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**NC Division of Mental Health,
Developmental Disabilities &
Substance Abuse Services**

**State-Funded Facility-Based
Crisis Service for Children
and Adolescents**

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1.0 Description of the Service

Facility-Based Crisis Service for children and adolescents is a service that provides an alternative to hospitalization for an eligible individual who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility with 16 beds or less. Facility-Based Crisis Service is a direct and indirect, intensive short-term, medically supervised service provided in a physically secure setting, that is available 24 hours a day, seven (7) days a week, 365 days a year.

Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.

The Facility-Based Crisis Service includes professionals with expertise in assessing and treating mental health and substance use disorders and intellectual or developmental disabilities. The service must address the age, behavior, and developmental functioning of each individual receiving services to ensure safety, health and appropriate treatment interventions. The facility must ensure the physical separation of children (refer to Subsection 1.1) from adolescents (refer to Subsection 1.1) by living quarters, common areas, and in treatment. This separation may be accomplished by providing physically separate sleeping areas and by ensuring that different age groups' activities are scheduled for treatment areas and common areas, i.e. dining room, dayroom, and in- and outside recreation areas, at different times. If adults (18 years of age and older), children and adolescents are receiving services in the same building, the facility must ensure complete physical separation between adults and children/adolescents.

Facility-Based Crisis Service components include:

- a. assessments and evaluation of the condition(s) that has resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs;
- b. intensive treatment, behavior management support and interventions, detoxification protocols as addressed in the individual's treatment plan;
- c. assessments and treatment service planning that address each of the individual's primary presenting diagnoses if the child is dually diagnosed with mental health and substance use disorders or mental health or substance use with a co-occurring intellectual or developmental disability, with joint participation of staff with expertise and experience in each area;
- d. active engagement of the family, caregiver or legally responsible person, and significant others involved in the child's life, in crisis stabilization, treatment interventions, and discharge planning as evidenced by participation in team meetings, collaboration with staff in developing effective interventions, providing support for and input into discharge and aftercare plans;
- e. stabilization of the immediate presenting issues, behaviors or symptoms that have resulted in the need for crisis intervention or detoxification;
- f. monitoring of the individual's medical condition and response to the treatment protocol to ensure the safety of the individual; and

- g. discharge planning.

Discharge planning begins at admission and shall include the individual, legally responsible person and the Local Management Entity/Managed Care Organization (LME/MCO).

Discharge planning includes the following:

1. arranging for linkage to a higher level of care as medically necessary;
2. arranging for linkage to new or existing community based services that will provide further assessment, treatment, habilitation or rehabilitation upon discharge from the Facility-Based Crisis service;
3. coordination of aftercare with other involved providers, including the child's Primary Care Practitioner and any involved specialist for ongoing care of identified medical condition;
4. contact for re-entry planning purposes with the child's school or local school or Local Educational Authority as indicated.
5. identifying, linking to, and collaborating with informal and natural supports in the community; and
6. developing or revising the crisis plan to assist the individual and their supports in preventing and managing future crisis events.

1.1 Definitions

Children are defined as individuals 6 years of age through 11.

Adolescents are defined as individuals 12 years of age through 17.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

An eligible individual shall be enrolled with the LME-MCO on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

2.1.2 Specific

For state funds, an individual, 6 years of age through 17, is eligible for Facility-Based Crisis for Children and Adolescents. Individuals ages 18 and above are eligible for Facility-Based Crisis for Adults facilities.

3.0 When the Service Is Covered

3.1 General Criteria Covered

State funds shall cover the service related to this policy when medically necessary, and:

- a. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the individual's needs;
- b. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the service is furnished in a manner not primarily intended for the convenience of the individual, the individual's caregiver, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered for State Funds

State funds shall cover Facility- Based Crisis Service for children and adolescents when the individual:

