Optum

Crisis Residential and Stabilization Services Overview

March 2024

Agenda / Objectives

1. What is Crisis Residential and Stabilization Services
2. Review of Standards and Regulations
3. Crisis Residential and Stabilization Specifications
4. Case Scenario
5. Additional Resources

Crisis Residential and Stabilization Services Overview

Crisis Residential and Stabilization Services – Overview

Alaska Admin Code: 7 AAC 139.350

Crisis Residential and Stabilization (CSS) is a short-term residential, medically monitored stabilization service for individuals presenting with acute mental or emotional disorders requiring psychiatric stabilization.

CSS services are provided 24 hours a day, seven days a week and are designed to restore the individual to a level of functioning that does not require inpatient hospitalization.

United Behavioral Health operating under the brand Optum

Crisis Residential and Stabilization Services Standards and Regulations

Crisis Residential and Stabilization Services – Standards and Regulation Links

Crisis Residential and Stabilization Services (CSS):

Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Provider Services (state.ak.us)
7 AAC 139.350 Pages 83-85

The regulation for Crisis Residential and Stabilization Services (CSS) is located at Alaska Admin Code (akleg.gov) 7AAC 139.350

Crisis Residential and Stabilization Services Regulations – Admin Code

The regulation for Crisis Residential and Stabilization Services (CSS) 7AAC 139.350:

The crisis residential and stabilization services provided to an eligible individual presenting with acute mental or emotional disorders requiring psychiatric stabilization and care may be provided in a licensed general acute care hospital, a licensed psychiatric hospital, a United States Indian Health Service facility, a licensed critical access hospital, a community behavioral health services provider approved by the department under 7 AAC 136.020, or a licensed crisis stabilization center. The crisis residential and stabilization services must be provided:

As a short-term* residential program with 16 or fewer beds

As a medically monitored stabilization service designed to restore the individual to a level of functioning that does not require inpatient hospitalization

To assess the need for medication services and other post-discharge treatment and support services

*In this section, "short term" means not more than seven days and may be extended through a service authorization

Crisis Residential and Stabilization Services Specifications

Crisis Residential and Stabilization Services – Service Description

Service Description:

Crisis Residential and Stabilization (CSS) is a short-term residential, medically monitored stabilization service for individuals presenting with acute mental or emotional disorders requiring psychiatric stabilization. CSS services are provided 24 hours a day, seven days a week and are designed to restore the individual to a level of functioning that does not require inpatient hospitalization.

Crisis Residential and Stabilization Services – Service Components

Service Components:

- Individualized crisis assessment
- Psychiatric evaluation services
- Nursing services
- Medication services-including prescription, administration, and management
- Crisis intervention services which include therapeutic interventions to decrease and stabilize the presenting crisis
- Identification and resolution the contributing factors to the crisis when possible
- Stabilization of withdrawal symptoms if appropriate
- Advocacy, networking, and support to provide linkages and referrals to appropriate community-based services

Crisis Residential and Stabilization Services– Contraindicated Services

There are no contraindicated services for Crisis Residential and Stabilization Services (CSS)

Crisis Residential and Stabilization Services - Service Requirements

CSS services must provide:

- A short-term residential program with 16 or fewer beds. The short-term residential program is not more than 7 days in length.
- Medically monitored stabilization services designed to restore the individual to a level of functioning that does not require inpatient hospitalization.
- Assessment for the need for medication services and other post-discharge and support services.
- Individuals must be seen by a physician, physician assistant, psychiatrist, or advanced practice registered nurse within 24 hours of admission to conduct an assessment, address issues of care, and write orders as required.

Crisis Residential and Stabilization Services - Service Requirements - Continued

- An individualized crisis assessment based on an evidence-based risk assessment tool.
- An individualized crisis treatment plan.
- Daily documentation in the clinical record of the individual’s progress toward resolution of the crisis.
- At least one CSS service component per day must be provided by a medical professional with prescribing privileges.

Crisis Residential and Stabilization Services – Staff Qualifications

CSS services may be staffed by a multidisciplinary team of qualified professionals. Providers qualified to be reimbursed for eligible services include:

- Licensed Physicians
- Licensed Physician Assistants
- Advanced Practice Registered Nurses
- Licensed Registered Nurses
- Licensed Practical Nurses
- Mental Health Professional Clinicians
- Substance Use Disorder Counselors
- Certified Medical Assistants/Certified Nursing Assistants
- Community Health Aides
- Behavioral Health Clinical Associates
- Behavioral Health Aides
- Peer Support Specialists

Crisis Residential and Stabilization Services– Target Population and Service Location

Target Population:

Individuals who are presenting with acute mental or emotional disorders requiring psychiatric stabilization and care.

