



Defining a Behavioral Health Crisis & Patient Scenarios: Policy Interpretation and Recommendations

***Policy Question:** When a patient is evaluated for a Behavioral Health Crisis, how are hospitals expected to define a crisis under current MassHealth policy and guidance? What clinical presentations define a crisis?*

Executive Summary

For Hospitals who provide Behavioral Health Crisis Evaluations for patients, it may be challenging to accurately define a crisis. MassHealth policy language does not have explicit language defining a crisis, and therefore, this task is left to each hospital to determine. Behavioral health crisis interpretations vary across organizations and are largely influenced by their own internal compliance and legal teams.

To help concretize what defines a crisis, below is Acute Hospital RFA language and several patient scenarios hospitals have shared where their team determined a patient to be in crisis.

RY2026 Acute Hospital RFA Language

Behavioral Health Crisis definition:

- **Behavioral Health Crisis** – A situation in which an individual demonstrates signs or symptoms of a mental health disorder, substance use disorder, co-occurring mental health and substance use disorder, or co-occurring behavioral health and medical condition that led to significant impairment in the individual's functioning and/or to behavior that puts the individual at risk of harming themselves, harming others, or being unable to appropriately care for themselves.



Behavioral Health Crisis Evaluation definition:

- **Behavioral Health Crisis Evaluations** – An evaluation provided in an Emergency Department or on a medical/surgical floor by qualified clinical professionals to members experiencing a Behavioral Health Crisis during the first calendar day of their readiness to receive such an evaluation. The evaluation includes the initial comprehensive assessment of risk, diagnosis, and treatment needs, the initial crisis interventions, the initial determination and coordination of appropriate disposition, and required reporting and community collaboration activities.

Behavioral Health Crisis Evaluation within an ED:

- (1) The Hospital shall offer Behavioral Health Crisis Evaluations as described in **Appendix I** to all Members presenting with a mental health and/or substance use disorder crisis in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24. Furthermore, the Hospital is responsible for disposition planning, including assisting in placement for fee-for-service Members requiring inpatient psychiatric treatment or Behavioral Health Diversionary Services, in conjunction with the referring provider and MassHealth.

If/Then Hospital Scenarios

Hospitals identified several if/then scenarios, each determine a patient to be in crisis:

- ✓ *If there is a referral made to an Addiction Consult Service (ACS) team, and the ACS team determines a crisis assessment is necessary, then a patient is in crisis*
- ✓ *If a patient scores high on specific assessments (this may be more applicable for an ED-based encounter), then a patient is in crisis*
- ✓ *If a patient presents with acute SUD needs, even if the initial/ presenting need is physical, then a patient is in crisis*
- ✓ *If a patient on med/surg or in an ED and has a SUD that may necessitate referring them to a different level of care (ATS, CSS, OTP, etc after they are medically cleared), then a patient is in crisis*



Patient Scenarios

All three patient scenarios qualify as crisis cases based on policy analysis and available information. The scenarios below are hypothetical and represent composite examples of clinical presentations commonly encountered in hospital settings. Furthermore, all patient scenarios are informed by input from hospitals across Massachusetts that have partnered with Aligned Solutions to successfully implement crisis billing.

Scenario 1: Young female with a history of bipolar 1 and a history of lithium overdose resulting in prolonged admission to Hospital A with trach, dialysis from Li toxicity, alcohol use disorder in remission, cocaine use disorder in remission, opioid use disorder in remission on suboxone 8mg SL daily who is admitted to the hospital from her halfway house with abdominal pain. Lipase and CT abd/pelvis c/w pancreatitis which is working diagnosis. She is continued on her suboxone 8mg daily and Dilaudid was titrated up to 2mg IV every 3 hours as needed for acute abdominal pain. She was recently started on baclofen as outpatient for cocaine cravings. Last heroin, cocaine, and alcohol use was reported to be 3 years ago. After physician assessment, medical provider felt continuing Suboxone and continuing with Dilaudid 2mg IV every 3 hours as needed was helping and appropriate with plan to increase her Suboxone to 8mg twice a day after stopping Dilaudid in 1-3 days (targeted).

Scenario 2: Young male currently lives with his mom and experiencing challenges. Patient's mom called EMS out of concern he was non-compliant with medications and was potentially using although she could not confirm this. At the hospital, he denies use for the last 10 years. Of note, however, patient did initiate Methadone about 1 month ago with dose titrated up to 90mg out of fear he was going to relapse. He is working a lot and using his prescribed Adderall, nicotine pouches and caffeine to stay awake so he can keep up with work demands. Patient denies suicidal or homicidal thoughts. He cannot confirm the last time he was at the Methadone clinic but thinks it was about 3 days ago. Physician reached out to patients' home clinic via telephone and email to confirm dose/timing before an order is placed. Patient also has an emergency services program (ESP) consult, and physician was able to see the patient before ESP. Physician prescribed long-acting Adderall and short acting Adderall as outpatient along with Gabapentin.



Scenario 3: Young adult male presents to the ED seeking withdrawal management level of care from Methamphetamine use (which patient reports smoking and has used for the past year). Patient wants to enter a detox, and the physician has connected him with the hospital's treatment navigator to see if a bed can be obtained - but there are some barriers 1) patient's only drug use is meth 2) patient has poorly controlled type 1 diabetes with labile blood glucose and is not using insulin regularly while actively using substances. It is challenging to admit a patient who has poorly controlled T1 diabetes into a detox as he can't explain his home insulin regimen. No other substance use reported; patient uses meth as sexual enhancer and asking to be tested for HIV (which the hospital is currently doing). He is not interested in off-label but does express interest in first line vivitrol/Wellbutrin outpatient management. Physician discusses alternative treatment pathways, including engaging in the hospital's day treatment program, especially after detox if he is accepted into program.

Resources

1. Acute Hospital RFA: [Massachusetts COMMBUYS](#)



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