- a. has a Mental Health, or Substance Use Disorder diagnosis or Intellectual or Developmental Disability as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or any subsequent editions of this reference material based on the designation of the facility;
- b. meets American Society of Addiction Medicine (ASAM) Level 3.7 criteria as found in the current edition, if the child's primary admitting diagnosis is a substance use disorder,
- c. is experiencing an acute crisis requiring short-term placement due to serious cognitive, affective, behavioral, adaptive, or self-care functional deficits secondary to the DSM-5 diagnosis (es) which may include, but is not limited to:
 1. danger to self or others;
 2. imminent risk of harm to self or others;
 3. psychosis, mania, acute depression, severe anxiety or other active severe behavioral health symptoms impacting safety and age level appropriate functioning;
 4. medication non-adherence;
 5. intoxication or withdrawal requiring medical supervision, but not hospital detoxification; and
- d. has no evidence to support that alternative interventions would be equally or more effective, based on current North Carolina community practice standards (such as Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, and American Society of Addiction Medicine) and
- e. the individual has been determined to have no acute medical/psychiatric condition that requires a more intensive level of medical/psychiatric monitoring and treatment.

3.2.2 Continued Service Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time-frame outlined in the individual's service plan or the individual continues to be at risk for relapse based on history or the tenuous nature of the functional gains or ANY of the following applies:

- a. the individual has achieved initial service plan goals and additional goals are indicated;
- b. the individual is making satisfactory progress toward meeting goals;

- c. the individual is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the individual's pre-crisis level of functioning are possible or can be achieved;
- d. the individual is not making progress; the service plan must be modified to identify more effective interventions; or
- e. the individual is regressing; the service plan must be modified to identify more effective interventions.

3.2.3 Discharge Criteria

The individual meets the criteria for discharge if one of the following applies:

- a. The individual has improved with respect to the goals outlined in the service plan and
 - 1. goals have been achieved or
 - 2. the child has regained pre-crisis level of functioningAND
 - 3. discharge to a lower level of care is indicated.
- b. The individual is
 - 1. not benefiting from treatment or
 - 2. not making progress in treatment or
 - 3. is regressingAND
 - 4. all realistic treatment options with this modality have been exhausted.

For individuals receiving state funded services who are new to the enhanced MH/DD/SAS service delivery system, a completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

3.2.4 Exception

Per General Statutes 122C-261(f), 122C-262(d), and 122C-263(d)(2), 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 are determined by the Director of the Division of MH/DD/SAS or designee.

4.0 When the Service Is Not Covered

4.1 General Criteria Not Covered

State Funds shall not cover the service related to this policy when:

- a. the individual does not meet the eligibility requirements listed in **Section 2.0**;

- b. the individual does not meet the criteria listed in **Section 3.0;**
- c. the service duplicates another provider's service; or
- d. the service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered State Funds

State funds shall not cover Facility-Based Crisis Service delivered to a child or adolescent stepping down from an inpatient level of care including a psychiatric residential treatment facility.

Note: State funds and Community Mental Health Block Grant funds outside of UCR may be used to support an individual who is an inmate in a public correctional institution. Substance Abuse Prevention and Treatment Block Grant funds may not be used for this purpose.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Individuals receiving state-funded services must have authorization for all units of Facility-Based Crisis Services for Children and Adolescents.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit authorization requests for individuals meeting criteria for a state-funded Benefit Plan to the LME-MCO.

The authorization process ensures that the level of the service is appropriate and continued reviews 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.

5.2.2 Specific

The authorization request must comply with the following provisions:

- a. The authorization request must be submitted within two business days of admission; and
- b. The request must include all health records and any other records that confirm the individual has met the specific criteria in Subsection 3.2 of this policy.

5.3 Entrance Process

Involuntary evaluations and admissions must be processed in compliance with NC General Statute 122C-Article 5, Part 7.

For state-funded Facility-Based Crisis Service, a service order is required on the date of admission. A verbal order is acceptable; it must be received by a Registered Nurse and must be signed within 2 business days. The service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice, and must include a statement indicating that the service is medically necessary. The service order must be based on an individualized assessment of the individual's needs.

