POLICY TITLE:	EMERGENCY AND POST-STABILIZAITON CARE SERVICES	POLICY # 5.17	REVIEW DATES	
Topic Area:	UTILIZATION MANAGEMENT	ISSUED BY: Chief Executive Officer		
Applies to:	LRE Staff, Member CMHSPs, Network Providers			
Developed and Maintained by:	LRE CEO or Designee	APPROVED BY: Chief Executive Officer		
Supersedes:	N/A	Effective Date: 12/19/2024	Revised Date:	

I. PURPOSE

Federal regulations, Michigan statute, and the Michigan Department of Health and Human Services (MDHHS)-Prepaid Inpatient Health Plan (PIHP) contract require that PIHPs be responsible for the coverage and payment of emergency services and post-stabilization care services. 42 CFR §438.114(b). The purpose of this policy is to provide 1) definitions for emergency services and post-stabilization care services, including behavioral health and substance use disorder (SUD), and 2) guidance related to the payment of emergency services and post-stabilization care services for which a PIHP is responsible, ensuring compliance with federal and state requirements.

II. POLICY

Lakeshore Regional Entity (LRE) is responsible for the coverage and payment of emergency services and post-stabilization care services. This policy defines emergency services and post-stabilization care services, including behavioral health and substance use disorder (SUD), covered by LRE and its Member Community Mental Health Service Programs (CMHSP) and provides guidance related to payment requirements.

III. DEFINITIONS

Adult Crisis/Crisis Situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability and one of the following applies:

a. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
b. The individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.

c. The individual has mental illness that has impaired his or her judgment so that the individual is unable to understand his or her need for treatment and presents a risk of harm.[1]

Children Crisis/Crisis Situation means a situation in which at least one of the following applies:

a. The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance.
b. The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally.
c. The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning.
d. The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement.[2]

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.[3]

Emergency Services means covered inpatient and outpatient services that are as follows:

a. Furnished by a provider that is qualified to furnish these services under this Title.
b. Needed to evaluate or stabilize an emergency medical condition.[4]

Emergency Situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a minor is experiencing a serious emotional disturbance, and one of the following applies:

a. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
b. The individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming,

[1] Michigan Medicaid Provider Manual (MMPM) January 1, 2024: Section 3 – Covered Services, 3.7, pp. 18-19; Section 5 – Clubhouse Model Programs, 5.6.B.4. Crisis Services, p. 17 & 21; Section 9 – Intensive Crisis Stabilization Services, 9.1 Adult Services, p. 78.
[2] (MMPM) January 1, 2024: Section 9 – Intensive Crisis Stabilization Services, 9.2 Children's Services, p. 80.
[3] 42 CFR §438.114(a).
[4] 42 CFR §438.114(a).

dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.

c. The individual has mental illness that has impaired his or her judgment so that the individual is unable to understand his or her need for treatment and presents a risk of harm.[5]

Enrollee means a Medicaid beneficiary who is currently enrolled in a PIHP in a given managed care program. Also referred to as recipient, beneficiary, consumer, or person-served.[6]

Post-stabilization Care Services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition or to improve or resolve the enrollee's condition.[7]

IV. MONITORING AND REVIEW

This policy will be reviewed annually by LRE CEO or designee.

V. APPLICABILITY AND RESPONSIBILITY

LRE, Member CMHSPs, Network Providers

This policy does not apply to Crisis Stabilization Units created under Chapter 9A of the Michigan Mental Health Code or any other service that is certified directly through the State of Michigan.

A. RESPONSIBILITY AND DELEGATION

1) LRE is responsible for the coverage and payment of emergency and post-stabilization care services.[8]
2) LRE delegates the coverage and payment of emergency and post-stabilization care services to its Member Community Mental Health Service Providers (CMHSPs).
3) LRE and its Member CMHSPs adhere to the Michigan Mental Health Code, Chapter 3 – State and County Financial Responsibility when an enrollee requires emergency services from a different PIHP or CMHSP outside the catchment area of Region 3.

