

**BEHAVIORAL HEALTH
POLICY AND BILLING MANUAL**
**For Providers Treating
Medicaid Beneficiaries**



2019

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<https://www.nmbhpa.org/clinical-supervision-implementation-guide/>
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http://www.hsd.state.nm.us/uploads/FileLinks/e7cfb008157f422597cccdc11d2034f0/Fee_Schedule_Behavioral_Health_for_July_1_2018_distributed_and_posted_2nd_713_18_rs.pdf
- M: Tip Sheet for Practitioners in Integrated Care Settings: Practice Principles and Functions for use in behavioral health center
- N: “Interdisciplinary Teaming in Behavioral HealthCare”
- O: Practice Standards for Family Teaming
- P: Highlights of the 1st Four Encounters in the Treat First Clinical Model
- Q: Treat First Approach Protocol
- R: Adult and Child Self Check-In and Session Check-Out instruments
- S: Treat First Talks: How to become a Treat First Agency www.treatfirst.org
- T: This appendix intentionally left blank
- U: Comprehensive Assessment & Service Plan Adult Form
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- X: ABA Billing Instructions
http://www.hsd.state.nm.us/uploads/FileLinks/e7cfb008157f422597cccdc11d2034f0/ABA_Pricing_3.28.16.pdf
- Y: Healthy Lifestyle Questionnaire
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- ZE: This appendix intentionally left blank
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- ZI: IOP Provider Application
- ZJ: IOP Site Visit Preparation Form
- ZK: IOP Process Flow

ZL: IOP Site Visit Tool
ZM: ACT Readiness Tool
ZN: ACT Review Tool
ZO: DACTS/G01Scale: Dartmouth Assertive Community Treatment Scale
ZP: ACT Chart Audit Tool
ZQ: ACT Service Audit Tool
ZQQ: TMACT Updated Fidelity Tool
ZR: ACT Process Flow
ZS: OTP Regulations Crosswalk
ZT: OTP Clinic and Personnel Check List
ZU: OTP Counselor Questionnaire
ZV: OTP Personnel site review form
ZW: OTP Patient Record Audit Form
ZX: Prudent Parenting and Prevention of Sex Trafficking

Section One: Introduction & General Principles

1.1 Purpose of this Manual

The purpose for the Behavioral Health Policy & Billing Manual (BH Manual) is to provide a reference for the policies and processes related to Behavioral Health for administration of Medicaid behavioral health services, as defined in New Mexico Administrative Code (NMAC), Section 8.321.2. The BH Manual will also provide supplemental material as direction for the Managed Care Organizations (MCOs).

The BH Manual was developed by the Human Services Department's (HSD's) Medical Assistance Division (MAD), Behavioral Health Services Division (BHSD), and the Children, Youth and Families Department (CYFD). The provisions of the BH Manual reflect the general operating policies and essential procedures specific to behavioral health services, are not all inclusive, and may be amended or revoked at any time by the HSD. If there is a conflict between the BH Manual and the NMAC rules, the NMAC rules will control.

The BH Manual will be updated on a regular basis, and HSD reserves the right to change, modify or supersede any of these policies and procedures with or without notice at any time. As policies are revised throughout the year, they will be incorporated into the BH Manual. The BH Manual may be viewed or downloaded from MAD's home page at www.hsd.state.nm.us, and on the Network of Care <http://newmexico.networkofcare.org/mh/>. A summary list of the policy revisions will also be posted each year.

The BH Manual will be issued and maintained by HSD. It is the responsibility of all providers and entities affiliated with Medicaid in New Mexico to review, and be familiar with, the BH Manual and any amendments.

The reader should also refer to the Behavioral Health Fee Schedule which has information on providers who can bill specific procedure codes, payment information, referring and rendering provider requirements, and information on billing units.

1.2 Severe Emotional Disturbance (SED): see appendix A for NM State definition.

1.3 Serious Mental Illness (SMI): see appendix B for NM State definition.

1.4 Trauma Informed Care (TIC)

Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of *trauma*.

Behavioral health providers are aware of the pervasive, adverse impact of trauma commonly found with persons who are experiencing mental health and/or substance use disorders. The entire system of care is therefore designed to be trauma informed to create a healing environment that utilizes evidenced-based best practices in the treatment process from intake to discharge.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) concept of a trauma informed approach, "A program, organization, or system that is trauma informed:

- 1) *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- 2) *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- 3) *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- 4) Seeks to actively resist *re-traumatization*.

A trauma informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

A trauma informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting or sector specific. All areas below cite examples, but are not limited to those examples:

- 1) **Safety**
No chairs in the center of a waiting room only along walls, not asking clients to sit with their backs toward any entryways, practicing and modeling consent with touch and space, and respecting the wishes of people who need more space or no touch.
- 2) **Trustworthiness and Transparency**
Communicating exactly what will happen next at every step of service, clearly explaining services – who, why, when, where and how, keeping to any agreements made – not being late and following through. Do not assume that as a provider you will be treated as trustworthy; demonstrate behavior that earns the trust of your clients.
- 3) **Peer support**
Having peers as part of your staff teams and allowing them to be accessible to clients; provide appropriate and healthy support for peers.

- 4) Collaboration and mutuality
Seeking the input of all parties involved; no unilateral decision making about the direction of a case; “nothing about us without us”; treating others with high level of respect, compassion, and dignity while assuming the positive intention of all people.
- 5) Empowerment, voice and choice
Finding and fostering the individual strengths of all people and leveraging them; creating and holding space for people to communicate their opinions, ideas and hopes, and then following up with opportunities for choice in any given situation.
- 6) Cultural, Historical, and Gender Issues
Practicing cultural awareness and curiosity while understanding that there are events that have occurred that profoundly changed a culture. Historical trauma can include genocide, slavery, forced relocation, and destruction of cultural practices, among other things. Many of these things are still occurring today; it is critical to welcome dialogue and opinions on these experiences. It is not trauma informed to speak for a culture that you do not identify as being a part of; nor is it trauma informed to call out a member of your community to be a spokesperson for a particular culture or historical event. Recognize that there are gender disparities that affect all aspects of our work, including limiting gender to a binary, birth definition. Gender and sexuality are part of individual human identity and are sometimes not recognized within our patronormative and heteronormative culture. This can have a very traumatic effect on clients and staff. Trauma informed work includes awareness of the spectrum of identity and creating brave and courageous space for people to be fully themselves.

From SAMHSA’s perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA’s definition of recovery, services and supports that are trauma informed build on the best evidence available; consumer and family engagement; empowerment; and collaboration.

Trauma-specific intervention programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful;
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety; and
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers.

Exhibits/Appendices/Forms

Appendix C: Monitoring Tool for Trauma Informed Care (TIC) A suggested tool for use by administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma informed programs.

Appendix D: Creating Cultures of Trauma Informed Care

1.5 Recovery and Resiliency

A. Recovery

The process of recovery is highly personal and individualized. Its definition is reflective of what challenges each person has overcome so that challenge no longer impedes in that person's quality of life. Recovery is characterized by continual growth and improvement in one's health and wellness, social and spiritual connection, and renewed purpose. A person's recovery is a reflection of their strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person, the person in their community, and is supported by peers, friends, and family members.

Recovery may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. These recovery support services are culturally and linguistically appropriate to facilitate individuals and families to work toward recovery from mental and/or substance use problems and/or trauma. They incorporate a full range of social, legal, and other services that facilitate recovery, wellness, and linkage to, and coordination among service providers and other supports including their families. This approach has been shown to improve quality of life for people seeking recovery.

Recovery support services also include access to evidence-based practices such as supported employment, supported education, supportive housing, assertive community treatment, disease management, and peer-operated services. Recovery support services may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support services. These services, provided by professionals and peers, are delivered through a variety of community and faith-based groups, treatment providers, schools, and other specialized services.

SAMHSA has delineated four major dimensions that support a life in recovery:

- 1) **Health** - overcoming or managing one's disease(s) or symptoms. For example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem, and for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- 2) **Home** - having a stable and safe place to live.
- 3) **Purpose** - conducting meaningful daily activities, such as a working, school volunteerism, family caretaking, or creative endeavors; and having the independence, income, and resources to participate in society.
- 4) **Community** - having relationships and social networks that provide support, friendship, love, and hope.

B. Resiliency

Resiliency is the ability to "bounce back" from adverse, traumatic, or highly stressful experiences. Resilience is the positive and protective response that many individuals cultivate to move past negative effects of a traumatic experience. Though there might not be specific evidence informed

approaches to teach resiliency, a focus on strategically timed, culturally relevant, comprehensive programs across multiple settings that are of sufficient length and depth to address the magnitude of the problem, can maximize outcomes. Additionally, because the effects of interventions might be delayed, unexpected, or indirect, it is important to consider more complex models of change and monitor outcome over time, in multiple domains and at multiple system levels. Such comprehensive prevention approaches acknowledge the multiplicity of risks and the cumulative trauma that many children and adults face and emphasize the importance of promoting competence and building protection across multiple domains in order to achieve a positive outcome. (retrieved from: apa.org, 2018).

1.6 Cultural Competency

Culturally competent health care is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families (Goode, 2002). Practices are designed and implemented to match the unique needs of individuals, children, families, organizations and communities served. Culturally competent systems of care are driven by consumer preferred choice, not by culturally blind or culture-free interventions. Culturally competent practice also includes a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care. Services and support are delivered in the preferred language and/or mode of delivery of the population served; and written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the population. Culturally competent interpretation and translation services comply with all relevant federal, state, and local mandates governing language access; and clients receive high quality, culturally appropriate care (Goode, 2002).

Appendix E: Promoting Cultural Diversity and Cultural Competency - Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs, NCCC, GUCDC. Goode, T. (2002).

1.7 Clinical Supervision

Clinical supervision instructs, models, and encourages self-reflection of the supervisee's acquisition of clinical practice and administrative skills through observation, evaluation, feedback, and mutual problem-solving. However, there may be opportunity in which the clinical supervisor chooses to give professional direction based on experience, expertise, and/or ethical or safety concerns. Clinical supervision is delivered within the supervisor's professional practice and ethical standards.

Clinical supervision is provided to all treatment/clinical staff who are either employed or under contract by an agency or an individual provider. The Clinical Supervisor:

- Meets the standards for clinical supervision as defined by their professional practice board;
- Provides support, consultation, and oversight of clients' treatment to include assessment of needs; diagnoses/differential diagnoses, mental health (MH), substance abuse (SA) and co-occurring disorders (COD); clinical reasoning and case formulation, to include documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; and tracking and adjusting interventions;
- Continuously reviews and adjusts interventions according to an individual's status, success and challenges;
- Teaches the importance of retaining continuity throughout all documentation;
- Ensures plans, interventions, goals and supports are appropriate to diagnosis;
- Addresses the supervisee's steps to ensure a consumer's active involvement at all levels and ensures the consumer's voice and choice are clearly represented and documented;
- Assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the consumer's continued recovery and success;
- Assures that appropriate safety, crisis management and advanced directive plans are in place at the onset of service delivery; and
- Addresses ethics and ethical dilemmas, (aligned with professional practice board).

Clinical Supervisors will document the date, duration, and the content of the supervision session for their supervisee(s), which may include a professional development plan. All documents pertaining to clinical supervision will be readily available to the supervisee.

Note that a provider or provider group, other than an agency authorized to utilize non-independent practitioners, or one with a clinical supervision certificate, cannot bill for the services of a supervised practitioner except as specifically allowed as part of an educational program. For example, a service rendered by a non-independently licensed practitioner, cannot be billed showing the supervisor as the rendering provider, unless billed by an agency that holds a clinical supervision certificate, or the supervision is being provided as part of the educational program of the unlicensed practitioner.

A. Exhibits/Appendices/Forms

Appendix F: Clinical Supervision Implementation Guide: A practical implementation guide for community-based behavioral health organizations.

B. Resources

American Psychological Association. (2014). Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from <http://www.apa.org/about/policy/guidelines-supervision.pdf>

Association for Counselor Education and Supervision (ACES) of the American Counseling Association. (2011). Best Practices in Clinical Supervision of the Association for Counselor Education and Supervision (ACES)/Division of the American Counseling Association. Retrieved from: https://www.acesonline.net/sites/default/files/ACES-Best-Practices-in-clinical-supervision-document-FINAL_0_0.pdf

Falender, C. A., Grus, C., McCutcheon, S., Goodyear, R. K., Ellis, M. V., Doll, B., ...Kaslow, N. J. (2016). Guidelines for clinical supervision in health services psychology: Evidence and implementation strategies. *Psychotherapy Bulletin*, 51(3), 6-16. Retrieved from: <http://societyforpsychotherapy.org/wp-content/uploads/2016/10/Appendix-Special-Feature.pdf>

Falender, C. A., & Shafranske, E. P. (2004). Therapist Evaluation Checklist as adapted and reprinted in *Clinical Supervision: A Competency-Based Approach*. Washington, DC: APA. Original author is Susan Hall-Marley (2000). Retrieved from: <http://calender.com/Appendix%2013.6.TherapistEvaluationChecklist.html>

Falender, C. A., & Shafranske, E. P. (2004). Supervisor Evaluation Form as adapted and reprinted in *Clinical Supervision: A Competency-Based Approach*. Washington, DC: APA. Original author is Susan Hall-Marley (2001). Retrieved from: <http://calender.com/Appendix%2013.S%20%20Hall%20Marley%20SUPERVISOREVALUATIONFORM.pdf>

1.8 Supervisory Certification

A. Purpose

To create a process and expectation that quality clinical supervision is occurring for non-independently licensed clinicians working within agencies so that they may improve, and enhance, their clinical practice as they move forward to their independent license.

B. Policy

The request for certification demonstrates that the agency is in alignment with the clinical supervision requirements under the Clinical Supervision section of this Policy and Billing Manual. If an agency was previously approved under the OptumHealth Supervisory Protocol, that agency need not request new certification. However, grandfathered agencies must have their rosters approved by BHSD prior to MCO contracting. Approval from BHSD requires all providers to submit rosters to the MCOs for contracting their non-independently licensed clinicians.

Behavior Health Agencies and Opioid Treatment Programs qualify for Supervisory Certification. Agencies must hold an agency NPI and Medicaid number and each rendering provider, whether independently licensed or non-independently licensed, must also hold their own NPI and Medicaid number.

Follow the instructions in the Supervisory Certification Attestation, Appendix I. Note each item in the attestation as the agency must have policy and procedures to validate what they have attested to. BHSD reserves the right to perform a retrospective review of agencies with Supervisory Certification. These reviews may include a desk audit of policy and procedure, supervision documentation, personnel records, treatment records, as well as quality improvement records.

Services approved for supervisory certification include:

- 90791 - psychiatric diagnostic evaluation
- 90832, 90833, 90834, 90836, 90837, 90838 - psychotherapy
- 90846, 90847, 90849, 90853 - family and group psychotherapy

C. Definitions

Clinical Supervisor - refers to an independently licensed practitioner approved by their professional licensing board to provide clinical supervision. Examples include: LISW/LCSW, LPCC, LMFT, LPAT, psychologist, psychiatrist, and LADAC for substance use disorder (SUD) only.

Master's level non-independent BH professional - LMHC, LMSW, LPC, LAMFT, LSAAAs, psychology interns & post-doctoral students.

Unlicensed BH staff - a master's level behavioral health intern, psychology intern, pre-licensure; psychology post doctorate student; certified peer support worker; provisional or temporary licensures, or certified family peer support worker.

D. Procedures

See process flow for detail.

E. Exhibits/Appendices/Forms

Appendix G: Supervisory Certification Roster of Approved Agencies

Appendix H: Supervisory Certification Process Flow

Appendix I: Supervisory Certification Attestation Form

Appendix II: Clinical Supervision Implementation Guide: Practical Resources and Tools

<https://www.nmbhpa.org/clinical-supervision-implementation-guide/>

1.9 Quality

Vision

The vision of continuous quality programming supports ongoing, customer-focused, data-driven, and outcome-based approaches to service delivery. We are mindful of the community served and the need for improving access throughout the state. Behavioral health service systems shall be anchored in the belief of resiliency and recovery.

In order for New Mexicans to succeed and lead healthier lives, agencies and providers are encouraged to have continuous quality improvement core values that positively impact the individual in service, the community, and other stakeholders. These core values are:

- **Customer-focused, recovery-oriented, with an emphasis to clinical excellence** - Services that promote and preserve well-being and expand choices to support person-centered goals that are culturally and linguistically appropriate. Expecting clinical excellence that improves quality of care, expands services and access to services, and achieves outcomes that are recovery oriented, with an emphasis and support to train clinical staff in evidence-based approaches and interventions.
- **Communication with compassion and respect** - A commitment to compassionate, respectful communication that provides appropriate, consistent, and accurate information through active listening, sharing ideas, cooperative problem-solving, tact, and courtesy, while valuing all contributions.
- **Improvement, innovations, and integrity** - A commitment to implementing innovative processes that are continually reviewed and improved, while understanding that incremental changes do make an impact, and that there are always ways to make things better. All operations are conducted in an honest, fiscally responsible, ethical manner with dedication to quality that meets and exceeds customer expectations.
- **Staff Development** - A commitment to providing a work environment that fosters teamwork, mutual support, learning and development, recognition, and effective leadership while recognizing that effective programs require the involvement of a prepared and informed staff at all levels.
- **Inclusive and Diverse Partnerships** - A commitment to focusing on common goals through collaboration, teamwork, and consensus-building while sustaining the development of strong, positive, long-term relationships between staff and stakeholders. These partnerships are diverse, creative, supportive, and are always focused on supporting our quality improvement mission.
- **Data Driven** - A commitment to the creation of successful processes and informed decisions that use data to inform practice and quality improvement policy.

Our missions are to improve access to quality behavioral health care for New Mexicans and to reduce barriers that prevent access. Objectives to support those missions and the overall vision for quality improvement include, but are not limited to:

- Prevention;
- Early intervention;
- Exceeding the expectations of consumers and their families in meeting their behavioral health needs as they define them;
- Ensuring access to services that provide appropriate evidence-based treatment and promising practice-based evidence while promoting and supporting recovery;
- Services that are culturally and linguistically appropriate;
- Effectively and efficiently managing state, federal, and other resources;
- Facilitating linkages, consensus building, and collaboration among State agencies, consumers and their families, and other public policy makers;
- Actively seeking and implementing consumer, provider, and other stakeholder involvement in the design and delivery of BH-related services;
- Strengthening integration between behavioral and other health services; and
- Increasing health care innovation and best practice implementation.

1.10 Mental Health Parity and Addiction Equity Act of 2008

A. General Requirements

- 1) The MCO is directed to provide MH/SUD services in all benefit classifications, i.e. inpatient, outpatient, emergency care, and prescription drugs.
- 2) The MCO will cooperate with HSD to establish and demonstrate ongoing compliance with 42 CFR Part 438, subpart K regarding parity. This will include, but is not limited to: participating in meetings, providing information requested by the State to assess ongoing parity compliance, working with the State to resolve any non-compliance, and notifying the State of any changes to benefits or limitations that might impact parity compliance.
- 3) If requested by HSD, the MCO will conduct an analysis to determine compliance with 42 CFR Part 438, subpart K regarding parity and provide the results of the analysis to the State.

B. Aggregate Lifetime or Annual Dollar Limits (AL/ADLs)

The MCO will not apply AL/ADLs to MH/SUD services (see 42 CFR 438.905).

C. Financial Requirements

- 1) The MCO will follow State policy regarding co-payment requirements, including the populations subject to a co-payment, the amount of the co-payment, populations and services exempt from co-payments, as well as the out-of-pocket maximum.
- 2) Quantitative Treatment Limits and Exceptions Process to be applied to Behavioral Respite Services (T1005)
 - a. Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caretaker. Additional hours may be requested if an eligible beneficiary's health and safety needs exceed the specified limit.
 - b. For children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 days. Additional hours may be requested if an eligible beneficiary's health and safety needs exceed the specified limit.

D. Non-Quantitative Treatment Limitations (NQTLs)

Per 42 CFR 438.910(d), the MCO will not impose a non-quantitative treatment limitation (NQTL) for MH/SUD services in any classification, i.e. inpatient, outpatient, emergency care, or prescription drugs, unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors applying the NQTL for physical health services in the classification.

NQTLs include, but are not limited to: medical management standards; standards for provider participation, including reimbursement rates; fail-first policies; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, other criteria that limit the scope or duration of services; and standards for providing access to non-participating providers (42CFR 438.910(d)(2)).

E. Availability of Information

Per 42 CFR 438.915(b), the MCO will make available to the member the reason for any denial by the MCO of reimbursement or payment for MH/SUD services to the member.

1.11 Critical Incidents

All agencies in New Mexico providing Behavioral Health (BH) services are required to report Critical Incidents within 24 hours of knowledge of the occurrence. The critical incident(s) should be reported to the member's MCO and/or Adult Protective Services (APS) or Child Protective Services (CPS), as necessary.

Critical incident reporting responsibilities and reporting requirements include:

- A. Home and Community Based Services (HCBS) critical incidents involving recipients with a qualifying Category of Eligibility (COE)** must be reported on the HSD Critical Incident Reporting System for the following reportable incidents: abuse; neglect; exploitation; death; environmental hazard; missing/elopement; law enforcement; and emergency services.

Qualifying COEs include: 001; 003; 004; 081; 083; 084; 090; 091; 092; 093; and 094. Also qualifying are COEs 100 and 200, if they have a Nursing Facility Level of Care (NF LOC).

- B. BH critical incidents and all Sentinel Events** are defined by the Behavioral Health Critical Incident Protocol.

- 1) Critical incidents involving BH services for members with a non-qualifying COE must be reported on the Centennial Care Behavioral Health Critical Incident form for any known, alleged or suspected events of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.
- 2) The MCO shall have a process and designate one fax line to receive critical incident reports from BH providers for Medicaid recipients. The MCO shall provide this fax number to HSD and the MCO contracted BH provider network.
- 3) The MCO is responsible for reviewing and ensuring complete follow up has occurred regarding all submitted BH critical incidents reported by or on behalf of their members, including APS and CPS.
- 4) The MCO will notify BHSD of all sentinel events in accordance with the Behavioral Health Critical Incident Protocol.

- C. MCO processes for reporting of critical incidents by Behavioral Health Service Providers**

- 1) Criteria: The licensing status of the provider and the eligibility status of the recipient determine which incidents will be reported and what process the reporting will follow. The MCO is responsible for collecting and acting upon the information in each report for its members to ensure the member's health and safety, and the delivery of quality services. The MCO must monitor the compliance of its provider network related to the rules and regulations for reporting critical incidents.

- 2) Sentinel events are defined within the Behavioral Health Critical Incident Protocol. This Protocol may be found at: <http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx>. The MCO will notify BHSD of all Sentinel events via email to hsd.csbhbsd@state.nm.us within 24 hours of receipt of the Critical Incident Report.
- 3) All providers are required to report critical incidents. Only sentinel events are reported directly to the Human Services Department/Behavioral Services Division. Refer to the Critical Incident Reporting Protocol (2018) for additional information and reporting resources.

This process does not supplant any reporting requirements that are mandated by another agency such as the Children Youth and Families Department, Aging and Long-Term Services Department or the Department of Health.

The HSD critical incident web-based system is used by home and community based service providers who are contracted with a MCO to provide Centennial Care services and benefits to recipients eligible for the Medicaid categories of eligibility (COEs): 001, 003, 004, 081, 083, 084, 090, 091, 092, 093, 094, 100 (only COE 100 recipients with nursing facility level of care), and 200 (only COE 200 recipients with nursing facility level of care).

The MCO shall designate one fax line and have a process to receive critical incident reports from behavioral health providers for Medicaid with a COE not listed above. The MCO shall provide this fax number to HSD and to the MCO contracted behavioral health provider network.

- 4) The MCO shall direct adult behavioral health provider facilities as follows:
 - a. For Centennial Care (CC) or Fee for Service (FFS) members receiving adult behavioral health services:
 - (i) A CC/FFS member's COE can be found on the New Mexico Medicaid Portal:
<https://nmmedicaid.portal.conduent.com/static/index.htm>
 - (ii) If the member has a COE listed above, the CIR is entered into the HSD web-based critical incident reporting system:
<https://criticalincident.hsd.state.nm.us>.
 - CC: When online access is not an option the CIR form shall be faxed to the MCO designated fax line. The MCO is responsible for entering these reports into the CIR portal website listed above and is responsible for reviewing and ensuring complete follow up has occurred on all submitted critical incidents reported on their members.
 - FFS: When online access is not an option the CIR form shall be faxed to HSD/MAD Quality Bureau (505) 827-3195. The HSD/MAD Quality Bureau is responsible for reviewing and ensuring complete follow-up has occurred.

- (iii) For recipients of behavioral health services who have COE 095 (Medically Fragile Waiver) or COE 096 (Developmental Disability Waiver) CIRs should be reported to: NM Department of Health (DOH) Incident Management Bureau; phone: (800) 445-6242; fax: (505) 584-6057.
- (iv) For CC members with a COE NOT listed above, the behavioral health provider facility shall fax the critical incident to the member's MCO's fax line, using an approved CIR form from the MCO. The MCO is responsible for reviewing and ensuring complete follow-up has occurred.
- (v) For FFS Medicaid recipients, the HSD/MAD Quality Bureau is responsible for reviewing and ensuring complete follow-up has occurred. The CIR shall be faxed to the HSD/MAD Quality Bureau: (505) 827-3195.
- (vi) A CIR protocol document is available to assist providers with reporting critical incidents for those members whose COE falls outside of the categories reported on the HSD portal. A link to the protocol document can be found on the HSD website at:
<http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx>

D. Critical Incident Reporting for Non-Medicaid Recipients: For recipients of behavioral health services who are NOT Medicaid recipients: The adult behavioral health provider agency shall fax the critical incident to BHSD at (505) 476-9272 using an approved HSD/BHSD template. BHSD is responsible for reviewing or providing follow-up on these incidents.

A link to the HSD/BHSD Critical Incident Report Form template can be found on the HSD website at: <http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx>. This template features drop-down menu options, and can be filled out, saved, and sent without printing.

E. Summary: The MCO shall follow and instruct the adult behavioral health provider on the required processes for reporting critical incidents and sentinel events as required by the agency or department that has the oversight of the report, including but not limited to: HSD, DOH, CYFD, ALTSD, and BHSD.

The MCO shall provide initial and ongoing training to behavioral health providers in its network on this process at a minimum of once a calendar year. Training dates and sites should be considered in conjunction with other events that are relevant to the same professional within the behavioral health service model. The MCO shall provide the Adult Behavioral Health Critical Incident Protocol to their adult behavioral health provider network.

F. Exhibits/Appendices/Forms

Appendix J: Critical Incident Report Form

Appendix K: Behavioral Health Provider Critical Incident Reporting Protocol

1.12 Telemedicine

A. Purpose

The purpose of telemedicine is to extend access to assessment, evaluation and therapeutic services.

B. Definitions

Telemedicine - the use of electronic information, imaging and communication technologies, including interactive audio, video, data communications as well as store and forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education” (NMSA, 1978, Section 24-25-3. C)

Forwarding an image or information to a different provider for interpretation is not considered store-and-forward technology eligible for reimbursement unless it is to obtain information necessary for treating the recipient during the telemedicine session.

Telemedicine services - includes both an originating site and a distant site. An interactive telehealth communication system must include both interactive audio and video and be delivered on a real-time basis at both the originating and distant sites.

Originating site - the location of an eligible Medicaid recipient at the time the service is furnished via a telecommunications system. The originating site can be any medically warranted site, (see 8.310.2 NMAC).

Distant site - sometimes called the remote site, the telemedicine site where the medical provider or specialist is located while using telemedicine connections to treat the recipient who is at the originating site.

The terms telehealth and telemedicine are used interchangeably in the Medicaid program. To qualify as a billable telemedicine service, the system must meet all federal requirements for interactivity using a secure connection as meets HIPAA standards for privacy and security.

C. Use of Telemedicine While Providing Medication Assisted Treatment (MAT)

Under the Ryan Haight Act of 2008, where controlled substances are prescribed by means of the Internet, the general requirement is that the prescribing Practitioner must have conducted at least one in-person medical evaluation of the patient. U.S.C. § 829(e). However, the Act provides an exception to this requirement, 21 USC § 829 (e)(3)(A). Specifically, a DEA-registered Practitioner acting within the United States is exempt from the requirement of an in-person medical evaluation as a prerequisite to prescribing or otherwise dispensing controlled substances by means of the Internet if the Practitioner is engaged in the practice of telemedicine and is acting in accordance with the requirements of 21 U.S.C. § 802(54).

Under 21 U.S.C. § 802(54)(A),(B), for most (DEA-registered) Practitioners in the United States, including Qualifying Practitioners and Qualifying Other Practitioners (“Medication Assisted Treatment Providers”), who are using FDA approved Schedule III-V controlled substances to treat opioid addiction, the term “practice of telemedicine” means the practice of medicine in accordance with applicable Federal and State laws, by a practitioner (other than a pharmacist) who is at a

location remote from the patient, and is communicating with the patient, or health care professional who is treating the patient using a telecommunications system referred to in (42 CFR § 410.78(a)(3)) which practice is being conducted:

- 1) While the patient is being treated by, and physically located in, a DEA-registered hospital or clinic registered under 21 U.S.C. § 823 (f) of this title; and by a practitioner who:
 - a. is acting in the usual course of professional practice;
 - b. is acting in accordance with applicable State law; and
 - c. is registered under 21 U.S.C. § 823 (f) with the DEA in the State in which the patient is located.

OR

- 2) While the patient is being treated by, and in the physical presence of, a DEA-registered practitioner who:
 - a. is acting in the usual course of professional practice;
 - b. is acting in accordance with applicable State law; and
 - c. is registered under 21 U.S.C. § 823 (f) with the DEA in the State in which the patient is located.

The distant Practitioner engaged in the practice of telemedicine must be registered with the DEA in the state where they are physically located and, in every state, where their patient(s) is (are) physically located, 21 U.S.C. § 822 (e)(1); 21 CFR § 1301.12 (a); Notice 69478 Federal Register Vol. 71, No. 231, Friday, December 1, 2006.

All records for the prescribing of an FDA approved narcotic for the treatment of opioid addiction need to be kept in accordance with 21 CFR § 1304.03(c), 21 CFR § 1304.21(b), and with all other requirements of 21 CFR Part 1300 to End.

This document reflects DEA's interpretation of the relevant provisions of the Controlled Substances Act (CSA) and DEA regulations, to the extent it goes beyond merely reiterating the text of law or regulations, it does not have the force of law and is not legally binding on registrants. Because this document is not a regulation that has the force of law, it may be rescinded or modified at DEA's discretion.

