1 PRS <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC-A
4	2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – team compositions cannot consist of 2 QMHP-Es <b>or</b> 2 CSACs <sup>x</sup> <b>or</b> 1 QMHP-A/QMHP-C <b>and</b> 1 CSAC <sup>x</sup>
5	1 Licensed <sup>x</sup> <b>and</b> 1 QMHP(QMHP-A, QMHP-C or QMHP-E) <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC <sup>x</sup>

<sup>x</sup> Includes those in their regulatory board approved residency/supervisee/trainee status in accordance with DHP regulations and

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	<p>Certified Preadmission Screening Clinicians who are not a LMHP, LMHP-R, LMHP-RP or LMHP-S directly supervised by a LMHP.</p> <ul style="list-style-type: none"> <li>• Assessments must be conducted by a LMHP, LMHP-S, LMHP-R, LMHP-RP.</li> <li>• Pre-admission screenings must be provided by a DBHDS Certified Preadmission Screening Clinician. If the DBHDS Certified Preadmission Screening Clinician is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the prescreening must be directly supervised and signed off by an LMHP.</li> <li>• Care Coordination must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC-Supervisee*, or CSAC-A*.</li> <li>• Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.</li> <li>• Health Literacy Counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC* or CSAC-Supervisee*.</li> <li>• Individual and Family Therapy must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S.</li> <li>• Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.</li> <li>• Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC-Supervisee*.</li> </ul> <p><i>*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</i></p> <p>All Mobile Crisis Response staff must 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.</p>
<b>Mobile Crisis Response Service Authorization and Utilization Review</b>	
Service Authorization	Providers must submit a registration to the individual’s MCO or FFS contractor within one business day of admission. The registration form

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	<p>must be submitted with the required DBHDS crisis data platform reference number. The registration permits eight hours (32 units) in a 72 hour period. Units billed must reflect the treatment needs of the individual and be based on individual meeting medical necessity criteria. The 72 hours must be consecutive hours during the registration period but may occur over four calendar days.</p> <p>If additional units are needed, providers should submit a new registration form with the MCO/FFS contractor and engage in required DBHDS call center and crisis data platform engagement in accordance with DBHDS guidelines. Individuals must meet admission criteria. Registrations may have overlapping dates with a previous registration based on medical necessity.</p> <p>Concurrent registrations/billing with two separate Mobile Crisis Response teams are allowable only if a prescreening evaluation is needed to allow prescreening activities to be completed and billed.</p> <p>Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at <a href="http://www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/">www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/</a>.</p>
Documentation and Utilization Review	<p>Refer to Chapter VI of this manual for all documentation and utilization review requirements.</p> <p>The individual’s clinical record must 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.</p>

<b>Mobile Crisis Response Billing Requirements</b>	
<ol style="list-style-type: none"> <li>1. One unit of service equals 15 minutes.</li> <li>2. To bill for a team Medicaid rate for team compositions #2 - #5, both team members must 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 must still indicate that both team members were providing a covered service for units billed.</li> <li>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. The</li> </ol>	

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- exception to this rule is when a team member separates from their teammate and the individual participating in service in order to conduct care coordination activities.
4. DBHDS Certified Preadmission Screening Clinician billing for the purpose of conducting a prescreening must be a LMHP, LMHP-R, LMHP-RP or LMHP-S or directly supervised and the prescreening approved and signed by an LMHP.
  5. Mobile Crisis Response teams must 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.
  6. Teams that consist of two LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss (any combination) may bill using the HT modifier. LMHPs are not required to be registered with DHP as a QMHP to bill using this modifier.
  7. Teams #2 and #4 must bill the rate for team # 1, #3 or #5 for the timeframe the assessment was completed by the LMHP.
  8. Providers conducting an assessment through telemedicine or a telemedicine assisted assessment must 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 should 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 must be provided by a qualified provider (see Provider qualification and staff requirements section)
Team Composition(s) #	Modifier	Modifier Meaning		
1	HO	1 Licensed <sup>x</sup>		
2	HT, HM	1 QMHP-A/QMHP-C/CSAC <sup>x</sup> <b>and</b> 1 PRS <b>or</b> 1 QMHP-A/QMHP-C/CSAC <sup>x</sup> <b>and</b> 1 CSAC-A		
3	HT, HO	1 Licensed <sup>x</sup> <b>and</b> 1 PRS <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC-A <b>or</b>		
4	HT, HN	2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – cannot consist of 2 QMHP-Es <b>or</b> 2 CSACs <sup>x</sup> <b>or</b> 1 QMHP-A/QMHP-C <b>and</b> 1 CSAC <sup>x</sup>		

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5	HT	1 Licensed <sup>x</sup> <b>and</b> 1 QMHP(QMHP-A, QMHP-C or QMHP-E) <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC <sup>x</sup>
Modifiers can be used as an addition to Team 1, 3, or 5.	32	Prescreening under an Emergency Custody Order (ECO) 1 Certified Preadmission Screening Clinician (LMHP, LMHP-R, LMHP-RP, LMHP-S or DBHDS Certified Preadmission Screening Clinician directly supervised by an LMHP)
	HK	Prescreening not under an ECO 1 Certified Preadmission Screening Clinician (LMHP, LMHP-R, LMHP-RP, LMHP-S or DBHDS Certified Preadmission Screening Clinician directly supervised by an LMHP).

