#06-53-04

Bulletin

September 28, 2006

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Community Mental Health Centers
- Adult MH Initiatives
- Tribal Health Directors
- ARMHS Providers
- CSP Providers
- Health Plans
- Hospitals w/psychiatric units
- Rule 36 programs
- Child MH Crisis Services Providers
- County Directors
- Social Services Supervisors and Staff
- MA Crisis Response Services Providers

ACTION/DUE DATE

Crisis programs must meet enrollment standards. Counties must include the required information in any contracts with crisis response providers upon receipt. October 15, 2006

EXPIRATION DATE

Until further notice or two years from the issuance date.

Update on Adult Mental Health Crisis Response Services

TOPIC

Medicaid Billable Adult Mental Health Crisis Response Services.

PURPOSE

To assist counties and providers in understanding the contracting, enrollment and provision standards for adult crisis response services.

CONTACT

Larraine Pierce
(651) 431-2243
larraine.pierce@state.mn.us

SIGNED

WES KOOISTRA
Assistance Commissioner
Chemical and Mental Health Administration

BACKGROUND

In 2001, Minnesota Statute, section 256B.0624 created a new set of adult mental health services reimbursable via Medicaid was passed. These services included the crisis response services of crisis assessment, crisis intervention, and crisis stabilization. As enacted, crisis response services allow service provision in a broad range of sites, identifies qualifications for providers of the service, encourages hours of services to expand to seven days a week, 24 hours a day, 365 days a year, uses a team model, and adds a mobile capacity to services.

LEGAL REFERENCES

Minnesota Statues section, 256B.0624 Adult Crisis Response Services.

NEW INFORMATION

Answers to Frequently Asked Questions

1. What are Medical Assistance (MA) Adult Mental Health Crisis Response Services?

Crisis response services are broken into four parts: Crisis Assessment; Crisis Intervention; Crisis Stabilization and Community Intervention.

a) Mental health crisis assessment means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner who is under the clinical supervision of a mental health professional. This assessment follows a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency.

b) Mental health mobile crisis intervention services means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

c) Mental health crisis stabilization services means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

d) Community intervention services are intervention activities conducted on behalf of a recipient. The intent of the intervention is to alleviate or reduce recipient's barriers to community integration or independent living; to improve the support system for the recipient's community integration and independent living; and to minimizing risk of relapse, hospitalization, or a living arrangement that is more restrictive. Community intervention involves significant others such as recipients' relatives, friends, landlords, employers, teachers, neighbors, other provider entities and others. The services must be directed exclusively to the

treatment of the recipient; and may be conducted in person or by phone with or without the presence of the recipient. Community intervention is also an ARMHS service.

2. What is the goal of Medical Assistance (MA) Adult Mental Health Crisis Response Services?

The goal of Adult Crisis Response Services is to respond to needs of people experiencing a mental health crisis or mental health emergency [see Minnesota Statutes, section 256B.0624, subd. 2. (a) and (b).] These services are intended

a) to diminish crisis/emergency-related suffering of the recipient
b) to assist the recipient with returning to the level of functioning prior to the crisis/emergency;
c) to avoid, where possible, more restrictive service settings; and
d) to maintain community living by the recipient.

Crisis Response Services may also make referrals to longer-term supports that will assist the recipient in regaining functioning.

3. Must a county provide or contract for these services?

No. these crisis response services are Medical Assistance services and therefore are a MA "entitlement benefit" for eligible recipients when the service is medically necessary. These are not "county-mandated" services. Rather, the state is primarily responsible to implement these services and to obtain comparability and state-wideness of services. DHS has collaborated with the Association of Minnesota Counties in planning and implementing these services. County participation and leadership is essential for successful implementation of these services.

4. Who can provide Adult Crisis Response Services?

Adult Crisis Response Services must be provided either by a Mobile Crisis Response Team or by a Residential Crisis Stabilization Provider. The Mobile Team or Stabilization Provider must be either a

1. County **or**
2. A provider who holds a contract with the county or an Adult Mental Health Initiative (AMHI) established under the Joint Powers Act that has authority to contract for a county or a group of counties to make crisis response services available.

The provider must contract with each county in which it plans to provide services unless these counties are part of an AMHI with a joint powers agreement.