D. Best Practice Guidelines

All efforts must be made to furnish telemedicine services consistent with national best practice and comply with HIPAA regulations. Please see American Telemedicine Association Practice Guidelines for Telemental Health with Children and Adolescents (2017), American Telemedicine Association Practice Guidelines for Video Based Online Mental Health Services (2009), American Telemedicine Association's Evidence Based Practice for Telemental Health (2009), and American Telemedicine Association Practice Guidelines for Video-conferencing Based Telemental Health (2009). The following are some links for further information:

<https://www.telehealthresourcecenter.org/>

<https://www.telehealthresourcecenter.org/toolbox-module/legal-issues-privacy-and-contracting-services>

<https://www.telehealthresourcecenter.org/toolbox-module/getting-started>

<https://www.telehealthresourcecenter.org/toolbox-module/facilities-provider-site>

E. Prescribing Medications via Telehealth

All prescribing via telehealth must be compliant with the Ryan Haight Act. Please refer to Federal Register dated Monday April 6, 2009, Part II from Department of Justice Drug Enforcement Administration, 21 CFR Part 1300, 1301, 1305, et al (Implementation of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008; Final Rule) for details. Prescribers are prohibited from prescribing, dispensing or administering drugs or medical supplies to a patient when there is no established prescriber-patient relationship. This includes prescribing over the Internet, or via other electronic means, based solely on an online questionnaire. Physicians, psychologists with prescriptive authority, physician assistants and advanced practice nurses may prescribe online during a live video exam. The prescribing clinician must: obtain a medical history, obtain informed consent and generate a medical record. A physical exam is recorded as appropriate by the telehealth practitioner or an on-site practitioner such as a physician, advanced practice nurse, or physician assistant; or the exam is waived when a physical exam would not normally be part of a typical physical face-to-face encounter with the patient for the services being provided (see 16.108.8 NMAC).

F. Additional Requirements

When the originating site is in New Mexico and the distant site is outside New Mexico, a physician at the distant site must be licensed in New Mexico for telemedicine or meet federal requirements for Indian Health Service or tribal contract facilities, (8.310.2 NMAC). Non-physician practitioners at distant sites must be licensed in New Mexico to the extent required by their practicing boards.

G. Billing Instructions

- 1) Reimbursement is made to the originating site for an interactive telehealth system fee utilizing HCPCS code Q3014.
- 2) New Mexico Medicaid will reimburse for services provided under telemedicine at the same rate as when the services are furnished without the use of a telecommunication system.
- 3) School-based services provided via telemedicine are covered.
- 4) Indian Health Services: A telemedicine communication fee is paid for the originating site at fee schedule rates using the CMS 1500 format; not the OMB rate. The originating clinical service fee is billed at the OMB rate. Both the originating and distant sites may be IHS or tribal facilities with two different locations; or a distant site can be under contract to the IHS or tribal facility. If the

distant site is an IHS or tribal facility, the distant site may also bill the OMB rate when the service is typically paid at OMB rates.

- 5) FQHC: A telemedicine communication fee is paid for the originating site at fee schedule rates using the CMS 1500 format; not the encounter rate. The originating clinical service fee is billed at the encounter rate.

1.13 Billing for Behavioral Health

A. Key to Provider Types

A list of the BH provider types and specialties are attached to the BH Fee Schedule, Appendix L.

B. General Principles (not for FQHCs or IHS or Tribal 638s)

- 1) All providers must be enrolled in Medicaid.
- 2) Rendering providers are required on most OP claims. These may be on the header level if a single provider is the rendering or on the line level if there are several services on the same claim. Exceptions are indicated on the current version of the fee schedule.

When a new employee of an agency is awaiting completion of their enrollment in Medicaid and is providing services, the supervisor's name and NPI may be placed in the rendering field with a U7 modifier, signifying the service was done by someone under their supervision for which they are assuring all licensing and required certifications are in order. To use the U7 modifier, an enrollment application must have already been submitted to MAD. This process can only be used for six months. Once the employee is enrolled in Medicaid, the agency is required to start listing the employee as the rendering provider instead of the supervisor with the U7 modifier.

For interns which may be short term practitioners in an agency, the supervisor's NPI may be utilized in the rendering field with a U7 modifier on the CPT or HCPCS code until their enrollment is complete.

- 3) Must follow the Medicaid national correct coding initiative, NCCI, rules that delineate which services cannot be billed together on the same day. The NCCI website for Medicaid is:
<https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html>
- 4) For Accredited Residential Treatment Centers (ARTCs), Residential Treatment Centers (RTCs) and Group Homes, the referring or ordering provider must be listed in the attending field.
- 5) To distinguish different services that should be reimbursed separately on the same day utilize the following modifiers:
 - a. XE - A service that is distinct because it occurred during a separate encounter;
 - b. XP - A service that is distinct because it was performed by a separate practitioner;
 - c. XU - A service that is distinct because it does not overlap usual components of the main service.

C. Federally Qualified Health Center (FQHC) Billing

- 1) Most evaluation and treatment services are paid at the FQHC rate which is specific to each provider. They are billed on a UB claim form, with the revenue code of 0919 for behavioral health claims. The specialized behavioral health services are best identified using the CMS 1500 format and corresponding 837-P electronic transactions. Therefore, the FQHC must bill for the specialized BH services to MCOs using the CMS 1500 format but will be reimbursed based on their encounter rate. They may bill for the specialized services only when they are approved to provide specific specialized behavioral health services, unless another rate has been negotiated. Using the CMS 1500 format permits the MCO to determine the utilization of services and manage the qualifications of the provider.

The FQHC is entitled to, at a minimum, the fee-for-service FQHC encounter rate. However, the MCO and the FQHC may negotiate a different rate for each Specialized BH Service. For example, the FQHC rate for IOP does not need to be the same as for Day Treatment.

This is not applicable to Rural Health Clinics (RHCs) and Hospital Based Rural Health Clinics (HB-RHC). When a RHC or HB-RHC qualifies to render any of the Specialized Behavior Health Services, they obtain a separate Medicaid provider for their Specialized Behavioral Health Services and enroll separately as a BHA, CMHC, or CSA, as appropriate. These Specialized Behavioral Health Services are not part of the core services for these types of providers and are therefore not paid at their encounter rates.

It is important that the MCO edit the claims to ensure that no more than one encounter rate is paid per day unless the recipient goes to the FQHC more than once in a day with a different diagnosis or had two distinct types of visits such as: 1) A physical health visit and a dental visit on the same day; 2) A physical health visit and a separate behavioral health service provided by a different provider on the same day; or 3) More than one distinct Specialized Behavioral Health service which does not otherwise overlap or is prohibited from being billed in conjunction with another Specialized BH Service per the NMAC for Specialized Behavioral Health Services.

- 2) If another entity such as a CLNM Health Home is part of the FQHC and has a separate provider number and NPI, they are billed on a CMS 1500 utilizing CPT and HCPCS codes based on either a fee schedule rate, or capitated payment.
- 3) For specialized behavioral health services, if the provider chooses to use the Medicaid fee schedule rather than the FQHC rate, they may do so. Those claims are billed on a CMS 1500 claim form utilizing CPT and HCPCS codes. Please see State of New Mexico Medical Assistance Program Manual Supplement 16-13.
- 4) The MAD encounter rate includes all practitioner services unless choosing to use fee schedule rates. The encounter is billed when a practitioner sees a patient at the clinic or in a hospital or nursing facility or in the community. In addition to the

revenue code, all procedure codes must be listed on the claim even though the reimbursement will be at the FQHC rate.

- 5) If seeing the patient for a behavioral health service that is for either a different specialized service or with a different provider, utilize the modifiers below on the CPT/HCPCS codes to signify multiple encounters.
 - a. XE - A service that is distinct because it occurred during a separate encounter;
 - b. XP - A service that is distinct because it was performed by a separate practitioner;
 - c. XU - A service that is distinct because it does not overlap usual components of the main service.

D. Indian Health Services and Tribal 638 Clinics Billing

- 1) For IHS and Tribal 638 clinics, all individual therapy, counseling, peer support, and most of the specialized services are paid at the Office of Management and Budget (OMB) rate, using the UB claim form and a revenue code for behavioral health of 0919.
- 2) Some services are not paid at the OMB rate; they are billed on the CMS 1500 form and are paid at regular fee schedule rates. Some of those services are:
 - a. Group therapy codes of 90846, 90847, 90849, and 90853
 - b. Telehealth originating communication fee: Q3014
 - c. Smoking cessation: 99406, 99407
 - d. Crisis Intervention – 24-hour crisis line: H2011 U1
 - e. Accredited residential treatment centers
 - f. Non-accredited residential treatment centers
 - g. Group homes
 - h. Treatment foster care
 - i. Partial hospitalization
 - j. CLNM Health Home services

Note: If rates, other than OMB rates, are negotiated when applying for delivery of any of the specialized services with MAD or the MCOs, those would apply. For services not paid at the OMB rate, MCOs cannot pay less than the fee schedule rate.

- 3) No prior authorization is required for any of the BH services at IHS or Tribal 638 clinics.
- 4) Billing options for services provided by non-tribal providers under a written care coordination agreement to provide services to American Indian or Alaska Natives (AI/AN):
 - a. The non-tribal provider may bill directly for the services at the MAD fee schedule rate;
 - b. The non-tribal provider assigns its claim for payment to the tribal facility in return for payment from the facility, and the tribal facility bills Medicaid for the service;

- (i) The tribal facility identifies services provided by non-IHS/tribal providers that are within the scope of covered services of the IHS/tribal facility (“IHS/tribal facility services”) and can receive the facility (OMB) rate for those services. These services are billed on the UB claim form with the revenue code 0919.
 - (ii) For services that are *not* classified as IHS/tribal facility services, the tribal facility bills for them on a CMS 1500 claim form with the applicable CPT or HCPCS code and is reimbursed at the fee schedule rate.
 - c. If interested in changing “clinic” status to FQHC status, consult with the MAD Program Policy Bureau. No other steps need be taken by the Tribal Health program.
- 5) Option to bill specialized services at fee schedule rates so that multiple services within the same day may be billed. See IHS/Tribal 638 instructions within each specialized service in this manual.

Section Two: Screening, Assessment, Medication and Therapies

2.1 Integrated Care and Interdisciplinary Teaming

A. Purpose

To clarify and define interdisciplinary teaming requirements for specialized behavioral health services as used throughout 8.321.2 NMAC.

Centennial Care emphasizes the importance of integrated care to achieve positive health outcomes for individuals and populations. Those expectations require an opportunity rather than merely a philosophy. The opportunity for physical health and behavioral health practitioners to collaborate to achieve whole person health outcomes for an individual can be achieved by allowing a small number of providers (three) to bill for a meeting of the team where the member is included, and an interdisciplinary teaming approach is used. There may be more than three different providers, community, or family members at the session, but only three may bill concurrently.

B. Policy

Interdisciplinary teaming is a set of case-level learning, reasoning, and decision processes involving appropriate service providers joining together with the individual to achieve agreed upon goals for an individual receiving service. It is a dynamic process, not a static group or a discrete event, and involves coordinating and collaborating without a prescribed or rigid team structure.

From a “person-centered” point of view, case-level interdisciplinary teaming happens only when the individual whose needs and services are being discussed is present at the team meeting. Any meeting at which the individual is absent when their needs and services are discussed is an *agency staffing*.

At times, a meeting of team members may be warranted. Such a meeting must include the individual, as well as an interdisciplinary team of health professionals, and may include representatives of community agencies. The purpose of the meeting is to plan and coordinate activities of the individual’s care, particularly when a change in condition has occurred, and the result is a service plan update. This session becomes a billable event.

Core Elements of Teaming:

Teaming involves ongoing group-based processes that build and sustain:

- 1) Communication - ongoing exchange of essential information among team members (supporting individual receiving services) that is necessary for achieving and maintaining situational awareness in case practice.
- 2) Coordination - organization of information, strategies, resources, and participants into complex arrangements enabling team members to: work together, identify a person’s needs and goals, select strategies for a course of action, assign

responsibilities for action, contribute and manage resources, and track and adjust strategies and supports to achieve goals.

- 3) Collaboration – operation of shared decision-making processes used to identify needs, set goals, formulate courses of action, implement supports and services, and evaluate results.
- 4) Consensus – negotiated agreements necessary for achieving common purpose and unity of effort among members of a person’s team.
- 5) Commitment – promises made by members of a person’s team to help achieve a set of goals, related courses of action, and resources supplied by members to the same.
- 6) Contribution – provision of time, funds, or other resources committed by the person and members of his or her team necessary to support ongoing teaming and to implement the course of action agreed to by the person and his or her team members.

These six elements of teaming may be performed by using a variety of media (with the person’s knowledge and consent) e.g., texting members to update them on an emergent event; using email communications to ask or answer questions; sharing assessments, plans, and reports; conducting conference calls via telephone; using skype conferences; and, conducting face-to-face meetings with the person present when key decisions are made. Only the last element, conducting face-to-face meetings with the person present when key decisions are made, is a billable event.

C. Definitions

Interdisciplinary Teaming - a dynamic activity, not a static group or structure. Interdisciplinary teaming involves coordinating and collaborating without a prescribed or rigid team structure. A team is composed of professionals who are specialists in different areas and who work together with an individual to coordinate the care of an individual whose medical and/or behavioral health conditions have complexities that require more than one focus of care from different or related disciplines.

Lead Agency - a MAD enrolled agency that has current responsibility for the individual. The Lead Agency has a designated and qualified Team Lead who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made.

Participating Agency - a MAD enrolled agency that has the expertise pertinent to the needs of the individual. This agency may already be providing service to this individual or may be new to the case.

Shared Decision Making - a key component of person-centered health care. It is a process in which the individual and service providers work together to make decisions and select the right care for the individual that balances risks and expected outcomes with the individual’s preferences and values.

D. Procedures

Interdisciplinary teaming provides the central learning, decision-making, and service integrating elements that weave practice functions together into a coherent effort for helping an individual meet needs and achieve life goals.

E. Documentation

The Lead Agency, Participating Agencies and any other team members attending the interdisciplinary team meeting, must be identified in the treatment record. Capturing the signature (written or electronic) of those attending, along with the date and time of the meeting, fulfills this requirement.

Documentation must include progress toward the treatment goals including any barriers preventing goal achievement, periodic reassessment of the individual's needs and goals and the revision of the treatment plan. All issues impacting the individual's treatment plan, and/or the discharge planning should be recorded.

F. Exhibits/Appendices/Forms

Appendix M: *Tip Sheet for Practitioners in Integrated Care Settings: Practice Principles and Functions* for use in behavioral health center

Appendix N: "Interdisciplinary Teaming in Behavioral HealthCare"

Appendix O: Practice Standards for Family Teaming

G. Billing Instructions

There are two types and directions for billing which are only covered for outpatient services and must include the patient: 1) for serious emotional disturbance (SED), severe mental illness SMI, substance use disorder (SUD) and co-occurring conditions; and 2) all other BH diagnoses with other co-occurring diagnoses.

- 1) For recipients with SMI, SED, and SUD conditions and any other co-occurring diagnoses requiring multiple provider disciplines to be working together; conferences are billable when a critical juncture or change in status requires the treatment plan to be changed:
 - a. The lead agency
 - (i) may only be 1 of the 11 listed here: CMHC, FQHC, IHS, Tribal 638, CYFD, hospital OP, CSA, CTC, BHA, OTP, or a governmental agency;
 - (ii) bill **G0175, U1** for conference of 30-89 minutes (less than 30 minutes is not billable);
 - (iii) bill **G0175, U1, 2 units** for conference 90 minutes or more
 - b. The participating agency
 - (i) any agency or provider type
 - (ii) 1 practitioner attending for 30-89 minutes: **G0175, U2**
 - (iii) multiple practitioners from same agency attending for 30-89 minutes: **G0175, U3**
 - (iv) 1 practitioner for 90 minutes or more: **G0175, U2, 2 units**

- (v) multiple practitioners from same agency for 90 minutes or more:
G0175, U3, 2 units
 - c. Only 3 agencies may bill for a single session; if more than 3 attend the group decides, based on level of change for their discipline, which will bill.
- 2) For recipients with any BH diagnosis requiring multiple provider disciplines to be working together.
- a. The lead agency
 - (i) any provider type;
 - (ii) for a 30-minute conference, bill **S0220, U1**
 - (iii) for a conference of 60 minutes or more, bill **S0221, U1**
 - b. The participating agency
 - (i) any provider type;
 - (ii) for a 30-minute conference, bill **S0220, U2**
 - (iii) for a 60 minute or greater conference bill **S0221, U2**
 - c. Only two agencies or providers may bill for the same session.

2.2 Treat First Clinical Model

A. Purpose

To clarify and define Treat First Clinical Model for specialized behavioral health services as used throughout 8.321.2 NMAC and specifically in 8.321.2.14 and 8.321.2.18 NMAC.

This section will describe the Treat First Clinical Model, participation in the Treat First Learning community, data collection requirements and training expectations.

B. Policy

Currently, no-show rates at many sites are between 40-60% and are usually because the client's need (i.e., their reason for requesting services) was not addressed at the first visit. The Treat First Approach corrects the problem of delay by emphasizing the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a quick response for any urgent matters when a new person presents with a problem and requests help from the agency.

This policy provides an overview of a Treat First Approach and describes service elements and activities associated with the first four visits or sessions provided to a person requesting services. It is intended to provide guidance for practitioners who are implementing the practice concepts and steps.

Use of a Treat First Approach overcomes historic difficulties encountered by a person requesting services and having to wait until many required data collection tasks are completed before getting help. Delays discourage some persons from returning for a second visit. Ensuring a timely and effective response to a person's request for services is a first priority in the Treat First Approach. This strategy provides a way to achieve immediate formation of a therapeutic relationship and initiation of a response to the person's concern while gathering needed historical, assessment and treatment planning information over the course of a small number of sessions or visits.

C. Definitions

Clinical Practice Functions - Typical practice functions include: connecting with a person based on a recognition of the person's identity and situation; detecting and responding to any urgent problems; building positive rapport and a trust-based working relationship; engaging the person in a positive life-change process; understanding the person's strengths, needs, and preferences; defining wellness and recovery goals to be achieved; building common purpose and unifying efforts through teamwork (when longer-term services are indicated); planning intervention strategies, supports, and services; implementing plans; and tracking and adjusting strategies until desired outcomes are achieved.

Self Check-In Instrument - A four question Self Check-In is conducted with the person to assess how well he/she is doing at the beginning of the session and to determine what has changed since the last session. This is repeated for each of the first 4 visits. Participating agencies shall enter the data from the instruments into the Treat First web-based data collection program on a timely basis.

Session Check-Out Instrument - A four question Session Check-Out is conducted with the person at the end of each of the first 4 visits. Rating scale results are used by the practitioner to evaluate the person's perspective on how useful and beneficial the session has been in making progress. This is repeated for each of the first 4 visits. Participating agencies shall enter the data from the instruments into the Treat First web-based data collection program on a timely basis.

Certificate of Acknowledgement - A certificate issued by the Behavioral Health Services Division (BHSD) to agencies who have: completed the Treat First Participation Agreement; regularly participated in the Treat First Learning Community, entered required data into the Treat First web-based data system on a timely basis; and, attested to having their relevant clinical and administrative staff complete internal training on the Treat First Clinical Model.

D. Procedures

The Clinical Model

A segment of the population of persons requesting behavioral health services may be served successfully using a short intervention approach. For others who may require longer, more extensive or specialized interventions, the early steps in the Treat First Approach would enable the service provider to gather sufficient assessment information in order to develop a clinical case formulation and comprehensive service plan by the fourth visit. **In any case, a provisional diagnosis must be obtained in each of the visits.** The concepts, principles, and processes used in the Treat First Approach provide a responsive way of initiating a service process for a person requesting help. Brief intervention techniques such as a Treat First Approach are part of a full continuum of behavioral health care services provided in community-based services. Highlights of activities in the four visits can be accessed in Appendix P.

Tip sheets are provided in Appendix Q for the practice functions used in the first four interactions of a Treat First Approach.

Use of Comprehensive Community Support Services (CCSS) within the Treat First Clinical Model

When identifying a need for Comprehensive Community Support Services (CCSS), if the provider agency is utilizing the “Treat First” clinical model, the member may be placed in this service for up to four encounters without having had a psychiatric diagnostic evaluation completed. The utilization of a provisional diagnosis is used for billing purposes. After four encounters, an individual must have a comprehensive needs assessment, a diagnostic evaluation, and a CCSS treatment plan.

E. Documentation

The use of the Treat First Clinical Model may be billed with a provisional diagnosis for up to four encounters. After four encounters, if continuing treatment is required, a diagnostic evaluation must be performed, and subsequent reimbursement is based on the diagnosis and resulting service and treatment plan.

One exception to the four encounter limit is for individuals at an ASAM 0.5 clinical level requiring only group participation. In these cases, a provisional diagnosis may be utilized until other clinical treatment is requested. This level of care often builds awareness of other needs.

F. Exhibits/Appendices/Forms

Appendix P: Highlights of the 1st Four Encounters in the Treat First Clinical Model

Appendix Q: Treat First Approach Protocol

Appendix R: Adult and Child Self Check-In and Session Check-Out Instruments

Appendix S: Treat First Talks: How to become a Treat First Agency www.treatfirst.org

G. Billing Instructions

- 1) OP therapy and all special services can be initiated and billed before a diagnostic evaluation has been completed. This may not be completed until the 4th therapy session.
- 2) All claims will contain a provisional diagnosis. This shall include all appropriate ICD 10 classified external causes of morbidity (V, X, and Y diagnosis codes), factors influencing health status (Z diagnosis codes), and signs/symptoms and abnormal lab values (R diagnosis codes).
- 3) All claims will bill with the appropriate CPT or HCPCS code until the final diagnosis has been established.
- 4) CCSS can be billed upon an initial intake, if needed, and before a SMI/SED diagnosis has been determined. A provisional diagnosis, which may not be a SMI or SED, will be utilized for billing purposes.
- 5) If a crisis intervention is required, H2011 will be billed and considered outside of the 4 visits.
- 6) A FQHC, IHS or Tribal 638 facility may bill more than one encounter or OMB rate on the same day for completely different services such as a behavioral health visit.

2.3 The Comprehensive Assessment

A. Definition

The Comprehensive Assessment is used for recipients with SMI, SED and moderate to severe SUD as defined by New Mexico to determine a member's needs related to physical and behavioral health, long-term care, social and community support resources and natural and family supports. The collection of information and data is used to guide and shape the initial service plan and can be used to highlight elements that need to be addressed in a service plan. The Comprehensive Assessment should be completed not only with the individual in service, but it may also require collection of collateral information from other supports, natural or paid.

It is not a diagnostic evaluation (90791-92) to determine eligibility; it is a screening and assessment tool to establish service needs. If no diagnosis from previous records is available, a diagnostic evaluation must also be completed.

B. Policy

1) The Comprehensive Assessment

- Assesses preliminary risk conditions and health needs;
- Must document that a provider contacted and/or met with an individual to at least begin the assessment within the mandated timeframe for a specific service;
- Must be conducted face-to-face or through telemedicine;
- May enroll an individual during the first visit if using the Treat First model. The Comprehensive Assessment can be completed over the course of four appointments; when completed, the level of care or intensity of intervention must be defined.

Note:

- For children involved with the NM Children Youth and Families Department in Protective Services and/or Juvenile Justice, a Child and Adolescent Needs and Strengths assessment may also be indicated; however, the Comprehensive Assessment is still required.
- For ages 0 to three, it is recommended the four encounters be conducted in multiple sites; i.e. office, home, day care, etc. to obtain a complete picture of interactions with the child and significant others.

2) The Initial Service Plan

Is developed with the individual to create a map toward self-management of physical and behavioral health conditions and is specifically designed to assist an individual in identifying needs, how to meet them, and how to achieve goals. The Service Plan is a document intended to be updated frequently to reflect identified needs and to communicate services an individual will receive. It serves as a shared plan for the individual, their family or representatives, and service providers. The plan is intended to be supplemented by treatment plans, discharge plans, safety plans and/or crisis plans developed by practitioners when appropriate and indicated by service type.

The Service Plan

- Requires active participation from the individual, identified family, caregivers, and team members;
- Requires consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, and other participants involved in the individual's care;
- Identifies additional health recommended screenings;
- Addresses long-term and physical, behavioral, and social health needs;
- Is organized around an individual's goals, preferences and optimal clinical outcomes, including self-management. The plan includes as many short-term and long-term goals as needed;
- Specifies treatment and wellness supports that bridge behavioral health and primary care;
- Includes individualized *crisis/emergency plan* listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency;
- Includes individualized discharge plan, that is inclusive of specific referrals for lower level of treatment if necessary, and resource information for maintenance and progressive recovery;
- Is shared with members and their providers; and
- Is updated with status and plan changes.

3) Service Plan Update

The Service Plan Update always includes the individual, significant members of that individual's team and is person or family centered and driven by the needs of the individual. The service plan is updated based upon need. The Service Plan Update is to be completed under the following circumstances:

- Significant change in level of care, health status, or change in recovery;
- No significant change over a period of time in which change should have occurred;
- At the individual's or guardian's request.

4) Independently licensed BH practitioners may conduct the comprehensive assessment and initial service plan. LMHCs, LMSWs, LAMFTs, LPCs, psychology interns, post-doctoral students may conduct the comprehensive assessment and initial service plan under the supervision of an independently licensed BH practitioner. Registered nurses may contribute to the assessment and initial service plan to the extent of forming clinical impressions and according to scope of practice.

5) Agencies are encouraged to utilize the State developed comprehensive assessment and service plan Appendix U for the adult version, and Appendix V for the child version.

6) Comprehensive bio-psychosocial assessment for non-SMI, non-SED, and mild SUD recipients can be conducted by the agency types listed below and practitioners listed above in #4.

C. Exhibits/Appendices/Forms

Appendix U: Comprehensive Assessment & Service Plan - Adult Form

Appendix V: Comprehensive Assessment & Service Plan - Child/Adolescent Form

D. Billing Instructions

- 1) Only the following agency types are reimbursed for these services:
 - a. a community mental health center (CMHC)
 - b. a federally qualified health clinic (FQHC)
 - c. an Indian health services (IHS) hospital, clinic or FQHC
 - d. a PL 93-638 tribally operated hospital, clinic or FQHC
 - e. children, youth and families department (CYFD)
 - f. a hospital and its outpatient facility
 - g. a core service agency (CSA)
 - h. a crisis triage center licensed by the department of health (DOH)
 - i. a behavioral health agency (BHA)
 - j. an opioid treatment program in a methadone clinic
 - k. a political subdivision of the state of New Mexico^{3.1}

- 2) For recipients with SMI, SED, or moderate to severe SUD use **HCPCS H2000**. This code involves the collection of data from multiple sources: the recipient; providers already interacting with the recipient; other community supports; and natural supports. If taking multiple encounters to develop the assessment and service plan, bill only the last encounter when it is completed. Always place the lead author in the rendering field if more than one provider had input.

- 3) For all other recipients use **HCPCS H0031** (no modifier)

- 4) Both codes include the development of the initial service plan with the assessment

- 5) Practitioners: 317, 431, 435, 436, 444, 445

- 6) FQHC: UB claim form; revenue code 0919 for encounter rate

- 7) IHS/638: UB claim form; revenue code 0919 for OMB rate

- 8) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

2.4 Crisis and Safety Planning

Crisis and safety are two different things, so there may be a need for an individual to have a crisis plan, a safety plan or both. Generally, individuals define what qualifies as a crisis for them, while entities (state or federal government, providers, schools, etc.) set standards and definitions of safety or what qualifies as “safe enough.”

A crisis is different than a safety situation. Crises may create a sense of disequilibrium or a sense of helplessness but may or may not require immediate action or reaction. A safety situation is a time when basic health is compromised, and risk is high, and it requires immediate action or reaction to keep an individual or family safe.

Crisis planning can help people feel better and provide suggestions on how to manage, while safety planning is intended to mitigate or reduce severe or imminent risk.

For many individuals seeking behavioral health services, crisis should be: expected and anticipated; defined by the person having it; an opportunity to practice strength-based and creative interventions; and a gateway to develop a range of self-care and/or support activities.

A. Safety Plan

A Safety Plan is an *in-community, in-the-moment* tool used by an individual to reduce or manage worsening symptoms, promote wanted behaviors, prevent or reduce the risk of harm or diffuse dangerous situations. The specifics of the Safety Plan must be meaningful to, and actionable by, the individual.

For many individuals, such as those experiencing a first or infrequent crisis episode or who are addressing behaviors in the home that are unlikely to rise to the level of emergency services, this will often be the one and only crisis planning tool that is used.

B. Crisis Plan

A Crisis Plan provides a method for individuals to communicate in advance and in writing to providers of crisis support or intervention. It paves the way for future episodes of crisis support or intervention to more closely meet the needs of the individual. In general, a Crisis Plan is useful when an individual has experienced crisis episodes in the past and expects that there will be more, or when communication is difficult during a crisis. The Crisis Plan is generally best completed when an individual feels able to sort out and summarize preferences and previous experiences, most likely during a low crisis period. A Crisis Plan gives an individual a chance to think about likely crisis scenarios, how they would like that future intervention to unfold, and what they would like those who provide future crisis support or intervention to know.

C. Billing Instructions

There is no separate reimbursement for the crisis and safety plans; they are included in the reimbursement for the assessment and initial service plan.

2.5 Treatment Plan

Treatment plans are specific to a service and any specific instruction is contained with that service's section.

A. Billing Instructions

Treatment plan development and updates are considered part of the service being performed and are not billable as individual services.

2.6 Psychiatric Evaluations, Counseling, Therapy, Peer Support, Activity Therapy, and Medication Management

A. Billing Instructions

- 1) Always enter the rendering provider when billing if required as indicated on the Behavioral Health Fee Schedule.
- 2) Pricing for Psychiatric Clinical Nurse Practitioners and Psychiatric Clinical Specialists:

When the above clinicians are in private practice or group private practice, their reimbursement is calculated at 90% of the reimbursement, if providing services within an agency.

- 3) For all services listed below:
 - a) If service is delivered after regular business hours or 10 pm, whichever is earlier, or for days for which the provider would otherwise be closed, add modifier UH;
 - b) If service is delivered on weekends or holidays, add modifier TV; for any holiday for which the provider would be closed, add modifier TV.
- 4) Psychiatric diagnostic evaluation: Use CPT code **90791**
- 5) Psychiatric evaluation w medical service: Use CPT code **90792**
- 6) Individual therapy & counseling: Use CPT codes **90832 - 90838, and +90863**
 - a) Code depends on time spent with patient
- 7) Psychotherapy for crisis: Use CPT code **90839** for first 60 minutes & **90840** for add on 30-minute increments
 - a) Original code: 1 unit; add on code 4 units
- 8) Family therapy: Use CPT codes **90846 - 90847**
 - a) Unit = 1 hour
 - b) For functional family therapy EBP use modifier HK on CPT code **90847**
- 9) Group therapy: Use CPT codes **90849 and 90853**
 - a) Bill for each member in group
- 10) Prolonged service billing:
 - a) **99354 – 99355** are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the office or other outpatient setting, even if the time spent on that date is not continuous. These codes are reported separately from the original Evaluation and Management (E/M) or psychotherapy session. Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.

