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• If you have any questions please send an email to CivilRightsCoordinator@dmas.virginia.gov
About Today’s Webinar

• The presentation portion of this webinar will be recorded and posted to the DMAS website along with the powerpoint presentation.
• Access the recorded training on our Youtube Channel: Virginia Medicaid
  • https://www.youtube.com/channel/UCbE_bPvIPQfjCS2MfCmVHA
• The CHAT function has been disabled
• All participants are muted
• DMAS will not be answering questions during the presentation.
  ▪ If time permits, DMAS will answer questions at the end of the presentation
  ▪ Please use the Q&A function to type in your questions
  ▪ If your question(s) is not answered you may email the DMAS Behavioral Health Division at enhancedbh@dmas.virginia.gov

Agenda Today

• Background and Context
  • Project BRAVO: Enhancement of BH Services
  • Purpose and Function of Mobile Crisis and Community Stabilization in the Medicaid System
  • Provider Manual Overviews
• Question and Answer Session (recording will be off)
Agenda Today

Provider Manual Overviews

- Mobile Crisis Services
  - Service Definition
  - Critical Features and Service Components
  - Provider Qualifications and Staff Requirements
  - Service Authorization
  - Medical Necessity Criteria
    - Admission Criteria: Diagnosis, Symptoms and Functional Impairment
    - Exclusion Criteria
    - Continued Stay Criteria
    - Discharge Criteria
    - Service Limitations
  - Billing Guidance

- Community Stabilization
  - Service Definition
  - Critical Features and Service Components
  - Provider Qualifications and Staff Requirements
  - Service Authorization
  - Medical Necessity Criteria
    - Admission Criteria: Diagnosis, Symptoms and Functional Impairment
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    - Continued Stay Criteria
    - Discharge Criteria
    - Service Limitations
  - Billing Guidance

Crisis System: Current Functioning

*Lack of alternative crisis services have contributed to an increasing number of temporary detention orders, and an acute, state-wide psychiatric bed crisis.*

- Emergency rooms remain a primary door by which Virginians access crisis care and these environments are not optimal for de-escalation and stabilization.
- NASMHPD estimates that 96% of individuals who receive a direct referral to crisis do not require an ED visit.

*Meaningful change in our system starts with a comprehensive crisis transformation*
Current Crisis Reform Efforts are Interconnected

Enhanced Behavioral Health Services for Virginia

Project BRAVO

Behavioral Health Redesign for Access, Value and Outcomes

Vision

- High Quality
- Evidence-Based
- Trauma-Informed
- Cost-Effective

Implement fully-integrated behavioral health services that provide a full continuum of care to Medicaid members. This comprehensive system will focus on access to services that are:

- Quality care from quality providers in community settings such as home, schools and primary care
- Proven practices that are preventive and offered in the least restrictive environment
- Better outcomes from best-practice services that acknowledge and address the impact of trauma for individuals
- Encourages use of services and delivery mechanism that have been shown to reduce cost of care for system
The North Star Behavioral Health Services Enhancement

Continuum of Behavioral Health Services Across the Life Span

Promotion & Prevention | Recovery Services | Outpatient Intensive Community Based Support | Intensive Crisis-Facility Based Support | Comprehensive Crisis Services | Group Home & Residential Services | Inpatient Hospitalization
---|---|---|---|---|---|---
Behavioral Therapy Supports | >>>> | Case Management* | >>>> | Recovery & Rehabilitation Support Services*

Home visitation • Comprehensive family programs • Early childhood education
Screening & assessment* • Early intervention Part C

Permanent supportive housing • Supported employment • Psychosocial rehabilitation
Peer and family support services* • Independent living and recovery/maternity services

Disruptive behavior therapy* • Treated school-based behavioral health services
Integrated physical & behavioral health • Psychiatric/medical services

Intermediate/homemaker-based services • Multisystemic Therapy • Functional family therapy
High fidelity wraparound • Intensive community treatment • Assertive community treatment

INTEGRATED PRINCIPLES/MOALITIES

- Trauma informed care
- Universal prevention / early intervention
- Seamless care transitions
- Telemental health

*Key STEEP service alignment

Comprehensive Crisis Services are the buffer between community-based services and “out of home” or institutional placement

