Professional Treatment Services in Facility-Based Crisis Program – Children and Adolescents

Medicaid and North Carolina Health Choice (NCHC) Billable Service

WORKING DRAFT Revision Date: September 11, 2014

Service Definition and Required Components
Professional Treatment Services in a Facility-Based Crisis Program - Children and Adolescents is a service for children and adolescents* who have a mental illness, intellectual/developmental disability (IDD), and/or substance use disorder and is provided in a 24-hour residential facility, licensed under 10A NCAC 27G .5000, with 16 beds or less. A Facility-Based Crisis provider must meet the criteria and be designated as an involuntary treatment facility by DHHS in accordance with 10A NCAC 26C .0100. The Facility-Based Crisis Program is under the clinical oversight of a psychiatrist. This is a short term service that provides disability-specific care and treatment in a non-hospital setting for individuals requiring acute crisis stabilization. This crisis stabilization service includes a comprehensive clinical assessment, treatment intervention, behavior management or support plan, and aftercare planning. This service is designed as a time-limited alternative to hospitalization for an individual in crisis.

***Note:** This service is for children and adolescents 6 through the age of 17 for both Medicaid and North Carolina Health Choice funded services. For beneficiaries ages 18 and older, Professional Treatment Services in a Facility-Based Crisis Program– Adult must be utilized.

Each Facility Based Crisis provider must designate the population to be served as follows:

I. Individuals with a primary mental health or substance use disorder;

OR

II. Individuals with a primary intellectual developmental disability or IDD with co-occurring mental illness and/or a substance use disorder

OR

III. Individuals with a primary mental health or substance use disorder and Individuals with a primary intellectual developmental disability or IDD with co-occurring mental; illness and/or substance use disorder.

The Facility Based Crisis program must address the age, behavior, and developmental functioning of each beneficiary to ensure safety, health and appropriate treatment interventions within the program milieu. The facility must ensure the physical separation of children (age 6-11) from adolescents (age 12-17) by living quarters, common areas, and in treatment, etc. If adults and children are receiving services in the same building, the facility must ensure complete physical separation between adults and children. All facilities serving both children and adults must have 16 beds or fewer.

This medically necessary service directly addresses the beneficiary's diagnostic and clinical needs, evidenced by symptoms which may indicate the presence of a diagnosable mental illness, intellectual/developmental disability, or substance related disorder (as defined by the DSM-5 or any subsequent editions of this reference material).

Under the direction of a psychiatrist, this service provides short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.
For facilities serving individuals with intellectual/developmental disabilities, therapeutic interventions must be under the direction of a psychiatrist and a licensed practicing psychologist.

Facility-Based Crisis includes, but is not limited to:

- assessments and evaluation of the condition(s) that has resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs;
- intensive treatment, behavior management support and interventions, detoxification protocols as addressed in the beneficiary's service plan;
- active engagement of the family, caregiver and/or legally responsible person in crisis stabilization and treatment interventions as appropriate;
- stabilization of the immediate presenting issues, behaviors or symptoms that have resulted in the need for crisis intervention or detoxification;
- monitoring of his/her medical condition and response to the treatment protocol to ensure the safety of the individual; and
- discharge planning which begins at admission, including:
    - arranging for linkage to new or existing services that will provide further treatment, habilitation and/or rehabilitation upon discharge from the Facility-Based Crisis service;
    - arranging for linkage to a higher level of care as medically necessary;
    - identifying, linking to, and collaborating with informal and natural supports in the community; and
    - developing or revising the crisis plan to assist the beneficiary and his or her supports in preventing and managing future crisis events.

Provider Requirements

Facility-Based Crisis must be delivered by practitioners employed by mental health, intellectual/developmental disability and/or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); and
- fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity-Managed Care Organization (LME-MCO). Additionally, within one year of enrollment as a provider of this service with DMA, the organization must achieve national accreditation with at least one of the designated

accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

For Medicaid and NCHC services, the organization is responsible for obtaining authorization from the Medicaid or NCHC approved vendor for medically necessary services. The Facility-Based Crisis Program provider organization must comply with all applicable federal, state, and Department of Health and Human Services (DHHS) requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

In partnership with the LME-MCO, the Facility-Based Crisis provider organization is expected to collaborate with relevant community stakeholders for access to services, care coordination, and continuity of care.

