

Behavioral Health Urgent Care (BHUC)

Service Definition and Required Components

Behavioral Health Urgent Care (BHUC) is a designated service for individuals four (4) years or older experiencing a behavioral health crisis related to a substance use disorder, mental health disorder, and/or I/DD diagnosis or any combination of the above. A BHUC is designed to provide triage, crisis risk assessment, evaluation and intervention to individuals whose crisis response needs are deemed to be urgent or emergent. A BHUC is an alternative, but not a replacement, to a community hospital Emergency Department (ED). Individuals receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care.

A Behavioral Health Urgent Care can either be identified as a Tier III or a Tier IV.

A Tier III BHUC has operational hours of at least 12 hours per day 7 days a week, 365 days a year. At least 6 operational hours must occur after 4:00 PM each day.

A Tier IV BHUC is open 24 hours a day, 7 days a week, 365 days a year.

Both Tier III and Tier IV BHUC settings must be able to provide at a minimum the following:

- Involuntary Commitment First Evaluations capable (IVC)
- Crisis/Risk Assessment
- Physical Health Screening/Medical Screenings
- Clinical Evaluation
- Psychiatric services
- Referrals and case management
- Disposition & discharge planning
- Inclusion of family or natural supports (as available, with consent).

Treatment Program Philosophy, Goals and Objectives

BHUC offers a safe alternative and diversion from the use of hospital emergency departments to address the needs of individuals experiencing behavioral health crises. A BHUC is a service containing Triage, Crisis Assessment, Interventions, Disposition and Discharge Planning.

Triage

Triage consists of an intensity of needs screening to be initiated within 15 minutes of arrival. During the triage process releases of information will be completed to obtain any needed information from supports and/or community providers. This screening will result in a behavioral health urgency determination status of routine, urgent or emergent and may determine the need for emergency medical attention. Only those meeting criteria for *urgent* or *emergent* are eligible for this BHUC

service. If an individual is screened and is determined to be routine, they will be referred to a community-based service provider for follow up.

A BHUC *urgent* determination status is defined in instances where the individual presents with moderate risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to a MH/IDD/SU diagnosis; as moderate symptoms and distress that may quickly escalate without prompt intervention; thoughts of harm to self or others, acute stressors and symptoms which may include impaired reality testing, self-care, intoxication or withdrawal.

A BHUC *emergent* determination status is defined as imminent danger to harm self or others due to symptoms of mental illness or substance use or any related medical complications; risk to self or others related to behavioral health distress; risk related to safety and supervision, severe incapacitation which may include impaired reality testing, self-care, intoxication or withdrawal.

Assessment

Crisis/Risk Assessment

The Crisis/Risk Assessment is designed to determine nature of crisis and risks associated with presenting concern. The Crisis/Risk assessment should be initiated within 2 hours of arrival at the BHUC. Components of the assessment can be gathered through interactions with all BHUC staff including but not limited to licensed professionals, nursing staff, and psychiatric prescribing professionals, peers, and qualified professionals (peers and QP's within their scope of practice). A licensed clinical professional is required to observe and interview the individual, establish a diagnosis, and compile an evaluation that will drive the services. The following elements must be addressed as part of the crisis assessment:

- a) Description of presenting illness/problem including source of distress, precipitating events and associated problems and symptoms;
- b) Demographic information;
- c) Behavioral health and medical treatment history;
- d) Access LME/MCO and Care Coordination information;
- e) Reason for referral;
- f) Comprehensive Risk assessment/status;
- g) Current medications;
- h) Medical Screening including biometric data (vitals: pulse, blood pressure, height and weight);
- i) Current medical status and any need for emergency medical treatment;
- j) Breathalyzer or urine drug screen as indicated;
- k) Biopsychosocial information;
- l) Mental Status Exam;
- m) Level of Care Determination including ASAM level of care;
- n) Establishment of a Diagnosis that will be the subject of treatment (may be Provisional or Differential Diagnosis);

- o) Use of specialty assessments using validated, standardized instruments (i.e.- Suicide Risk Assessment, Clinical Institute Withdrawal Assessment for Alcohol/CIWA-A rev., etc.) within the scope of practice for the individual conducting the assessment;
- p) Initial disposition.