Each provider must also be enrolled with DHS as an Adult Crisis Response Provider.

A Mobile Crisis Response Team may provide and bill for Crisis Assessment, Crisis Intervention, Crisis Stabilization, and Community Intervention.

A Residential Crisis Stabilization provider may provide and bill for Crisis Stabilization, Residential and Community Intervention only. An entity, which is only approved to bill for Residential Crisis Stabilization, may not bill for Crisis Assessment or Crisis Intervention Services. (See question #12 for possible combinations)

5. How many people are on a Mobile Crisis Team and what credentials does an individual need to have to be part of a Mobile Crisis Response Team?

A mobile crisis response team is composed of *at least* two individuals. These individuals must be either two mental health professionals or one mental health professional and one mental health practitioner who has received the required 30 hours of crisis training. Mental health professionals and mental health practitioners who are members of a mobile crisis response team may bill for crisis assessment, crisis intervention services, crisis stabilization services and community intervention services.

If the practitioner sees the recipient alone, the practitioner must consult with the mental health professional within three hours to review the crisis intervention plan.

Mental health rehabilitation workers who have received the required 30 hours of crisis training may be members of the mobile crisis response team but may provide only crisis stabilization services and community intervention services.

6. Must Crisis Teams be mobile and what does "mobile" mean?

Yes, Crisis Teams are required to be "mobile" and go on-site of the crisis/emergency 24 hours/day/365 days/year when it is determined by the screening to be the best response. Being "mobile" means that the crisis response team can provide services in sites outside the provider's office such as the home of the recipient. Research regarding crisis services indicates that the capacity to go "onsite" or be "mobile" during the mental health crisis or emergency is a best practice. This capacity can potentially improve the response time of the intervention, make for better assessment of and intervention with the recipient's stressors and support systems, more quickly prevent the situation from worsening, more quickly lessen the suffering of the recipient, and lessen use of more restrictive service setting.

Exceptions:

1. Staff safety is a valid consideration in screening the situation to determine the crisis response strategy. If, in the clinical judgment of the mental health professional, dispatching a mobile team to an out-of-office site would result in significant risk of harm to the mobile team staff, the team may choose to provide services in some other way. They may choose to reduce the risk by going on-site accompanied by law enforcement officials, or they may offer to meet the person experiencing the crisis in a public setting or an emergency department.
2. A supervised, licensed setting that provides only crisis stabilization services does not need to have a mobile component.

7. In what settings can mobile crisis assessment and intervention services be provided?

Mobile crisis services can be provided to the recipient in the recipient's home, homes of recipient's relatives and friends, recipient's community residential treatment programs, foster homes, board and lodgings, emergency rooms of hospitals, and provider office sites.

Services cannot be provided in inpatient hospitals following admission of the recipient. In addition, residents of certain settings (such as institutions of mental diseases and prisons) are not eligible for MA.

8. What if counties cannot meet the 24/7 provision?

DHS recognizes that attaining a 24/7 level of mental health professional and/or practitioner staffing presents hardships in some parts of the state. In order to facilitate availability of the service, we have requested an amendment to the state plan that will henceforth be referred to as the federal variance from the Centers for Medicare and Medicaid Services (CMS). This variance, if approved, will allow counties to provide crisis response services differently or for only a portion of the 24/7 period of time as long as crisis services are expanded beyond office hours. For instance, a county may wish to provide mobile crisis services from 5 pm until midnight Monday through Friday and from 8 am until Midnight on weekends and holidays. Providers will be notified immediately of the CMS decision.

Until the federal variance is approved, DHS will continue to approve reasonable phase-in proposals from counties and providers. See questions 13.b) and 14.b) for the application process. Counties wishing to request permission to phase in the 24/7 requirement should send a request in writing to:

Crisis Contact
DHS Mental Health Division
PO Box 64981
St. Paul, Minnesota 55164-0981
FAX 651-431-7418

The request must include a detailed plan describing how the program will eventually achieve full staffing capacity, the credentials of the staff who will be providing services, the hours of service to be provided at present and how the full service array will be phased in. Phase in may take up to two years, but counties must submit progress reports at six month intervals. If the CMS variance is approved, DHS will notify counties that are phasing in services of their option to remain at a less intensive service level. Until the CMS waiver request is approved, DHS will continue to work with counties and providers regarding reasonable extensions of the phase-in period.

