Enhanced Crisis Response

H2011 U5 U1 – Weekly unit
H2011 U5 TS – 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 a team approach, including a licensed clinician, which provides an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth at risk of admission to the emergency department (ED) or youth in a non-therapeutic home and 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. 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. The service will last until the child and family have been established in sufficient supports.

Service elements/treatment interventions include the following:

- Crisis management: Crisis intervention and support is provided in collaboration with Mobile Crisis Management (MCM) 24 hours a day, seven day a week, 365 days a year.
- Intensive case management: This component helps members gain access to necessary care, including 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: Another component is linkage to Therapeutic Foster Care and other programs as appropriate/clinically warranted.
- Intensive supports for children in Department of Social Services (DSS) homes or kinship placements: These include DSS foster homes and DSS group homes.
- Discharge and aftercare planning: These processes allow the team to decide what the member needs for a smooth transition from one level of care to another and for ongoing monitoring.

Expected Outcomes

ECR is expected to prevent ED assessments/admissions among members who are at risk of presenting to the ED. If a member is ready for discharge from the ED but does not have an appropriate placement to return to, 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, the ECR shall help engage the family, decrease crisis events, link to services, and maintain the member in the community with outpatient/enhanced services.

Child and family goals:

1. Stabilize present issue/concern
2. Assess and eliminate barriers to accessing behavioral and physical health services and supports through active family engagement strategies

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3. Link to appropriate services and supports as needed by the family and youth
4. Promote emotional and behavioral functioning
5. Empower and educate families and children to monitor, manage, and cope with similar situations in the future
6. Establish and build resiliency skills
7. Strengthen the family and youth's natural support system

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 Partners 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).

As this service includes a case management component, providers must clearly outline on the member's care plan how they will collaborate with the Tailored Care Management provider 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. The number of contacts per week is based on the risk assessment and the child and family needs.

Phase One – Response and Screening/Assessment:

- Initial in-person or virtual meetings with the youth/adolescent and family by staff occurs within 24 hours of crisis referral for follow-up.
- Completion of the NC Crisis Assessment Tool (CAT) occurs within 72 hours of the initial appointment.

Phase Two – Ongoing Stabilization, Engagement, and Transitions: Many children and families will require follow-up care and support after a behavioral health crisis incident. The level of follow-up care and support is based on the assessment of the youth and family needs.

The subsequent delivery of services depends, in part, on the assessed acuity levels but also considers family needs and preferences and clinical judgment.

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/developmental disability (MH/SU/IDD) provider organization that meets the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Use 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 Partners 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 North Carolina Department of Health and

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Human Services (NCDHHS).

Staffing Requirements

Position	Minimum Staffing	Staff Qualifications
Clinical Program Director	1 FTE	The Clinical Program Director shall be a licensed mental health professional holding any of the following licenses: Licensed Psychologist, Licensed Clinical Social Worker, Licensed Clinical Social Worker Associate, Licensed Clinical Mental Health Counselor, Licensed Clinical Mental Health Counselor Associate, Licensed Marriage and Family Therapist, or Licensed Marriage and Family Therapist Associate. The Clinical Program Director shall have three years of clinical experience with children with serious emotional disturbance, with a minimum of two years post-graduate school.
Qualified Professional	1 FTE	An individual who (a) who meets the requirements of a "qualified professional; or Associate Professional; or Paraprofessional" specified in 10A NCAC 27G .0104(19); (b) has the knowledge, skills, and abilities required by the population and age to be served to provide case monitoring and support tasks, as well as education related to skill development and reinforcement/practice of those skills with members and their families; and (c) has at least one year of experience with the population and ages to be served.
Child and Family Partner	1 FTE	The Child and Family Partner has specialized training in trauma-informed care, knowledge of local resources, and how local systems (DSS, courts, schools) function, and has lived experience with the child and family behavioral health system. The Child and Family Partner must be certified or in the process of seeking certification.

Supervision

Staff must receive scheduled supervision that focuses on the child and family needs from the Program Director on a weekly basis. In addition, supervision must help delineate roles so that each team member knows what they need to focus on with the child and family, as well as provide crisis support as needed. If supervising more than one staff member, one of the required supervision meetings may occur as a group supervision. Program Director must also be available to staff as needed to staff cases when requested by the staff or to provide coverage for staff member(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 staff complete the required NCDHHS credentialing process and maintain their licensure, if applicable.

For licensed professionals: The provider organization will complete the CAQH application, (and if needed, enroll with NCTracks and obtain an NCID and NPI. To provide ECR, there must always be a team consisting of a Program Director, Qualified Professional, and a Family Partner. For new providers, the Program Director may begin seeing members prior to hiring a Qualified Professional and Family Partner.

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Provider must be available 24/7/365 to service as the crisis responder for the youth.

In instances of staff turnover, the provider may use other staff to ensure adequate coverage but must alert Vaya Partners if this occurs and have a written plan for coverage. In addition, the staff providing coverage must have completed the required trainings to best support the child and family. Vaya Partners 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
Clinical Program Director	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) • Incident Report Training • Trauma-Informed Care	CPI Refresher
Qualified Professional	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) • Incident Report Training • Trauma-Informed Care	CPI Refresher
Child and Family Partner	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) • Incident Report Training • Trauma-Informed Care	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 Partners region, be enrolled in the Vaya Partners Tailored Plan or Medicaid Direct PIHP, 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 also meets at least one of the following:

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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 toward 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.

Prior Approval Requirements

Members will receive a passthrough of one billable unit per week for eight weeks. If a member needs services beyond the eight-week passthrough, n 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 passthrough can be requested for four additional units per reauthorization 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 following:

- 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: Services include Therapeutic Foster Care and other programs as appropriate/ clinically warranted (these services would overlap for 30-60 days).

Transition or Discharge Criteria

Any of the following are sufficient for discharge from ECR:

1. The child/youth's goals for the ECR service have been met, barriers to service engagement have been addressed, and youth/family has started and engaged in services with the appropriate service provider.
2. The assessment indicates that the youth would benefit from a higher or lower intensity of service, and the youth has started and is engaged with this higher or lower level of services.
3. The caregiver/family has withdrawn consent for treatment, and there is no court order requiring such treatment.

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 age 21 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

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practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain their 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

- This is a periodic service and 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 Partners.
- 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.
- Documentation required for this service should be maintained in the provider's medical record for the individual, and a full-service note is required for each contact. This should include a note of the activities performed, amount of time spent, agencies contacted (if applicable), and signature and credentials of the individual providing the service.
- If the services are delivered telephonically or through telehealth methods, the documentation must clearly support why this is the most appropriate service delivery method.
- A signed service order must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), licensed psychologist, physician assistant (PA), or a nurse practitioner (NP) according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which the service was ordered. A service order must be in place prior to or on the day that the service is initially provided to bill for the service. The service order is valid for one year from the date of the original service order. Service orders may not be backdated.
- Providers shall make all documentation supporting claims for ECR reimbursed by Vaya Partners available to Vaya Partners, NCDHHS, and CMS upon request.

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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 Partners' fee schedule and other requirements, and any other relevant documents for specific coverage and reimbursement for Medicaid.

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

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