Intervention

Interventions include strategies and actions for the purposes of providing crisis de-escalation, assessment, therapeutic interventions and supports. The following interventions may be applied:

- a) Conduct ongoing safety, crisis and specialty assessments'
- b) Administer crisis de-escalation interventions;
- c) Ability to perform overdose reversal;
- d) Initiate or continue medication management;
- e) Monitor ongoing medical status and any need for emergency medical treatment;
- f) Facilitate individual psychoeducation activities;
- g) Educate on voluntary admissions versus IVC;
- h) Complete first evaluations to initiate, uphold or release from the IVC process;
- i) Plan in place to address modifiable risk factors;
- j) Educate individuals about Psychiatric Advance Directives (PAD).

Disposition and Discharge Planning

Discharge from BHUC

- a) The Crisis has resolved and the BHUC staff has completed all components of the Disposition and Discharge Planning section (see below) the individual and the BHUC staff agree and arrange for outpatient services as a follow up within 7 calendar days;
OR
- b) It has been determined that inpatient care is needed and there is a bed available, either voluntarily or through IVC;
OR
- c) Consent for treatment is withdrawn and the individual does not meet criteria for IVC;
OR
- d) The individual's medical and/or behavioral health condition indicates the need to transfer to a higher level of care; i.e., an Emergency Department.

Discharge Planning

Disposition and Discharge Planning is provided to ensure the individual served through BHUC is linked to the least restrictive and most appropriate level of care. Disposition coordination and discharge planning from BHUC includes the use of person-centered strategies and processes that:

- a) Provide education and information regarding community services and resources;
- b) Facilitate engagement of natural supports;
- c) Communicate with LME/MCO Care Coordination and/or other care management entities;
- d) Communicate with current community providers, including primary care and/or make referrals with written consent;
- e) Provide a discharge plan that includes safety and aftercare instructions, including appointments and point of contact with contact information for agencies and medication instructions. A copy of this is to be placed in the individuals record;
- f) Arrange admissions to psychiatric hospitals, Facility Based Crisis, emergency departments, or other clinically appropriate services;
- g) Assistance with housing and transportation;
- h) Provide education and linkage to medication assistance;
- i) Develop and revise individual crisis plan;
- j) If individual expresses interest, refer her/him to facilitator to develop PAD.

Upon discharge from BHUC individuals will be provided with written discharge instructions including information such as medications, community resource referrals, and scheduled appointment date, time and location.

If the individual is at a Tier IV BHUC and it is determined that there is a need for admission to a community hospital or an FBC and there is no immediate bed available (within two (2) hours) the individual will be placed into Observation status. See Observation section below.

OBSERVATION

Observation is designed to provide ongoing evaluation and stabilization of individuals in crisis. Observation status is only available to Tier IV BHUC's. Individuals meeting the following criteria can be eligible for observation services:

- A. Continued supervision and assistance with the de-escalation of the crisis could result in the avoidance of unnecessary hospitalization or higher level of care;
OR
- B. Continued assessment is needed to determine the clinically appropriate level of care;
OR
- C. Awaiting placement to a clinically appropriate higher level of care (inpatient/FBC) and there is no immediate bed available (within two (2) hours).

A voluntary individual is able to stay in Observation for a maximum length of stay of 23 hours and 59 minutes (23:59). Individuals that meet medical necessity for IVC can be held in observation beyond the 23 hours and 59 minutes under NC 112C-263.2. During this time the individual is continuously being assessed for the need of continued stay or determination that the crisis has been resolved, and the person is able to return independently to the community with follow up services.

Prior to determination of Observation status, the individual must have all components of the BHUC assessment completed. Each BHUC must have policies and procedures in place for observation status that clearly identifies the on-going continued assessments that will be completed, and the time frames that the specific assessments will be completed within.

Discharge from Observation

- A. The Crisis has resolved and the BHUC staff has completed all components of the Disposition and Discharge Planning section (see page three) the individual and the BHUC staff agree and arrange for outpatient services as a follow up within 7 calendar days;
- OR
- B. It has been determined that inpatient care is needed and there is a bed available. either voluntarily or through IVC;
- OR
- C. Consent for treatment is withdrawn and the individual does not meet criteria for IVC;
- OR
- D. The individual's medical and/or behavioral health condition indicates the need to transfer to a higher level of care; i.e., an Emergency Department.

Upon discharge from BHUC individuals will be provided with written discharge instructions including information such as medications, community resource referrals, and scheduled appointment date, time and location.

