Blue Cross Blue Shield of Michigan

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Clinical program requirements

For behavioral health crisis services

For Blue Cross commercial, Medicare Plus Blue℠
Blue Care Network commercial and BCN Advantage℠

Revised January 2024

In this document

This document shows the specifications for Mobile Crisis programming and Crisis Stabilization Units for behavioral health services for Blue Cross commercial, Medicare Plus Blue, Blue Care Network commercial and BCN Advantage members.

Mobile crisis program requirements

1. Mobile Crisis services are a distinct level of care that have a written affiliation/link to additional crisis services including but not limited to Crisis Stabilization and Crisis Residential services or other existing behavioral health levels of care.
2. The Mobile Crisis Program offers emergency mobile psychiatric and mental health intervention for children and adults. This program is designed to assess clinical need, reduce symptoms, initiate co-occurring treatment, provide care management and follow-up as indicated if Member is not triaged to a higher or alternative level of care that meets their needs. Coordination of referrals to other levels of care is a key component with complete transmittal of the assessment and progress with interventions so the next level of care has a complete picture of what has been successful to the Member's progress.
3. The Health Plan behavioral health Medical Director and leadership team may review Provider's credentials, outcomes, programming, and quality to ensure adequate treatment
4. The initial service is a face-to-face crisis intervention in the community to de-escalate the crisis and develop a follow up/aftercare plan with the Member. Face-to-Face can be directly in person or, if applicable, audiovisual but not telephonic-only. This could occur in a variety of settings such as:
    a. Home
    b. Work
    c. Emergency department of a general hospital
    d. Urgent care facility
    e. A school setting
    f. Physician office

5. Initial evaluation and assessment along with preliminary treatment plan needs to occur at the time of the initial meeting along with institution of the plan and initiation of treatment interventions. Any additional consultations need to be initiated (such as: medical evaluation, psychiatric consultation, testing, laboratory, radiological, or psychological).
6. An individualized treatment plan must be completed for all Members within 48 hours of the initial crisis intervention. (This could be considered completed if included in the warm handoff of the preliminary treatment plan to the next level of care to finalize.) This should be coordinated and presented to the Member and or their medical advocate with decision-making capacity for agreement.
7. Mobile Crisis services may occur for up to thirty days after the initial intervention. This may include additional crisis intervention. The Mobile Crisis team may clinically refer to other outside services, such as:
    a. Counseling and other psychotherapies, including family therapy
    b. Medical care (please refer to Member benefits for correct process)
    c. Social determinants of health assessment and intervention including but not limited to:
        i. Housing assistance
        ii. Food assistance
        iii. Other community referrals
8. The program must be staffed by qualified and licensed masters level mental health professionals and supported by certified peer support specialists. The medical director must be on-call for consultation or emergencies.
9. Provider will conduct and track progress and disposition/outcomes for annual review for the Health Plan. Provide an annual report including, but not limited to number of cases, services used, dispositions, follow up and aftercare results.
10. Initiation of any involuntary processes would be part of this team's responsibility if imminent danger involving the Member has not already been addressed by a referring entity. This may involve coordination with the appropriate authorities to triage the Member to a safe environment (likely 911 or EMS call to transport to an emergency department or hospital facility).
11. Additional services outside of the Mobile Crisis program can be reimbursed separately using standard reimbursement (e.g., IOP, PHP, psychiatric evaluation, medication monitoring)

Behavioral health crisis stabilization program requirements

1. Crisis Stabilization Unit (CSU) is a 24/7 crisis program that offers emergency behavioral health intervention services for children and adults. The services are designed to assess clinical need, reduce symptoms, and initiate co-occurring treatment both psychotherapeutic, medication or other interventions to quickly stabilize and improve symptoms such that will facilitate transition to the least-restrictive level of behavioral health care.
2. Crisis Stabilization services are performed by a multidisciplinary team including but not limited to:
    a. Psychiatrist
    b. Nurses
    c. Masters level clinicians
    d. Certified peer support specialists
3. The Health Plan behavioral health Medical Director and leadership team may review Provider's credentials, outcomes, programming, and quality to ensure adequate treatment. It is expected that the facility would be certified by the local governing entity if certification is available.
4. Program components include:
    a. Room and board support
    b. Psychiatric assessment and treatment
    c. Systematic disease process screening tool usage (evidence-based tools to be utilized, for example PHQ-9, GAD-7, YBOCS, BRS, PANSS or similar according to the condition being treated)
    d. Suicide risk assessment utilizing evidence-based tools and screening (e.g. Columbia Suicide Risk assessment)
    e. Routine evidence-based tools for acuity scoring such as the LOCUS, CAFAS, and ASAM.
    f. Medication, initiation, management, and education. Specialty Pharmacy medication may be separately reimbursed.
    g. Bio-psychosocial assessment
    h. Psychotherapy initiation

i. Nursing assessment, psychoeducation, medication instruction and services including medication reconciliation

j. Certified peer support services

k. Individualized treatment plan

l. Medical assessment

m. Discharge planning

n. Coordination of care with outside treating professional(s) including PCP and follow-up treating provider

5. Disposition and treatment plan are targeted to occur within 24 hours, but no longer than 48 hours. After receiving CSU intervention from the multidisciplinary team, Members may receive ongoing aftercare services via a new level of care with an Affiliated Provider.

6. Initiation of any involuntary processes would be part of this team's responsibility if imminent danger involving the Member has not already been addressed by a referring entity. This may involve coordination with the appropriate authorities to triage the Member to a safe environment (likely 911 or EMS call to transport to an emergency department or hospital facility).

7. Appropriate security measures in place to track individuals who leave against medical advice. Provider must notify appropriate authority when harm to self or others is indicated.

8. Provider will conduct and track progress and disposition/outcomes for annual review for the Health Plan. Provide an annual report including, but not limited to:

   a. Number of cases

   b. Services used

   c. Length of stay

   d. Dispositions

   e. Follow up and aftercare results