<sup>x</sup> Includes those in their regulatory board approved residency/supervisee status in accordance with DHP regulations.

### Community Stabilization

Community Stabilization Level of Care Guidelines	
Service Definition	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 experiencing a behavioral health crisis.
Critical Features & Service Components	<p>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.</p> <p>The goal of Community Stabilization services 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.</p> <p>Critical Features of Community Stabilization include:</p>

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	<ul style="list-style-type: none"> <li>• Recovery-oriented, trauma-informed, culturally congruent and developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;</li> <li>• <b>Assessment</b> and screening, including explicit screening for suicidal or homicidal ideation;</li> <li>• <b>Care Coordination:</b> <ul style="list-style-type: none"> <li>○ Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care;</li> <li>○ Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use;</li> <li>○ Engaging peer/natural and family support to strengthen the individual’s participation and engagement;</li> </ul> </li> <li>• <b>Crisis Intervention:</b> <ul style="list-style-type: none"> <li>○ Brief Therapeutic Interventions;</li> <li>○ Crisis education, safety, prevention planning, and support;</li> <li>○ Interventions to integrate natural supports in the de-escalation and stabilization of the crisis;</li> </ul> </li> <li>• <b>Skills Restoration:</b> <ul style="list-style-type: none"> <li>○ Skill Building;</li> <li>○ Psychoeducation</li> </ul> </li> </ul> <p>Covered Services components of Community Stabilization include:</p> <ul style="list-style-type: none"> <li>• Assessment, including telemedicine assisted assessment</li> <li>• Care Coordination</li> <li>• Crisis Intervention</li> <li>• Health Literacy Counseling</li> <li>• Individual and Family Therapy</li> <li>• Peer Recovery Support Services</li> <li>• Skills Restoration</li> <li>• Treatment Planning</li> </ul>
Required Activities	<p>In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to Community Stabilization:</p> <ul style="list-style-type: none"> <li>• The provider must engage with the DBHDS crisis data platform as required by DBHDS.</li> </ul> <p><b>Assessment:</b></p> <ul style="list-style-type: none"> <li>• At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment to determine the individual’s</li> </ul>

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	<p>appropriateness for the service. This assessment must be done in-person or through a telemedicine assisted assessment. The assessment requirement can be met by one of the following:</p> <ul style="list-style-type: none"> <li>• A Comprehensive Needs Assessment (see Chapter IV for requirements).</li> <li>• Prescreening assessment: If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment.</li> <li>• A DBHDS approved assessment for crisis services if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.</li> </ul> <p><b>Care Coordination:</b></p> <ul style="list-style-type: none"> <li>• 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 contractor, service providers and other collateral contacts.</li> <li>• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).</li> </ul> <p><b>Crisis Intervention:</b></p> <ul style="list-style-type: none"> <li>• Development of a plan to maintain safety in order to prevent the need for a higher level of care; <b>or</b></li> <li>• Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; <b>or</b></li> <li>• If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.</li> </ul> <p><b>Treatment Planning:</b></p> <ul style="list-style-type: none"> <li>• Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be</li> </ul>
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	<p>collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S.</p> <ul style="list-style-type: none"> <li>• Discharge planning and transition to an appropriate level of care must occur as soon as possible.</li> <li>• Services must be provided in-person with the exception of the telemedicine assisted assessment and care coordination activities.</li> <li>• Services must 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.</li> <li>• Service delivery must be individualized. Group delivery of service components is not appropriate for this service.</li> </ul>
<b>Community Stabilization Medical Necessity Criteria</b>	

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<p>Admission Criteria</p> <p>Diagnosis, Symptoms, and Functional Impairment</p>	<p>Individuals must meet the following criteria:</p> <ol style="list-style-type: none"> <li>1) 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; <b>and</b></li> <li>2) The individual has demonstrated a level of acuity indicating that they are at risk for crisis-cycling or dangerous decompensation in functioning and additional support in the form of community stabilization is required to prevent an acute inpatient admission; <b>and</b></li> <li>3) Prior to admission the individual must meet either a. or b. below: <ol style="list-style-type: none"> <li>a. The individual is residing in a Therapeutic Group Home or ASAM 3.1; <b>or</b></li> <li>b. The individual needs community stabilization as a transition due to either i. or ii. below and also meets iii. below: <ol style="list-style-type: none"> <li>i. A LMHP, LMHP-R, LMHP-RP or LMHP-S at a Community Services Board (CSB) same day access intake, a Managed Care Organization, or Fee-For-Service contractor determines Community Stabilization is needed to support a transition in care and link an individual to appropriate services; or</li> <li>ii. The individual is being discharged from one of the below services: <ol style="list-style-type: none"> <li>(a) 23-Hour Crisis Stabilization</li> <li>(b) Acute Psychiatric Inpatient Services</li> <li>(c) ASAM levels 3.1 – 4.0</li> <li>(d) Hospital Emergency Department</li> <li>(e) Short-term detention or incarceration</li> <li>(f) Mobile Crisis Response</li> <li>(g) Partial Hospitalization Program (Mental Health or ARTS)</li> <li>(h) Psychiatric Residential Treatment Facility</li> <li>(i) Residential Crisis Stabilization Unit</li> <li>(j) Therapeutic Group Home</li> </ol> </li> </ol> </li> <li>iii. Individuals meeting either criteria i. or criteria ii. above must also meet the following additional criteria:</li> </ol> </li> </ol>
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	<p>(a) The service that the individual needs and is recommended by a professional listed in item i. above or a professional coordinating the discharge plan from services listed in item ii. above is not currently available for immediate access;</p> <p>(b) A clinically appropriate and specific behavioral health service provider referral(s) has been identified and a plan for the timeline of transition from Community Stabilization to that provider has been established and documented. 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.</p>
Continued Stay Criteria Diagnosis, Symptoms, and Functional Impairment	<p><b>All</b> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The individual continues to meet admission criteria;</li> <li>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;</li> <li>3. Safety plan includes support system involvement unless contraindicated;</li> <li>4. There is documented, active discharge planning starting at admission;</li> <li>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.</li> </ol>