CURRENT MEDICAID CRISIS SERVICES

PROBLEMATIC RATES AND UNIT STRUCTURE
INTERSECTION WITH HOUSING CRISIS

LACK OF SERVICE CONTEXT SPECIFICITY
CHALLENGES IN COLLABORATION BETWEEN PRIVATE AND CSB PROVIDERS
Current vs. BRAVO services

<table>
<thead>
<tr>
<th>CRISIS INTERVENTION</th>
<th>MOBILE CRISIS SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRISIS STABILIZATION</td>
<td>COMMUNITY STABILIZATION</td>
</tr>
<tr>
<td>MISSING ELEMENTS</td>
<td>OPT CRISIS, 23 OBS, RCSU</td>
</tr>
</tbody>
</table>

Role of Comprehensive Crisis Services

Alleviation of the Psychiatric Bed Crisis

- Access to community-based crisis response is critical for diversion from psychiatric hospitalization
- Aligned with values of supporting members in the least restrictive environment (trauma informed) and research supports system utility (evidence-based)

80% of crisis resolved through the call center

70% of mobile responses resolved in the community

Small proportion of initial calls result in hospitalization

Balfour, Hahn, Winski & Goldman (2020)
Why do we need call center infrastructure?

THE SAFETY NET TO THE SAFETY NET

988 Legislation

- National Suicide Hotline Designation Act of 2020
  - July 16, 2022

- SB 1302 Crisis Call Center Fund

- GOALS:
  - 988 as conspicuous in the American consciousness as 911
  - Integration of National Suicide Prevention Hotline with Mobile Crisis Dispatch Functionality
State-Wide Crisis Volume Estimates

Five Regional Call Centers

- Strong public infrastructure to support coordination between public and private responders
- Geographically bound call center areas with accountability for standards
  - 1 hour response time
- 24/7 dispatch availability
Coordination at Every Level

**Federal:** 988 Integration required by July 2022

**State:** coordinated technological infrastructure to ensure that an “Air Traffic Control” function and “safety net to the safety net” is possible whether call center is state or regional.

**Regional:** STEP-VA funded with sustainability (Medicaid) mobile crisis teams with specialized teams for youth, developmental disability and other special populations. Regional hubs hold contracts with all mobile crisis teams within the region and serve as the single point of coordination with dispatch.

**Local:** Marcus alert protocols and coordination with law enforcement, law enforcement reforms, magistrates, emergency services, and other first responders.

Comprehensive Crisis Infrastructure

- **DE-ESCALATION AND NO REFERRAL NEEDED OR DESIRED**
- **COMMUNITY StABILIZATION**
- **REFERRAL TO APPROPRIATE SERVICE**

MOBILE CRISIS SERVICES
Medicaid’s Role in Transformation

- Financial sustainability for services
- Contributions to administrative cost
- Service definition and rate setting
- Expansion and management of provider network
- Potential for Managed Care innovations in payment structures in the future

Crisis in the context of Project BRAVO

Project BRAVO aims to build out the behavioral health continuum to address gaps

Prior to Hospitalization

Crisis calls will be distributed between the mobile crisis teams and walk-ins at CSBs
Interventions include -
1. 23-hour Crisis Stabilization
2. Residential Crisis Stabilization Unit
3. Community Stabilization

After Inpatient Care or Crisis Care

BRAVO services provide diverse discharge options, including
- Partial Hospitalization Programs
- Intensive Outpatient services
- Multisystemic Therapy
- Functional Family Therapy
- Assertive Community Treatment

BRAVO Integrates the Crisis System into the larger continuum of care in Medicaid

Expansion of the provider network to include private providers supports greater access to these services and less pressure on CSBs in fulfilling code mandated Emergency Services
The Role of Medicaid Across The Crisis Continuum

Structure Established & In Development

- Call center
  - Can work to help support administrative costs
- Mobile Crisis Response
  - Rates based on team composition
  - Support building out networks
  - Mechanism for billing ES
- Community Stabilization
  - Reimbursement for the warm hand hold until handoff
- 23-Hour Crisis Stabilization
  - Allows for non-admission option
  - Detox/withdrawal management
- Residential Crisis Stabilization Units
  - Per Diem Structure
  - Additional TDO setting

Where can I find the provider manuals?

Direct Link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

- The BRAVO services are located in the newly named “Mental Health Services Manual”
- Mobile Crisis Response and Community Stabilization will be located in Appendix G “Comprehensive Crisis Services”
Where can I find the provider manuals?