- b) **99356 – 99357** are used to report the total duration of time spent by a physician or other qualified health care professional in an inpatient or nursing facility on delivering face-to-face service at the bedside and time spent on the patient's floor or unit on a given date providing prolonged service, even if the time spent on that date is not continuous.
- c) **99354 or 99356** are used to report the first hour of prolonged service on a given date, depending on the place of service. They are to be listed separately from the original E/M or treatment code. **99355 or 99357** are used to report each additional 30 minutes. Either code may also be used to report the final 15-30 minutes on a given date. Prolonged service of less than 15 minutes beyond the first hour or beyond the final 30 minutes is not reported separately.
- d) Any prolonged service of less than 30 minutes total on the same day beyond the original session is not reported; it is considered included in the original session.

The following table illustrates the correct reporting of prolonged professional service in the office setting beyond the usual service time.

Total Duration of Prolonged services	Code(s)
Less than 30 minutes	Not reported separately
30 – 74 minutes (30 min to 1 hr & 14 min)	99354 Unit of 1
75 - 104 minutes (1 hr 15 min to 1 hr 44 min)	99354 Unit of 1 and 99355 Unit of 1
105 minutes or more (1 hr 45 min or more)	99354 Unit of 1 and 99355 Unit of 2 or more for each additional 30 minutes

These codes can be reported by all licensed clinicians delivering psychotherapy within their scope of practice. The pricing will be incorporated in the next version of the Behavioral Health fee schedule.

- 11) Peer Support Services – individual or group: use HCPCS **H0038**
 - a) Unit is for 15 minutes with a maximum of 12 units
 - b) Use modifier HQ for group setting
 - c) Providers: 430, specialties 114 certified peer specialist; 115 certified family peer specialist; 117 correctional peer support specialist
- 12) Activity therapy – use HCPCS **G0176**
 - a) Provider type: billable by the 13 agency types only
 - b) Rendering provider by those qualified by scope of practice or agency policy

- c) Per session; 1 unit
 - d) Use modifier HQ for groups
- 13) Inpatient and ED consultation – telehealth: must identify both rendering & referring on claim
- a) 15 minutes - **G0406**
 - b) 25 min - **G0407**
 - c) 35 min - **G0408**
- 14) Comprehensive med service - **H2010**
- a) 15 min unit
 - b) Includes medication assessment, administration, monitoring and recipient education

2.7 Behavioral Health Pharmacology

A. Prior Authorization and Co-payments

- 1) Use of brand name drugs
A MCO can require a recipient to use a generic version of a drug prescribed as a brand name unless the prescriber specifically states on the prescription “brand medically necessary”. When the “brand medically necessary” is written by hand on the prescription (not a rubber stamp), a pharmacy bills using a “dispense as written” indicator on the National Council for Prescription Drug Programs (NCPDP) transaction. In this case, the MCO must pay for the brand name version; this is a federal requirement.
- 2) Effective March 1, 2019, or as approved by CMS:
There are co-payments for non-preferred prescription drugs for individuals in Centennial Care. The co-payment for non-preferred prescription drugs is \$8.00 per prescription. Legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions are exempt from the co-payment requirement. Minor tranquilizers, sedatives, hypnotics, and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision and are included in the co-payment requirement. See NMAC 8.308.14 for details regarding the applicability and limitation of co-payment.
- 3) There can be no prior authorization for buprenorphine in any formulation when used to treat opioid use disorders. Any formulation of buprenorphine used for the treatment of opioid use disorders is exempt from the generic-first coverage provisions 8.324.4.12 NMAC. Prescribers should specifically state on the prescription in writing “brand medically necessary”. The pharmacy then bills using the “dispense as written” indicator on the NCPDP. Best clinical practices when prescribing buprenorphine for the treatment of opioid use disorders (e.g. systematic checking of the prescription monitoring programs and periodic urine drug screening) should be addressed through a provider alert rather than a prior authorization process.
- 4) There can be no prior authorization for extended release naltrexone IM.

B. Availability of Medically Necessary Drug Items

A MCO Preferred Drug List (PDL) cannot be used to remove recipient access to drug item absolutely. There must be a process that allows every drug to be available to a recipient if it is medically necessary. This pertains to all drug items, not just to behavioral health drugs. The MCO may review the medical justification to determine if the use is medically necessary. However, a MCO can construct their PDL as follows:

- 1) A preferred drug list with items that do not require prior authorization may also note items that do require prior authorization. The items that require prior authorization, including those that require step therapy, are often referred to as the “second tier” of a PDL.

- 2) All atypical antipsychotic drug items must be on the first or second tier of the PDL. Atypical antipsychotics must be available to the same extent as a non-atypical drug item. The requirement for accessing an atypical antipsychotic drug cannot require step therapy when the medical justification for use of the atypical antipsychotic meets medical necessity requirements. Step therapy can only be used when trying a non-atypical drug is medically appropriate.
- 3) Even items that are not on the first tier or second tier of a PDL must still be covered when a case for medical necessity is made. This is a federal requirement; unlike some commercial plans, the PDL cannot be used to deny access to a drug item that is medically necessary.

C. Oversight and Monitoring of Controlled Substance Prescribing and Use

Centennial Care MCOs shall monitor the use of controlled substances retrospectively in order to detect potential abuse or overuse and to assure the appropriate use of the drugs as the MCO would for all drug items with diversion potential. In addition, the Centennial Care MCOs shall together convene a task force to develop a standard monitoring program for controlled substance utilization. The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for an ongoing MCO controlled substance oversight group that reports regularly to HSD and the Behavioral Health Collaborative, as requested. The MCOs shall notify the appropriate providers in their networks regarding this initiative and shall inform providers that utilization and prescribing patterns will be monitored.

D. Opioids

Opioid addiction is a brain disease. It develops from fundamental, long-term changes to the structure and functioning of the brain. Scientists classify addiction as a chronic disease because areas of the brain are altered from the normal healthy state in long-lasting ways. These are physical changes to the brain that can strongly influence behavior; it's a chronic disease as is diabetes and high blood pressure and is treatable.

In response to the opioid crisis in New Mexico, the New Mexico Human Services Department (HSD) is addressing opioid overutilization in order to prevent overdose deaths and diversion of opioids by implementing opioid edits and limits according to some of the strategies recommended in the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain - 2016.

2.8 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Effective 1/01/2019 subject to CC2.0 Waiver and State Plan Amendment approval.

A. Purpose

To better address behavioral health concerns, often otherwise not assessed through medical services, SBIRT affords the ability to treat patients in a more holistic manner aimed at increased patient awareness and minimizing behavioral health stigma and associated risks for the purpose of maximizing improved whole person health outcomes.

Medical facilities will be certified in accordance with an agreement, MOU or other instrument outlining requirements and responsibilities of the entity with respect to delivery of SBIRT services.

B. Screening

A comprehensive universal screen will be administered using the NM Healthy Lifestyle Questionnaire (HLQ) screen or another validated screening tool which has been psychometrically tested for reliability, validity, and sensitivity.

The State developed HLQ to assess for mild, moderate and risky alcohol/and other substance use/misuse, with the intended outcome of aiding toward reducing substance use and misuse. The HLQ also identifies co-occurring disorders as well as mental health disorders including anxiety, depression and trauma. The HLQ includes 3 questions from the AUDIT-10 as the alcohol screen, 2 questions from the DAST-10 as the drug screen, 2 questions from the PHQ-9 as the depression screen, 2 questions from the GAD-7 as the anxiety screen and 3 questions from the PCL-C as the trauma screen. Results from the HLQ or other selected screening instrument will be scored to determine the following next step which can include:

- 1) SBIRT positive score indicates need for one of the following treatment categories:
 - a. Brief Intervention (BI);
 - b. Brief Treatment (BT); or
 - c. Referral to Treatment (RT).
- 2) SBIRT negative prescreen
 - a. Screening only

Practitioners review screen scores to determine patients' risk categories and service eligibility by score. Screen scoring is included in the more in-depth certification training manual.

- 1) If, during the course of conducting a BI, the patient discloses more or different information than the initial screen indicated, a second screen inclusive of more accurate updated information should be completed.
- 2) BH providers may choose to also include additional instruments. For SBIRT purposes, the following are the most commonly used:
 - AUDIT-10: Alcohol Screen
 - DAST-10: Drug Abuse Screening Test
 - PHQ-9: Patient Health Questionnaire
 - GAD-7: Generalized Anxiety Disorder Screen

- PCL-C: Post-Traumatic Stress Disorder Checklist

C. Procedures

Screens should be given to established patients a minimum of every three months. On a case-by-case basis, more frequent screens may be necessary, particularly when there is an indication of changes in circumstances which may suggest increased mental health distress or increasing substance use.

Screens are to be given to patients at clinic or hospital check-in or in examination rooms. Assistance in completing the form may be offered by SBIRT trained practitioners. Once completed, the instrument is scored by the SBIRT practitioner and determined as a positive or negative score. Negative scores need no action but may include education. Positive scoring results in the SBIRT practitioner conducting a face-to-face score review and brief intervention (BI) with the patient. The SBIRT practitioner may also provide referrals to treatment when indicated. Practitioners may also only review scores and then provide a warm hand-off to another SBIRT trained practitioner.

Warm hand-offs may involve the initial read on the HLQ scoring followed up with the patient's consent for a face-to-face introduction to another SBIRT practitioner. This practitioner will then conduct a more thorough scoring review, conduct the BI, and, when appropriate, and with permission from the patient, assist with referrals to treatment. A warm hand-off may also be given to a Behavioral Health Counselor, either an in-house counselor, or to an outside Behavioral Health professional, in accordance with HIPAA.

D. Staff Training and/or Certification Requirements for Approved Practitioners

- 1) General requirements:
 - Attest to all agency/clinic mandatory trainings and clearances;
 - Evidence of current professional licensure;
 - Peer Support Workers - evidence of current CPSW or family support worker (CFPSW) certification or enrollment in classes to receive certification; and
 - Evidence of annual HIPAA training.
- 2) Specific training (all required):
 - Harm Reduction 101;
 - SBIRT 101 including reviews of Audit 10; GAD-7; PCL-C; PHQ-9 and DAST-10 and warm hand-off process;
 - Current 42 CFR part 2; and
 - Naloxone/Overdose prevention.
- 3) Suggested Trainings:
 - Seeking Safety
 - IMPACT
 - Motivational Interviewing by a MINT trainer
 - QPR (Suicide Prevention)
 - Community Reinforcement Approach (CRA)

E. Documentation

All services including Screens/Scores, Brief Interventions, Brief Treatment, Referrals to Treatment (inpatient or intensive outpatient) must be documented in accordance to clinic policy. Service eligibility must be documented in accordance with agency and State billing policies.

In addition to the standard client record documentation requirements for all services, the following is required for CPSW: case notes identifying client treatment category based on the screen; description of the services provided; all activities and location of services; duration of service span (e.g., 1:00-2:00 pm), behavior change plan; and referrals, including referral agency information, when appropriate.

F. Exhibits/Appendices/Forms

Appendix Y: Healthy Lifestyle Questionnaire

Appendix YY: Healthy Lifestyle Questionnaire (Spanish)

Cuestionario Respecto a la Salud y la Vida

Appendix Z: DAST - 10: Drug Abuse Screening Test

Appendix ZA: AUDIT - 10: Alcohol Screen

Appendix ZB: PHQ-9: Patient Health Questionnaire

Appendix ZC: PCL-C: Post Traumatic Stress Disorder Checklist

Appendix ZD: GAD-7: Generalized Anxiety Disorder Screen

G. Billing Instructions

- 1) Screening - H0049
- 2) Brief Intervention - H0050
- 3) Practitioners: Must all be trained in SBIRT
301, 302, 305, 306, 313, 317, 411, 430, 431, 435, 436, 438, 440, 443, 444, 445
- 4) FQHC: UB claim form; revenue code 0919 for encounter rate
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate

2.9 Other Screens

A. Definition

Validated screening tools which have been psychometrically tested for reliability, validity, and sensitivity are covered services.

B. Billing Instructions

G0444 – Behavioral health screening; no diagnosis needed

G0443 – Brief intervention; use a provisional diagnosis

Section Three: Special Outpatient Services for Adults & Children

3.1 Applied Behavior Analysis (ABA)

A. Policy

The Medical Assistance Division (MAD) pays for medically necessary, empirically supported, Applied Behavior Analysis (ABA) services for eligible recipients 12 months up to 21 years of age who have a documented medical diagnosis of Autism Spectrum Disorder (ASD). ABA services are provided to a recipient as part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment which stipulates that ABA services be provided in coordination with other medically necessary services (e.g., family infant toddler program services (FIT), occupational therapy, speech language therapy, medication management). The information provided to the recipient's parent or caregiver must be culturally responsive and understandable.

Following a referral to an Autism Evaluation Practitioner (AEP) Stage 1 services begin. The AEP confirms the presence of or risk for ASD through a comprehensive, multi-modal evaluation which results in the development of an Integrated Service Plan (ISP). At Stage 2, the Autism Provider (AP) agency's Behavior Analyst (BA) develops a Treatment Plan based on the results of the Behavior or Functional Analytic Assessment, interviews with family and others, and ISP recommendations. ABA Stage 3 services include implementation of the ABA Treatment Plan, family services (e.g., guidance and social skills groups), ABA Stage 3 Case Supervision, and Clinical Management.

Quality ABA services are complex and require highly trained practitioners to evaluate, assess and deliver services. MAD requires ABA Stage 2 Behavior Analysts (BAs) to be certified by the Behavior Analyst Certification Board (BACB®) or be a BACB recognized qualifying psychologist. It is of value (although not required) for a MCO or MAD's Third-Party Assessor (TPA) to employ or contract with a BCBA®, BCBA-D®, or a BACB Qualifying Psychologist (Qualifying Psychologist) to review requests for ABA Stage 3 prior authorized services.

B. Related Policies

ABA services may be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, etc.). ABA services are part of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program; see 8.320.2 and 8.320.6 NMAC. [CFR 42 section 441.57].

Review 8.302.2 NMAC for general billing instructions; specifically, how to bill for less than full units of service.

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_302_2\(3\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_302_2(3).pdf)

ABA Services Delivered Via Telemedicine

See Subsection M of 8.310.2.12 NMAC and 8.308.9 NMAC for detailed description of telemedicine covered and non-covered services and the manner in which the covered services must be rendered.

The BICC, BACB, and New Mexico Regulation and Licensing Department (RLD) psychologist's practice board allows and supports the use of telehealth to deliver ABA Stage 2 and 3 services. MAD allows and encourages the utilization of telemedicine to deliver MAD ABA Stage 2 and 3 services to assist AEPs and AP agencies provide cost effective and home and community-based services to rural and frontier areas of New Mexico.

Telemedicine is not a service as such, it is the way a MAD approved service is delivered. The use of telemedicine delivered MAD ABA Stage 2 and 3 services is appropriate at the same locations as other face-to-face services.

There is no New Mexico telemedicine license for an in-state AEP, MAD ABA Qualifying Psychologist, BCBA-D, BCBA, BCaBA, RBT or BCAT, or a non-certified BT to render ABA Stage 1 and 3 services delivered through telemedicine. If the AEP is located out of state, the New Mexico Medical Board does require a MD or DO to obtain a telemedicine license.

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_9\(1\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_9(1).pdf)

<http://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx>

C. Definitions

Applied Behavior Analysis (ABA) - the use of techniques and principles used to bring meaningful and positive changes in behaviors. Applied behavior analysis (ABA) is the science in which the principles of the analysis of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change.

Autism Provider (AP) - an agency approved by MAD to provide Stage 2 and 3 ABA services. The AP agency contracts or employs Behavior Analysts (BA) to conduct the Behavior or Functional Analytic Assessment. Utilizing the assessment and the recipient's ISP recommendations, the BA develops an individualized ABA Treatment Plan.

At-Risk for developing ASD - a recipient ages 12 months to 36 months who presents with multiple risk factors as evidenced by developmental delays and/or deficits, characteristics often seen in children with ASD, and genetic status, but who may not meet the full diagnostic criteria for a diagnosis of ASD.

Autism Evaluation Practitioner (AEP) - a practitioner who meets the requirements to conduct the Medical Assistance Division (MAD) approved ABA Stage 1 Comprehensive Diagnostic Evaluation (CDE), Targeted Evaluation, or Targeted Risk Evaluation. The AEP completes Evaluation Reports and develops the Integrated Service Plan (ISP).

Autism Spectrum Disorder (ASD) - a neurodevelopmental disorder as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Behavior Analyst (BA) - a practitioner who is certified by the Behavior Analyst Certification Board (BACB) to be a Board-Certified Behavior Analyst (BCBA) or a Board-Certified Behavior Analyst-D (BCBA-D), or a practitioner who the BACB recognizes as a Qualifying Psychologist who are collectively referred to as BAs. The BA must be approved to supervise BACB Board Certified Assistant Analyst (BCaBA or BAA) or a BACB Registered Behavior Technician (RBT or BT) or a Behavioral Intervention Certification Council (BICC) Board Certified Autism Technician (BCAT). A BCBA who has completed the course work and the practicum hours but lacks certification while waiting for the next offered exam or exam results, may perform the duties of a certified BCBS other than supervising, providing the BCBA's work is supervised.

Behavior or Functional Analytic Assessment - addresses needs associated with both skill acquisition and meaningful and positive changes in behaviors. The Behavior or Functional Analytic Assessment results in the individualized development of an ABA Treatment Plan (as appropriate for the ABA service model).

Board Certified Assistant Behavior Analyst (BCaBA®) (BAA) - a practitioner who is certified by the BACB and approved by his or her BA and the BACB to supervise BTs.

Behavior Analyst Certification Board (BACB®) - a national certification board for BAs, BCaBAs, and Registered Behavior Technicians (RBTs).

Board Certified Autism Technician® (BCAT®) - a practitioner who is certified by the Behavioral Intervention Certification Council. The BCAT is included in the term BT. A BCAT is supervised by a BA, and if approved, a BAA.

Board Certified Registered Behavior Technician (RBT) - a practitioner who is certified by the BACB. The RBT renders ABA Stage 2 and 3 services under the supervision of a BA or, if approved, a Supervising BAA. A RBT is included in the term BT.

Behavioral Intervention Certification Council® (BICC®) - a national certification council for BCAT practitioners.

Behavior Technician (BT) - a RBT, BCAT, or a non-certified behavior technician (time limited) practitioner who assists a BA in rendering ABA Stage 2 services and renders, under supervision, ABA Stage 3 services.

Comprehensive ABA - refers to one of the two approaches to the treatment of a recipient where there are multiple targets across most or all developmental domains that are affected by the recipient's ASD. For a recipient who meets the At-Risk Criteria, Comprehensive ABA services are available from age 12 months up to 3 years of age. For a recipient who has an AEP rendered diagnosis of ASD, Comprehensive ABA services are available from age 12 months up to compulsory school age.

Comprehensive Diagnostic Evaluation (CDE) - is a multi-informant and multi-modal evaluation process that allows for the careful evaluation of the presence of symptoms consistent with a diagnosis of ASD, and if a diagnosis is rendered, allows for the careful consideration of medically necessary services, including ABA. A CDE includes a thorough review of the recipient's behavior and development and includes interviewing the parents and caregivers. It may also include a hearing and vision screening, genetic testing, neurological testing, and other medical testing. This is a part of ABA Stage 1 services.

Focused ABA - refers to one of the two approaches to the treatment of a recipient for a limited number of behavioral targets. It is available to recipients 12 months up to the age of 21 with an AEP rendered diagnosis of ASD.

Integrated Service Plan (ISP) - a detailed document which pulls together the results of the CDE into a plan which prioritizes all medically necessary services. Results of the CDE, Targeted Evaluation, or the Targeted Risk Evaluation are used to develop an ISP. An ISP is required under ABA Stage 1 services either as a separate document or as an embedded part of the Targeted Risk Report. An AEP may conduct a follow-up ISP without conducting a CDE or Targeted Evaluation when medically necessary. When a recipient who had a Targeted Risk Evaluation presentation markedly changes, the AEP will conduct a CDE and issue an initial ISP.

Level of Care (LOC) - the intensity of medical care provided.

Specialty Care Practitioner (SCP) - a practitioner who renders specialized ABA Stage 2 and 3 services to recipients who meet the criteria for Specialty Care services.

Targeted Risk Evaluation - is conducted for a recipient aged 12 months to 3 years who meets the At-Risk Criteria for developing ASD. The Targeted Risk Evaluation results in an ISP embedded in the Risk Evaluation Report. An AEP cannot conduct a Targeted Evaluation when the recipient only has a Targeted Risk Evaluation. If there is marked change in the recipient's presentation, the AEP conducts a CDE.

Third Party Administrator - the MAD contractor who approves ABA Stage 3 services for a recipient utilizing his or her Fee-for-Service benefit plan.

D. Identified Population

ABA services are provided to recipients 12 months up to 21 years of age. A recipient's eligibility for ABA Stage 1 services requires a screening of the recipient and the results of the screening determines access to ABA Stage 1 services. A recipient's eligibility for ABA Stage 2 and 3 services falls into one of two categories: *At Risk for ASD* or *Diagnosed with ASD*. A recipient residing in an out-of-home placement may receive ABA Stage 1, 2, and 3 services. An eligible recipient must meet the level of care (LOC) ABA Admission and ABA Continuation of Services Criteria detailed below.

ABA Criteria for Admission, Continuation of Services, Discharge, and Exclusion: MAD has developed separate criteria for a recipient to enter into ABA services, continue ABA services, and be discharged from ABA services, or meet the criteria to be excluded from ABA services.

- 1) Admission Criteria: Services are determined to be medically necessary when:
 - a. The eligible recipient cannot adequately participate in home, school, or community activities because the presence of behavioral excesses and/or the absence of functional skills interfere with meaningful participation in these activities; and/or
 - b. The eligible recipient presents a safety risk to self or others. (The presence of safety risk to self or others does not need to meet the threshold criteria for out-of-home placement.)
 - c. There is a reasonable expectation that ABA services will result in measurable improvement in the acquisition of functional, adaptive skills, and/or the reduction of non-functional, maladaptive behavior.
 - (i) The eligible recipient follows the prescribed three-stage comprehensive approach to evaluation, assessment, and treatment.
 - (ii) The eligible recipient meets one of the following two categories:
 - *At-risk for ASD:* An eligible recipient may be considered “At-Risk for ASD,” and therefore eligible for time-limited, Comprehensive ABA Services if he or she does not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when he or she meets all of the following criteria:
 - Is between 12 and 36 months of age; and
 - Presents with developmental differences and/or delays as measured by standardized assessment; and
 - Demonstrates some characteristics of the disorder (i.e., impairment in social communication and early indicators for the development of restricted and repetitive behavior); and
 - Presents with at least one genetic risk factor (e.g., the eligible recipient has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD; the eligible recipient has a diagnosis of Fragile X syndrome).
 - *Diagnosed with ASD:* Eligible recipient 12 months up to 21 years of age who has an AEP rendered diagnosis of ASD.
- 2) Continued Eligibility Criteria (must meet a and b for continuation of ABA services)
 - a. The recipient continues to meet the ABA admission criteria.
 - b. The recipient responds positively to ABA services, as evidenced by quantitative data submitted by the BA when requesting an ABA Stage 3 Service Authorization for the initial and ongoing 6-month prior authorization for continuation of ABA service.
 - c. If the recipient is not responding positively to ABA Stage 3 services for reason(s), including but not limited to, inadequate family participation,

insufficient service intensity, or issues with the goals and/or associated interventions outlined in the ABA Treatment Plan, the BA may work with the Managed Care Organization Care Coordinator to address identified barriers.

- d. The BA must first make every attempt internally to identify and address the lack of response. However, if the coordinated efforts of the AP and MCO Care Coordinator do not result in positive behavior change, the BA may request the AEP:
 - (i) Complete a new CDE and ISP;
 - (ii) Complete a Targeted Evaluation and new ISP (when a CDE has been completed, but a full CDE is not required);
 - (iii) Complete a CDE and develop an ISP when only a Targeted Risk Evaluation has been completed;
 - (iv) Complete an updated ISP;
 - (v) Refer to a Specialty Care Practitioner for increased clinical support;
 - (vi) Provide alternative opportunities for a parent or caregiver that is not able to attend ABA Stage 3 sessions at the recommended level or
 - (vii) Discharge from ABA services to allow time for barriers to be resolved.

E. Discharge Criteria

- 1) Discharge criteria: the recipient must meet one of a-d, below. Individualized discharge criteria are developed with appropriate, realistic, and timely follow-up care and these criteria are included in the initial ABA Treatment Plan. An eligible recipient may be discharged from ABA services when:
 - a. The recipient has met his or her individualized discharge criteria; or
 - b. The recipient has reached the defining age limit as specified for *At-Risk for ASD* eligibility or for *Diagnosed with ASD* eligibility; or
 - c. The recipient can be appropriately treated at a less intensive level of care based on the most current ISP or Behavior or Functional Analytic Assessment findings; or
 - d. After exhausting item (d) under Continued Eligibility Criteria, the recipient continues to demonstrate success in goals and the ISP recommends prioritizing another service instead of continuing ABA services at this time.
- 2) Exclusionary criteria: A recipient may be excluded from ABA services when, at the time the recipient requests ABA services, he or she is 11 months or younger or has reached the maximum age of 21 years.

F. Screening and Referral

Prior to a referral for a CDE or Targeted Risk Evaluation, a recipient must first be screened by a practitioner whose scope of practice allows him or her to perform and score a Level 1 screen. The

screeners must be able to administer and score Level 1 ASD screen (e.g., Modified Checklist for Autism in Toddlers, Revised with Follow-Up; M-CHAT-R/F™ or Social Communication Questionnaire; SCQ).

If the screening results are positive, a MAD approved referring practitioner may then refer the eligible recipient to an AEP for ABA Stage 1 services.

If the eligible recipient completed a MAD CDE and an ISP within the past continuous 36-month period of time, and the CDE led to the eligible recipient being diagnosed with ASD, the eligible recipient may begin ABA Stage 2 services without further screening or evaluation. This may happen when a parent or caregiver determines the eligible recipient is not ready for such services and delays the start until he or she is older.

Suspected of having ASD: for recipients 12 months up to 21 years of age who are suspected of having ASD, referral to Stage 1 can be initiated following (a) screening, and if the results are positive, (b) referral to an AEP for Targeted Risk Evaluation, ISP development, and the determination of medical necessity for ABA.

- 1) An eligible recipient who does not have an AEP rendered diagnosis of ASD may be referred to an AEP for Targeted Risk Evaluation if:
 - a. A Level 1 ASD screener (e.g., Modified Checklist for Autism in Toddlers, Revised with Follow-Up; M-CHAT-R/F™ or Social Communication Questionnaire; SCQ) has been administered, and the screener yields a positive result; and
 - b. The referring party believes the screener results to be valid based on his/her direct observation or recipient's development. Although not required, the referring party is encouraged to use a Level 2 screener (e.g., the Screening Tool for Autism in Toddlers™; STAT™) or gather additional information through another clinical assessment mechanism whenever the Level 1 screener result is inconsistent with other clinical data.

- 2) A recipient may be screened and referred to an AEP by:
 - a. The primary care provider (PCP) or another licensed health care practitioner including, but not limited to, a speech-language pathologist, occupational therapist, or a MAD recognized behavioral health practitioner who is a LPCC, LISW/LCSW, psychologist, CNP or CNS, LMHC, or LMSW who also has qualifications to render a Level 2 screen; or
 - b. A Department of Health (DOH) Family Infant Toddler (FIT) Program Service Coordinator, if the recipient is concurrently being evaluated for FIT services or if he or she has been evaluated and is currently receiving FIT intervention services; or
 - c. A school-based health or educational professional involved in the recipient's special education eligibility determination process.

At-Risk for developing ASD: for recipients 12 months to 36 months of age who are at risk for developing ASD based on the criteria identified above, but for whom a Comprehensive Diagnostic Evaluation is not initially indicated, ABA Stage 1 is initiated following screening and referral for

a Targeted Risk Evaluation ISP development, and the determination of medical necessity for ABA services.

- 1) A recipient may be referred to an AEP if there is:
 - a. Concern on the part of the referring party that a recipient 12 month up to 36 months of age is at-risk for ASD by virtue of his or her genetic status, but does not necessarily screen positive on a Level 1 ASD screener such as the Modified Checklist for Autism in Toddlers, Revised with Follow-Up™; M-CHAT-R/F™; and
 - b. Concern that the recipient is demonstrating developmental delay(s) and/or difference(s), including early manifestation of one or more ASD characteristics. See Admission Criteria for detailed information.
- 2) A recipient may be referred to an AEP by:
 - a. His or her PCP or another licensed health care practitioner including, but not limited to, a speech-language pathologist, occupational therapist, a MAD behavioral health practitioner who is a LPCC, LISW/LCSW, psychologist, CNP, CNS, LMHC or LMSW who has the qualifications to render a Level 2 screen; or
 - b. A FIT Program Service Coordinator, if the recipient or his or her biological sibling with ASD is concurrently being evaluated for FIT services, or if the recipient or his or her biological sibling with ASD has been evaluated and is currently receiving FIT intervention services.

G. Provider Types and Qualifications for Services at Each Stage

STAGE 1

Provider Qualifications: Autism Evaluation Practitioner (AEP)

MAD enrolls individual AEPs, not an agency that employs or contracts with AEPs. An AEP conducts the CDE, or Targeted Evaluation, or a Targeted Risk Evaluation and develops the ISP for a recipient. An approved AEP must:

- 1) Be a New Mexico Regulation and Licensing Department (RLD) licensed, doctoral-level clinical psychologist or a physician who is board certified or board eligible in developmental behavioral pediatrics, pediatric neurology, or child psychiatry;
- 2) Have experience in, or knowledge of, the medically necessary use of ABA and other empirically supported intervention techniques;
- 3) Be qualified to conduct and document both a CDE, Targeted Evaluation and a Targeted Risk Evaluation for developing an ISP;
- 4) Have advanced training and clinical experience in the diagnosis and treatment of ASD and related neurodevelopment disorders, including knowledge about typical and atypical child development and experience with variability within the ASD population;

- 5) Have advanced training in differential diagnosis of ASD from other developmental, psychiatric, and medical disorders;
- 6) Sign an attestation form affirming that all AEP practitioner requirements as outlined above have been, and will continue to be, met.

Stage 1 Service Requirements

The AEP must develop a scheduling process to ensure priority is given to recipients who have the probability of being At-Risk for the development of ASD. The AEP will determine if the recipient requires a full CDE and ISP; a Targeted Evaluation and ISP, or Targeted Risk Evaluation, Risk Report, and ISP; or simply an ISP based upon a current CDE.

It is the AEP's responsibility to provide information to the recipient's parent/caregiver that describes the current presentation of the recipient and all adjunct practitioners whose input is necessary to fully evaluate, write the report, and complete an ISP which details and prioritizes medically necessary services to the recipient, including ABA services, when appropriate.

