System Analysis and Recommendations to Reduce Psychiatric Boarding and to Support Persons in Emergency Departments

Emergency Department Boarding Workgroup

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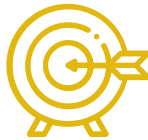
Statement of Issue

Emergency Department (ED) Boarding of Medicaid members with psychiatric disorders across the Commonwealth is a challenge and is associated with several adverse outcomes. There are numerous strategies and tools that are being explored to implement in various settings to reduce Medicaid member boarding.

The ED Boarding workgroup was tasked to look at this growing issue and develop strategies that may be adopted by the Primary Contractors (PCs), their Behavioral Health Managed Care Organizations (BH MCOs) and network hospitals.

Introduction - Charter of the Workgroup

The purpose of the Emergency Department Boarding Workgroup is to research and better understand ED boarding issues across the state of Pennsylvania. Through review of county-specific data, research models to divert from and treat individuals in an ED that can reduce trauma and in many cases change the disposition of needing admission to a psychiatric hospital, and discussion of existing ED diversion strategies, this team worked to develop a resource document that can be used to enhance the system to reduce the use of EDs for non-emergent MH needs and to enhance the treatment of MH when needed in an ED.



Executive Summary

The "*System Analysis and Recommendations to Reduce Psychiatric Boarding and to Support Persons in Emergency Departments*" paper is a culmination of the analysis of Emergency Department (ED) boarding data, best practices, funding strategies and partnerships to divert from the use of EDs.

The efforts of the workgroup offered a look at **Data on ED Boarding** that not only tracks ED boarding, but what happens to those persons who were discharged from the ED without receiving treatment, providing insight into the impact on such boarding. Current and developing **Diversions Models** were collected, offering a look into what is currently available to divert persons from going to the ED for access to acute mental health services. For those individuals who are in need of acute mental health treatment that present in the ED, **Mental Health Treatment Models for an ED** were researched, offering options to begin services while in the ED and focus resources that are trained and dedicated to this population. Finally, to better engage and facilitate local discussion on how to address this issue, **Funding Strategies** were achieved in partnership with the Office of Mental Health and Substance Abuse Services and the Office of Medical Assistance Programs as well as **Factors to Consider When Developing an ED Boarding Plan** are offered as a guide to engage the local hospitals and mental health system.

There is no one easy answer to relieve the ED Boarding of persons seeking mental health treatment, but it is intended that this paper can serve as a roadmap for productive discussions, system enhancements and collaborative efforts to support those who are in need of mental health services. Ultimately, it is our objective that by expanding on the ideas presented in this paper will result in the reduction of trauma experienced by consumers, families and ED staff as a result of ED boarding.

Data Summary on ED Boarding

To assist in the development of this document, a data review was conducted to determine which populations experience ED boarding as well as the patterns of boarding and dispositions of those impacted. Attachment 2 provides a review of boarding over a 2-year, 9-month period, maintained by the Capital Area Behavioral Health Collaborative (CABHC) and PerformCare, of Members in the Counties of Cumberland, Dauphin, Lancaster, Lebanon and Perry who were in the HealthChoices Behavioral Health and Community Health Choices program. This represents about 280,000 covered lives. Members who are included in this data report are children/adolescents (C/A) who were in the ED for 48 hours or more and adults who were in the ED for 72 hours or more. The data looks at the boarding by hospital ED, the number of adults and children per month who were boarding, the number of members who were discharged from the ED that were never transferred to a Mental Health Inpatient (MH IP) facility and the barriers contributing to the boarding.

Attachment 3 and Attachment 4 is a report that was prepared by CABHC that looked at the disposition of Members who were boarding in an ED and were subsequently discharged prior to transfer to a MH IP facility due to the change in the Member's disposition. The data presented provides a snapshot of behavioral health services utilized by Members after being discharged from the ED as well as readmissions and eventual MH IP admissions. As presented in Attachment 4:

- Table 1: *Adult Utilization of Behavioral Health Services from 1-30 days after ED Discharge*, shows services that persons accessed and are broken out by days post discharge before they received service.
- Table 2: *Child/Adolescent Utilization of Behavioral Health Services from 1-30 days after ED Discharge,* shows services C/A accessed and are broken out by the days post discharge before the received the service.
- Table 3: *Additional ED Visits Within 60 Days of the Initial ED Boarding Discharge Date*, shows the number of adults and C/A who returned to the ED for a psychiatric related visit within 60 days of the initial ED boarding discharge date.
- Table 4: *ED Visits followed by MH Inpatient Services Within 60 Days of ED Discharge*, shows the number of adults and C/A who eventually utilized inpatient services within sixty days of the initial ED boarding discharge date.

This report further validates that persons boarding in an ED can have their disposition change when no actual MH treatment is provided and yet can return to the community. It is presented in this paper that if treatment and support can be provided upon medical clearance in the ED, a significant number of persons could be stabilized, have their trauma experience greatly reduced and avoid the need to go to a MH IP facility when the proper supports can be made available, both while in the ED and after being discharged from the ED.

Diversion Models as Alternative to Use of EDs

The ED workgroup researched models and conducted a survey of Primary Contractors/BH MCOs to identify programs used to divert from and treat individuals in an ED. Attachment 5 is a listing of existing or in development programs specifically designed to offer an alternative to persons going to the ED for mental health access. Below is a brief summary of the diversion models being used across the United States to enhance systems and to reduce the use of EDs for non-emergent MH needs and to enhance the treatment of MH when needed in an ED.

Family Support Partners

Family Support Partners (FSP), a grant-based initiative implemented by Allegheny Family Network, provides behavioral health peer support to caregivers of youth in crisis. Family peer support offers emotional support, linkage to community resources, and empowerment of self-advocacy skills to parents and guardians. Utilization of FSP through Resolve Crisis Services in Pittsburgh, PA has resulted in promising outcomes in hospital diversion, readmissions, and length of stay. Allegheny Family Network in collaboration with UPMC Western Psychiatric will provide FSP in the psychiatric emergency department to support parents and guardians of youth. AFN | Parent Family Advocacy | Pittsburgh PA (alleghenyfamilynetwork.org)

Mental Health Urgent Care

The Oaks Integrated Care Model is designed to offer psychiatric urgent care for adults (ages 18 and older) in New Jersey's Camden and Cumberland counties. The goal of the Integrated Care Model is to assist individuals in developing coping skills and support networks. Visitors seeking urgent care services are welcomed into a therapeutic environment designed to replicate a "living room" with comfortable chairs, computers, televisions, books, and board games. Citing urgent care as an alternative to traditional emergency room visits and inpatient hospitalization, Oaks Integrated Care Model can provide on-site services to individuals in a community-based setting for up to 30 days. Walk-in appointments are offered daily with an estimated number of 100 walk-ins reported per site per month. Treatment options include individual counseling, peer support, medication treatment, psychiatric consultations, skill building groups, support groups, access to community resources and referral follow-up services. Staff include Certified Registered Nurse Practitioners (CRNP), Therapists, Case Managers and Peer Specialists. Mental Health Urgent Care – Oaks Integrated Care (oaksintcare.org)

MH Treatment Models for ED Adoption

Trauma Focused

Trauma is a pervasive problem impacting individuals across all walks of life. Research indicates that "Individuals who have experienced repeated, chronic, or multiple traumas are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas as well as treatment."

1) Individuals experiencing the effects of trauma often present to emergency departments for treatment. Medical procedures and the oft-times chaotic environment of an emergency department can result in patient dysregulation and maladaptive behaviors.
2) Implementation of a trauma-informed approach in the emergency department setting can ease patient discomfort by creating safe and empowering environments. Trauma-Informed Care (TIC) promotes enhanced communication between client and provider to improve screening and assessment, treatment planning, and service delivery while decreasing the risk for re-traumatization. Proponents of TIC state, "Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors."
3) In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) published *Concept of Trauma and Guidance of a Trauma-Informed Approach* asserting that "addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment."

4) Successful integration of TIC in Emergency Departments requires support across all levels of an organization. Alignment is necessary in leadership, policy, physical environment, engagement, cross-sector collaboration, treatment services, workforce, quality assurance, financing, and program evaluation. SAMHSA recommends four key assumptions to guide organizations in the implementation of a trauma-informed approach.
5) Key Assumptions:

    1. **Realization:** Staff have a realization about trauma and its impact on individuals, families, groups, organizations, and communities.
    2. **Recognize:** Staff have the knowledge and tools to recognize the signs of trauma.
    3. **Respond:** Staff respond by implementing a trauma-informed approach to include changes in language, behavior, and organizational policies.
    4. **Resist Re-Traumatization:** Organizations resist re-traumatization of clients and staff by revising policies and practices that might interfere with healing and recovery.

Given the prevalence of trauma experienced by individuals, both with and without mental health and substance use diagnoses, healthcare providers are encouraged to ask patients not "What's wrong with you?" but rather "What happened to you?" thereby encouraging dialogue to obtain a complete picture of the patient's past and present life situation. According to SAMHSA, implementation of a trauma-informed approach adheres to the following six key principles.

1. **Safety**: Promote physical and psychological safety throughout the organization, staff and people served.
2. **Trustworthiness and Transparency**: Build and maintain trust with clients, families, staff through organizational transparency.
3. **Peer Support**: Utilize peer services to foster trust, enhance collaboration, and promote recovery.
4. **Collaboration and Mutuality**: Support partnerships and leveling of power differentials to ensure that all staff understand their roles in a trauma-informed organization.
5. **Empowerment, Voice, and Choice**: Encourage empowerment through shared decision-making, choice, goal setting and the cultivation of self-advocacy skills.
6. **Cultural, Historical, and Gender Issues**: Incorporate policies and protocols that are responsive to racial, ethnic, and cultural needs and gender issues of clients.

While there is no magic cure for remediating the effects of trauma, TIC provides a framework for emergency departments to support survivors, ease discomfort, increase trust, and improve health outcomes.

1. Trauma-Informed Care: A Sociocultural Perspective - Trauma-Informed Care in Behavioral Health Services - NCBI Bookshelf (nih.gov)
2. Trauma-informed care (TIC) best practices for improving patient care in the emergency department - PMC (nih.gov)
3. What is Trauma-Informed Care? - Trauma-Informed Care Implementation Resource Center (chcs.org)
4. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Brief Assessment and Treatment

To address psychiatric patient needs in the Emergency Department, Wellspan Philhaven incorporated the role of Behavioral Health Coordinators (BHC) within their staffing

complement. Onsite 24/7, BHCs are master-level clinicians who serve as liaisons to communicate updates, conduct therapy consults and coordinate care. Throughout the duration of a patient's stay in the Emergency Department, BHC therapy consults are conducted at regular intervals. Consults include suicide assessments, mental status exams and written narratives of clinical impressions. Within the framework of Solution-Focused Brief Therapy (SFBT), BHCs employ accommodation and acceleration strategies. Accommodation strategies provide skills training when patient safety impedes diversion from psychiatric inpatient to community settings. Acceleration strategies such as consults with prescribers and family supports, change talk, safety planning and resource linkages are used to identify treatment options and expedite dispositions. Additional duties of the BHC include safety screenings, mental health assessments, behavioral health emergency response, precertification, referrals, bed searches, disposition planning and coordination of psychiatric consults.