• Under Providers Menu, select “Behavioral Health”

Where can I find the provider manuals?


• Scroll down to Resources
• Select “Regulations/Provider Manual”
Where can I find the provider manuals?


• Click on link for Provider Web Portal

MOBILE CRISIS RESPONSE SERVICES

Provider Manual Overview
Mobile Crisis Response Services

Service Definition

- Rapid response, assessment and early intervention to individuals experiencing crisis
- Provided 24/7
- Purpose:
  - Assisting people in returning to their equilibrium,
  - prevention of harm to the individual or others,
  - provision of quality intervention in the least restrictive setting,
  - development of immediate plan of safety to help avoid higher level of care

Critical Features

- Recovery-oriented, trauma-informed, developmentally appropriate, integrating Zero Suicide / Suicide Safer Care principles
- Sensitive to cultural identity and humility and respect for lived experiences
- Assessment and screening
- Inclusive of pre-screening activities for involuntary commitment
- Provided in community location where individual exists
- De-escalation and resolution of crises
- Brief therapeutic and skill building interventions
- Engaging peer and natural supports
- Safety-Crisis Planning
- Coordination with the crisis call center
- Linkage with ongoing services and supports
- Coordination with law enforcement, emergency responders, state certified pre-screeners

Service Components

- Assessment, including telemedicine assisted assessment
- Treatment Planning
- Individual and Family Therapy
- Crisis Intervention
- Care Coordination
- Peer Recovery Support Services
- Health literacy Counseling/Psychoeducation
- Pre-admission screening for involuntary commitment
Mobile Crisis Response Services

Required Activities

• Engagement with the crisis call center is required prior to initiating services
  • Further information to come on how to communicate referrals at Crisis Receiving Centers / Walk-In Settings to connect the data for DBHDS tracking

• LMHP, LMHP-R, LMHP-RP, LMHP-S, to conduct an assessment to determine appropriateness for the service.
  • In person or through tele-medicine assisted assessment
  • At a minimum must include: risk of harm, functional status, medical, addictive and psychiatric co-morbidity, recovery environment, treatment & recovery history, and engagement.

• If there is an existing Crisis Education and Prevention Plan (CEPP), the provider should, at a minimum, review the CEPP and update as necessary.

• Services must be provided in-person with the exception of the telemedicine assisted assessment and care coordination activities.

• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

What is Tele-Assisted Assessment?

Definition and Clarification

• The face-to-face 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.

First version: LIVE
LMHP type is available via telehealth device during the entire mobile response to listen, support, advise.

Second version: MEDICAL MODEL
QMHP/CSAC performs activities and then contacts remote LMHP to confer; LMHP then joins with individual and QMHP via telehealth to do their own brief review with the individual to assure they concur on assessment and recommendation.
Mobile Crisis Response Services

Service Limitations

- **Mobile Crisis Response Services** may only be provided in inpatient hospital settings for the explicit functions of a DBHDS certified pre-screener.

- Services may be provided in a Therapeutic Group Home (TGH), Psychiatric Residential Treatment Facility (PRTF) and ASAM Levels 3.1 – 4.0 as long as the TGH, PRTF or ARTS Provider is not also the Mobile Crisis Response Provider.

- **Activities not authorized or reimbursed within Mobile Crisis Response:**
  - Inactive time or time spent waiting to respond to a behavioral situation;
  - Pre-admission screenings performed by DBHDS certified pre-screeners who are not LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss that are not supervised directly and signed off by an LMHP;
  - Supervision hours of the staff;
  - Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers;
  - Contacts that are not medically necessary;
  - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher’s aide, or an academic tutor;
  - Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
  - Respite care; temporary housing.
  - Transportation for the individual or family. Additional medical transportation for service needs, which are not considered part of Mobile Crisis Response, may be covered by the transportation service through the fee-for-service (FFS) Non-Emergency Medical Transportation Broker or Managed Care Organization (MCO).
  - Covered services that have not been rendered;
  - Services provided to the individual’s family or others involved in the individual’s life that are not to the direct benefit of the individual in accordance with the individual’s needs and treatment goals identified in the individual’s plan of care;
  - Anything not included in the Mobile Crisis Response description;
  - Any intervention or contact not documented or consistent with the approved CEPP goals, objectives, and approved services.