The following assessments and evaluations are required:

- a. A pre-admission nursing screen conducted by an assessment by a Registered Nurse to determine medical appropriateness for this level of care to rule out acute or severe chronic co-morbidities or medical conditions, such as brittle diabetes, pending birth of a child, uncontrolled seizures, that require or could potentially require complex medical intervention in a higher level of care.
 - b. Following admission, the RN must complete a nursing assessment within 24 hours of admission to follow up on any medical needs identified in the screen that did not preclude admission to the facility.
 - c. An onsite psychiatric evaluation must be completed by the psychiatrist within 24 hours of admission;
 - d. A clinical assessment at the time of admission to include:
 1. the individual's presenting problem(s);
 2. the individual's needs and strengths;
 3. a provisional or admitting diagnosis(es), with an established diagnosis(es) prior to discharge;
 4. a pertinent social, family, and medical history; and
 5. recommendations for other evaluations or assessments as appropriate.
1. A comprehensive clinical assessment (CCA) documenting medical necessity must be completed by a licensed professional prior to discharge as part of the provision of this service. The CCA must be in compliance with the requirements of the Division of Medical Assistance Clinical Coverage Policy 8C and also address the following:
 - A. screening for trauma exposure and symptoms related to that exposure and recommendations for interventions.
 - B. detailed assessment of the presenting problem(s), including input from other licensed professionals if the child is dually diagnosed;
 - C. review of any available prior assessments, including functional behavior analyses; and
 - D. recommendations for any needed community services or supports to prevent future crises.
 2. 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 and in the development of the comprehensive clinical assessment required upon admission.

At a minimum, the licensed professional in coordination with all other appropriate clinical staff, the nursing staff, the individual receiving services, and the legally responsible person shall develop a treatment plan and a crisis plan to direct treatment and

interventions during the admission. During the course of the Facility-Based Crisis admission, the treatment plan must be modified as clinically indicated.

For an individual receiving state-funded Facility-Based Crisis services, the Facility-Based Crisis Service provider shall contact the LME-MCO to determine if the individual is currently enrolled with another service provider agency that has first responder responsibilities or if the individual is receiving care coordination. If the individual is not already linked with a care coordinator, a referral should be made to the LME-MCO for care coordination. These contacts must occur within 24 hours of admission into Facility-Based Crisis Service.

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

Relevant diagnostic information must be obtained and included in the individual's service plan.

5.4 Expected Clinical Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from the individual's clinical assessment and to meeting the identified goals that assist the individual and his or her supports in:

- a. reduction of acute psychiatric symptoms that precipitated the need for this service;
- b. reduction of acute effects of substance use disorders with enhanced motivation for treatment or relapse prevention;
- c. stabilizing or managing the crisis situation;
- d. preventing hospitalization or other institutionalization;
- e. accessing services as indicated in the comprehensive clinical assessment; and
- f. reduction of behaviors that led to the crisis.

5.5 Documentation Requirements

Refer to DMH/DD/SAS *Records Management and Documentation Manual* (<http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf>) 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, dated, and signed by the person(s) who provided the service. Documentation should reflect progress made in relation to the discharge plans or service plan for the individual receiving services. Each full service note must contain:

- a. individual's name;
- b. service record number;
- c. service provided (such as Facility-Based Crisis Service);
- d. date of service;
- e. type of contact (face-to-face, telephone call, collateral);
- f. purpose of the contact;
- g. description of the provider's interventions, specifying the relationship of the intervention to the problems and goal(s) identified in the treatment plan;
- h. amount of time spent performing the interventions;

- i. description of the effectiveness of the interventions; and
- j. signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature).

Additional Documentation requirements:

The following plans must be documented and included in the service record, and a copy given to the individual (and the legally responsible person as appropriate) and the LME-MCO.

- a. A treatment plan that includes the goal(s), objectives, treatment interventions and the individual responsible for carrying out the intervention.
- b. A discharge plan that includes the identification of the individual's responsible person; the date, time and location of first follow up appointment, diagnosis and discharge medications; living and educational or vocational arrangements
- c. An after care plan that addresses the current treatment and care coordination needs and specifies the behavioral health services to be provided, the service provider's name, address and contact information and the child's primary care physician's name, contact and follow up visit(s), where indicated.
- d. A crisis plan developed in partnership with the individual, his or her legally responsible person, and the community based treatment provider if one exists, that includes informal and formal supports and interventions to divert any readmission into a crisis setting.
- e. A completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.
- f. Documentation of the psychiatric, psychological, comprehensive clinical, and nursing assessments must be documented in the service record no later than 24 hours from the time the assessment was conducted.

