Carelon NMNC 4.401.09 Mobile Crisis

Mobile Crisis provides onsite assessment and crisis intervention to members in an active state of a behavioral health crisis. The purpose of a Mobile Crisis service is to provide rapid response, assessment, and timely intervention for adults, children/ adolescents and families experiencing a behavioral health crisis.

This service is usually provided 24 hours a day, seven days a week, and the crisis team should be able to meet with the member at the site of the crisis, whether at home, at the workplace, or in other community based settings, in a timely manner. The intervention should include a crisis assessment, de-escalation interventions and, if the member remains in the community after the intervention, the development of a risk management/safety plan.

Optimally, Mobile Crisis teams are comprised of 2 people, to increase safety for responders. One of the responders should be a licensed and/or credentialed clinician, capable of assessing the risk and clinical needs of the individual in crisis. Best practices include the opportunity for peer support in mobile crisis services as well. The specific operations of a Mobile Crisis team need to be tailored to the community in which it operates and the resources available.

If the crisis is able to be deescalated without referral to higher levels of care, and the member is not in treatment at the time of the crisis, then linkage and coordination of services are provided to connect members and their families to other service providers and community supports to assist with maintaining the member's functioning and treatment in the least restrictive, most appropriate setting along the behavioral health continuum of care. If applicable, the Mobile Crisis clinician will coordinate with the member's community providers, primary care physician, behavioral health providers, or any other care management program providing services to the youth or adult, in order to develop a plan tailored to the member's needs. Primary goals of Mobile Crisis services include the prevention of unnecessary emergency department visits, hospitalizations, and involvement of law enforcement. Mobile Crisis Services are typically delivered face-to-face (in person). Telehealth is a consideration depending on acuity of member, the location of the member relative to mobile crisis hubs, state/regulatory requirements, and other clinical considerations.

Admission Criteria

All of the following criteria must be met:

1. Member must be in an acute, emergent, or imminent state of crisis
2. Member must have insufficient or limited resources to cope with the immediate crisis without further assistance at the time of the crisis
3. The crisis has not been resolved by a crisis call center professional (where applicable), outpatient provider or other community intervention
4. Member demonstrates and/or collateral contact(s) report at least one of the following:
    a. suicidal/assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others, **OR**
    b. impairment in mood / thought / behavior that is disruptive to home, school, or the community and is causing dysfunction in daily living, **OR**

   c. Significantly impaired judgment or impulse control as a result of intoxication, psychosis or cognitive disability.
5. Immediate intervention is necessary to attempt to stabilize member's condition safely, and behavior is escalating to the extent that a higher intensity of services will likely be required without this intervention
6. Situation does not present an immediate personal or public safety response, requiring emergency medical services or law enforcement dispatch for transport
7. Member (or member's guardian) is able to engage in evaluation, treatment planning and express understanding of the planned intervention(s)

CONTINUED STAY CRITERIA

Continued stay criteria for this service are met in the following instances:

1. Member's crisis has not stabilized or resolved, OR
2. Referral or placement determined by mobile crisis clinician to be clinically necessary, has not yet occurred.

DISCHARGE CRITERIA

Any *one* of the following criteria must be met:

1. Crisis assessment and other relevant information indicate that the crisis has been stabilized, and member can participate in treatment planning and crisis prevention planning, including referral or planned follow-up with the identified providers/community resources, OR
2. Crisis assessment and other relevant information indicate that member's symptoms and behaviors require a more intense level of care, and that level of care is available and accessible so that member can be released or transferred to an appropriate treatment setting, with a warm hand-off from the Mobile Crisis team, OR
3. Member's physical condition necessitates transfer to an inpatient medical facility and the provider has communicated member risk management/ safety plan to the receiving provider, OR
4. It has been determined that the member (or member's guardian) has the capacity to make an informed decision and consent for treatment is withdrawn, or a court has denied involuntary treatment

EXCLUSIONS

A member's inability or unwillingness to participate in the assessment may result in referral/admission to a higher level of care.

Any *one* of the following criteria is sufficient for exclusion from this level of care:

1. Member is currently under the care of a PACT team
2. Member currently resides at one of the following facilities:
   a. Mental health or substance use disorder residential treatment facility
   b. Inpatient psychiatry unit,
   c. Inpatient detoxification center
   d. Hospital emergency department
   e. Nursing home
   f. Correctional facility

CPT Codes

Northeast 1: H2011-HN, H2011-HO, S9485, S9485HB, S9485HE, S9485U1
MI (Total Health): H2011 Crisis intervention service per 15 min, 90839 Psychotherapy for crisis first 60 min

REFERENCES

Beacon's Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice. In the course of reviewing the criteria annually there is an extensive literature search conducted and each of the following sources are consulted to determine if there is any relevant research or update:

1. Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP); American Association for Emergency Psychiatry (AAEP)
2. National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Behavioral Health Care Guidelines (formerly known as Milliman Care Guidelines); Change Healthcare's InterQual® Behavioral Health Criteria
3. National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4. Professional publications and psychiatric texts:
    - *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit*. Substance Abuse and Mental Health Services Administration (2020).
    - *Building State Capacity to Address Behavioral Health Needs Through Crisis Services & Early Intervention*. Stuart Yael Gordon. Milbank Memorial Fund. November 2020. Accessed via: https://www.milbank.org/wp-content/uploads/2020/11/Building-States-Capacity-for-BH-Crisis_4.pdf
    - *Crisis Services: Meeting Needs, Saving Lives*. National Association of State Mental Health Program Directors. August 2020. Accessed via: https://www.nasmhpd.org/sites/default/files/2020paper1.pdf
5. Federal/state regulatory and industry accreditation requirements, including CMSs National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
   National industry peer organizations, including managed care organizations MCOs) and behavioral health organizations (BHOs)