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Discharge Criteria	<p>Once an individual meets criteria for discharge, services are no longer eligible for reimbursement.</p> <p><b>At least one</b> of the following discharge criteria is met:</p> <ol style="list-style-type: none"> <li>1. The individual no longer meets admission criteria;</li> <li>2. A safe discharge plan has been established and an appropriate level of care has been initiated;</li> <li>3. An effective safety plan has not been established and the individual requires a higher level of care;</li> <li>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;</li> <li>5. The individual’s physical condition necessitates transfer to an acute, inpatient medical facility.</li> </ol>
Exclusions and Service Limitations	<p>Individuals who meet any of the following criteria are not eligible to receive Community Stabilization Services (with exception for transitions, see billing requirements section):</p> <ol style="list-style-type: none"> <li>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 contractor;</li> <li>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 contractor;</li> <li>3. The individual’s psychiatric condition is of such severity that it cannot be safely treated in this level of care;</li> <li>4. The individual’s acute medical condition is such that it requires treatment in an acute medical setting.</li> </ol> <p>In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV, the following service limitations apply:</p> <ol style="list-style-type: none"> <li>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. 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</li> </ol>

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	<p>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 must be addressed through non-Medicaid funding or services related to housing. Community 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.</p> <p>2. 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.</p>
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**Community Stabilization Provider Participation Requirements**

Provider Qualifications	<p>Community Stabilization service providers must be licensed by DBHDS as a provider of Outpatient Crisis Stabilization services and enrolled as a provider with DMAS (see Chapter II).</p> <p>Community Stabilization providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.</p> <p>Community Stabilization Teams must have an active Memorandum of Understanding with the regional crisis hub via DBHDS by July 31, 2022.</p>
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Staff Requirements	<p>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)</p>
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#	Staffing/Team Composition (s)
1	1 QMHP-A or QMHP-C or 1 CSAC <sup>x</sup>
2	1 Licensed <sup>x</sup>
3	1 Licensed <sup>x</sup> <b>and</b> 1 PRS <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC-A
4	1 Licensed <sup>x</sup> <b>and</b> 1 QMHP-E or QMHP-C or QMHP-A <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC <sup>x</sup>

<sup>x</sup> Includes those in their regulatory board approved residency/supervisee status.

- Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP.

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	<ul style="list-style-type: none"> <li>• Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.</li> <li>• Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee*.</li> <li>• Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.</li> <li>• Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC*, or CSAC Supervisee*.</li> <li>• Individual and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.</li> <li>• Skills Restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E.</li> <li>• Peer recovery support services must be provided by a Registered Peer Recovery Specialist.</li> </ul> <p>All Community Stabilization staff must 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.</p> <p>*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</p>
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<b>Community Stabilization Service Authorization and Utilization Review</b>	
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Service Authorization	<p>Community Stabilization requires a service authorization and service providers delivering Community Stabilization shall meet all the service requirements listed in this section.</p> <p>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.</p> <p>Service authorization requests must include, at a minimum:</p> <ol style="list-style-type: none"> <li>1. A complete service authorization request form. The service authorization form must be submitted with the required DBHDS crisis data platform reference number.</li> </ol>
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	<p>2. Documented referral from discharging provider, if applicable. The referral must include the name of both the referring provider and the community stabilization provider.</p> <p>Service units are authorized based on medical necessity with a unit equaling fifteen minutes.</p> <p>If additional services are clinically required, the provider shall submit an authorization request to the FFS 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:</p> <ol style="list-style-type: none"> <li>1. A complete service authorization request form. The service authorization form must be submitted with the required DBHDS crisis data platform reference number.</li> <li>2. An assessment meeting one of the following: <ol style="list-style-type: none"> <li>a. A Comprehensive Needs Assessment (see Chapter IV for requirements); <b>or</b></li> <li>b. Prescreening assessment: If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment; <b>or</b></li> <li>c. A DBHDS approved assessment for crisis services if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; <b>and</b></li> </ol> </li> <li>3. A current addendum to the above assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria;</li> <li>4. A safety plan; <b>and</b></li> <li>5. 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; <b>and</b></li> <li>6. Any housing needs must be noted on the service authorization request form for the purposes of care coordination.</li> </ol> <p>The information provided for service authorization must 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 must reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria.</p>
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	<p>The referring provider must 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 and should contact the MCO/FFS contractor, caregivers and natural supports prior to initiating Community Stabilization services.</p> <p>Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at <a href="http://www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/">www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/</a>.</p>
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

**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. To bill for a team Medicaid rate for team compositions #3 - #4, both team members must 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 must still indicate that both team members were providing a covered service for units billed.
4. 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.
5. Community Stabilization staff must be engaged and actively delivering services to the eligible individual, family member or collateral contact during the time billed.
6. 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.
7. 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

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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 contractor.