Comprehensive Diagnostic Evaluation (CDE)

The AEP determines the eligible recipient requires a CDE resulting in a thorough Evaluation Report and ISP when:

- 1) The recipient has never received such an evaluation by an AEP; or
- 2) The recipient has received such an evaluation by an AEP or a practitioner meeting the requirements to be an AEP, but not within the previous consecutive 36 months; or
- 3) The recipient has received such an evaluation by an AEP or a practitioner meeting the requirements to be an AEP within the previous consecutive 36 months, but there is sufficient reason to believe that the recipient's presentation has changed markedly such that the previously rendered diagnosis may no longer be valid or additional diagnoses may be present.

A CDE to confirm the presence of ASD must be conducted in accordance with current practice guidelines as offered by professional organizations such as the American Academy of Child and Adolescent Psychiatry, American Psychological Association, American Academy of Pediatrics, and American Academy of Neurology. Although aspects of the evaluation will vary depending on the recipient's age, developmental level, diagnostic history, etc., it is expected that the evaluation be multi-informant, multi-modal, ASD-specific, and conducted by an AEP. It is expected of the AEP conducting the CDE that the evaluation tools employed during the diagnostic process are used to aid in the development of the recipient's ISP.

The AEP determines the eligible recipient requires a CDE resulting in a thorough Evaluation Report and ISP when:

- 1) The recipient has never received such an evaluation by an AEP; or

- 2) The recipient has received such an evaluation by an AEP or a practitioner meeting the requirements to be an AEP, but not within the previous consecutive 36 months; or
- 3) The recipient has received such an evaluation by an AEP or a practitioner meeting the requirements to be an AEP within the previous consecutive 36 months, but there is sufficient reason to believe that the recipient's presentation has changed markedly such that the previously rendered diagnosis may no longer be valid or additional diagnoses may be present.

Targeted Evaluation

A Targeted Evaluation is conducted when the recipient's AEP determines a targeted evaluation of specific aspects of the recipient's current presentation have markedly changed from the current CDE findings. Because a Targeted Evaluation was completed, an initial ISP based on the Targeted Evaluation's results is required. When an AEP is called upon to conduct a Targeted Evaluation for the purpose of developing only the initial ISP, the AEP is expected to use clinical discretion regarding the evaluation tools needed to develop the ISP that meets the recipient's needs. A Targeted Evaluation requires the same considerations and use of multi-informants as clinically indicated. This means that for the specific behaviors or lack of behaviors being evaluated, the AEP must use his or her clinical judgement to determine whether other practitioner's input is required to produce a valid report and ISP.

The AEP must include the following elements when completing the Evaluation Report and developing the recipient's ISP.

Multi-informant: CDEs or a Targeted Evaluation must include information from the recipient himself or herself via direct observation and interaction; and

- 1) The recipient's legal guardian or other primary caregiver; and
- 2) Whenever possible, one additional informant who has direct knowledge of the recipient's functioning as it pertains to skill deficits and behavioral excesses associated with ASD:
 - a. Recipient's educational or early interventionist provider; or
 - b. Recipient's PCP; or
 - c. Recipient's physical, behavioral and long-term care health provider (e.g., Speech-Language Pathologist, Social Worker, Occupational Therapist, Physical Therapist, Psychologist, Psychiatrist, Behavior Analyst, etc.).

Multi-modal: CDE or a Targeted Evaluation must rely on various modes of information gathering, including but not limited to:

- 1) Review of educational and/or early interventions, physical, behavioral and long-term care health records; and
- 2) Legal guardian or primary caregiver interviews for historical information, as well as determination of current symptom presentation; and

- 3) Direct observation of, and interaction with the recipient; and
- 4) Clear consideration of, but ideally direct and/or indirect assessment of multiple areas of functioning, including but not limited to:
 - a. developmental, intellectual, or cognitive functioning; and
 - b. adaptive functioning; and
 - c. social functioning; and
 - d. speech, language, and communicative functioning; and
 - e. medical and neurological functioning.

ASD-specific: The CDE or a Targeted Evaluation must be specific enough to adequately assess symptoms associated with ASD, yet broad enough to make a valid differential diagnosis and consider possible co-morbid conditions. As such, the AEP should use one or more standardized diagnostic instruments (e.g., The Autism Diagnostic Observation Schedule™, Second Edition [ADOS™-2]; Autism Diagnostic Interview™-Revised [ADI™-R]), as well as assessment tools (i.e., standardized assessment measures, interviews, etc.) to evaluate symptoms associated with ASD.

Stage 1 CDE or Targeted Evaluation Documentation Requirements

A copy of the following documents must be included in the recipient's record, and a copy must be provided to the recipient's legal guardian and the PCP, if different from the AEP. The Evaluation Report must be signed by the AEP; and the ISP must be signed by the AEP, the recipient and the recipient's legal guardian.

Evaluation Report: This applies to either a CDE or a Targeted Evaluation. Within 60 calendar days of completion of the evaluation, the AEP must issue a thorough report that documents the evaluation process, evaluation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the recipient.

If the CDE does not result in a diagnosis of ASD, an ISP is not required. However, the AEP's Evaluation Report must offer individualized, clinical recommendations to guide further assessment and intervention services specific for the recipient.

Integrated Service Plan (ISP): The AEP must issue an individualized ISP. If the AEP conducted the CDE, the ISP must be issued within 90 calendar days of the conclusion of the CDE. This allows for the AEP to issue the Evaluation Report in a timely manner (i.e., within 60 calendar days), but allows 30 additional calendar days to refine and issue the ISP, if necessary.

However, in cases where the AEP is only tasked with evaluation for the purposes of ISP development (i.e., the AEP is not tasked with completion of a CDE because one was already conducted) or when a Targeted Evaluation is conducted, an ISP must be issued within 30 calendar days (or no more than 45 calendar days) at the conclusion of the AEP's evaluation. When developing and issuing the ISP, the AEP must adhere to the following requirements:

- 1) If the AEP determines that ABA services are clinically indicated, the ISP must include a statement that the AEP expects that the requested ABA services will result in measurable improvement in the recipient's ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA

services are therefore prescribed.

- 2) The ISP must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up).

The ISP must indicate what each recommended service provider should address in the context of his or her therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target). As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.

- 3) The ISP must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), specifically Part C for infants and toddlers and Part B for pre-school-aged children.
- 4) The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the recipient can be realized. ABA alone has been shown to be less effective, and therefore it is necessary that the AEP design and document an ISP that includes complementary, rather than contraindicated, components.
- 5) The ISP must be linked to findings from the CDE and reflect input from the recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the recipient's care.
- 6) ISP development must include a realistic assessment of available resources as well as characteristics of the recipient that may affect the intervention positively or negatively.
- 7) The ISP must be based on the recipient's current clinical presentation, while being mindful of the long-term vision for the recipient's potential.
- 8) The ISP must address needs associated with the recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
- 9) Given that the needs of a recipient with ASD are characteristically numerous, the ISP must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the recipient or others.
- 10) The ISP must include a plan for ongoing monitoring across multiple areas of functioning such that the plan can evolve as the recipient's behavioral presentation changes in response to treatment.

Stage 1 Requirement Variations for Recipients Identified as At-Risk

For recipients 12 months up to 36 months who may be at-risk for developing ASD, but for whom a CDE is not initially indicated, the Stage 1 Variation involves a Targeted Risk Evaluation and a Risk Report with an embedded ISP.

- 1) Determine and document the recipient's genetic risk status, which may involve reviewing the medical records of the older biological sibling(s) with ASD, and/or reviewing the recipient's own medical records to confirm the presence of a genetic condition associated with ASD (e.g., Fragile X).
- 2) Utilize various modes of information gathering, including but not limited to:
 - a. Review of physical, behavioral and long-term care health records; and
 - b. Legal guardian and/or primary caregiver interview for historical information, with particular attention to the prenatal, perinatal, and neonatal periods in order to gain information related to causal factors associated with early developmental delays and/or differences; and
 - c. Legal guardian and/or primary caregiver interview for developmental progression and current functioning; and
 - d. Direct observation of, and interaction with, the recipient; and
 - e. Direct and/or indirect assessment, or at minimum, consideration of the recipient's functioning across domains, including but not limited to:
 - (i) Overall developmental functioning;
 - (ii) Adaptive functioning;
 - (iii) Social functioning;
 - (iv) Speech, language, and communicative functioning; and
 - (v) Physical and neurological functioning.
- 3) Clearly document the developmental delay(s) and/or difference(s) that, when coupled with consideration of the recipient's genetic status, raise concern for his or her risk for developing ASD.

Stage 1 Documentation Requirement for Variation for At-Risk Recipients

A copy of the following documents must be included in the recipient's record, and a copy must be provided to the recipient's legal guardian and the PCP, if different from the AEP. The Risk Evaluation Report must be signed by the AEP; and the ISP must be signed by the AEP and the recipient's legal guardian.

Risk Evaluation Report: Within 30 calendar days of completion of the Targeted Risk Evaluation, the AEP must issue a thorough Risk Evaluation Report that documents the Targeted Risk Evaluation process, assessment results, and case conceptualization and formulation, with special consideration of the criteria for accessing ABA services as an At-Risk recipient. Rather than issuing a separate ISP, the AEP must provide detailed recommendations for intervention and ongoing monitoring in, or accompanying, the Risk Evaluation Report. The Risk Evaluation Report must be signed by the AEP and the recipient's legal guardian. The document will dually function as the recipient's Targeted Risk Evaluation Report and ISP.

Integrated Service Plan (Embedded in Risk Evaluation Report): When developing and issuing the recipient's Risk Evaluation Report with embedded ISP, the AEP must adhere to the following requirements:

- 1) If the AEP determines that ABA services are clinically indicated due to notable risk for the development of ASD, the ISP must include a statement that the AEP expects that the requested ABA services will result in measurable risk reduction, and ABA services are therefore recommended.
- 2) The ISP must ensure that all areas of need are adequately addressed through other medically necessary services, as indicated (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up).
- 3) The ISP must support access and participation in services afforded through Part C of the IDEA, if eligible.
- 4) The AEP must ensure that, if services other than ABA are recommended, they are aligned with ABA such that the anticipated benefits to the recipient can be realized. It is imperative as an ISP that involves a mixture of methods, especially those which lack proven effectiveness, have proven to be less effective than ABA alone.
- 5) The ISP must be linked to findings from the Risk Evaluation and reflect input from legal guardians, caregivers, and others involved in the recipient's care.
- 6) ISP development must include a realistic assessment of available resources as well as characteristics of the recipient that may affect the intervention positively or negatively.
- 7) The ISP must be based on the recipient's current clinical presentation, while being mindful of the long-term vision for his or her potential.
- 8) The ISP must address needs associated with the recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
- 9) If the needs of the recipient are numerous, the ISP must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the recipient or others.
- 10) The ISP must also include a plan for ongoing monitoring across multiple areas of functioning such that the plan can evolve as the recipient's behavioral presentation changes in response to treatment. Plans for monitoring should allow for services to end once the risk for ASD is sufficiently reduced, or in unfavorable circumstances where risk increases rather than decreases, support for a referral to the AEP for a CDE.

MAD Approved CDE and ISP Requirements

MAD will accept for a limited period of time into ABA Stage 2 and 3 services an eligible recipient who has an ASD diagnosis from a non-AEP practitioner when that practitioner is one of the following:

- 1) A New Mexico Regulation and Licensing Department (RLD) licensed Psychologist;
- 2) A New Mexico Board of Nursing licensed:
 - a. Psychiatric Clinical Nurse Specialist; or
 - b. Certified Nurse Practitioner with a specialty in Pediatrics or Psychiatry.
- 3) A New Mexico Medical Board licensed MD or DO specifically licensed as a:
 - a. Psychiatrist who is Board Certified in Child and Adolescent; or
 - b. Pediatrician.

STAGE 2

Provider Qualifications: ABA Stage 2 and 3 Practitioners

Behavior Analyst

A BA who conducts the Behavior or Functional Analytic Assessment process and is responsible for the development of case supervision and clinical management and, if applicable, the implementation of the ABA Treatment Plan, is the only practitioner eligible to bill for ABA Stage 2 services. To be a MAD approved BA, there are three certification and licensing BA paths open to a practitioner:

- 1) Hold and maintain a BACB BCBA-D certificate.
- 2) Hold and maintain a BACB BCBA certificate.
- 3) Hold and maintain a New Mexico Regulation and Licensing Department Board of Psychologist Examiners psychology license; is certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology; and was tested in ABA. This practitioner is also known as a Qualifying Psychologist.

The second type is a Stage 2 provider without BACB certification. This provider type is able to assist, but not work independently. This provider type without BACB certification must:

- (a) possess a minimum of a master's degree from an accredited university that was conferred in behavior analysis, education, or psychology, or conferred in a degree program in which the candidate completed a BACB® approved course sequence;
- (b) have completed graduate level instruction in the following behavior analytic content areas (b) (i) through (b) (x):
 - (i) ethical and professional conduct (at least 45 classroom hours);
 - (ii) concepts and principles of behavior analysis (at least 45 classroom hours);
 - (iii) measurement (at least 25 classroom hours);
 - (iv) experimental design (at least 20 classroom hours);
 - (v) identification of the problem and assessment (at least 30 classroom hours);
 - (vi) fundamental elements of behavior change, and specific behavior change procedures (at least 45 classroom hours);
 - (vii) intervention and behavior change considerations (at least 10 classroom hours);
 - (viii) behavior change systems (at least 10 classroom hours);
 - (ix) implementation, management, and supervision (at least 10 classroom hours);
 - (x) discretionary coursework (at least 30 classroom hours);
- (c) have experience in the design and delivery of ABA services through supervised independent field work (non-university based) of at least 1500 hours, practicum experience (university based) of at least 1000 hours, or intensive practicum experience (university based) of at least 750 hours,

supervised in accordance with the BACB®'s requirements for supervised experience; a significant portion (at least one third) of the supervised experience must have been accrued with an ASD or closely related population (e.g., Fragile X, Intellectual Disability); All Stage 2 providers must complete 32 hours of continuing education in behavior analysis every two years.

The BCBA exam is offered four times per year and results are not available for two months. (The schedule can be viewed at <https://www.bacb.com/examination-information/exam-dates/>) A Stage 2 provider without BACB® certification may begin work with supervision; however, within one year from the date the provider starts employment as a supervisor, the provider must sit for and pass the exam. The Stage 2 provider without BACB® certification must pass the exam in order to continue working.

BACB Board Certified Assistant Behavior Analyst® (BCaBA)

- 1) A BCaBA, also known as a BAA, assists a BA during ABA Stage 2.
- 2) The BAA may provide ABA Stage 3 services under the supervision of a BA.
- 3) When the BAA meets the BACB requirements to supervise a BT, and has the approval of his or her supervising BA, the BAA may render ABA Stage 3 Case Supervision the BAA may provide Case Supervision of a BT.
- 4) A BCaBA must successfully complete a criminal background registry check and possess and maintain his or her BCaBA certification.

ABA Stage 2 and 3 Behavior Technicians

MAD recognizes three types of Behavior Technicians (BTs): two types of certified BTs and a non-certified BT.

Certified BT

There are two types of certified BTs: Registered Behavioral Technician (RBT®) certified by BACB; or Board Certified Autism Technician® (BCAT) certified by the Behavioral Intervention Certification Councils® (BICC)

The RBT or BCAT must:

- 1) Be at least 18 years of age;
- 2) Possess a minimum of a high school diploma or equivalent; and
- 3) Successfully complete a criminal background registry check.
- 4) A RBT must complete four hours of ASD training including but not limited to training about prevalence, etiology, core symptoms, characteristics, and learning differences, in addition to any other BACB requirements.

Non-Certified BTs

MAD approves a non-certified BT who is studying to be certified as a RBT or BCAT to assist a BA complete an ABA Stage 2 and 3 service for up to six continuous months while working towards his or her RBT or BCAT certification. If the non-certified BT fails to earn his or her certification within the allotted timeframe, the non-certified BT is to no longer assist a BA complete the ABA Stage 2 assessment and render ABA Stage 3 services until he or she is certified as a RBT or BCAT. See below for an exception to this requirement.

The AP agency must retain in the non-certified BT's personnel file documentation of the following requirements and must provide MAD a written attestation that the non-certified BT meets all of the following:

- 1) Be at least 18 years of age;
- 2) Possess a minimum of a high school diploma or equivalent;
- 3) Successfully complete a criminal background registry check;
- 4) Complete a minimum of four hours of training in ASD including but not limited to training about prevalence, etiology, core symptoms, characteristics, and learning differences prior to rendering ABA Stage 2 and 3 services;
- 5) Complete 40 hours of training in ABA (provided by a MAD approved BA) that meets RBT or BCAT certification requirements;
- 6) Prior to rendering ABA services, the non-certified BT has completed at least 20 hours of the required RBT or BCAT trainings with the remaining RBT or BCAT trainings accrued no more than 90 calendar days following the first date of the non-certified BT rendering services;
- 7) Complete all other requirements for registration as a RBT® or BCAT® (e.g., passing the identified competency assessment, submitting the necessary documentation to the BACB or BICC); and
- 8) Secure and hold a RBT or BCAT certificate within the first continuous six-months from the first date of rendered ABA services.
- 9) If the non-certified BT fails to earn his or her certification within the allotted timeframe, the non-certified BT is to no longer assist a BA complete the ABA Stage 2 assessment and render ABA Stage 3 services until he or she is certified as a RBT or BCAT.
 - a. However, as the RBT and BCAT testing dates for are not available each month and the certification board may take up to 2 months to provide the results of testing, MAD is allowing a non-certified BT to render ABA services for up to 2 months after the certification testing date when there is documented proof in the non-certified BT's AP agency personnel file:

- (i) the non-certified BT has completed the course work within 90 calendar days of the first date ABA services were rendered; and
- (ii) the non-certified BT registered for the next available testing date; and
- (iii) the proposed notification date of testing results.

MAD encourages a BCBA candidate to apply for a RBT, BCAT or a BCaBA certificate while working on his or her BCBA certification. The same is true for a BCaBA candidate to apply for a RBT or BCAT certificate while working on his or her BCaBA certification. In this way the AP agency is able to allow the candidate to assist a BA for ABA Stage 2 services and to bill as BAA or a BT for rendering ABA Stage 3 services before and after taking the BCBA exam while awaiting his or her testing results to become certified.

Each provider type has standards for supervision:

BCaBA

https://www.bacb.com/wp-content/uploads/Standards-for-Supervision-of-BCaBAs_180924.pdf

RBT

<https://www.bacb.com/rbt/responsible-certificants/>

BCAT

https://behavioralcertification.org/Content/Downloads/BCAT_CANDIDATE_HANDBOOK.pdf

Requirements for supervisors of BCaBAs, BCAT and RBTs

<https://www.bacb.com/requirements-for-supervisors/>

Stage 2 Service Requirements

If the AEP recommends ABA services as part of the recipient's ISP, the BA conducts the ABA Stage 2 Behavior or Functional Analytic Assessment and develops an ABA Treatment Plan. It is the BA's responsibility to provide information which fully describes the current presentation of the recipient and all adjunct practitioners whose input is necessary to fully complete a Behavior or Functional Analytic Assessment and an ABA Treatment Plan. The ABA Treatment Plan prioritizes goals for the recipient to ensure the health and safety of the recipient and his or her family.

Approved ABA Stage 2 and 3 Services in the Absence of a CDE and ISP

With a referral from an approved non-AEP practitioner, a recipient may receive ABA Stage 2 and 3 services for a limited period of time. The recipient, parent or guardian provides the AP agency the recipient's ASD diagnosis rendered by one of the approved MAD practitioners; see CDE exceptions under ABA Stage 1 services. At this point, the BA schedules a Behavior or Functional Analytic Assessment, and upon completion, ABA Stage 3 service may begin.

After the start of the ABA Stage 2 and 3 in the Absence of a CDE and ISP the following must occur:

- 1) The recipient's parent or caregiver must schedule a CDE appointment that affords

the AEP sufficient time to conduct and complete a CDE and ISP within 3 months of the start of ABA Stage 2 services.

- 2) The CDE and ISP must be completed within 12 months of the first date of ABA Stage 2 services.

Termination of Services in the Absence of a CDE and ISP

- 1) Failure to schedule the CDE timely may result in ABA Stage 2 and 3 services terminating until a CDE and ISP are completed with the recipient diagnosed with ASD.
- 2) The CDE does not lead to a diagnosis of ASD for the recipient. MAD allows one month of transition ABA Stage 3 services in this situation.

Behavior or Functional Analytic Assessment Requirements

The Behavior or Functional Analytic Assessment addresses needs associated with both skill acquisition and behavior, and as a result informs an individualized ABA Treatment Plan. The supervising BA works with the family to teach generalizable ABA practices and provides support to family and the recipient. The BA provides supervision of BAAs and BTs. The BA provides supervision of BAAs and BTs. Based on the individualized BCaBA supervision contract, the BAA may be allowed to supervise BTs under the direct supervision of the managing BA.

The BA conducting a Behavior or Functional Analytic Assessment incorporates developmentally appropriate questions for the recipient assessment strategies and assessment measures. The Behavior or Functional Analytic Assessment must identify strengths and weaknesses across domains. The data from the assessment is the basis for developing the individualized ABA Treatment Plan. A Behavior Analytic Assessment should utilize data obtained from multiple methods and multiple informants, such as:

- 1) *Direct observation and measurement of behavior:* Direct observation, measurement, and recording of behavior are defining characteristics of ABA services. The data serve as the primary basis for identifying pre-treatment levels, discharge goals, and evaluation of response to an ABA Treatment Plan. Direct observation and measurement of behavior assists the BA in developing and adapting treatment protocols on an ongoing basis. Direct observation of behavior should happen during naturally occurring opportunities as well as structured interactions.
- 2) *File review and administration of behavior scales or other assessments as appropriate:* The types of assessments utilized by the BA should reflect the goal of treatment and should be responsive to ongoing data as they are collected and analyzed.
- 3) *Interviews with the recipient, legal guardians, caregivers, and other professionals:* Legal guardians, caregivers and other stakeholders are included when selecting treatment goals, protocols, and evaluating progress. These

interviews, rating scales, and social validity measures should be used to assess the legal guardian and caregiver's perceptions of the recipient's skill deficits and behavioral excesses, and the extent to which these deficits and excesses impede the functioning of the recipient and his or her family. The recipient should also participate in these processes as developmentally appropriate.

Selection and Measurement of Goals

Once the Behavior or Functional Analytic Assessment has been executed and data gathered, the BA must select goals for intervention and determine how these goals will be measured.

- Development of a target-behavior definition, method and frequency of measurement, and data presentation must be individualized to each situation, behavior, and available resources.
- Behavioral targets should be prioritized based on their risk to the recipient's safety, independence, and implications for his or her short and long-term health and well-being.
- Baseline performance should be measured, and treatment goals should be developed for each critical domain and specified in terms that are observable and measurable so that there is agreement between stakeholders (i.e., the recipient's legal guardian, the AP agency or the MCO regarding the presence, absence, or degree of behavior change relative to treatment goals and discharge criteria.
- The ABA Treatment Plan should specify objective and measurable treatment protocols.

Data collection and analysis by the supervising BA should occur at each ABA Stage 3 Clinical Management session to permit changes to intervention procedures at a rate that maximizes progress. Data should be represented in graphical form, with visual inspection of graphed performance informing treatment modification, whenever possible.

Service Model Determination: Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number of behavioral targets, specific aspects of those behaviors, and the recipient's response to treatment protocols help determine which model is most appropriate. Although existing on a continuum, these models can be generally categorized as *Focused ABA* or *Comprehensive ABA*.

Focused ABA

Identified Population

A recipient, 12 months up to 21 years of age with an AEP rendered CDE diagnosis of ASD, as well as an At-Risk recipient, 12 months up to 3 years of age, may receive Focused ABA Stage 3 services. Focused ABA services are not restricted by cognitive level or co-occurring conditions.

Focused ABA Service Requirements

- 1) Focused ABA refers to treatment provided directly to the recipient for a limited number of behavioral targets.

- 2) For a recipient identified as being At-Risk for a diagnosis of ASD, Focused ABA should not exceed 10 hours per week without prior authorization from the recipient's MCO or TPA.
- 3) For a recipient with an ASD diagnosis, focused ABA should not exceed 20 hours per week without prior authorization from the recipient's MCO or TPA; and
- 4) Although the presence of a problem behavior may trigger a referral for Focused ABA services more often than skill deficits, the absence of appropriate behaviors should be prioritized, as this is often the precursor to serious behavior problems. Therefore, a recipient who needs to acquire skills (e.g., communication, tolerating change in environments and activities, self-help, social skills) is also appropriate for Focused ABA.
- 5) All Focused ABA Treatment Plans that target reduction of dangerous or maladaptive behavior must concurrently introduce and strengthen more appropriate, functional behavior.
- 6) Examples of skill acquisition targets in a Focused ABA Treatment Plan include, but are not limited to, establishing compliance with medical and dental procedures, sleep hygiene, self-care skills, and safe and independent play/leisure skills.
- 7) Examples of behavior reduction targets in a Focused ABA Treatment Plan include, but are not limited to, self-injury, aggression towards others, dysfunctional speech, stereotypic motor behavior, property destruction, noncompliance and disruptive behavior, and dysfunctional social behavior.
- 8) MAD supports Focused ABA as delivered in home, clinic, and community-based settings.
- 9) ABA services may be delivered in a school's facility but must be rendered after school hours and must not be included in a recipient's Individualized Treatment Plan that is part of his or her Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

A public or private school setting may be utilized for a BA, BAA or BT to render ABA Stage 2 or 3 services during non-educational instruction time. Rendering ABA Stage 3 services at these facilities may be before or after school hours where the public or private school is acting simply as a location for rendering ABA Stage 2 or 3 services.

In order for a BA to develop an ABA Stage 3 Treatment Plan, he or she may be required to observe the eligible recipient in a variety of situations, such as in the eligible recipient's home, in the BA's clinic, or within the community.

MAD does not allow ABA Stage 3 services to supplant an eligible recipient's

educational instruction time. If an eligible recipient is receiving his or her compulsory public education at a public and private school or home school, the BA, BAA or BT cannot render ABA Stage 3 services during the student's educational instruction time.

Specific to public and private schooling, the scheduling of ABA Stage 3 services during recesses, lunch, and other breaks in-between the eligible recipient's educational instruction time may or may not be in the eligible recipient's best interest. If services are rendered during this time, the rationale for providing services must be documented in the eligible recipient's clinical file. Extra care must be taken to ensure ABA services are not rendered during compulsory educational instruction time.

Example: ABA Stage 3 services cannot be rendered to assist an eligible recipient transitioning from and to another classroom or school activity, such as a lunch.

Specific to home schooling, the Public Education Department requires a compulsory school-aged student to have an educational instruction schedule. ABA Stage 3 services may be rendered before or after the start or close of the student's educational instruction scheduled time.

Example: A student's home schooling schedule begins at 8:30 am and ends at 11:30 am and then starts back at 1:00 pm to 5 pm. ABA Stage 3 services may be rendered from 11:30 am to 1 pm and from 5 pm to 7 pm.

ABA Stage 3 services prior authorization requests must identify that Focused ABA is being used.

Comprehensive ABA

Identified Population

- 1) A recipient who meets the criteria for At-Risk for ASD is eligible for Comprehensive ABA services.
- 2) A recipient with an AEP rendered diagnosis of ASD is eligible to receive Comprehensive ABA services when he or she has not yet reached the age for compulsory school attendance. Compulsory school age is defined as a recipient who is five years of age before 12:01 a.m. on September 1st of the year. Some recipients whose fifth birthdays occur following the start of the school year will be eligible to receive Comprehensive ABA after they turn five years of age, if the continuation for ABA services criteria are met.

Comprehensive Services Requirements

Comprehensive ABA is an intensive intervention and refers to treatment where there are multiple targets across most or all developmental domains that are affected by the recipient's ASD. The overarching goal of early, intensive, behavioral intervention is to close the gap

between the recipient's level of functioning and that of typically developing peers.

Comprehensive ABA (not to exceed 40 hours per week) without prior authorization from the recipient's MCO or TPA.

- 1) Targets are drawn from multiple domains related to cognitive, communicative, social, emotional, and adaptive functioning. Targets also include reducing maladaptive behavior such as aggression, self-injury, disruption, and stereotypy. Given the nature of comprehensive intervention, there must be a prior authorization from the recipient's MCO or TPA if services are rendered less than 20 hours per week on average.
- 2) Treatment hours are increased or decreased as a function of the recipient's response to treatment as well as the intensity needed to reach treatment goals. In some cases, direct treatment hours increase gradually, are maintained at maximum intensity for a period of time and are then systematically decreased in preparation for discharge. In other cases, treatment may begin at maximum levels.
- 3) Initial treatment is often intensive and provided mostly in structured intervention sessions. Less structured treatment approaches are utilized if the recipient demonstrates the ability to benefit from them. As the recipient progresses and meets established criteria for participation in larger or different settings, treatment in those settings and in the larger community should be provided.
- 4) Training and participation by legal guardians and caregivers are also seen as important components. This is also a required covered service. If the parent or caregiver is unable to participate in every ABA Stage 3 session, the BA is required to provide alternative methods to the parent or caregiver for their participation.

MAD supports Comprehensive ABA as delivered in home, clinic, and community-based settings. Due to the age of the eligible recipient, he or she may receive child care services, or be enrolled in Early Head Start or Head Start or be receiving FIT service or other Part B services. ABA Stage 3 services may be rendered during the time the eligible recipient is engaged in these services as they are not public school compulsory educational services.

- 5) ABA Stage 3 services prior authorization requests must identify that Comprehensive ABA is being used.

Selection and Measurement of Goals

Once the Behavior Analytic Assessment has been executed and data gathered, the BA must select goals for intervention and determine how these goals will be measured. The MCO or TPA will review the goals and progress when prior authorization for ABA Stage 3 services is requested. Selection and development of measurements and goals should include:

- 1) Development of a target-behavior definition, method and frequency of measurement, and data presentation must be individualized to each situation, behavior, and available resources.
- 2) Behavioral targets should be prioritized based on their risk to recipient's safety, independence, and implications for his or her short and long-term health and well-being.
- 3) Baseline performance should be measured, and treatment goals should be developed for each critical domain and specified in terms that are observable and measurable so that there is agreement between stakeholders (i.e., the recipient's legal guardian, the AP, the MCO UR, TPA) regarding the presence, absence, or degree of behavior change relative to treatment goals and discharge criteria.
- 4) The ABA Treatment Plan should specify objective and measurable treatment protocols. It should include the service setting and level of service for the recipient. Data collection and analysis by the supervising BA should occur frequently enough to permit changes to intervention procedures at a rate that maximizes progress. Data should be represented in graphical form, with visual inspection of graphed performance informing treatment modification, whenever possible.

