72 HOUR PRESUMPTIVE ELIGIBILITY PROGRAM

Mental Health Crisis Stabilization Program administered by the

Addictive and Mental Disorders Division (AMDD)

June 2016

PROGRAM OVERVIEW

- 2-year funding from Legislature
- Develop community mental health crisis services
- Services for adults (18 years and older)
- “Presumptive eligibility” of individuals experiencing a psychiatric crisis
- Medically necessary crisis stabilization services up to 72 hours

Definition of a Crisis

The following definition must be used to determine eligibility for crisis stabilization services:

" a serious situation resulting from an individual's apparent mental illness in which the symptoms are of sufficient severity, as determined by a mental health practitioner, to require immediate care to avoid:

- *jeopardy to the life or health of the individual; or*
- *death or bodily harm to the individual or to others"*

Goals of Crisis Stabilization

- Stabilize the crisis
- Immediately reduce crisis-related symptoms
- Gain diagnostic clarity
- Avoid, when possible, more restrictive care
- Treat symptoms that can be improved within brief period of time
- Arrange **appropriate follow-up care and provide referral**

Goals of Crisis Stabilization

- Observation of symptoms and behavior
- Support or training for self-management of psychiatric symptoms
- Close supervision of the individual
- Psychiatric medications
- Monitoring behaviors after administering medication
- Laboratory services

Provider Goals

- Establish and maintain a cohesive service system
- Ensure that individuals experience coordinated care
- Enhance community based crisis stabilization services in the least restrictive environment possible
- Provide advocacy and support

Client Eligibility

- **Age**: 18 years or older
- **Financial**: NA
- **Eligibility Assessment**: Face-to-face interview by a mental health practitioner
- **Duration**: up to 72 hours from the date/time the crisis evaluation is performed

Eligibility Determination Procedures

Mental health practitioner must:

- Complete face-to-face crisis evaluation
- Determine if individual meets crisis definition
- Complete both pages of the 72 Hour Crisis Stabilization or Crisis Intervention & Response form
- Ensure the 72 Hour form is given to the Crisis Care Manager
- Fax or e-mail form to AMDD Benefits Management Team

Presumptive Eligibility

Presumptive eligibility continues up to 72 hours unless or until:

- The client refuses services
- Crisis is stabilized

Eligibility Determination

The following information is required on the form:

- Mental Health Practitioner
- Client demographic information
- Clinical information
  - Referral source
  - Symptoms and behaviors
  - Assessment of crisis
- Provisional diagnostic formulation
- Signature of mental health practitioner and date

Provider Requirements

- Must be enrolled as a Medicaid provider, or employed or contracted by an enrolled provider

- Providers must complete a 72 Hour Provider Enrollment Addendum that must be approved by AMDD prior to providing services

