REIMBURSEMENT POLICY

Mobile Crisis and Stabilization Services

Active

Policy Number: Behavioral Health – 006
Policy Title: Mobile Crisis and Stabilization Services
Section: Behavioral Health
Effective Date: 05/19/15

Product: ☒Commercial ☒FEP ☐Medicare Advantage ☐Platinum Blue

Description

Mobile crisis and stabilization services assist a person who is experiencing a mental health crisis to cope with that crisis and stay in their own home and/or return to a baseline level of functioning.

To be eligible for mobile crisis services, individuals must be experiencing a mental health emergency or crisis, including those recipients with a co-occurring substance abuse and mental health disorders.

Definitions

Covered mobile crisis and stabilization services include:

- Crisis Assessment - A crisis assessment is an immediate, face-to- face evaluation by a physician, mental health professional or crisis- trained mental health practitioner.
- Crisis Intervention - Mobile crisis interventions are face-to-face, short-term, intensive mental health services provided during a mental health crisis or emergency.
- Crisis Stabilization - Crisis stabilization services are mental health services, provided after crisis intervention, to help the recipient return his/her functioning to the level it was before the crisis.
- Community Intervention - When provided in the context of crisis response services, community intervention may be used to educate the recipient's family and significant others on mental illness and ways to support the recipient.

Policy Statement

Eligible providers

Eligible provider must be enrolled through DHS as a crisis service provider (adult and child).
The following services must be submitted on an 837P claim format.
Crisis Service Billing

Code	Description of Service	Billing Unit
S9484	adult or child crisis assessment, intervention, and stabilization individual, licensed professional or individual rehab worker	1 unit per 60 minutes
H2011	adult or child crisis assessment, intervention, and stabilization individual, licensed professional or individual rehab worker	1 unit per 15 minutes

Timed Unit Reporting
When a procedure/service indicates time, more than half of the designated time must be spent performing the service for a unit to be billed. In the case of a 60-minute service, at least 31 minutes of the service must be performed.

Coverage of services is subject to available plan benefits.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Updated clinical documentation is required for ongoing service reviews.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A	
ICD-10 Diagnosis:	N/A	
ICD-10 Procedure:	N/A	
CPT/HCPCS:	S9484	H2011
Revenue Codes:	N/A	
Deleted Codes:	N/A	

Policy History

Initial Committee Approval Date:	May 19, 2015
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Cross Reference:	N/A