9. Who can provide Residential Crisis Stabilization Services?

A supervised, licensed, residential setting such as an Intensive Residential Treatment program (IRT) or a foster care home may provide Residential Crisis Stabilization Services. The program must have 24 hour a day residential staffing. These staff people must have 24-hour access (in person or by phone) to the mental health professional.

a) **Settings with four or fewer recipients:** If the setting serves no more than four adults and no more than two are recipients of crisis stabilization, the setting must minimally have 8 hours a day of a mental health professional, crisis-trained mental health practitioner, or crisis-trained rehabilitation worker staffing on site. A mental health professional or practitioner must make face-to-face contact with the recipient on a daily basis while they are staying at the setting. The setting must be licensed as an adult foster care program.

b) **Settings serving more than four adults:** If the setting serves more than four adults and one or more are receiving crisis stabilization, there must be a mental health professional, a crisis-trained mental health practitioner, **or** a crisis-trained rehabilitation worker present 24 hours per day. During the first 48 hours of crisis stabilization, at least two staff must be present 24 hours per day (only one need be trained in providing crisis services). Unless the setting has a special exemption as a 5-bed adult foster care program, it must be licensed under Rule 36 or IRT.

10. Must a county provide Mobile Crisis Response Team Services in order to provide Residential Crisis Stabilization Services?

No. DHS recognizes that the population of some counties is too small or sparse to make a Mobile Crisis Response Team a viable service. Counties may wish to develop Adult Residential Crisis Stabilization Services as an alternative.

11. Does a recipient have to receive crisis intervention services to be eligible for crisis stabilization services?

Yes. A person can be eligible for crisis stabilization based on recommendations following crisis assessment and intervention provided in the following manner:

a) in an emergency room, urgent care or inpatient setting.
b) by a mental health professional or
c) by a Mobile Crisis Response team

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12. Must a provider entity provide all the components of Adult Crisis Response Services?

No, a county may provide and/or contract with a single provider to provide all of the crisis response services or might contract with multiple providers for differing portions of the services. The various combinations of crisis services are listed below a) to f). For best practices reasons, crisis assessment and crisis intervention services should not be contractually separated.

A county entity may provide or contract with a single provider entity to provide:

a) all crisis response services - crisis assessment, crisis intervention, stabilization (both "in-community" and "residential"), and community intervention; or
b) only crisis assessment, intervention and community intervention services; or
c) crisis assessment, crisis intervention, "in-community" stabilization (not "short-term residential"), and community intervention services; or
d) "in-community" and "short-term residential" crisis stabilization and community intervention services; or
e) only "in-community" crisis stabilization and community intervention services **or**
f) only "residential" crisis stabilization (not "in-community") and community intervention services.

13. How does a county become an Adult Mental Health Crisis Provider?

To enroll as a Crisis Provider for the first time, a county must follow the instructions here.

a) If the County is choosing to provide services 24 hour per day, seven days per week, 365 days per year:

- Complete Form *# DHS-4717 Adult Crisis Response Services* indicating what services will be provided. *Do not check Assessment and Intervention if not provided as part of a mobile team.*
  This form can be found at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4717-ENG. A copy is included in Attachment A at the end of this bulletin.
- Inform the Adult Mental Health Division of the terms for the length of service, not to exceed two years, during which the county will provide the crisis services,

b) If the County is asking permission to phase-in services for less than 24/7/365

- Complete items in a) above;
- In addition, submit a written request to phase-in the 24/7/265 requirement. Include a detailed plan describing how the program will eventually achieve full staffing capacity and the hours of service the county intends to provide at present. Phase in may take up to two years;
- **Submit progress reports every six months to the Adult Mental Health Division Crisis Contact**.

14. How does a Non- County Provider become an Adult Mental Health Crisis Provider?

a) If the Provider is offering to provide services 24 hour per day, seven days per week, 365 days per year:

- Establish a contract with the local mental health authority for the county in which services will be provided;
  (a) Crisis contracts must contain the "Legal Entity Name" within the contract and the dates of service. Note that any name change within a corporation is considered a significant change. The provider must inform provider

enrollment and submit an addendum to the current contract stating the new name.

