

**Policy terminated because coverage is provided under equivalent Medicaid
Policy 8A: Enhanced Mental Health and Substance Abuse Services
(Mobile Crisis Management)**

Table of Contents

1.0 Description of the Procedure, Product, or Service..... 1

2.0 Eligible Recipients 1

 2.1 General Provisions 1

3.0 When the Procedure, Product, or Service Is Covered..... 1

 3.1 General Criteria..... 1

 3.2 Specific Criteria 1

4.0 When the Procedure, Product, or Service Is Not Covered..... 2

 4.1 General Criteria..... 2

 4.2 Specific Criteria 2

5.0 Requirements for and Limitations on Coverage 2

 5.1 Prior Approval 2

6.0 Providers Eligible to Bill for the Procedure, Product, or Service 3

7.0 Additional Requirements 3

 7.1 Compliance 3

8.0 Policy Implementation/Revision Information..... 3

Attachment A: Claims-Related Information 4

 A. Claim Type 4

 B. Diagnosis Codes 4

 C. Procedure Code(s)..... 4

 D. Modifiers..... 4

 E. Billing Units..... 4

 F. Place of Service 4

 G. Co-payments 4

 H. Reimbursement 4

1.0 Description of the Procedure, Product, or Service

Crisis evaluation and stabilization (CES) is typically a hospital-based comprehensive assessment and treatment plan development for a recipient experiencing a crisis. Emphasis is on crisis intervention services necessary to stabilize and return the recipient to a safe level of functioning, or to refer the recipient for hospitalization as necessary. Twenty-three hours is generally considered the maximum amount of time for CES services. At any point during the twenty-three hours or at the end of twenty-three hours, an appropriate level of care should be determined by the treatment team. This service is not appropriate for recipients who by history or clinical presentation require services in an acute care setting.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

Note: Most children will be able to get all the services they need under the core (basic) plan of NC Health Choice. A child who qualifies as having special needs may be able to receive additional services not covered by the core plan.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. CES is covered, subject to outpatient discounts specified in the facility's contract.
- b. CES is covered as inpatient hospital charges if the disposition is to an inpatient level of care at the hospital which provided both the CES and the inpatient services.
- c. CES is covered in a facility based crisis setting which is owned and operated by the Local Management Entity (LME).

- d. Hospitals or free-standing facility-based crisis settings (as noted in **Subsection 3.2.c**) may be reimbursed for more than 23-hours of CES when it is medically necessary to stabilize a recipient in crisis to prevent the need for inpatient hospitalization, and when prior approved by DMA's vendor.

Note: Refer to **Subsection 5.1.d**

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

CES care rendered in a hospital not accredited by JCAHO is not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Approval for CES is required by DMA's vendor which will conduct a clinical review with the treating provider(s) to determine the medical necessity of crisis evaluation and stabilization.
- b. Prior approval by DMA's vendor is required for the following services if utilized during CES:
 1. Biofeedback
 2. Psychological testing
- c. Prior approval by DMA's vendor is also required prior to the recipient being transitioned to either inpatient, partial hospitalization, or an Intensive Outpatient Program (IOP). If the recipient is transitioned to outpatient services, prior approval must be obtained from DMA's vendor when the recipient has already exhausted the 26 outpatient visits allowed without case management.
- d. Rationale for admission must support:
 1. An established psychiatric or chemical dependency diagnosis (current edition of ICD or DSM).

2. That further assessment and immediate intervention are required for careful management of the recipient's condition and to determine the level of care most appropriate for treatment.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Revenue Code(s)
0760
0761
0762

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital and Free-Standing Facility-Based Crisis Setting

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.