Vaya Health

Enhanced Crisis Response

H2011U5U1 - weekly unit
H2011U5TS - subsequent unit

Service

Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The service utilizes fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth in the emergency department (ED) or in a non-therapeutic home who are at risk of admission to the ED, the practitioner will respond as soon as possible, no longer than two hours from receipt of referral. For other referrals, response will be on the same day or by the end of the following day.

This service is intended to be short-term, with services lasting on average 60-90 days. During this time, staff work with the child/family to diffuse the imminent crisis and link the family to appropriate community-based services that allow the child to thrive and meet their goals. The service is intended to be provided primarily face-to-face in community or home settings. Coordination activities or triage may occur telephonically.

Service Elements/Treatment Interventions include the following:

- Crisis Management: Crisis intervention and support on 24 hours a day/7 day a week/365 days a year basis.
- Intensive Case Management: Assists members to gain access to necessary care: medical, behavioral, social, and other services appropriate to their needs.
- Linkage to individualized Therapeutic and Behavioral Support Services: Services may include In Home Therapy Services, Family Centered Treatment, Multi-systemic Therapy, Respite, and Day Treatment. (These services would overlap for two weeks to ensure linkage.)
- Linkage to Residential Treatment: Therapeutic Foster Care and other programs as appropriate/clinically warranted. (These services would overlap for 30-60 days.)
- Intensive supports for children in Department of Social Services (DSS) Homes or Kinship placements: DSS Foster Home/DSS group home (recommended service provision: 60-90 days).
- Discharge and aftercare planning: Processes to decide what the member needs for a smooth transition from one level of care to another and for ongoing monitoring.

Expected Outcomes

When ECR becomes involved with a member at-risk of presenting to the ED, it is expected that an ED assessment/admission will be prevented. If a member is at-risk of abandonment in the ED, the goal is to engage the member's guardian for the member to remain in the home and prevent the member going into DSS custody. Overall, it the ECT shall help engage the family, decrease crisis events, link to services, and maintain the member in the community with outpatient/enhanced services.

Service Exclusions:

ECR should not be requested for a member that already has an enhanced service provider involved (e.g., services outlined in Clinical Coverage Policy 8A), unless otherwise approved by Vaya Health under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The provider shall submit their weekly billable claims once the minimum hours of service have been met. For any week where less than the required two hours of service is provided, a billable claim

should not be submitted. The provider must submit encounter claims (with a modifier) to account for all time being spent with the member (total number of contacts as well as frequency).

Since this service includes a case management component, providers must clearly outline on the member's care plan how they will collaborate with Tailored Care Management to ensure there is no duplication of services. The case management function of this service is to support the treatment being done within the program to ensure progress and decrease the need for a higher level of care for the services.

Service Frequency and Intensity:

The program is to be provided primarily face to face in community or home settings. Coordination activities or triage may occur telephonically. A minimum of two hours of services with/on behalf of the member per week is required.

Provider Requirements

The provider delivering this service shall meet the following requirements:

Enhanced Crisis Response services must be delivered by staff employed by a mental health, substance use, or intellectual and developmental disability (MH/SU/DD) provider organization that meets the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being a member of Vaya Health provider network. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina. Additionally, within one year of enrollment as a provider with NC Medicaid, the organization shall achieve national accreditation with one of the accrediting bodies approved by the N.C. Department of Health and Human Services (NCDHHS).

Staffing Requirements

Position	Minimum Staffing	Staff Qualifications
Supervisor (MANDATORY)	1 FTE (position may pro-rated based on caseload)	The supervisor shall be a licensed mental health professional holding any of the following licenses: Licensed Psychologist, Licensed Clinical Social Worker, Licensed Clinical Mental Health Counselor, or Licensed Marriage and Family Therapist. The supervisor shall have three years of clinical experience with children with serious emotional disturbance, with a minimum of two years post-graduate school.
Licensed Clinician (MANDATORY)	1 FTE (for no more than 20 members)- position may be pro-rated if caseload less than 20)	Fully licensed clinician(s) must have at least one year of post-graduate experience working with children with serious emotional disturbance. The licensed clinician shall be a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapist.