8. Mobile Crisis Response, 23-Hour Crisis Stabilization and RCSU may be billed on the same day as Community Stabilization; however, services may not be delivered simultaneously.
9. Providers of telemedicine assisted assessment must 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 a telemedicine assisted assessment. Providers should not bill originating site fees. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
S9482 with appropriate modifier	Per 15 minutes	Community Stabilization		Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S
90792	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a	Psychiatrists, Physician Assistants, and

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			psychiatrist, physician assistant or nurse practitioner completes the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	Nurse Practitioners
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Staff/Team Composition #	Modifier	Modifier Meaning
1	HN	1 QMHP-A or QMHP-C or 1 CSAC <sup>x</sup>
2	HO	1 Licensed <sup>x</sup>
3	HT, HM	1 Licensed <sup>x</sup> <b>and</b> 1 Peer <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC-A
4	HT	1 Licensed <sup>x</sup> <b>and</b> 1 QMHP-E or QMHP-C or QMHP-A <b>or</b> 1 Licensed <sup>x</sup> <b>and</b> 1 CSAC <sup>x</sup>

<sup>x</sup> Includes those in their regulatory board approved residency/supervisee status.

### 23-Hour Crisis Stabilization

23-Hour Crisis Stabilization Level of Care Guidelines	
Service Definition	23-Hour Crisis Stabilization provides ongoing assessment, crisis intervention and clinical determination for level of care to individuals experiencing a behavioral health crisis. Services are provided for a period of up to 23 hours in a community and center-based crisis stabilization setting including outpatient hospital settings that have an Outpatient Crisis Stabilization license. This service must be accessible 24/7 and is indicated for those situations wherein an individual is experiencing a behavioral health crisis and requires a safe environment for observation and assessment prior to determination of the next level of care. Although not required, 23-Hour Crisis Stabilization services typically co-locate with RCSUs as part of a continuum of crisis care.
Critical Features & Service Components	

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	<p>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.</p> <p>The goals of this service include but are not limited to:</p> <ul style="list-style-type: none"> <li>● 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.</li> <li>● <b>Assessment:</b> <ul style="list-style-type: none"> <li>○ Psychiatric evaluation</li> <li>○ Further diagnostic testing (drug screens, lab tests and monitoring for emergent medical needs),</li> <li>○ Level of care determination</li> </ul> </li> <li>● <b>Care Coordination:</b> <ul style="list-style-type: none"> <li>○ Screening and referral for appropriate behavioral health services and community resources.</li> </ul> </li> <li>● <b>Crisis Intervention:</b> <ul style="list-style-type: none"> <li>○ Improvement of acute symptoms,</li> <li>○ Resolution of acute intoxication,</li> <li>○ Safety planning</li> </ul> </li> <li>● <b>Health Literacy Counseling:</b> <ul style="list-style-type: none"> <li>○ Provision of medication (if clinically indicated) and monitoring of response</li> <li>○ Targeted education concerning diagnosis and treatments</li> </ul> </li> </ul> <p>Covered Service Components of 23-Hour Crisis Stabilization include:</p> <ul style="list-style-type: none"> <li>● Assessment</li> <li>● Care Coordination</li> <li>● Crisis Intervention</li> <li>● Health Literacy Counseling</li> <li>● Individual and Family Therapy</li> <li>● Peer Recovery Support Services</li> <li>● Skills Restoration</li> <li>● Treatment Planning</li> </ul>
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Required Activities	<p>In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to 23-Hour Crisis Stabilization:</p> <p><b>Assessment:</b></p> <ul style="list-style-type: none"> <li>• At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment for determining medical necessity criteria and the individual’s appropriateness for the service. The assessment requirement can be met by one of the following: <ul style="list-style-type: none"> <li>○ A Comprehensive Needs Assessment (see Chapter IV for requirements).</li> <li>○ A prescreening assessment completed by the provider.</li> <li>○ If a prescreening assessment has been completed within 72 hours prior to admission by another provider, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment.</li> <li>○ A DBHDS approved assessment for 23-Hour Crisis Stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.</li> <li>○ For individuals admitted with a primary diagnosis of substance use disorder, providers may choose to complete a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual.</li> </ul> </li> <li>• A psychiatric evaluation must be completed at admission by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist. <ul style="list-style-type: none"> <li>○ 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 must be in the clinical record.</li> </ul> </li> <li>• 23-Hour Crisis Stabilization providers must have 24 hour in-person nursing. At a minimum, a nursing assessment must be completed at the time of admission to determine current medical needs. Nursing can be shared among co-located programs.</li> </ul> <p><b>Care Coordination:</b></p>
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	<ul style="list-style-type: none"> <li>• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).</li> <li>• Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports.</li> <li>• Appropriate transition to the next level of care shall be required. Documentation must include a demonstration of active transitioning from 23-hour crisis stabilization to an appropriate level of care which includes care coordination and communication with the individual's MCO or FFS Contractor, service providers and other collateral contacts.</li> </ul> <p><b>Crisis Intervention:</b></p> <ul style="list-style-type: none"> <li>• Development of a plan to maintain safety in order to prevent the need for a higher level of care; <b>or</b></li> <li>• Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; <b>or</b></li> <li>• If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.</li> </ul> <p><b>The following components must be available to individuals in the treatment program and provided in accordance with the individual's assessed needs:</b></p> <ul style="list-style-type: none"> <li>• Individualized treatment planning;</li> <li>• Individual and family therapy</li> <li>• Nursing on-site 24/7;</li> <li>• Skills restoration and health literacy counseling;</li> <li>• Assessment and evaluation as well as additional clinically indicated psychiatric and medical consultation services;</li> <li>• Medical, psychological, psychiatric, laboratory, and toxicology services available on-site or by consult or referral;</li> <li>• Crisis intervention and safety planning support available 24/7;</li> <li>• Peer recovery support services, offered as an optional supplement for individuals;</li> </ul>
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	<ul style="list-style-type: none"> <li>• Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:</li> <li>• The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;</li> <li>• The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;</li> <li>• The provider shall collaborate with the individual’s primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.</li>   <li>• At a minimum, required components of 23-Hour Crisis Stabilization include: assessment (psychiatric, nursing and LMHP), crisis intervention, and care coordination. Providers must have the capacity to provide any of the above components for up to 23 hours based on the individual’s needs.</li>   <li>• Services must be provided in-person with the exception of the psychiatric evaluation and care coordination.</li>   <li>• Service delivery must be individualized. Group delivery of service components is not appropriate for this service.</li> </ul>
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**23-Hour Crisis Stabilization Medical Necessity Criteria**