Mobile Crisis Response Services

Provider Qualifications

- **Licensed** by DBHDS as a provider of a Crisis Stabilization Services

- **Credentialed** with the individual’s Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.

- **Trained** according to DBHDS requirements.

- **Hold an Active Memorandum of Understanding** with the regional crisis hub via DBHDS.

- **Must follow** all general Medicaid provider requirements specified in Chapter II of this manual.
Mobile Crisis Response Services

• Staff Requirements

Mobile Crisis Response providers must meet at least one of the team staffing composition requirements (#1-5). The ideal team composition consists of a two staff person team so teams may provide immediate, effective crisis interventions and care coordination simultaneously.

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.

<table>
<thead>
<tr>
<th>#</th>
<th>Team Composition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Licensed-</td>
</tr>
<tr>
<td>2</td>
<td>1 QMHP- A/QMHP-C/CSAC and 1 PRS or 1 QMHP- A/QMHP-C/CSAC- and 1 CSAC-A</td>
</tr>
<tr>
<td>3</td>
<td>1 Licensed- and 1 PRS or 1 Licensed- and 1 CSAC-A</td>
</tr>
<tr>
<td>4</td>
<td>2 QMHPs (QMHP- A, QMHP-C, QMHP-E) – team compositions cannot consist of 2 QMHP- Es or 2 CSACs or 1 QMHP- A/QMHP-C and 1 CSAC</td>
</tr>
<tr>
<td>5</td>
<td>1 Licensed- and 1 QMHP (QMHP- A, QMHP-C or QMHP- E) or 1 Licensed- and 1 CSAC-</td>
</tr>
</tbody>
</table>

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

What if we want to send two LMHPs out on a team? How can we bill?

Mobile Crisis Response Services

• Staff Requirements

Mobile Crisis Response providers must meet at least one of the team staffing composition requirements (#1-5). The ideal team composition consists of a two staff person team so teams may provide immediate, effective crisis interventions and care coordination simultaneously.
Mobile Crisis Response Services

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</tr>
</tbody>
</table>

*Includes those in their regulatory board approved residency/supervisee/trainee status in accordance with DHP regulations.*

If two LMHPs go out together, they can bill as if they are a TEAM 5.

Yes, we will look into developing a rate for two LMHPs in the future.

---

What about certified pre-screeners?
Mobile Crisis Response Services

- **Staff Requirements**
  
  Mobile Crisis Response providers must meet **at least one** of the team staffing composition requirements (#1-5). The ideal team composition consists of a two staff person team so teams may provide immediate, effective crisis interventions and care coordination simultaneously.

<table>
<thead>
<tr>
<th>#</th>
<th>Team Composition(s)</th>
<th>Pre-screeners are not a provider type in Medicaid and should bill based on their status as an LMHP or QMHP type or CSAC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Licensed-</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1 QMHP-A/QMHP-C/CSAC</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1 Licensed- and 1 PRS or 1 Licensed- and 1 CSAC-PRS or 1 Licensed- and 1 CSAC-</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – team compositions cannot consist of 2 QMHP-Es or 2 CSACs or 1 QMHP-A/QMHP-C and 1 CSAC</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1 Licensed- and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed- and 1 CSAC-PRS or 1 Licensed- and 1 CSAC-PRS or 1 Licensed- and 1 CSAC-</td>
<td></td>
</tr>
</tbody>
</table>

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

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**Mobile Crisis Response Services**

**Providers: Who is allowed to do what?**

<table>
<thead>
<tr>
<th>Service Component</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments, conducted either in person or through a telemedicine assisted assessment.</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S,</td>
</tr>
<tr>
<td>Pre-Admission Screenings</td>
<td>DBHDS certified pre-screeners. Note: If the DBHDS certified pre-screener is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the pre-screening must be directly supervised either in person, or through tele-health assisted assessment and signed off by an LMHP in order to bill for the assessment.</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E, CSAC*, CSAC-Supervisee*</td>
</tr>
<tr>
<td>Health Literacy Counseling</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC* or CSAC-Supervisee*</td>
</tr>
<tr>
<td>Peer Recovery Support Services</td>
<td>Registered Peer Recovery Specialist</td>
</tr>
<tr>
<td>Individual and Family Therapy</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S</td>
</tr>
</tbody>
</table>

*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
Mobile Crisis Response Services

Initial Service Authorization / Registration

- Mobile Crisis Response reimbursement is authorized by a registration process for 8 hours (32 units) in a 72 hour period.
- Concurrent registrations are allowable for mobile crisis response only if a pre-screening evaluation is needed to allow the pre-screening to be billed by a separate provider entity.
  - For example, private provider mobile response team goes out and has to call in a CSB-employed Certified Pre-Screener.
- Providers shall submit service authorization requests within one business day of admission for initial service authorization.
- If submitted after the required time frame, the begin date of authorization will be based on the day of receipt.
- 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 www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/.