ABA Treatment Plan

The ABA Treatment Plan must identify all target behaviors that are to be addressed by the BTs and/or the BAs in direct service. The following elements are required in the treatment plan:

- 1) Must be completed as expeditiously as possible, but no later than two months after the completion of the Behavior or Functional Analytic Assessment and be updated no less than every 6 months;
- 2) Address the maladaptive behavior(s), skill deficit(s), and symptom(s) that present a safety risk to self or others or prevent the recipient from adequately participating in home, school, and community activities, which may necessitate planned collaboration with an ABA Specialty Care Provider;
- 3) Include a goal of working with the family or caregiver of the recipient in order to assist with the acquisition, maintenance, and generalization of functional skills;
- 4) Incorporate strategies for promoting generalization and maintenance of the goal's behavior change with the parent or caregiver;
- 5) Specify where services are delivered (e.g., home or clinic) in each ABA Stage 3 Service Authorization - initial and ongoing - and in the ABA Treatment Plan; take into account all school or other community resources available to the recipient, provide evidence that the requested ABA Stage 3 services are not redundant with other services already being provided or otherwise available, and coordinate therapies (e.g., from school and special education), with other interventions and treatment (e.g., speech, occupational therapy, physical

therapy, individual and family outpatient counseling, and medication management, both physical and behavioral health);

- 6) Include other interventions and treatment; (e.g., speech therapy, occupational therapy, physical therapy, family counseling, medical, and medication management - both behavioral health and physical health);
- 7) Be signed by the BA responsible for ABA Treatment Plan development and oversight of its implementation by one or more BAAs or BTs, if services are not implemented by the BA directly;
- 8) Be time-limited such that the ABA Treatment Plan can be executed within the time authorized by MAD (i.e., six months), with ongoing prior authorization requests and during the approved Service Authorization period as long as the recipient continues to meet the continuation of services criteria, and with the understanding from the MCO or TPA that clear and compelling positive behavior change from comprehensive early intervention services may not be observed following the initial and possible next six-month prior authorization periods;
- 9) Be child-centered, family-focused, and minimally intrusive, with a focus on family engagement, training, and support; if the parent or caregiver cannot face-to-face attend the eligible recipient's sessions, then other opportunities must be explored, such as the parent or caregiver participating via telemedicine (in real-time or through store-and-forward means);
- 10) Be specific and individualized to the recipient, with clear identification and description of the target behaviors and symptoms;
- 11) Include objective data on the baseline level of each target behavior/symptom in terms of directly observed and measured frequency, rate, latency, or duration, and include scores and interpretation from criterion-referenced, norm-referenced, and/or standardized assessment tools (e.g., The Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], The Assessment of Basic Language and Learning Skills-Revised [ABLLS-R]), as applicable;
- 12) Include a comprehensive description of interventions and intervention procedures specific to each of the targeted behaviors/symptoms, including documentation of approximately how many service units (hours or partial hour) will be allocated to each;
- 13) Establish treatment goals and objective measures of progress on each goal specified to be accomplished in the 6-month authorization period;
- 14) Incorporate strategies for promoting generalization and maintenance of behavior change; and
- 15) Offer measurable discharge criteria and discharge planning that begins the first date of ABA Stage 3 services.

STAGE 3

Stage 3 Service Requirements

ABA treatment must be rendered in accordance with the recipient's ABA Treatment Plan and within any identified constraints associated with the request for prior authorization of services.

- 1) Throughout all phases of ABA treatment, including Stage 3 delivery of treatment, the BA is ultimately responsible for ensuring that the following essential practice elements are apparent:
 - a. Behavior and Functional Analytic Assessment that describes specific levels of behavior at baseline and informs subsequent establishment of ABA treatment goals;
 - b. An emphasis on understanding the current and future value (or social importance) of behavior(s) targeted for treatment;
 - c. A practical focus on establishing small units of behavior which build towards larger, more significant changes in functioning related to improved health and levels of independence;
 - d. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals;
 - e. Efforts to design, establish, and manage the social and learning environment(s) to minimize problem behavior(s) and maximize rate of progress toward all goals;
 - f. An approach to the treatment of problem behavior that links the function of (or the reason for) the behavior to the programmed intervention strategies;
 - g. Use of a carefully constructed, individualized and detailed behavior or functional analytic assessment to develop the ABA Treatment Plan that utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;
 - h. Use of treatment that is implemented repeatedly, frequently, and consistently across environments until discharge criteria are met;
 - i. An emphasis on ongoing and frequent direct assessment, analysis, and adjustments (Clinical Management) to the ABA Treatment Plan (by the BA) based on the recipient's progress as determined by observations and objective data analysis;
 - i. An emphasis on ongoing and frequent case supervision of the BAA or BT rendering ABA Stage 3 services to the recipient;
 - j. Direct support and training of the recipient's family, caregivers, and other involved professionals to promote optimal functioning, generalization and maintenance of behavioral improvements; and
 - k. A comprehensive infrastructure for clinical management and case supervision of all assessment and treatment by a BA, BAA, and BT.
- 2) A record must be maintained by the AP agency and, as appropriate, the ABA Specialty Care Practitioner for each recipient.
- 3) All CDE, Targeted Evaluations, or Targeted or Risk Evaluations, and Reports, ISP,

Behavior or Functional Analytic Assessments, and ABA Treatment Plans, along with updates to the aforementioned documents, must be maintained as part of the recipient's record by the AP agency.

- 4) A contact log which documents the delivery of all billable services (including Case Supervision and Clinical Management activities), as well as all clinically significant non-billable services, must be maintained.
- 5) Each ABA Stage 3 session must be documented by a progress note. The note must include the date of service, the time and duration of service, location/setting, the practitioner(s) present during the delivery of service, parent or caregiver present, and the clinical content of the session, quantitative data to support the clinical content, and a plan for the next visit. Progress notes must be signed by the BAA, the BT and the supervising BA, unless the service is rendered by the BA him or herself, in which case only his or her signature is required. The recipient's parent's or caregiver's signature is not required.
- 6) An ABA Treatment Plan Update and Progress Report must be prepared and submitted with each ongoing 6-month prior authorization request and maintained as part of the recipient's record.

Stage 3 Authorizations

Service Authorization for ABA Stage 3 Service Implementation

When the BA and recipient/family agrees to the developed ABA Treatment Plan (Stage 2), the BA must submit a Service Authorization request to the MCO or TPA prior to starting ABA Stage 3 services.

The Service Authorization request summarizes the Behavior or Functional Analytic Assessment, critical elements of the recipient's CDE, Targeted Evaluation or Targeted Risk Assessment, with corresponding ISPs and lists overarching goals for the recipient for ABA Stage 3 services, and proposed discharge criteria.

Detailed descriptions of goals and protocols are found in the 6-month Prior Authorization requests. Once approved by the MCO or TPA, Service Authorization allows for the implementation of ABA Treatment Plan.

Initial 6-Month and Concurrent Prior Authorization of ABA Stage 3 Service

There are two types of prior authorizations: Initial and Concurrent. Both must provide ample information to substantiate the need for services. The BA is to work with the MCO or TPA to obtain the most current prior authorization request form. Information for Initial and Concurrent prior authorizations include:

- 1) If the BA and family agree on services being rendered as outlined in the developed ABA Treatment Plan (during ABA Stage 2), the BA must submit an initial 6-month Prior Authorization request and concurrent Prior Authorization requests every 6 months thereafter.

- 2) When the Service Authorization is approved, the MCO or TPA will then review the submitted initial and thereafter a 6-month Prior Authorization of Stage 3 services.
- 3) At any time during the Service Authorization period the family or BA may request from the recipient's AEP, an ISP update or the BA may conduct a new Behavior or Functional Analytic Assessment if immediate changes are warranted to preserve the health of the recipient or to meet the current needs of the recipient.
- 4) To secure the initial and ongoing 6-month prior authorizations, the BA must submit the request, specifically noting all of the following:
 - a. The requested treatment model (i.e., Focused or Comprehensive);
 - b. The maximum number of units or partial units by CPT code requested per week; see 8.302.2 NMAC for information how units and partial units are billed;
 - c. The number of units of Case Supervision requested per week, if more than 2 units (hours) of supervision per 20 delivered units (10 hours) of intervention is requested. If the BA knows at the time of the request that more than 75% of Case Supervision will be delivered via telemedicine, this information is to be included in the request (see Supervision delivered through Telemedicine section below);
 - d. The number of units (hours) of Clinical Management requested per week, if more than 2 units (hours) of clinical management per 20 delivered units (10 hours) of intervention is requested;
 - e. The number of hours allocated to other services including Early Intervention through FIT, speech therapy, physical therapy, and others for the MCO or TPA to determine if the requested intensity (i.e., hours per week) is feasible and appropriate;
 - f. The number of hours allocated for family individual or group services;
 - g. For ongoing 6-month Prior Authorization requests, discussion of progress made towards the eligible recipient's discharge criteria stated in the 36-Month Service Authorization; and documentation that demonstrates progress toward goal acquisition or barriers currently presented by the eligible recipient;
 - h. Location of services; list all that are applicable (home, clinic, doctor's office, riding in a vehicle, playgrounds, etc.); this may be general as the authorization period is 6 months in advance;
 - i. The need for collaboration with an ABA Specialty Care Practitioner, if such a need has been identified; note that Specialty Care services may be requested at any time during a 6-month Prior Authorization period; and

H. Case Supervision and Clinical Management

To achieve the desired, medically necessary outcome, all recipients must receive Clinical Management rendered by the supervising BA, and Case Supervision rendered by a BA or a Supervising BAA. As such, MAD requires at least one unit (one hour) each of Clinical Management and Case Supervision at or shortly after every 20 units (10 hours) of delivered ABA Stage 3 services. A BA must provide both these functions described and a Supervising BAA (as approved) must provide Case Supervision described, in a timely manner with documentation in the recipient's AP agency file. Failure to provide these services as described will result in possible

recoupment of the recipient's paid claims. To ensure high-quality Clinical Management and Case Supervision such that ABA Stage 3 services result in the medically necessary behavior change, MAD requires the BA to bill for no more than 40 hours of service (combinations of clinical management, case supervision, direct ABA Stage 3 services) to Medicaid or non-Medicaid recipients per week across no more than 24 cases or a Supervising BAA to bill for no more than 40 hours of service (combinations of clinical management, case supervision, direct ABA Stage 3 services) to Medicaid or non-Medicaid recipients per week across no more than 20 cases. A BT tasked with implementing the recipient's ABA Treatment Plan, requires frequent and ongoing Case Supervision and Clinical Management from the BA. Provision of both Clinical Management and Case Supervision allows for the individualization of the recipient's ABA Treatment Plan, careful and detailed collection and analysis of data, and timely modifications to treatment protocols, all of which are essential to ensuring treatment effectiveness.

BACB and BICC supervision requirements

The BACB and BICC require that a BA conduct ongoing supervision of a BCBA without certification, BAA, a RBT or BCAT. The certifying boards' supervision requirements are in addition and separate from MAD ABA Stage 3 Case Supervision and Clinical Management and is not reimbursable by MAD. A BA must be a BACB Responsible Certificant which allows the BA to provide supervision to a BCBA without certification, BAA, BCaBA, RBT, or BCAT for the practitioner to remain in good-standing with his or her certification board. MAD requires the same level of BACB or BICC supervision of a non-certified BT by the BA who is a BACB Responsible Certificant in addition to the ABA Stage 3 Case Supervision and Clinical Management. The national websites are the source for the supervision requirements. Refer to section 7 of this policy manual for the websites.

AP agencies are instructed to ensure their clinical and billing staff utilize the Physician's Current Procedure Terminology (CPT) code 97155 for ABA Stage 3 Adaptive Behavior Treatment by Protocol Modification with one recipient. This code is utilized when a BA or Supervising BAA is rendering face-to-face or telemedicine delivered services where the BA or Supervising BAA solves at least one problem and may, at the same time coach the BAA or BT and caregiver, in how to oversee the treatment protocols. The recipient must be present during this session, including the time instructions are provided to the BAA or BT and caregiver. Billing for adaptive behavior treatment with protocol modification (97155) is to be included in the initial and ongoing 6-month Prior Authorizations.

Case Supervision

MAD has developed modifiers to utilize with CPT codes to distinguish between practitioner types and services. In particular, the CPT code T1026 is used for Stage 1 and Stage 3 services.

Case Supervision CPT T1026 Modifier UD: One Unit = 1 Hour of Time

A second modifier is used to distinguish who rendered the Case Supervision service:

- U5 for a Qualifying Psychologist;
- U4 for a BCBA-D;
- U3 for a BCBA or BCBA without certification; and
- U9 for a BAA.

At least one unit (one hour) and up to two units (two hours) of Case Supervision must be rendered for every 20 units (10 hours) of intervention per recipient. Up to two units (two hours) may be rendered without an additional prior authorization request; however, if more than two units (two) hours of Case Supervision is required, a prior authorization from the recipient's MCO or TPA must be secured. Case Supervision must be clearly differentiated from staff training and from the BAA's or BT's certification requirements, which are not reimbursable ABA services.

- 1) Given that both Direct and Indirect Case Supervision are crucial to producing good treatment outcomes, MAD reimburses for both forms of supervision. Specifically, billing for both Indirect and Direct Case Supervision is reimbursed in order for the Supervising BA or Supervising BAA to gather observational data about the recipient response to intervention, as well as the BAA's or BT's implementation of the intervention. Ongoing, frequent supervision permits changes to intervention procedures at a rate that maximizes progress and allows treatment integrity issues to be addressed expediently.
- 2) Direct supervision involves the Supervising BA or Supervising BAA observing the BAAs or BTs in their delivery of ABA Stage 3 services in real time, either in person or via telemedicine. Indirect supervision involves the Supervising BA or Supervising BAA meeting with the BAAs or BTs prior to, or following, their delivery of ABA Stage 3 services.
- 3) For each recipient, the Supervising BA or Supervising BAA is responsible for adhering to the following ratios for Case Supervision unless otherwise allowed when Case Supervision is delivered via telehealth in excess of the ratio below (see Supervision and Telemedicine below):
 - a. at least 50% of supervision must be direct case supervision; and
 - b. no more than 75% of direct supervision may be delivered via telemedicine; and
 - c. up to 100% of indirect supervision may be provided via telemedicine.

Clinical Management

Clinical Management CPT T1026 Modifier UC: One Unit = One Hour of Time

A second modifier is used to distinguish who rendered the Clinical Management service:

- U5 for a Qualifying Psychologist;
- U4 for a BCBA-D; and
- U3 for a BCBA.

At least 1 unit (1 hour), and up to 2 units (2 hours) of Clinical Management must be rendered for every 20 units (10 hours) of intervention, per recipient. Up to two units (2 hours) may be rendered without a prior authorization request; however, if more than two units (2 hours) of clinical management is required, an initial or updated prior authorization request from the recipient's MCO or TPA must be secured. Activities conducted by the BA that are associated with the delivery of intervention, but are not better characterized as Case Supervision, may be considered Clinical Management. An example of Clinical Management activities is when implementing a recipient's ABA Treatment Plan with fidelity requires the BT to possess knowledge and skills that go beyond his or her knowledge base but does not exceed expectations regarding the scope of practice for

BTs. Clinical Management hours may be used to develop the required knowledge and skills. Clinical Management hours may not be used for staff's general continuing education or remediate knowledge and skill deficits associated with ABA practitioner requirements and must be differentiated from the BAA's or BT's certification board's supervision requirements.

Justification for Additional Hours

A number of factors may be cited as justification for a short or long-term increase in Case Supervision and/or Clinical Management, including:

- Treatment dosage/intensity;
- Barriers to progress;
- Issues of recipient's health and safety (e.g., certain skill deficits, dangerous problem behavior);
- The sophistication or complexity of treatment protocols;
- Family dynamics or community environment;
- Lack of progress or increased rate of progress;
- Changes in treatment protocols;
- Transitions with implications for continuity of care.

I. Stage 3 ABA Specialty Care Practitioner (SCP)

ABA Specialty Care services provide different areas of specialization of ABA Stage 3 services; for example, areas such as aggression and self-injury. Each ABA Specialty Care Area is conceptualized as a continuum of services. The continuum extends from least-to-most intensive, which is determined by the level of service required to support the recipient. A more intensive level of service requires the BA to have extensive education and training beyond his or her certification or licensing board requirements to practice.

Prior to requesting ABA Specialty Care services, a Specialty Care Practitioner (SCP) must complete an ABA Stage 2 Functional Analytic Assessment specific to the area(s) of concern. As ABA Stage 2 services do not require prior authorization, no prior authorization is required for this service.

If, after assessment, the SCP determines the medical necessity for ABA Specialty Care services, the SCP submits a 3-month Prior Authorization request. Prior Authorization request for ABA Specialty Care services are typically given to support moderate to severe cases. Justification of ABA Specialty Care services is determined by:

- a. frequency, intensity, or chronicity of behavior;
- b. potential for harm to self or others,
- c. disruption of quality of life for the eligible recipient and for his or her family; or
- d. combinations of (a) through (c).

ABA Specialty Care Areas

The following areas have been identified as Specialty Care Areas. This list should not be considered exhaustive. In coordination with the BA and the SCP:

- 1) ABA Specialty Care services may be rendered, alongside the recipient's ABA Treatment Plan services; or
- 2) ABA Stage 3 services may be placed on a temporary hold or reduced while specific areas of ABA Specialty Care services are initiated. ABA Treatment Plan services may then be re-introduced at a rate agreed upon by the BA and the SCP.

Aggression - behaviors that place other individuals at risk of harm (e.g., hitting, kicking, biting). At times, other forms of behavior not considered aggression might place others at risk. For example, property destruction (e.g., throwing chairs, breaking windows) may impose a risk to others that warrants specialty care.

Threats of aggression do not typically warrant ABA Specialty Care services. Threats may warrant ABA Specialty Care services if the threat is deemed plausible. Threats of aggression might warrant coordination with other practitioners (e.g., psychiatrist) and/or utilization of other supports (e.g., inpatient hospitalization).

Self-injury - behaviors that place the recipient at risk of harm (e.g., head banging, biting). The behaviors are not limited to harm resulting from self-injury. For example, elopement might create a substantial risk of harm (e.g., running into traffic).

Sleep dysregulation - the recipient's hours of sleep is consistently much less than the recommended levels (e.g., National Sleep Foundation recommendations, American Academy of Pediatrics recommendations) and/or disruption of caregiver or family sleep patterns (e.g., missing work due to sleep deprivation) result from unusual sleep patterns of the recipient.

Feeding disorders - the recipient is at high-risk for health issues associated with eating (e.g., short gut, breathing problems), severe lack of eating (e.g., less than 20% of nutritional needs by mouth), high levels of inappropriate behavior during meals, and ingestion of non-edible items (i.e., pica).

Food selectivity, increasing variety, advancing textures do not typically warrant ABA Feeding Specialty Care, unless there are further complications as listed above.

ABA Specialty Care Provider Requirements

ABA Specialty Care is rendered by a BA who has the necessary advanced training and experiences necessary to address one or more of the ABA Specialty Care Areas. There are multiple methods for demonstrating credentialing and training experiences. However, a practitioner seeking MAD ABA SCP status must meet Requirement 1, and either Requirement 2 or Requirement 3, below.

Requirement 1

The SCP applicant must be a BCBA, BCBA-D or a Qualifying Psychologist.

Requirement 2

ABA Specialty care practitioner graduate coursework and experiential training:

- 1) The SCP applicant must hold documentation of graduate level coursework specific to the assessment and treatment of an ASD referral concern associated with an ABA Specialty Care Area. The graduate level coursework must be the equivalent of at least one 3-credit hour course i.e., 45 classroom contact hours and 45 non-classroom contact hours, specific to the ABA Specialty Care Area he or she intends to address with a recipient. In other words, a SCP can only render ABA Specialty Care services for the ABA Specialty Care Area for which he or she has met the advanced training and experience requirements; and
- 2) Complete 500 hours in the specific ABA Specialty Care Area under supervision from a BCBA®, BCBA-D®, a Qualifying Psychologist, or other credentialed practitioner who has 3 or more years of documented experience in the specific ABA Specialty Care Area. The 500 hours must be in a specific ABA Specialty Care Area implementing treatment protocols by either working directly with a recipient or directing a BAA or BT working with a recipient with at least 125 delivery hours acquired post master's degree. Not more than 350 delivery hours may be counted from meeting his or her BCBA, BCBA/D, or Qualifying Psychologist certification requirements, implementing the specific ABA Specialty Care treatment protocols with working directly with a recipient or directing a BAA or BT working with a recipient. The 500 hours must include 25 hours of directly supervised case management in the ABA Specialty Care Area.

Requirement 3

Experiential training only:

- 1) The SCP applicant must complete:
 - a. 1,000 hours in the specific ABA Specialty Care Area under supervision by a BCBA, BCBA-D, Qualifying Psychologist, or other credentialed practitioner who has 3 or more years of documented experience in the ABA Specialty Care Area.
 - b. The 1,000 hours must be in a specific ABA Specialty Care Area implementing treatment protocols by either working directly with a recipient or directing a BAA or BT working with a recipient with at least 250 delivery hours acquired post master's degree.
 - c. Not more than 712.5 delivery hours may be counted from meeting his or her BCBA, BCBA/D or Qualifying Psychologist certification requirements, implementing the specific ABA Specialty Care treatment protocols with working directly with a recipient or directing a BAA or BT working with a recipient.
 - d. The 1,000 hours must include 37.5 hours of directly supervised case management in the ABA Specialty Care Area.

Enrolling as a SCP

A currently MAD enrolled BA must submit a Specialty Care Provider attestation to Dauna Howerton at BHSD.

For a SCP applicant who is currently enrolled as a MAD ABA Stage 2 and 3 BA, the SCP attestation is added to his or her provider file which allows the BA/SCP to now render ABA Specialty Care services.

For a SCP applicant who is not a currently MAD enrolled BA, he or she must complete the appropriate SCP attestation when the applicant only wishes to render ABA Specialty Care services.

A SCP may be employed or contracted with more than one AP agency. Each AP agency must complete a SCP attestation for each SCP they employ or contract.

If the SCP applicant elects to render ABA Stage 3 services, then he or she must complete a MAD BCBA, BCBA-D, or a Qualifying Psychologist attestation along with the SCP attestation.

If the SCP attestation is approved, the SCP applicant must then enroll as a MAD provider through Conduent, attaching or uploading his or her SCP approval letter provider agreement when completing the enrollment documents. Go to:

<https://nmmedicaid.acs-inc.com/static/index.htm> to complete and submit the necessary enrollment documents.

Billing as a SCP

The SCP bills ABA Stage 2 CPT codes. ABA Specialty Care services are billed utilizing CPT code 0373T with the appropriate U3, U4, or U5 modifier.

- U3 indicates the SCP is a BCBA;
- U4 indicates the SCP is a BCBA-D; and
- U5 indicates the SCP is a Qualifying Psychologist.

The approved SCP may contract with the MCOs by providing them a copy of his or her SCP approval letter to render specific ABA Specialty Care Area services.

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised\(1\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised(1).pdf)

http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_9.pdf

J. Non-covered Services

MAD does not reimburse for the following when rendering ABA services:

- 1) Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA Treatment Plan;

- 2) Activities that are not based on the principles and application of behavior analysis;
- 3) Activities that are not empirically supported (i.e., activities that are not supported by a substantive body of peer-reviewed, published research);
- 4) Activities that take place during school hours and/or have the potential to supplant educational services;
- 5) Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the provider has expertise in the provision of ABA;
- 6) Activities that are characterized as staff training or certification/licensure requirements, rather than ABA Stage 3 Case Supervision.

K. Exhibits/Appendices/Forms

All MAD attestation templates for ABA providers and Specialty Care Providers are located at: <http://www.hsd.state.nm.us/providers/provider-packets.aspx>

Task Lists

RBT Task List <https://www.bacb.com/wp-content/uploads/2017/09/161019-RBT-task-list-english.pdf>

BCAT Task List <https://www.behavioralcertification.org/Content/Downloads/TASKLIST-BICC-2015.pdf>

BCBA and BCaBA <https://www.bacb.com/wp-content/uploads/2017/09/160101-BCBA-BCaBA-task-list-fourth-edition-english.pdf>

Handbooks

BCAT

https://www.behavioralcertification.org/Content/Downloads/BCAT_CANDIDATE_HANDBOOK.pdf

Standards for Supervision

BCaBA

<https://www.bacb.com/wp-content/uploads/161216-standards-for-supervision-of-BCaBAs.pdf>

RBT

<https://www.bacb.com/rbt/responsible-certificants/>

BCAT

https://www.behavioralcertification.org/Content/Downloads/BCAT_Supervision_Requirements.pdf

3.2 Comprehensive Community Support Services (CCSS)

A. Purpose

The purpose of Comprehensive Community Support Services (CCSS) is to surround individuals/families with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following functional domains: independent living, learning, working, socializing and recreation. CCSS consists of a variety of interventions primarily face-to-face and in community locations that address barriers that impede the development of skills necessary for independent functioning in the community.

Comprehensive Community Support Services also includes assistance with identifying and coordinating services and supports identified in an individual's treatment plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

A licensed provider must determine CCSS eligibility by providing a diagnosis and documenting impairment in one or more of the 5 functional domains: 1) independent living; 2) education and learning; 3) working; 4) socializing; and, 5) recreation. This must result in a Treatment Plan.

B. CCSS Treatment Plan

The Treatment Plan must specify natural and facilitated community supports and any other treatment interventions needed for the individual. CCSS must address the goals identified in the Treatment Plan. Community support activities and providers must be clearly identified in the Treatment Plan and be coordinated by the primary community support worker and not duplicate CCSS provided by the primary community support worker. The assessment determines the recipient's readiness for change and identifies strengths and challenge areas that may affect treatment decisions toward his or her recovery, and his or her family's involvement in the recovery process. It utilizes a strength-based approach to capitalize on client, family and community assets.

C. Procedures

Any designated agency wishing to provide CCSS must ensure that their staff has the appropriate training from state approved trainers. Prior to rendering service, the designated agency must:

- 1) Contact BHSD with their interest in providing CCSS.
- 2) BHSD will acknowledge the interest by responding within two weeks with a request for the completed attestation.
- 3) Once BHSD receives the attestation, they will return a letter to the agency allowing provision of CCSS and identifying them as having the specialty service 107.

D. Staff Training Requirements

- 1) Minimum staff training requirements for a Community Support Worker includes:

- a. An initial training comprised of twenty (20) hours of documented education within the first 90 days of employment comprised of:
 - (i) CCSS training as per state approved curriculum
 - (ii) Clinical and psychosocial needs of the target population
 - (iii) Managing side effects of psychiatric medication and communicating with your clinician
 - (iv) Principles of states of change
 - (v) Principles of motivational interviewing
 - (vi) Crisis management
 - (vii) Principles of recovery, resiliency and empowerment
 - (viii) Cultural considerations
 - (ix) Ethics and professionalism
 - (x) Enhancing interpersonal supports
 - (xi) Mental Health/Developmental Disabilities Code
 - (xii) Children's Code
 - (xiii) Client/family-centered practice
 - (xiv) Treatment and discharge planning with an emphasis on recovery and crisis planning
 - (xv) Psychiatric Advance Directive
 - (xvi) Strategies for engagement in services
 - b. Documentation of ongoing training comprised of twenty (20) hours is required of a CSW every year, after the first year of hire, with content of the education based upon agency assessment of staff need.
- 2) Minimum staff training requirements for supervisors:
 - a. The same twenty (20) hours of documented training or continuing education as required for the CCSS community support work;
 - b. An attestation of training related to providing clinical supervision of non-clinical staff.

E. Documentation Requirements

In addition to the standard client record documentation requirements for all services, the following is required for CCSS:

- 1) Case notes identifying all activities and location of services; duration of service span (e.g., 1:00-2:00 pm); and description of the service provided with reference to the comprehensive service plan and related service goal and objective.
- 2) CCSS Treatment Plan:
The CCSS treatment plan must specify the community support and other treatment interventions needed for the individual. CCSS must address the goals identified in the CCSS treatment plan. Objectives for each goal should be identified in addition to action steps toward achieving the identified objectives.

F. Designated Agency and Community Support Worker (CSW)

There is no certification process from DOH or CYFD. Instead, an agency must receive CCSS training through the State or UNM, and attest that they have received this training when contacting

the State's fiscal agent to add the specialty service 107, CCSS to their existing enrollment in Medicaid. Once they added this specialty, it remains with them without any type of re-certification process.

Individuals that meet the target population criteria for CCSS services must have one designated CCSS agency and primary CSW that will have the primary responsibility of assisting the individual and family with implementing the CCSS treatment plan. The CSW will also be a key member of any interdisciplinary service team within the agency.

G. Procedures

- 1) Assistance to the individual in the development of a recovery/resiliency plan.
- 2) Development of a psychiatric advance directive.
- 3) Assessment, support and intervention in crisis situations including the development and use of crisis plans which recognize the early signs of the individual's crisis/relapse, use of interpersonal supports, use of alternatives to emergency departments and inpatient services.
- 4) Revision of the crisis plan over time based on newly identified triggers and what is known to be effective for the individual.
- 5) Individualized interventions, with the following objectives:
 - a. Coaching in the development of interpersonal community coping and functional skills including adaptation to home, school and work environments, including:
 - Socialization skills;
 - Developmental issues;
 - Daily living skills;
 - School and work readiness activities; and
 - Education in co-occurring illness.
 - b. Encouraging the development and eventual succession of natural supports in workplace and school environments;
 - c. Assistance in learning symptom monitoring and illness self-management skills (e.g. symptom management, relapse prevention skills, knowledge of medication and side effects and motivational/skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living and supports individuals to maintain employment and school tenure;
 - d. Providing support and coaching to the individual to obtain and maintain stable housing.
- 6) The agency providing CCSS will make every effort to provide services in the community outside of clinic settings. The community support worker must provide follow-up to determine if the services accessed have adequately met the individual's needs.

- 7) The CSW will make every effort to engage the individual and/or the family in achieving treatment/recovery goals.
- 8) Behavior Management interventions are not considered to be Comprehensive Community Support Services and should be billed under Behavior Management Services.

H. Billing Instructions

- 1) HCPCS code **H2015**
- 2) Rendering provider is required
- 3) 15 minute unit
- 4) Modifier is required:
 - HO = masters level practitioner
 - HN = bachelors level practitioner
 - HM = less than a bachelors or peer specialist
- 5) For CCSS delivered in the community add modifier CG as a second modifier
- 6) FQHC: UB claim form; revenue code 0919 for encounter rate
- 7) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 8) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

3.3 Crisis Intervention Services

A. Purpose

- 1) Insure individuals and families experiencing a behavioral health crisis can access immediate care;
- 2) Reduce use of hospital emergency rooms for behavioral health crisis; and
- 3) Divert individuals who experience a behavioral health crisis from incarceration to appropriate treatment.

B. Definition

Crisis services always include triage, de-escalation, and stabilization.

C. Policy

- 1) Crisis services in mobile units, clinics or stabilization centers must have a partnership with the New Mexico Crisis and Access Line (NM Cal), or their own 24-hour crisis line.
- 2) Partnerships with local EMS and police departments with agreed upon processes must be in place for all crisis services.
- 3) Crisis stabilization centers are optimally open 24 hours, 7 days a week, but recipient stays must be less than 24 hours to constitute outpatient status.
- 4) If a crisis stabilization center is open less than 24/7, policy and procedure must be in place to assure an individual's stabilization before closing. This could mean remaining open until a safe alternative is in place.