This service must be provided in a licensed facility under 10A NCAC 27G .5000.

A Facility-Based Crisis provider must be designated as an involuntary treatment facility by DHHS in accordance with 10A NCAC 26C .0100.

Staffing Requirements
For Facility Based Crisis providers that designate to serve:

I. Individuals with a primary mental health or substance use disorder
The facility must be staffed at a minimum of:

- 0.5 FTE Medical Director who is a board-eligible or board certified child psychiatrist or a general psychiatrist with a minimum of two years experience in the treatment of children and adolescents. A psychiatrist must be available 24 hours a day, 7 days a week, and 365 days a year (this includes the required on call availability). The psychiatrist provides clinical oversight of the Facility Based Crisis service. The psychiatrist must conduct a psychiatric assessment on site within 24 hours of admission. The psychiatrist must provide on site consultation to and supervision of staff. The psychiatrist may bill separately for face-to-face evaluation and management services, additional psychiatric evaluations (excluding the initial evaluation), and other therapeutic services provided to beneficiaries,

AND

- Nursing coverage 24/7/365 must include a Registered Nurse with a minimum of one year of experience with the population to be served.
    - At least one Registered Nurse Qualified Professional must be on-site 24 hours per day.
    - All nursing staff must actively participate in the provision of treatment, monitor beneficiary's' medical progress, and provide medication administration;

AND

- at least one (1.0) FTE Licensed Professional with the disability-specific knowledge, skills, and abilities required by the population and age to be served who actively participates in the provision of treatment, and provides clinical supervision for the program. This function may be filled by one or more professionals.

- For facilities serving individuals with substance-related disorders as a presenting problem, a Licensed Clinical Addiction Specialist (LCAS) is required. Note: Facilities must have adequate and qualified staffing to address co-occurring disorders when present.

AND

- Additional staff including Licensed Professionals, Associate-level Professionals, Licensed Practical Nurse, Qualified Professionals, Associate Professional and/or Paraprofessionals with disability-specific knowledge, skills, and abilities required by the population and age to be served.

For Facility Based Crisis providers that designate to serve:

II. Individuals with a primary intellectual developmental disability or IDD with co-occurring mental; illness and/or substance use disorder

The facility must be staffed at a minimum of:

- 0.5 FTE Medical Director who is a board-eligible or board certified child psychiatrist or a general psychiatrist with a minimum of two years experience in the treatment of children and adolescents. A psychiatrist must be available 24 hours a day, 7 days a week, and 365 days a year (this includes the required on call availability). The psychiatrist provides clinical oversight of the Facility Based Crisis service. The psychiatrist must conduct a psychiatric assessment on site within 24 hours of admission. The psychiatrist must provide on site consultation to and supervision of staff. The psychiatrist may bill separately for face-to-face evaluation and management services, additional psychiatric evaluations (excluding the initial evaluation), and other therapeutic services provided to beneficiaries,

AND

- FTE Licensed Practicing Psychologist with a minimum of two years experience in the treatment of children and adolescents with Intellectual/Developmental Disabilities. A psychologist must be available 24 hours a day, 7 days a week, and 365 days a year (this includes the required on call availability). The psychologist must be available for on-site consultation to staff, observation, to develop a behavioral plan, for consultation with the psychiatrist and clinical staff, and to recommend or conduct other assessments as appropriate.

AND

- Nursing coverage 24/7/365 must include a Registered Nurse with a minimum of one year of experience with the population to be served.
    - At least one Registered Nurse Qualified Professional must be on-site 24 hours per day.
    - All nursing staff must actively participate in the provision of treatment, monitor beneficiary's medical progress, and provide medication administration;

AND

- Additional staff including Licensed Professionals, Associate-level Professionals Licensed Practical Nurse, Qualified Professionals, Associate Professional and/or Paraprofessionals with disability-specific knowledge, skills, and abilities required by the population and age to be served.

Note: Facilities must have adequate and qualified staffing to address co-occurring disorders when present.