Service Authorization Forms

Registration Form

- *NEW AND IMPROVED* Adobe Forms
- Best efforts made to:
  - Make form fields more functional
  - Reduce duplication of information
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision as needed for process improvement
Service Authorization Processes

Fee for Service Vendor and Managed Care Organizations

• FFS: Magellan BHSA
• Forms
  ▪ [url=content-page]https://www.magellanofvirginia.com/for-providers/provider-tools/forms/[/url]
• Provider Portal
  ▪ [url=content-page]https://www.magellanprovider.com/MagellanProvider/do/LoadHome[/url]

• Managed Care Organizations

Mobile Crisis Response Services

Documentation & Utilization Review

• Refer to Chapter VI of this manual for documentation and utilization review requirements.

• 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.

[Visual diagram of mobile crisis response services]
Mobile Crisis Response Services

Medical Necessity Criteria: Admission Criteria

• This service is available to any individual meeting the below criteria, regardless of diagnosis.

• Individuals must meet all of the following criteria:
  ▪ The individual must be in an active behavioral health crisis that was unable to be resolved by the crisis call center phone triage process or other community interventions;
  ▪ Immediate intervention is necessary to stabilize the individual’s situation safely;
  ▪ The individual or collateral contact reports at least one of the following:
    • suicidal/assaultive/destructive ideas, threats, plans or actions;
    • an acute loss of control over thoughts, behavior and/or affect that could result in harm to self or others; or
    • 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; and/or;
    • the symptoms are escalating to the extent that a higher level of care will likely be required without intervention;

• Without immediate 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

Exclusion Criteria

• Consent for a voluntary evaluation and mobile crisis response intervention is refused.

• Note: Not applicable to cases where pre-screening assessment for involuntary commitment is required
Mobile Crisis Response Services

Discharge Criteria

• Any one of the following criteria must be met:
  ▪ The assessment and other relevant information indicate that the individual needs another level of care, either more or less intensive and that level of care is sufficiently available;
  ▪ The individual is linked or transferred to an appropriate treatment setting based on the assessment and resolution;
  ▪ Consent for treatment is withdrawn except during mandated assessments under the Code of Virginia §37.2-800 et. seq. for adults and §16.1-335 et seq. for youth under age eighteen; or
  ▪ A Temporary Detention Order has been issued.

Mobile Crisis Response Services

Billing Guidance

• One unit of service equals fifteen minutes.
• 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.
  ▪ The exception to this rule is when one team member separates from their teammate and the individual participating in the service in order to conduct care coordination activities.
• 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 exception to this rule is when the unlicensed staff has separated from their teammate and the individual participating in service in order to conduct care coordination activities.
• DBHDS certified pre-screeners billing for the purpose of conducting a prescreening must be a LMHP, LMHP-R, LMHP-RP or LMHP-S or directly supervised and signed off by an LMHP.
Mobile Crisis Response Services

Billing Guidance

- 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.
- 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.
- Providers of telemedicine assisted assessment should follow the provision of telehealth described in the “Telehealth Services Supplement”. 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.

Mobile Crisis Response Services

Billing Codes

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Unit</th>
<th>Description</th>
<th>Notes</th>
<th>Provider Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2011</td>
<td>1 unit =15 minutes</td>
<td>Mobile Crisis Response</td>
<td>Same Code is used by Emergency Services staff performing Pre-Screening Assessment activities</td>
<td>Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)</td>
</tr>
</tbody>
</table>

Locations: There are no limitations on the location of services where mobile crisis can be provided; thus, this service could be provided to walk-ins at a Crisis Receiving Center type location.