EmPATH

EmPATH (Emergency Psychiatric Assessment, Treatment, Healing) by Dr. Scott Zeller, is an innovative approach designed to supply acute psychiatric emergency care in a therapeutic setting. In sharp contrast to the high-stress atmosphere of an emergency room, EmPATH units are constructed to create calm, comforting environments that promote patient movement and interaction. EmPATH units replace individual beds and rooms with one large, comfortable central room or milieu. The physical space is designed to encourage hope through natural and ambient lighting, peaceful murals, and high ceilings. Recliners or sleeper chairs are available for patients to rest. Snacks, beverages, and linens are readily accessible at stations set up within the milieu. Gone is the traditional, glass enclosed nursing station. Therapists, nurses, social workers, and peer support staff intermingle with the patients reinforcing the belief that human interaction is beneficial for individuals in crisis.

An alternative to psychiatric patients languishing in emergency departments while waiting on assessment and disposition, individuals on an EmPATH unit are seen by a psychiatric provider as quickly as possible. During a stay on an EmPATH unit psychiatric evaluations, treatment and observations occur prior to disposition decisions. Prior to discharge, follow-up appointments are scheduled. The EmPATH unit conducts 'caring contact' calls to patients within 24 hours of discharge to confirm follow-up appointments. The EmPATH model can be modified to accommodate staffing, resources and physical plant constraints.

Implementation of the EmPATH model shows promising results (Lockwood, 10/13/2020)

- Hospitalizations for patients with acute psychiatric needs have dropped 70-80%.
- Boarding for this patient population in the emergency department has dropped by 90%.
- Average length of stay for patients with acute psychiatric needs has dropped to 16 hours.
- Recidivism rates for this patient population has dropped significantly.
- At one institution, nearly $1 million was added to the emergency department' finances by the addition of an EmPATH unit, making ER beds available for other patients presenting with physical ailments and traumas.

Lockwood, 10/13/2020
EmPATH Units: Improving Psychiatric Emergency Care - BWBR
CentraCare Helmsley EmPATH Unit (mnpsychsoc.org)
emPATH Units as a Solution for ED Psychiatric Patient Boarding - Psychiatry AdvisorEmergency Mental Health Services: The EmPATH Model - BWBR

Funding Strategy for MH Treatment in an ED

The previous sections discussed the issues with ED boarding, ways to enhance diversion from people going to the ED for psychiatric treatment and models that can afford hospitals treatment of persons presenting with a mental health need in the ED. The current funding model for EDs is typically a case rate that pays the hospital a negotiated fee when a person is admitted to the ED. Some additional costs such a lab work, x-rays, and others may be paid in addition to the case rate, but those are very limited. For a hospital to consider providing mental health assessment and treatment in the ED, funding for these services must be made available.

The workgroup analyzed Medicaid hospital bills paid by the HealthChoices Physical Health MCOs for persons boarding in an ED to see what BH specialty services (psychiatric consultation) were paid for by PerformCare in the CABHC Counties. The result of this review yielded very few claims for this service despite being allowed under the HealthChoices BH program. The workgroup then assessed the 2022 OMHSAS Behavioral Health Services Reporting Classification Chart (BHSRCC). This document provides a listing of all services included in the HC BH contract terms and their corresponded billing codes that act as a guide to the BHMCOs. This review yielded limited services that could be paid when delivered in an ED location (Place of Service #23).

The approach that was developed to expand the ability of Primary Contractors/BH MCOs was to work with OMHSAS and OMAP to determine if listed services, by provider type, could add the POS #23 into the chart. Both Deputy Secretaries charged their staff to work with the workgroup to develop the ability for the HealthChoices BH program to pay for MH services in the ED. Attachment 6 provides a summary of the changes that were incorporated into the BHSRCC chart, 01.2023. Attachment 7 is the actual BHSRCC that was issued. The final effort in working with DHS staff was to expand the provider type code 01, hospitals, the ability to provide MH treatment in the POS 23 (ED). As a result of these efforts, three viable options were developed that would allow PC/BHMCO the ability to work with hospitals in developing MH treatment provided in an ED and thus getting paid for this service. It should be noted, most all of these services and models are only allowed to be used under the HealthChoices and Community Health Choices BH Medicaid programs, and not under the Medicaid Fee For Service program.

MH Supplemental Service Billing Model

This model builds off the BHSRCC chart that allows provider type 11/112 Medicaid enrolled clinicians to bill for MH services. The new BHSRCC chart added POS 23 to enable the approved services to be delivered in an ED. To enroll this provider type into MA, the BH MCO must facilitate their credentialing for licensed clinicians and work with the hospital to develop a model that can be enrolled in Medicaid so that the clinician/agency can be reimbursed by the BH MCO. With this model, the clinician can be embedded or available to assess and engage in therapy with the person and their family while in the ED. Attachment 9 provides an overview of how this can be set up and how the billing is managed and permitted by OMHSAS.

MH Licensed OP Clinic Mobile Mental Health Treatment Billing Model

Licensed MH OP services are allowed to bill for treatment in the person's home or community when they are not able to get into the clinic site. The regulations describe what is needed to be written into a service description to be approved for the delivery of MMHT. The service must be "prescribed" for the clinic to bill using this model. Attachment 8 describes how such a model could be operated in the ED while complying with the MH OP regulations. OMHSAS has

reviewed this and have agreed this complies with the MMHT regulations. This model can be developed when a hospital also operates a licensed MH Outpatient Clinic or can enter into an agreement with a provider that operates such a clinic to deliver this service in the ED.

Hospital Direct Delivery of MH Services in an ED Billing Model

This section is pending OMHSAS/OMAP making a decision on this funding strategy. Once obtained and if approved, this will be added to the document for re-release.

Role of PA's CIS Regulations and Expansion

The Office of Mental Health and Substance Abuse Services has prioritized the development of Crisis Intervention Regulations that will further define the best practice of the comprehensive delivery of Crisis Intervention Services. Core to this initiative is for PA to adopt the SAMSHA best practice of the delivery and array of services. Research supports that following this best practice will greatly improve the responsiveness to the needs of persons experiencing a psychiatric crisis resulting in the reduction of incarceration, burdening emergency departments, reducing MH commitments and supporting families and significant others involved with the person in crisis.

Roadmap to Ideal Crisis System

In March of 2021, the Group for the Advancement of Psychiatry (GAP) published a comprehensive report proposing essential elements, standards, and best practices for a behavioral health crisis response. This document, *Roadmap to the Ideal Crisis System*, is developed on the premise that in "the ideal crisis system, people have access to effective and helpful services and supports in a broad continuum of settings. The choice of which type of service or setting may be most appropriate at any given time should be largely driven by considering safety, effectiveness, the least restrictive setting, and resource intensity/cost." (1) Supporting this premise is the conviction that crisis episodes are not linear in need and may require varying service levels within the crisis continuum. The following elements of the continuum were identified as essential in an ideal crisis system:

- Crisis center or crisis hub
- 24-hour (988) call center or crisis line
- Deployed crisis-trained first responders
- Medical triage and screening (Non-ER and ER)
- Mobile crisis teams
- Behavioral health urgent care
- Intensive community based continuing crisis intervention services
- 23-hour observation and extended evaluation
- Residential crisis program continuum
- Peer respite and sobering support services
- Hospitals: ERs, psychiatric consultation, psychiatric emergency services
- Psychiatric hospitalization
- Intensive outpatient continuing crisis intervention services
- EMS and non-EMS transportation. (Transportation and transport)

In an ideal system, crisis centers are secure, physical locations with 24/7 telephone, walk-in and first responder access that serve as an alternative to emergency departments and jail. Crisis centers are equipped to provide access to services such as emergent psychiatric interventions, assessments, evaluations, care coordination, outreach, engagement, MAT, peers, dispositions,

and resource linkages. Crisis centers should be equipped to provide non-emergent medical treatment. Crisis centers may also serve as communication hubs for service and care coordination within the community.

Group for the Advancement of Psychiatry. "Roadmap to the Ideal Crisis System." Roadmap to the Ideal Crisis System - National Council for Mental Wellbeing (thenationalcouncil.org). Accessed 1 June 2023.

Contributing Factors to Consider in Developing an ED Boarding Plan

As this workgroup engaged in research via literature reviews and collaborative conversations, reoccurring themes emerged as essential for consideration and to stack the odds in favor of success moving forward. These themes included: education and training considerations for emergency department staff and leadership in Model Change, strategies for presenting proposed model to emergency departments and hospitals, ED policies with the potential to impact success of model implementation (ex. parental/guardian expectations during a child's psychiatric crisis), education and accurate information re: community behavioral health services, interoperability of ED model with programs and services aimed at support for social determinants of health, and EMTALA considerations.

Education of ED Staff/Director in Model Change

The models and interventions explored by the workgroup and being recommended for consideration represent (emerging) best practices in the space of emergency psychiatric response in ED settings. The innovative nature and model-specific interventions require new information, skills, and approaches be adopted and practiced by the emergency medicine staff who will be key collaborators in implementation. For this reason, this workgroup strongly recommends that any healthcare system, emergency department, or service provider looking to move forward with a model highlighted in this report, do so with a clear strategy for educating staff and leadership in the specifics of the model, outcome expectations, peer partnerships for collaborative learning opportunities, troubleshooting options, and support resources. Ideally, the training and education process will create a sense of hope and opportunity and put emergency room staff in a position to be enthusiastic leaders in this change process. Any model implemented should improve the experience of psychiatric health crisis for the individual, their family, and the ED workers involved.

An effective training and education strategy should include input and guidance from staff themselves. An overview of the model and its goals should be presented to current staff, with an opportunity for feedback and idea-sharing about how next steps should look. Leadership should be prepared to manage resistance or hesitancy by presenting fact-based model outcome that reflect an improved experience in the ED, as well as validation of staff concerns with a real commitment to hearing, understanding, and problem solving. Finally, yet extremely critical to the change process, is the inclusion of persons and families with lived experience. This will allow for the sharing of their experiences and how they would improve supports and engagement with persons and staff in the ED. Next steps should include an iterative learning process that involves presentation of information, practice, implementation, and repeat. Staff should have access to information about how the model is working, outcomes for individuals impacted, and an opportunity to ask questions and provide direct level insights along the way.

How to present model as a way to address/support the ED and hospital

This ED Boarding Workgroup meets regularly with membership, including representatives from healthcare systems, emergency departments and crisis services. In addition, members conduct

outside research and information solicitation from their respective communities. Through this process, a recommendation has emerged about how any proposal to improve statewide ED psychiatric boarding crisis must come with a sensitivity to experiences of the local emergency departments and staff who provide care there. Emergency Departments have been on the front line of history-making developments for many years. A global pandemic, civil unrest, natural disasters, and a crisis in access to care have all weighed heavily on the resources and resiliency of ED's, and yet they continue to demonstrate a commitment to doing right by the communities they serve. With this in mind, the recommendations contained in this paper are presented with every intention to result in improved work environments, job satisfaction, and a sense of achievement of mission for ED staff involved and impacted. Any changes presented that represent only increased burden and does not include ED staff and leadership directly in the key decision making, implementation, and oversight processes are not in line with the spirit of this groups recommendations and unlikely to succeed in achieving a psychiatric crisis response option(s) that benefits all parties involved.