Service Location:

05-Indian Health Service Free-standing Facility
06-Indian Health Service Provider-based Facility
07-Tribal 638 Free-standing Facility
08-Tribal 638 Provider-based Facility
23- Emergency Room
53-Community Mental Health Center
99-Other appropriate place of service

Telehealth may be allowable for this service if prior authorization is obtained.

Crisis Residential and Stabilization Services – Service Frequency/Limits, Service Authorization, Service Code, Unit Value and Relationship to Other Services

Service Frequency/Limits: 7 days/units per State Fiscal Year

Service Authorization: Service Authorization may be requested after State Fiscal Year limits have been reached.

Service Code: S9485 V2

Unit Value: 1 unit = 1 day

Time-based billing rules apply per 7 AAC 105.230

Relationship to Other Services: Crisis Residential and Stabilization services may be provided concurrently with any service listed in standards manual that is not otherwise contraindicated.

Crisis Residential and Stabilization Services– Additional Information

Programs may employ a multidisciplinary team of professionals to perform Crisis Residential and Stabilization Services; however, to be eligible to draw down the per unit rate, each unit of services must be provided:

- Directly by a physician, physician assistant, psychiatrist, or advanced practice registered nurse, or
- At the direction of a physician, physician assistant, psychiatrist, or advanced practice registered nurse

Qualified providers of CSS services are recommended to follow the SAMHSA “Essential Principles for Modern Crisis Care Systems” from the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary.
samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

All minimum service requirements must be met to bill for the daily rate. If all minimum service requirements are not met, a provider may bill individually for the services the member participated in on that day.

Case Scenario

Crisis Residential and Stabilization Services – Case Scenario

Tate is a 25-year-old male admitted to Set Free Alaska on August 1, 2023, into the Crisis Residential and Stabilization (CSS) level of care under the care of Lucas Bridgerton, MD.

Tate has been experiencing suicidal ideation for the past month with no current plan. He also has a history of major depression and has anxiety. He also has episodes of impulsive behavior which worsens when he is in stressful situations.

Tate has also used alcohol, marijuana and cocaine to escape from his depression and he realizes this is not helping his mental health issues. He has one past suicide attempt by taking an overdose when he was 18 after an argument with his girlfriend at the time.

He describes this relationship as toxic and dysfunctional and they broke up shortly after his attempt at taking his life.

Crisis Residential and Stabilization Services – Case Scenario (continued)

Tate is conflicted and withdrawn at times and has troubled relationships with his parents, siblings and peer group. His self-care and hygiene is neglected frequently due to his depression. He reports issues of poor sleep and has not eaten a healthy meal in at least two weeks.

Tate has had some part time jobs off and on but ends up leaving them due to not feeling motivated to go into work. He currently lives with his parents who are at their wits end as they try to help Tate, but he feels life is not worth living.

Crisis Residential and Stabilization Services – Case Scenario (continued)

Tate has been diagnosed with Major Depressive Disorder recurrent, mild (DSM F33.0) and Generalized Anxiety Disorder (DSM F41.1) and feels it is getting worse. He denies any psychosis and says he has never heard voices or seen things that are not there. He has been on anti-depressants and anti-anxiety medications in the past and has also been on mood stabilizers. He has not been on any medication for over a month. He states he felt best when he was on Zoloft and Depakote.

Tate also has Type 1 Diabetes Mellitus, but he does not use his insulin regularly.

Tate shares he has not used Alcohol or Drugs recently due to lack of finances and feeling his depression is spiraling out of control and he knows the substances would just make him feel worse. He has never been diagnosed with a substance use disorder.

Crisis Residential and Stabilization Services – Case Scenario (continued)

Tate has had significant disruption with his current situations due to his “crippling depression and anxiety” and feeling he has nowhere to turn. He rates his current stress level at a 10 out of 10 with 10 being the highest level on the scale.

Tate feels if he does not get help now, he cannot go on. He also has experienced interpersonal loss and conflict with his peer relationships due to his depression and inability to hold down a job. He also feels alone even though is parents are supportive, but he would prefer they leave him alone.