B. COVERED EMERGENCY SERVICES

1) LRE, through delegation to its Member CMHSPs, provides coverage for the following types of emergency services either within an emergency department, hospital setting, or through community providers and will include preadmission screening:
   a. **Adult Intensive Crisis Stabilization Services.** Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team, including but not limited to a mobile intensive crisis stabilization team, and

[5] MCL §330.1100a(30).
[6] 42 CFR §438.2.
[7] 42 CFR §438.114(a) & (e).
[8] 42 CFR §438.114(b).

designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.[9]

b. **Child Intensive Crisis Stabilization Services.** Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement.[10]

c. **Crisis Intervention.** Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.[11]

2) Member CMHSPs must provide crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.[12]

C. PAYMENT OF EMERGENCY SERVICES[13]

1) LRE, through its Member CMHSPs,
   1. Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the PIHP.
   2. May not deny payment for treatment obtained under either of the following circumstances:
      i. An enrollee had an emergency condition meeting medical necessity criteria, including cases in which the absence of immediate medical attention would not have had the outcomes specified as an emergency condition.
      ii. A LRE or CMHSP representative instructs the enrollee to seek emergency services.
   3. May not limit what constitutes an emergency condition on the basis of lists of diagnoses or symptoms.
   4. May not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the LRE, enrollee's CMHSP, or MDHHS of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
   5. May not hold an enrollee, who has an emergency medical condition, liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
   6. Agree that the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that the determination is binding LRE,

[9] MMPM, January 1, 2024, Section 9 – Intensive Crisis Stabilization Services, 9.1 Adult Services, p. 78.
[10] MMPM, January 1, 2024, Section 9 – Intensive Crisis Stabilization Services, 9.2 Children's Services, p. 80.
[11] MMPM, January 1, 2024, Section 3 – Covered Services, 3.7 Crisis Interventions, p. 19.
[12] MCL §330.1206(1)(a).
[13] 42 CFR §438.114(c) & (d).

through its Member CMHSPs, as being responsible for coverage and payment for emergency services.

D. COVERED POST-STABILIZATION CARE SERVICES

LRE, through delegation to its CMHSP Participants, provides coverage for the following types of post-stabilization care services, which are rendered after an enrollee is stabilized to maintain the stabilized condition or to improve or resolve the enrollee's condition:

1) **Crisis Residential.** Services are intended to provide a short-term alternative to inpatient psychiatric services for enrollees experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. Services must be designed to resolve the immediate crisis and improve the functioning level of the enrollees to allow them to return to less intensive community living as soon as possible.[14]
    i. Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless it is licensed as a "children's therapeutic group home."[15]
2) **Inpatient Psychiatric Hospital Admission - Adult.** Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based upon the assumption that the enrollee is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.[16]
3) **Inpatient Psychiatric Hospital Admission – Children Through Age 21.** Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the child, youth, or young adult is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.[17]
4) **Outpatient Partial Hospitalization – Adult.** Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the enrollee does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the enrollee's present treatment needs. The SI/IS criteria for admission assume that the enrollee is displaying signs and symptoms of a serious

[14] MMPM, January 1, 2024, Section 6 – Crisis Residential Services; 6.2 Covered Services, p. 57.
[15] MCL §777.111(1)(h).
[16] MMPM, January 1, 2024, Section 8 – Inpatient Psychiatric Hospital Admission, 8.5.B, p. 71.
[17] MMPM, January 1, 2024, Section 8 – Inpatient Psychiatric Hospital Admission, 8.5.C, p. 73.

psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.[18]