(b) Counties must define contracted Crisis Services in accordance with the following:

(i) Include a provision defining the contracted provider as part of the welfare system with appropriate linkage and communication within and between other parts of the welfare system;

(ii) Specify the crisis services the contractee will provide for the county. A county may contract with an individual provider for all services or certain component pairs or triads or quads; and,

(iii) Define eligible recipients as persons over the age of 18 or older

a) who are screened as possibly experiencing a mental health crisis or emergency as defined in Minnesota Statute, section 256B.0624 Subd. 2, **or**

b) have been assessed as experiencing a mental health crisis or emergency **and**

c) mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

- Provider Standards and Capabilities: The provider of adult mental health crisis response services must meet the requirements in legislation (Minnesota Statute, section 256B.0624) and MA provider requirements.
- Upon signature by ALL parties, a copy of the signed contract and a copy of Attachment A must be sent to the Adult Mental Health Division. FORM # *DHS-4717 Adult Crisis Response Services* must be completed by the County to ensure county coordination of services.
- The length of service for which the vendor will provide the crisis services is established in the signed contract (not to exceed two years).
- Non-county entities are reminded that regardless of the date DHS receives the contract, the provider may back-bill for services for up to one year if the necessary documentation is available that verifies services were provided and DHS approves the begin date.

b) What if a vendor requests a phase-in for services less than 24/7/365

- Establish a contract with the local mental health authority in the county services will be provided;
- Submit a copy of the signed contract and a copy of Form # *DHS-4717 Adult Crisis Response Services* to the Adult Mental Health Division;
- Submit a written request to phase-in the 24/7/265 requirement that includes a detailed plan describing how the program will achieve full staffing capacity and the hours of service to be provided at present. Phase-in may take up to two years;
- **Submit progress reports every six months to the Adult Mental Health Division Crisis Contact**.
- DHS staff will review the crisis services proposal and the phase-in plan upon submission of all requested materials. Upon approval, which may/may not

require additional follow-up with the provider, DHS will submit the approval to DHS Provider Enrollment.

15. What does a county need to do to continue enrollment as a Crisis Services Provider when their identified length of service is ending?

- For counties that provided crisis services during the previous year, resubmit a copy of Form # *DHS-4717 Adult Crisis Response Services* indicating the services that will be provided and the dates of service, to the Adult Mental Health Division.
- These materials must be sent to:
  Crisis Contact Person
  DHS Mental Health Division
  PO Box 64981
  St. Paul, Minnesota 55164-0981
  FAX 651-431-7418

16. What does a Non-County Provider need to do to continue enrollment as a Crisis Services Provider when their contract with the county is renegotiated?

- To continue billing for crisis services, non-county entities must have the local mental health authority resubmit the following items for the new contract dates as soon as feasible:
  a) Signed contract specifying crisis services to be provided; and
  b) Form *# DHS-4717 Adult Crisis Response Services* Form (completed by the local mental health authority).
- Non-county entities need to be reminded by the contracting county agency of the contract end date to prevent lapses in billing. Read the section "Continuation of Crisis Services Enrollment" to ensure continuous billing.
- DHS will attempt to send reminders prior to contract expiration dates; however, it is the responsibility of the county and the contracted entities to indicate interest in continuing service and billing.
- These materials must be sent to:

  Crisis Contact Person
  DHS Mental Health Division
  PO Box 64981
  St. Paul, Minnesota 55164-0981
  FAX 651-431-7418

17. What does DHS do with the information above? How long does it take?

- DHS Mental Health Division reviews the materials for compliance with state statutes and policy.
  a) If compliance is evident, the materials are forwarded to Provider Enrollment.
  b) If not, DHS staff contacts the county.

c) If the provider is not already an MA provider, additional information may be needed.
d) If you need information on becoming an MA provider, please contact Julie Hervas of the Provider Enrollment Section at 651-431-2704 or 800-366-541
e) DHS has a goal of reviewing and acting on all materials within two weeks of full submission of materials. If there are questions regarding the submitted information, additional time will be required to complete the review and make final determination.