Tate wishes he did not feel like a failure, but he does not remember the last time he felt happy.

Crisis Residential and Stabilization Services – Case Scenario (continued)

Tate’s family is supportive of him but feels with his current symptoms, they are afraid he will harm himself and they would be devastated if anything happens to him. His younger siblings still live in the home and his parents worry if Tate does not get the help he needs, his younger brothers might follow in his footsteps.

Tate’s parents are willing to be involved in his treatment and are agreeable to family sessions once he has stabilized and are also agreeable to him returning to live with them if that is what he desires.

Crisis Residential and Stabilization Services – Case Scenario (continued)

Tate has demonstrated an inconsistent capacity to deal with stressors and maintain emotional stability. Previous experience in treatment at a lower level of intensity has not been successful in relief of symptoms or optimal control of symptoms as he has tried Outpatient psychotherapy as well as Medication Management with Dr. Bridgerton.

Tate has maintained recovery in the past for periods of time, but only with strong professional support and/or peer supports or in structured settings.

Crisis Residential and Stabilization Services – Case Scenario (continued)

Tate has some hesitancy and fear in accepting his diagnosis of depression and anxiety. He feels he does not have the confidence to be successful in life and asks is life worth living and at present has limited desire to change his intentions.

Tate relates to treatment with some difficulty and establishes few trusting relationships. He has a history of agreeing to treatment but does not utilize the available resources independently and will go to treatment at his parent's request.

Tate has limited ability to accept responsibility for recovery.

Applying the LOCUS Dimensions

Crisis Residential and Stabilization Services – Applying the LOCUS Dimensions

Risk of Harm:

Tate has current suicidal ideation with no current plan but feels if he does not get help, he does not know what he will do. He feels his depression and anxiety are the worse they have ever been. He can contract for safety in the facility but is not sure what might happen if he was discharged at this time.

Functional Status:

Tate is conflicted and withdrawn at times and has troubled relationships with his parents, siblings and peer group. His self-care and hygiene is neglected frequently due to his depression. He reports issues of poor sleep and has not eaten a healthy meal in at least two weeks.

Crisis Residential and Stabilization Services – Applying the LOCUS Dimensions

Co-Morbidity: Developmental, Medical, Substance Use and Psychiatric:

Tate has depression and anxiety and feels it is getting worse. He denies any psychosis and says he has never heard voices or seen things that are not there. He has been on anti-depressants and anti-anxiety medications in the past and has also been on mood stabilizers. He has not been on any medication for over a month. He states he felt best when he was on Zoloft and Depakote. Tate also has Type 1 Diabetes Mellitus, but he does not use his insulin regularly which puts him at risk.

Recovery Environment (Environmental Stress):

Tate feels his depression and anxiety are “crippling” and if he does not get help, he is not sure he can go on.

Crisis Residential and Stabilization Services – Applying the LOCUS Dimensions

Recovery Environment (Environmental Support):

Tate's family (his parents and his two younger siblings) are supportive and want to help Tate but need guidance on how to help him. They are willing to attend family sessions once the initial crisis phase for Tate has subsided.

Resiliency and Treatment History:

Tate relates to treatment with some difficulty and establishes few trusting relationships. He has a history of agreeing to treatment but does not utilize the available resources independently and will go to treatment at his parent's request. Tate has limited ability to accept responsibility for recovery.

Crisis Residential and Stabilization Services – Applying the LOCUS Dimensions

Treatment Acceptance and Engagement:

Tate has been able to develop relationships with previous providers but when things become stressful for him, he tends to stop treatment and does not fully understand and accept the “why” and how his providers have defined the problem and consequences.

Tate needs help with accepting responsibility for his behaviors and to fully cooperate in treatment planning and maintaining tenure in the community once stabilized.

Crisis Residential and Stabilization Services – Applying the LOCUS Dimensions

Clinical Rationale:

Based on the clinical information provided, Tate meets criteria for LOCUS Service Intensity Level 6 – Medically Managed Residential Services due to his current presentation of stressors, suicidal ideation without plan, impulsiveness, substance abuse issues and inability to safely be treated in a less restrictive environment at this time.

The requested level of care will provide interventions to address the participant's current symptoms/chronic conditions/barriers including psychotherapy, medication, patient education, stable housing, and peer support services to ensure needs have been fully met.

