Sentara® Health Plans

Medicaid

Community Stabilization, BH 32

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual *.

Purpose:

This policy addresses Community Stabilization

Service Requirements:

Mental Health Services (formerly CMHRS), App. G - Comprehensive Crisis and Transition Services p. 45 (8/21/2023)

Community Stabilization requires a service authorization and service providers delivering Community Stabilization shall meet all the service requirements listed in this section.

Providers shall submit service authorization requests within one business day of admission for initial service authorization requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt.

Service authorization requests must include, at a minimum:

- A complete service authorization request form. The service authorization form must be submitted with the required DBHDS crisis data platform reference number.
- Documented referral from discharging provider, if applicable. The referral must, at a minimum, include the name of the individual, the name and credentials of the referring provider, the reason for the referral, anticipated length of service needed and the name of the community stabilization provider submitting the authorization.
- The safety plan developed by the referring provider (Only for individuals being referred from Mobile Crisis Response, 23-Hour Crisis Stabilization or RCSU),

- If an individual meets admission criteria for this service and housing is an assessed need, this should be noted as a need on the service authorization request submitted to support coordination of resources for the individual.

Service units are authorized based on medical necessity with a unit equaling fifteen minutes.

If additional services are clinically required, the provider shall submit an authorization request to the FFS 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:

- A complete service authorization request form. The service authorization form must be submitted with the required DBHDS crisis data platform reference number.
- An initial assessment meeting one of the following:
    - A Comprehensive Needs Assessment completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S (see Chapter IV for requirements); or
    - 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; or
    - A DBHDS approved assessment for community stabilization can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; and
- A current addendum to the above assessment (can be in a progress note) that 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;
- A safety plan; and
- Documentation of care coordination activities. Service authorization requests may require the submission of documentation of referrals to post-discharge services at the appropriate level of care based on the assessed needs of the individual; and
- Any housing needs must be noted on the service authorization request form for the purposes of care coordination.

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.

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.

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/.

Description & Definitions:

Mental Health Services (formerly CMHRS), App G. - Comprehensive Crisis and Transition Services p. 37 (8/21/2023)

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. Community Stabilization is a bridge service that supports an individual as they are making a transition between certain levels of care when there is a gap in availability of services. Services may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-

escalation and stabilization of the crisis, and coordination of follow-up services. Services involve advocacy and networking to provide linkages and referrals to appropriate community-based services and assisting the individual and their natural support system in accessing other benefits or assistance programs for which they may be eligible.

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.

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
- **Care Coordination:**
    - Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care
    - Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use
    - Engaging peer/natural and family support to strengthen the individual's participation and engagement
- **Crisis Intervention:**
    - Brief Therapeutic Interventions
    - Crisis education, safety, prevention planning, and support
    - Interventions to integrate natural supports in the de-escalation and stabilization of the crisis
- **Skills Restoration**:
    - Skill Building
    - Psychoeducation

Covered Services components of Community Stabilization include:

- Assessment
- Care Coordination
- Crisis Intervention
- Health Literacy Counseling
- Individual and Family Therapy
- Peer Recovery Support Services
- Skills Restoration
- Treatment Planning

Exclusion Criteria:

Mental Health Services (formerly CMHRS), App. G - Comprehensive Crisis and Transition Services p. 42 (8/21/2023)

Individuals who meet **1 or more** of the following criteria are not eligible to receive Community Stabilization services (with exception for transitions, see billing requirements section):

- 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;
- 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;
- The individual's psychiatric condition is of such severity that it cannot be safely treated in this level of care;
- The individual's acute medical condition is such that it requires treatment in an acute medical setting.

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

- 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.
    - 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 must 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.
- 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.

Admission Criteria:

Mental Health Services (formerly CMHRS), App. G - Comprehensive Crisis and Transition Services p. 40-42 (8/21/2023)

Community Stabilization is considered medically necessary for **1 or more of the following**:

