Sustainable Funding for Mental Health Crisis Services

Healthcare Crisis Service Coding Guidelines to Support Standardized Billing and Access to Coverage from All Insurers



NASMHPD



CrisisNow.com

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Many communities across the United States have limited or no access to true "no wrong door" crisis services; defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health or substance use crisis to care in real time.

The typically available alternatives represent systemic failures to those in need; including incarceration for misdemeanor offences or drop-off at emergency departments that are far too often ill-equipped to address a mental health crisis. Unacceptable outcomes of this healthcare gap are high rates of incarceration for individuals with mental health and substance use challenges, crowding of emergency departments that realize lost opportunity costs and higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available. For many others in crisis, individuals simply fail to get the care they need; contributing to mental illness's position as the most prevalent disability in the United States and representing one of the highest sources of lost economic opportunity in communities throughout the nation.

Crisis services, when available, are reimbursed through a patchwork of dedicated local (state and/or county) funds, federal grant allocations and Medicaid payment within forward-thinking states that have established structures to reimburse for these essential services. To establish a full continuum of crisis services for all Americans, every person needs access to these essential services in a manner like their physical health counterparts. This paper identifies standardized existing healthcare codes that every insurer should reimburse; including commercial, Medicare, Medicaid, VA, FEHB and Tricare.

No later than July 2022, 988 will become available as an emergent three-digit call option to support individuals experiencing suicidal ideation, mental health and substance use crisis. The promise of 988 represents a fundamental shift from calling 911 and the limited dispatch options of fire, emergency medical services (EMS) and law enforcement. To offer care that aligns with access to care for physical health emergencies, the system must offer (1) someone to talk to (911/988), someone to come to you (ambulance/crisis mobile team) and (3) a place to go (hospital emergency department/crisis receiving center).



All of these no-wrong-door resources are designed to serve anyone, anywhere and anytime.

This document is designed to provide straightforward guidance on health care billing and coding opportunities for behavioral health crisis services; solidifying reimbursement for these vital no-wrong-door crisis services that deliver real-time access to care when and where the person needs it. The reimbursement strategies outlined here are necessary to establishing parity in care and evolving a funding foundation that will support the evolution of service delivery systems that improve access to emergent mental health and substance use care. The simplicity of the coding recommendations defined throughout this document are summarized in the table below.

Service	Recommended Coding Option Approach
Crisis Line	H0030 – Behavioral Health Hotline Service and contract as a safety net resource to augment funding
Mobile Crisis Team	H2011 - Crisis Intervention Service per 15 minutes Note: The HT modifier can be utilized in combination with this code to denote a multi-disciplinary team if these codes are utilized for multiple crisis delivery modalities.
Crisis Stabilization Facility (non-hospital 23-hour observation)	S9484 - Crisis Intervention Mental Health Services per Hour S9485 - Crisis Intervention Mental Health Services per Diem Note: The TG modifier can be utilized in combination with this code to denote a complex level of care if these codes are utilized for multiple crisis delivery modalities

Establishing a common definition for "crisis services" is essential to this coding process given the ever expanding inclusion of the term "crisis" by entities describing offerings that do not truly function as no-wrong-door safety net services as contemplated in the recently published SAMHSA *National Guidelines for Behavioral Health Crisis Care*. Examples of safety net services seen in communities around the country include (1) 911 accepting all calls and dispatching support based on the assessed need of the caller, (2) law enforcement, fire or ambulance dispatched to wherever the need is in the community and (3) hospital emergency departments serving everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.** Similarly, crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller (SAMHSA pages 14-17), (2) mobile crisis teams dispatched to wherever the need is in the community (SAMHSA pages 18-21) and (3) crisis receiving and stabilization facilities that serve anyone that comes through their doors from all referral sources (SAMHSA pages 22-24). These services are for **anyone, anywhere and anytime.** A multitude of other similar and important services contribute to a community's system of care but only three fundamental components of a crisis system are contemplated in detail within this paper.

Crisis services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical healthcare system.

The table that follows provides a look at similarities between crisis services and their physical health counterparts; offering a framework that can be used to model reimbursement for these similar services in a manner consistent with public expectations of parity.