<u>ED policy on Parental or Guardian being required to remain at ED or will treat as abandonment/OCYF.</u>

As Emergency Departments consider models and options available to them to improve and alleviate the psychiatric boarding crisis, review of current policies and procedures will be an essential undertaking. Staffing ratio requirements, medical clearance standards, pre-certification procedures, and referral protocols are examples of the kind of policies that need to be reviewed and considered as a new model or way of operation is explored. A policy this workgroup reviewed and would like to highlight as an example of potentially having an impact on the success of any support or diversion model is regarding the expectations of parents or guardians during a child's psychiatric crisis. Case examples were explored in workgroup sessions where parents were instructed that if they left the emergency setting, the local child welfare agency would be engaged via an abandonment report. The workgroup reviewed anecdotes of parents having to choose between facing repercussions for leaving the child in crisis to attend to children at home, or potentially facing allegations of not caring for the children at home because they stayed with the child in crisis. In another scenario, a mother in need of insulin to manage her own diabetes was told if she left to get her medication, she would be reported. There is no easy answer, and ED's are in incredibly challenging positions, but policies that center punitive consequences for individuals and families, will be incompatible with trauma-informed recommendations made by this workgroup.

<u>Educating and updating community BH Services availability</u>

While the focus of this group is on the ED setting, this workgroup recognizes that any successful effort to remedy the psychiatric ED boarding crisis will include improvements and collaboration across the continuum of care and intervention. The accessibility and support of community behavioral health services are key factors in preventing ED presentations (prevention), minimizing time in ED's when a crisis can be managed (intervention), and decreasing crisis recidivism (post-vention). Model implementation strategies must include education to and enhanced communication protocols with community behavioral health services. The workgroup is aware of efforts in communities across the Commonwealth to increase access to community-based care, enhanced collaboration between community and emergency providers, and implement community provider data bases to improve and simplify referral processes from emergency settings. It is the recommendation of this workgroup that those efforts are supported and that their success is seen as tied to the success of the models and opportunities described in this paper.

Social Determinants of Health integration and Access with ED use

Social Determinants of Health (SDOH) have significant impacts on individuals who seek care in ED settings. ED settings serve many people who are low-income, are either uninsured or underinsured and for whom economic instability affects employment, housing status, and food security. We know that these factors can negatively impact overall health, both physical and mental. It is critical for other system partners; housing, food, and criminal justice for example, to see ED boarding within their sphere of influence. We recognize there is a need for developed processes to identify SDOH and to facilitate access to resources to increase the health and wellbeing of patients and reduce recidivism. We have seen an increased focus on the integration of clinical and community based data to support this and believe that working to identify the challenges people in ED settings are facing and connecting to available resources will increase the health and wellbeing of our communities.

EMTALA considerations

The Emergency Medical Treatment and Labor Act (EMTALA) mandates that patients who present to Emergency Departments be given appropriate screening examinations, regardless of their ability to pay for their care. If an emergency medical condition is found during that examination, the law requires that patients be stabilized before discharge or transfer. The Act defines as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. If an ED does not have the ability to stabilize the patients, the law allows transfer of the patients and requires outside facilities to accept the transfers if they have the capacity and capability to treat the patients.

Attachment 10 explores frequently ask questions related to intersection of EMTALA and psychiatric emergencies. Attachment 10 is intended to provide information regarding EMTALA and the obligations of providers to screen and stabilize patients who present with emergency medical conditions. The FAQ does not constitute legal advice.

Summary

Psychiatric Boarding in Hospital Emergency Departments has been increasing over the past several years, with no single cause to this strain on Emergency Department resources. This paper was prepared with the objective to offer recommendations on how the HealthChoices Behavioral Health Program can engage the hospitals and their EDs with the Primary Contractors, their BHMCO partners and other stakeholders to address and offer approaches to reduce the ED Boarding of persons with a mental illness.

Although there is no single collection point that tracks the number of cases that are boarding in EDs at any given time or over a set period of time, representative data shows that just the number of Medicaid children and adults boarding is prevalent across reported counties and hospitals with no single concentration. Data also shows that over 40% of all reported boarding cases are discharged from the ED and never placed in the intended MH Inpatient hospital setting, despite little treatment being provided when the person is boarding.

Two approaches were explored that would have the intention to reduce the boarding of persons seeking MH IP services; the development of services that would offer an alternative to access treatment rather than going to the ED and the assessment and treatment of persons who present

with a mental illness while they are in the ED. Research has demonstrated that diversion from EDs will greatly reduce the frequency of boarding and that offering treatment to persons in the ED will greatly reduce the duration of boarding. Traditional funding models for EDs do not incentivize hospitals to include MH treatment for persons who are boarding. Opportunities have been explored and approved that can assist the hospital in the financial cost to develop such services. It will be imperative that both of these approaches be explored and developed in unison to achieve the desired reduction of ED boarding.

The question at hand is how can all stakeholders be brought together to begin this dialogue and develop a comprehensive plan to better meet the emergent/urgent needs of persons experiencing a mental illness. All communities, hospitals and resources are different throughout the Commonwealth when looking at this task. Therefore, it is imperative that this be developed within the local community and to approach this has a shared responsibility to develop the needed relationships, trust and ultimately the improved care of the persons who are in need of treatment. This paper provides a summary of key considerations when beginning this journey and should be fully understood that what works for one group may not for another. Dialogue must be the starting point and collective action must be the objective.

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Attachments

Attachment 1: Final ER-BH Report

Attachment 2: County Trends

Attachment 3: ED Boarding Report Summary

Attachment 4: ED Boarding Access Data

Attachment 5: ED Diversion Models Inventory

Attachment 6: Summary List of Allowed BH Billing Place of Service Codes

Attachment 7: BHSRCC January 2023

Attachment 8: Using Mobile Mental Health Treatment in ED setting.

Attachment 9: MH Supplemental Service Billing Model

Attachment 10: EMTALA

Attachment 1: Final ER-BH Report

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<u>REPORT</u>

Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health

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<tr><td>Project Manager:</td><td>Yvonne Llewellyn Hursh, Counsel</td></tr>
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Grant Rosul, Staff Attorney
Wendy L. Baker, Executive Assistant</td></tr>
<tr><td colspan="2">The report is also available on our website http://jsg.legis.state.pa.us/publications.cfm</td></tr>
</table>

Link to report: **http://jsg.legis.state.pa.us/publications.cfm**

Attachment 2 County Trends

ED Time Frames		
Barriers		
Date Range of Data: 10/12/2020-7/31/2023		
Children/Adolescents		
Barrier	**C/A**	**Avg. Days**
Member acuity	290	6
No capacity	464	11
(blank)	21	4
Medical acuity	47	6
member acuity, medical acuity	1	6
Grand Total	**823**	**9**
Date Range of Data: 10/21/2020-7/31/2023		
Adults		
Barrier	**Adults**	**Avg. Days in ER**
Member acuity	239	6
No capacity	63	4
(blank)	8	5
Medical acuity	108	6
medical and member acuity	4	6
Grand Total	**422**	**6**

Child Monthly Trend																		
	Cumberland			Dauphin			Lancaster			Lebanon			Perry			Totals		
Month	**C/A**	**Avg. LOS**	**Left ED**	**C/A**	**Avg. LOS**	**Left ED**	**C/A**	**Avg. LOS**	**Left ED**	**C/A**	**Avg. LOS**	**Left ED**	**C/A**	**Avg. LOS**	**Left ED**	**C/A**	**Avg. LOS**	**Left ED**
Oct. 2020	2	5		2	5		2	11		2	18	2	1	9	1	9	9	3
Nov. 2020	3	6	1	8	5	2	3	7		1	14	1				15	6	4
Dec. 2020				6	5	3	4	4	1	1	7					11	5	4
Jan. 2021	3	5	1	5	9		7	5	1	3	5		2	4		20	6	2
Feb. 2021	4	6	3	6	34	3	10	4	2	4	9		1	3		25	12	8
Mar. 2021	4	6		16	5	2	9	4	2	6	4	1	2	10	1	37	5	6
Apr. 2021	7	4	3	9	5	6	8	4	3	8	17		2	5		34	7	12
May. 2021	7	8	4	13	6	6	12	11	6	6	5	3	3	6	1	41	8	20
June, 2021	2	3	2	4	5	2	4	5		2	4	1				12	4	5
July, 2021	1	12	1	2	6		2	3								5	6	1
Aug., 2021	5	3	2	6	6	3	3	5		1	4					15	5	5
Sept., 2021	1	6	1	12	7	5	14	4	5	3	3	1	3	5		33	5	12
Oct., 2021	3	10	2	11	6	4	13	4	5	7	5	4	3	6	1	37	5	16
Nov. 2021	10	6	7	9	6	2	18	6	8	7	4	1				44	6	18
Dec. 2021	13	6	9	8	4	4	5	7	4	7	7	2	1	2		34	6	19
Jan. 2022	4	5		10	5	3	9	7	3	7	5	3				30	6	9
Feb. 2022	5	4	2	10	5	4	20	5	7	9	6	4	2	3		46	5	17
Mar. 2022	12	4	4	14	5	7	14	5	7	11	3	3	1	7		52	5	21
Apr. 2022	2	8	1	9	4	3	9	4	1	9	5	2	3	3	1	32	5	8
May. 2022	2	5	2	10	4	6	9	6	4	9	6	2				30	5	14
June, 2022				3	5		2	6	1	2	5	2				7	5	3
July, 2022	1	3		5	4		2	3		4	4	1				12	4	1
Aug, 2022	1	3		5	4		4	4	1				2	3		12	4	1
Sept., 2022	1	3		15	4	2	8	4	2	4	4	1	1	11		29	4	5
Oct., 2022	3	5	2	10	4	2	10	4	1	5	9		2	5	1	30	5	6
Nov., 2022	6	5	3	7	4	3	9	4	2	8	5	5	4	6	1	34	5	14
Dec., 2022	2	5	1	3	6		7	4	3	1	4	1				13	4	5
Jan., 2023	1	6	1	5	7	2	4	4	1	1	3					11	5	4
Feb., 2023	4	3		2	5	1	11	6	7	3	7	2	3	6	2	23	6	12
Mar., 2023				4	5	1	11	6	1	5	5	3				20	6	5
Apr., 2023	2	6		1	3		6	5	2				1	6	1	10	5	3
May, 2023				1	6	1	6	5	4	3	5	1				10	5	6
June, 2023				2	5	1				1	6		1	5		4	5	1
July, 2023							1	6	1							1	6	1
Grand Total	**119**	**5**	**54**	**246**	**11**	**85**	**269**	**8**	**92**	**149**	**11**	**48**	**40**	**7**	**12**	**823**	**9**	**291**