Any of the following criteria may exclude admission to Observation Status:

- Medical instability
- Behavioral/psychiatric or withdrawal symptoms determined to require a higher level of care
- Referral/determination of individual inappropriateness of 23-hour chairs

Provider Requirements

Behavioral Health Urgent Care services must be delivered by practitioners employed by mental health or substance use provider organizations that meet the requirements of 10A NCAC 27G, the provider qualification policies, procedures, and standards established by the Department of Health and Human Services. 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 and contracted by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing and contracting process, DMH/DD/SAS Joint Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

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

**State-Funded Behavioral Health Urgent Care
(BHUC)
Effective Date: February 1, 2020**

Providers of Behavioral Health Urgent Care services should utilize any tools, training, documents, forms, and learning opportunities provided by the Department of Health and Human Services.

Staffing Requirements

At a minimum a fully Licensed Clinician per 10A NCAC 27G .0104 (cannot be a Licensed Clinical Addictions Specialist-LCAS), must be onsite during all operational hours for a Tier III BHUC and onsite for a minimum of 16 hours per day for a Tier IV BHUC. All BHUCS must have licensed staff available during all hours of operation to complete crisis assessments or IVC evaluations when deemed medically necessary. Tele-Health can be utilized for services provided by fully licensed staff for up to 8 hours per day at a Tier IV BHUC to the degree that is allowable under the LME-MCO's Tele-Health Policy. In addition, Tele-Health, to the degree allowable under the LME-MCO's Tele-Health Policy, can be used to provide access to additional fully licensed staff at any time to assist with high patient volume. The assessment and diagnosis must be completed by the licensed clinician.

At a minimum, a qualified nursing staff (registered nurse or licensed practical nurse) must be onsite during operational hours. The qualified nursing staff must complete the medical screening, biometric assessments, vital signs, coordinate with the prescriber and administer medication as needed.

At a minimum, 1.0 FTE Qualified Professional (for the population served), must be on-site at all times.

At a minimum, 1.0 FTE A Licensed Clinical Addiction Specialist (LCAS or LCAS-A) or a Certified Substance Abuse Specialist (CSAC) must be on staff for the BHUC.

A Certified Peer Support Specialist (CPSS) or additional staff from above may be added as indicated by the volume of need at the BHUC. The use of Tele-psych can be utilized for the need of additional licensed clinicians, with the LME-MCO approval, for immediate short-term staffing needs.

If a QP or higher with I/DD experience is not on staff, the BHUC must have policies and procedures in place to demonstrate they have access to staff with I/DD expertise during operational hours for case consultation.

Minimum onsite staffing FTE's cannot count towards staffing ratios for other agency programs.

Consultation Staffing

A Psychiatrist, Physician's Assistant who is supervised by a psychiatrist, or a Nurse Practitioner, who meets the criteria outlined under NC Medicaid Clinical Coverage Policy 8C 6.1m, is available either in person for further evaluation/medication assessment or via Tele-Health, to the degree that is allowable under the LME-MCO's Tele-Health Policy, for consultation during the times that the BHUC is operating.

Staffing Qualifications, Credentialing Process, and Levels of Supervision Required

Staff Competencies and Training Requirements

All BHUC staff must be trained in agency new employee orientation and all applicable core competencies as required by state, LME/MCO or provider agency policies. Unless included in the below mentioned

standard training materials, staff shall also be educated in an LME/MCO or provider-based curriculum to include the following within the first 90 calendar days of employment: Refer to below training grid.

Training Requirements

All BHUC staff shall be trained according to the following training schedule:

- a. Within 30 days of hire to provide BHUC services or within 30 calendar days of the effective date of this policy all staff shall complete the following training requirements:
 1. BHUC service definition required components (three hours);
 2. Crisis Response training (three hours);
 3. Trauma Informed Care (three hours); and
 4. Medication Assisted Treatment (three hours).
- b. Within 90 days of hire to provide this service, or within 90 calendar days of the effective date of this policy ALL BHUC staff shall complete the following training requirements:
 1. Motivational Interviewing (six hours) and
 2. Special population training based on staff experience and training needs (mental health, substance use disorder, I/DD, geriatric, traumatic brain injury, deaf and hard of hearing, children and pregnant women. Six hours).
- c. A minimum of 10 hours of continuing education relevant to the services offered and/or the population served at the BHUC must be completed annually.

These initial training requirements may be waived if the employee can produce written documentation certifying their successful completion of the required trainings within the past 12 months.