Services for Responding to a Health Crisis		
	Physical Health	**Mental Health & Substance Use**
Emergency Call Center	911	Crisis Line
Community-Based Response	Ambulance / Fire	Mobile Crisis Team
Emergency Facility Option	Emergency Department	Crisis Receiving and Stabilization (23-hour)

Crisis Service Levels of Care

The National Action Alliance for Suicide Prevention established a Crisis Services Task Force that defined essential levels of care within a crisis system continuum; resulting in the *Crisis Now* model that is more tightly defined in the SAMHSA *National Guidelines for Behavioral Health Crisis Care; A Best Practice Toolkit*. The Task Force studied elements of successful programs from around the country and reviewed their effectiveness. While some communities were viewed as crisis-ready, there were very few communities where all key elements of crisis care were in place. Core structural elements of the crisis care continuum defined by the Task Force include:

- Regional or statewide crisis call centers coordinating in real time;
- Centrally deployed, 24/7 mobile crisis services; *and*
- Short-term, crisis receiving and stabilization programs.

Despite the widespread support of the *Crisis Now* model in public sector mental health systems throughout the United States, no standardized billing coding has been applied to these services and there has been an inconsistent application of available "crisis" codes; including their use by behavioral health providers who do not operate true no-wrong-door crisis services. The lack of consistency in crisis coding application makes the establishment of statewide, regional or even health plan-specific rates nearly impossible given the broad application of these codes results in reimbursement of a very broad range of actual services. True crisis programs must staff and operate in a manner that equips them to accept all referrals while other programs will screen referrals to fit the program; limiting their impact on diversion from the justice system or emergency departments. For example, a "mobile" crisis team that assesses individuals in a hospital emergency department has much lower operational costs than a community-based crisis team that is actually mobile. The cost of that hospital-based intervention is much higher given the inclusion of an emergency department bill along with the "mobile" crisis bill while the typically cost of the community-based response is much lower even when reimbursed at an enhanced community response rate. SAMHSA's *National Guidelines for Behavioral Health Crisis Care*, published in February of 2020, further detail minimum expectations and best practice standards for the delivery of these three distinct crisis services so coding and reimbursement can be tied to alignment with the *National Guidelines*.

Coding of Core Crisis Services

Healthcare Coding of Crisis Services

Coding of crisis services must be standardized to support reimbursement for these important services. Coding for mobile and facility-based crisis services offers a clear path to reimbursement for services delivered to eligible individuals much like what currently exists for ambulance and emergency department service providers. Although a bit difference than the 911 service analogy that largely focuses on dispatching support, crisis line services represent an essential element of improving access to care that incorporates the delivery of telephonic or telehealth services in a manner widely eligible for reimbursement during this time of COVID-19 service delivery flexibilities.

Regional Crisis Call Hub Services – Someone To Talk To

Crisis Call Center: This service represents the incorporation of a readily accessible crisis call center that is equipped to efficiently connect individuals in a mental health crisis to needed care; including telehealth support services delivered by the crisis line itself. Recognizing the provider's limited ability to verify insurance and identification over the phone, these services may be best funded through regional or statewide contracts that cover the program's operational costs as a safety net resource; possibly pulling in insurer funding as contributions based on membership size in the region in lieu of solely funding through the state or county. Another option is to bill for services delivered to eligible individuals using the HCPCS code of H0030 - Behavioral Health Hotline Service. The limitation to the direct billing approach is that it can be very difficult to acquire adequate information to verify healthcare coverage and the identity of the service recipient during the phone interaction. However, some level of direct billing for care could be used to augment the funding received by regional and state government entities to support operations.

Crisis line providers do indeed deliver telehealth support to insured callers every day. Data elements such as membership phone numbers of Medicaid enrolled or privately insured individuals can be combined with caller ID technology to support eligibility verification.

Some states have taken the approach of surveying callers to estimate a portion of calls coming from Medicaid members. The state may be able to leverage a 50% administrative FMAP for the determined percentage of Medicaid callers to offset a portion of crisis call centers cost when operating in alignment with the SAMHSA National Guidelines. These call centers deliver telephonic support in a manner that typically resolves 90% of the calls telephonically; dispatching mobile and/or other supports for the remaining 10%.

