NEW YORK STATE | Office of Mental Health | Office of Addiction Services and Supports

Crisis Stabilization Center Billing Guidance 04/01/2024

Contents

Crisis Stabilization Centers

Crisis Stabilization Centers (CSC) are jointly certified by the Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) pursuant to Article 36 of the Mental Hygiene Law and regulations codified in Part 600 of Title 14 of the New York Codes, Rules, and Regulations. CSCs are categorized as either a Supportive Crisis Stabilization Center or an Intensive Crisis Stabilization Center.

Supportive Crisis Stabilization Center (SCSC) means a center that provides support and assistance to individuals with mental health and/or substance use crisis symptoms. Services are for recipients experiencing challenges in daily life that do not pose the likelihood of serious harm to self or others. Such challenges may also create risk for an escalation of behavioral health symptoms that cannot reasonably be managed in the recipient's home and/or community environment without on-site supports. The Center provides voluntary services with an emphasis on peer and recovery support. SCSCs will provide, or contract to provide, all SCSC services on-site, twenty-four hours per day, seven days per week. Recipients may receive services in a SCSC for up to twenty-four hours.

Intensive Crisis Stabilization Center (ICSC) means a center that provides urgent response and/or treatment services to recipients experiencing an acute mental health and/or substance use crisis. ICSCs offer all services provided at an SCSC including an emphasis on peer and recovery support, while also providing rapid access to services for acute symptoms, assisting in diversion from a higher level of care, and prescribing or administering medications to manage substance use and mental health symptoms. Like an SCSC, the ICSC provides voluntary crisis treatment services with an emphasis on peer and recovery support in a safe and therapeutic environment. ICSCs will provide stabilization and referral services twenty-four hours per day, seven days per week on site. Recipients may receive services in an ICSC for up to twenty-four hours.

Regions

Regions, as defined by the Department of Health and assigned to providers based upon the geographic location of the program's site location, are defined as follows:

- Downstate: 5 boroughs of New York City, counties of Nassau, Suffolk, Westchester, Rockland, Putnam, Orange, and Dutchess.
- Upstate: Rest of state

Billing

Standards pertaining to reimbursement:

Only CSCs certified jointly by the OMH and OASAS may submit claims and be reimbursed for CSC services.

CSCs are carved out of Medicaid Managed Care upon initial implementation. Claims must be submitted to Medicaid Fee for Service (FFS) using the appropriate rate code. General FFS institutional billing guidance for eMedNY can be found here.

The State will issue separate guidance to Plans and providers when the CSC benefit is implemented in Managed Care.

The appropriate rate code, procedure code and modifier combinations should be used. The primary reason for receiving services will dictate modifier combination:

Service Name	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit
Supportive Crisis Stabilization - Brief	4632	S9484	HH **OR** HF	Up to 3 hours	1
Supportive Crisis Stabilization - Full	4633	S9485	HH **OR** HF	Per Diem	1
Intensive Crisis Stabilization - Brief	4630	S9484	HH, HK **OR** HF, HK	Up to 3 hours	1
Intensive Crisis Stabilization - Full	4631	S9485	HH, HK **OR** HF, HK	Per Diem	1

- The HH (brief) or HH, HK (full) modifier combination is to be used to specify mental health as the primary visit reason.
- The HF (brief) or HF, HK (full) modifier combination is to be used to specify addiction as the primary visit reason.

Diagnosis Code:

- Applicable mental health or substance use diagnosis codes should be included on claims.
- If no diagnosis was made during the CSC visit, the Center should bill either R69 or F99 for claims reimbursement.
- In the event an MH or SUD diagnosis is not made, the modifier above that best aligns with the initial client presentation should be used.

The maximum billable period of a single CSC visit is 24-hours. No attempt to circumvent this limitation through discharge and readmission is permissible.

- The 24-hour period is based on when an individual presents and begins receiving services.
- CSCs should submit one claim per visit (*additional information regarding multiple same day claims can be found in a note on page 5). The date of service on the claim should be the date the individual arrived at the Center.
- CSCs may bill for either a brief or full per diem visit in a twenty-four-hour period.
    - A brief claim consists of the CSC continuously providing at least one (1) service, in addition to supervision, progress monitoring, and planning for up to three hours.
    - A full claim consists of the CSC continuously providing at least one (1) service, in addition to supervision, progress monitoring, and planning for more than three hours.
- CSCs may submit a separate claim outside of the daily CSC rates for pharmacy and laboratory services, which include medication and toxicology services.

Under no circumstance should the 24-hour threshold for claims established in the Medicaid State Plan be circumvented. While there may be rare occasions where a recipient is seen over

23 hours and 59 minutes, the recipient may remain at the Center without additional reimbursement until discharge is complete. A new claim should not start because a discharge was not completed within 23 hours and 59 minutes.

Discharge and Aftercare planning are fundamental services involving the creation of clear pathways to continuity of care in collaboration with the recipient. At the time of discharge, CSCs must connect recipients with community supports and services that have been identified to meet their needs. CSCs will make every effort to verify that aftercare appointments(s) have occurred and offer follow-up care to each recipient for additional support.

*Note: Multiple same day claims for a single recipient from the same provider are not allowable. Since a CSC will only be reimbursed one claim, either a brief or a full from the same recipient per 24-hour period, billing software should be configured to only submit one CSC claim, per day, per recipient. If a recipient has two same-day visits, one brief and the other full, submitting the full claim is recommended.

There are no annual claim limits associated with CSC service provision at the time of publication. CSC services are allowable in combination with other services with the expectation that service periods are not concurrent. NYS will monitor claims submissions on an ongoing basis and reserves the right to amend billing limitations in the future. All determinations of scope, frequency, and duration must be in accordance with medical necessity or an individualized treatment plan.

For more information on CSC service definitions and parameters, staff and supervisory qualifications, and staff training requirements please refer to the program guidance.

Posted Medicaid Reimbursement Rates

- Crisis Stabilization Center Fee Schedule

Telehealth

Certified CSCs may be approved by the NYS OMH and OASAS to deliver services via telehealth in accordance with 14 NYCRR Part 602 and applicable guidance, upon adoption. Telehealth Attestations submitted in accordance with 14 NYCRR Part 602 will be jointly reviewed by the OMH and OASAS. In order for services that are provided via telehealth to qualify for reimbursement, the recipient must receive these services onsite.

When allowable, the following billing modifiers for telehealth services as outlined in regulation and applicable guidance are required to be included on the claim:

- If one or more service were provided using *only* Audio and Video Telehealth Services, the Medicaid claim should include the Audio and Video Telehealth Services modifier (GT).

- If one or more service were provided using *only* Audio Only Telehealth Services, the Medicaid claim should include the Audio Only Telehealth Services Modifier (FQ).
- If services were provided using a combination of Audio and Video Telehealth Services and Audio Only Telehealth Services, the Medicaid claim should include both the Audio and Video Telehealth Services modifier and the Audio Only Telehealth Modifier (GT & FQ).

References

For Medicaid enrollment questions, including Category of Service, NPI, or MMIS, please refer to the eMedNY Provider Enrollment site, or contact the eMedNY help desk at 1-800-343-9000.

Program guidance can be found here.