

**SERVICE DESCRIPTION**  
**Intensive Crisis Stabilization Services – Adults and Children**

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

**1. Description of Service**

a. Adult Intensive Crisis Stabilization Services (ICSS)

- i. Adult ICSS are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.
- ii. The PIHP must seek and maintain MDHHS approval for adult intensive crisis stabilization services in order to use Medicaid funds for program services.
- iii. These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.
- iv. Individuals must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.
- v. A crisis situation is one in which an Individual is experiencing a serious mental illness or a developmental disability and one of the following applies:
  - (1) The Individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally.
  - (2) The Individual is unable to provide him/herself clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the Individual or to another individual.
  - (3) The Individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior, as a result of the mental illness, developmental disability, or emotional disturbance, can reasonably be expected in the near future to result in physical harm to the Individual or to another individual.
- vi. Adult ICSS are intensive treatment interventions delivered by an intensive stabilization treatment team under the supervision of a psychiatrist. Component services for adult ICSS include:
  - (1) Intensive individual counseling/psychotherapy;
  - (2) Assessments (rendered by the treatment team);
  - (3) Family therapy;
  - (4) Psychiatric supervision;
  - (5) Therapeutic support services by trained paraprofessionals.

b. Children's Intensive Crisis Stabilization Services

- i. Children's ICSS are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement.
- ii. The PIHP must seek and receive MDHHS approval, initially and every three years thereafter, for the children's intensive crisis stabilization services to use Medicaid funds for program services.

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- iii. These services must be available to children or youth ages 0 to 21 with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD), and their parents/caregivers who are currently residing in the catchment area of the approved program and are in need of intensive crisis stabilization services in the home or community.
- iv. A crisis situation means a situation in which at least one of the following applies:
  - (a) The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance.
  - (b) The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally.
  - (c) The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning.
  - (d) The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement.
- v. The goals of children's ICSS are as follows:
  - (a) To rapidly respond to any non-imminently life threatening emotional symptoms and/or behaviors that are disrupting the child's or youth's functioning;
  - (b) To provide immediate intervention to assist children and youth and their parents/caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the child's or youth's functioning ability;
  - (c) To prevent/reduce the need for care in a more restrictive setting (e.g., inpatient psychiatric hospitalization, detention, etc.) by providing community-based intervention and resource development;
  - (d) To effectively engage, assess, deliver and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve functioning; and
  - (e) To enhance the child's or youth's and parent's/caregiver's ability to access any identified community-based supports, resources and services.
- vi. Component services for children's ICSS include
  - (a) Assessments (rendered by the treatment team)
  - (b) De-escalation of the crisis
  - (c) Family-driven and youth-guided planning
  - (d) Crisis and safety plan development
  - (e) Intensive individual counseling/psychotherapy
  - (f) Family therapy
  - (g) Skill building
  - (h) Psychoeducation
  - (i) Referrals and connections to additional community resources
  - (j) Collaboration and problem solving with other child- or youth-serving systems, as applicable
  - (k) Psychiatric consult, as needed

### 1. Practice Principles

- a. Providers are encouraged to offer evidence-based and promising practices as part of the Medicaid covered specialty services where applicable. Providers shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended.
- b. Provider will comply with the principles of person-centered planning as outlined in the MDHHS BHDDA Person-Centered Planning Policy.
- c. MDHHS encourages the use of natural supports to assist in meeting an Individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the Individual's individual plan of service.
- d. Length of stay is authorized by CMSHP.