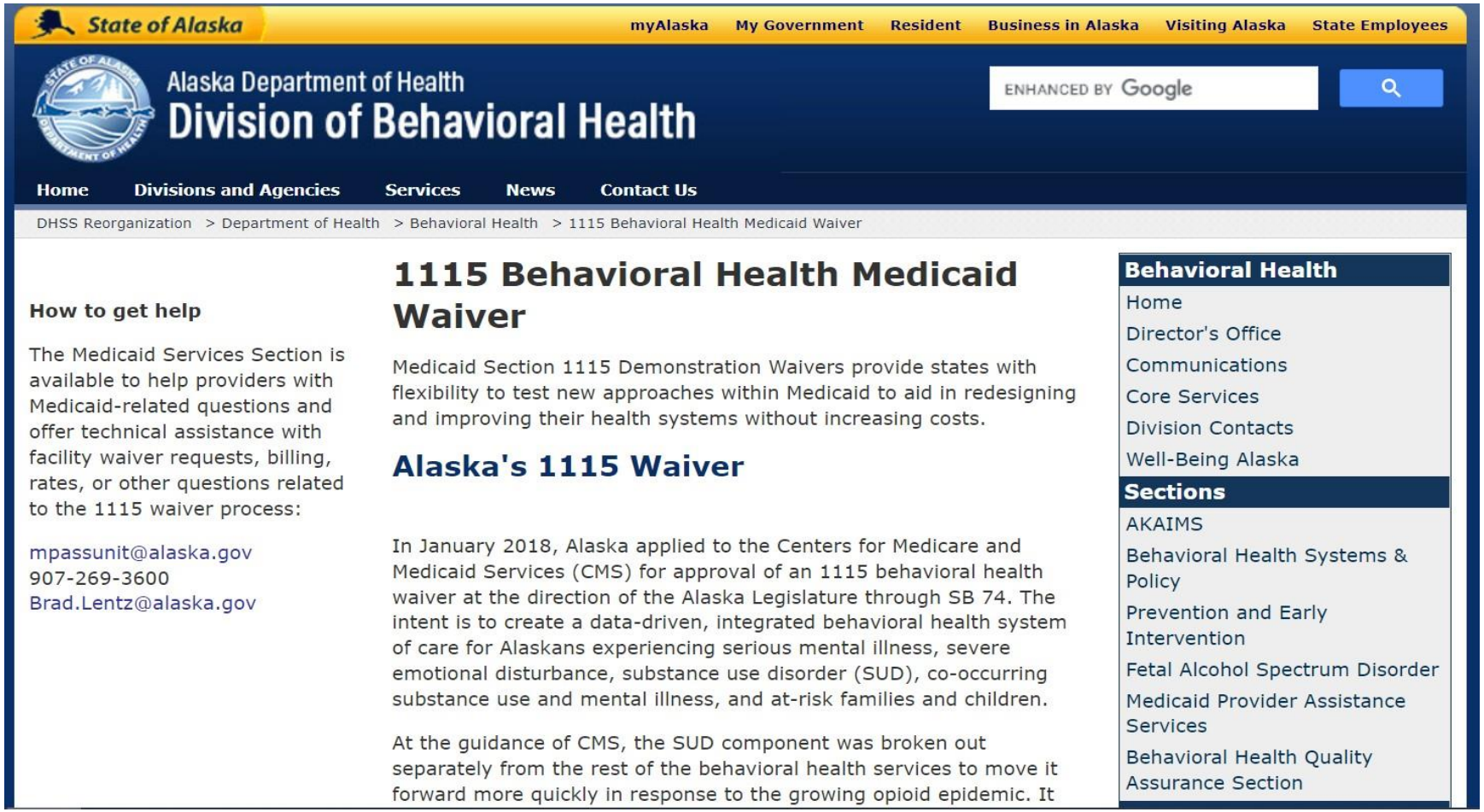
Once stabilized, the aftercare plan includes transitioning to the Mental Health Partial Hospitalization Program (PHP) level of care to learn new skills for a successful transition to a stable recovery-positive lifestyle to maintain community tenure.