<p>Admission Criteria</p> <p>Diagnosis, Symptoms, and Functional Impairment</p>	<p><b>All of the following criteria must be met (1-5)*:</b></p> <ol style="list-style-type: none"> <li>1. The individual must be experiencing an active behavioral health crisis; <b>and</b></li> <li>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; <b>and</b></li> <li>3. The individual or collateral contact reports at least <b>one</b> of the following: <ol style="list-style-type: none"> <li>a. suicidal/assaultive/destructive ideas, threats, plans or actions; <b>or</b></li> <li>b. an acute or increasing loss of control over thoughts, behavior and/or affect that could result in harm to self or others; <b>or</b></li> <li>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; <b>or</b></li> <li>d. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; <b>or</b></li> </ol> </li> </ol>
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	<p>e. Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment <b>and</b></p> <p>4. There is evidence of at least <b>one</b> of the following:</p> <p>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 <b>or</b></p> <p>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 <b>and</b></p> <p>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.</p> <p><i>*The medical necessity for individuals admitted under a Temporary Detention Order (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).</i></p>
Continued Stay Criteria	There is no continued stay for this service, the service is a total maximum of 23 hours per episode.
Diagnosis, Symptoms, and Functional Impairment	
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: <ul style="list-style-type: none"> <li>• Whether the individual no longer meets admission criteria or meets criteria for a less or more intensive level of care;</li> <li>• Determination and availability of the service or natural supports to which the individual is to be discharged into the care of.</li> </ul>
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: <ol style="list-style-type: none"> <li>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.</li> </ol>

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	<p>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 must 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.</p> <p>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</p>
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**23-Hour Crisis Stabilization Provider Participation Requirements**

Provider Qualifications	<p>23-Hour Crisis Stabilization service providers must be appropriately licensed by DBHDS as an Outpatient Crisis Stabilization provider and enrolled with DMAS (see Chapter II).</p> <p>This service must be provided in a licensed location that meet DBHDS physical site requirements within the Licensing Regulations. The licensed location must 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 must follow all general Medicaid provider requirements specified in Chapter II of this manual.</p> <p>If the provider provides services to an individual under a Temporary Detention Order, the provider must have a stipulation on their DBHDS license authoring the provider to serve individuals who are under a Temporary Detention Order in accordance with 12VAC35-105-580.</p>
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Staff Requirements	<p>These programs must be supervised by a LMHP who is acting within the scope of their professional license and applicable State law.</p> <p>A licensed psychiatrist or nurse practitioner (who is acting within the scope of their professional license and applicable State law) must be available to the program 24/7 either in person or via telemedicine to provide assessment, treatment recommendations and consultation. A nurse practitioner or</p>
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	<p>physician assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist.</p> <p>Service components must be provided by the following:</p> <ul style="list-style-type: none"> <li>• Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP</li> <li>• Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.</li> <li>• Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.</li> <li>• Health Literacy Counseling must 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.</li> <li>• Individual and Family Therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.</li> <li>• Nursing services must be provided by either a RN or a LPN who is present on the unit. The LPN must work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70.</li> <li>• Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.</li> <li>• Skills Restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a residential aide under the supervision of at least a QMHP-A or QMHP-C.</li> <li>• Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee*</li> </ul> <p><i>*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</i></p> <p>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 (§ <a href="#">54.1-3000</a> 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.</p>
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**23-Hour Crisis Stabilization Service Authorization and Utilization Review**