18. What if a provider has a contract with another county to provide Adult Crisis Response Services?

- In the situation where another host county has a contract with a provider entity to provide these services, additional counties could contract with that provider entity. The contract should state that services will be provided consistent with the existing host county contract.
- Counties may also delegate contracting authority to a joint powers board or another legal entity that would have the authority to contract for a group of counties.

19. Who are eligible recipients of MA Adult Crisis Response Services?

An eligible recipient is:

- an MA eligible individual who is age 18 or older;
- has been screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and
- has been assessed as experiencing a mental health crisis or emergency, and
- mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

20. Does an individual need to have a mental illness diagnosis to receive Adult Crisis Response Services?

- The eligible individual *does not need* to have a previously diagnosed mental illness to be assessed. The crisis assessment determines the need for intervention and stabilization services...
- A mental health diagnosis **is** required for intervention and stabilization. However, this may be a provisional diagnosis based on the crisis assessment. A full diagnostic assessment is *not* required.

21. Can more than one member of the mobile crisis team bill for services provided?

Yes. The legislation requires that the mobile crisis team must have at least two members. This does not mean that both have to be "on site" to do a face-to-face assessment and intervention with the recipient. The team determines the appropriate setting and number of team members who should be involved on site based on the screening and assessment information. Each team member involved in face-to-face assessment and intervention can bill for the relevant service. Consultation time (face-to-face or over the phone) between

team members during the assessment and intervention is billable by all involved team members. Depending on crisis-specific tasks assumed, one team member might be doing community intervention with the recipient's significant others and that team member may bill for this service. At the same or different time, another team member/s might be doing face-to-face assessment or intervention and may bill for these services.

22. Are MA Adult Crisis Response Services the same as MA Children Crisis Response Services?

No. While the services are very similar, they are not the same. Both are based on service models of mobile teams and both include assessment, intervention and stabilization. However, the following differences exist:

a. the children's crisis response services are bundled into a single service
b. children's crisis response services do not include a short-term residential crisis stabilization component or community intervention (children's residential services are funded through a different method).
c. adult crisis response services divide assessment, intervention, stabilization, and community intervention into distinct billable services.
d. adult and child crisis response services have different rates and thresholds.

Some county entities and provider entities provide both children and adult crisis response services and must be cognizant of these differences.

23. Will Adult Crisis Response services be available to people not eligible for MA?

Medical Assistance (MA) can only reimburse for services if provided to MA eligible recipients. Other people not eligible for MA may need crisis response-type services. One of the challenges to planning and implementing these services is determining how to fund a larger crisis response system that addresses the crisis needs of others. Since the State is assuming responsibility for the non-federal share of this new MA coverage, and since many counties now use local and state grant funds for crisis services, DHS expects that new MA revenues will free up existing state and local funds to serve those who are not MA-eligible. Providers of crisis response services must bill any eligible third party payer regardless of the recipient's MA status. Insurance dollars should be considered a resource in recovering costs incurred from providing these services.

Some counties and provider entities have looked to other avenues to increase funding for crisis services. Some have contracted to provide crisis mental health services for local hospitals that do not have mental health professionals or practitioners on staff. Some have arranged billing agreements with private insurance providers to further increase revenues. These services have the potential for reducing hospitalization and hold costs for the counties and for insurance providers.

24. How are Crisis Response Services different from Community Support Program (CSP) and Adult Rehabilitative Mental Health Services (ARMHS) crisis assistance services?

Crisis Assistance is a service component of a county-mandated CSP to serve adults recovering from a serious and persistent mental illness. Crisis assistance and relapse

prevention are service components of ARMHS to serve eligible recipients. Crisis assistance and relapse prevention services assist a consumer in monitoring stressors in their lives, improving coping skills, improving formal and informal support systems, and assisting the consumer in developing plans to prevent relapse and crisis in the consumer's life. These services are primarily preventative. A crisis assistance plan is developed prior to a crisis and implemented when a consumer's mental health status is at risk of a crisis or emergency. Crisis assessment and intervention services are offered when a crisis or emergency exists. CSP or ARMHS staff should directly, or indirectly through the consumer or case manager, contact crisis response services when a crisis assessment and intervention may be needed.