5.6 Utilization Management

For state-funded Facility-Based Crisis Service, prior approval and continued stay reviews, if indicated, are required for this service. The initial prior approval process ensures that the level of the service is appropriate and continued reviews 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.

5.7 Service Exclusions/Limitations

Any other service provided after admission to and before discharge from Facility-Based Crisis shall be coordinated with Facility-Based Crisis Service for the purpose of transition into and discharge from the service and must have prior authorization.

State funds shall not cover Facility-Based Crisis Service for more than 30 calendar days in a 365 consecutive day period.

6.0 Provider(s) Eligible to Bill for the Service

To be eligible to bill for the service related to this policy, the provider(s) shall:

- a. meet LME-MCO qualifications for participation;

- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

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

- a. 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
- b. meet the requirements under 10A NCAC 27G.

This service must be provided in a facility licensed by the Division of Health Services Regulation, under the provisions in NCGS 122c: Mental Health, Developmental Disabilities and Substance Abuse Act, by meeting all standards required for licensure as a mental health facility and Facility-Based Crisis service as provided for in 10A NCAC 27G .5000.

A Facility-Based Crisis Service provider shall meet the criteria for and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC Subchapter 26C Section .0100.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO for state funded services. Additionally, within one year of enrollment as a provider of this service with the LME-MCO, the organization must achieve national accreditation with at least one of the designated accrediting agencies approved by DHHS. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of Provider Credentialing, DMH/DD/SAS Bulletins, and service implementation standards.

For state-funded services, the organization shall be responsible for obtaining authorization from the LME-MCO for medically necessary services (refer to **Subsection 5.2.2**).

In partnership with the LME-MCO for individuals receiving state funded services, the Facility-Based Crisis Service provider organization shall collaborate with relevant community stakeholders for access to services, care coordination, and continuity of care.

6.2 Staffing Requirements

The facility shall be staffed at a minimum of:

- a. 0.5 FTE Medical Director who is a board-eligible or board certified Child Psychiatrist. If a provider is unable to hire a board eligible or board certified Child Psychiatrist, the provider must seek an exception, with justification, from the LME-MCO. The exception request, with accompanying updated justification, must be requested on an annual basis. A psychiatrist shall be available 24 hours a day, 7 days a week, 365 days a year (this includes the required on call availability). The psychiatrist shall provide clinical oversight of the Facility- Based Crisis Service. The psychiatrist shall conduct a

psychiatric assessment of each individual on site within 24 hours of admission. The psychiatrist shall provide onsite consultation to and supervision of staff. When providing face to face evaluation and management services, additional psychiatric evaluations (excluding the initial evaluation) and other therapeutic service to individuals, the psychiatrist may bill separately.

- b. 0.5 FTE Licensed Practicing Psychologist with a minimum of two years' experience in the treatment of children and adolescents with Intellectual/Developmental Disabilities. The psychologist must provide onsite behavioral assessment, observation and service planning within 24 hours of admission for individuals with IDD. The psychologist must be available for face-to-face in person consultation with staff. The psychologist will also be responsible for conducting other assessments with individuals presenting with mental health or substance use issues as clinically indicated.
- c. Nursing coverage on site 24 hours a day, 7 days a week, 365 days a year must include a Registered Nurse with a minimum of one year crisis service experience with the population to be served. All nursing staff must actively participate in the provision of treatment, monitor the individual's medical progress, and provide medication administration.
- d. One FTE Licensed Professional(s) with a minimum of two years' experience with the population served (at least one year postgraduate) who possesses the knowledge, skills, and abilities to treat co-occurring mental health and substance use disorders; who provides onsite observation, assessment and actively participates in the provision of treatment of individuals with mental health and substance use disorders. The Licensed Professional, with the psychiatrist provides clinical supervision for the program. This position cannot be filled by more than two professionals;