Service Authorization	<p>Providers must submit a registration for one 23-hour episode/one unit to the individual’s MCO or FFS contractor within one business day of admission.</p> <p>Consecutive registrations from the same or different provider are not permitted.</p> <p>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 <a href="http://www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/">www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/</a>.</p>
Documentation and Utilization Review	<p>The individual’s clinical record must 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.</p> <p>Refer to Chapter VI of this manual for documentation and utilization review requirements.</p>

**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. If an individual is admitted to 23-Hour Crisis Stabilization and it is determined that RCSU services are needed, the 23-Hour Crisis Stabilization provider should bill the first 23.00 hours with the 23-Hour Crisis Stabilization (S9485) procedure code and the Residential Crisis Stabilization Unit (H2018) procedure code for any subsequent 24-hour period. The provider should not bill multiple per diems for the first 24-hours of care and must request appropriate service registration for each service.
4. The same provider cannot bill multiple per diems in the same calendar day for 23-Hour Crisis Stabilization (S9485), RCSU (H2018) or ARTS services that are paid at a per diem rate.
5. Psychiatric evaluation may be provided through telemedicine. Providers must 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	Provider Qualifications
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S9485		Per Diem	23-Hour Crisis Stabilization		Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
S9485	32	Per Diem	23-Hour Crisis Stabilization – Emergency Custody Order	Billing modifiers are determined by the status of the individual at the time of admission.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
S9485	HK	Per Diem	23-Hour Crisis Stabilization – Temporary Detention Order	Billing modifiers are determined by the status of the individual at the time of admission.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
90791	n/a	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S

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90792	n/a	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a psychiatrist, physician assistant or nurse practitioner completes the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service	Psychiatrists, Physician Assistants, and Nurse Practitioners
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### Residential Crisis Stabilization Unit (RCSU)

<b>Residential Crisis Stabilization Unit (RCSU) Level of Care Guidelines</b>	
Service Definition	RCSUs provide short-term, 24/7, residential psychiatric and substance related assessment and brief intervention services. The service supports the following individuals:
Critical Features & Service Components	<ul style="list-style-type: none"> <li>• Individuals experiencing changes in behavior noted by impairment or decompensation in functioning that may result in the need of a higher level of care.</li> <li>• Individuals stepping down from a higher level of care that need continued monitoring, stabilization and mobilization of resources.</li> <li>• Individuals who need a safe environment for assessment, stabilization, and prevention of further escalation or decompensation.</li> </ul> <p>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.</p> <p>The goals of Residential Crisis Stabilization Unit 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-</p>

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	<p>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:</p> <ul style="list-style-type: none"> <li>• Assessment (medical, psychiatric evaluation, nursing assessment, etc.)</li> <li>• Care Coordination</li> <li>• Crisis Intervention</li> <li>• Health Literacy Counseling</li> <li>• Individual, Group and/or Family Therapy</li> <li>• Peer Recovery Support Services</li> <li>• Skills Restoration</li> <li>• Treatment Planning</li> </ul>
Required Activities	<p>In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to RCSUs:</p> <p><b>Assessment:</b></p> <ul style="list-style-type: none"> <li>• At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must 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. The assessment requirement can be met by one of the following: <ul style="list-style-type: none"> <li>• A Comprehensive Needs Assessment (see Chapter IV for requirements).</li> <li>• A prescreening assessment completed by the provider; <ul style="list-style-type: none"> <li>○ If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment;</li> </ul> </li> <li>• A DBHDS approved assessment for residential crisis stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S;</li> <li>• For individuals admitted with a primary diagnosis of substance use disorder, providers may choose to complete a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual. For individuals admitted directly from ASAM 3.7, the provider may choose to complete a new assessment or update the assessment completed when the individual was admitted to ASAM 3.7.</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>• A psychiatric evaluation by a psychiatrist nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist is required.</li> <li>• At a minimum, a brief psychiatric intake assessment completed by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist must 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.</li> <li>• A comprehensive psychiatric evaluation must be completed within 24 hours of admission.</li> <li>• 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, must be in the clinical record.</li> <li>• RCSU providers must have 24 hour in-person nursing. (<i>RCSU providers have until 11/30/2023 to fully meet this requirement</i>) At a minimum, a nursing assessment must be completed at the time of admission to determine current medical needs. Nursing can be shared among co-located programs.</li> </ul> <p><b>Care Coordination:</b></p> <ul style="list-style-type: none"> <li>• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).</li> <li>• Appropriate transition to the next level of care shall be required. Documentation must include a demonstration of active transitioning from RCSU to an appropriate level of care which includes care coordination and communication with the individual's</li> </ul>
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	<p>MCO or FFS Contractor, service providers and other collateral contacts.</p> <ul style="list-style-type: none"> <li>• Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports.</li> </ul> <p><b>Crisis Intervention:</b></p> <ul style="list-style-type: none"> <li>• Development of a plan to maintain safety in order to prevent the need for a higher level of care; <b>or</b></li> <li>• Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; <b>or</b></li> <li>• If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.</li> </ul> <p><b>Treatment Planning:</b></p> <ul style="list-style-type: none"> <li>• Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S.</li> </ul> <p><b>The following components must be available to individuals in the treatment program and provided in accordance with the individual's ISP.</b></p> <ul style="list-style-type: none"> <li>• Individualized treatment planning;</li> <li>• Individual, group and family therapies;</li> <li>• Nursing in-person 24/7;</li> <li>• Skills restoration and health literacy counseling;</li> <li>• Assessment and evaluation as well as additional clinically indicated psychiatric and medical consultation services must be available;</li> <li>• Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral;</li> <li>• Crisis intervention and safety planning support available 24/7;</li> <li>• Peer recovery support services, offered as an optional supplement for individuals;</li> </ul>
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	<ul style="list-style-type: none"> <li>• Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following: <ul style="list-style-type: none"> <li>• The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;</li> <li>• The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;</li> <li>• The provider shall collaborate with the individual’s primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.</li> </ul> </li> <li>• To bill the per diem on days other than the day of admission, providers must 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 must, at a minimum, provide at least two of the following daily: <ul style="list-style-type: none"> <li>○ Crisis Intervention</li> <li>○ Health Literacy Counseling</li> <li>○ Peer Recovery Support Services</li> <li>○ Psychiatric Evaluation</li> <li>○ Skills Restoration</li> </ul> </li> <li>• Services must be provided in-person with the exception of the psychiatric evaluation and care coordination.</li> </ul>
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**Residential Crisis Stabilization Medical Necessity Criteria**

