MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Addictive and Mental Disorders Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: July 1, 2020 **Date revised:** July 1, 2020
Policy Number: *450*	**Subject:** Crisis Stabilization Program

Definition

Crisis Stabilization Program is short-term emergency treatment for crisis intervention and stabilization. It is a residential alternative to divert from Acute Inpatient Hospitalization. The service includes medically monitored residential services to provide psychiatric stabilization on a short-term basis. The service reduces disability and restores members to previous functional levels by promptly intervening and stabilizing when crisis situations occur. The focus is on goals for recovery, preventing continued exacerbation of symptoms, and decreasing risk of need for hospitalization or higher levels of care.

(1) "Inpatient crisis stabilization facility" means 24-hour supervised residential treatment of fewer than 16 beds for adults with a mental illness for the purpose of stabilizing the member's symptoms.

(2) "Outpatient crisis stabilization facility" means an outpatient program operated by a licensed hospital or a licensed mental health center that provides evaluation, intervention, and referral for individuals experiencing a crisis due to mental illness or a mental illness with a co-occurring substance use disorder for no more than 23 hours and 59 minutes from the time the member arrives at the program.

Medical Necessity Criteria

Any mental health diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis and at least one of the following:

(1) Dangerousness to self as evidenced by behaviors that may include, but not be limited to any of the following:

(a) self-injurious behavior or threats of same with continued risk without ongoing supervision;

(b) current suicidal ideation with expressed intentions and/or past history of carrying out such behavior with some expressed inability or aversion to doing so, or an inability to contract for safety;

(c) self-destructive behavior or ideation that cannot be adequately managed and/or treated at a lower level of care without risk to the member's safety or clinical well-being; or

(d) history of serious self-destructive or impulsive, parasuicidal behavior with current verbalizing of intent to engage in such behavior, with the risk, as judged by a licensed clinical mental health professional, being significantly above the member's baseline level of functioning.

(2) Dangerous to others, as evidenced by behaviors that may include expressed intent to harm others, current threats to harm others with expressed intentions of carrying out such behavior, with some expressed inability or aversion to doing so.

(3) Grave disability as exhibited by ideas or behaviors, as evidenced by behaviors that may include:

(a) mental status deterioration sufficient to render the member unable to reasonably provide for his/her own safety and well-being;

(b) an acute exacerbation of symptoms sufficient to render the member unable to reasonably provide for his/her own safety and well-being;

(c) deterioration in the member's functioning in the community sufficient to render the member unable to reasonably provide for his/her own safety and well-being;

(d) an inability of the member to cooperate with treatment combined with symptoms or behaviors sufficient to render the member unable to reasonably provide for his/her own safety and well-being, or;

(e) a licensed clinical mental health professional's inability to adequately assess and diagnose a member, as a result of the unusually complicated nature of a member's clinical presentation, with behaviors or symptoms sufficient to render the member unable to reasonably provide for his/her own safety and well-being, but not sufficient to require the intensity of inpatient treatment.

Provider Requirements

Crisis Stabilization Program must be provided by a licensed hospital or licensed MHC and must be approved by the department.

Service Requirements

(1) Crisis Stabilization Program must be billed as a bundled service and includes the following:

(a) 24-hour awake direct care staff;

(b) 24-hour on call licensed clinical mental health professional;

(c) crisis stabilization services;

(d) psychotropic medications administered and monitoring behavior during the crisis stabilization period;

(e) observation of symptoms and behaviors;

(f) case management services;

(g) support or training for self-management of psychiatric symptoms; and

(h) individual, family, or group psychotherapy.

(2) It is not required that each member receiving the Crisis Stabilization Program bundle receive every service listed above. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

Utilization Management

(1) Prior authorization is not required. Admission to Crisis Stabilization Program requires documentation in the member's file of a current DSM or ICD diagnosis, as the primary diagnosis. The member is a danger to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

(2) Continued stay reviews are required for more than eight days in the Crisis Stabilization Program, and will be required every three days thereafter, and may be submitted via Auto-Authorization (Policy 206/206a).

(3) Inpatient crisis stabilization facility must show the following:

(a) Any mental health diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis and all the following:

(i) active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria; and

(ii) a lower level of care is inadequate to meet the member's treatment or safety needs.

(b) In addition to (1) above, either (a), (b), or (c) below:

(i) there is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the inpatient setting;

(ii) there is a high likelihood of either risk to the member's safety, clinical well-being, or further significant acute deterioration in the member's condition without continued care and lower levels of care are inadequate to meet these needs; or

(iii) the appearance of new impairments meeting admission guidelines.

(4) The provider must document in the file of the member that he or she meets the medical necessity criteria.