For Facility Based Crisis providers that designate to serve:

III. Individuals with a primary mental health or substance use disorder and Individuals with a primary intellectual developmental disability or IDD with co-occurring mental; illness and/or substance use disorder)

The facility must be staffed at a minimum of:

- 0.5 FTE Medical Director who is a board-eligible or board certified child psychiatrist or a general psychiatrist with a minimum of two years experience in the treatment of children and adolescents. A psychiatrist must be available 24 hours a day, 7 days a week, and 365 days a year (this includes the required on call availability). The psychiatrist provides clinical oversight of the Facility Based Crisis service. The psychiatrist must conduct a psychiatric assessment on site within 24 hours of admission. The psychiatrist must provide on site consultation to and supervision of staff. The psychiatrist may bill separately for face-to-face evaluation and management services, additional psychiatric evaluations (excluding the initial evaluation), and other therapeutic services provided to beneficiaries.

AND

- 0.5 FTE Licensed Practicing Psychologist with a minimum of two years experience in the treatment of children and adolescents with Intellectual/Developmental Disabilities. A psychologist must be available 24 hours a day, 7 days a week, and 365 days a year (this includes the required on call availability). The psychologist must be available for on-site consultation to staff. The psychologist must be available for on-site consultation to staff, observation, to develop a behavioral plan, for consultation with the psychiatrist and clinical staff, and to recommend or conduct other assessments as appropriate.

AND

- Nursing coverage 24/7/365 must include a Registered Nurse with a minimum of one year of experience with the population to be served.
    - At least one Registered Nurse Qualified Professional must be on-site 24 hours per day.
    - All nursing staff must actively participate in the provision of treatment, monitor **beneficiary's** medical progress, and provide medication administration;

AND

- 0.5 Licensed Professional with the disability-specific knowledge, skills, and abilities required by the population and age to be served who actively participates in the provision of treatment, and provides clinical supervision for the program. This function may be filled by one or more professionals.

- For facilities serving individuals with substance-related disorders as a presenting problem, a Licensed Clinical Addiction Specialist (LCAS) is required.

Note: Facilities must have adequate and qualified staffing to address co-occurring disorders when present.

AND

- Additional staff including Licensed Professionals, Associate-level Professionals, Licensed Practical Nurse, Qualified Professionals, Associate Professional and/or Paraprofessionals with disability-specific knowledge, skills, and abilities required by the population and age to be served.

For ALL Facility –Based Crisis providers:

As a facility designated for the custody and treatment of involuntary beneficiaries, the facility must have adequate staffing and provide supervision to ensure the protection of the individual to be served.

A Facility-Based Crisis Program must be staffed twenty-four hours a day and must maintain staffing ratios that ensure the treatment, health and safety of beneficiaries served in the facility that includes:

- a licensed professional, in addition to the Registered Nurse, must be available for 24/7 on site admissions
- awake staff to beneficiary ratio of no less than 1:3 on premises at all times
- a minimum of two awake staff persons on premises at all times
- the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individual beneficiaries.

At no time when a Facility-Based Crisis staff member is actively fulfilling his/her Facility-Based Crisis Program role may he or she contribute to the staffing ratio required for another service.

Therapeutic interventions are implemented by staff under the direction of a Licensed Professional.

At least one Licensed Professional providing Facility-Based Crisis services must demonstrate competencies in crisis response and crisis prevention. At a minimum, he or she must have a minimum of 1 year's experience in a crisis management setting or service during which the individual provided crisis response (such as by serving as an Mental Health or Substance Use Disorder first responder for enhanced services, in an emergency department, or in another service providing 24/7 response in emergent or urgent situations).

All staff providing Facility-Based Crisis Program services must complete a minimum of 20 hours of training specific to the required components of the Facility-Based Crisis service definition, including crisis intervention strategies and Person-Centered Thinking, within the first 90 days of each staff member's initial delivery of this service.

Service Type/Setting

A Facility-Based Crisis Program is a direct and indirect service, licensed under 10A NCAC 27G .5000 that is available at all times, 24 hours a day, 7 days a week, and 365 days a year. A Facility-Based Crisis

provider must meet the criteria and be designated as an involuntary treatment facility by DHHS in accordance with 10A NCAC 26C .0100.