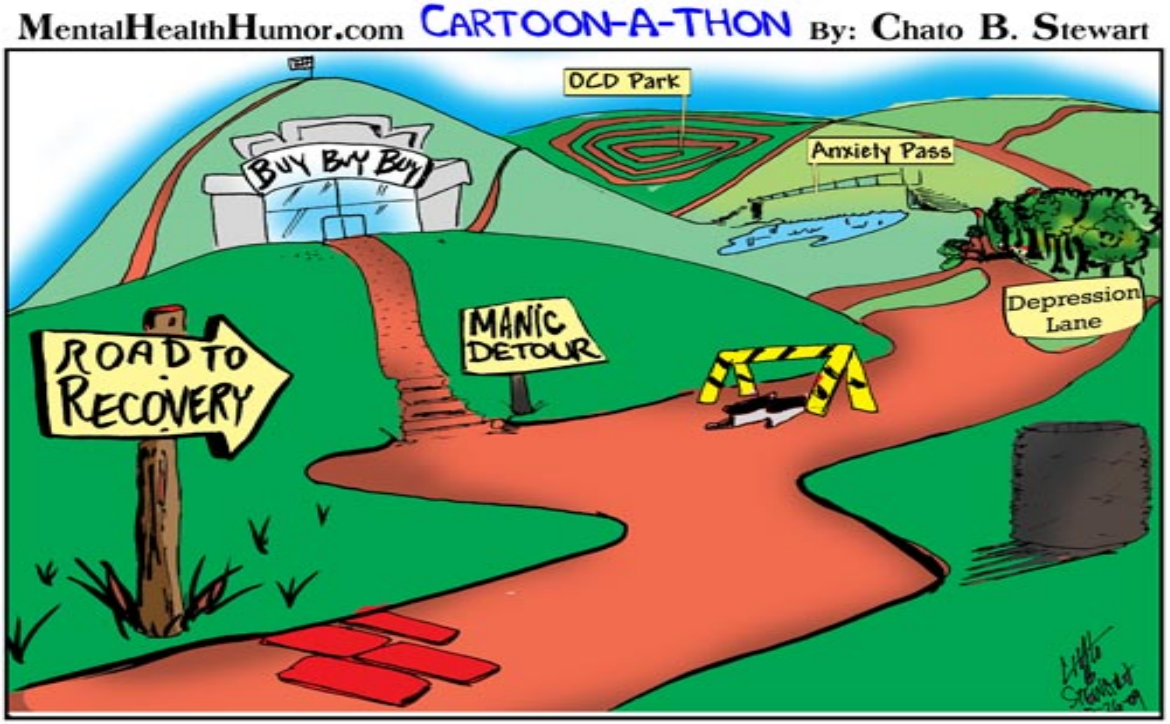
Standards for Provider Participation

- Hire or subcontract with mental health professionals and mental health direct care staff
- Ensure the availability of immediate mental health evaluation and crisis stabilization services
- Ensure staff and subcontractors are trained and skilled in delivery of program services
- Implement appropriate, culturally competent services
- Maintain a thorough knowledge of community resources

Mental Health Practitioner

- Licensed physician
- Licensed professional counselor
- Licensed social worker
- Licensed psychologist
- Licensed psychiatric mental health nurse practitioner or clinical nurse specialist
- Licensed physician assistant with clinical mental health experience

Services



Road To Recovery

June 2016

General Guidelines for Services

- Services must be provided during 72 hour period to eligible individuals experiencing a mental health crisis
- Services must be based on an crisis evaluation by enrolled mental health practitioner
- 72 hour presumptive eligibility period begins with the evaluation
- Crisis stabilization plan must delineate services to be provided during the 72 hour period
- Crisis Care Manager is responsible for monitoring the crisis stabilization plan

Requirements for Crisis Stabilization Plan

- Describe how services are being coordinated if the individual is currently receiving mental health services
- Identify the referral and transition activities to occur at discharge
- Delineate specific responsibilities for implementing the interventions and services

Required Services

- Psychiatric diagnostic interview examination (evaluation)
- Care coordination, arranging for appropriate follow-up care

Covered Services

- Individualized psychiatric emergency interventions and services provided in a safe environment
- Delivered or contracted for by an enrolled provider
- Time limited within the 72 hour period (may extend across 4 days)
- Medically necessary
- Delivered in direct response to the crisis
- Delivered according to the crisis stabilization plan

Covered Services

- Individual psychotherapy
- Family psychotherapy with or without the patient
- Services delivered by a psychiatrist, physician, APRN or PA for identifying psychiatric conditions and/or for medication management
- Crisis management services

All services must be delivered face-to-face, with the exception of care coordination and family therapy.

Services Provided in Detention Facilities

- An eligible individual in protective custody or who is awaiting trial in a detention facility can be offered individual psychotherapy
- Individuals who are serving sentences in detention facilities are NOT eligible for services under the 72 Hour Presumptive Eligibility Program. These individuals are considered an inmate

Services Provided in Detention Facilities

The 72 Hour Presumptive Eligibility Program provides reimbursement for services provided to an individual who is in protective custody or is awaiting trial. These services must include:

- Crisis evaluation, and
- Consultation with detention officers and/or medical staff

Non-Covered Services

Non-Covered Services and Activities

- Services provided to individuals enrolled in Medicaid
- Services that are not medically necessary or not directly related to stabilizing the crisis
- Room and board
- Nursing home services by a nursing home facility
- Strictly medical services

Non-Covered Services and Activities

- Services provided by the same provider within 7 days after a covered 72 hour period of eligibility
- Non-urgent mental health or drug/alcohol treatment services
- Medications
- Services covered by another payment source