Admission Criteria  Diagnosis, Symptoms, and Functional Impairment	Individuals must meet <b>all</b> of the following criteria (1-5)*: <ol style="list-style-type: none"> <li>1. <b>One</b> of the following must be present: <ol style="list-style-type: none"> <li>a. The individual must be experiencing a behavioral health crisis <b>or</b></li> <li>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 <b>and</b></li> </ol> </li> <li>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; <b>and</b></li> <li>3. <b>One</b> of the following must be present: <ol style="list-style-type: none"> <li>a. Substantial changes in behavior noted by significant impairment or decompensation in functioning related to a behavioral health crisis; <b>or</b></li> </ol> </li> </ol>
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	<p>b. Actual or potential danger to self or others as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Suicidal thoughts or behaviors and/or recent self-injurious behavior with suicidal intent; <b>or</b></li> <li>2. Hopelessness and helplessness likely to lead to self-injury <b>or</b></li> <li>3. Threatening harm to others or homicidal ideation; <b>or</b></li> <li>4. Command hallucinations or delusions; <b>or</b></li> <li>5. Acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation; <b>or</b></li> </ol> <p>c. Significant loss of impulse control that threatens the safety of the individual and/or others; <b>or</b></p> <p>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; <b>or</b></p> <p>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; <b>or</b></p> <p>f. Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment; <b>or</b></p> <p>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; <b>and</b></p> <p>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; <b>and</b></p> <p>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.</p> <p><i>*The medical necessity for individuals admitted under a Temporary Detention Order (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).</i></p>
Continued Stay Criteria	<p><b>All</b> of the following criteria must be met (1-8):</p> <ol style="list-style-type: none"> <li>1. The individual continues to meet admission criteria</li> <li>2. Another less restrictive level of care would not be adequate to meet the individual’s safety needs</li> </ol>

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Diagnosis, Symptoms, and Functional Impairment	<ol style="list-style-type: none"> <li>3. Treatment is still necessary to reduce symptoms and improve functioning so that the individual may participate in a less restrictive level of care</li> <li>4. There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care</li> <li>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</li> <li>6. Psychiatric medication monitoring is occurring as clinically indicated.</li> <li>7. Individual/family/guardian/caregiver/natural support is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway</li> <li>8. Coordination of care and active discharge planning are ongoing, with goal of transitioning the individual to a less intensive level of care</li> </ol>
Discharge Criteria	<p>Any <b>one</b> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>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; <b>or</b></li> <li>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; <b>or</b></li> <li>3. Functional status is restored as indicated by one or both of the following: <ol style="list-style-type: none"> <li>a. no essential function is significantly impaired; and/or</li> <li>b. an essential function is impaired, but impairment is manageable at an available lower level of care</li> </ol> </li> </ol>
Exclusion Criteria and Service Limitations	<p>Any <b>one</b> of the following criteria is sufficient for exclusion from this level of care:</p> <ol style="list-style-type: none"> <li>1. The individual’s psychiatric condition is of such severity that it can only be safely treated in an inpatient setting due to violent aggression or other anticipated need for physical restraint, seclusion or other involuntary control; <b>or</b></li> <li>2. The individual’s medical condition is such that it can only be safely treated in a medical hospital as deemed by a physician; <b>or</b></li> </ol> <p>In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV, the following service limitations apply:</p>