Each Facility Based Crisis provider must designate the population to be served as follows:

I. Individuals with a primary mental health or substance use disorder;

OR

II. Individuals with a primary intellectual developmental disability or IDD with co-occurring mental; illness and/or substance use disorder

OR

III. **Individuals with a primary mental health or substance use disorder and Individuals with a primary intellectual developmental disability or IDD with co-occurring mental; illness and/or substance use disorder)**.

Units are billed in one-hour increments.

This service is an intensive short-term, medically supervised service that is provided in licensed 24-hour service sites.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Program Requirements

A Facility-Based Crisis Program is a 24-hour service that is offered seven days a week. This program must accept admissions on a 24/7/365 basis. The staff to beneficiary ratio must ensure the treatment, health and safety of beneficiaries served in the facility and comply with 10 NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time Out and Protective Devices Used for Behavioral Control. A Facility-Based Crisis provider must meet the criteria and be designated as an involuntary treatment facility by DHHS in accordance with 10A NCAC 26C .0100.

All beneficiaries will be seen by the psychiatrist on site within twenty-four hours of their admission to the Facility-Based Crisis Program. All beneficiaries will receive a comprehensive clinical assessment by a licensed professional upon admission. All beneficiaries with Intellectual/Developmental Disabilities will also be seen by the psychologist on site within twenty-four hours of their admission to the Facility-Based Crisis Program. The program must be under the supervision of a psychiatrist, and a psychiatrist must be on call on a 24-hour per day basis.

The Facility Based Crisis program must address the chronological age and developmental functioning of the population served to ensure safety, health and appropriate treatment interventions within the program milieu.

When medically necessary, the Facility Based Crisis program must make a referral to a service providing an appropriate level of care if the individual's needs exceed the program capabilities.

All staff who provide substance use disorder treatment interventions must be registered with the North Carolina Substance Abuse Professional Practice Board in accordance with the North Carolina Practice Act (G.S. 90-113.30).

For beneficiaries requiring detoxification, the Facility-Based Crisis Program must have procedures and protocols in place to initiate detoxification. When a higher level of detoxification is medically necessary, the Facility-Based Crisis Program must make a referral to a facility licensed (e.g., inpatient hospital) to provide detoxification in accordance with the American Society of Addiction Medicine (ASAM) criteria.

For beneficiaries who are new to the enhanced Mental Health, Intellectual Disability, Substance Abuse (MH/IDD/SAS) service delivery system, Facility-Based Crisis staff must develop an aftercare plan that includes a detailed crisis plan with the beneficiary and his or her family, caregiver or legally responsible person before discharge. For beneficiaries who are currently enrolled in another enhanced service, the Facility-Based Crisis staff must work in partnership with the Qualified Professional responsible for the plan to recommend the needed revisions to the crisis plan component of the Person Centered Plan.

For all beneficiaries, effective discharge planning must include collaboration with the family, caregiver and/or legally responsible person and their informal and natural supports as well as other agencies involved (i.e., schools, Social Services, Juvenile Justice, other treatment providers) as appropriate. For beneficiaries who are engaged in receiving services from a clinical home provider, the Facility-Based Crisis Program will involve the clinical home provider in treatment, discharge planning, and aftercare.

Eligibility Criteria

The beneficiary is eligible for this service when:

A. There is a Mental Health, Intellectual Developmental Disability, or Substance Use Disorder diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material) based on the designation of the facility.

AND

B. For beneficiaries with a substance use disorder diagnosis, the American Society of Addiction Medicine Criteria (ASAM Criteria) are met for Level 3.7.

AND

C. The beneficiary is experiencing an acute crisis requiring short term placement as evidenced by <u>one of the following</u>:

- a danger to self or others;
- imminent risk of harm to self or others;
- psychosis, mania, or medication adherence;
- intoxication or withdrawal requiring medical supervision, but not hospital detoxification.