25. How will crisis response services be reimbursed?

These services are included in the MA State Plan approved by the federal Center for Medicare and Medicaid Services (CMS), the federal Medicaid agency, and are reimbursed on a fee-for-service basis. They are not funded through a grant or a waiver. There is intent to cover these services under managed care organizations contracted to provide Prepaid Medical Assistance (PMAP) as early as January 1, 2007.

26. Where can I find the reimbursement rates?

See Attachments B and C for information about crisis response service codes and rates. Crisis assessment and mobile crisis intervention are reimbursed based on the credentials of the mental health professional. A mental health professional licensed with a Ph.D. is reimbursed at 100% of the rate, and a masters' level provider at 80% of the rate. Should a mental health practitioner conduct either of these services, the HN modifier must be used and the rate is reduced by one-half. The specific reimbursement amount depends on the credentialing of the billable licensed professional. The information in Attachment B may be found at the end of the chapter in the following website:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_058038
The information in Attachment C can be found at the following website:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_029315

27. Is there a limit on the amount of crisis response service that MA will pay for?

Yes, see Attachment C for authorization thresholds for the services. Crisis stabilization services can exceed these limits with prior authorization if medically necessary services

28. Can a person receive all these services in the same day? From more than one provider?

Yes. A person could potentially receive all services on a single day. Multiple providers may bill for the services for the same recipient as long as they do not exceed the service thresholds. For individuals who are in a residential crisis stabilization setting, the per diem rate includes all crisis stabilization and community intervention services provided to an individual in a day.

29. Are public pre-paid (PMAP, Minnesota Care) plans responsible for providing these services?

At the present time, Adult Crisis Response Services are not required to be provided by the health plans. Enrollees who meet the eligibility criteria for services may receive them under fee-for-service (providers submit claims to DHS as they would for other MA recipients not enrolled in a health plan). Crisis response services may be included in public pre-paid plans effective January 1, 2007.

30. Could the State Operated Services (SOS) staff have involvement as a provider of these services?

Yes. SOS staff currently providing services through the Adult Mental Health Initiative (AMHI) process may provide these services. Arrangements between SOS and other entities may vary by location and service configuration. DHS encourages discussion among all parts of the service system to facilitate the provision of needed crisis services. If SOS is the provider entity, the SOS program must meet the requirements described in Question # 14.

31. What is the billable unit for residential crisis stabilization?

Residential crisis stabilization is billable now using a per diem rate identified in Attachment C.

32. What is the definition of a day for purposes of billing residential crisis stabilization?

A day means a calendar day in which an individual occupied a bed in the residential program and received crisis stabilization services. The day of admission is billable regardless of the time of admission. The day of discharge is <u>not</u> billable. If more than one provider is involved, the providers and host county must work out a method for sharing the per diem payment.

33. Does the per diem include room and board?

No. Medicaid prohibits the inclusion of room and board in this service. Counties and providers must use other funding such as client fees, Group Residential Housing (GRH), or grant funds. DHS recommends that providers apply the GRH definition of room and board found in Minnesota Statutes, section 256I.03, subd. 6.

34. Can an individual receive crisis stabilization and other covered services in the same day?

Yes, if

a.) medical necessity is documented,
b.) the recipient is eligible for the service and
c.) the services are distinct and not duplicative.

MA-covered services can be provided to supplement the crisis stabilization services. Note that ARMHS billing is limited to transition services; all other ARMHS services are included in the residential crisis per diem.

35. Our program provides crisis stabilization in a family foster care setting which does not include 24 hour per day staffing. Should that be billed on a per diem basis?

No, residential crisis stabilization must include 24 hour staffing. Services might qualify for reimbursement as non-residential crisis stabilization (see Question # 5 for specific requirements).

36. What are the requirements for a crisis intervention treatment plan?

The mobile crisis intervention team must develop an initial **crisis intervention treatment plan** as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. This plan should be **brief** and focus primarily on assisting the recipient to return to pre-crisis functioning level. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment team must document when goals have been met and the plan must be updated as needed to reflect current goals and services.