Adult Monthly Trend																		
	Cumberland			Dauphin			Lancaster			Lebanon			Perry			Total Sum of Consumer		
Months	**Adult**	**Avg. LOS**	**Left ED**	**Adult**	**Avg. LOS**	**Left ED**	**Adult**	**Avg. LOS**	**Left ED**	**Adult**	**Avg. LOS**	**Left ED**	**Adult**	**Avg. LOS**	**Left ED**	**Adult**	**Avg. LOS**	**Left ED**
Oct. 2020	1	6	1	1	6		2	22								4	14	1
Nov. 2020	2	7		3	6	2				2	7					7	6	2
Dec-20				2	9		2	12	1	1	9					5	10	1
Jan. 2021	1	5		4	4	1	4	5	4	1	5					10	5	5
Feb. 2021				3	5	2	3	12	2							6	9	4
Mar. 2021	1	7	1	1	3	1	5	5	2							7	5	4
April, 2021				7	4	4	5	5	1	2	4					14	4	5
May, 2021	2	6	1	4	4	2	5	4	2	1	6					12	4	5
June, 2021				8	5		1	8								9	5	0
July, 2021				4	4	2	2	5	2	1	6					7	5	4
Aug., 2021	2	7	1	6	5	4	5	6	4	1	6		1	4		15	6	9
Sept., 2021	1	5		12	5	5	4	3	2	3	5	1				20	5	8
Oct., 2021	5	5	1	6	5	4	3	4	2	6	5	2	2	4	1	22	5	10
Nov. 2021	1	4	1	10	5	6				2	5					13	5	7
Dec. 2021	2	9		5	8	2	1	9		1	4			15		9	8	2
Jan. 2022	7	5	3	9	6	6	14	7	4	5	6	3				35	6	16
Feb. 2022				4	12	2	2	7		1	11					7	10	2
Mar. 2022	1	3		5	5	2	1	4		6	6	1				13	5	3
Apr. 2022	2	6	1	5	5	2	1	6	1	4	5					12	5	4
May. 2022	2	6	1	3	11	2										5	9	3
June, 2022	2	8	2	6	5	5	2	8	2	1	4	1				11	6	10
July, 2022	3	8	2	6	5	5	2	8	2	1	4	1				12	6	10
Aug., 2022	1	5		4	4	2	4	4	1	2	4	1				11	4	4
Sept., 2022	3	5	1	8	5	3	7	4	4	7	5	2				25	5	10
Oct., 2022				4	5	3	3	5	1	6	4	1				13	5	5
Nov., 2022	2	8	1	6	6	3	3	4		4	6	2	1	5	1	16	6	7
Dec., 2022	1	5		6	8	3	1	4		2	6	1				10	7	4
Jan., 2023	2	6	1	2	5	1	8	8	3	9	5	1	2	5		23	6	6
Feb., 2023	2	5		5	5	3	4	5	2	1	5					12	5	5
Mar., 2023	1	5		2	9	1	1	11	1	1	6	1				5	8	3
Apr., 2023	2	6	2	1	5		1	6	1							4	6	3
May, 2023				1	5					1	6	1				2	6	1
June, 2023	1	6	1	3	6	2	1	6	1							5	6	4
July, 2023				5	6	5										5	6	5

Attachment 3: ED Boarding Report Summary

An Analysis of Service Utilization Following an ED Boarding Event

Presented by

Jenna O'Halloran-Lyter

Insufficient access to psychiatric Inpatient care has created boarding issues for hospital emergency departments nationwide. Unfortunately, limitations to available psychiatric inpatient beds often restrict or delay utilization of medically necessary services for Members with acute behavioral health needs. Consequently, boarded individuals often stay in the emergency department (ED) for an indeterminate period of time until a bed is identified or the individuals' psychiatric presentation improves and they are discharged.

This report analyzed ED Boarding and the utilization of behavioral health (BH) services to gain a clinical picture of service utilization after ED discharge of Members who were never admitted for MH IP treatment from the ED.

To be included in this report, Members must have been discharged from the ED between November 3, 2020 - January 31, 2022 and enrolled with PerformCare during the ED stay and 30 days post ED discharge. CABHC identified the names of Children/Adolescents (C/A) and adults who have boarded in the ED for at least 48 and 72 hours respectively, and discharged before an inpatient bed was identified. The final list of Members was comprised of 71 distinct adult Members with 75 ED discharges and 123 distinct C/A Members with 140 ED discharges.

CABHC examined Members' utilization of BH services up to **30** days from the ED boarding discharge date. In addition, this report analyzed both the ED recidivism rate within **60** days from the original ED discharge event and if Members ultimately were admitted to Inpatient within the 60-day timeframe.

Table 1: ***Adult Utilization of Behavioral Health Services from 1-30 days after ED Discharge Date***, shows the BH services Members accessed following the ED discharge. This data was used to determine how quickly Members accessed their first BH service after ED discharge. Data was grouped by the number of days after the ED Discharge date. Days/timeframes were divided into five group: 01-05 days after the ED discharge date, 6-10 days, 11-15 days, 16-20 days, and 21-30 days. The table shows the number of times a BH service was the first service accessed, following an ED discharge, for each of the five groups. The percent of all ED discharges who accessed the first BH service, following discharge, for each group/timeframe is included as well.

According to the data, there were 75 ED boarding discharges. Among the 75 discharges, 42 (56%) resulted in a BH service being utilized within 30 days of the ED discharge date. Of the 42 discharges, 24 (57%) were followed by a BH service within 01-05 days of the ED discharge date. Services commonly utilized during this timeframe included Outpatient, Blended Case Management, Crisis, and Partial Hospitalization services. Six (14%) of discharges were followed by a BH service within 6-10 days of the ED discharge date. Service(s) commonly used during this timeframe included Outpatient.

Attachment 4: ED Boarding Access Data

Table 1: Adult Utilization of Behavioral Health Services from 1-30 days after ED Discharge Date N=75

Days After ED Discharge	BH Service Utilized	Discharges [1]	% of Discharges [2]
01-05 Days	09 - Psych Outpt - Outpatient Clinic	3	
01-05 Days	10 - Psych Outpt - Partial Hosp	3	
01-05 Days	12 - Psych Outpt - Physician or Psych	4	
01-05 Days	17B - Outpt D&A Meth Main	2	
01-05 Days	23 - Crisis Intervention	4	
01-05 Days	25 - Targeted MH Case Mgmnt - ICM	1	
01-05 Days	27 - Targeted MH Case Mgmnt - BCM	5	
01-05 Days	36A - Mental Health General	2	
01-05 Days	**Total Discharges**	**24**	57%
06-10 Days	09 - Psych Outpt - Outpatient Clinic	2	
06-10 Days	12 - Psych Outpt - Physician or Psych	2	
06-10 Days	17A - Outpt D&A Clinic	1	
06-10 Days	42A - Other - Outpatient	1	
06-10 Days	**Total Discharges**	**6**	14%
11-15 Days	17A - Outpt D&A Clinic	1	
11-15 Days	23 - Crisis Intervention	1	
11-15 Days	**Total Discharges**	**2**	5%
16-20 Days	17A - Outpt D&A Clinic	1	
16-20 Days	17B - Outpt D&A Meth Main	1	
16-20 Days	23 - Crisis Intervention	2	
16-20 Days	42B - Other - Outpt Telehealth	1	
16-20 Days	**Total Discharges**	**5**	12%
21-30 Days	09 - Psych Outpt - Outpatient Clinic	1	
21-30 Days	17A - Outpt D&A Clinic	1	
21-30 Days	23 - Crisis Intervention	2	
21-30 Days	27 - Targeted MH Case Mgmnt - BCM	1	
21-30 Days	**Total Discharges**	**5**	12%
Total	**Total Discharges**	**42**	

[1]Discharges: the number of times a BH service was the first service accessed following an ED discharge.

[2]% of Discharges: the percent of total ED discharges who accessed their **first** BH service, following discharge, during the designated timeframe.

Table 2: Child/ Adolescent Utilization of Behavioral Health Services from 1-30 days after ED Discharge Date N=140

Days After ED Discharge	BH Service Utilized	Discharges[1]	% of Discharges [2]
01-05 Days	09 - Psych Outpt - Outpatient Clinic	11	
01-05 Days	10 - Psych Outpt - Partial Hosp	6	
01-05 Days	12 - Psych Outpt - Physician or Psych	6	
01-05 Days	13F - BHRS - MH - MT	1	
01-05 Days	17A - Outpt D&A Clinic	1	
01-05 Days	23 - Crisis Intervention	7	
01-05 Days	24 - Family Based Services C&A	11	
01-05 Days	25 - Targeted MH Case Mgmnt - ICM	1	
01-05 Days	27 - Targeted MH Case Mgmnt - BCM	11	
01-05 Days	28 - Targeted MH Case Mgmnt - RC	3	
01-05 Days	36A - Mental Health General	4	
01-05 Days	49C - IBHS - BC	1	
01-05 Days	49E - IBHS - EBP	1	
01-05 Days	49F - IBHS - Mobile Therapy	2	
01-05 Days	49G - IBHS - BHT	2	
01-05 Days	49H - IBHS - BHT Group	1	
01-05 Days	49I - IBHS - ABA BC	1	
01-05 Days	49J - IBHS - ABA BC-BA	1	
01-05 Days	53A - EPSDT - CRR	1	
01-05 Days	**Total Discharges**	**72**	62%
06-10 Days	09 - Psych Outpt - Outpatient Clinic	9	
06-10 Days	10 - Psych Outpt - Partial Hosp	4	
06-10 Days	12 - Psych Outpt - Physician or Psych	1	
06-10 Days	17A - Outpt D&A Clinic	1	
06-10 Days	27 - Targeted MH Case Mgmnt - BCM	1	
06-10 Days	28 - Targeted MH Case Mgmnt - RC	2	
06-10 Days	36A - Mental Health General	1	
06-10 Days	42A - Other - Outpatient	1	
06-10 Days	49F - IBHS - Mobile Therapy	2	
06-10 Days	**Total Discharges**	**22**	19%
11-15 Days	09 - Psych Outpt - Outpatient Clinic	6	
11-15 Days	23 - Crisis Intervention	2	
11-15 Days	36A - Mental Health General	1	
11-15 Days	49F - IBHS - Mobile Therapy	1	
11-15 Days	**Total Discharges**	**10**	9%
16-20 Days	09 - Psych Outpt - Outpatient Clinic	3	
16-20 Days	10 - Psych Outpt - Partial Hosp	1	
16-20 Days	27 - Targeted MH Case Mgmnt - BCM	1	
16-20 Days	**Total Discharges**	**5**	4%
21-30 Days	09 - Psych Outpt - Outpatient Clinic	3	
21-30 Days	11 - Psych Outpt - Rural Hlth Clinic	1	
21-30 Days	24 - Family Based Services C&A	1	
21-30 Days	36A - Mental Health General	2	
21-30 Days	**Total Discharges**	**7**	6%
Total	**Total Discharges**	**116**	

[1]Discharges: the number of times a BH service was the first service accessed following an ED discharge.

[2]% of Discharges: the percent of ED discharges that accessed the **first** BH service, following discharge, during the designated timeframe.