Service Definition - Behavioral Health Hotline Services	
Procedure Code Description	**CPT*/HCPCS PROCEDURE CODE**
Behavioral Health Hotline Services	H0030
Service Description	**Example Composition of Services**
Services delivered by designated crisis call centers offering telephonic real-time access to a live person for individuals in mental health and substance use crisis. Telephonic crisis intervention services must align with National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement. Efforts are made to resolve the crisis while delivering behavioral health hotline services and individuals are connected to additional services / supports based on the unique needs of the individual served.	Assessment of crisis Active listening and empathic responses Effective verbal and behavioral responses to warning signs of crisis related behavior Active problem solving, planning, and interventions Referral to appropriate levels of care Mobilize natural support systems Arrange transportation to additional care based on need Peer support
Critical Feature	
Behavioral health hotline service staffing includes clinicians overseeing clinical triage and other trained team members to respond to all calls received from individuals with suicidal ideation or another mental health or substance use crisis. The hotline is expected to answer all incoming calls in a manner that meets all of the minimum crisis call center expectations defined in SAMHSA's National Guidelines for Behavioral Health Crisis Care. Call center staff members will assess risk of suicide in a manner that meets NSPL standards and danger to others within each call while coordinating connections to crisis mobile team services, facility-based crisis care or other supports through warm hand-offs. The hotline should coordinate transportation to supports as needed.	

Applicable Population	**Unit**	**Duration**
☑ Child (0-10)	☐ Encounter	At least 1 minute of service for 1 unit. Additional units bill to nearest 15 minutes interval for up to 4 hours per episode maximum.
☑ Adolescent (11-17)	☐ Per Diem	
☑ Young Adult (18-20)	☑ 15 Minutes	
☑ Adult (21-64)	☐ 1 Hour	
☑ Geriatric (65+)		

Staffing - Behavioral Health Hotline Services
Licensed Clinician
Trained Call Center Support Workers
Billing Guidance
1. Behavioral Health Hotline Services are not subject to prior approval due to the urgent nature of the service.
2. Only bill for time actively engaged with the caller or collateral contacts and supports to meet the needs of the individual.
3. Service must be delivered by a designated crisis call center.
4. Provider follow-up contact with individuals previously served should bill using the appropriate service code but no Behavioral Health Hotline Services.

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis services are typically comprised of a two-person crisis response teams (licensed clinician and peer partnerships are common) that offers outreach and support where people in crisis are; either in the person's home or a location in the community.

Services should be billed using the nationally recognized HCPCS code of H2011 Crisis Intervention Service per 15 Minutes. Limiting the use of this code to only community-based mobile crisis team services positions a funder to set a reimbursement rate that represents the actual cost of delivering this safety net service much like a fire department of ambulance service reimbursement rate. When applicable, transportation services should be billed separately. Many communities currently offer "mobile crisis" response services in hospital emergency departments.

These represent a different service in that the team does not experience the same level of unproductive travel time, does not necessarily have to bear any of the cost of being mobile and can likely deliver this level of care through an individual given the hospital emergency department is a more controlled / supported environment. If hospital emergency department psychiatric consultation services are needed in the community, billing these services through established assessment codes (such as H0031) based on the credentials of the assessor would free up the crisis stabilization code for crisis care that aligns with the National Guidelines .

Service Definition - Mobile Crisis Intervention (Community-Based Multi-Disciplinary Team)	
Procedure Code Description	**CPT*/HCPCS PROCEDURE CODE**
Crisis Intervention, per 15 mins	H2011 HT
Service Description	**Example Composition of Services**
Crisis intervention aervices are provided by a mobile team that travels to the place where the person is having the crisis (e.g., person's place of residence or community setting). Crisis intervention services incllude services aimed at the assesssment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress. The purpose of this service is to: (1) Stabilize acute psychiatric or behavioral symptoms; (2) Evaluate treatment needs; and (3) Develop plans to meet the needs of the persons served. Based on need, the person may be transported to a more approporiate facility for further care (e.g., a crisis services center).	Crisis and emergency services assessments
	Dispatch and coordination through Crisis Hotline Services
	Therapeutic Interventions based on needs of the individual
	De-escalation
	Short-term stabilization
	Develop Crisis and/or Safety Plan
	Medication
	Counseling
	Referrals
	Peer support
	Linkage to ongoing services



