BlueCross BlueShield of North Carolina | Healthy Blue Care Together

North Carolina Utilization Management Guideline for Medicaid

Subject: Enhanced Crisis Response (ECR) ILOS

Current Effective Date: 02/10/2025

Status: Active

Last Review Date: 02/10/2026

Description

Enhanced Crisis Response (ECR) Rapid Response Team (RRT) services are directed to children and adult individuals ages 5-64 that are experiencing an acute behavioral health crisis that have presented in an Emergency Department (ED) and/or for step down from Inpatient. This service includes crisis intervention, stabilization, linkage to supports and treatment needed and next day follow up after discharge. ECR RRT services are available 24-hours a day, 7 days a week, 365 days a year. This service provides an immediate evaluation, triage and access to acute mental health, intellectual developmental disabilities, and substance use services, treatment, and supports to effect symptom reduction, harm reduction, or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports or services needed.

These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response. Enhanced Crisis Response- RRT includes the development of a crisis plan for individuals served, assessment and linkage to social determinant of health needs, follow up and monitoring after linkage, as well as basic case management to link individuals to services/resources that are needed. Specific supports and interventions are unique to each individual and spelled out in the crisis plan. This service is meant to serve as a bridge between ED or inpatient utilization and access to services available in the community. This service is not meant to duplicate or replace enhanced services, it should provide linkage to appropriate levels of care. Crisis Management Services must be community based and provided in a least restrictive setting.

The Enhanced Crisis RRT shall determine if the child/youth/adult is enrolled with a provider that should and can provide or be involved with the crisis response. Rapid Response Team will contact the first responder if the individual is already engaged in treatment so the first responder can take the lead. This service allows for a longer enhanced crisis response than is allowed in typical crisis management responses. Based in the home, this service fulfills a gap in care, targeting those youth who are in DSS custody and at an imminent risk of DSS involvement due to abandonment or other crisis behavior symptoms.

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Clinical Indications

The Enhanced Crisis Response (ECR) - Rapid Response Team service is designed to be a short-term intervention. The primary goal during this period is to address and mitigate the immediate crisis faced by the child and family, while connecting them with appropriate community resources to support the child's long-term success and goal achievement. This service is mainly delivered in-person within community or home environments, although some coordination or crisis triage may be conducted over the phone. Key elements of the service include 24/7 crisis intervention and support, intensive case management to help members access essential medical, behavioral, and social services, and connections to specialized therapeutic and behavioral support services. These may encompass In Home Therapy, Family Centered Treatment, Multi-systemic Therapy, Respite, and Day Treatment, with certain services overlapping for up to two weeks to ensure seamless transitions. Additionally, the service includes links to residential treatment options such as Therapeutic Foster Care, with potential overlaps of 30 to 60 days, and intensive support for children placed in Department of Social Services (DSS) homes or kinship arrangements. Discharge and after-care planning are also integral components, ensuring a smooth transition between levels of care and ongoing monitoring.

Eligibility

To be eligible for ECR, the member must:

- Have NC Medicaid
- Be enrolled in the NC Medicaid Healthy Blue Care Together plan

Eligible members:

- Are ages 5 to 64 with:
- Mental health diagnoses.
- Co-occurring mental health and intellectual/developmental disability diagnoses.
- Co-occurring mental health and substance use disorder diagnoses.
- Must be at risk for abandonment, crisis episodes, or restrictive levels of care. Includes those who:
    - Present at the ED or Child/Adolescent Facility-Based Crisis facility without needing inpatient treatment, with a parent/guardian who has stated they may not return home.
    - Are admitted to an inpatient unit with discharge barriers, such as lack of

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parental/guardian engagement or need for specialty care.
    - Are in non-therapeutic environments like DSS foster homes, shelters, or kinship placements, at risk for ED or inpatient admission due to escalating behavioral symptoms or trauma.
- Additional criteria:
    - Must be in, or at risk of entering DSS custody due to potential parental abandonment and meet at least one of the following:
    - Exhibited suicidal gestures, attempts, or self-injurious behavior, or has related ideation, not needing acute care.
    - Exhibited physical aggression or violent behavior towards people, animals, or property, including current threats.
    - Runaway within the last 60 days, shown sexual aggression, or experienced known trauma (as assessed).
    - Been hospitalized for behavioral health in the past 30 days.
    - Meets one of the above and needs coordinated efforts to stabilize DSS placement (including kinship placements) to prevent an ED visit.
    - Abandoned in the ED but assessed as safe to return to the community.
- Members have a pass-through of one billable unit per week for the first eight weeks.
- Authorization is required for services beyond the initial eight weeks.
- If receiving enhanced services at referral, a Service Authorization Request (SAR) must be submitted.
- Utilization Management conducts a clinical review to prevent service duplication.
- After the initial eight units, up to four additional units can be requested with each re-authorization.