Table 3: Additional ED Visits Within 60 Days of the Initial ED Boarding Discharge Date

Age Group	*Days to Next BH ED Visit	ED Visits	Members
Adult	01-05 Days	11	11
Adult	06-10 Days	4	4
Adult	11-15 Days	3	3
Adult	16-20 Days	4	4
Adult	21-60 Days	8	8
Adult	**Total**	**30**	****26**
Child	01-05 Days	19	17
Child	06-10 Days	6	5
Child	11-15 Days	3	3
Child	16-20 Days	4	4
Child	21-60 Days	16	16
Child	**Total**	**48**	****33**

* Days to **first** subsequent BH ED visit following the index ED discharge. A subsequent ED visit was counted as BH if the primary diagnosis on an ED claim was an ICD10 code falling in the range F00 - F99 (Mental and behavioral disorders) or R40 - R46 (Symptoms and signs involving cognition, perception, emotional state and behavior)

**Number is Unduplicated Recipients

Table 4: ED Episodes Followed By MH Inpatient Services Within 60 Days of ED Discharge

Age Group	Episodes	Recipients
Adult	23	23
Child	25	23

Attachment 5: ED Diversion Models Inventory

Attachment 4.1

Listing of Current and To Be Developed Models of BH Intervention to Divert the Use of Emergency Departments/MH IP

Please add additional models to this document. CIS in and of itself is designed to intervein and when appropriate, divert persons from EDs/MH IP to other appropriate services. Therefore, do not list CIS (phone, walk-in or mobile) unless it was developed as a unique stand alone model that intervenes in ED or MH IP use.

ED Diversion Strategy Name/Program	Description	Currently in use? Y or N	Licensed	Counties located in	Assigned BHMCO	Contact Information	Submitted By
BH Urgent Care Center	6 day per week urgent care center that supports MH and SUD assessment and treatment. Draft reinvestment plan shared.	N	TBD	Dauphin and Lancaster	CABHC/PerformCare	Scott Suhring, CABHC CEO ssuhring@cabhc.org	Scott Suhring
Lancaster Diversion Program	This is a short term, high treatment intensity 24/7 program for adults with SMI used to divert persons from MH IP admissions and SH admissions	Y	RTF A	Lancaster	County Base Funded	Julie Holtry, Lancaster MH/ID/EI holtryj@co.lancaster.pa.us	Scott Suhring
WellSpan Philhaven ED Treatment	WellSPan Philhaven has embedded MH treatment teams in each of WellSpan's ED. Current DC/diversion from MH IP is around 50%.	Y	N	York, Lancaster, Lebanon	Not part of BH HCO funding at this time	Dale Brickley, VP Development, WellSpan Philhaven dbrickley@wellspan.org	Scott Suhring
Bucks County Mobile Crisis Program	BC Mobile Crisis program includes a forensic response team to divert from EDs and jail.	Y	Crisis	Bucks	Magellan	Kris Thompson kris.thompson@lenapevf.org	Monica Stefanik
Bucks County Crisis Residential Program	Program designed to divert adults from higher levels of care, AIP and EDs - on the campus of a hospital	Y	Crisis Res	Bucks	Magellan	Kris Thompson kris.thompson@lenapevf.org	Monica Stefanik
Bucks County Site Based Crisis Program	Located in Doylestown Hospital, this walk-in crisis program completes a LOC assessment, potentially diverting from the ED	Y	Crisis	Bucks	Magellan	Kris Thompson kris.thompson@lenapevf.org	Monica Stefanik
Nulton Diagnostics: Behavioral Health Urgent Care Model	Program designed for Mbr's who present at ED and/or Crisis that are too urgent to wait for op services but do not meet MNC for AIP admission. This is not a walk-in/on demand service. This program is coordinated with the NDTC scheduler.	Y		Cambria	Magellan	Tracy Shultz Tshultz@magellanhealth.com	Lauren Keane
Resolve Crisis Services	24/7 telephone, mobile, walk-in, and residential services	Y	Y	Allegheny	Community Care	Michael Edelstein edelsteinme2@UPMC.edu 412-3138417	Jewel Denne
Central Recovery Center	24/7 Jail and hospital diversion overnight program	Y	N	Allegheny	County Funded		Jewel Denne
Lycoming/Clinton MH/ID/A	Our typical Crisis program is in the process of expanding crisis services in our catchment to include 24 hr. walk in availability and interim housing. This will include 1 Supervisor, 7 CI Specialists, 1 Certified Peer Support, 1 Certified Recovery Specialist and 1 Nurse.	N	Y	Lycoming	CCBH	Jim Hicklin jhicklin@joinder.org	Jacqueline Miller
Wesley Family Services Adult Crisis Diversion and Stabilization	The primary goal of the Adult Diversion and Stabilization (DAS) program is to divert hospitalizations where possible while stabilizing psychiatric crises. We are a fourteen bed, 24-hour residential program that provides psychiatric assessments, medication monitoring, individual crisis counseling, group counseling focused on crisis stabilization, and service linkage to mental health and substance abuse competent programs. The program is designed to have a home-like environment that offers a comfortable and private setting for adults to be evaluated and participate in crisis stabilization activities.	Y	Y	Allegheny	Beacon and County	Kim Linguist, Adult DAS Coordinator	Debra Luther
SPHS Behavioral Health Crisis Stabilization/Diversion Unit	SPHS offers a crisis stabilization/diversion unit for residents of Washington County. The unit offers an alternative to behavioral health hospitalizations or is an option to step down from the hospital prior to reintegrating into the community. At the crisis unit, staff develop treatment plans and coordinate care for individuals upon discharge from the unit	Y	Y	Washington	Beacon and County	Kimberly Scalise or Vince Campbell, vcampbell@sphs.org, kscalise@sphs.org	Debra Luther
Cambria County Walk-In Crisis program	The targeted population for the Cambria County Walk in Crisis program are adults ages 18 years of age and older who are MA eligible and experiencing a mental health crisis. In maintaining a recovery focused approach, HealthChoices of Cambria County (BHoCC) will develop a new Walk in Crisis program to assist members who are experiencing a mental health crisis. The core goal of this program is to meet individuals and their families where they are in their lives when a mental health crisis occurs and develop more adaptive functioning across settings.	N (06/22)	Crisis	Cambria	Magellan	Michael Robb, President and CEO, mrobb@ccrinfo.org	Lauren Keane

Attachment 6: Summary List of Allowed BH Billing Place of Service Codes

Emergency Department Boarding Workgroup
OMHSAS/OMAP Expanded BH Billing Place of Service Code 23
January 1, 2023

The following billing codes are permitted to be used with the POS code 23, Emergency Department. This has been expanded by OMHSAS/OMAP in both the BH Services Reporting Classification Chart (BHSRCC) and additional allowances that are not referenced in the chart at the request of the ED Boarding Workgroup.

Although not listed as POS 23, OMHSAS has verified in writing that all of the following Clinic Mobile Mental Health Treatment can be paid for when services are provided in an ED.

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
CLINIC - MOBILE MENTAL HEALTH TREATMENT								
08	074	90792			Psychiatric diagnostic evaluation with medical services (Psychiatric Eval, Exam & Eval of Patient)	occurrence	15	43
08	074	90832			Psychotherapy, 30 minutes with patient	30 min	15	43
08	074	90834			Psychotherapy, 45 minutes with patient	45 min	15	43
08	074	90837			Psychotherapy, 60 minutes with patient	60 min	15	43
08	074	90846	UB		Family Psychotherapy (without the patient present)	15 min	15	43
08	074	90847	UB		Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	15	43
08	074	96127			Brief emotional/behavioral assessment (eg. depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	occurrence	15	43
08	074	96160			Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	occurrence	15	43

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
MENTAL HEALTH - FAMILY BASED REHAB SERVICES								
11	115	H0004	UB	HE	Behavioral health counseling and therapy, per 15 minutes (Team member w/ Consumer)	15 min	02, 10, 12, 99, **	24
11	115	H0004	UB	HE; HK	Behavioral health counseling and therapy, per 15 minutes (MH Svc During Non-Psych Inpatient Admission)	15 min	02, 21, 31, 32, **	24
11	115	T1016	UB		Case management, each 15 minutes (MH Svc During Non-Psych Inpatient Admission)	15 min	02, 21, 31, 32, **	24
11	115	T1016	UB	HK	Case management, each 15 minutes (MH Svc During Psych Inpatient Admission)	15 min	02, 21, **	24

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
MENTAL HEALTH - PEER SPECIALIST								
11	076	H0038			Self help/peer services, per 15 minutes	15 min	02, 10, 11, 12, 21, 23, 31, 32, 49, 52, 99	44

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
MENTAL HEALTH / SUBSTANCE ABUSE - SUPPLEMENTAL								
11	112	H0004		HE	Behavioral health counseling and therapy, per 15 minutes (MH Outpatient Practitioner)	15 min	02, 10, ***23,*** 31, 32, 99	36
11	111	H0039		HB	Assertive community treatment, face to face, per 15 minutes (Community Treatment Teams)	15 min	02, 10, ***23,*** 31, 32, 99	33
11	111	H0039		HE	Assertive community treatment, face to face, per 15 minutes (ACT)	15 min	02, 10, ***23,*** 31, 32, 99	33

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
OPIOID USE DISORDER CENTERS OF EXCELLENCE - Coding is not new to the chart but is being added to Attachment G and H								
01	232	G9012			Other specified case management service not elsewhere classified	per month	02, 11, 12, 22, 23, 99	48

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
PHYSICIAN								
31	339	99241			Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	visit	02, 10, 11, 12, 22, 23, 24, 31, 32, 54, 65	12
31	339	99242			Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	visit	02, 10, 11, 12, 22, 23, 24, 31, 32, 54, 65	12
31	339	99243			Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	visit	02, 10, 11, 12, 22, 23, 24, 31, 32, 54, 65	12
31	339	99244			Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	visit	02, 10, 11, 12, 22, 23, 24, 31, 32, 54, 65	12
31	339	99245			Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	visit	02, 10, 11, 12, 22, 23, 24, 31, 32, 54, 65	12
31	315, 316, 322, 339, 345	99281			Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional	visit	02, 23	12
31	315, 316, 322, 339, 345	99282			Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making	visit	02, 23	12
31	315, 316, 322, 339, 345	99283			Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making	visit	02, 23	12
31	315, 316, 322, 339, 345	99284			Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	visit	02, 23	12
31	315, 316, 322, 339, 345	99285			Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making	visit	02, 23	12
31	339	99291			Critical care, evaluation and management	1 hour	21, 23	12
31	339	99292			Critical care, evaluation and management, each additional 30 minutes	30 min	21, 23	12

Although not listed on the BHSRCC chart, OMHSAS/OMAP confirmed in writing that the following services delivered by a CRNP can be paid with POS 23.