Non-Covered Services and Activities

- Services provided by non-enrolled persons or entities
- Services that do not meet service requirements, including staff that do not meet qualifications
- Services provided before or after the 72 hour period
- Inpatient hospital services

Non-Covered Services and Activities

- Outreach activities
- Time spent “on call”
- Activity that is normally billable but total time is less than half of the billable unit
- Activities to complete or perform billing services
- Unavoidable down time

Non-Covered Services and Activities

- Personnel/management activities
- Staff training, orientation and development
- Clinical supervision
- Crisis Intervention and Response (CIR) screenings on medical floor, ICU, etc. of hospitals (screenings can be completed in ER only). Exceptions will be considered on a case by case basis

Billing

Billing Crisis Management Services

- Paid on all-inclusive bundled hourly rate to enrolled hospitals
- Crisis management services provided by trained individuals employed or contracted by enrolled providers
- All services MUST be medically necessary and documented

Billing Crisis Management Services

- Psychiatric diagnostic interview examination/evaluation (limit: two)
- Care coordination
- Individual psychotherapy
- Family therapy with or without the patient
- Services delivered by a psychiatrist, physician, APRN or PA for identifying psychiatric conditions and/or for medication management

Forms

Submittal of Crisis Stabilization Services Report

Submit completed **Crisis Stabilization Services Report** form to AMDD Benefit Management Team within **sixty** (60) days of discharge of the individual

Forms

- 72 Hour Crisis Intervention & Response Program
- 72 Hour Crisis Stabilization Program

- These forms must be filled out completely or they will not be processed

72 Hour Crisis Intervention & Response Program Form

- The Crisis Intervention and Response Program Form will only be used for screenings done by a CIR

- (This form encompasses the next 5 slides)

CRISIS INTERVENTION & RESPONSE PROGRAM
Addictive and Mental Disorders Division - State of Montana

FAX COVER SHEET

DATE Submitted: _____

TO: AMDD Benefit Management Team Telephone: 406-444-3964
Fax: 406-444-7391/secure email: hhsamddmhspwaiver@mt.gov

FROM: Crisis Care Manager: _____

Tel: _____ Fax: _____

Email: _____

RE: Crisis Intervention & Response Program (CIR)

pages (including cover): _____

Instructions:

Please complete the following two pages, and fax or email to the AMDD Benefit Management Team, using this page as the cover sheet.

ONLY USE FOR 72 HOUR CRISIS INTERVENTION AND RESPONSE – This form would only be used for screenings done by a CIR

THIS FORM MUST BE SUBMITTED WITHIN 45 DAYS OF DATE OF SERVICE FOR CIR SERVICES
This form cannot be processed if the information submitted is illegible or incomplete. May 2016

CRISIS INTERVENTION & RESPONSE PROGRAM

Addictive and Mental Disorders Division - State of Montana

CLIENT INFORMATION			
LAST NAME:		**FIRST NAME:**	
ADDRESS:		**CITY:**	**ZIP CODE:**
SSN:	**D.O.B.:**	**COUNTY:**	**GENDER: M ☐ F ☐**
Marital Status: single ☐	married ☐	separated/divorced ☐	domestic partnership ☐
Race / Ethnicity: ☐ Caucasian	☐ Native American	☐ Latino	☐ Unknown

PROVIDER INFORMATION	
Date(s) of Service:	
Mental Health Practitioner Name:	Telephone Number:
CIR Agency & Name:	City:
Telephone Number:	Fax Number:

ELIGIBILITY ASSESSMENT

Does this individual's situation meet the definition of Crisis? **Yes ☐** **No ☐**
If yes - Please specify:

Referral for Crisis Intervention services made by:

☐ Ambulance / EMT	☐ Self	☐ Hospital ER / ED
☐ Family / Friend	☐ Homeless Shelter	☐ Probation / Parole / Prerelease
☐ Law Enforcement	☐ Nursing Home	☐ Crisis Facility / Program

☐ Jail (please specify): ☐ serving criminal sentence ☐ awaiting sentencing ☐ under protective custody
☐ Date of incarceration:

☐ **Other (please specify)**:

THE INDIVIDUAL IS: **☐ AT RISK TO SELF** **☐ AT RISK TO OTHERS**

BECAUSE OF THESE SYMPTOMS & BEHAVIORS

☐ Agitated/Aggressive	☐ Florid Mania	☐ Suicidal -Means/Plan/Intent
☐ Delusions	☐ Hallucinations	☐ **Other (please specify)**:
☐ Disoriented	☐ Homicidal	

OTHER FACTORS: ☐ Domestic Violence ☐ Homeless ☐ Under the influence of alcohol / drugs.
Suspected substance(s): Drug of Choice: Date of Last Use:

PRESENTING ISSUE

☐ Mental Health Issue ☐ Substance Abuse ☐ Co-occurring

CRISIS INTERVENTION & RESPONSE PROGRAM

Addictive and Mental Disorders Division - State of Montana

Mental Health Practitioner Signature:	
RECOMMENDATIONS	
Strengths/Resources/Natural Supports:	
DISCHARGE INFORMATION	
Was this individual the client of a mental health service provider or agency at the time of this crisis? Yes ☐ No ☐	
Discharge To:	**Date of appointment:**

Client refused referrals: ☐	Prescriptions given at discharge: Yes ☐ No ☐	Client refused medication: ☐

Written information provided to (please specify information given and to whom):	
☐ Client:	☐ Family/friend:
☐ Community Supports (i.e., 12 step, religious/spiritual):	
☐ Other (i.e., MD, MHC, OPT, Detention Officer, etc.):	

DISCHARGED TO:			
☐ Acute Inpatient Psychiatric Unit	☐ Home	☐ Homeless Shelter	☐ **Other (please specify):**
☐ Crisis Stabilization Program	☐ Family / friend	☐ Montana State Hospital	
☐ Client left crisis stabilization services against medical advice.			

CIR SERVICES	Agency/Facility/Detention Name:		
DATE & Time In-Time Out:	Units	CIR Code	90832 – Crisis therapy 16-37 min 90839 – Crisis therapy 60 min - *supporting Documentation must be submitted H2011 – Care Coordination
Crisis Care Manager Signature:			Date:

THIS FORM MUST BE SUBMITTED WITHIN 45 DAYS OF DATE OF SERVICE FOR CIR SERVICES

This form cannot be processed if the information submitted is illegible or incomplete. May 2016

72 Hour Crisis Stabilization Program Form

- This Crisis Stabilization Program Form will be used by hospitals and any crisis home where more than 24 hours are spent

- (This form encompasses the next 5 slides)

72-HOUR CRISIS STABILIZATION PROGRAM
Addictive and Mental Disorders Division - State of Montana

FAX COVER SHEET

DATE Submitted: _____

TO: AMDD Benefit Management Team Telephone: 406-444-3964
Fax: 406-444-7391 or Secure Email: hhsamddmhspwaiver@mt.gov

FROM: Crisis Care Manager: _____

Tel: _____ Fax: _____

Email: _____

RE: 72-Hr Crisis Stabilization Program

pages (including cover): _____

Instructions:

Please complete the following two pages, and fax or email to the AMDD Benefit Management Team, using this page as the cover sheet.

Reimbursement is available only for the services/codes listed on the form.

ONLY USE FOR 72 HOUR CRISIS STABILIZATION – This form would be used for hospitals and any crisis home where more than 24 hours are spent.

THIS FORM MUST BE SUBMITTED WITHIN 60 DAYS OF ADMISSION TO CRISIS STABILIZATION SERVICES
This form cannot be processed if the information submitted is illegible or incomplete. May 2016

72-HOUR CRISIS STABILIZATION PROGRAM

Addictive and Mental Disorders Division - State of Montana

CLIENT INFORMATION			
LAST NAME:		**FIRST NAME:**	
ADDRESS:		**CITY:**	**ZIP CODE:**
SSN:	**D.O.B.:**	**COUNTY:**	GENDER: M ☐ F ☐
Marital Status: single ☐	married ☐	separated/divorced ☐	domestic partnership ☐
Race / Ethnicity: ☐ Caucasian	☐ Native American	☐ Latino	☐ Unknown