Utilization Management:

- No Initial Prior Authorization (PA) for first 8 weeks.
- Initial authorization for services is for one billable unit/week.
- Service Authorization Request (SAR) is required within 7 days of starting service.
- Reauthorization is required after 8 weeks if crisis unresolved. Service typically does not exceed 12 weeks.

Documentation Requirements: SAR, Crisis Plan and Person-Centered Plan (PCP)

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If/when members are linked to another service, a SAR must also be submitted to allow for the overlap of services if needed, based on the below:

Linkage to individualized Therapeutic and Behavioral Support Services:
Services may include In Home Therapy Services, Family Centered Treatment, Multi-systemic Therapy, Respite, and Day Treatment (these services would overlap for two weeks to ensure linkage).

Linkage to Residential Treatment:
Therapeutic Foster Care and other programs as appropriate/clinically warranted. (These services would overlap for 30-60 days.

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, Qualified Professional or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. That is unsafe, ineffective, experimental or investigational.
2. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

1. If the service, product or procedure requires prior approval, the fact that the beneficiary is

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under 21 years of age does NOT eliminate the requirement for prior approval.

2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide and on the EPSDT provider page. The web addresses are specified below.

NC Tracks Provider Claims and Billing Assistance Guide:

nctracks.nc.gov/content/public/providers/provider-manuals.html

Program Requirements

Enhanced Crisis Response RRT are supported by a crisis resolution delivery model that consists of 4 phases: intervention, stabilization, prevention, and follow up. This delivery model provides an opportunity for expeditious access to crisis services that would have ordinarily not been available. The goals of RRT response will not exceed 2 hours to the ED to reduce unnecessary boarding, divert hospitalization or re-admission to the ED, prevent unnecessary incarceration, stabilize individuals in behavioral health crisis, and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Providers are required to submit weekly claims after meeting the minimum service hours. They must also submit encounter claims with modifiers to account for all time spent with the member, detailing the total number of contacts and frequency. Typically, members receive this service for 60-90 days, with a maximum of one billable unit per week for 12 weeks.

The expected outcomes for the ECR service include the prevention of ED assessments or admissions for members at risk of presenting there. For members who face potential abandonment in the ED, the goal is to engage their guardians to ensure the member can remain at home, thereby avoiding entry into the custody of the DSS. More broadly, ECR aims to actively engage families, reduce the frequency of crisis events, facilitate connections to appropriate services, and ensure members can be maintained within the community with the support of outpatient and enhanced services.

Supervision Guidelines
Licensed clinicians are required to receive intensive supervision on a weekly basis. If a supervisor

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oversees multiple clinicians, one of these sessions may be conducted as a group supervision. Supervisors must also be readily available to assist clinicians with case consultations upon request or to provide necessary coverage for clinicians.

Credentialing Requirements
All employees must satisfy the minimum education, experience, and licensure criteria applicable to their positions, as dictated by governing rules or service definitions, with adherence to the more stringent of these guidelines. Providers are responsible for ensuring that all licensed staff complete the requisite HBCT credentialing process and maintain their professional licensure.

For Licensed Professionals
Provider organizations are responsible for completing the CAQH application and, if needed, enrolling with NCTracks, and obtaining an NCID and NPI before submitting the credentialing application to Healthy Blue Care Together.

Providers of ECR services must maintain a team comprising a supervisor and a licensed clinician at all times. For new providers not yet reaching a caseload of 20, the supervisor may begin seeing members before hiring a licensed clinician. The total number of individuals served must not exceed 20. Once a licensed clinician is employed, the supervisor must transfer cases to ensure compliance with caseload limits as outlined below.

Caseload Management
A licensed clinician is permitted to manage an active caseload of up to 20 members; however, this should be adjusted based on the intensity of needs of the members on their caseload, with referrals being accepted only when feasible.

If a supervisor (also a licensed clinician) provides direct services and does not oversee any supervisees, they may maintain an active caseload of 20 members. However, once supervisees are assigned, the supervisor's caseload must not exceed 10.

Overall, a supervisor may oversee up to 60 members, including any individuals from their personal caseload.