09-CRNP

90792	Psychiatric diagnostic evaluation with medical services (Psychiatric Eval, Exam & Eval of Patient)	occurrence	09	103
90832	Psychotherapy, 30 minutes with patient	30 min	09	103
90834	Psychotherapy, 45 minutes with patient	45 min	09	103
90837	Psychotherapy, 60 minutes with patient	60 min	09	103

99242	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	visit	09	103
99243	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	visit	09	103
99244	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	visit	09	103
99245	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family	visit	09	103
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor.	visit	09	103

Attachment 7: BHSRCC January 2023

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
			INPATIENT PSYCHIATRIC SERVICES				
1	Inpatient Psychiatric Services	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	**DRG's:** 424-432	01	01
					Revenue Codes: 0114, 0124, 0134, 0154, 0204,		
					0760 ,0761, 0762, 0769, 0900, 0901, 0902, 0903,		
					0904, 0909, 0910, 0911, 0914, 0915, 0916, 0917,		
					0918, 0919, 0920, 0929, 0949		
2	Inpatient Psychiatric Services	01 - Inpatient Facility	011 - Private Psychiatric Hospital or		**Revenue Codes:** Same as Line Item 1	01	01
			022 - Private Psychiatric Unit				
3	Inpatient Psychiatric Services	01 - Inpatient Facility	018 - Extended Acute Psych	Any*	**Revenue Codes:** Same as Line Item 1	01	01
			Inpatient				
			INPATIENT DRUG & ALCOHOL WITHDRAWAL MANAGEMENT				
4	Inpatient Drug & Alcohol	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	**DRG's:** 433, 521, 522, 523	02	02
	Withdrawal Management				**Revenue Codes:** 0116, 0126, 0136, 0156, 0760,		
					0761, 0762, 0769, 0949		
5	Inpatient Drug & Alcohol	01 - Inpatient Facility	019 - D&A Rehab Hosp or		**Revenue Codes:** 0116, 0126, 0136, 0156, 0760,	02	02
	Withdrawal Management		441 - D&A Rehab Unit		0761, 0762, 0769, 0949		
			INPATIENT DRUG & ALCOHOL REHABILITATION				
6	Inpatient Drug & Alcohol Rehab	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	**DRG's:** 433, 521, 522, 523	04	02
					Revenue Codes: 0118, 0128, 0138, 0158, 0760,		
					0761, 0762, 0769, 0944, 0945, 0949		
7	Inpatient Drug & Alcohol Rehab	01 - Inpatient Facility	019 - D&A Rehab Hosp or		**Revenue Codes:** 0118, 0128, 0138, 0158, 0760,	04	02
			441 - D&A Rehab Unit		0761, 0762, 0769, 0944, 0945, 0949		

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
			NON-HOSPITAL RESIDENTIAL, DETOXIFICATION & REHABILITATION				
8	Non-Hospital Residential, Detoxificatio	11 - Mental Health /	131 - D&A Halfway House	Any*	**Procedure Code:** H2034	05	03
	Rehabilitation, Halfway House Services	Substance Abuse	132 - D&A Medically Monitored Detox		**Procedure Code:** H0013, H0012, H0012/TG		
	D&A Dependence/Addiction		185 - D&A Non-Hosp Residential		**Procedure Code:** H2036		
			Clinically Managed				
			186 - D&A Non-Hosp Residential		**Procedure Code:** H2036		
			Medically Monitored				
			PSYCHIATRIC OUTPATIENT SERVICES				
9	Psychiatric Outpatient Clinic Services	08 - Clinic	110 - Psychiatric Outpatient	Any	**Procedure Codes:** See Pages 7-11 of Attach G	06	04
					(excluding H0034/HK, H2010/HK, 99407)		
		01- Inpatient	183 - Hospital Based Med Clinic	Any	**Procedure Codes:** 90870, G0378, G0379	06	04
43	Psychiatric Outpatient Mobile Services	08 - Clinic	074 - Mobile Mental Health Trtmt	Any	**Procedure Codes:** See Pages 2 - 3 of Attach G	06	04
10	Psychiatric Outpatient Services	11 - Mental Health /	113 - Partial Psych Hosp Children or	Any*	**Procedure Codes:** See Page 16-17 of Attach G	03	04
		Substance Abuse	114 - Partial Psych Hosp Adult		(excluding H2010/HK)		
11	Psychiatric Outpatient Clinic Services	08 - Clinic	080 - FQHC or 081 - RHC	Any*	**Procedure Code:** T1015/HE, T1015/HE/HQ, ***G1028***,	06	04
>>>>>					G2215, G2216		
12	Psychiatric Outpatient Services	19 - Psychologist	190 - General Psychologist	Any*	**Procedure Codes:** See Pages 31-32 of Attach G	06	04
					(excluding 99407)		
		31 - Physician	339 - Psychiatry	Any*	**Procedure Codes:** See Pages 19-30 of Attach G	06	04
					(excluding H2010/HK/U1 and 99407)		
		31 - Physician	315 - Emergency Medicine	Any*	**Procedure Codes:** 99281, 99282, 99283, 99284,	06	04
					99285		
			316 - Family Practice		**Procedure Codes:** 96127, 96160, 99202, 99203,		
			322 - Internal Medicine		99204, 99205, 99211, 99212, 99213, 99214, 99215,		
			345 - Pediatrics		99281, 99282, 99283, 99284, 99285, 99484, 99492,		
					99493, 99494		
			RESIDENTIAL TREATMENT SERVICES FOR CHILDREN & ADOLESCENTS - JCAHO				
15	Residential Treatment Facilities (RTF)	01 - Inpatient	013 - RTF (JCAHO certified) Hospital	Any*	**Revenue Codes:** 0114, 0124, 0134, 0154, 0185,0204,	08	07
	Children & Adolescents - JCAHO				0900, 0901, 0902, 0903, 0904, 0909, 0910, 0911,		
					0914, 0915, 0916, 0917, 0918, 0919, 0920, 0929,		
					0949		
			RESIDENTIAL SERVICES FOR CHILDREN & ADOLESCENTS - NON-JCAHO				
16	Residential Treatment Facilities (RTF)	56 - RTF	560 - RTF (Non-JCAHO certified)	Any*	**Procedure Code:** H0019/SC	09	08
	for Children & Adolescents	52 - CRR	520- C&Y Lic Group Home w/ MH	100000120 0045	**Procedure Codes:** H0018, H0019/HQ		
>>>>>	Non-JCAHO		Treatment Component	***~~100728011 0021~~***			
			OUTPATIENT DRUG & ALCOHOL SERVICES				
17	Outpatient Drug & Alcohol	08 - Clinic	184 - D&A Outpatient	Any*	**Procedure Codes:** See Pages 3-7 of Attach G	10	05
					(excluding 99407)		
		08 - Clinic	084 - Methadone Maintenance	Any*	**Procedure Codes:** H0020/HG, H0020/UB, T1015/HG		
18	Outpatient Drug & Alcohol	08 - Clinic	080 - FQHC or 081 - RHC	Any*	**Procedure Code:** T1015/HF, T1015/HF/HQ, ***G1028,***		
>>>>>					G2215, G2216		
48	Opioid Use Disorder Centers of	01 - Inpatient Facility	232 - Opioid COE		**Procedure Code:** G9012	10	05
	Excellence	08 - Clinic					
		11 - Mental Health/					
		Substance Abuse					
		19 - Psychologist					
		21 - Case Manager					
		31 - Physician					

			ANCILLARY SERVICES				
19	Laboratory Studies/Diagnostic Radiolo Medical Diagnostic Ordered by BH Physicians	01 - Inpatient Facility	183 - Hospital Based Med Clinic	Any*	Refer to the MA Reference File for available CPT codes.	12	09
		28 - Laboratory	280 - Independent Laboratory				
20	Laboratory Studies/Diagnostic Radiolo Medical Diagnostic Ordered by BH Physicians	31 - Physician	339 - Psychiatry	Any*	Refer to the MA Reference File for available CPT codes.	12	09
21	Clozapine	01 - Inpatient Facility	010 - Acute Care Hospital	Any* w/special enroll	N/A	13	09
22	Clozapine Support Services	31 - Physician	339 - Psychiatry	Any*	**Procedure Code:** H2010//HK/U1	13	09
		08 - Clinic	110 - Psychiatric Outpatient		**Procedure Codes:** H0034/HK, H2010/HK		
		11 - Mental Health/ Substance Abuse	113 - Partial Psych Hosp Children or		**Procedure Code:** H2010/HK		
			114 - Partial Psych Hosp Adult		**Procedure Code:** H2010/HK		
			COMMUNITY SUPPORT SERVICES				
23	Crisis Intervention	11 - Mental Health/ Substance Abuse	118 - MH Crisis Intervention	Any*	**Procedure Codes:** H0030, H2011, H2011/UB/HE, H2011/U9/HK, H2011/U7/HT, S9484, S9485	14	10
24	Family Based Services for Children & Adolescents	11 - Mental Health/ Substance Abuse	115 - Family Based MH	Any*	**Procedure Codes:** H0004/UB/HE, H0004/UB/HK, H0004/UB/HT,H0004/UB/UK, H0004/UB/HE/HK, T1016/UB, T1016/UB/HK, T1016/UB/HT, T1016/UB/UK	15	10
25	Targeted MH Case Management - Intensive Case Management	21 - Case Manager	222 - MH TCM, Intensive	Any*	**Procedure Codes:** T1017/UB, T1017/UB/HK, T1017/UB/HE/HK	16	10
27	Targeted MH Case Management - Blended Case Management	21 - Case Manager	222 - MH TCM, Intensive	Any*	**Procedure Codes:** T1017/UB/UC, T1017/UB/HK/UC, T1017UB/HE/HK/UC	16	10
28	Targeted MH Case Management - Resource Coordination	21 - Case Manager	221 - MH TCM, Resource Coordination	Any*	**Procedure Codes:** T1017/TF, T1017/TF/HK, T1017/TF/HE/HK	16	10
44	Peer Support Services	11 - Mental Health/ Substance Abuse	076 - Peer Specialist	Any	**Procedure Codes:** H0038	19	98

			OTHER SERVICES (Defined Supplemental)				
			Outpatient Psychiatric (Defined Supplemental)				
29	Rehabilitative Services	11 - Mental Health/ Substance Abuse	123 - Psychiatric Rehab	Any*	**Procedure Codes:** H0036/HB, H2030	18	98
30	Mental Health General	11 - Mental Health/ Substance Abuse	110 - Psychiatric Outpatient	Any*	**Procedure Code:** H0031	98/96	98
31	Residential & Housing Support Service	11 - Mental Health/SA	110 - Psychiatric Outpatient	Any*	**Procedure Codes:** H0018/HE, T2048/HE, T2048	98/96	98
52	Integrated Community Wellness Center	08 - Clinic	111 - Community Mental Health		**Procedure Cod**e: W0500	06	98
			Community Support (Defined Supplemental)				
33	Mental Health General	11 - Mental Health/ Substance Abuse	111 - Community Mental Health	Any*	**Procedure Codes:** H0039/HB, H0039/HE	98/96	98
			Outpatient Drug and Alcohol (Defined Supplemental)				
34	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	084 - Methadone Maintenance	Any*	**Procedure Codes:** H0020/HG, H0020/UB, T1015/HG	98/97	98
			129 - D&A Partial Hospitalization	Any*	**Procedure Codes:** H0012, H0012/TG, H0020**,** H0035/HF, H2035	98/97	98
			184 - Outpatient D&A	Any*	**Procedure Codes:** H0001, H0022	98/97	98
		21 - Case Manager	138 - D&A Targeted Case Mgmt	Any*	**Procedure Codes:** H0006, H0006/TF	98/97	98
35	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	128 - D&A Intensive Outpatient	Any*	**Procedure Codes:** H0012, H0012/TG, H0015	98/97	98
			Supplemental Other (Defined Supplemental)				
36	Mental Health General	11 - Mental Health/ Substance Abuse	112 -OP Practitioner - MH	Any*	**Procedure Code:** H0004/HE	98/96	98
			119 - MH - OMHSAS	Any*	**Procedure Code:** H0046/HW	98/96	98
			110 - Psychiatric Outpatient	Any*	**Procedure Code:** H0037	98/96	98
37	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	127 - D&A OP	Any*	**Procedure Code:** H0004/HF	98/97	98
			184 - Outpatient D&A	Any*	**Procedure Codes:** H0047/HA, H0047/HW	98/97	98
			OTHER SERVICES (MA Defined - Non-Behavioral Health)				
38	Case Management Services	21 - Case Manager	212 - MA Case Management for under 21 years of age	Any*	**Procedure Code:** T1016/U8	98/96	98
			OTHER SERVICES (MA Defined - Behavioral Health)				
39	Outpatient Behavioral Health	17 - Therapist	171 - Occupational Therapist		**Procedure Code:** 97150/GO	98/96	98
40	Tobacco Cessation	01 - Inpatient Facility	370 - Tobacco Cessation	Any* w/special enroll	**Procedure Code:** 99407	98/96	98
		05 - Home Health					
		08 - Clinic					
		09 - CRNP					
		19 - Psychologist					
		27 - Dentist					
		31 - Physician					
		37 - Tobacco Cessation					
			OTHER SERVICES (MA Defined - Behavioral Health - Supplemental)				
41 >>>>>	Ancillary Services	31 - Physician	339 - Psychiatry	Any*	**Procedure Codes:** ~~99211/UB~~**,** 99241/UB	98/96	98