OR

0.5 Licensed Professional with a minimum of two years' experience with the population served (at least one year postgraduate) who possesses the knowledge, skills, and abilities to treat persons with mental health disorders and who provides onsite observation, assessment and actively participates in the provision of treatment, and with the psychiatrist, provides clinical supervision for the program;

and

0.5 Licensed Professional with a minimum of two years' experience with the population served (at least one year postgraduate) who possesses the knowledge, skills, and abilities to treat substance use disorders, who provides onsite observation and assessment, and who actively participates in the provision of treatment, and with the psychiatrist, provides clinical supervision for the program;

Note: A "Licensed Professional" includes both a fully Licensed Professional as well as an Associate Licensed Professional who meet the experience and knowledge, skills and abilities to assess and treat the population served in the Facility-Based Crisis-Child setting.

- e. Additional staff including Licensed Professionals, Licensed Practical Nurse, Qualified Professionals, Associate Professional or Paraprofessionals with disability-specific knowledge, skills, and abilities as required by the age, disability and acuity of the population being served.

The facility-based crisis shall also meet the following staffing provisions:

The Facility-Based Crisis Service provider shall designate an individual who is responsible for the programmatic operations of the facility.

- a. As a facility designated for the custody and treatment of individuals who are involuntarily committed, the facility must have adequate staffing and provide supervision to ensure the protection of the individual to be served. To be designated, the Facility-Based Crisis service must demonstrate:
 1. adequacy of staff capability to manage individuals who are more violent or aggressive ;
 2. adequacy of security procedures including elopement and suicide prevention procedures;
 3. staff training in de-escalation to avoid the use of seclusion and restraint and training in seclusion and restraint policies and procedures;
 4. capacity to increase staffing levels when indicated by the acuity and number of individuals being served; and
 5. appropriate separation of children and adolescents and adequate supervision of individuals who are vulnerable.
- b. A Facility-Based Crisis must be staffed 24 hours a day and must maintain staffing ratios that ensure the treatment, health and safety of individuals served in the facility that includes:
 1. a licensed professional, in addition to the Registered Nurse, must be available 24 hours a day, 7 days a week for on-site admissions;
 2. awake staff-to-individuals receiving services ratio of no less than 1:3 on premises at all times;
 3. a minimum of two awake staff on premises at all times; and
 4. the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individuals receiving services.
- c. At no time when a Facility-Based Crisis staff member is actively fulfilling his or her Facility-Based Crisis Service role may he or she contribute to the staffing ratio required for another service.
- d. Therapeutic interventions are implemented by staff under the direction of a Licensed Professional.
- e. At least one Licensed Professional providing Facility-Based Crisis Service shall demonstrate competencies in crisis response and crisis prevention. At a minimum, the licensed professional shall have a minimum of one year's experience in a crisis management setting or service, during which the individual provided crisis response (e.g., serving as a Mental Health or Substance Use Disorder first responder for enhanced services, in an emergency department, or in another service providing 24 hours a day, 7 days a week response in emergent or urgent situations).
- f. All staff providing Facility-Based Crisis Service shall complete a minimum of 20 hours of training specific to the required components of the Facility-Based Crisis Service definition, including crisis intervention strategies applicable to the populations served, impact of trauma and Person-Centered Thinking, within the first 90 calendar days of each staff member's initial delivery of this service. All staff providing Facility-Based Crisis Service shall complete a minimum of 10 hours of training per year relevant to

their professional discipline and job responsibilities. These trainings could include de-escalation, seclusion and restraints, developmental disorders, children's development, substance use disorders, family systems, etc.

6.3 Provider Certifications

See provider requirements in **Subsection 6.1**.

7.0 Additional Requirements

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMH/DD/SAS's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Service Requirements