Supervision
Licensed clinicians must receive scheduled intensive supervision weekly. If supervising more than one clinician, one of the required supervision meetings may occur as a group supervision. Supervisors must also be available to clinicians as needed to staff cases when requested by the licensed clinician or to provide coverage for clinician(s) when necessary.

Credentialing
All employees must meet the minimum education, experience, and licensure criteria established for their position as required in rules or service definitions, whichever is most restrictive. Provider will ensure that all licensed staff complete the required LME/MCO credentialing process and maintain their licensure.

For licensed professionals
Provider organization will complete the CAQH application, (and if needed, enroll with NCTracks, and obtain an NCID, and NPI) and submit the credentialing application to Vaya Health.

To provide ECR, there must always be a team consisting of a supervisor and a licensed clinician. For new providers that have not reached a caseload of 20, the supervisor may begin seeing members prior to hiring a licensed clinician. The number of individuals served may not exceed 20. When a licensed clinician is hired, the supervisor must transition cases to the clinician to comply with the caseload limits as outlined below.

Case Load
- A licensed clinician may hold an active caseload of no more than 20 members; however, this should be based on intensity of need of the members on the clinician's caseload (i.e., provider should only accept referrals as they are able).
- If the supervisor (a licensed clinician) is providing direct service (and does not have a supervisee), they may have an active caseload of 20 members, however, once they have supervisees, the caseload cannot exceed 10
- The supervisor may only provide oversight to a maximum of 60 members (which includes their individual caseload, if applicable).

Crisis Response
The licensed clinicians(s) or supervisor must be available 24/7/365 to service as the crisis responder for the youth.

In instances of staff turnover, the provider may use back up staff for coverage but must alert Vaya Health if this occurs and have a written plan for coverage. Vaya Health will review the plan to determine if referrals would be suspended or continue based on the coverage plan.

Staff Training Requirements

Position	Within 30 days of Hire	Within 90 days of Hire	Annual
Supervisor	Crisis Response (3 hours)	Introductory Motivational Interviewing (13 hours) Introduction to System of Care (11 hours) Person-Centered Thinking (12 hours) CPI/Prevention (8 hours)	CPI Refresher
Licensed Clinician	Crisis Response (3 hours)	Introductory Motivational Interviewing (13 hours Introduction to System of Care (11 hours) Person-Centered Thinking (12 hours) CPI/Prevention (8 hours)	CPI Refresher

Member Eligibility Requirements

To be eligible for ECR, the member must have NC Medicaid based on residence in a county located within Vaya's region and be enrolled in the State of North Carolina MH/IDD/SAS Health Plan waiver authorized pursuant to section 1915(b) of the Social Security Act, and meet the following criteria:

Designed for members ages 3-21 with mental health (MH) diagnoses, co-occurring MH and intellectual/ developmental disability (I/DD) diagnoses, and/or co-occurring MH and substance use disorder (SUD) diagnoses, OR potential diagnoses of the above based on current symptoms/behavioral health needs. Members must be at risk for abandonment, crisis episodes, or restrictive levels of care. This includes members who:

1. Present to the ED or Child/Adolescent Facility Based Crisis facility and whose symptoms do not require inpatient treatment and whose parent/guardian has stated that they may not return home.
2. Are admitted to an inpatient unit where there are barriers to discharge, such as lack of parent or guardian engagement in discharge planning, need for further specialty care that is not yet identified, etc.
3. Members in a non-therapeutic home such as a DSS foster home, DSS shelter, or kinship placement and at risk for an ED or inpatient admission based on escalation of behavioral symptoms or known trauma.