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	<ol style="list-style-type: none"> <li>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 in no instances may exceed 48 hours.</li> <li>2. Mobile Crisis Response, Community Stabilization, 23-Hour Crisis Stabilization may be billed on the same day as RCSU; however, services may not be delivered simultaneously.</li> <li>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.</li> </ol>
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**Residential Crisis Stabilization Unit Provider Participation Requirements**

Provider Qualifications	<p>Residential Crisis Stabilization Unit service providers must be licensed by DBHDS as a provider of Residential Crisis Stabilization Programs, Group Home Service REACH or DD Group Home Service REACH and be enrolled with DMAS (see Chapter II).</p> <p>If RCSUs choose to provide ASAM 3.7 (medically monitored intensive inpatient) services, they must also be licensed by DBHDS for the ASAM 3.7 service(s).</p> <p>If RCSUs provide services to an individual under a Temporary Detention Order, the provider must have a stipulation on their DBHDS license authoring the provider to serve individuals who are under a Temporary Detention Order in accordance with 12VAC35-105-580.</p> <p>This service must be provided in a DBHDS licensed location that meets the physical site requirements within DBHDS Licensing Regulations. The licensed location must be identified on the provider’s DBHDS license. Services may not be provided in other locations outside of the licensed site.</p> <p>Residential Crisis Stabilization Unit providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.</p>
Staff Requirements	<p>A LMHP (who is acting within the scope of their professional license and applicable State law) must supervise this program.</p>

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	<p>A licensed psychiatrist or nurse practitioner (who is acting within the scope of their professional license and applicable State law) must 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.</p> <p>Service components must be provided by the following:</p> <ul style="list-style-type: none"> <li>• Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP.</li> <li>• Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee*, or CSAC-A*.</li> <li>• Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.</li> <li>• Health Literacy Counseling must 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.</li> <li>• Individual, Group, and Family Therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.</li> <li>• Nursing services must be provided by either a RN or a LPN who is present on the unit. The LPN must work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70.</li> <li>• Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.</li> <li>• Skills Restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a residential aide under the supervision of at least a QMHP-A or QMHP-C.</li> <li>• Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee*</li> </ul>
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	<p><i>*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</i></p> <p>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 (§ <a href="#">54.1-3000</a> 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.</p>
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**Residential Crisis Stabilization Service Authorization and Utilization Review**

Service Authorization	<p>Providers must submit a registration to the individual’s MCO or FFS contractor within one business day of admission. The registration permits five calendar days/five units of service. Units billed must reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria.</p> <p>If additional activities beyond five calendar days/five units are clinically required, the provider shall submit an authorization request to the FFS 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:</p> <ol style="list-style-type: none"> <li>1. An assessment meeting one of the following: <ol style="list-style-type: none"> <li>a. A Comprehensive Needs Assessment (see Chapter IV for requirements);</li> <li>b. A prescreening assessment completed by the provider;</li> <li>c. An update or addendum to the prescreening assessment;</li> <li>d. A DBHDS approved assessment for residential crisis stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S;</li> <li>e. For individuals admitted with a primary diagnosis of substance use disorder, a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual; <b>and</b></li> </ol> </li> <li>2. A current addendum to the above assessment, (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; <b>and</b></li> </ol>
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	<p>3. Nursing Assessment; <b>and</b></p> <p>4. Psychiatric Evaluation; <b>and</b></p> <p>5. Individual Service Plan; <b>and</b></p> <p>6. A safety plan; <b>and</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at <a href="http://www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/">www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/</a>.</p>
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.
<b>Residential Crisis Stabilization Billing Requirements</b>	
<ol style="list-style-type: none"> <li>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.</li> <li>Day of discharge is billable if the minimum required activities to bill the RCSU per diem are met.</li> <li>Mobile Crisis Response, Community Stabilization, 23-Hour Crisis Stabilization may be billed on the same day as RCSU; however, services may not be delivered simultaneously.</li> <li>Individuals who meet criteria for RCSU may transition from ASAM Level 3.7 to RCSU services.</li> <li>The same provider cannot bill multiple per diems in the same calendar day for 23-Hour Crisis Stabilization (S9485), RCSU (H2018) or ARTS services that are paid at a per diem rate.</li> <li>The individual should be directly admitted to a level of care that is appropriate to meet their treatment needs ie. Individuals likely to need greater than 23 hours of stabilization should be directly admitted to RCSU versus admitting to 23 hour Crisis Stabilization.</li> <li>A psychiatric evaluation may be provided through telemedicine. Providers must follow the requirements for the provision of telemedicine described in the “Telehealth Services</li> </ol>	

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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
H2018		Per Diem			Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H2018	32	Per Diem	Residential Crisis Stabilization Unit – 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 must be provided by a qualified provider (see Provider qualification and staff requirements section)
H2018	HK	Per Diem	Residential Crisis Stabilization – Temporary Detention 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 must be provided by a qualified provider (see Provider qualification and staff requirements section)

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90791	n/a	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S
90792	n/a	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a psychiatrist, physician assistant or nurse practitioner completes the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service	Psychiatrists, Physician Assistants, and Nurse Practitioners