AND

D. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (including Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process

For Medicaid and NCHC funded Facility-Based Crisis, a service order is required on the date of admission. A verbal order in accordance with the DMH/DD/SAS Records Management and Documentation Manual is acceptable. This must be completed by a psychiatrist, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice, and must be accompanied by other documentation requirements outlined in this policy. The service order must be based on an individualized assessment of the beneficiary's needs.

The following assessments and evaluations are required:

- A nursing assessment by a Registered Nurse must be completed at the time of admission to this service;
- An on site psychiatric evaluation must be completed by the psychiatrist within 24 hours of admission;
- A comprehensive clinical assessment which documents medical necessity must be completed by a licensed professional upon admission as part of the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning**,** and contains all the required elements as outlined in community practice standards as well as in all applicable federal, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment. It may be utilized in the development of the comprehensive clinical assessment required upon admission.
- All beneficiaries with Intellectual/Developmental Disabilities will also be seen by the psychologist on site within twenty-four hours of their admission to the Facility-Based Crisis Program.

Prior approval will be required for this service. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. For Medicaid beneficiaries, the Facility-Based Crisis provider must contact the LME-MCO to determine if the individual is currently enrolled with another service provider agency that has first responder responsibilities. This should occur at the onset of the crisis whenever possible, but prior to discharge from Facility-Based Crisis.

A completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO for Medicaid and NCHC funded Facility-Based Crisis services.

Relevant diagnostic information must be obtained and included in the individual's service plan. For Medicaid and NCHC, in order to request an authorization, the required authorization request form must be submitted to the Medicaid or NCHC approved vendor.

Continued Service Criteria

The beneficiary continues to meet eligibility (medical necessity) criteria.

AND

The beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the service plan.

Discharge Criteria

One of the following applies:

A. The beneficiary's level of functioning has improved with respect to the goals outlined in the service plan.

OR

B. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services.

For Medicaid beneficiaries who are new to the enhanced MH/IDD/SUD service delivery system, a completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

Note: General Statutes 122C-261(f), 122C-262(d), and 122C-263(d)(2) prohibit the admission of individuals with mental retardation, or suspected mental retardation, and co-occurring mental illness, to state psychiatric hospitals with limited exceptions. If an individual with mental retardation and a co-occurring mental illness is determined to need hospitalization, arrangements must be made for an inpatient admission to a non-state hospital in collaboration with the LME-MCO. All requests for an exception will be determined by the Director of the Division of MH/DD/SAS or designee.

Note: Any denial, reduction, suspension, or termination of service requires notification to the beneficiary and/or legally responsible person about his or her appeal rights in accordance with the Department's beneficiary notices procedure.

Expected Clinical Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals which assist the beneficiary and his or her supports in:

- reduction of acute psychiatric symptoms that precipitated the need for this service
- reduction of acute negative effects of substance related disorders with enhanced motivation for treatment and/or relapse prevention
- stabilizing or managing the crisis situation
- preventing hospitalization or other institutionalization
- accessing services as indicated in the comprehensive clinical assessment
- reduction of behaviors that led to the crisis

Documentation Requirements

Refer to DMA Clinical Coverage Policies and the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, the documentation requirement includes, at a minimum, a full service note per shift by the nursing staff and a full service note per intervention (e.g., individual counseling, group, discharge planning) per date of service, written and signed by the person(s) who provided the service. Each note must include:

- Beneficiary's name
- Medicaid or NCHC identification number
- Service provided (e.g., Facility-Based Crisis)
- Date of service
- Type of contact (face-to-face, telephone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)

A documented service plan, aftercare, discharge, and crisis plan must be developed in partnership with the beneficiary, his or her legally responsible person, and the clinical home provider if one exists. These plans must be included in the service record and a copy must be given to the legally responsible person (and the beneficiary as appropriate).

In addition, a completed LME-MCO Consumer Admission and Discharge Form must be submitted to the Local Management Entity.

Utilization Management

For Medicaid and NCHC funded services, prior approval will be required for this service. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

Units are billed in one-hour increments. This is a short-term service that is not reimbursable for more than 30 days in a calendar year.

Service Exclusions/Limitations

- No service provided after admission to and before discharge from Facility-Based Crisis shall be reimbursed.