If service providers at walk-in locations are any type of LMHP, they may also bill Outpatient Psychotherapy Codes for Crisis (90839 and +90840) and these codes do not require any kind of service authorization process.
### Mobile Crisis Response Services
#### Billing Modifiers

<table>
<thead>
<tr>
<th>Team Composition (s) #</th>
<th>Modifier</th>
<th>Corresponding Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HO</td>
<td>1 Licensed*</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>Prescreening under an Emergency Custody Order (ECO) 1 Certified Pre-screener (LMHP, LMHP-R, LMHP-RP or LMHP-S)</td>
</tr>
<tr>
<td></td>
<td>HK</td>
<td>Prescreening not under an ECO 1 Certified Pre-screener (LMHP, LMHP-R, LMHP-RP or LMHP-S)</td>
</tr>
<tr>
<td>2</td>
<td>HT, HM</td>
<td>1 QMHP-A/QMHP-C/CSAC* and 1 PRS or 1 QMHP-A/QMHP-C/CSAC* and 1 CSAC-A</td>
</tr>
<tr>
<td>3</td>
<td>HT, HO</td>
<td>1 Licensed* and 1 PRS or 1 Licensed* and 1 CSAC-A or</td>
</tr>
<tr>
<td>4</td>
<td>HT, HN</td>
<td>2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – cannot consist of 2 QMHP-Es or 2 CSACs* or 1 QMHP-A/QMHP-C and 1 CSAC*</td>
</tr>
<tr>
<td>5</td>
<td>HT</td>
<td>1 Licensed* and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed* and 1 CSAC*</td>
</tr>
</tbody>
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### COMMUNITY STABILIZATION SERVICES

*Provider Manual Overview*
Community Stabilization Services

Service Definition

- “The warm hand hold”
- Short term
- Natural environment
- Referral and linkage
- Coordination
- Advocacy and networking

The goal of Community Stabilization services is to stabilize the individual within their community and support the individual and/or support system during the periods:

- 1) between an initial Mobile Crisis Response and entry into an established follow-up service at the appropriate level of care
- 2) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access or
- 3) as a diversion to a higher level of care

Community Stabilization Services

Critical Features

- Community Stabilization teams must be available to provide services to an individual in their home, workplace, or other convenient and appropriate setting and must be able to provide services 24 hours per day, 7 days per week.
- Critical Features of Community Stabilization include:
  - Recovery-oriented, trauma-informed, culturally congruent and developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;
  - Assessment and screening, including explicit screening for suicidal or homicidal ideation;
  - Brief Therapeutic Interventions;
  - Skill Building;
  - Interventions to integrate natural supports in the de-escalation and stabilization of the crisis;
  - Health Literacy / Psychoeducation;
  - Crisis education and prevention planning and support;
  - Engaging peer/natural and family support to strengthen the individual’s participation and engagement;
  - Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care
Community Stabilization Services

Critical Features / Covered Services
• Covered Services components of Community Stabilization include:
  ▪ Assessment
  ▪ Treatment Planning
  ▪ Individual and Family Therapy
  ▪ Crisis Intervention
  ▪ Care Coordination
  ▪ Peer Recovery Support Services
  ▪ Health Literacy Counseling
  ▪ Skills Restoration

Required Activities / Service Components
• The following required activities apply to Community Stabilization:
  ▪ Engagement with the crisis call center is required prior to initiating services.
  ▪ At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S must conduct an assessment to determine the individual’s 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:
    • Providers may choose to complete a Comprehensive Needs 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.
    • A DBHDS approved assessment for crisis services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
Community Stabilization Services

Required Activities / Service Components

- A Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements is required for Community Stabilization and must be current. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S.
- If an individual is transitioning between crisis services, the provider may review and update an existing CEPP in accordance with DBHDS guidelines.
- CEPPs must be reviewed and updated as an individual moves between crisis services (Mobile Crisis Response, Community Stabilization, Residential Crisis Stabilization Unit, 23-Hour Crisis Stabilization) according to DBHDS requirements.
- Services must be provided in-person with the exception of the telemedicine assisted assessment and care coordination.
- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

Community Stabilization Services

Service Limitations

- In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV, the following service limitations apply:
  - Community Stabilization may not be billed concurrently beyond a seven day overlap with any Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health (EBH) Services or Addiction and Recovery Treatment Services (ARTS).
  - Community Stabilization shall not be delivered in inpatient hospitals, psychiatric residential treatment facilities, therapeutic group homes or ASAM levels 3.1 – 4.0. A 48 hour overlap in services as an individual is transitioning from an inpatient hospital to a community setting is allowed.
  - Services shall not be provided for the sole reason of providing temporary housing to an individual; if the individual meets other admission criteria and housing is an additional assessed need, this should be noted on the service authorization request to support continued coordination of resources for the individual.
Community Stabilization Services