Team members shall have a minimum of one year of experience in a crisis management setting or service during which the individual provided crisis response (such as by serving as a mental health/substance abuse first responder for enhanced services, MCM, in an emergency department, or in another service providing 24/7 response in emergent or urgent situations).

Consultation staff do not require the above trainings.

Administrative and Clinical Supervision Requirements

All staff that provide services within a BHUC must have administrative oversight and clinical supervision as required by agency policy or licensure board requirements.

Staff will receive clinical supervision by a fully licensed professional. Written clinical supervision agreements will be developed as required per discipline based on 10A NCAC 27G .0104. A prescriber preferably a psychiatrist, will be available 24/7/365 for consultation.

Each BHUC is required to have policies and procedures in place that indicates the initiation and progress of treatment post triage for individuals screened as urgent and emergent. All BHUC's will also have policies and procedures that outline:

- Referrals with area urgent, cares, medical offices and/or Emergency Departments for further medical assessments as indicated.

- Agreements with Facility Based Crisis Centers, Non-Hospital Medical Detox Centers, Community Inpatient Psychiatric Hospitals, ADATC and State Psychiatric Hospitals for the transfer of appropriate individuals including arrangements for transportation to the named facilities.
- Evaluating individuals for Substance Use withdrawal.
- The self-administration of an individual's medications including procedures for securing the medication while the individual is on-site including the continues access for individuals on Medication Assisted Treatment.
- The safety and security of the individuals served, and staff and should incorporate the use of CIT training for personnel when available.
- The process for admission and discharge from observation status in Tier IV BHUC's.

Documentation Requirements

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

The minimum standard is a service note for each contact, service event, or intervention that includes the required elements outlined in the *Manual*.

Service note must include the following:

- a. Individual's name;
- b. Record identification number;
- c. Date of the service provision;
- d. Name of service provided (e.g. BHUC, Observation);
- e. Purpose of the contact;
- f. Description of the intervention provided. Documentation of the intervention must accurately reflect intervention(s) for the duration of time indicated;
- g. Duration of service, amount of time spent performing the intervention;
- h. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goals;
- i. Date and signature and credentials or job title of the staff member who provided the service; and
- j. Each service note page must be identified with the individual's name and service record number.

Service Exclusions and Limitations

- a) BHUC is not a step-down service for inpatient/FBC discharge and does not count as a follow up appointment upon discharge.
- b) BHUC is not for routine follow up for medication management and cannot administer routine injectable medications (IM).
- c) BHUC is not to replace first responder services for enhanced services.
- d) BHUC is not to replace Mobile Crisis Management (MCM) nor to be used as a diversion from MCM.

- e) BHUC is not to be billed at the same time as other services.

Expected Outcomes

- Individuals will be triaged, and a level of urgency will be determined within 15 minutes of entering the BHUC for services.
- Individuals will receive services and supports at the BHUC that reduce the potential Emergency Department admission.
- Individuals will be linked to clinically appropriate community-based services to decrease the recurrence of crisis.
- Individuals will be linked to a higher level of care when clinically indicated.
- At least 75% of members seen will receive the full crisis assessment which will include – at a minimum – initial screening for health and safety, assessment by a nurse for any potential medical concerns, assessment by a licensed clinician and/or psychiatrist that includes assessment of safety to return to a community setting and intervention detailed in this service definition. Some members may need diversion to emergency medical attention or leave Against Medical Advice (AMA), but this should be the exception.
- BHUC staff will attempt to follow up with 100% of individuals discharged from the BHUC back into the community via phone within five (5) calendar days of the service ending.

Tier III and Tier IV BHUC’s will complete a tracking tool, provided by NC DMH/DD/SAS to document outcomes. The completed tracking data must be provided to NC DMH/DD/SAS by the 15th of the month following the end of the quarter.

Policy Implementation and History

Original Effective Date: February 1, 2020

History:

Date	Section or Subsection Amended	Change

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (837P transaction)

All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 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), 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)	Billing Unit
T2016-U5 (without Observation)	1 unit = 1 event
T2016-U8 (with Observation)	1 unit = 1 event

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 U5 modifier is used with HCPCS code T2016 for a BHUC event without observation and U8 is used with HCPCS code T2016 for a BHUC event with observation.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Units are billed as an event.

LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their network providers' adherence to service guidelines to assure quality services for individuals.

F. Place of Service

Office and clinics as clinically indicated.

G. Co-payments

None

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

Note: DMH/DD/SAS will not reimburse for conversion therapy.