Critical Feature		
Services are delivered in the community, home, school, or other community-based environments and are face-to-face with the individual and/or family providing appropriate crisis intervention strategies. The person in crisis must be present for a majority of the service delivery duration. Crisis intervention services shall be available 24 hours a day, seven days a week, wherever the need presents. The service requires the availability of a licensed practitioner who will screen and triage all calls to recommend crisis intervention care dispatch through an accredited hotline.		
Applicable Population	**Unit**	**Duration**
☑ Child (0-10)	☐ Encounter	At least 8 minutes of service for 1 unit. Additional unit bills to nearest 15 minute interval for up to 4 hours per episode maximum.
☑ Adolescent (11-17)	☐ Per Diem	
☑ Young Adult (18-20)	☑ 15 Minutes	
☑ Adult (21-64)	☐ 1 Hour	
☑ Geriatric (65+)		
Two Person Team Options Include:		
2:1 (Licensed Staff with a Peer)		
2:1 (Licensed Staff with a QMHP)		
2:1 (QMHPs with a QMHP)		
2:1 (QMHP Staff with a Peer)		
Staffing Notation(s)		
Licensed Mental Health Professionals		
Qualified Mental Health Professionals		
Peer Recovery Support Specialist		
*Unlicensed staff working alone are not allowed to bill the Medicaid reimbursed rate		
*Training and Certification in Crisis Intervention and/or Emergency Services may be required		

Limitations
The following activities are not covered under Mobile Crisis Intervention:
1. Services beyond the initial mobile crisis intervention and assessment time when additional services are not medically necessary.
2. Time spent doing, attending, or participating in recreational activities.
3. Services provided to teach academic subjects or as a subsitute for educational personnel.
4. Child Care services or services provided as a subsitute for the individuals responsible for providing care and supervision.
5. Respite care.
6. Covered services that have not been rendered
7. Services not in compliance with established service expectations or licensure standards in the state.
8. Services provided that are not within the provider's scope of pracitce.
9. Anything not included in the approved Crisis service description.
10. Services provided in a hospital of inpatient setting.
Billing Guidance
1. Crisis intervention services are not subject to prior approval due to the urgent nature of the service.
2. Activities beyond the initial 4 hour period may require a prior authorization by the State or its designee. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode.
3. If a provider has both a mobile crisis team and a crisis facility, the provider may not bill using the mobile crisis codes within 24 hours of admission to their own facility *(facility crisis service will be paid instead for episode).*
4. Transportation provided to the person receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Providers receiving referrals to visit inidividuals at home following a visit to an emergency rooms will bill only the follow-up community based crisis stabilization HCPCS codes.
Face-to-face contacts with youth and relevant family and kinship network members and collateral contacts are billable. The rates set include costs for the following:
1. Direct contacts with individuals and relevant family, caregivers and kinship network members
2. Direct contacts with clinically relevant collateral contacts such as teachers, school administrators, social workers, probation officers and some social network contracts when clinically indicated
3. Indirect contact, such as phone calls, with both individuals, caregivers, and relevant family and kinship network members, and collateral contacts.
4. Costs of certification, training and data documentation as well as time spent performing these tasks.

Crisis Receiving and Stabilization Services – A Place to Go

Crisis Receiving and Stabilization Facility Services: Crisis stabilization services are an immediate and unscheduled behavioral health intervention provided in response to an individual's behavioral health issue to prevent imminent harm and to stabilize or resolve an acute behavioral health issue. The 23 hour crisis stabilization service program is staffed with a multidisciplinary team that includes a prescriber (psychiatrist and/or psychiatric nurse practitioner), nurse, therapist, and peer.

Nationally recognized HCPCS codes of S9484 Crisis Intervention Mental Health Services per Hour and S9485 Crisis Intervention Mental Health Services per Diem can be used to reimburse for services delivered.