Additional Resources

State of Alaska, Division of Behavioral Health Website

Division of Behavioral Health (alaska.gov)

1115 Behavioral Health Medicaid Waiver (alaska.gov)

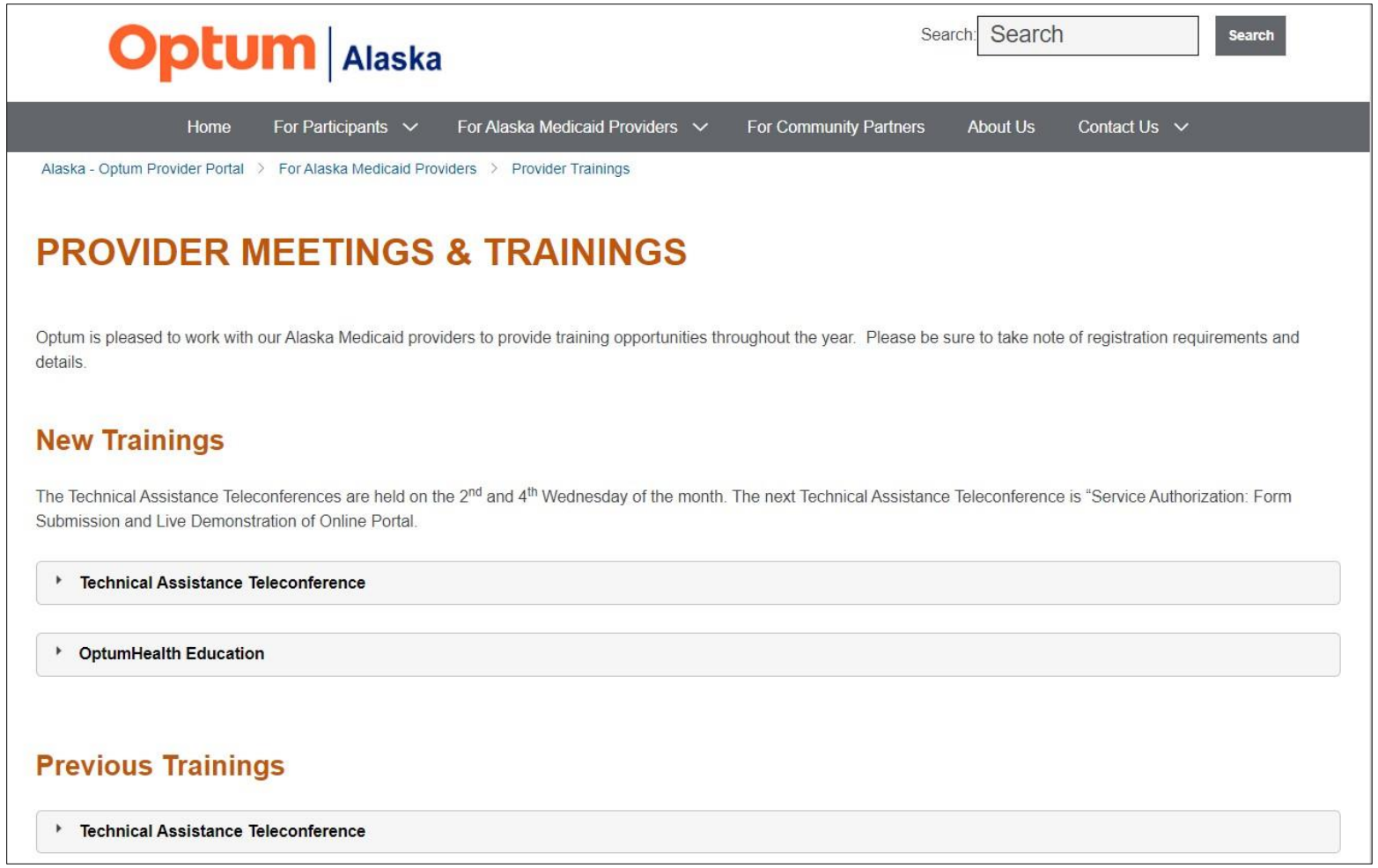


Optum Alaska Website

alaska.optum.com

Optum Alaska Provider Trainings Webpage

[Optum Alaska - Provider Trainings]



Contact Information for Optum Alaska

The Optum Alaska Call Center:

Phone: 800.225.8764

Hours: 8 a.m. to 6: p.m. AKST, Monday through Friday

Optum Alaska Provider Relations:

Email: akmedicaid@optum.com

Please ensure that any email inquiries sent to Provider Relations are sent securely if PHI is present. General inquiries that do not contain PHI can be sent via regular unsecure email. When submitting an inquiry to Provider Relations, please be sure to include the following:

- Non-PHI (regular email)
- Date of Service
- Provider Name and NPI/TIN
- Reason for the inquiry (as much detail as possible)

Q&A