The member must also be in the custody of DSS or is at risk of entry into DSS custody based on potential parental abandonment, and meets at least one of the following:

1. Has exhibited suicidal gestures or attempts, self-injurious behavior or current ideation related to suicidal or self-injurious behavior and is not in need of acute care.
2. Has exhibited physical aggression or violent behavior towards people, animals, or property (this risk may also be evidenced by current threats of such aggression).
3. Has run away from home or placements within the last 60 days, has had an occurrence of sexual aggression, or has known trauma (i.e., has had a trauma assessment).
4. Has had a hospitalization for behavioral health in the past 30 days.
5. Meets one of the above and needs coordinated efforts to stabilize their DSS placement (may include a kinship placement) to prevent an ED visit.
6. Has been abandoned in the ED and determined to be able to safely return to the community.

Utilization Management

The provider shall submit their weekly claims once the minimum hours of service has been met. The provider shall also submit encounter claims (with a modifier) to account for all time being spent with the member (total number of contacts as well as frequency). The average member will receive this service for 60-90 days, with maximum utilization of one billable unit per week for 12 weeks. Subsequent encounters are submitted in 15-minute units.

Members will receive a pass-through of one billable unit per week for eight weeks. If a member needs services beyond the eight-week pass through, an authorization is required. If a member is receiving an enhanced service at the time of the initial referral, a Service Authorization Request (SAR) must be submitted by the provider. Utilization Management completes a clinical review for medical necessity to ensure the services are not duplicative. Authorization after the initial eight-unit pass through can be requested for four additional units per re-authorization request.

If/when members are linked to another service, a SAR must also be submitted to allow for the overlap of services if needed, based on the below:

- Linkage to individualized Therapeutic and Behavioral Support Services:
    - Services may include In Home Therapy Services, Family Centered Treatment, Multi-systemic Therapy, Respite, and Day Treatment (these services would overlap for two weeks to ensure linkage).

- Linkage to Residential Treatment:
    - Therapeutic Foster Care and other programs as appropriate/clinically warranted. (These services would overlap for 30-60 days.)

EPSDT SPECIAL PROVISION

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- That is unsafe, ineffective, or experimental or investigational
- That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment

EPSDT and Prior Approval Requirements

If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

Important additional information about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide and on the EPSDT provider page.

Service limitations on scope, amount, duration, frequency, location of service and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problem.

Documentation Requirements

These services shall be properly and contemporaneously documented in accordance with this section and the Division of MHDDSAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya Health. Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements. Providers shall make all documentation supporting claims for services reimbursed by Vaya Health available to Vaya Health, NCDHHS and CMS upon request.

Claims-Related Information

Providers shall comply with the NCTracks Provider Claims and Billing Assistance Guide, applicable Medicaid bulletins issued by the NC Division of Health Benefits (DHB), applicable NC Medicaid Clinical Coverage Policies, this service definition, Vaya Health's fee schedule and other requirements and any other relevant documents for specific coverage and reimbursement for Medicaid and NC Health Choice.

1. Claim Type: Professional (CMS-1500/837P transaction) billed through Vaya Health.
2. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)
    a. Provider(s) shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description.
    b. A diagnosis of a mental health disorder (can be co-occurring with SU or IDD) must be present to bill for this service. (See 42 CFR § 435.110)
3. Codes and Modifiers: Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
4. Billing Units: Providers bill this service on a unit basis. 1unit = 1 week.
5. Place of Service: community
6. Prior Authorization: No prior auth as members can receive a pass thru of 1 billable unit per week for 8 weeks.
7. NCTracks Enrollment: Providers must be enrolled through NCTracks and ensure valid NPIs, taxonomies, sites, zip code (+4) and all other provider demographic information provided to Vaya Health matches the information in NCTracks to bill Vaya Health and be reimbursed for this service.
8. Coordination of Benefits: Providers must file with primary payor(s) prior to submission of claims for payment to Vaya Health, if applicable.
9. Vaya Health reimburses providers for clean claims for services rendered in accordance with this Service Definition.