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- e. The focus is to promote recovery of Individuals served. Symptom escalation can be frequent and characterized by rapid onset. Level of functioning varies depending on severity of symptoms. Maintaining optimal behavioral health and integration in the community requires an assertive approach that provides ongoing assessment to titrate interventions to meet changing needs.
- f. Treatment is directed toward meeting the Individual's needs through targeted interventions. For example, treatment may be focused on reducing the risk of relapse, reinforcing pro-social behaviors and assisting with the healthy reintegration into the community. Treatment plans are individualized. Treatment may consist of a daily regime that could include individual and group therapeutic and rehabilitative counseling, didactics, peer therapy and recovery supports.
- g. The program must reflect the principles and practices of person-centered planning and recovery.
- h. Formulation and implementation of a treatment plan within 48 hours after resolution of immediate crisis situation.
- i. Assessment, coordination, and referral to ancillary and supportive services necessary to resolve the crisis.
- j. Facilitate connection with and assist in development of natural/community supports.
- k. Provide individual and family therapy per the stabilization plan.
- l. Formulate a discharge plan, including a different level of care, if indicated, and forward to responsible CMHSP.

### 2. **Credentialing Requirements** *Refer to current Medicaid Provider Manual for updated requirements*

- a. Provider will assure that licensed professional staff are licensed and/or registered in the State of Michigan provide services at the level authorized by the Payor. Licensed professionals shall act within the scope of practice defined by their license.
- b. Provider shall assure that all staff providing services are qualified and trained to provide services at the level authorized by the Payor.
- c. Provider shall ensure that all vehicles used for transporting the Individual(s) under this agreement are in safe operating condition and contain first aid equipment.
- d. Provider shall permit only responsible staff with an appropriate valid driver's license and insurance, as required by State law, to operate motor vehicles while transporting Individual(s) as evidenced by annual driving record and insurance checks.
- e. Provider shall maintain a copy of training records for each staff person for review if requested by the Payor, the PIHP, or an external review team.
- f. Providers of services must:
  - i. Be at least 18 years of age.
  - ii. Be able to prevent transmission of any communicable disease from self to others in the environment where they are providing supports.
  - iii. Be able to communicate expressively and receptively in order to follow individual plan requirements and Individual-specific emergency procedures, and report on activities performed. Understanding and skill must be documented.
  - iv. Be in good standing with the law as outlined in the MDHHS/PIHP contract.
- g. Adult ICSS must be provided by a treatment team of mental health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. Individuals providing intensive crisis stabilization services must be mental health professionals. Nursing services/consultation must be available. The treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to Individuals with serious mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists.
- h. Children's ICSS must be provided by a mobile intensive crisis stabilization team consisting of at least two staff who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared Qualified Intellectual Disabilities Professional (QIDP), if applicable) and the second team member may be another professional or paraprofessional under appropriate supervision.

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- i. Paraprofessionals must have at least one year of satisfactory work experience providing services to children with serious emotional disturbance and/or intellectual/developmental disabilities, as applicable.
- ii. Team members must have access to an on-call psychiatrist by telephone, as needed.
- iii. At a minimum, all team members must be trained in crisis intervention and de-escalation techniques.

### 3. Service Requirements

- a. Intensive crisis services are intensive treatment interventions delivered by an intensive crisis stabilization treatment team under the supervision of a psychiatrist.
- b. Provide screening, data collection/reporting, assessment, and treatment planning.
- c. Ability to admit Individuals after hours and during the weekend.
- d. Adult ICSS may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive crisis stabilization services treatment plan must be developed. The intensive crisis stabilization treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the Individual. The case manager (if the Individual receives case management services) must be involved in the treatment and follow-up services.
  - i. The individual plan of service (IPOS) must contain:
    - (1) Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
    - (2) Identification of the services and activities designed to resolve the crisis and attain his/her goals and objectives.
    - (3) Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.
- e. Children's ICSS may be provided initially to alleviate an immediate crisis. However, following resolution of the immediate situation, an existing individual plan of service and crisis and safety plan must be updated or, for children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed.
  - i. If the child or youth is a current recipient of CMHSP services, mobile intensive crisis stabilization team members are responsible for notifying the primary therapist, case manager, or wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. It is the responsibility of the primary therapist, case manager, or wraparound facilitator to follow-up with the child or youth and parent/caregiver. The child or youth, parent/caregiver and the relevant treatment team members must revisit the current individual plan of service and crisis and safety plan and make adjustments where necessary to address current treatment needs.
  - ii. If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include appropriate referrals to the mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require. The mobile intensive crisis stabilization team is responsible for providing necessary information and referrals. The follow-up plan must also include the next steps for obtaining needed services, timelines for those activities, and identify the responsible parties. Mobile intensive crisis stabilization team members must contact the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan.
  - iii. For children's ICSS, the treatment plan must address the child's needs in context with the family needs. Educational services must also be considered and the treatment plan must be developed in consultation with the child's school district staff.