- Initial Care with **all of the following:**
    - 1. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the Diagnostic and Statistical Manual and/or International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis
    - 2. The individual is at risk of repeat admissions to crisis services, emergency departments, or psychiatric inpatient services or dangerous decompensation in functioning and additional support in the form of community stabilization is required to prevent an acute inpatient admission
    - Prior to admission the individual must meet #3 or #4 (**or more** of the following):
        - 3. The individual is residing in a Therapeutic Group Home or ASAM 3.1
        - 4. The individual is transiting from **one of the following** services and the necessary service is not immediately available:
            - i. 23-Hour Crisis Stabilization
            - ii. Acute Psychiatric Inpatient Services
            - iii. ASAM levels 3.1 – 4.0
            - iv. CSB Emergency Services
            - v. Hospital Emergency Department
            - vi. Short-term detention or incarceration
            - vii. Mobile Crisis Response
            - viii. Partial Hospitalization Program (Mental Health or ARTS)
            - ix. Psychiatric Residential Treatment Facility
            - x. Residential Crisis Stabilization Unit
            - xi. Therapeutic Group Home
            - If the individual meets criteria #4, then **all of the** following additional criteria must be met:
                - 5. Without immediate access to the identified community-based service, there is evidence that the individual would be at risk for a higher level of care during the transition to the next service
                - 6. Clinically appropriate behavioral health service referral(s) has been identified and a plan for the timeline of transition from Community Stabilization to that provider has been established. If the timeline for transition exceeds 2 weeks, the Community Stabilization provider should initiate referrals to additional follow-up service providers.
- Continuation of services with **all of the** following:
    - The individual continues to meet admission criteria
    - 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

- Safety plan includes support system involvement unless contraindicated
- There is documented, active discharge planning starting at admission
- There is documented active care coordination with other service providers. If care coordination is not successful, the reasons are documented, and efforts to coordinate care continue. If the timeline for this transition exceeds 2 weeks, the Community Stabilization provider has documented communications with additional, specific service providers to support alternative service options or potentially faster access to the recommended service type.

Discharge Guidelines:

Mental Health Services (formerly CMHRS), App. G - Comprehensive Crisis and Transition Services p. 42 (8/21/2023)

Once an individual meets criteria for discharge, services are no longer eligible for reimbursement.

At least **1 or more** of the following discharge is met:

- The individual no longer meets admission criteria
- A safe discharge plan has been established and an appropriate level of care has been initiated;
- An effective safety plan has not been established and the individual requires a higher level of care
- 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
- The individual's physical condition necessitates transfer to an acute, inpatient medical facility

Required activities:

Mental Health Services (formerly CMHRS), App. G – Comprehensive Crisis and Transition Services p. 38 (8/21/2023)

In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to Community Stabilization:

- The provider must engage with the DBHDS crisis data platform as required by DBHDS.

Assessment:

- At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S 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:
  - A Comprehensive Needs Assessment completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S (see Chapter IV for requirements).
  - 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.
  - A DBHDS approved assessment for Community Stabilization if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. Providers may use an existing DBHDS approved assessment for individuals transitioning from Mobile Crisis Response, 23-Hour Crisis Stabilization, RCSU or another Community Stabilization provider. At a minimum, an LMHP, LMHP-R, LMHP-RP or LMHP-S must review and update the DBHDS approved assessment

Care Coordination:

- Community Stabilization services shall link/transition the individual to follow-up services and other needed resources to stabilize the individual within their community.
- Active transitioning from Community Stabilization to an appropriate level of care shall be required; which includes care coordination and communication with the individual's MCO or FFS contractor, service providers and other collateral contacts. Documentation of care coordination must include, at a minimum, attempts to contact the MCO, who the provider spoke to and outcomes of the contact.

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

Crisis Intervention:

- Development of a plan to maintain safety in order to prevent the need for a higher level of care; **or**
- 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; **or**
- 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.

Treatment Planning:

- 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.
- Discharge planning and transition to an appropriate level of care must begin at admission.
- Services must be provided in-person with the exception of care coordination activities.
- 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.

- Service delivery must be individualized. Group delivery of service components is not appropriate for this service.

Coding:

Medically necessary with criteria:

Coding	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
S9482	Family stabilization services, per 15 minutes

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2024: June – DMAS manual updated 8/21/202. Admission criteria bullet 2 updated language to include individual“ is at risk of repeat admissions to crisis services, emergency departments, or psychiatric inpatient services.”
- 2023: June
- 2022: June, September

Reviewed Dates:

Effective Date:

- December 2021

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Behavioral health professionals are involved in the decision-making process for behavioral healthcare services.

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services. Revision Date: 8/21/2023 Appendix G: Comprehensive Crisis Services. Retrieved 5.15.2024 https://vamedicaid.dmas.virginia.gov/sites/default/files/2024-02/MHS%20-%20Appendix%20G%20%28updated%208.21.23%29_Final.pdf

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP Community Stabilization, SHP Behavioral Health 32