Service Limitations

- Activities that are not reimbursed or authorized:
  - Inactive time or time spent waiting to respond to a behavioral situation;
  - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions;
  - Supervision hours of the staff;
  - Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers;
  - Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
  - Respite care;
  - Transportation for the individual or family. Additional medical transportation for service needs not considered part of Community Stabilization services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to Community Stabilization providers may be billed to the transportation broker;
  - Covered services that have not been rendered;
  - Services not in compliance with Code of Virginia, the Mental Health Services Manual or licensure standards;
  - Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's crisis/safety plan(s);
  - Services provided that are not within the provider's scope of practice;
  - Anything not included in the approved service description;
  - Changes made to the service that do not follow the requirements outlined in the provider contract, provider manual, or licensure standards; or
  - Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, service manual, or licensure standards

Provider Qualifications

- **Licensed** by DBHDS as a provider of a Crisis Stabilization Services

- **Credentialed** with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.

- **Trained** according to DBHDS requirements.

- **Hold an Active Memorandum of Understanding** with the regional crisis hub via DBHDS.

- **Must follow** all general Medicaid provider requirements specified in Chapter II of this manual.
Community Stabilization Services

Staff Requirements

<table>
<thead>
<tr>
<th>#</th>
<th>Staffing/Team Composition (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 QMHP-A or QMHP-C or 1 CSAC-</td>
</tr>
<tr>
<td>2</td>
<td>1 Licensed</td>
</tr>
<tr>
<td>3</td>
<td>1 Licensed and 1 PRS or 1 Licensed and 1 CSAC-A</td>
</tr>
<tr>
<td>4</td>
<td>1 Licensed and 1 QMHP-E or QMHP-C or QMHP-A or 1 Licensed and 1 CSAC-A</td>
</tr>
</tbody>
</table>

* Includes those in their regulatory board approved residency/supervisee status.

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. Providers must bill using the modifier associated with the team delivering the covered service component.

Community Stabilization Services

Providers: Who is allowed to do what?

<table>
<thead>
<tr>
<th>Service Component</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E, CSAC*, CSAC-Supervisee*</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E, CSAC*, CSAC-Supervisee*</td>
</tr>
<tr>
<td>Peer Recovery Support Services</td>
<td>Registered Peer Recovery Specialist</td>
</tr>
<tr>
<td>Individual and Family Therapy</td>
<td>LMHP, LMHP-R, LMHP-RP, LMHP-S</td>
</tr>
</tbody>
</table>

*CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per §54.1-3507.1 and §54.1-3507.2
Community Stabilization Services

Initial Service Authorization / Registration

- Community Stabilization reimbursement is initially authorized by a registration process for 7 calendar days / 112 units.
- Providers shall submit service authorization requests within one business day of admission for initial service authorization.
- If submitted after the required time frame, the begin date of authorization will be based on the day of receipt.
- 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 www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

Community Stabilization Services

Continued Stay Authorization / Consecutive Requests

- If additional activities beyond this are clinically required, the provider shall submit an authorization request to the FFS contractor or MCO through a continued stay service authorization request accompanied by a CEPP.
- The continued stay service authorization request must be submitted no earlier than 48 hours before the requested start date of the continued stay.
- Consecutive registrations from the same or different provider are not permitted with the exception of individuals moving out of the catchment area during the registration period.
- If an individual moves during the initial 7 calendar day registration period and needs to transfer to another provider, a new registration is allowed but the total registration period between the two providers may not exceed 7 calendar days/112 units.
- A continued stay service authorization is always required beyond the initial 7 calendar days/112 units.
Service Authorization Forms

Registration Form

- **NEW AND IMPROVED** Adobe Forms
- Best efforts made to:
  - Make form fields more functional
  - Reduce duplication of information
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision as needed for process improvement

Service Authorization Processes

Fee for Service Vendor and Managed Care Organizations

- FFS: Magellan BHSA
- Forms
  - [https://www.magellanofvirginia.com/for-providers/provider-tools/forms/](https://www.magellanofvirginia.com/for-providers/provider-tools/forms/)
- Provider Portal
  - [https://www.magellanprovider.com/MagellanProvider/do/LoadHome](https://www.magellanprovider.com/MagellanProvider/do/LoadHome)
- Managed Care Organizations
Community Stabilization Services

Documentation & Utilization Review

• Refer to Chapter VI of this manual for documentation and utilization review requirements.