PROVIDER INFORMATION	
Date of Service:	
Mental Health Practitioner Name:	Telephone Number:
Crisis Stabilization Agency / Facility Name:	City:
Telephone Number:	Fax Number:

ELIGIBILITY ASSESSMENT		
Does this individual's situation meet the definition of Crisis: Yes ☐ No ☐ **If yes - Please specify:**		
Referral for Crisis Stabilization services made by:		
☐ Ambulance / EMT	☐ Self	☐ Hospital ER / ED
☐ Family / Friend	☐ Homeless Shelter	☐ Probation / Parole / Prerelease
☐ Law Enforcement	☐ Nursing Home	☐ Crisis Facility / Program
☐ Jail (please specify):		
☐ **Other (please specify):**		
THE INDIVIDUAL IS: ☐ **AT RISK TO SELF** ☐ **AT RISK TO OTHERS**		
BECAUSE OF THESE SYMPTOMS & BEHAVIORS		
☐ Agitated/Aggressive	☐ Florid Mania	☐ Suicidal -Means/plan/Intent
☐ Delusions	☐ Hallucinations	☐ **Other (please specify):**
☐ Disoriented	☐ Homicidal	
OTHER FACTORS: ☐ Domestic Violence ☐ Homeless ☐ Under the influence of alcohol / drugs		
Suspected substance(s):		

PRESENTING ISSUE		
☐ Mental Health Issue	☐ Substance Abuse	☐ Co-occurring
Mental Health Practitioner Signature & Credentials:		

72-HOUR CRISIS STABILIZATION PROGRAM

Addictive and Mental Disorders Division - State of Montana

CRISIS STABILIZATION PLAN	
Problems:	**Interventions:**
Strengths/Resources/Natural Supports:	

DISCHARGE INFORMATION		
Was this individual the client of a mental health service provider or agency at the time of this crisis? Yes ☐ No ☐		
Referred to Provider/Agency:	**Date of appointment:**	
Client refused referrals: ☐	Prescriptions given at discharge: Yes ☐ No ☐	Client refused medication: ☐
Written information provided to (please specify information given and to whom):		
☐ Client:	☐ Family/friend:	
☐ Community Supports (i.e., 12 step, religious/spiritual):		
☐ Other (i.e., MD, MHC, OPT, Detention Officer, etc.):		

DISCHARGED FROM 72 HR PROGRAM TO:			
☐ Acute Inpatient Psychiatric Unit	☐ Home	☐ Homeless Shelter	☐ **Other (please specify):**
☐ Crisis Stabilization Program	☐ Family / friend	☐ Montana State Hospital	
☐ Client left crisis stabilization services against medical advice.			

The following information will be used to authorize reimbursement.

CRISIS STABILIZATION SERVICES PROVIDED			
Services Began: Date: Time:			**Services Ended:** Date: Time:
PROFESSIONAL SERVICES	**Code**	Units	**Providing Practitioner's Name**
Care Coodination	**H2011**		
CRISIS MANAGEMENT SERVICES		**Agency / Facility Name:**	

Crisis Management Hours	Code	Date	# of Hours
Hours 1 - 24	S9484 U1		
Hours 25 - 48	S9484 U2		
Hours 49 - 72	S9484 U3		

Crisis Care Manager Signature: **Date:**

THIS FORM MUST BE SUBMITTED WITHIN 60 DAYS OF ADMISSION TO CRISIS STABILIZATION SERVICES

This form cannot be processed if the information submitted is illegible or incomplete. May 2016

Submittal of 72 Hour Forms

- Submit completed forms to AMDD Benefit Management Team within sixty (60) days of the individual's discharge
- Send forms by fax to (406) 444-7391 or secure email hhsamddmhspwaiver@mt.gov
- Please allow 2 weeks for AMDD to process requests
- Eligibility will show on the web-portal after 2 weeks if approved

Contact Information

Jo Thompson, Bureau Chief
jothompson@mt.gov or (406) 444-9657

Bernadette Miller, Clinical Manager
bmiller3@mt.gov or (406) 444-3356

Jean Steber, MHS Program Specialist
jsteber@mt.gov or (406) 444-9530


Questions?


Tag By Adena
ThankYou
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