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- f. Adult ICSS may be provided where necessary to alleviate the crisis situation, and to permit the Individual to remain in, or return more quickly to, his/her usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs. Intensive crisis stabilization services may not be provided in:
  - iv. Inpatient settings;
  - v. Jails or other settings where the Individual has been adjudicated; or
  - vi. Crisis residential settings.
- f. Children's ICSS must be provided where necessary to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment. However, children's ICSS may not be provided in:
  - i. Inpatient settings;
  - ii. Jails or detention centers; or,
  - iii. Residential settings (e.g., Child Caring Institutions, Crisis Residential)
- g. Mobile intensive crisis stabilization teams must be able to travel to the child or youth in crisis for a face-to-face contact in one hour or less in urban counties, and in two hours or less in rural counties, from the time of the request for intensive crisis stabilization services.
- h. Psychiatric consultation is available. Services must include evaluations for psychotropic medication (by qualified medical professionals) when need is identified. Provider must assume responsibility to provide for psychotropic medication needs for thirty (30) days after discharge unless a subsequent service Provider assumes this responsibility earlier.
- i. Provider's supports and services will be based upon the Individual's IPOS, and in coordination with any additional plans of the Individual (e.g. nursing, occupational therapy, physical therapy, behavior support plans). Said documents are to be present (hard copy or electronically) at the service site, and accessible to Provider's staff responsible for delivering the supports and services.
- j. Provider shall notify the Individual's care manager when the Individual's IPOS requires revision or modification.
- k. Provider shall provide services in the least restrictive and most integrated settings, unless the less restrictive levels of treatment, service or support have been unsuccessful or cannot be safely provided for that Individual.
- l. Provider shall ensure coordination of care occurs between the Individual's primary health care physician and Medicaid Health Plan (as appropriate). Medical care should be coordinated through the Individual's primary care physician. Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment, and as specified in an Individual's plan of service.
- m. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed, and at no cost to the Individual. Provider shall be responsive to the particular needs of Individuals with sensory or mobility impairments, and provide necessary accommodations.
- n. Provider shall complete service documentation and records that meet the PIHP/CMHSP's requirements for reimbursement. Provider's services and documentation/records shall comply with the standards of the PIHP, CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third party payers.
- o. The Individual's record must contain sufficient information to document the provision of services, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of contacts must take into consideration the health and safety needs of the Individual.

#### 4. Training Requirements

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings
- b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

**5. Reauthorization Procedures**

- f. Intensive Crisis Stabilization services are reauthorized prospectively. Reauthorizations for this service will be performed by the PIHP or CMSHP.
- g. Prior to the end of the original authorization, a CMHSP staff will review the case and either authorize continued stay or recommend discharge.
- h. After the review, all necessary data shall be entered or sent to the PIHP or CMSHP authorization system by Provider within twenty-four (24) hours, or the next working day following weekends and holidays.
- i. It is expected that lengths of stay will vary according to clinical acuity and complexity.
- j. The expectation is that Provider, involved community systems, and professionals will be working to ensure that care episodes are as brief and effective as possible.
- k. If the request for additional days is denied by the PIHP or CMSHP, Provider can request reconsideration through the PIHP or CMSHP Access/Utilization Management process.

**6. Eligibility Criteria/Access Requirements/Authorization Procedures**

- f. Individuals presenting for mental health services will be engaged in a person-centered planning process through which diagnostic information and service eligibility will be determined. Eligibility tools may be used in conjunction with the person-centered planning process to determine and document medical/clinical necessity for the requested service.
- g. Waiver eligibility requires verification of no change in waiver status.
- h. The [PIHP Guide to Services](#) provides a summary of service eligibility, access to services, and service authorization. Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.