Crisis Response
Licensed clinicians or supervisors must be available around the clock, every day of the year, to provide crisis response services for youth.

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In the event of staff turnover, providers may deploy backup personnel for coverage. However, they must notify HBCT and submit a written coverage plan. HBCT will assess the plan to decide whether referrals can continue or should be suspended based on the proposed coverage strategy.

Staffing:

1. **Licensed Professional QP**: Must be a Qualified Professional (QP) with two years post-graduate experience with the relevant population. They must hold clinical licensure from the state of North Carolina, including fields such as physician, licensed psychologist, social worker, counselor, marriage and family therapist, or licensed clinical addictions specialist. Clinical and administrative supervision must be provided by a Licensed Professional or Associate Licensed Professional. Training in crisis intervention and relevant service areas is required.

2. **Licensed Clinical Social Worker (LCSW)**: Needs a master's degree in social work accredited by CSWE or an equivalent foreign body, with at least one year of crisis management experience in assertive outreach or community treatment settings. Must pass the ASWB Clinical Exam and have 20 hours of crisis intervention training within the first 90 days of employment.

3. **Paraprofessionals**: May also be included in the team and are supervised by a QP. A supervising professional must be available for consultation when a Paraprofessional provides service. Training in crisis intervention is mandatory.

Coding			
Procedure Code	**Service Description**	**Rate**	**Billing Frequency**
H2011 U5 U1	Enhanced Crisis Response Rapid Response Team	Based on Fee Schedule or Contract	Weekly

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North Carolina Department of Health and Human Services (NCDHHS) that supports the Enhanced Crisis Rapid Response Team model:

"Rapid Response Team is billed in lieu of Mobile Crisis. This service does not replace the first responder responsibilities of other enhanced providers. This service is connected to the Emergency Department or Inpatient unit to rapidly respond to and transition members with mental health, intellectual or developmental disabilities or substance use disorders out of the ED or Inpatient care into a setting for stabilization." NC Medicaid+2NC Medicaid+2

Additionally: "The current Clinical Coverage Policy 8A specifies that Mobile Crisis Management Services must be mobile, community based and provided in a least restrictive setting. The alternative service definition targets individuals in or at high risk for accessing the Emergency Department of a hospital and will provide an additional service option for those who need to physically come to an identified location to receive crisis services that will include crisis intervention, stabilization, prevention, and follow up and avoid an unnecessary admission into an Emergency Department or inpatient stay." NC DHHS+1

Discussion/General Information

Service Exclusions:

- ECR services should not be requested for members who are already receiving enhanced services (as specified in Clinical Coverage Policy 8A), unless prior approval is obtained under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.
- Providers are to submit weekly billable claims only after the minimum service hours have been fulfilled. If less than the required two hours of service is delivered in a week, no billable claim should be submitted.
- All time spent with the member must be recorded through encounter claims, utilizing a modifier to reflect the total number of contacts and their frequency.
- Given that this service includes a case management component, providers must explicitly outline in the member's care plan how they will collaborate with Care Management to prevent the duplication of services.

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- The case management aspect is designed to support the ongoing treatment within the program, ensuring progress and reducing the need for more intensive levels of care.

- Encounter data will be tracked and reported against H2011 U5 U1 on encounters on a quarterly basis.

- Healthy Blue Care Together will have consistent weekly reporting that encompasses data sources for measurement, including enrollment and engagement. In addition to data reporting from the vendor, we will also be conducting an internal claims-based analysis.

Definitions

In Lieu of Services (ILOS): Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

Acronyms

ILOS: In Lieu of Services
CCP: Clinical Coverage Policy
SAR: Service Authorization Request

References

Centers for Medicare & Medicaid Services. (n.d.). *In Lieu of Services and Settings (ILOS).* Federal guidance pursuant to 42 C.F.R. § 438.3(e)(2) and 42 C.F.R. § 438.6.NC

NC Medicaid/DHHS Clinical Coverage Policy 8A — Enhanced Mental Health and Substance Abuse Services (Amended Jan 1, 2025).

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NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C

DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) Items 1 through 12, under Contents of a Service Note, Chapter 7 of the RMDM.

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act].

Websites for Additional Information

NC Tracks Provider Claims and Billing Assistance Guide:
nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: ncdhhs.gov/dma/epsdt

History

Status	Date	Action
Draft	11/22/2025	Revised
Approved	02/10/2026	Approved by Medical Operation Committee (MOC)

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