D. Staff Education & Competencies

- 1) Received 20 hours of crisis intervention training by a trained crisis worker, i.e. a licensed independent mental health professional with two years crisis work experience.
- 2) Six hours of training must be received prior to working all crisis services; the balance is received within the first 12 hours.
- 3) The six (6) hours of crisis training prior to providing services must include:
 - a. De-escalation techniques
 - b. Trauma informed approaches
 - c. Patient rights and least restrictive methods
- 4) Supervised crisis call experience.
- 5) Received documented training in:
 - a. Assessing individual functional strengths and needs;

- b. Symptoms of mental illness and substance related disorders;
 - c. Medications and side effects;
 - d. Recovery, resiliency and natural supports;
 - e. Psychiatric advance directives;
 - f. Accessing and utilizing community resources and services;
 - g. Pertinent referral procedures and criteria; and
 - h. How to provide crisis services with cultural humility.
- 6) Ten (10) hours of crisis related continuing education annually.

E. Billing Instructions

- 1) Crisis call center (telephone):
 - a. **H2011 U1** - 15 min units
 - b. Use call center billing NPI in rendering field
- 2) Clinic crisis services:
 - a. **H2011 U2** – 15 min units
 - b. Use facility NPI in rendering field
 - c. FQHC: UB claim form; **0919** revenue code for FFP rate
 - d. IHS/638: UB claim form; **0919** revenue code for OMB rate
- 3) Mobile crisis team:
 - a. **H2011 U3** – 15 min units, covers transportation and direct patient contact.
 - b. 2-person team included in rate of service
 - c. Use agency NPI in rendering field
 - d. FQHC: UB claim form; 0919 revenue code for FFP rate
 - e. IHS/638: UB claim form; 0919 revenue code for OMB rate
- 4) OP Crisis stabilization centers:
 - a. Billed services must be mutually exclusive, i.e. only 1 service at a time, with the single exception of a practitioner working directly with the recipient while the peer support worker is working with family support or navigation/referrals, on behalf of the recipient
 - b. Immediate crisis assessment: **H2011 U4** - 15 min unit
 - c. Peer support as navigation services or face-to- face living room support: **H0038** – self-help peer services - 15 min unit; max 48 units
 - d. Family support services (MCO members only) – **S5110**
 - e. Counseling: Use fee schedule codes and rates for therapy and counseling services
 - f. Physical examination:
 - For MD or CNS or CNP utilize E & M codes
 - For RN – **T1001** for 30 min (nursing assessment/evaluation)
 - g. Observation services rendered by a nurse: **G0493** (Skilled services of an RN for the observation and assessment of the patient’s condition, each 15 minutes; (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment)

- h. Medication administration/management by an RN: **H2010** for 15 min; max 4 units
- i. Medication assisted treatment: Buprenorphine and Naloxone: **J0571** oral Buprenorphine 1 mg; **J0572** w/Naloxone 3 mg; **J0753** w/Naloxone 6 mg; **J0574** w/Naloxone 10 mg; **J0574** w/Naloxone over 10 mg; and **J0592** Naloxone injection (must be licensed as required by the Board of Pharmacy)
- j. On site laboratory services: Use fee schedule codes and rates. The provider must be CLIA-certified. Payment for Medicaid-covered lab services only
- k. Collection of blood by routine venipuncture: **36415**

3.4 Crisis Triage Centers (CTC)

A. Living Room Model

Clinical staff run residential crisis care models have been found to provide outcomes comparable to those of hospital care to patients who are willing to accept voluntary treatment (Fenton et al., 1998 and Fenton et al., 2002).

An example of a living room model described below is a practical example of what this may look like in New Mexico.

Peer-Hybrid crisis respite is The Living Room, located in a Chicago suburb, and is a community crisis respite center that offers individuals in crisis an alternative to obtaining services in an emergency department (ED). *The Living Room* utilizes one counselor, one psychiatric registered nurse, and three peer counselors for staffing on a regular basis, all of whom have extensive experience working with persons in crisis (Heyland, 2013). In its first year of operation, *The Living Room* hosted 228 visits by 87 distinct individuals (termed “guests”). Guests were deflected from EDs on 213 of those visits – a 93% deflection rate. These deflections represent a savings of approximately \$550,000 to the State of Illinois since guests of *The Living Room* were overwhelmingly individuals with Medicaid or no insurance of any kind. On 84% (n=192) of the occurrences in which guests were deflected from EDs, they alleviated their crises sufficiently to decide to leave *The Living Room* and return to the community. These guests reported an average decrease of 2.13 points on the Subjective Units of Distress Scale. (Heyland, 2013).

Until the Department of Health has promulgated the licensing rules for which all NM CTCs are subject, no further development of this section will occur.

B. Billing Instructions: Crisis triage center services are reimbursed through an agency specific cost based bundled rate relative to type of services rendered.

- (1) Bill both types, specialty 246 – residential/non-residential, and specialty 247 – non-residential on a UB claim form utilizing revenue codes
- (2) For residential/non-residential:
 - a. Bill rev code 0169, room and board if staying more than 24 hours
 - b. Bill rev code 0513, psychiatric clinic if staying less than 24 hours
 - c. Type of bill is 089X
- (3) For non-residential (outpatient only) centers:
 - a. Bill rev code 0513, psychiatric clinic
 - b. Type of bill is 0131
- (4) For both specialty types, residential/non-residential and non-residential only bill any of these revenue codes if that specific service was rendered:
 - a. 0905 – Intensive OP - psychiatric
 - b. 0906 – intensive OP chemical dependency
 - c. 0914 – Individual therapy
 - d. 0915 – group therapy
 - e. 0916 – family therapy
 - f. 0944 – drug rehab
 - g. 0945 - alcohol rehab
 - h. 0961 - psychiatric

- i. 0984 - medical social services
- j. laboratory: use rev code specific to type of lab service

3.5 Family Support Services (MCO members only)

A. Billing Instructions

- 1) HCPCS code **S5110**, 15 min units; max 32 units; rendering provider required
- 2) FQHC: UB claim form; revenue code **0919** for encounter rate
- 3) IHS/638: UB claim form; revenue code **0919** for OMB rate

3.6 Family Peer Support Services (FPSS)

A. Definition

FPSS supports parents and other primary caregivers to ensure their voice is heard, that their preferences are incorporated into their children’s plans of care, and that their natural support systems are strengthened. FPSS helps families gain the knowledge, skills and confidence to effectively manage their own needs and ultimately move to more family independence. Family Peers Support Workers (FPSWs) serve as role models demonstrating effective relationships, interactions, and behaviors, sharing their experience, as appropriate, to establish a bond based on similar experience.

The FPSWs are primary caregivers who have “lived-experience” of being actively involved in raising a child or youth who experiences emotional, behavioral, mental health and/or substance use challenges. This includes children and youth with neurobiological differences as well as those diagnosed with a serious emotional disorder or a substance use disorder. FPSWs have experience navigating child-serving systems and have received specialized training to empower other families who are raising children or youth with similar experiences. FPSWs use a strengths-based and culturally sensitive approach that recognizes the individual child, youth and family identity, cultural history, life experiences, beliefs, and preferences.

B. Policy

- 1) Family Peer Support Services must be identified as a service need in the recipient’s comprehensive assessment or diagnostic evaluation;
 - a. If the Medicaid recipient is a child or youth, the need for support for their parent or other primary caregiver must be identified in the Medicaid recipient’s comprehensive assessment or diagnostic evaluation; or
 - b. If the Medicaid recipient is a parent or primary caregiver struggling with support of their child with a BH diagnosis, the need for FPSS must be identified in their comprehensive assessment or diagnostic evaluation; or
 - c. If the Medicaid recipient is an adult providing primary support to either a partner or sibling or other identified family member the need for FPSS must be identified in the Medicaid recipient’s comprehensive assessment or diagnostic evaluation; or
 - d. If the Medicaid recipient is an adult that is being primarily supported by a partner or sibling or other family member, the need for FPSS for that supporting family member must be identified in the Medicaid recipient’s comprehensive assessment or diagnostic evaluation.
- 2) All family peer support services are delivered under the supervision of an independent practitioner or personnel trained or certified in supervising peers.
- 3) Services must include:
 - a. Review of the existing social history and other relevant information with the member and family;
 - b. Review of the existing service and treatment plans;
 - c. Identification of the recipient and family functional strengths and any barriers to resiliency;

- d. Education or referral for education for the family on the recipient's behavioral health condition and its effect on behavior; and
 - e. Participation in service planning with the member and family.
- 4) The specific services provided are tailored to the individual needs of the recipient and family according to the individual's treatment or service plan and may include, but are not limited to, support needed to:
- a. Direct the member and family toward recovery, resiliency, restoration, enhancement and maintenance of the member's functioning;
 - b. Increase the family's ability to effectively interact with the member;
 - c. Navigate the community-based systems and services that impact the member's life; and
 - d. Skills building for the family to support the member and may involve support activities such as:
 - (i) Identifying natural and community supports;
 - (ii) Assisting the member and family to understand, adjust to, and manage behavioral health crises and other challenges;
 - (iii) Facilitating effective access and use of the behavioral health service system to achieve recovery and resiliency.

C. Training for Family Peer Support Workers (FPSW)

The NM Children, Youth and Families Department Behavioral Health Services (CYFD BHS) collaborated with the HSD Behavioral Health Services Division (BHSD) and the NM Credentialing Board for Behavioral Health Professionals (NMCBBHP) to develop FPSW certification, to include the protocols for training, coaching, ethics, exams, and recertification. Training and certification began in spring, 2018.

CYFD BHS offers a training program for individuals seeking to work as Certified Family Peer Support Workers (CFPSW), utilizing the Family Run Executive Director Leadership Association (FREDLA) Parent Peer Support (PPS) Practice Model Participant, Supervisor, and Train the Trainer curricula. The five-day CFPSW training covers topics such as: building family strengths, leadership, responsibility, communication, resources, systems, and behavioral health and treatment. There are three goals of this training: 1) to assist CFPSWs in developing the skills and resources to serve families of children and youth with mental, emotional, or behavioral disorders; 2) to enhance and build upon expertise based on lived experiences; and 3) to prepare CFPSWs for roles and responsibilities on treatment and planning teams. To be considered for CFPSW and supervisor trainings, an application must be submitted to CYFD BHS. This includes a written application and a brief interview to confirm that eligibility requirements are met. Following successful completion of the training and endorsement by CYFD BHS, participants are permitted to take the NMCBBHP credentialing exam to obtain certification. Recertification occurs every two years.

BHSD, soon, will offer Family Peer Support Worker training as an adjunct to their Peer Support Worker Training. This role will serve the same listed services to adult family peers; that is partners, siblings or other significant support systems for adults with mental health or substance use disorders.

D. Billing Instructions

- 1) Use HCPCs code **H0038** in 15 min units, Peer support for self-help
- 2) Use modifier HQ for group
- 3) FQHC: UB claim form; revenue code 0919 for encounter rate
- 4) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

3.7 Intensive Outpatient Program for Substance Use Disorders

A. Policy

An Intensive Outpatient Program (IOP) provides a time-limited, multi-faceted approach to treatment for individuals who require structure and support to achieve and sustain recovery. IOP must utilize a research-based model and target specific behaviors with individualized behavioral interventions. Models already approved are:

- Matrix Model Adult Treatment Model
- Matrix Model Adolescent Treatment Model
- Minnesota Treatment Model
- Integrated Dual Disorder Treatment
- Seven Challenges

Any models other than those identified above must be approved by the Interdepartmental Council for Medicaid or the Collaborative, as appropriate for other funding sources. The process for approval is as follows:

- 1) The agency submits a narrative explaining why the above models will not work for their service delivery and outlines their alternative EBP or evidence informed model;
- 2) The interdepartmental council reviews the model and request;
- 3) The interdepartmental council and the agency enter into a discussion about the request;
- 4) If deemed appropriate, the IDC will send a letter of approval to the agency; if not deemed appropriate, the IDC and agency will remain in dialogue until an appropriate level, revision, or middle ground has been established.

Services are a combination of individual, group and family work. Adolescent IOP is offered at least 6 hours a week and adult IOP minimally 9 hours a week. This program is highly structured, targets substance use, and often co-occurring mental health disorders. The IOP services are provided through an integrated interdisciplinary approach or through coordinated, concurrent services with mental health providers, and cannot exclude consumers with co-occurring disorders.

Services are linguistically and culturally-sensitive and incorporate recovery and resiliency values into all service interventions. The service requires a comprehensive assessment, which identified IOP as a need, and the findings must carry through IOP treatment planning, intervention and discharge. The IOP agency is required to incorporate and utilize a system of program outcome evaluation.

B. Interdepartmental Council (IDC)

Oversees IOP services and manages the application process for providers wanting to add IOP to their menu of services. The IDC is comprised of the Medical Assistance Division (MAD),

Behavioral Health Services Division (BHSD), and the Children, Youth and Families Department (CYFD).

C. Procedures

Before engaging in an IOP program, the consumer must have a Diagnostic Evaluation and an Individualized Service Plan that includes IOP as an intervention and addresses all behavioral health concerns.

IOP program core services

- 1) discharge/transition services planning
- 2) individual and group therapy (group membership may not exceed 15 in number)
- 3) psychoeducation for the individual and their family

Treatment follows the provider's IOP model and must maintain fidelity to the model. The interdisciplinary team uses ONE service plan to direct coordinated, individualized care for all persons enrolled in the IOP, including when mental health counseling outside of IOP service is in place. Treatment services may include medication management to oversee use of psychotropic medications.

Duration

The duration of IOP intervention is typically 3 to 6 months with treatment plan updates every 90 days. After 6 months, the agency must demonstrate through treatment plan updates and ongoing documentation that the service is appropriate and meets medical necessity. The amount of weekly services per individual is directly related to the goals and objectives specified in the individual's treatment plan.

If discharge planning includes other outpatient services, referrals are made before the recipient is discharged from the program.

D. Staff Training

IOP personnel and agency records must contain documentation of the training of IOP staff in the chosen model.

E. Application Process for an Agency to Add IOP as a Medicaid Covered Service

- 1) Communicate interest in developing the service with the BHSD Clinical Services Manager (CSM) for an adult program or CYFD IOP lead staff for an adolescent program.
- 2) BHSD CSM or CYFD IOP lead staff will send application materials to the agency within 5 business days.

- 3) Agency returns materials to the BHSD CSM or CYFD IOP lead staff, who then brings the materials to the Interdepartmental Council for review. Materials will include: Attestation form, Certification tool, Policy & Procedures, and other documents accompanying the tool.
- 4) The review will be completed within 30 days, and if qualified, the agency is issued a provisional approval. If the application is lacking, the agency will be asked to submit additional information.
- 5) When provisional approval is attained, the agency receives a letter granting provisional approval with the understanding the service will be initiated within 90 days.
- 6) Agency sends all rendering providers to model training.
- 7) Agency provides approval letter when contacting MAD fiscal agent for the addition of IOP to their provider profile list of special services for which they are approved.
- 8) Agency takes approval letter and contacts all MCOs to add program to their contract.
- 9) Agency notifies BHSD CSM or CYFD IOP lead staff the first day services are delivered. The IDC schedules a site visit 180 days from the notice.
- 10) After the site visit, the agency will receive notice of corrective action or become fully approved for the service.
- 11) Agencies with multiple sites may have more than one site reviewed.
- 12) The IDC reserves the right to make annual site reviews, if deemed necessary.

F. Process for Approval of New Evidence-Based Practice (EBP)

To request approval of a different practice model the following domains must be described:

- 1) Trauma informed;
- 2) Culturally and linguistically relevant to the population being served;
- 3) Recovery and resiliency oriented;
- 4) Consistent with national best practice guidelines;
- 5) Evidence-based, or evidence informed; and
- 6) Fidelity monitoring and quality management.

G. Exhibits/Appendices/Forms

ZF: IOP Attestation Form
ZG: IOP Certification Tool
ZH: IOP Provider Certification Information
ZI: IOP Provider Application
ZJ: IOP Site Visit Preparation Form
ZK: IOP Process Flow
ZL: IOP Site Visit Tool

H. Billing Instructions

- 1) HCPCS **H0015** – 1 hour unit
- 2) Use agency NPI in rendering field
- 3) FQHC: UB claim form; revenue code 0919 for encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
- 4) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

3.8 Intensive Outpatient Program for Mental Health Conditions

A. Policy

An Intensive Outpatient Program (IOP) provides a multi-faceted approach to treatment for individuals who require structure and support to achieve and sustain recovery. IOP must utilize a research-based model or provide care consistent with national clinical best practice guidelines. All models must be approved by the Interdepartmental Council.

Services are a combination of individual, group and family work. Adolescent IOP is offered at least 6 hours a week and adult IOP minimally 9 hours a week. If an individual is consistently requiring more than 18 hours/week, the level of care should be reviewed. This program is highly structured, targets mental health conditions, and often co-occurring substance use disorders. The IOP services are provided through an integrated interdisciplinary approach or through coordinated, concurrent services with other providers. IOP services cannot exclude consumers with co-occurring disorders unless the presence of these conditions increases the acuity of the recipient to such a degree that a higher level of care is required.

Services are trauma informed, linguistically and culturally-sensitive, and incorporate recovery and resiliency values into all service interventions. The service requires a comprehensive assessment, and the findings must carry through treatment planning, intervention and discharge. The IOP agency is required to incorporate and utilize a system of program outcome evaluation.

Before engaging in an IOP program, the consumer must have a Diagnostic Evaluation and an individualized Service Plan that includes IOP as an intervention and addresses all behavioral health concerns.

B. Interdepartmental Council (IDC) & Approval of Practice Model

Oversees IOP services and manages the application process for providers wanting to add mental health IOP to their menu of services. The IDC is comprised of the Medical Assistance Division (MAD), Behavioral Health Services Division (BHSD), and the Children, Youth and Families Department (CYFD).

To request approval of a practice model, the specific implementation plan must be described addressing the following domains:

- 1) Trauma informed;
- 2) Culturally and linguistically relevant to the population being served;
- 3) Recovery and resiliency oriented;
- 4) Consistent with national best practice guidelines;
- 5) Evidence-based, or evidence informed; and
- 6) Fidelity monitoring and quality management.

C. Procedures

- 1) Assessment;
- 2) Treatment plan;
- 3) Discharge/transition services planning;
- 4) Individual, group therapy, and family therapy or multi-family therapy if indicated; and
- 5) Psychoeducation, illness management, and recovery skills for the individual and family, if indicated.

Treatment follows the provider's IOP model and must maintain fidelity to the model. The interdisciplinary team uses ONE service plan to direct coordinated, individualized care for all persons enrolled in the IOP, including when other related services outside of IOP service are in place.

Treatment plan updates occur every 90 days. The amount of weekly services per individual is directly related to the goals and objectives specified in the individual's treatment plan.

If discharge planning includes other outpatient services, referrals are made before the recipient is discharged from the program.

D. Staff Training

IOP personnel and agency records must contain documentation of the training of IOP staff in:

- 1) Trauma informed approach;
- 2) Culture and linguistics relevant to the population being served;
- 3) Recovery and resiliency;
- 4) Consistency with national best practice guidelines for chosen clinical model;
- 5) Evidence-based, or evidence informed practice; and
- 6) For supervisory and administrative staff, fidelity monitoring and quality management.

E. Application Process for an Agency to Add IOP as a Medicaid Covered Service

- 1) Communicate interest in developing the service with the BHSD Clinical Services Manager (CSM) for an adult program or CYFD IOP lead staff for an adolescent program.

- 2) BHSD CSM or CYFD IOP lead staff will send application materials to the agency within 5 business days.
- 3) Agency returns materials to the BHSD CSM or CYFD IOP lead staff, who then brings the materials to the Interdepartmental Council for review. Materials will include: Attestation form, Certification tool and Policy & Procedures.
- 4) The review will be completed within 30 days, and if qualified, the agency is issued a provisional approval. If the application is lacking, the agency will be asked to submit additional information.
- 5) When provisional approval is attained the agency receives a letter granting provisional approval with the understanding the service will be initiated within 90 days.
- 6) Agency sends all rendering providers to model training.
- 7) Agency takes approval letter and contacts all MCOs to add program to their contract.
- 8) Agency notifies BHSD CSM or CYFD IOP lead staff the first day services are delivered. The IDC schedules a site visit 180 days from the notice.
- 9) After the site visit, the agency will receive notice of corrective action or become fully approved for the service.
- 10) Agencies with multiple sites may have more than one site reviewed.
- 11) The IDC reserves the right to make annual site reviews, if deemed necessary.

F. Billing Instructions

- 1) HCPCS **H0015** - 1 hour unit
- 2) Use agency NPI in rendering field
- 3) FQHC: UB claim form; revenue code 0919 for encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
- 4) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 5) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

3.9 Medication Assisted Treatment for Buprenorphine (MAT)

A. Procedure for Delivering MAT with Telemedicine

Under the Ryan Haight Act of 2008, where controlled substances are prescribed by means of the Internet, the general requirement is that the prescribing Practitioner must have conducted at least one in-person medical evaluation of the patient. U.S.C. § 829(e). However, the Act provides an exception to this requirement. 21 U.S.C. § 829(e)(3)(A). Specifically, a DEA-registered Practitioner acting within the United States is exempt from the requirement of an in-person medical evaluation as a prerequisite to prescribing or otherwise dispensing controlled substances by means of the Internet if the Practitioner is engaged in the practice of telemedicine and is acting in accordance with the requirements of 21 U.S.C. § 802(54).

Under 21 U.S.C. § 802(54)(A),(B), for most (DEA-registered) Practitioners in the United States, including Qualifying Practitioners and Qualifying Other Practitioners (“Medication Assisted Treatment Providers”), who are using FDA approved Schedule III-V controlled substances to treat opioid addiction, the term “practice of telemedicine” means the practice of medicine in accordance with applicable Federal and State laws, by a practitioner (other than a pharmacist) who is at a location remote from the patient, and is communicating with the patient, or health care professional who is treating the patient using a telecommunications system referred to in (42 CFR § 410.78(a)(3)) which practice is being conducted:

- 1) While the patient is being treated by, and physically located in, a DEA-registered hospital or clinic registered under 21 U.S.C. § 823(f) of this title; and by a practitioner
 - a. who is acting in the usual course of professional practice;
 - b. who is acting in accordance with applicable State law; and
 - c. is registered under 21 U.S.C. § 823(f) with the DEA in the State in which the patient is located.

OR

- 2) While the patient is being treated by, and in the physical presence of, a DEA-registered practitioner
 - a. who is acting in the usual course of professional practice;
 - b. who is acting in accordance with applicable State law; and
 - c. is registered under 21 U.S.C. § 823(f) with the DEA in the State in which the patient is located.

The distant Practitioner engaged in the practice of telemedicine must be registered with the DEA in the state where they are physically located and, in every state, where their patient(s) is (are) physically located. 21 U.S.C. § 822 (e)(1); 21 CFR § 1301.12 (a); Notice 69478 Federal Register, Vol. 71, No. 231, Friday, December 1, 2006.

All records for the prescribing of an FDA approved narcotic for the treatment of opioid addiction need to be kept in accordance with 21 CFR § 1304.03(c), 21 CFR § 1304.21(b), and with all other requirements of 21 CFR Part 1300 to End.

HHS has developed the following case scenario to provide clinicians with an example of a clinical practice engagement consistent with the DEA statement and applicable HHS administered authorities.

- A patient is being seen in a rural health clinic staffed by a nurse practitioner licensed in the state and has a DEA registration consistent with the nurse practitioner's scope of practice.
- The nurse practitioner conducts an examination of the patient and determines that treatment with buprenorphine for opioid addiction is clinically indicated, and the patient agrees to treatment.
- The nurse practitioner does not have a DATA 2000 waiver to prescribe buprenorphine for the treatment of opioid addiction, but the clinic has an agreement with an addiction specialist in a large city in the same state (or in another state so long as the remote addiction specialist is also registered with the DEA and licensed in the state where the patient is located) to provide remote telemedicine services for addiction treatment.
- The remote addiction specialist has a DATA 2000 waiver to prescribe buprenorphine for the treatment of opioid addiction and is licensed and DEA-registered in the state where the rural health clinic is located.
- At the patient visit, the nurse practitioner connects the patient to the remote addiction specialist via an appropriately safeguarded interactive telecommunications system.
- The addiction specialist, after engaging with the patient remotely, concurs with the nurse practitioner that buprenorphine is clinically indicated for this patient and issues a prescription for a specific formulation and dosage of a buprenorphine product to be filled at the patient's local pharmacy.
- After the initial encounter, the patient continues to have his/her buprenorphine treatment managed by the remote DATA 2000-waived practitioner (who remains the buprenorphine prescriber of record) in collaboration with the local nurse practitioner.
- The patient will be considered a patient of the DATA 2000-waived practitioner for purposes of 21 U.S.C. § 823(g)(2), and 42 CFR Part 8, Subpart F when applicable.

B. Best Practice Guidelines for MAT via Telemedicine

All efforts must be made to furnish telemedicine services consistent with national best practice and comply with HIPAA regulations. Please see American Telemedicine Association Practice Guidelines for Tele mental Health with Children and Adolescents (2017), American Telemedicine Association Practice Guidelines for Video Based Online Mental Health Services (2009), American Telemedicine Association's Evidence Based Practice for Tele mental Health (2009), and American Telemedicine Association Practice Guidelines for Video-conferencing Based Tele mental Health (2009). The following are some links for further information:

<https://www.telehealthresourcecenter.org/>

<https://www.telehealthresourcecenter.org/toolbox-module/legal-issues-privacy-and-contracting-services>

<https://www.telehealthresourcecenter.org/toolbox-module/getting-started>

<https://www.telehealthresourcecenter.org/toolbox-module/facilities-provider-site>

C. Billing Instructions

- 1) Diagnosing, assessing, prescribing, and initial induction
 - a. Practitioners with the DATA 2000 waiver; physicians, CNS, and CNP
 - b. Use **E & M** codes for history & physical
 - c. Induction: **H0033**

- 2) Medication Administration (after initial induction)
 - a. Practitioners: RN (317) or PA (305) under supervision of an M.D. or CNP
 - b. **H2010**

- 3) Subsequent MD/CNP/PA visits: use **E & M** codes

- 4) FQHC: UB claim form; revenue code 0919 for encounter rate

- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate

3.10 Partial Hospitalization Services in Acute Care or Psychiatric Hospital

A. Billing Instructions

- 1) Facility billing
 - a. Bill on a UB; **revenue code 0912**
 - b. **HCPCS code S0201** per diem. However, the rate for S0201 represents 8 hours of partial hospitalization. If the recipient is in the partial hospitalization program for less than 8 hours, the quantity of service must be billed in the units of 0.25 (2 hours); 0.5 (4 hours), or 0.75 (6 hours). If the recipient is in the partial hospitalization program for more than 8 hours in one day, the units may be increased as 1.25 (10 hours); 1.5 (12 hours); 1.75 (14 hours); or 2 (16 hours).
 - (i) Includes all hospital staff that are required for the PH program: independently licensed supervisor, registered nurse, non-independent behavioral health practitioner;
 - (ii) Includes optional staff such as licensed practical nurse, physician assistant, peer support worker, and medical technician.
 - c. Type of bill 131
- 2) Professional billing

For other professional services by physician, psychiatrist, psychologist, certified nurse practitioner, clinical nurse specialist, independently licensed behavioral health practitioners, and occupational therapists, bill on a CMS 1500 claim form.

 - a. **97530** – occupational therapy; therapeutic activities, each 15 minutes
 - b. **G0410** – Group psychotherapy other than with a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
 - c. **G0411** – Interactive group psychotherapy in a partial hospitalization setting, approximately 45 to 50 minutes
 - d. **90832** – **90838** – Individual Psychotherapy
 - e. Evaluation and management services, utilize E & M codes with fee schedule reimbursement
 - f. 90870-90871 – Electroconvulsive Therapy Treatment
 - g. Bill professional services on the CMS 1500 format (837P)
 - h. Other medical services that are not related to the purpose of the partial hospitalization can be reimbursed if they are medically necessary

3.11 Peer Support Services

A. Definition

Peer support services are delivered by individuals who have common life experiences with the people they are serving (retrieved from: SAMHSA.org.). A Certified Peer Support Worker (CPSW) is an individual in recovery with mental health and/or substance use conditions who has successfully completed a training class and passed a certification exam. CPSWs use their experience to inspire hope and instill in others a sense of empowerment. They are trained to deliver an array of support services and to help others identify and navigate systems to aid in recovery. Through wisdom from their own lived experience, they inspire hope and belief that recovery is possible. The following are some examples of peer support services:

- 1) Providing support for clients' physical health conditions or concerns;
- 2) Giving assistance with independent living skills (e.g. money management problem solving, establishing boundaries, reducing stress);
- 3) Working together to develop socialization and recreational skills;
- 4) Setting a plan to provide aid and comfort to a person in crisis; and
- 5) Developing recovery and resiliency skills.

B. Purpose

The Certified Peer Support Worker is an integral and highly valued member of the interdisciplinary team. They provide formalized peer support and practical assistance to people who have or are receiving services to help regain control over their lives in their own unique recovery process. Through a collaborative peer process, information sharing promotes choice, self-determination and opportunities for the fulfillment of socially valued roles and connection to their communities.

C. Policy

- 1) Peer Support Services must be identified as a service need in the recipient's comprehensive assessment or diagnostic evaluation;
- 2) All peer support services are delivered under the supervision of an independent practitioner or personnel trained or certified in supervising peers.

D. Procedures

- 1) Prerequisites for applying to become certified:
 - a. 18 years of age or older;
 - b. Self-identify as a current or former consumer of mental health and/or substance abuse services;
 - c. High school diploma or GED;
 - d. A minimum of two years in recovery with a required reference letter for verification; and
 - e. Have no convictions for domestic violence, sexual offenses or other serious crimes against persons.

- 2) Complete on-line application at:
<https://nmpeers17.wufoo.com/forms/m186ziiq19b6fkk/>
- 3) Complete the Peer Support Worker training offered through the Office of Peer Recovery and Engagement by State Approved Trainers.
- 4) Complete 40 hours of pre-exposure hours at a community based behavioral health agency.
- 5) Supply a letter of reference and/or support from a person familiar with your recovery, including contact information for the reference.
- 6) Take and pass CPSW examination. Offered by the New Mexico Credentialing Board for Behavioral Health Professionals (NMCBBHP):
<http://www.nmcbbhp.org/examination-dates.html>
- 7) Agree to abide by the New Mexico Certified Peer Support Worker's Code of Ethics.

E. Billing Instructions

- 1) **H0038**; 15 minute unit
- 2) Add modifier HQ for groups
- 3) FQHC: UB claim form; revenue code 0919 for encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
- 4) IHS/638: UB claim form; revenue code 0919 for OMB rate unless otherwise negotiated with the facility.