If a recipient receives either residential or non-residential crisis stabilization services, the provider of stabilization services must develop an **individual crisis stabilization treatment plan**. This plan must be a written plan that is completed within 24 hours of beginning services with the recipient.

This crisis stabilization treatment plan must include, at a minimum:

1. a list of problems identified in the assessment;
2. a list of the recipient's strengths and resources;
3. concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;
4. specific objectives directed toward the achievement of each of the goals;
5. documentation of the participants involved in the service planning. The recipient, whenever possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why recipient signature was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;
6. planned frequency and type of services initiated;
7. a crisis response action plan if a crisis should occur;
8. clear progress notes on outcome of goals

Crisis intervention and crisis stabilization treatment plans must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Special Needs

This information is available in other forms to people with disabilities by contacting us at 651-431-2225 (voice)) or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 7-1-1 or 1-877-627-3848 (speech-to-speech relay service).

Minnesota Department of Human Services

Adult Crisis Response Services Enrollment Information

DHS-4717-ENG 7-06

The following form should be filled out by the county for each provider of Adult Crisis Response Services and submitted to DHS with the signed contract or service agreement. Please use a separate form for each provider.

Are the following elements of services available in your county? Please check relevant areas:
(See Medicaid Provider Manual for description of services requirements.)

LEGAL NAME OF PROVIDER (FOR THE PURPOSE OF MHCP ENROLLMENT)	CRISIS SERVICE TELEPHONE # (TO BE POSTED ON THE MHCP WEB SITE)

For Contract Period of: _____ (MONTH, DAY, YEAR) **through** _____ (MONTH, DAY, YEAR)

Service	Qualified Staff?	Needed Staffing Configuration?	Mobile Capability?	24 hour availability?
Assessment	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
Intervention	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
Stabilization - In Home	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
Stabilization - Residential	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO

Which of the above services will this provider offer?	☐ Assessment ☐ Intervention ☐ Stabilization - In Home ☐ Stabilization - Residential	Hours available (If the provider offers more than one service and the hours of availability differ; please identify availability for each service.)	

COUNTY CONTACT NAME AND TITLE (for questions regarding Enrollment of Crisis Response Services)	TELEPHONE NUMBER (_____) - _____ - _____ EXT: _____	E-MAIL

AGENCY CONTACT NAME AND TITLE (for questions regarding Enrollment of Crisis Response Services)	TELEPHONE NUMBER (_____) - _____ - _____ EXT: _____	E-MAIL

This form was completed by:

NAME (please print)	**SIGNATURE**
COUNTY	**TELEPHONE** (_____) - _____ - _____ EXT: _____

Mail form to: Minnesota Department of Human Services
Attention: Crisis Response
PO Box 64981
St. Paul, MN 55164-0981

Attachment B

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_058038

Billing for Adult Crisis Response Services

Bill for direct, face-to-face service(s) provided to an eligible recipient by a qualified staff person;
• Use MN–ITS 837P or CMS-1500;
• Enter the actual place of service code (POS); POS may not be 23 (emergency department) for mobile team billing; and
• Enter the individual treating provider number.
When qualified state staff provides adult crisis response services, they are considered part of the certified local provider entity and may bill MHCP for qualifying services

Adult Crisis Response Billing

Code	Modifier	Service Description	Unit	Additional Requirements
H0031		**Adult Crisis Assessment; mental health professional**	**15 min**	**• Maximum 2 hours (8 units) per day.** **• Authorization is required for more than 4 ¾ hours (19 units) per calendar month, or 8 hours (32 units) per calendar year.** **• Each team member providing on-site, face-to-face services may bill.** **• If an off-site team member works with an on-site team member, the off-site team member may bill for time spent working directly with the on-site member.**
	HN	**Adult Crisis Assessment; mental health practitioner**		
	HW	**Adult Crisis Assessment; when mental health professional is a state staff person**		
	HN HW	**Adult Crisis Assessment; when mental health practitioner is a state staff person**		