Medications, radiology, laboratory, CPT codes and professional evaluation and treatment services may be billed separately or bundled into reimbursement rates. If the crisis stabilization facility is attached to, or a part of, a hospital, then the hospital may be required to bill using institutional forms and revenue codes which do not include room and board (i.e., 1001 – residential treatment – psychiatric) and bill the room and board to the client or another payer source as applicable. Given the expectation that crisis receiving and stabilization facilities accept all referrals, it is important to offer an hourly and per diem option given some individuals in crisis will only require brief interventions that would not justify per diem reimbursement for those services. Per diem codes are typically triggered after a minimum duration of services (such as 5 hours) and should not be billed as one would bill for an inpatient psychiatric bed (in the bed at midnight) given the ongoing 24/7 flow of a crisis receiving and stabilization facility.

Service Definition - 23 Hour Crisis Receiving and Stabilization	
Procedure Code Description	**CPT*/HCPCS PROCEDURE CODE**
Crisis Intervention Mental Health Services, per diem	S9485
Service Description	**Example Composition of Services**
23-Hour Crisis Stabilization provides short-term, 24/7, facility-based psychiatric/substance related crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress.	Assessment of crisis
	Active listening and empathic responses
	Effective verbal and behavioral responses to warning signs of crisis related behavior
	Active problem solving, planning, and interventions
	Referral to appropriate levels of care
	Mobilize natural support systems
	Arrange transportation to additional care based on need
	Peer support
	Follow-up contact and coordination of care

Critical Feature	
This level of service is appropriate for individuals who have needs which exceed the abilities and the resources of collateral, provider, community member) to effectively resolve the situation or when an individual's ability to cope in the the community is severely compromised and it is expected the crisis can be resolved in 23 hours. These services also include screening and referral for appropriate outpatient services and community resources. While these services are provided in a facility-based program, utilization of these services do not require an inpatient admission to the facility.	

Applicable Population	Unit	Duration
☑ Child (0-10)	☑ Encounter	Per diem code billed for episodes 4 hours 30 minutes or longer. Hourly code (S9484) billed for episodes up to 4 hour 29 minutes in duration. Max of 1 per diem unit per episode.
☑ Adolescent (11-17)	☑ Per Diem	
☑ Young Adult (18-20)	☐ 15 Minutes	
☑ Adult (21-64)	☐ 1 Hour	
☑ Geriatric (65+)		

Staffing - Multi-Disciplinary Team Includes 24/7 Care with Access to:
Peer Support Specialist
Licensed Clinician
Registered Nurse
Psychiatrist or Psychiatric Nurse Practitioner (ability to practice independently)

Limitations
The following activities are not covered under Mobile Crisis Intervention:
1. Services beyond the initial mobile crisis intervention and assessment time when additional services are not medically necessary.
2. Covered services that have not been rendered.
3. Services not in compliance with established service expectations or licensure standards in the state.
4. Services provided that are not within the provider's scope of practice.
5. Anything not included in the approved crisis service description.

Billing Guidance
1. Crisis intervention services are not subject to prior approval due to the urgent nature of the service.
2. The first four hours of this service should be billed using the hourly (S9484) code while any episode lasting more than four hours should be billed using the per diem (S9485) code.
3. If a provider has both a mobile crisis team and a crisis facility, the provider may not bill using the mobile crisis codes within 24 hours of admission to their own facility *(facility crisis service will be paid instead for the episode)*.
4. Professional and assessment services *(clinical, nursing and psychiatric)* may be billed in addition to the per diem but all other services are included as part of the bundled rate.
5. Providers follow-up contact with individuals discharged from the program considered part of the initial service reimbursement and cannot be billed seperately.
6. Service includes up to 23 hours and 59 minutes of continuous observation, monitoring, and support in a secure supervised environment. For individuals in need of additional support, the program must coordinate connection to care based on those needs.
7. For providers offering multiple levels of care billed with a per diem rate, only one per diem can be billed in a calendar day.
8. The bundled rate includes but is not limited to peer support, case management, care coordination, engagement with collateral contacts, discharge planning, certification of need and documentation activities.
9. Codes S9484 or S9485 cannot be billed on the same date of service for the same client by the same provider.