- a. A Facility-Based Crisis Service is a 24-hour service that is offered seven days a week. This service must accept admissions on a 24 hours a day, 7 days a week, and 365 days a year basis. The staff to individual receiving services ratio must ensure the treatment, health and safety of all individuals served in the facility and comply with 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time Out and Protective Devices Used for Behavioral Control. A Facility-Based Crisis Service provider shall meet the criteria and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC 26C .0100.
- b. Due to the high levels of exposure to trauma and toxic stress, the Facility-Based Crisis Service staff shall create a sense of psychological and physical safety through:
 1. Training of staff in behavior management techniques and trauma informed care;
 2. Programming that creates routines of predictability and calm; and
 3. Screening for exposure to traumatic events and any symptoms related to that exposure.
- c. All individuals shall be seen by the psychiatrist on site within 24 hours of their admission to the Facility-Based Crisis Service. An individual receiving services shall receive a nursing assessment by the RN as follow up to the pre-admission screen and a full comprehensive clinical assessment by a licensed professional prior to discharge. An individual with Intellectual or Developmental Disabilities shall be seen by the psychologist on site within 24 hours of their admission to the Facility-Based Crisis Service.
- d. The service must be under the supervision of a psychiatrist, and a psychiatrist shall be on call on a 24-hour per day basis.
- e. The Facility-Based Crisis Service must address the chronological age and developmental functioning of the population served to ensure safety, health and appropriate treatment interventions within the program milieu.

- f. Interventions should be related to goals of crisis stabilization and connecting individuals receiving services and their families to effective services in the community.
- g. When medically necessary, the Facility-Based Crisis Service must make a referral to a service providing an appropriate level of care if the individual's needs exceed the service capabilities.
- h. All staff who provide substance use disorder treatment interventions shall be registered with the North Carolina Substance Abuse Professional Practice Board in accordance with the North Carolina Practice Act (G.S. 90-113.30).
- i. For an individual requiring detoxification, the Facility-Based Crisis Service must have procedures and protocols in place to initiate detoxification. When a higher level of detoxification is medically necessary, the Facility-Based Crisis Service 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.
- j. For an individual who is new to the enhanced Mental Health, Developmental Disabilities, Substance Abuse (MH/DD/SAS) service delivery system, Facility-Based Crisis Service staff shall develop an aftercare plan that includes a detailed crisis plan with the individual and his or her family, caregiver or legally responsible person before discharge. For an individual who is currently enrolled in another enhanced service, the Facility-Based Crisis Service 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. A copy of the Crisis Plan must be submitted to the individual's LME-MCO. A copy of the plan must be submitted to all providers, as approved by the parents or guardians involved in the implementation of the plan.
- k. For each individual receiving services, effective discharge planning must include collaboration with the family, caregiver or legally responsible person, their informal and natural supports and the LME-MCO, as well as other agencies involved (such as schools, Social Services, Juvenile Justice, other treatment providers) as appropriate. For an individual who is engaged in receiving services from another community-based provider, the Facility-Based Crisis Service must involve the community based provider in treatment, discharge planning, and aftercare.

8.0 Policy Implementation and History

Original Effective Date: January 1, 2016

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	New policy implementing Facility- Based Crisis Service for Children and Adolescents.
10/15/19	6.2 c. Staffing Requirements	Removed Qualified Professional from nursing experience requirement.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, DMH/DD/SAS bulletins, fee schedules, DMH/DD/SAS's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for state funds:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Ninth Revisions, Clinical Modification (ICD-9-CM) and Procedures

Provider(s) shall report the ICD-9-CM and procedures code(s) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-9 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-9-CM procedure codes, and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)
S9484 HA

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines. The HA modifier is used with HCPCS code S9484 as noted above. HA indicates a child/adolescent program.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). A provider may bill up to 24 units per day, and bill for units of service provided on day of discharge.

Units are billed in one-hour increments.

F. Place of Service

A Facility-Based Crisis Service must be provided in a facility licensed by DHSR under 122C NCGA, per **Subsection 6.1** of this policy, that is available at all times, 24 hours a day, 7 days a week, and 365 days a year. A Facility-Based Crisis Service provider must meet the criteria for and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC 26C .0100.

Each Facility-Based Crisis provider must serve individuals with the following: mental health disorder, substance use disorder, intellectual or developmental disability, and co-occurring disorders

G. Reimbursement

Provider(s) shall coordinate with the LME-MCO regarding billing State funds for Facility-Based Crisis services.

A qualified provider who renders services to an individual meeting DMH/DD/SAS Benefit Plan eligibility shall bill all other third-party payers, including Medicaid, Medicare, before submitting a claim for state funded reimbursement.