5) **Outpatient Partial Hospitalization – Children and Adolescent.** Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the enrollee does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the enrollee's present treatment needs. The SI/IS criteria for admission assume that the enrollee is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.[19]
6) **SUD Sub-Acute Detoxification.** Services defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required. Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate. Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Criteria and individualized determination of client need.[20]
7) **SUD Medication Assisted Treatment (MAT).** Services that use medications often used in combination with counseling and behavioral therapies to provide a whole-patent approach to the treatment of substance use disorders (SUDs). Medications used in MAT are approved by the Food and Drug Administration (FDA). MAT programs are clinically driven and tailored to meet each patient's need.[21]

[18] MMPM, January 1, 2024, Section 10 – Outpatient Partial Hospitalization Services, 10.1 Adult, p. 84.
[19] MMPM, January 1, 2024, Section 10 – Outpatient Partial Hospitalization Services, 10.2 Children & Adolescents, p. 86.
[20] MMPM, January 1, 2024, Section 12 – Substance Abuse Services, 12.4 Sub-Acute Detoxification, p. 101.
[21] MMPM, January 1, 2024, Section 12 – Substance Abuse Services, 12.2 Medication Assisted Treatment (MAT), p. 95.

8) **SUD Residential Services**. An intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the enrollee to participate and benefit from less intensive treatment. Residential treatment must be staffed 24 hours per day. This intensive therapeutic service is limited to those enrollees who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

E. PAYMENT OF POST-STABILIZATION CARE SERVICES[22]

1) LRE, through its Member CMHSPs,
   i. Must pay, consistent with 42 CFR §422.214, for medically-necessary post-stabilization care services obtained within or outside Region 3 that are pre-approved by LRE or one of its Member CMHSPs.
   ii. Must pay for post-stabilization care services obtained within or outside Region 3 that are not pre-approved by LRE or one of its Member CMHSPs, but administered to maintain the enrollee's stabilized condition within one (1) hour of a request to a PIHP/CMHSP for pre-approval of further post-stabilization care services.
   iii. Must pay for post-stabilization care services obtained within or outside Region 3 that are not pre-approved by LRE or one of its Member CMHSPs, but administered to maintain, improve, or resolve the enrollee's stabilized condition if the LRE/Member CMHSP:
      1. Does not respond to a request for preapproval within 1 hour;
      2. Cannot be contacted; or
      3. LRE/Member CMHSP representative and the treating physician cannot reach an agreement concerning the enrollee's care and an LRE/Member CMHSP physician is not available for consultation. In this situation, the LRE/Member CMHSP must give the treating physician the opportunity to consult with a LRE/Member CMHSP physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in II(G)(2) is met.
2) LRE's or its Member CMHSPs' financial responsibility for post-stabilization care services that it has not pre-approved ends when:
   i. An LRE/Member CMHSP physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
   ii. An LRE/Member CMHSP physician assumes responsibility for the enrollee's care through transfer;
   iii. An LRE/Member CMHSP representative and the treating physician reach an agreement concerning the enrollee's care; or
   iv. The enrollee is discharged.[23]

[22] 42 CFR §422.113(c).
[23] 42 CFR § 422.113(c)(3).

3) LRE, through its Member CMHSPs, must limit charges to enrollees for post-stabilization care services to an amount no greater than what the LRE/Member CMHSP would charge the enrollee if he or she had obtained the services through the LRE/Member CMHSP. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

VI. REFERENCE AND SUPPORTING DOCUMENTS

- 42 CFR § 422.113(c) – Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services
- 42 CFR § 422.214 – Special rules for services furnished by noncontract providers
- 42 CFR § 438.114 – Emergency and post-stabilization services
- Michigan Mental Health Code, Act 258 or 1974
- Michigan Medicaid Provider Manual, Behavioral Health and Intellectual Developmental Disability Supports and Services Chapter
- MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract

VII. RELATED POLICIES AND PROCEDURES

- LRE Utilization Management Policy 5.0
- LRE Utilization Management Procedure 5.0a

VIII. CHANGE LOG

Reason for Change	Date of Change	Description of Change	Responsible Party
N/A		New Policy	Chief Executive Officer