



Community Crisis Stabilization (CCS) Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Community Crisis Stabilization (CCS)		
MNG #: 116	<input checked="" type="checkbox"/> CCA Senior Care Options (HMO D-SNP) (MA) <input checked="" type="checkbox"/> CCA One Care (FIDE SNP) (MA)	Prior Authorization Needed? <input type="checkbox"/> Yes (always required) <input type="checkbox"/> Yes (only in certain situations. See this MNG for details) <input checked="" type="checkbox"/> No
Benefit Type: <input type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid	Original Approval Date: 02/09/2023	Effective Date: 05/15/2023; 02/08/2024; 01/09/2025; 01/08/2026
Last Revised Date: 02/08/2024; 01/09/2025; 01/08/2026	Next Annual Review Date: 02/09/2024; 02/08/2025; 01/09/2026; 01/08/2027	Retire Date:

OVERVIEW:

This level of care is a facility- or community-based program where individuals with an urgent/emergent need can receive crisis stabilization services in a staff-secure, safe, structured setting that is an alternative to hospitalization. It provides continuous 24-hour observation and supervision for individuals who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from a short-term, structured stabilization setting. Services at this level of care include crisis stabilization, initial and continuing bio- psychosocial assessment, care management, medication management, and mobilization of family/guardian/natural supports and community resources. Some of the functions, such as medication management, administration, and physical care, will require access to medical services while other services can be provided by mental health professionals. Medical services may include psychopharmacological treatment or other medical treatment that would require nursing support. The primary objective of the crisis stabilization service is to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that requires a less restrictive level of care. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated; frequency should occur based on individual needs.

DEFINITIONS:

Licensed Behavioral Health Clinician: a behavioral health professional that is permitted to practice by law within the scope of their license or certification. Examples include psychiatrists, psychologists, Licensed Clinical Social Workers (LCSW), Licensed Independent Clinical Social Workers (LICSW), Licensed Mental Health Counselors (LMHC) or Licensed Marriage and Family Therapists (LMFT).

Primary Care Provider (PCP): a physician or a physician assistant or nurse practitioner who operates under the supervision of a physician.

Psychopharmacological treatment: the use of medication in treating behavioral health conditions.



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DECISION GUIDELINES:

Clinical Coverage Criteria:

All of the following criteria are necessary for admission to this level of care:

1. The individual demonstrates active symptomatology consistent with a DSM-5-TR diagnosis, which requires and can reasonably be expected to respond to intensive, structured intervention within a brief period of time;
2. An adult demonstrates a significant incapacitating disturbance in mood/thought/behavior, interfering with activities of daily living so that immediate stabilization is required;
3. Clinical evaluation of the individual's condition indicates recent significant decompensation with a strong potential for danger to self or others, and the individual cannot be safely maintained in a less-restrictive level of care;
4. The individual requires 24-hour observation and supervision but not the constant observation of an inpatient psychiatric setting except when being used as an alternative to an inpatient level of care; and
5. Clinical evaluation indicates that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less-intensive level of care within a brief time frame.
6. It is reasonably expected that a short-term crisis stabilization period in a safe and supportive environment will improve the individual's symptoms.

Continued Stay Criteria

All of the following criteria are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission criteria at this level of care;
2. The individual's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available;
3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5-TR diagnosis, which is amenable to continued treatment at this level of care;
4. Care is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan;
5. Treatment planning is individualized and appropriate to the individual's age and changing condition, with realistic, specific, and attainable goals and objectives stated. Treatment planning should include active family or other support systems social, occupational, and interpersonal assessment with involvement unless contraindicated. Expected benefit from all relevant treatment modalities, including family and group treatment, is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities;
6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;
7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident;
8. The individual is actively participating in treatment to the extent possible consistent with the individual's



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- condition;
9. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated;
 10. There is documented active discharge planning starting with admission; and
 11. There is documented active coordination of care with behavioral health providers, the member's CCA Care Partner, the primary care provider (PCP), and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate care continue.

Discharge Criteria

Any of the following criteria is sufficient for discharge from this level of care:

1. The individual no longer meets admission criteria or meets criteria for a less- or more-intensive level of care;
2. Treatment goals have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less-intensive level of care. A follow-up aftercare appointment is arranged for a time frame consistent with the individual's condition;
3. The individual and/or legal guardian is not engaged in treatment or is not following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment;
4. Consent for treatment is withdrawn, and either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment;
5. Support systems that allow the individual to be maintained in a less-restrictive treatment environment have been secured;
6. The individual is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or
7. The individual's physical condition necessitates transfer to a medical facility.

LIMITATIONS/EXCLUSIONS:

Any of the following criteria is sufficient for exclusion from this level of care:

1. The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting;
2. The individual's medical condition is such that it requires treatment in an acute medical setting;
3. The individual/parent/guardian does not voluntarily consent to admission or treatment;
4. The individual can be safely maintained and effectively treated in a less-intensive level of care;
5. The primary problem is not psychiatric. It is a social, legal, or medical problem, without a concurrent major psychiatric episode meeting criterion for this level of care; or
6. Admission is being used as an alternative to incarceration, the juvenile justice system, protective services, specialized schooling, or as an alternative to medical respite or housing;
7. Conditions that would not be appropriate for treatment at this level of care are:
 - a. permanent cognitive dysfunction without acute DSM-5-TR diagnosis



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- b. primary substance use disorder requiring treatment in a specialized level of care.
 - i. Note: Some CCS programs may be able to provide uncomplicated withdrawal management where safe and appropriate to do so.
- c. medical illness requiring treatment in an acute medical setting.
- d. impairment with no reasonable expectation of progress toward treatment goals at this level of care
- e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning.

KEY CARE PLANNING CONSIDERATIONS:

- An evaluation by licensed behavioral health clinician within the last 24 hours that determined the need for CCS treatment is required.
- Evaluation of informal supports to provide the service should be considered (e.g., family member or friend).
- A review of other existing supports in the care plan should be done before initiating services that may be duplicative.

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

Code	Description
S9485 (ET)	Crisis intervention mental health services, per diem (1 unit = 1 day)



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Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual® criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

RELATED REFERENCES:

MassHealth's Behavioral Health vendor's criteria for Community Crisis Stabilization services

REVISION LOG:

REVISION DATE	DESCRIPTION
1/8/2026	Medical Policy Committee approval with minor formatting changes
1/9/2025	Updated formatting and minor language changes
2/8/2024	Updated CCA Senior Clinical Lead Name/Signature

APPROVALS:

Jeffrey Sedlack	Senior Medical Director Utilization Review and Medical Policy
CCA Clinical Lead	Title
	1/8/2026
Signature	Date
CCA Senior Operational Lead	Title
Signature	Date
CCA CMO or Designee	Title