A Call for Parity



Establishing universally recognized and accepting code for crisis services is an essential step towards delivering on our nation's promise of parity; moving mental healthcare out of the shadows and into mainstream care of the whole person. Parity should be the expectation and that means that, for individuals experiencing a mental health or substance use crisis, access to timely and effective care based on the person's needs must be equivalent to that of a person with a physical health emergency. Unfortunately, access to effective care during a mental health crisis is widely known to be deficient in healthcare settings across the country. "8 in 10 ED Doctors Say Mental Health System is Not Working for Patients" according to a survey by the American College of Emergency Physicians (ACEP). Thousands of Americans are dying from suicide every month, many family members of those coping with serious mental illness or loss of loved ones to suicide are experiencing unspeakable pain, individuals with limited options are getting the wrong care in the wrong place with jails, EDs and inpatient care substituting for mental health crisis services and law enforcement is functioning as defacto mobile crisis units.

Anyone! Anywhere! Anytime!

According to the 2019 published Road Runner study by the Treatment Advocacy Center, more than $17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness.

If extrapolated to law enforcement agencies nationwide, this number is approximately $918 million or 10% of law enforcement's annual operating budget. Additionally, mental illness is the most prevalent disability in the United States. The time is now to solidify better access to crisis care and change these unacceptable outcomes that are adversely impacting our communities, filling our jails and crowding emergency departments. A nationally recognized framework for delivering a full continuum of crisis care has been established by the National Action Alliance for Suicide Prevention Crisis Services Task Force with resources found on the National Association of State Mental Health Program Director's (NASMHPD's) www.crisisnow.com website and healthcare coding, as defined in this document, is available to support reimbursement for care. Additionally, SAMHSA has offered *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit* that offers tangible resources to advance crisis care in any community.

The table below summarizes the recommended crisis specific codes by service type:

Service	Recommended Coding Option Approach
Crisis Line	H0030 – Behavioral Health Hotline Service and contract as a safety net resource to augment funding
Mobile Crisis Team	H2011 - Crisis Intervention Service per 15 minutes Note: The HT modifier can be utilized in combination with this code to denote a multi-disciplinary team if these codes are utilized for multiple crisis delivery modalities.
Crisis Stabilization Facility (non-hospital 23-hour observation)	S9484 - Crisis Intervention Mental Health Services per Hour S9485 - Crisis Intervention Mental Health Services per Diem Note: The TG modifier can be utilized in combination with this code to denote a complex level of care if these codes are utilized for multiple crisis delivery modalities

Modifiers
HK Special high-risk mental health population
HT – Multi-Disciplinary Team Modifier
HW State mental health agency funded
TG – Complex/High tech level of care Modifier