3.12 Recovery Services (Managed Care/Centennial Care enrollees only)

A. Definition

The process of recovery is highly personal and individualized. Its definition is reflective of what challenges each person has overcome so that challenge no longer impedes in that person's quality of life. Recovery is characterized by continual growth and improvement in one's health and wellness, social and spiritual connection, and renewed purpose. A person's recovery reflects a person's strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person, the person in their community, and is supported by peers, friends, and family members.

B. Purpose

Recovery may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. These recovery support services should be culturally and linguistically appropriate and assist individuals and families working toward recovery from mental and/or substance use problems and/or trauma. Recovery support services incorporate a full range of social, legal, and other services that facilitate recovery; wellness; linkage to and coordination among service providers and other supports shown to improve quality of life for people in, and seeking, recovery and their families.

C. Procedures

- 1) Services occur individually or with consumers who support each other to optimize learning new skills. This skill enhancement then augments the effectiveness of other treatment and recovery support initiatives.
- 2) Focuses on the individual's wellness, ongoing recovery and resiliency, relapse prevention, and chronic disease management.
- 3) Recovery services activities include, but are not limited to:
 - a. screening, engaging, coaching, and educating;
 - b. emotional support that demonstrates empathy, caring, or concern to bolster the person's self-esteem and confidence;
 - c. sharing knowledge and information or providing life skills training;
 - d. provision of concrete assistance to help others accomplish tasks; and
 - e. facilitation of contacts with other people to promote learning of social and recreational skills, creating community and acquiring a sense of belonging.

D. Billing Instructions

- 1) HCPCS code H2030 in 15 min units
- 2) Rendering provider required
- 3) H0038; (Peer Support) 15 min units
- 4) FQHC: UB claim form; revenue code 0919 for encounter rate
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate

3.13 Smoking Cessation Counseling

Smoking cessation: MAD covers tobacco cessation services for a pregnant eligible recipient and for an eligible recipient under the age of 21.

A. Eligible practitioners

- 1) By or under the supervision of a physician; or
- 2) By any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law;
- 3) Counseling service must be prescribed by a MAD enrolled licensed practitioner.

B. Covered Services

- 1) Tobacco cessation drug items prescribed by a practitioner.
- 2) Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session requires face-to-face contact.
- 3) Intermediate session (greater than three minutes up to 10 minutes);
- 4) Intensive session (greater than 10 minutes).

C. Documentation for Counseling Services

Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered.

D. Referrals

Department of Health offers a smoking cessation program which can be accessed at www.nmtupac.com

E. Billing Instructions (Individual counseling only)

- 1) 99406: 3 – 10 minutes
- 2) 99407: Over 10 minutes
- 3) FQHC: Use CMS 1500 at fee schedule rates
- 4) IHS/Tribal 638: Use CMS 1500 at fee schedule rates

Section Four: Special Outpatient Services for Children and Adolescents

4.1 Behavioral Health Respite Care

A. Billing Instructions

- 1) MCO coverage only
- 2) Provider types that can bill are CSA (446), BHA (432), or TFC (218)
- 3) HCPCS code **T1005** in 15 min units
- 4) Annual limit of 720 hours or 30 days. If needing more, request to MCO with medical necessity.
- 5) FQHC & IHS/Tribal 638 bill as contracted with MCO(s)

4.2 Behavior Management Services (BMS)

These instructions apply in conjunction with applicable legislation, laws, codes and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

A. Definition

Behavior Management Services are individualized, trauma informed care which provides skill development through an individualized treatment plan designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. Behavior management skills development services are delivered to clients in need of intervention to avoid inpatient hospitalization, residential treatment or separation from his/her family; or require continued intensive or supportive services following hospitalization or out-of-home placement as a transition to maintain the client in the least restrictive environment possible. Each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable Certification Requirements are met. Services are client-driven, evidence-based best practices based on outcomes.

B. Policy

- 1) Initial Screening: (7.20.11.23 NMAC)
 - a. Initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment;
 - b. Assessment for risk of behavior that is life-threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

- 2) Comprehensive assessment (7.20.11.23 and 7.20.11.28 NMAC)
 - a. The agency conducts a comprehensive assessment of each client's clinical needs prior to writing the comprehensive treatment plan. The comprehensive assessment includes the following:
 - (i) assessment of the client's personal, family, medical and social history;
 - (ii) relevant previous records and collateral information;
 - (iii) relevant family and custodial history, including non-familial custody and guardianship;
 - (iv) client and family abuse of substances;
 - (v) medical history, including medications;
 - (vi) history, if available, as a victim of physical abuse, sexual abuse, neglect, or other trauma;
 - (vii) history as a perpetrator of physical or sexual abuse;
 - (viii) the individual's and family's perception of his or her current need for services;
 - (ix) identification of the individual's and family's strengths and resources;
 - (x) evaluation of current mental status;

- (xi) a psychosocial evaluation of the client’s status and needs relevant to the following areas, as applicable:
 - Psychological functioning
 - Intellectual functioning
 - Educational/vocational functioning
 - Social functioning
 - Developmental functioning
 - Substance abuse
 - Culture
 - Leisure and recreation
 - (xii) Evaluation of high risk behaviors or potential for such; and
 - (xiii) A summary of information gathered in the clinical assessment process, in a clinical formulation that includes identification of underlying dynamics that contribute to identified problems and service needs.
 - b. If the comprehensive assessment is completed prior to admission, it is updated at the time of admission for each certified service;
 - c. Assessment information is reviewed and updated as clinically indicated, and is documented in the client’s record;
 - d. For clients who have been in the service for one year or longer, an annual mental status exam and psychosocial assessment are conducted and documented in the client’s record as an addendum to previous assessment(s); and
 - e. The agency makes every effort to obtain all significant collateral information and documents its efforts to do so. As collateral information becomes available, the comprehensive assessment is amended.
- 3) BMS Treatment Plan (7.20.11.28 NMAC)
 Clinical review of assessment information enables the completion of the BMS treatment plan within 14 days of admission to BMS. The treatment plan includes:
- a. Client needs;
 - b. Measurable goals;
 - c. Interventions; and
 - d. A discharge plan developed through partnership with other agencies or individuals involved in the client’s care including links or referrals to aftercare, as indicated.
- 4) Discharge Plan Criteria (7.20.11.7 and 7.20.11.28 NMAC)
- a. Establishes a projected discharge date;
 - b. Describes behavioral and other clinical criteria as conditions under which discharge will occur;
 - c. Includes level of care, specific services to be delivered, and the living situation into which discharge is projected to occur;
 - d. Lists individuals responsible for implementing each action specified in the discharge plan;
 - e. Identifies barriers to discharge; and
 - f. Identifies discharge plan revisions, as indicated.
- 5) Clinical Supervision (7.20.11.7, 7.20.11.16 and 7.20.11.28 NMAC)

- a. All services are provided under the supervision of a clinical director who is a licensed independent practitioner that provides clinical oversight of the program;
 - b. All supervision to agency staff is documented;
 - c. Supervision may be direct, or may occur through a clinical supervisor who is directly supervised by the clinical director;
 - d. When the therapist and clinical supervisor are the same person, another properly credentialed clinician, either from within the agency or from outside the agency, provides supervision at least one time per month to the clinical supervisor.
- 6) BMS-Specific Supervision
- a. BMS specialists receive supervision by a New Mexico licensed practitioner with a doctoral or master's degree from an accredited institution in a human service related field who has at least two years' experience working with children, adolescents and families;
 - b. Exception: If a supervisor with the above qualifications cannot be recruited, the supervisor must possess, at a minimum, a B.S.W., B.A., B.S., or B.U.S. in a human service related field plus four years' experience working with seriously emotionally disturbed or neurobiological disordered children and adolescents;
 - c. Supervision is provided for a minimum of two hours per month, depending upon the complexity of the needs presented by clients and the supervisory needs of the behavior management skills development specialist; and
 - d. All clinical supervision/consultation is documented and includes:
 - Theme
 - Date
 - Length of time of supervision
 - Signatures of those participating

C. Related Policies

- 1) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC
- 2) Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC
- 3) Health Facility Sanctions and Civil Monetary Penalties, 7.18 NMAC
- 4) New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997)
- 5) Governing Background Checks and Employment History Verification, 8.8.3 NMAC
- 6) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.2.11 and 8.321.2.27 NMAC

D. Billing Instructions

- 1) **H2014:** 15 min units
- 2) Practitioners: 430, specialty 113 (BMS worker)
- 3) Utilize agency NPI in rendering field
- 4) FQHC: UB claim form; revenue code 0919 for encounter rate
- 5) For FQHC, if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

4.3 Day Treatment Services (DTS)

These instructions apply in conjunction with applicable legislation, laws, codes, and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

A. Policy

Day Treatment Services are individualized, trauma informed care provided in a school or other community setting and are distinct from partial hospitalization services provided in a psychiatric hospital. Education services are provided through the public-school system or through a New Mexico accredited private school in coordination with this service. Coordinated intensive structured therapeutic services are individualized and provided for children, adolescents and their families living in the community. Each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable Certification Requirements are met. Services are client-driven, evidence-based best practices based on outcomes.

B. Related Policies

- 1) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC
- 2) New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997)
- 3) Governing Background Checks and Employment History Verification, 8.8.3 NMAC
- 4) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.20

C. Day Treatment Services Treatment Plan (7.20.11.7, 7.20.11.23 and 7.20.11.27 NMAC)

The treatment planning process is individualized and ongoing. It includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.

- 1) Initial Treatment Plan
 - a. Developed and documented within 72 hours of admission to the service;
 - b. Individualized treatment goals and objectives are targeted the first 14 days of treatment.
- 2) Comprehensive Treatment Plan
 - a. Developed and documented within 14 days of admission to the service;
 - b. Based on the comprehensive assessment; developed within 14 days of admission.
- 3) Initial and Comprehensive Treatment Plan Requirements
 - a. Involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible;
 - b. Reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record;

- c. Conducted in a language the client and/or family members can understand, or is explained to the client in language that invites full participation;
 - d. Designed to improve the client's motivation and progress, and strengthen appropriate family relationships;
 - e. Designed to improve the client's self-determination and personal responsibility;
 - f. Utilizes the client's strengths;
 - g. Is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable him/her to conduct treatment planning;
 - h. Treatment plans meet the provisions of the Children's Code, NMSA 1978, Sections 32A-6-10, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children's Code;
 - i. Documents in measurable terms:
 - (i) Specific behavioral changes targeted, including potential high-risk behaviors;
 - (ii) Corresponding time-limited intermediate and long-range treatment goals and objectives;
 - (iii) Frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures;
 - (iv) Staff responsible for each intervention;
 - (v) Projected timetables for the attainment of each treatment goal;
 - (vi) A statement of the nature of the specific problem(s) and needs of the client;
 - (vii) A statement and rationale for the plan for achieving treatment goals;
 - (viii) Specifies and incorporates the client's permanency plan, for clients in the custody of the department; and
 - (ix) Provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised to ensure their safety and that of others.
- 4) Discharge Planning Requirements:
- a. Establishes a projected discharge date, which is updated as clinically indicated;
 - b. Describes behavioral and other clinical criteria as conditions under which discharge will occur;
 - c. Requires that the client has achieved the objectives of the treatment plan;
 - d. Evaluates high risk behaviors or the potential for such;
 - e. Documents that discharge is safe and clinically appropriate for the client;
 - f. Documents level of care, specific services to be delivered, and the living situation into which discharge is projected to occur;
 - g. Establishes specific criteria for discharge to a less restrictive setting;
 - h. Explores options for alternative or additional services that may better meet the client's needs;
 - i. Documents individuals responsible for implementing each action specified in the discharge plan;

- j. Identifies barriers to discharge; and
- k. Revises plan as indicated.

D. Billing Instructions

- 1) **H2012:** 1hour unit
- 2) Utilize agency NPI in rendering field
- 3) FQHC: UB claim form; revenue code 0919 for encounter rate
- 4) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 5) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

4.4 Multi-systemic Therapy (MST)

A. Concurrence with Other Legislation and Regulations

These instructions apply in conjunction with applicable legislation, laws, codes, and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

B. Multi-systemic Therapy for Youth with Problem Sexual Behaviors

Basic Program Description

Multisystemic Therapy (MST) is an intensive family and community, evidence-based treatment that addresses the multiple causes of serious antisocial behavior across key systems within which youth are embedded (family, peers, school, and neighborhood). MST for sexual offenders (MST-PSB) focuses on aspects of a youth's ecology that are functionally related to the problem sexual behavior and includes reduction of parent and youth denial about the sexual offenses and their consequences; promotion of the development of friendships and age-appropriate sexual experiences; and modification of the individual's social perspective-taking skills, belief system, or attitudes that contributed to sexual offending.

Target Population

Youth, 10 to 17.5 years old who have committed, or have been accused of committing, a sexually victimizing offense against another. Youth can be both adjudicated and non-adjudicated, and youth may present with other antisocial or delinquent behaviors. The program will also accept youth returning home following residential or out of home placement. Services require the willingness of at least one caregiver to actively participate in the program.

Service Delivery

Referred families receive services in the home and community for a period of 5-7 months. Therapists have 3-5 families on their caseloads and are available to the family 24 hours a day 7 days a week, based on the needs of the family and the youth.

Primary Treatment Goals

- 1) Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s);
- 2) Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school, and neighborhood problems.

Exclusionary Criteria

- 1) Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.

- 2) Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors.
- 3) Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- 4) Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.

C. Billing Instructions

- 1) **H2033:** modifier required
 - a. HO = Masters level rendering
 - b. HN = Bachelors level rendering
- 2) Unit = 15 min
- 3) Provider types: BHA, CMHC, CSA, FQHC, Tribal 638, IHS
- 4) Utilize agency NPI in rendering field
- 5) FQHC: UB claim form; revenue code 0919 for encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
- 6) IHS/638: UB claim form; revenue code 0919 for OMB rate unless otherwise negotiated with the facility.
- 7) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

SECTION FIVE: SPECIALIZED OUTPATIENT SERVICES FOR ADULTS

5.1 Assertive Community Treatment Services (ACT)

A. Policy

The ACT model defines an interdisciplinary mental health staff as an accountable, mobile mental health agency or group of treaters who function interchangeably to provide the treatment, rehabilitation, and support services that persons with severe mental illnesses need to live successfully in the community. The primary goals of ACT treatment are:

- 1) To lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness;
- 2) To meet basic needs and enhance quality of life;
- 3) To improve functioning in adult social and employment roles and activities;
- 4) To increase community tenure; and
- 5) To lessen the family's burden of providing care.

ACT is a voluntary psychiatric, comprehensive case management and psychosocial intervention program provided on the following principles:

- 1) The service is available 24 hours a day, seven days a week;
- 2) The service is provided by an interdisciplinary ACT team that includes trained personnel as defined in Subsection A of 8.321.2.13 NMAC;
- 3) An individualized treatment plan and supports are developed and must be reviewed and updated every six months;
- 4) Approximately 90 percent of services are delivered as community-based, non-office-based outreach services (in vivo);
- 5) An array of services is provided based on the eligible recipient's need;
- 6) The service is recovery oriented;
- 7) Following the ACT evidence-based fidelity model guidelines, the ACT team maintains a low staff to patient ratio;
- 8) Mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations;
- 9) The team is not just a consortium of mental health specialists, but includes collaborative assessment and treatment planning for each recipient; cross-training

of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each recipient's care and services; and

- 10) The team will assist the eligible recipient to access other appropriate services in the community that are not funded by MAD.

B. Target Population

The ACT model is indicated for adults with severe and persistent mental illnesses, which are psychiatric disorders that cause symptoms and impairments in basic mental and behavioral processes. ACT services are intended primarily for individuals with psychiatric illnesses that are most severe and persistent, including schizophrenia and other psychotic disorders. In addition, ACT services are appropriate for some people who experience significant disability from other disorders and who have not been helped by traditional mental health services. Symptoms of these psychiatric illnesses are primarily psychotic (e.g. hallucinations, delusions, thought and speech disorganization), affective (e.g. depression, euphoria, or irritable mood, increased or decreased thinking and activity, impulsivity), or anxiety related (e.g. obsessions, compulsions, panic attacks) and typically occur in acute episodes that can last weeks to months and recur several times over the life span. During an episode, people are often unable to adequately care for themselves and need intensive services and supports, including hospitalization. The symptoms completely remit with effective treatment for the majority of clients, though for many individuals the symptoms remit only partially, and they continuously experience them. In some disorders, symptoms are continuous with fluctuating levels of intensity.

In addition to symptoms, a significant number of persons with severe psychiatric conditions have persistent impairments that are the major cause of long term disability and poor community functioning. The most prominent impairments occur in the following areas:

- 1) Thinking and planning - slowed thinking, decreased capacity to devise and carry out solutions to problems;
- 2) Problems in focusing attention, rapid forgetting of newly learned information, and difficulty making decisions; and
- 3) Sociability and emotional expression - restricted or blunted affect, reduced spontaneity and curiosity, social awkwardness and withdrawal, reduced ability to experience pleasure (i.e., anhedonia), and mood instability.

Where a history of repeated hospitalizations or incarcerations due to mental illness are present:

The definition of clients in greatest need include people who have major symptoms that improve only partially or not at all with medication and other treatments (e.g., greater than one-quarter of those with schizophrenia) (Shepherd, Watt, Falloon, & Smeeton, 1989; Kane & Marder, 1993; Marder, 1996) and who, as a result, have:

- (1) Severe persistent or intermittent symptoms that create personal suffering and distress (e.g., hallucinating and delusional most hours of the day and, consequently, fearful and isolated); **or**

- (2) Serious disability resulting from mental and behavioral impairments (e.g., multiple evictions because of poor care of residence and disruption of neighbors, job losses secondary to poor concentration and anxiety with co-workers).

Persons in greatest need are also individuals who may have coexisting substance use disorder, physical illnesses (e.g., diabetes), or disabilities (e.g., visual impairment) that aggravate psychiatric symptoms and impairments and magnify overall service needs.

C. Quality Measurement

An ACT program's success is evaluated based on outcomes which may include but are not limited to: improved engagement by the eligible recipient in medical and social services; decreased rates of incarceration; decreased rates of hospitalization; decreased use of alcohol or illegal drugs; increased housing stability; increased relationships of the eligible recipient with his or her family (as appropriate); increased employment; and increased attainment of goals self-identified by the eligible recipient for his own life. Fidelity to the specific evidence-based ACT service model will also be measured to assure that ACT, rather than some other form of intensive case management, is being provided.

- 1) ACT services must be provided to the eligible recipient by the treatment team members.
- 2) ACT program provides three levels of interaction with an eligible recipient:
 - a. face-to-face encounters are approximately 60 percent of all ACT team activities with approximately 90 percent of ACT encounters occurring outside of the ACT agency's office (in vivo);
 - b. a collateral encounter where the collaterals are members of the eligible recipient's family or household or significant others (e.g. landlord, criminal justice staff, and employer) who regularly interact with him or her and are directly affected by or have the capability of affecting the eligible recipient's condition, and are identified in the service plan as having a role in treatment; a collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff that is assisting an ACT eligible recipient in locating housing);
 - c. assertive outreach consists of the ACT team being 'assertive' about monitoring and connecting with an eligible recipient and acting quickly and decisively when action is called for, while increasing the eligible recipient's independence; the team must closely monitor the relationships that the eligible recipient has within the community and intervene early if a difficulty arises. This type of outreach is key to ACT, and is defined, in the ACT manual, as not merely discharging for lack of engagement or no-shows but being aggressive in trying to find and engage with the patient. For homeless individuals, or individuals who may leave their home this is a key to success;
 - d. collateral encounters and assertive outreach combined must not exceed 40 percent of the total ACT team activities for each eligible recipient; and

- e. all the above activities must be indicated in the eligible recipient's service plan.

D. Procedures

Agencies interested in pursuing ACT services should do the following:

- 1) Attend the state approved ACT training;
- 2) Communicate with the BHSD Clinical Services Manager their interest in developing the service;
- 3) Review the implementation manual and start up guide;
- 4) Determine if they have the ability to: build the ten-person team; administratively, financially and clinically meet all expected standards outlined in this BH Policy Manual; and meet 8.321.2.12 NMAC regulations;
- 5) Build agency Policy and Procedure for the implementation and oversight of the service; and
- 6) Submit an ACT application and accompanying materials to the BHSD CSM.

E. Exhibits/Appendices/Forms

Appendix ZM:	ACT Readiness Tool
Appendix ZN:	ACT Review Tool
Appendix ZO:	DACTS/ GOI: Dartmouth Assertive Community Treatment Scale
Appendix ZP:	ACT Chart Audit Tool
Appendix ZQ:	ACT Service Audit Tool
Appendix ZQQ:	TMACT Updated Fidelity Tool
Appendix ZR:	ACT Process Flow

F. Billing Instructions

- 1) **H0039:** 15 min unit
- 2) Modifier required:
 - a. **U1** = face-to-face
 - b. **U2** = collateral encounter
 - c. **U3** = assertive outreach
 - d. **U4** = group
- 3) Utilize agency provider ID and NPI in rendering fields
- 4) FQHC: UB claim form; revenue code 0919 for encounter rate
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 6) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

5.2 Cognitive Enhancement Therapy (CET)

A. Purpose

To help people with schizophrenia and related cognitive disorders improve brain and cognitive development, social cognition, and increase vocational capabilities.

B. Description

Cognitive Enhancement Therapy (CET) is a cognitive rehabilitation training program for adults with chronic or early-course schizophrenia or schizoaffective disorder (per DSM criteria) who are stabilized and maintained on antipsychotic medication and not abusing substances. CET is designed to provide cognitive training to participants to help them improve impairments related to neurocognition (including poor memory and problem-solving abilities), cognitive style (including impoverished, disorganized, or rigid cognitive style), social cognition (including lack of perspective taking, foresight, and social context appraisal), and social adjustment (including social, vocational, and family functioning), which characterize these mental disorders and limit functional recovery and adjustment to community living. Through CET, participants learn to shift their thinking from rigid serial processing to a more generalized processing of the core or gist of a social situation and a spontaneous abstraction of social themes.

CET is manually-driven and delivered over a period of 18 months, beginning with approximately 3 months of weekly 1-hour sessions of computer-assisted neurocognitive attention training conducted with pairs of participants. As the treatment proceeds over 18 months, participants engage in 60 hours of targeted, performance-based neurocognitive training exercises to improve their attention, memory, and problem-solving abilities. After approximately 3 months of neurocognitive training, participants start to attend social-cognitive group sessions, which last for 1.5 hours each and are held weekly; there are a total of 45 social-cognitive group sessions in the program. In these sessions, clinicians help groups of six to eight participants improve social-cognitive abilities (e.g., taking perspectives, abstracting the main point in social interactions, appraising social contexts, managing emotions) and achieve individualized recovery plans. Participants also use experiential learning and real-life cognitive exercises to facilitate the development of social wisdom and success in interpersonal interactions; enhance social comfort; respond to unrehearsed social exchanges; present homework and lead homework reviews; provide feedback to peers; and receive psychoeducation on social cognition and schizophrenia. Clinicians provide active, supportive coaching to keep each participant on task and to encourage greater understanding of social cognition and greater elaboration, organization, and flexibility in thinking and communication. After social-cognitive group sessions begin, neurocognitive training and social-cognitive training proceed concurrently throughout the remainder of the program.

C. Staffing

Both neurocognitive training and social-cognitive group sessions are facilitated by master's-level clinicians, psychologists, or CSWs who have at least 2 years' experience working with adults with serious mental illness and who have participated in a specialized training such as that offered by CET Cleveland, CET Training LLC or another training curriculum approved by BHSD. CET is designed to be implemented in agency and center-based treatment settings.

D. Additional Requirements

Agencies seeking to be designated to deliver CET must participate and complete a training program approved by BHSD such as CET Cleveland or CET Training, LLC. The computer assisted training modules and intervention manuals can be obtained as part of the training. Agencies that are actively participating in approved training and supervision can bill for services delivered while completing supervision requirements.

E. Billing Instructions

- 1) **G0515** – 15 min units
- 2) Agencies: CMHC, FQHC, IHS, Tribal 638, CSA, CLNM HH, BHA with Supervisory Certificate.
- 3) Utilize agency provider ID and NPI in rendering fields.
- 4) FQHC: UB claim form; revenue code 0919 for encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate unless otherwise negotiated with the facility.
- 6) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

5.3 Opioid Treatment Program (OTP)

A. Purpose

- 1) To clarify and define Opioid Treatment Programs and to accompany 8.321.2 NMAC;
- 2) Be consistent with, and complementary to, the SAMHSA/CSAT regulations, and the OTP accreditation requirements of nationally recognized accreditation bodies approved by SAMHSA/CSAT, such as CARF, TJC and COA;
- 3) Ensure access to treatment availability for other chronic medical conditions;
- 4) Consider the possible adverse impact on communities in which the OTP providers are located when making application approval decisions, and to provide measures to promote mutually satisfactory relationships between OTP providers and their communities; and
- 5) To provide medication assisted treatment for opioid addiction to an eligible recipient through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment Programs (OTP) for which the following services include, but are not limited to:
 - a. the administration of methadone (opioid replacement medication) to an individual for detoxification from opioids and/or maintenance treatment;
 - b. the administration/supervision which is delivered in conjunction with the overall treatment based upon a service plan, which must include counseling/therapy, case review, drug testing, and medication monitoring.

B. Policy

Approval & Accreditation

Agencies, in addition to receiving approvals outlined in 8.321.2.30 NMAC must be approved by the State Opiate Treatment Authority within the Behavioral Health Services Division (BHSD).

BHSD shall consider the operating history of the OTP provider in making its determination to grant or deny an application to a previously approved provider. Any existing OTP provider with the same owner and/or sponsor on a corrective action plan will be considered non-adherent and will not be granted approval to operate an OTP until adherence is achieved.

Renewal of Approval to Operate

OTP providers who wish to renew their approval to operate shall submit a renewal application and current Policy & Procedures (P&P) and any other requested documentation within 90 calendar days, and no more than 180 calendar days, before its license expiration date.

BHSD shall consider the operating history of the OTP provider in making its determination to grant or deny an application to a previously approved provider. Any existing OTP provider with

the same owner and/or sponsor on a corrective action plan will be considered non-adherent and will not be granted renewal to operate the OTP until adherence is achieved.

Supervisor Certification

OTPs may apply for and maintain Supervisory Certification through BHSD.

Admissions

- 1) The program sponsor shall ensure through policy and procedure that an individual is only admitted for opioid dependency treatment after the program medical director determines and documents all components outlined in Subsection C of 8.321.2.30 NMAC.
- 2) A program sponsor shall ensure that an individual requesting long-term or short-term opioid treatment withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period is assessed by the program medical director for other forms of treatment.
- 3) The OTP shall ensure that each patient at the time of admission:
 - a. provides written, voluntary, program-specific informed consent to treatment;
 - b. is informed of all services that are available to the patient through the program and of all policies and procedures that impact the patient's treatment; and
 - c. is informed of the following:
 - (i) the progression of opioid dependency and the patient's apparent stage of opioid dependence;
 - (ii) the goal and benefits of opioid dependency treatment;
 - (iii) the signs and symptoms of overdose and when to seek emergency assistance;
 - (iv) the characteristics of opioid dependency treatment medication, such as its effects and common side effects, the dangers of exceeding the prescribed dose, and potential interaction effects with other drugs, such as other non-opioid agonist treatment medications, prescription medications, and illicit drugs;
 - (v) the requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;
 - (vi) the requirement for a staff member to comply with the confidentiality requirements of title 42 CFR part 2 of the code of federal regulations, incorporated by reference;
 - (vii) drug screening and toxicological testing procedures;
 - (viii) requirements to receive take-home medication;
 - (ix) testing and treatment available for HIV and other communicable diseases, the availability of immunization for hepatitis A and B, and the availability of harm reduction services;

- (x) availability of counseling on preventing exposure to and transmission of human immunodeficiency virus (HIV), sexually transmitted diseases, and blood-borne pathogens;
 - (xi) the patient's right to file a complaint with the program for any reason, including involuntary discharge, and to have the patient's complaint handled in a fair and timely manner.
- 4) A program sponsor shall ensure that the program medical director or medical practitioner designee conducts a complete, fully documented physical examination of an individual who requests admission to the program before the individual receives a dose of opioid dependency treatment medication, and that the physical examination includes:
 - a. reviewing the individual's bodily systems;
 - b. obtaining a medical and family history and documentation of current information to determine chronic or acute medical conditions such as diabetes, renal diseases, hepatitis, HIV infection, tuberculosis, sexually transmitted disease, pregnancy or cardiovascular disease;
 - c. obtaining a history of behavioral health issues and treatment, including any diagnoses and medications;
 - d. initiating the following laboratory tests:
 - (i) a Mantoux skin test;
 - (ii) a test for syphilis;
 - (iii) a laboratory drug detection test for at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines and other substances as may be appropriate, based upon patient history and prevailing patterns of availability and use in the local area;
 - 5) Recommending additional tests based upon the individual's history and physical condition, such as:
 - a. complete blood count;
 - b. EKG, chest X-ray, pap smear or screening for sickle cell disease;
 - c. a test for hepatitis B and C; or
 - d. HIV testing.
 - 6) The full medical examination including test results must be completed within 14 days of admission to the program.
 - 7) A patient re-admitted within three months after discharge does not require a repeat physical examination unless requested by the program medical director.
 - 8) A program sponsor shall ensure that the results of a patient's physical examination are documented in the patient record.
 - 9) A patient may not be enrolled in more than one OTP program except under exceptional circumstances, such as residence in one city and employment that requires extended absences from that city, which must be documented in the patient chart by the medical directors of both programs:
 - a. an OTP shall make and document good faith efforts to determine that a patient seeking admission is not receiving opioid dependency treatment

- medication from any other source, within the bounds of all applicable patient confidentiality laws and regulations;
- b. the OTP shall confirm that the patient is not receiving treatment from any other OTP, except as provided in Subsection F of 7.32.8.19 NMAC, within a 50-mile radius of its location, by contacting any such other program, or by using the central registry described in Subsection G of 7.32.8.19 NMAC, when established.

Program Requirements

- 1) Both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations.
- 2) Programs must be staffed by:
 - a. Medical Director with the following responsibilities:
 - (i) Ensuring that all medical protocols are in writing;
 - (ii) Ensuring that all medical protocols are reviewed and approved by appropriate program officials on an annual basis.
 - (iii) Ensuring that the manner in which medical functions may be delegated to other staff is clearly articulated in the protocols.
 - (iv) Ensuring that individuals seeking admission to the OTP meet the admission criteria in 42 CFR Part 8 and in Section 5 of this rule.
 - (v) Establishing clinical standards for the following:
 - The induction of treatment medication for a patient upon admission;
 - The titration of a patient on treatment medication; and
 - The tapering of a patient off of a treatment medication.
 - (vi) Ensuring the following:
 - Patients admitted to the OTP shall have a complete physical examination;
 - The results of the physical examination shall be documented in the patient's records; and
 - Referral is made for identified service not provided by the OTP.
 - (vii) Ensuring the following:
 - All patients voluntarily choose maintenance opioid addiction treatment;
 - All relevant facts concerning the use of a treatment medication are clearly and adequately explained to the patient; and
 - Each patient provides written informed consent to treatment.
 - (viii) Ensuring the signing or countersigning and dating of all medical orders as required by federal or state law.
 - (ix) Ensuring that each patient's dose of treatment medication is appropriate for the patient's needs.
 - (x) Ensuring that appropriate laboratory tests or studies have been performed and reviewed.