			OTHER SERVICES (Non-MA Behavioral Health)				
42	Other - Outpatient	31 - Physician	339 - Psychiatry	Any*	**CPT Codes:** 90792/HE	98/96	98
		19 - Psychologist	190 - General Psychologist	Any*	**CPT Codes:** 90791/HE	98/96	98
42	Other - Outpatient continued	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	**CPT Codes:** 90792/HE, 90832/HE 90834/HE, 90846/HE, 90847/HE, 90853/HE,	98/96	98
		01 - Inpatient Facility	011 - Private Psych Hosp or 022 - Private Psych Unit	Any*	**CPT Codes:** 90792/HE, 90832/HE, 90834/HE 90846/HE, 90847/HE, 90853/HE, 90870	98/96	98
		08 - Clinic	080 - FQHC or 081 - RHC	Any*	**CPT Codes:** 90792/HE, 90846/HE, 90847/HE, 90853/HE	98/96	98
		08 - Clinic	110 - Psychiatric Outpatient	Any*	**CPT Codes:** 99347/HE, 99348/HE, 99349/HE	98/96	98
>>>>>		08 - Clinic	110 - Psychiatric Outpatient	Any* with OMHSAS approval for telehealth	**CPT Codes:** ~~***99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215***~~ , 99241, 99242, 99243, 99244, 99245, Q3014 - Submit encounters with POS 02 or 10	98/96	98
~~**>>>>>**~~		~~***08 - Clinic***~~	~~***110 - Psychiatric Outpatient***~~		~~***CPT Codes: 99202/HE, 99203/HE, 99204/HE, 99205/HE, 99211/HE, 99212/HE, 99213/HE, 99214/HE, 99215/HE***~~	~~***98/96***~~	~~***98***~~
		09 - CRNP	103 - Family & Adult Psychiatric Mental Health	Any*	**CPT Codes**: 90792, 90832, 90834, 90837, 90846/UB/U1 90847/UB/U1, 90853/UB/U1, 90870, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, 99292, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99343, H2010/HK/U1	06	04
		11 - Mental Health/ Substance Abuse	113 - Partial Psych Hosp Child		**Procedure Codes**: H0035/U6, H0035/U5/HB	03	04
			114 - Partial Psych Hosp Adult		**Procedure Codes**: H0035/U5		
			INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS)				
49	IBHS				**ICD 10 CM: any BH ICD-10 code other than intellectual disability codes <u>AND</u>**	07	06
		11 - Mental Health/ Substance Abuse	590 - Individual IBHS		**Procedure Codes:** 90791, H0031/UB, H0031/U9, H0032/UB, H0032/U9, H2014/UB, H2019, H2019/U9, H2019/U6/HA, H2021, H2033		
			591 - Group IBHS		**Procedure Codes:** 90791, H0031/UB, H0031/U9, H2021/U6/HQ, H2021/U5/HQ, H2021/U4/HQ		
49	IBHS continued	11 - Mental Health/ Substance Abuse	592 - Applied Behavior Analysis - IBHS		**Procedure Codes:** H0031/UB, H0031/U9, 90791, 97151, 97151/U7, 97152, 97152/U8, 97153, 97153/U8, 97154, 97154/U5, 97154/U6, 97155, 97155/U7, 97156, 97156/U7, 97158, 97158/U5, 97158/U6		
50	IBHS for Children & Adolescent with ID				**ICD 10 CM: any intellectual disability code <u>AND</u>**	17	06
		11 - Mental Health/ Substance Abuse	590 - Individual IBHS		**Procedure Codes:** 90791, H0031/UB, H0031/U9, H0032/UB, H0032/U9, H2014/UB, H2019, H2019/U9, H2019/U6/HA, H2021, H2033		
			591 - Group IBHS		**Procedure Codes:** 90791, H0031/UB, H0031/U9, H2021/U6/HQ, H2021/U5/HQ, H2021/U4/HQ		
			592 - Applied Behavior Analysis - IBHS		**Procedure Codes:** H0031/UB, H0031/U9, 90791, 97151, 97151/U7, 97152, 97152/U8, 97153, 97153/U8, 97154, 97154/U5, 97154/U6, 97155, 97155/U7, 97156, 97156/U7, 97158, 97158/U5, 97158/U6		
51	IBHS				**ICD-10-CM: R69 <u>AND</u>**	07	06
		11 - Mental Health/ Substance Abuse	590 - Individual IBHS		Procedure Code: 90791		

			EPSDT				
53	EPSDT	17 - Therapist	174 - Art Therapist		Procedure Code: H2032/UB	07	06
		17 - Therapist	175 - Music Therapist		Procedure Code: G0176/UB		
		19 - Psychologist	190 - General Psychologist		Procedure Codes: 90791		
		52 - CRR	523 - Host Home/Children		Procedure Codes: H0019		

Lines 2 and 3 - Code combinations listed in Lines 2 and 3 are allowed with either no DRG or any valid DRG other than 424 through 432.

Lines 5 and 7 - Code combinations listed in Lines 5 and 7 are allowed with either no DRG or any valid DRG other than 433, 521, 522, or 523.

Line 15 - Code combinations listed in Line 15 are allowed with either no DRG or any valid DRG

Attachment 8: Using Mobile Mental Health Treatment in ED setting

Using Mobile Mental Health Treatment to provide and fund services in an Emergency Department

OMHSAS has reviewed the following process that would allow a licensed MH OP Clinic to have an approved MMHT service description to then bill for services delivered in an ED. OMHSAS management are in agreement that this process would be allowed per the MH OP regulations.

1. Per 5200.51, MMHT must have an OMHSAS approved service description that will allow the provider to bill for MMHT. This approved service description will be key in the licensing review when assessing the use/delivery for MMHT.
2. Have the provider submit a MMHT service description that covers the following:
   a. Place of service would be the identified hospital/ED
   b. Staffing would be identified to provide the initial assessment and intervention/treatment
   c. If this is a person that is not open with the provider, the intake process can begin at the ED to open the case
   d. If this is a case that is open with the provider, the Tx plan would need updated to include the need for MMHT at the ED. Since EDs are emergent care, it would have to be added after the fact.
3. Compliance with 5200.31 Treatment Plan for new cases could be met for cases not already active with the provider as follows:
   a. Assessment is completed as part of the intake/initial engagement
   b. Involve the member and if a child, engage the family/guardian in the brief intervention plan. This can follow an acceptable intervention model such as Solution-Focused Brief Therapy techniques (SFBT)
   c. If the member is D/C from the ED by 20-30 days of engagement with the MH professional/therapist, then the records would indicate the assessment/brief intervention and D/C status, but no treatment plan would be required.
   d. If the member is on an extended ED period (30 days anticipated), a treatment plan would be developed with the member/family and the consulting psychiatrist via telehealth so all engaged persons would be part the plan, along with the ED medical director. If D/C is back to the community, the member can be immediately brought into the OP Clinic as identified in the plan.

All billing would be the same as services delivered in the MH OP clinic. If there are enhanced rates for MMHT, this could apply.

Attachment 9: MH Supplemental Service Billing Model

MH Supplemental Service Billing Model

The BHSRCC chart added place of service 23 (ED) to the Mental Health/Substance Abuse Supplemental Service category, specifically for:

11	112	H0004		HE	Behavioral health counseling and therapy, per 15 minutes (MH Outpatient Practitioner)

This is a very broad category that allows discretion by the Primary Contractor (PC) and BHMCO on how this provider type/specialty code can be paid for and reported. The following description provides guidance that allows the credentialing options, payment options and reporting when such services are delivered in an ED.

Credentialing Considerations for MH Supplemental Outpatient Practitioner

All MH Supplemental practitioners (clinicians) will require to be individually enrolled in Medicaid and be credentialed by the BHMCO. As a supplemental service, the MA enrollment is only for the HealthChoices BH program/BHMCO and not for FFS billing. This requires a two-step process that each BHMCO will have in their provider network P&Ps.

1. Credentialing The enrolling clinician will have to complete the credentialing application per the BHMCO's policies. This would be as an individual even if they are going to be working for a clinical group (i.e. LLP) or an organization other than a MH licensed program/agency. It is an industry standard and expectation that these clinicians must be licensed in their scope of service they are being credentialed in (LCSW, LMFT, etc.). Once the clinician has completed the due diligence of the credentialing process by the BHMCO, the next step that must be completed to finalizing being brought into network is they must enroll in MA under the supplemental service process.
2. MA Enrollment The enrollment process for a supplemental service provider will be completed by the clinician with the support of the BHMCO staff. Key to this enrollment is how they identify themself related to tax ID, payment assignment and location(s) of service. This will all tie into how the BHMCO pays for the services rendered and the reporting. So, the BHMCO will enroll the clinician 11/112 provider type and specialty as either an individual clinician or part of a group as determined by the provider submitting the in-plan application. Once the in-plan is approved, the BH MCO must sign off on the attestation form that goes along with the providers MA enrollment application using the In lieu of enrollment form. The provider's MA enrollment application must include all sites where they will provide services (PCP office, specialist office, emergency department, etc.). It is critical for this model that the address of the ED be listed.

Once the plan is approved, the BH MCO must sign off on the attestation form that goes along with the providers MA enrollment application using the In lieu of enrollment form. Upon enrollment with MA, the clinician can complete the credentialing process for network enrollment. The information from the MA enrollment approval and form will be used to set up the account by the BHMCO. All forms are attached as a reference to the described process.

Contracting/Payment Models for Consideration

As part of the credentialing and MA enrollment process, the clinician will need to indicate how payment will be made to them as part of the enrollment form.

On the MA enrollment form, the provider can list a "pay to entity". Most BHMCO will set up their provider profile for claims and identification using this information. There is one Tax ID associated with the pay to entity and although each clinician in the group gets their own MA ID#, that group may have any number of clinicians under the pay to entity. Unfortunately, DHS requires a group for each type of clinician, so a provider may have to manage multiple groups and "pay to" entities. Per their instructions:
Check "Fee Assignment" if you are:
a. Adding this provider to an existing provider group. Fee Assignment may only be made between "like provider types". If enrollee is a Group, attach a copy of your Corporation Papers

This means a provider may need to have an LPC group with a pay to entity that houses the LPCs, an LCSW group, a psychologist group, and a psychiatrist group. Hospitals can and do set up such groups as a separate MA enrolled entity with its own tax ID. Many times, these are referred to as "medical groups", such as Lancaster General Medical Group.