Code	Modifier	Service Description	Unit	Additional Requirements
H2011		**Adult Crisis Intervention; mental health professional**	**15 min**	**• Authorization is required for more than 10 hours in one day; more than 30 hours in 30 days; or more than 60 hours in a calendar year.** **• Bill community intervention, as appropriate, when a team member works directly with a family member or significant other while another team member works face-face with the recipient.**
	HN	**Adult Crisis Intervention; mental health practitioner**		
	HW	**Adult Crisis Intervention; when mental health professional is a state staff person**		
	HN HW	**Adult Crisis Intervention; when mental health practitioner is a state staff person**		
S9484		**Crisis Stabilization, non-residential; mental health professional or practitioner**	**60 min**	**• Authorization is required for more than 60 hours combined total of S9484, S9484 HQ, S9484 HM and H0048 in a 365-day period. One day of H0018 counts as 8 hours.** **• Authorization is required for more than 7**
	HM	**Crisis Stabilization, non-residential; mental health rehabilitation worker**		
	HQ	**Crisis Stabilization, non-residential; group setting**		
	HW	**Crisis Stabilization, non-residential; when mental health professional or practitioner is a state staff person**		
Code	Modifier	Service Description	Unit	Additional Requirements
H0018		**Crisis Stabilization, residential**	**1 day**	**Authorization is required for more than 7 days in a 365-day period.**
	HW	**Crisis Stabilization,**		

		residential; state staff person (add for either a mental health professional or practitioner)		

Attachment C

Excerpt of "Mental Health Codes, Maximum FFS Rates, and Providers"

Proc. Code	Mod	Service Name	Eligible Providers	Unit Length	Rate 01/01/04
H0031		Crisis Assessment – MOBILE (POS is not 23)	County or County Contracted Agency LP; LLP; LICSW; LMFT; CNS-MH: Psychiatrist; NP	15 min	Doctoral $32.50 Masters $26.00
H0031	HN	Crisis Assessment – MOBILE (POS is not 23)	County or County Contracted Agency Mental Health Practitioner	15 min	$22.58**
H2011		Crisis Intervention – MOBILE	County or County Contracted Agency LP; LLP; LICSW; LMFT; CNS-MH: Psychiatrist; NP	15 min	Doctoral $23.75* Masters $19.00*
H2011	HN	Crisis Intervention – MOBILE	County or County Contracted Agency Mental Health Practitioner	15 min	$16.49**
S9484		Crisis Stabilization -INDIVIDUAL -NON-RESIDENTIAL	County or County Contracted Agency LP; LLP; LICSW; LMFT; CNS-MH; Psychiatrist; NP; MH Practitioner	60 min	$54.21**
S9484	HM	Crisis Stabilization -INDIVIDUAL -NON-RESIDENTIAL	County or Contract Agency MH Rehabilitation Worker	60 min	$40.64**
S9484	HQ	Crisis Stabilization - GROUP - NON-RESIDENTIAL	County or County Contracted Agency LP; LLP; LICSW; LMFT; CNS-MH; Psychiatrist; NP; MH Practitioner, MH Rehabilitation Worker	60 min	$22.00
Proc. Code	Mod	Service Name	Eligible Providers	Unit Length	Rate 01/01/04
H0018		Crisis Stabilization – RESIDENTIAL	County or County Contracted Agency LP; LLP; LICSW; LMFT; CNS-MH; Psychiatrist; NP; MH Practitioner, MH Rehabilitation Worker	Per Diem	Negotiated
90882		Community Intervention	DHS Certified MH	15 min	12.51**

			Rehabilitation Agency LP; LLP; LICSW; LMFT; CNS-MH; Psychiatrist; NP; Certified MH Rehabilitation Professional; MH Practitioner		
90882	HM	Community Intervention	DHS Certified MH Rehabilitation Agency MH Rehabilitation Worker	15 min	$9.38**

* Procedure code subject to master's level cutback (master level pays at 80% of maximum allowed amount) and practitioner reduction (with modifier HN pays 50% of the supervisor's allowed amount). The master's cutback does not apply to services provided in a CMHC, but the practitioner reduction (50%) does apply

** Rate increase retroactive to 02/18/04 for services under ARMHS FCSS (CTSS as of 7/1/2004) and Crisis Response Services

The above information is an excerpt of "Mental Health Codes, Maximum FFS Rates, and Providers which can be found at the following web address.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_029315

Monday, October 2, 2006

Department of Human Services

Department of Human Services

Minnesota North Star Home Page

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