OASAS Crisis Intervention Service Guidance

I. Introduction:

Crisis Intervention Services were authorized in October 2015 in NYC and July 2016 for rest of state under the New York State 1115 waiver as a demonstration benefit[1]. While Mobile Crisis providers were utilizing this service, general outpatient providers had not been availed of the ability to utilize and be reimbursed for providing Crisis Intervention Services. Effective September 1, 2021, OASAS certified outpatient treatment providers will be able to provide this valuable and critical service.

PLEASE NOTE: MMCOs are to reimburse participating and non-participating providers for Mobile Crisis services at no less than the NYS calculated rates, unless the State approves an alternative reimbursement arrangement.

The following information is intended to guide providers in the use and reimbursement of this service.

If you have any questions regarding this guidance please email PICM@oasas.ny.gov

II. Crisis Intervention Services:

A mental health crisis is an unplanned event that requires a rapid, if not immediate response. Crisis Intervention Services are indicated for those individuals whose behavior put themselves or others at imminent risk of harm or death, including overdose, or whose mental health is deteriorating because or independent of substance use. Individuals in these situations may specifically state that they will harm themselves or others or they may have a history of at-risk behavior, such as non-fatal overdose or self-injury, that may be exacerbated by substance use.

Crisis Intervention Services utilize a variety of interventions to stabilize the individual and ensure the safety of the individual or others. Clinical staff and/or Peers work with the individual , their family members, and other collaterals to identify a potential mental health or personal crisis, develop a crisis management plan, and/or as appropriate, seek other supports to restore stability and functioning. The staff member assigned to an individual in crisis will be determined by the nature of the acute incident and the risk of harm to the

[1] The full context of this information can be found in Crisis Intervention Benefit: Mobile Crisis Component Benefit and Billing Guidance. Please note not all the information in this guidance is applicable to OASAS. OASAS Providers should consult the **OASAS Medicaid APG Clinical and Billing Manual**.

individual and/or others.. Appropriate training and supervision should be provided to all staff who are performing this service.

Who is appropriate for Crisis Intervention Services?

- Someone who states, or is reported by others to have stated, that they intend to harm themselves,
- Someone who states, or is reported by others to have stated, that they intend to harm others,
- Someone whose substance use puts them at risk for overdose,
- Someone whose substance use puts them , at risk for a mental health crisis that may require hospitalization,
- Someone who is not using substances but whose mental health is deteriorating and is at risk for hospitalization,

How is Crisis Intervention different than Complex Care Coordination?

- Complex Care Coordination focuses on care coordination whereas Crisis Intervention focuses on risk of harm mitigation,
- Complex Care Coordination involves multiple services organizations to meet the individual's needs, whereas Crisis Intervention is directly, or most immediately with the individual in need,

What are the components of Crisis Intervention Services?

- Triage and response,
- In person response,
- Telephonic or in-person follow-up.

How do we assess someone for Crisis Intervention Services?

Triage is the first line of intervention for Crisis Intervention Services. Most triage will happen by telephone with the individual or a family member or other collaterals, or but it can also happen in-person if someone walks into the clinic or is brought to the clinic by others.

Triage should include but is not limited to:

- Presenting problem(s)
- Suicide/Homicide Risk Assessment,

- Assessment for intoxication or overdose risk,
- Mental Status Examination
- Determining the need for immediate intervention by emergency services, such as the , police, the fire department, emergency medical services, etc.

What happens after someone is assessed as needing Crisis Intervention Services?

Document an initial plan of services which would include:

- Therapeutic communications and interactions to help alleviate symptoms due to a mental health condition and/or substance use.
- Development of a safety plan or crisis prevention plan.
- Referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care, or
- Decision to dispatch Crisis Services for further intervention.

When should crisis services be provided in the community?

- When telephonic interventions have not helped de-escalate the crisis or prevent at-risk behavior,
- When on site interventions may be more effective at de-escalating the crisis, or preventing or interrupting at-risk behaviors,
- When an onsite medical intervention could lead to MAT related intervention,
- When family members and/or friends are calling in the crisis and further on-site assessment is necessary,
- When on site intervention can help facilitate a connection with needed services.

What are Crisis Intervention follow-up services?

Follow-up services can occur within 14 days of the qualifying crisis episode[2]. They may be delivered telephonically or in person. Services may include but are not limited to:

[2] A qualifying crisis intervention episode begins with the provider's initial contact with the individual. The end of the crisis episode is defined by the amelioration of the individual's presenting symptoms or, if clinically indicated, when the person is transferred to the recommended level of care.

- Continued interventions such as counseling or medications to help the individual maintain stability,
- Facilitation of treatment services, care coordination, medical health or other needs related to the original crisis,
- Follow-up with the individual and collaterals to confirm enrollment in recommended treatment or services.

What will we need to add to our program to provide Crisis Intervention Services?

Policies and procedures for providing the service including but not limited to:

- Description of Crisis Intervention Service and each of its components,
- Staffing plan, including required staff credentials and/or training for different types of crisis situations,
- Clinical oversight
- emergency procedures/contacts
- staff training
- Linkages with inpatient withdrawal and stabilization services, emergency rooms, CPEPs, mental health services, and other services the individual may need in the community.

How should staffing be determined for Crisis Intervention Services?

Crisis Response Services **must be provided** by at least one of the following working **with appropriate supervision and within their Scope of Practice** :

- Licensed[3]:
  - Physician ,
  - Nurse Practitioner,
  - Physician Assistant,
  - Registered Nurse,
  - Psychologist,
  - Master or Clinical Social Worker (LMSW, LMHC),
  - Mental Health Counselors (LMHC, LMFT, LCAT),
- Unlicensed Clinical Staff:

[3] Supervision and SOP for Licensed Professionals as given by the NYS Office of Professions.

- Limited Permit staff issued by NYSED[2,4],
- Interns/Students[3],
- Credentialed Alcoholism and Substance Abuse Counselors (CASAC, CASAC-T)[3],

- Certified Recovery Peer Advocates (CRPA)[5, 6].

How will we be reimbursed for Crisis Intervention Services?

- Reimbursement is by Medicaid, commercial insurance, and/or self-pay.
- For Medicaid reimbursement, the following procedure codes should be utilized with the appropriate provider rate code:

  Crisis Intervention Brief: H2011 – 15 minute minimum

  Crisis Intervention Normative: S9485 – 90 minute minimum

- **Crisis Intervention Services** are billed per unit. H2011 is a 15 minute unit with a 6 unit/90 minute per day maximum. S9485 is a 90 minute unit, one unit per day maximum.

- Services delivered telephonically should utilize the GT Modifier on the claim.

PLEASE NOTE: Prior authorization for Mobile or Telephonic Crisis Response Services **is not allowed**. MMCOs may not subject Mobile Crisis services to utilization review. Mobile Crisis service activities must occur within the context of a potential or actual psychiatric crisis.

For complete Medicaid reimbursement information please review the **OASAS Medicaid APG Clinical and Billing Manual**.

[4] Supervision and SOP as given by NYS OASAS SUD Counselor Scope of Practice Guidelines.
[5] Supervision and SOP as given by OASAS CRPA Guidance Document.
[6] CRPA's are not clinical staff but can be utilized as support to an individual in crisis's collaterals, or to assist in follow-up engagement in treatment.