Healthcare Coding of Other Key Services

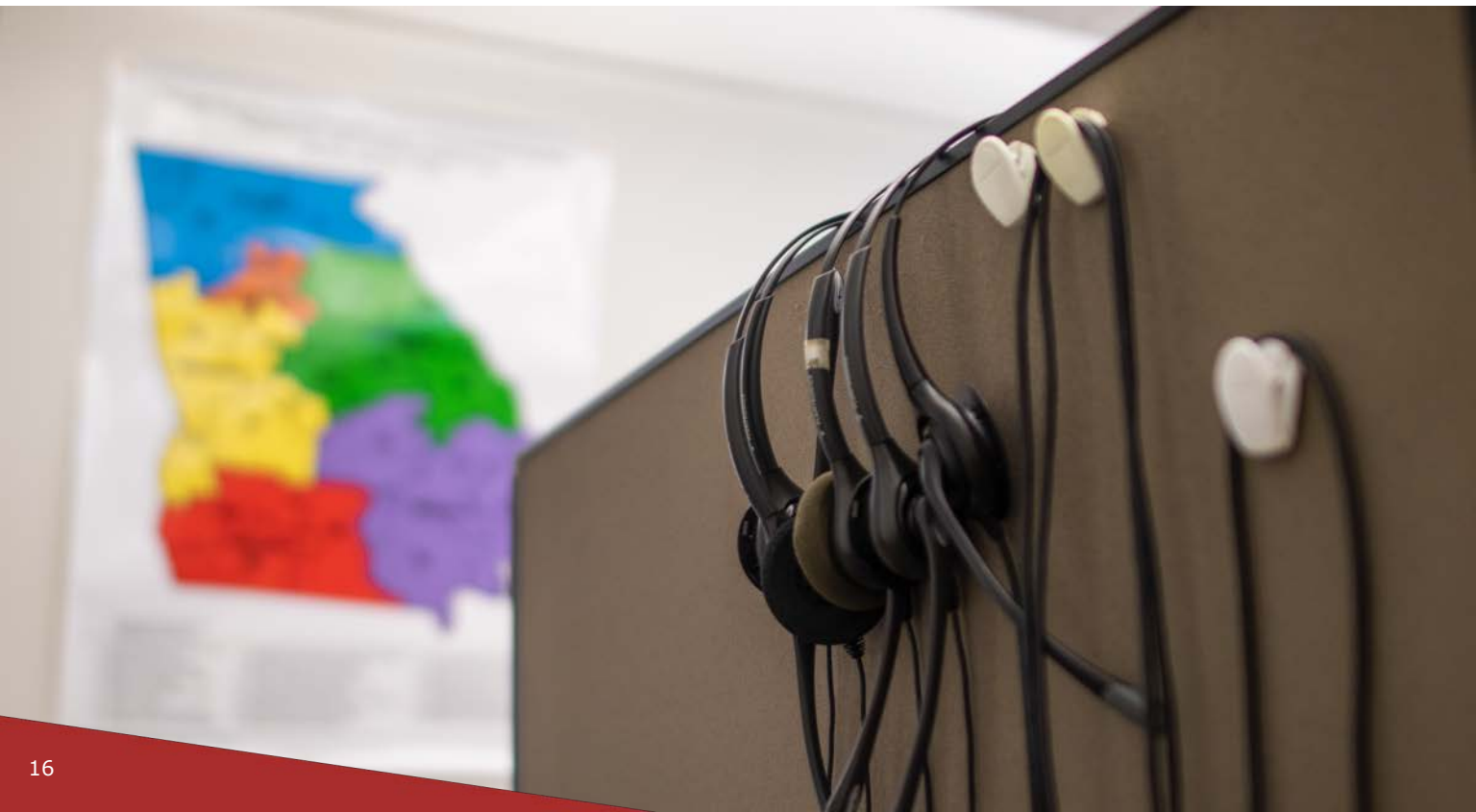
A multitude of other services often use the term "crisis" in their descriptor but do not operate in a manner consistent with SAMHSA's *National Guidelines for Behavioral Health Crisis Care*. Many services that do not meet the narrow definition of crisis care should still be viewed as essential parts of an efficient, responsive and well-designed mental health and substance use service delivery continuum. If this document where focused on emergent physical health service coding, discussion would narrowly focus on coding opportunities for (1) 911 (*although not truly delivering telehealth in a manner seen in crisis call centers*), (2) EMS/ambulance services and (3) hospital

emergency department care. However, the value of primary care, cardiology, skilled nursing facilities and urgent care centers is widely recognized as core elements of a healthcare continuum.

- "Crisis residential" – Recommend referring to these programs as short-term residential treatment programs that can utilize the H0018 HCPCS code - *Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem*
- "Crisis respite" - Recommend referring to these programs as respite or peer respite programs that can utilize the S5151 HCPCS code - *Unskilled respite care, not hospice; per diem* or use of S5150 HCPCS code - *Unskilled respite care, not hospice; per 15 minutes*
- "Mobile crisis" delivered in a hospital emergency department – Recommend referring to these programs as psychiatric consultation services. Billing for these services can be done through established assessment codes (such as H0031) based on the credentials of the clinician completing the assessment

Coding and funding approaches must evolve to successfully implement comprehensive crisis systems throughout the nation. 988 will bring a clear path to much-improved and focused crisis care but the promise of 988 can only be realized within communities that offer access to all three levels of no-wrong-door crisis care.

Data from providers around the nation indicates that 90% of crisis calls are resolved by phone. This means that 10% of those calls will require connection to mobile crisis services. Additionally, 30% of mobile team responses require facility-based care.



Produced by RI International

