

# Clinical Policy: Crisis Stabilization Unit and Specialty Psychiatric Hospital in Lieu of Services

Reference Number: FL.CP.BH.11

Date of Last Revision: 02/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

This policy describes the clinical criteria on which to review requests for Crisis Stabilization Unit services and Specialty Psychiatric Hospital In Lieu of Services for Sunshine Health's Managed Medical Assistance (MMA), Comprehensive (MMA and Long Term Care), HIV/AIDS, Serious Mental Illness (SMI), Children's Medical Services (CMS) and Child Welfare (CW) members. The goal is to provide crisis stabilization unit services and Specialty Psychiatric Hospital when medically necessary, as an alternative to an existing state benefit and to define criteria and limitations established for the use of crisis stabilization services as a diversion for members' emergency department visits, inpatient psychiatric hospital stays, or out-of-home placement.

## Policy/Criteria

- I. It is the policy of Sunshine Health that Crisis Stabilization Unit (CSU) or Specialty Psychiatric Hospital in Lieu of Services is **medically necessary** when all of the following criteria are met:
  - A. Member has a mental health disorder that CSU or Specialty Psychiatric Hospital services can shorten the length of stay in an inpatient psychiatric facility or eliminate the need for an inpatient psychiatric hospital stay;
  - B. Member meets criteria for InterQual BH: Adult and Geriatric Psychiatry - Inpatient Criteria Episode Day 1 or InterQual Child and Adolescent Psychiatry- Inpatient Criteria: Episode Day 1;
  - C. The treating provider must submit the following information and documentation with any *initial* request for Crisis Stabilization Unit or Specialty Psychiatric Hospital in Lieu of services:
    1. Medical documentation to support the criteria as noted in I.A. and I.B.;
    2. Documentation that the member has consented to the In Lieu of Services as an alternative to a covered state benefit.

*Note:* Emergency stabilization services at any facility do not require prior authorization from Sunshine Health. However, once the member's emergency condition is stabilized, an authorization for on-going care is required within two business days following the admission.

## Redetermination

*Prior to the expiration of the initial authorization period*, the requesting practitioner must submit information on the member's status to Sunshine Health's utilization management department for a review to determine if subsequent approval for *continued stay* is medically necessary using

## CLINICAL POLICY

### Crisis Stabilization Specialty Psychiatric Hospital in Lieu of Services

InterQual BH: Adult and Geriatric Psychiatry - Inpatient Criteria Episode Day 2-13 or Episode Day 14-X, Extended Stay; or

InterQual BH: Child and Adolescent Psychiatry Inpatient Criteria: Episode Day 2-13 or Episode Day 14-X, Extended Stay.

**II.** It is the policy of Sunshine Health that **discharge** from Crisis Stabilization Unit or Specialty Psychiatric Hospital in Lieu of Services is appropriate when one or more of the following criteria are met:

- A. Member no longer meets medical necessity criteria;
- B. Transfer to another service/level is more clinically appropriate;
- C. Member/family requests discharge and admission is voluntary.

**III.** It is the policy of Sunshine Health that Crisis Stabilization Unit or Specialty Psychiatric Hospital in Lieu of Services is considered **not medically necessary** when any of the following indications are met:

- A. Member can be safely maintained and effectively treated at a less intensive level of care;
- B. Member has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications;
- C. Member's primary problem is social, legal, economic (i.e., housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

*Note:* Members receiving these services for more than 15 days per month will be subject to IMD exclusions.

### Background

A Crisis Stabilization Unit is a freestanding Psychiatric Specialty Hospital providing a short-term alternative to inpatient psychiatric hospitalization and an integrated part of a designated public receiving facility under the authority of chapter 394, F.S. A CSU provides brief intensive services for individuals who are presented as acutely mentally ill on a 24-hour-a-day 7-day-a-week basis, under the licensing authority of the department. The average inpatient length of stay is three to 14 days.<sup>1</sup>

The purpose of a CSU is to examine, stabilize and redirect people to the most appropriate and least restrictive treatment settings consistent with their needs. Treatment is aimed at restoring the ability of the residents to maintain safety while enhancing their recovery, so they can successfully return to the community. Services include assessment and treatment services 24 hours a day, seven days a week for children, adolescents and adults, psychiatric evaluation, medication management, daily psychiatrist rounds and other appropriate services as needed.<sup>3</sup>

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

## CLINICAL POLICY

### Crisis Stabilization Specialty Psychiatric Hospital in Lieu of Services

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
90839	Psychotherapy for crisis; first 60 minutes (range: 30-74 minutes)
90840	Psychotherapy for crisis; each additional 30 minutes (must be used in conjunction with 90839)

HCPCS Codes	Description
S9485	Crisis intervention mental health services, per diem

Revenue Codes	Description
0129	Semi-private room (2 beds)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		06/18
Archer reload to fix system issue; no content review.		05/19
Annual review; current version of InterQual 2019 updated		06/20
Policy update; Added SMI and CMS products. Removed year from InterQual. Minor grammatical changes; updated references		08/20
Policy update; added Specialty Psychiatric Hospital to policy. Added delegated vendor for clinical reviewers.		01/22
Annual review; changed FLCMS to CMS		02/23
Transitioned policy to new state specific template, references updated and sent to market for approval; policy number changed from FL.UM.46.00 to FL.CP.BH.11.	01/24	
Annual review; minor grammatical changes only.	02/24	
Annual review; Added note under description that services are available to members with HIV. Minor rewording within criteria with no clinical impact. Background updated. References reviewed and updated. Reviewed by FL BH team.	02/25	
Annual review. Note removed following description and HIV/AIDS added in description section. Rewording to III. to change limitations/exclusions to not medically necessary criteria. "Member's" added to III.C. for clarity and III.D. removed with no impact to criteria meaning. Minor rewording with no impact to policy meaning. CPT codes 90839, 90840; HCPCS code S9485; Revenue code 0129 added. References reviewed and updated.	02/26	

### **References**

1. Agency for Health Care Administration (AHCA). Crisis Stabilization Units. <https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/crisis-stabilization-units>. Accessed January 21, 2026.
2. Florida Agency for Health Care Administration (AHCA). Statewide Medicaid Managed Care In Lieu of Services (ILOS). [https://ahca.myflorida.com/content/download/27219/file/SMMC\\_Highlight\\_ILOS\\_Chart\\_08\\_062025.pdf](https://ahca.myflorida.com/content/download/27219/file/SMMC_Highlight_ILOS_Chart_08_062025.pdf). Published July 16, 2025. Accessed January 21, 2026.
3. Agency for Health Care Administration (AHCA). ASPEN State Regulation Set: C 2.03 CSU and SRT Facilities. <https://ahca.myflorida.com/content/download/7243/file/CSU%20and%20SRT%20Facilities.pdf>. Published July 25, 2024. Accessed January 21, 2026.
4. Optum LLC. InterQual 2025, October Release, BH: Adult and Geriatric Psychiatry; Inpatient LOC criteria. Accessed January 21, 2026.
5. Optum LLC. InterQual 2025, March 2025 Release, BH: Child and Adolescent Psychiatry; Inpatient LOC criteria. Accessed January 21, 2026.
6. Billing and coding: outpatient psychiatry and psychology services (A57065). Centers for Medicare and Medicaid Services Web site. <http://www.cms.hhs.gov/mcd/search.asp>. Effective September 26, 2019 (revised November 6, 2025). Accessed February 2, 2026.

### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

## CLINICAL POLICY

### Crisis Stabilization Specialty Psychiatric Hospital in Lieu of Services

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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