Page 14 of the application form:

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health In Lieu Of and In Addition To Services
Fee Assignment Form for Group Members
Date: ___________________________
Group 13-Digit Provider ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Group Name: ___________________________
Contact Name: ___________________________
Contact Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Note: By signing, I am agreeing to assign my fees to the Group and Service Location, listed above.

1. ___________________ ___________________
____
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)
___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___________________
13 Digit Individual Provider Number Effective Date

2. ___________________ ___________________
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)
___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___________________
13 Digit Individual Provider Number Effective Date

A clinician can also enroll and identify themself as the entity to be paid directly. This is not common when setting up such a model of embedding a clinician either in an ED, PCP office or other physical health specialty service. In either case, it is the clinician that is enrolled in MA and the designation of the designated fee assignment will determine how the BHMCO sets up the clinician in its provider contract and files. BHMCOs may manage these arrangements differently, but it is common to show the claims paid by the group enrollment and then be able to expand this to show the claims by the individual clinicians, thus further helping in monitoring the service.

Service Codes That Can Be Used

All MH OP service codes used for billing can be used for the MH Supplemental Service 11/112 clinician service. It is the decision of the PC/BHMCO what services are appropriate to bill for when delivered in an ED and what the reimbursement rate will be. In some cases, you could use the same codes and associated rates used in a MH OP Clinic or you may want to have enhanced rates when the Place of Service is in the ED (23). There are no limits set on the use of the service codes other than those that are not within the scope of practice or licensing of the clinician.

Reporting with the 837 Files

When reporting claims paid using the MH Supplemental Service 11/112 clinician, the BHSRCC chart shows that the reporting service codes is H004 HE. This does not prevent the use of all the other MH OP codes as discussed in the Service Code section. What the PC/BHMCO must do is "roll up" all of the paid claims into the 11/112 H004 HE when reporting this in the 837. As stated on the BHSRCC document:

> Enclosed please find the January 2023 Behavioral Health Services Reporting Classification Chart (BHSRCC) to assist you with determining the appropriate coding of services for both financial and encounter data reporting for HealthChoices. The BHSRCC is intended to assist you in establishing edits in your reporting processes; however, it is not in any way intended to limit or expand behavioral health services in the HealthChoices Program. ***It is advisable to keep the previous charts as a reference guide. The BHSRCC is updated and distributed semi-annually.***

This allows the ability to be flexible and creative in how you set up the funding for this model of delivering MH services in and ED while meeting 837 reporting requirements.

Attachment 10: EMTALA

<u>EMTALA and Behavioral Health</u>
Frequently Asked Questions

"The contained information in this FAQ does not constitute legal advice. Hospitals, facilities, and providers should seek an advice from legal counsel if they have questions about the applicability of EMTALA or any other laws or regulations to their activities."

I. ***What is EMTALA?***

EMTALA is the commonly used abbreviation for the Emergency Medical Treatment and Labor Act, codified at 42 U.S.C. § 1395dd (§ 1867 of the Social Security Act), with accompanying regulations in 42 CFR §§ 489.24, 489.20(l), (m), (q), and (r).

In a broad sense, EMTALA is a federal law that requires Medicare participating hospitals with emergency departments to provide certain minimum care to anyone who comes to the emergency department, and prohibits them from refusing to provide a medical screening examination, and, as necessary for stabilization, treat patients with emergency medical conditions ("EMC").

II. ***What is an emergency medical condition?***

An EMC is defined in the regulations as:

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, **psychiatric disturbances** and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in -

> **(i)** Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
>
> **(ii)** Serious impairment to bodily functions; or
>
> **(iii)** Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions -

> **(i)** That there is inadequate time to effect a safe transfer to another hospital before delivery; or
>
> **(ii)** That transfer may pose a threat to the health or safety of the woman or the unborn child.

42 CFR 489.24(b).

III. ***When is a psychiatric condition an emergency medical condition?***

The same criteria as any other medical condition applies to the determination of whether a psychiatric issue is an emergency medical condition. (i.e. whether it places the health of the individual in serious jeopardy, seriously impairs bodily functions, or results in serious dysfunction of any bodily organ or part). Psychiatric emergencies include, but are not limited to,

individuals who are "expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others." State Operations Manual ("SOM"), Pub 100-07, Appendix V, Interpretive Guidelines § 489.24(d)(1)(i).

A psychiatric patient is considered stable when they are protected and prevented from injuring or harming self or others. *Id.* The administration of physical restraints or pharmacological sedation for the purposes of transferring an individual may stabilize a patient temporarily, but underlying medical conditions may persist. *Id.* Therefore, it is recommended to use care when determining if a medical condition is truly stable after the application of restraints or sedation. *Id.*

IV. ***What does it mean to "come to the emergency department?"***

An individual "comes to the emergency department" when an individual comes, alone or with another person, to a hospital's dedicated emergency department and a request is made by the individual or on the individual's behalf, or a prudent layperson observer would conclude from the individual's appearance or behavior, a need for examination or treatment of an EMC**.**

CMS has clarified that "a hospital's EMTALA obligations are triggered whenever an individual presents **on hospital property** [including parking lot, sidewalk and driveway] . . . in an attempt to **gain access to the hospital for emergency care** and requests examination or treatment for an [EMC]."

An individual may also be deemed to have come to the ED if they are in a hospital owned ambulance whether or not they are on hospital property with certain exceptions.

A hospital may permissibly direct a non-hospital owned ambulance to another facility if it is on "diversionary status" (including behavioral health diversion) if it **does not have the staff or facilities to accept any additional emergency patients.** However, if ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the patient has "come to the emergency department" and EMTALA obligations attach.

Additional considerations may be relevant in different factual scenarios, and hospitals should consult with legal counsel to determine their own obligations with respect to hospital arrivals and ambulances.

See 42 C.F.R. 489.24(b).

V. ***What is a "dedicated emergency department?"***

EMTALA regulations define "dedicated emergency department" broadly to include any department or facility of the hospital, whether on the main campus or off, that meets at least one of the following requirements:

1. it is licensed by the state as an emergency room or emergency department;
2. it is held out to the public (by name, posted sign, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without previously scheduled appointments; or
3. during the immediately preceding calendar year, based on a representative sample of patient visits, it provided at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

VI. ***Does EMTALA cover psychiatric hospitals?***

EMTALA obligations extent to all hospitals that accept Medicare, and have a dedicated emergency department. Therefore, these obligations will apply to psychiatric hospitals that meet these conditions. Notably, even if a psychiatric hospital does not have a traditional emergency department, it may still qualify as having a dedicated emergency department under EMTALA.

For example, if more than one-third of the patients coming to the intake or assessment area of a psychiatric hospital in the preceding year were treated for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, the intake area would be treated as a dedicated emergency department and EMTALA obligations would attach. State Operations Manual ("SOM"), Pub 100-07, Appendix V, Interpretive Guidelines, I. General Information.

VII. ***Does EMTALA cover urgent care clinics?***

The answer to this question will depend upon a factual assessment. Urgent care clinics can be organized in multiple different ways depending upon the preferences of the owners and the regulatory regime of the state where the urgent care is located.

Hypothetically, an urgent care clinic could meet the definition of a dedicated emergency department and, therefore, be subject to EMTALA. For example, a hospital-owned urgent care could meet the definition if it is a "facility of [a] hospital, whether on the main campus or off" and it provides care on an urgent basis without the need for a previously scheduled appointment.

This same analysis would be factual analysis would be required in the case of a behavioral health urgent care clinic to determine if it is covered by EMTALA.

VIII. ***What is an emPATH unit?***

EmPATH (**Em**ergency **P**sychiatric **A**ssessment, **T**reatment, and **H**ealing) is a model for psychiatric emergency care. *See, e.g* Scott Zeller, EmPATH Units as a Solution for Emergency Department Psychiatric Patient Boarding (2017). The model is based on the premise that the majority of psychiatric emergencies can be resolved in less than 24 hours with prompt, appropriate intervention. However, evidence shows that the environment of standard emergency departments may, in fact, exacerbate the symptoms of a psychiatric crisis. *Id.*

EmPATH units are "hospital-based outpatient programs which can promptly accept all medically-appropriate patients in a psychiatric crisis, even those on involuntary psychiatric detention." *Id.*

Generally an emPATH unit is either part of the emergency department or is located nearby, on the hospital's campus.

IX. ***If a hospital is required to comply with EMTALA, and a patient comes to the emergency department with a behavioral health issue, can the hospital transfer the patient?***

Generally, a patient presenting at a dedicated emergency department may not be transferred prior to stabilization (i.e. provision of such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility) unless certain conditions have been met. A transfer means "the movement (including discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated

or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person." 42 CFR § 489.24(b).

A. to another hospital?

Yes, a hospital may transfer a patient to another hospital, however it must meet certain criteria. In all cases, the transfer must be appropriate. (Meaning the transferring hospital must take certain steps to assure the transfer is carried out safely through qualified personnel and transportation with adequate life support measures in place; necessary records are sent; the transferring hospital provides treatment within its capacity to minimize the risk to the patient; and the receiving hospital has available space and qualified personnel for the treatment of the patient and has agreed to accept the transfer and treat the patient).

Additionally, one of the following must be true: (1) the individual has requested the transfer in writing, after being informed of the hospital's EMTALA obligations; (2) a physician has certified in writing that, based on available information, the medical benefits reasonably expected from the transfer outweigh the increased risks from being transferred; or (3) if a physician is not physically present in the emergency department at the time of transfer, a qualified medical person has signed such a certification, after consulting with a physician who agrees and countersigns such certification.

B. to an on-campus emPATH unit?

Yes, but such a move would **not** be considered a "transfer" under EMTALA. A patient may be moved to another hospital department or facility **on-campus** to receive further screening or stabilizing treatment, as long as (1) all persons with the same medical condition are moved in such circumstances, regardless of their ability to pay for treatment; (2) there is a bona fide medical reason to move the individual; and (3) appropriate medical personnel accompany the individual. *See,* State Operations Manual ("SOM"), Pub 100-07, Appendix V, Interpretive Guidelines § 489.24(a)(1)(i).

A. to a different unit, such as an emPATH unit, off the hospital campus or to a psychiatric hospital without a dedicated emergency department?

Yes, however any time a patient is moved outside of a hospital's facilities, even if the eventual destination is owned by the same hospital, this will be considered a "transfer" and must meet the same conditions described above. That is because the definition of "transfer" includes any movement **outside a hospital's facilities**. *See, e.g., id.* (explaining that, even in states that require psychiatric patients to be treated in certain facilities/hospitals, it is an EMTALA violation to transfer such a patient prior to conducting a medical screening exam and providing stabilizing treatment or otherwise meeting the criteria for transfers).

In the case of a transfer to a psychiatric hospital without a dedicated emergency department, "if an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department." State Operations Manual ("SOM"), Pub 100-07, Appendix V, Interpretive Guidelines § 489.24(f).

X. Does a hospital have any obligations under EMTALA even if it does not have a dedicated emergency department?

Although EMTALA does not apply when a hospital does not meet the conditions described above, certain Conditions of Participation still apply under the Medicare regulations with respect to emergencies. Specifically, "[i]f emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures in effect

with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate." 42 CFR 482.12(f).