Community Stabilization Services

Medical Necessity Criteria: Admission Criteria

• Individuals must meet all of the following criteria:
  ▪ The individual has experienced a recent behavioral health crisis (within 72 hours of admission) or the individual is transitioning from or at risk of a higher level of care and requires short-term support with identifying and engaging in the services necessary to maintain safety and stability in the community;
  ▪ Documentation indicates evidence that the individual meets criteria for a primary diagnosis consistent with the most recent version of the Diagnostic and Statistical Manual;

• There is evidence from the individual or collateral contact indicating at least one of the following is present:
  ▪ High potential for crisis-cycling without this support;
  ▪ 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/accessable;
  ▪ Individual has been engaged in alternative crisis services or treatment and no longer meets criteria for those services but continues to require community stabilization support;
  ▪ The individual currently has moderate to high intensity behavioral and/or emotional needs and without intervention, will further interfere with their ability to function in at least one life domain: family, living situation, school, social, work or community.
Community Stabilization Services

Exclusion Criteria

- Individuals who meet any of the following criteria are not eligible to receive Community Stabilization services:
  - The individual’s psychiatric condition is of such severity that it can only be safely treated in a 23-hour crisis stabilization, residential or inpatient setting;
  - The individual’s acute medical condition is such that it requires treatment in an acute medical setting;
  - The individual/parent/guardian does not voluntarily consent to treatment.

Concurrent Stay Criteria

- All of the following criteria must be met:
  - The individual’s condition continues to meet admission criteria at this level of care; The individual’s treatment may require a more-intensive level of care but the appropriate service is not available/accessible at this time;
  - 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;
  - Treatment planning is individualized and appropriate to the individual’s developmental level and changing condition, with realistic, specific, and attainable goals and objectives stated. CEPP should include support system involvement unless contraindicated;
  - There is documented, active discharge planning starting at admission; and
  - There is documented active coordination of care with other service providers. If care coordination is not successful, the reasons are documented, and efforts to coordinate care continue.
Community Stabilization Services

Discharge Criteria

- Any of the following criteria is sufficient for discharge from this level of care:
  - The individual no longer meets admission criteria;
  - CEPP has been sustained appropriately and/or a safe, discharge plan is arranged and services at an appropriate level of care have been initiated;
  - 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;
  - Consent for treatment is withdrawn;
  - Support systems that allow the individual to be stabilized while being connected to a more appropriate level of care have been secured;
  - The individual is not able to sustain the CEPP, and there is no reasonable expectation that they will be and escalation to a higher level of care is necessary;
  - The individual’s physical condition necessitates transfer to an acute, inpatient medical facility.

Billing Guidance

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Unit</th>
<th>Description</th>
<th>Notes</th>
<th>Provider Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9482</td>
<td>Per 15 minutes</td>
<td>Community Stabilization</td>
<td></td>
<td>Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)</td>
</tr>
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</table>
## Community Stabilization Services
### Billing Modifiers

<table>
<thead>
<tr>
<th>Team Composition (s) #</th>
<th>Modifier</th>
<th>Corresponding Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HN</td>
<td>1 QMHP-A/QMHP-C/CSAC&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>2</td>
<td>HO</td>
<td>1 Licensed&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>3</td>
<td>HT, HM</td>
<td>1 Licensed&lt;sup&gt;c&lt;/sup&gt; and 1 Peer OR 1 Licensed&lt;sup&gt;d&lt;/sup&gt; and 1 CSAC A</td>
</tr>
<tr>
<td>4</td>
<td>HT</td>
<td>1 Licensed&lt;sup&gt;c&lt;/sup&gt; and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed&lt;sup&gt;d&lt;/sup&gt; and 1 CSAC&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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

Thank you for your partnership, support and participation.

Additional Questions?

Please contact [EnhancedBH@dmas.Virginia.gov](mailto:EnhancedBH@dmas.Virginia.gov)

Access the recorded training on our Youtube Channel: Virginia Medicaid

[https://www.youtube.com/channel/UCbE_bPviPQTifCS2MfCmVHA](https://www.youtube.com/channel/UCbE_bPviPQTifCS2MfCmVHA)