- (xi) Ensuring that the program complies with all federal, state, and local statutes, ordinances, and regulations regarding the treatment of opioid addiction.

Further, it is the responsibility of the Medical Director to ensure that the OTP is operating as an interdisciplinary team, where providers with differing expertise are monitoring and managing the service plan and service delivery.

- b. A Program Physician, licensed in the State of New Mexico, who may also be the Medical Director, or work under the supervision of the Medical Director, with the requirement of being physically present in the facility for a minimum of ten hours per week for every five-hundred (500) enrolled patients; up to a maximum physician-patient ratio of one program physician per one thousand (1,000) enrolled patients.
- c. A Program Director with:
 - (i) three years of work experience providing services to individuals with substance use disorder;
 - (ii) a minimum of a bachelor's degree in a related field; and
 - (iii) three years of work experience in administration or personnel supervision in human services, specific to OTP services.The program director is responsible for the following:
 - (i) the day-to-day operations of the OTP;
 - (ii) delivery of treatment services;
 - (iii) the supervision of OTP staff; and
 - (iv) managing all other functions delegated by the medical director.
- d. Clinical Supervisor(s) who are approved by their respective Boards as Supervisors. For psychologists or BH clinicians:
 - (i) licensed psychologist (to supervise other psychologists); or
 - (ii) licensed independent social worker; or
 - (iii) licensed professional clinical counselor; or
 - (iv) licensed marriage and family therapist; and
 - (v) Certified Nurse Practitioner or Clinical Nurse Specialist or physician to supervise RNs/LPNs.

The OTP must hold Supervisory Certification to employ non-independently licensed providers under the supervision of the Clinical Supervisor(s).

- e. Registered nurse or licensed practical nurse with experience treating substance use disorders for a minimum of one full-time equivalent of forty (40) hours per week for every two hundred enrolled patients. Nurses must meet the following:
 - (i) maintain appropriate licenses to perform delegated and assigned nursing functions;
 - (ii) Supervise the administering of medication to OTP patients;
 - (iii) Perform other functions delegated by the medical director or a program physician.

A registered nurse or licensed practical nurse may administer opioid treatment medication only under the following circumstances: 1) when acting as the agent of a practitioner licensed under state law and registered under the appropriate state and federal laws to administer opioid treatment medication; or 2) when supervised by, and under the order of, a practitioner licensed under state law and registered under the appropriate state and federal laws to administer opioid treatment medication.

- f. Full time or part time pharmacist.

- g. Counselors, under appropriate supervision, that meet the following requirements:
 - (i) master's level education and license; or
 - (ii) LADACs; and
 - (ii) training, or experience to do the following:
 - contribute to the appropriate treatment plan for the patient;
 - monitor patient progress toward identified treatment goals;
- h. LSAAs and Peer Support Workers, under appropriate supervision, to render education, behavioral change and recovery and resiliency support.

Provider/Patient Capacity of the Clinic

The agency must identify the capacity of the clinic. Capacity includes the number of providers that are qualified and available to administer and monitor treatment (doctors, nurses, counselors, peer support workers) and how many private counseling spaces are available. OTPs must notify the State Opiate Treatment Authority (SOTA) when they reach 90% current capacity to discuss their plan for maintaining service provision while continuing to admit new patients.

Caseloads

Procedures for establishing substance abuse counselor caseloads and counselor to patient ratios are based on the intensity and duration of counseling required by each patient. The ratio for one full time counselor shall not exceed 75 patients. The OTP must request waiver from BHSD to temporarily exceed the counselor to patient ratio of 75. The request must explicitly state why the OTP requires a ratio exception and how the OTP will return to the established ratio.

Central Registry

Each OTP, as a condition of approval to operate, must participate in the central registry as directed by the State Opiate Treatment Authority (SOTA). All persons in New Mexico who are patients of a New Mexico OTP program must be enrolled in the central registry to prevent patients from surreptitiously receiving medication from more than one OTP. OTPs are required to upload their patient data each day to the central registry.

C. Procedures

Written policies and procedures are developed, implemented, complied with and maintained at the OTP for all services provided and must include, but are not limited to the following procedures:

- 1) Prevention of a patient from receiving OUD (opioid use disorder) treatment from more than one agency or physician concurrently.
- 2) Meeting the unique needs of diverse populations, such as pregnant women, children, individuals with communicable diseases, (e.g., hepatitis C, tuberculosis, HIV or AIDS), or individuals involved in the criminal justice system.
- 3) Conducting a physical examination, assessment and laboratory tests.

- 4) Establishing substance abuse counselor caseloads, based on the intensity and duration of counseling required by each patient. Counseling can be provided in person or via telehealth. Counselor to patient ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity. The ratio for one full time counselor shall not exceed 75 patients. The OTP must request approval from BHSD to exceed the counselor to patient ratio on a temporary basis to permit hiring new staff when new admissions cause a ratio imbalance or when current staff leave and must be replaced.
- 5) Criteria for when the patient's blood serum levels should be tested and procedures for having the test performed.
- 6) Performing laboratory tests, such as urine drug screens or toxicological tests, including procedures for collecting specimens for testing.
- 7) Addressing and managing a patient's concurrent use of alcohol or other drugs.
- 8) Providing take home medication to patients, to include insuring proper disposal of methadone containers. This shall include patient education about proper disposal of empty containers.
- 9) Conducting opioid treatment withdrawal.
- 10) Conducting an administrative withdrawal; administrative withdrawal is usually voluntary and used only when all therapeutic options have been exhausted. Given the short timeframe in which administrative withdrawal occurs and the poor prognosis of patients that are involuntarily discharged, the preferred approach is for OTPs to refer or transfer patients to a suitable alternative treatment program. Because of the risks of relapse following detoxification, patients should be offered a relapse prevention program that includes counseling, naloxone and opioid replacement therapy.
- 11) Voluntary discharge, including a requirement that a patient discharged voluntarily be provided or offered follow-up services, such as counseling or a referral for medical treatment.
- 12) Making an immediate, temporary or permanent transfer of a patient from the OTP to another OTP that includes provisions to stipulate that patient safety and care is paramount and that all aspects of the patient file are sent to receiving clinic; procedures will include the following:
 - a. Programs reserve the right to accept or deny any transfer, however, OTP's shall not deny a reasonable request for transfer and shall document reasons for denying a transfer;
 - b. OTPs will send or receive the reason for transfer and provide the most current medical, counseling, and laboratory information within five days of the request, unless an immediate transfer is warranted (emergencies, behavioral issues). Receipt of this information is not required prior to

- acceptance and the failure to receive this information does not preclude acceptance;
- c. The receiving clinic shall continue the patient's authorized drug dosage and take-home schedule unless new medical or clinical information requires changes. The patient must be informed of the reason for the change and it must be documented in the medical record;
 - d. The receiving clinic's physician will initiate an order for continuation;
 - e. Patients who transfer are continuing treatment; therefore, the sending clinic will include the last treatment plan and last physical exam. Neither admission procedures nor physical exams need to be repeated for transfer patients.
- 13) Receiving the temporary or permanent transfer of a patient from another OTP to the receiving OTP.
- 14) Minimizing the following adverse events:
- a. A patient's loss of ability to function;
 - b. A medication error;
 - c. Harm to a patient's family member or another individual resulting from ingesting a patient's medication;
 - d. Sale of illegal drugs on the premises;
 - e. Diversion of a patient's medication;
 - f. Harassment or abuse of a patient by a staff member or another patient;
 - g. Violence on the premises;
 - h. Any event involving law enforcement;
 - i. Patient death; and
 - j. Incarceration.
- 15) Responding to an adverse event, including:
- a. A requirement that the program sponsor immediately investigate the adverse event and the surrounding circumstances;
 - b. A requirement that the program sponsor develop and implement a plan of action to prevent a similar adverse event from occurring in the future; monitor the action taken; and take additional action, as necessary, to prevent a similar adverse event;
 - c. A requirement that action taken under the plan of action be documented;
 - d. A requirement that the documentation be maintained at the agency for at least two years after the date of the adverse event;
 - e. Procedures for infection control.
- 16) Criteria for determining the amount and frequency of counseling that is provided to a patient;
- a. A minimum of one-hour face-to-face counseling per month shall be provided to patients;
 - b. All counseling sessions shall be documented in the patient record. If additional sessions are clinically indicated based on assessment, this is justified and documented in the patient record;
 - c. Provision of unscheduled treatment or counseling to patients.

- 17) Ensuring that the facility's physical appearance is clean and orderly.
- 18) A process for resolution of patient complaints, including a provision that complaints which cannot be resolved through the clinic's process may be mediated by the program director and the BHSD:
 - a. A complaint process which is explained to the patient at admission;
 - b. The patient complaint process which is posted prominently in its waiting area or other location where it will be easily seen by patients and includes the BHSD contact information for use in the event that the complaint cannot be resolved through the clinic's process.
- 19) A process for employee continuing education that includes recovery and resiliency, trauma informed care, crisis intervention and suicide prevention.
- 20) A written quality assurance plan that is developed and implemented.
- 21) Information and instructions for the patient which are provided in the patient's primary language, and, when provided in writing, are clear and easily understandable by the patient.
- 22) Opioid treatment that is provided regardless of race, ethnicity, gender, age, or sexual orientation.
- 23) The program facility which is compliant with the Americans with Disabilities Act (ADA).
- 24) Opioid treatment which is provided with consideration for a patient's individual needs, cultural background, and values.
- 25) Unbiased language which is used in the provider's print materials, electronic media, and other training or educational materials.
- 26) HIV testing and education which are available to patients either at the provider or through referral.
- 27) A patient who is HIV-positive and who requests treatment for HIV or AIDS:
 - a. is offered treatment for HIV or AIDS either at the provider or through referral; and
 - b. has access to an HIV or AIDS-related peer group or support group and to social services, either at the provider or through referral to a community group; and
 - c. for patients with a communicable disease such as HIV, AIDS, or Hepatitis C, the provider has a procedure for transferring a patient's opioid treatment to a non-program medical practitioner treating the patient for the communicable disease when it becomes the patient's primary health concern.

D. Clinical Supervision

Clinical Supervision involves observation, evaluation, feedback, facilitation of the supervisee's self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving, and is conducted in a competent manner incorporating ethical standards. Clinical supervisor responsibilities are to provide support, consultation, and oversight of patients' treatment to include assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation; teaming with other stakeholders, treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. Clinical Supervision addresses the treatment staffs' steps to ensure a consumer's active involvement at all levels and that consumer voice and choice are clearly represented and documented. Clinical Supervision assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the consumer's continued recovery and success. Clinical Supervision involves observation, evaluation, feedback, facilitation of the supervisee's self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving and is conducted in a competent manner incorporating ethical standards. Clinical Supervisors will include the documented trends they observe in their supervisory activities in their Clinical Practice Improvement program.

The Clinical Supervisor shall have a minimum of one (1) year documented supervisory experience and a minimum of two (2) years documented experience in clinical practice with the population for whom clinical supervision is being provided.

Clinical Supervision is to be provided to all treatment staff a minimum of 4 hours a month in either an individual or a group setting. Individual supervision is required no less than two hours a month.

All Clinical Supervision must be documented and must include name of supervisee, date, length of time of supervision, ID numbers of patients discussed, and outcome/next steps for each patient. For supervision focused on clinical issues and not patients specifically, documentation must include details of topics discussed. For group supervision, documentation must include the names of all clinicians in attendance, date, length of time of supervision, either names or ID numbers of patients discussed, and outcome/next steps for each patient.

E. Counseling

Providers licensed with their respective boards to serve patients will provide individual therapy that addresses underpinning issues related to substance use. They may also provide treatment related to co-occurring disorders. If an agency does not provide therapy for those experiencing co-occurring disorders, the therapists must be trained to recognize indicators for co-occurring diagnoses, be trained in and make appropriate referrals and follow up after making the referrals. All services must be supervised by an independently licensed behavioral health provider who monitors services for indicators in patient's documentation that require referrals and additional support.

The program sponsor shall ensure that:

- 1) Substance abuse counseling and behavioral health treatment planning is provided by a practitioner licensed in the state of New Mexico to provide behavioral health

treatment services to each patient based upon the patient's individual needs, treatment plan and stage of readiness to change behavior.

- 2) The program has substance abuse counselors in a number sufficient:
 - a. to ensure that patients have access to counselors;
 - b. to implement patients' service plan; and
 - c. to provide unscheduled treatment or counseling sessions to patients.
- 3) Each patient seeking opioid treatment is screened for the presence of a co-occurring mental health disorder, and if indicated, referred for assessment and possible treatment if the program is not able to provide mental health services; an OTP referring a patient to another provider for mental health assessment shall make and document its good faith efforts to follow up with that provider on the results of the referral, and to coordinate its treatment with any subsequent treatment by other providers, within the limits of all applicable laws and regulations pertaining to release of patient information and confidentiality; (see screening and OTP referral sections below).
- 4) A program sponsor shall make good faith efforts to establish effective working relationships with the relevant behavioral health treatment providers in its patient catchment area in order to facilitate patient access to the services available through those providers.
- 5) A program sponsor shall ensure that a patient has access to a self-help group or support group, such as narcotics anonymous, either at the agency or through referral to a community group.
- 6) Treatment services are provided by appropriately licensed staff.

F. Additional Counseling: Clinical Mental Health, Substance Use & Co-occurring Disorders

Providers licensed with their respective boards will provide individual therapy that addresses underpinning issues. They may also provide treatment related to co-occurring disorders under appropriate supervision, when required. If an agency does not provide therapy for those experiencing mental health or co-occurring disorders, the therapists must be trained to recognize indicators for co-occurring diagnoses.

These counseling services can be billed in addition to the bundled rate that encompasses the one hour of substance use/HIV and supportive counseling. Please see OTP billing guidelines.

G. Intake, Assessment and Service Planning

Each of the following components must be addressed upon intake and throughout the course of service delivery.

Initial Screening

At the time of admission (and ongoing) each patient receives screening by an appropriately trained staff person, to address suicide risk, danger to self or others, urgent or critical medical conditions, and imminent harm:

- 1) The screening tools shall be validated and accepted as a standard appropriate screen relative to the condition;
- 2) Screens need to be reviewed by a licensed behavioral health professional and information obtained from screens shall be incorporated into the beginning crisis/safety plan (please see below) that will be finalized alongside the treatment plan;
- 3) Subsequently, licensed staff will further assess the severity of disease in terms of patient response to pharmacotherapy, recovery resources, coping skills, and psychosocial morbidity; and
- 4) Involve determining patient motivation and readiness for change.

Comprehensive Assessment and Psychiatric Diagnostic Evaluation

Once initial screening has taken place, a psychiatric diagnostic evaluation (90791) may be conducted to determine any co-occurring mental health diagnoses, unless there are previously diagnosed (within the past 12 months) conditions available. Providers authorized to conduct this evaluation are psychiatrists, psychologists, psychiatric certified nurse practitioners, psychiatric nurse clinicians, licensed clinical social workers, licensed professional clinical counselors, and licensed marriage and family therapists.

There are two types of comprehensive assessments covered through Medicaid reimbursement, and both include the development of the initial service plan. Please see Section 2.3 within this Policy Manual for a complete description.

- 1) An interdisciplinary comprehensive assessment (H2000) for recipients with co-occurring mental health diagnoses which entails the collection of input from multiple provider disciplines (e.g. mental health practitioners, primary care practitioners, other community supports, etc.) and the recipient and his/her natural supports. This assessment may take several sessions to complete and the collection of some of the collaborating data may extend beyond the 14 days; and
- 2) A comprehensive assessment (H0031) that does not necessarily entail other provider types, and focuses more specifically on the SUD diagnosis, but must cover all aspects of assessment:
 - a. a description of the patient's presenting substance abuse, identification of the patient's behavioral health symptoms and the behavioral health issue or issues that require treatment;
 - b. a description of the patient's presenting substance abuse issue, identification of the patient's behavioral health symptoms and the behavioral health issue or issues that require treatment;
 - c. a list of the medical services needed by the patient, as identified in the physical examination referenced in 7.32.8 NMAC;

- d. recommendations/referrals for further assessment or examination of the patient's needs (i.e. physical, mental health or substance use) if indicated;
- e. a list of current medications prescribed to the patient, including dosage;
- f. recommendations/referrals for treatment needed by the patient, such as psychosocial counseling or mental health treatment, if indicated;
- g. recommendations/referrals for ancillary services or other services needed by the patient (i.e. housing, workforce, transportation, parenting, specialized medical attention, domestic violence, crisis intervention), if indicated;
- h. the assessment shall include: a comprehensive summary of findings listed in a-g above, treatment recommendations to include level of care and frequency and duration of counseling services;
- i. the date, printed name, signature and professional licensing credential of the staff member developing the assessment.

A comprehensive assessment is conducted by a licensed behavioral health professional within 14 days of admission and updated each year thereafter. Either the interdisciplinary or comprehensive, as described above, satisfies the regulation and can be billed.

Service Plan and Service Plan Update

Please see Section 2.3 of this Manual for a complete description of the Service Plan.

- 1) Each OTP will ensure that adequate medical, psychosocial counseling, mental health, vocational, educational and other services identified in the initial and ongoing service plans are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.
- 2) Due to the high incidence of substance use and co-occurring mental health problems, OTPs can use validated mental health screens and assessments to determine if a patient is suffering from a trauma-related illness and/or other mental health disorders.

Treatment Plan

The treatment plan is the SUD component of the overall service plan and is not reimbursable:

- 1) The initial treatment plan is developed with the patient to establish patient's immediate treatment goals and OTP program participation (frequency of specific interventions such as individual counseling, group sessions and urine drug screens).
- 2) The initial treatment plan shall be signed and documented in the patient record within 24 hours of admission.
- 3) All components of the treatment plan are conducted by a licensed behavioral health professional or a LADAC under the supervision of an independently

licensed clinician (as defined by the NM RLD), when the individual presents with co-occurring conditions.

- 4) The individualized treatment plan is developed with the patient to establish patient's immediate treatment goals and OTP program participation (frequency of specific interventions such as individual counseling, group sessions and urine drug screens).
- 5) The updated individualized treatment plan shall be signed and documented in the patient record within 30 days of admission.
- 6) Goals are expressed in the words of the patient and are reflective of the informed choice of the person served.
- 7) Specific services or treatment objectives are reflective of the expectations of the person served and the treatment team, and reflect the patient's age, development, culture and ethnicity, disabilities/disorders, and are understandable to the person served, measurable, achievable, time specific and appropriate to the service/treatment setting.
- 8) Identification of specific interventions (current issues, behavioral health symptoms and issues that require treatment), modalities and or services to be used.
- 9) The frequency of specific interventions such as counseling (including individual and group sessions) and urine drug screens.
- 10) Recommendations for further assessment or examination of the patient's needs, if indicated.

Crisis Plan

This is a living document that is updated with the development of the treatment plan, then revised as needed alongside the treatment plan, or at a minimum, every 90 days. This document is a patient driven plan that providers and patients can refer to when the patient is experiencing a difficult time. This Crisis prevention and management plan includes at a minimum:

- 1) Name, address, current phone number, birthdate, gender;
- 2) Emergency contact information with an accompanying Release of Information (ROI);

Possible list of important people (children, partner, friends, relative, clergy) that the patient may want to contact for support during crisis. Include name, relationship and contact number, identify if any of these people should help in identifying "next steps" if the patient is in crisis;

- 3) List of service providers and whether any of them should be contacted in crisis (ROI required);

- 4) Description of what crises look like for the patient;
- 5) Description of what the patient finds helpful, or relieving, during times of crisis (people, places, things);
- 6) Steps the patient can take to seek support during crisis;
- 7) List of the most difficult feelings for the patient to experience, (it's often helpful to provide a list they can chose from), what happens when they feel them, what has been helpful in the past to help them move through the feelings;
- 8) Description of when the patient could and should reach out for support. When do they know it is time to contact someone or change a behavior?
- 9) Description of the patient's behavior when they are in crisis. Is there anything that might be scary for others to witness? How does the patient feel about those behaviors? What do they want others to know about them when they are having this behavior? What do they need to hear? How do they want to be treated? What might make it worse, what might make it better?
- 10) Description of things that the patient will not talk about during crisis; and
- 11) The date, printed name, signature and professional licensing credential of the counselor and patient developing the crisis plan.

Relapse Prevention Plan

At the time of treatment plan development, the counselor will develop a relapse prevention plan with the patient. This plan includes at a minimum: the patient's **most likely triggers for relapse** (examples, *withdrawal symptoms, post-acute withdrawal symptoms, poor self-care, people, places, things associated with use, uncomfortable emotions, relationships and sex, isolation and pride/overconfidence*); education of stages of relapse and how to mitigate relapse at an early stage:

Emotional Relapse - Patient is not thinking about using but emotions and behavior are setting them up for a possible future relapse (anxiety, intolerance, anger, defensiveness, mood swings, isolation, not asking for help, not interacting with support community, poor eating or sleeping).

Mental Relapse - Patient is thinking about using consciously or unconsciously (thinking about people, places or things associated with use, glamorizing past use, lying, hanging out with people who use, fantasizing about using, thinking about relapsing, planning a relapse.)

Physical Relapse - Actively using drug/substance of choice. Relapse prevention plans must include patient driven strategies for each of the above categories of relapse, with tangible plans for avoiding relapse, disrupting relapse if it is occurring and who to contact. The date, printed name, signature, credential of the counselor and patient developing the relapse prevention plan must be included in the document.

The signature and date signed by the patient, or documentation of patient refusal to sign, or the signature of the patient's guardian or agent is required. If the patient is a child, the patient's parent, guardian, or custodian is required to sign and date. Electronic signatures through the electronic health record are valid.

The individualized comprehensive treatment plan shall include:

- 1) the date, printed name, signature and professional licensing credential of the staff member completing the treatment plan; and
- 2) all updates or revisions to patient care shall be documented in the individualized comprehensive treatment plan within 24 hours of notification.

Individualized comprehensive treatment plans shall be reviewed and updated with the patient every 90 days. The individualized comprehensive treatment plan shall include a detailed summary of the patient's progress or challenges toward meeting new or existing goals based upon their recent progress. The update must include documentation of progress, non-progress or decline with each stated goal and next steps. Goals and objectives should be revised, as needed.

An aftercare/discharge plan is developed as a part of the individualized comprehensive treatment plan, within 30 days of admission and is updated, as needed, or at a minimum, every 90 days to reflect growth and needs of the patient so that the plans are consistent and cohesive and include:

- 1) family (when appropriate), community supports and collaboration;
- 2) the development level and any unique circumstances for the patient to continue in recovery; and
- 3) concrete steps that support the patient in recovery.

H. Take Home Medications

- 1) The program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:
 - a. criteria for determining when a patient is ready to receive take-home medication;
 - b. criteria for when a patient's take-home medication is increased or decreased;
 - c. a requirement that take-home medication be dispensed or distributed only after an order from the program Medical Director or physician, according to federal and state law;
 - d. a requirement that the program Medical Director or physician review a patient's take-home medication regimen at intervals of no less than 90 days and adjust the patient's dosage, as needed;
 - e. procedures for safe handling and secure storage of take-home medication in a patient's home; and
 - f. criteria and duration of allowing a physician to prescribe a split medication regimen.

- 2) Treatment program decisions on dispensing OTP medications to patients for unsupervised use, beyond that set forth in Subsection C of 7.32.8.23 NMAC below, shall be made by the program medical director, based on the following criteria:
 - a. absence of recent abuse of drugs, including alcohol;
 - b. regularity of program attendance;
 - c. length of time in comprehensive maintenance treatment;
 - d. absence of known criminal activity in which the patient has been charged;
 - e. absence of serious behavioral problems at the program;
 - f. special needs of the patient such as changes in physical health needs;
 - g. assurance that take-home medication can be safely stored in the patient's home;
 - h. stability of the patient's home environment and social relationships;
 - i. the patient's work, school, or other daily activity schedule;
 - j. hardship experienced by the patient in traveling to and from the program;
 - k. whether the benefit the patient would receive by decreasing the frequency of program attendance outweighs the potential risk of diversion.
- 3) A patient in comprehensive maintenance treatment may receive a single dose of take-home medication for each day that a provider is closed for business, including Sundays and state and federal holidays.
- 4) A program sponsor shall ensure that take-home medication is only issued to a patient in adherence with the following restrictions:
 - a. during the first 90 days of comprehensive maintenance treatment, take-home medication is limited to a single dose each week, in addition to any doses received as described in Subsection C of 7.32.8.23 NMAC.
 - b. during the second 90 days of comprehensive maintenance treatment, a patient may receive a maximum of two doses of take-home medication each week in addition to any doses received as described in Subsection C of 7.32.8.23 NMAC;
 - c. during the third 90 days of comprehensive maintenance treatment, a patient may receive a maximum of three doses of take-home medication each week in addition to any doses received as described in Subsection C of 7.32.8.23 NMAC;
 - d. in the remaining 90 days of the patient's first year, a patient may receive a maximum of 6 days of take-home medication each week;
 - e. after one year of continuous treatment, a patient may receive a maximum two-week supply of take-home medication;
 - f. after two years of continuous treatment, a patient may receive a maximum of one month's supply of take-home medication but must make monthly visits;
 - g. exceptions to the above take-home medication restrictions shall be made only as provided for in Center for Substance Abuse Treatment (CSAT) regulations and as approved by the State Opioid Treatment Authority.
- 5) A program sponsor shall ensure that a patient receiving take-home medication receives:
 - a. take-home medication in a secure locking container; and

- b. written and verbal information on the patient's responsibilities in protecting the security of take-home medication. This shall include providing patient education about proper disposal of empty containers.
- 6) The program sponsor shall ensure that the program Medical Director's determination made under Subsection B of 7.32.8.23 NMAC and the reasons for the determination are documented in the patient record.
- 7) In accordance with DEA regulations, the program shall not use U.S. mail or express services such as Federal Express or United Parcel Service to transport, furnish or transfer opioid treatment medication to any patient, agency, facility or person.
- 8) The program shall establish policy and procedure to provide for the safe and secure transportation of opioid treatment medication from its facility to another agency where the program's patient temporarily resides (for inpatient treatment or incarceration).

I. Patient Records

The OTP program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records. Please see 7.32.8 NMAC for additional guidelines.

Narcan/Naloxone

OTPs will develop policies & procedures for their use and/or distribution of Narcan/naloxone. OTPs will provide access to naloxone either through prescription or onsite distribution.

J. Quarterly Meetings

OTP providers are required to participate in quarterly meetings with the SOTA as a way to maintain open communication and dissemination of information.

K. Quality

See Quality section in BH Policy and Billing Manual.

L. Telemedicine

See telemedicine policy in the BH Policy and Billing Manual.

M. Related Policies

- 1) NMAC 8.321 Social Services Specialized Behavioral Health
- 2) NMAC 7.32.8 Opioid Treatment Program

N. Definitions

Accrediting bodies - nationally recognized organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF), which promulgate standards for OTPs that are approved by the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) and offer accreditation to programs that meet these standards.

Adherence - the act or process of complying with state regulation.

Administrative withdrawal - the procedure for withdrawal of a patient's opioid treatment medication coinciding with the patient's involuntary discharge from opioid treatment, typically resulting from non-payment of fees, violent or disruptive behavior or incarceration or other confinement.

Application form - the form created by the SOTA, which must be completed by a program sponsor who wishes to obtain approval to operate an opioid treatment program.

Approval and approval to operate - the written permission given to a program sponsor to operate an opioid treatment program.

Comprehensive initial assessment - the collection and analysis of a patient's social, medical, psychological and treatment history.

Comprehensive maintenance treatment - a program designed with the intention of lasting longer than six months, for the purpose of maintaining the patient such that he/she will be free of opioid withdrawal and cravings; such programs are typified by: 1) dispensing or administering an opioid treatment medication at stable dosage levels for a period in excess of 21 days to an individual for opioid addiction; and 2) providing medical, therapeutic and supportive services to the individual with opioid dependence.

Dispense - means the evaluation and implementation of a prescription, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to or use by a patient.

Diversión - the unauthorized transfer of an opioid agonist treatment medication, such as a street sale.

Dosage - the amount, frequency and number of doses of medication for an individual.

Dose - a single unit of opioid treatment medication.

Illicit opioid drug - an illegally obtained opioid drug, such as heroin, that causes dependence and reduces or destroys an individual's physical, social, occupational, or educational functioning, or misuse of legally prescribed medication.

Intake screening - determining whether an individual meets the initial criteria for receiving opioid treatment.

Long-term opioid treatment withdrawal procedure - a treatment program designed to dispense opioid treatment medication to a patient in decreasing doses, after first possibly achieving a stable dose, for a period of more than 30 days but less than 180 days as a method of bringing the individual to a drug-free state.

Medical practitioner - an individual who:

- 1) has been accredited through appropriate national procedures as a health professional;
- 2) fulfills the national requirements on training and experience for prescribing procedures;
- 3) is a registrant or a licensee, or a worker who has been designated by a registered or licensed employer for the purpose of prescribing procedures;
- 4) may be a physician, physician's assistant, registered nurse, nurse practitioner, or licensed practical nurse.

Opioid treatment

- 1) opioid treatment withdrawal procedure/treatment; and
- 2) comprehensive maintenance treatment.

Opioid treatment medication - a prescription medication that is approved by the U.S. food and drug administration under 21 U.S.C. section 355 and by the code of federal regulations title 42, part 8.12 for use in the treatment of opiate addiction.

Opioid treatment program (OTP) - a single location at which opioid dependence treatment medication, such as methadone and rehabilitative services, are provided to patients as a substantial part of the activity conducted on the premises.

Opioid treatment withdrawal procedure - dispensing or administering an opioid dependence treatment medication in decreasing medication levels to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state.

Physiologically dependent - means physically addicted to an opioid drug, as manifested by the symptoms of withdrawal in the absence of the opioid drug.

Program clinician - a behavioral health clinician practicing at an opioid treatment program who is licensed to practice substance abuse treatment in New Mexico.

Program medical director - a physician licensed to practice medicine in New Mexico, who assumes responsibility for administering all medical services, either by performing them directly or by delegating specific responsibility to authorized program medical practitioners functioning under the medical director's direct supervision.

Program sponsor - the person named in the application as responsible for the operation of the opioid treatment program and who assumes responsibility directly, by personal oversight, or through policy and procedure, or a combination of both, for the acts and omissions of staff members or employees of the opioid treatment program.

Short-term opioid treatment withdrawal procedure - a treatment program designed to dispense opioid treatment medication to a patient in decreasing doses, over a continuous period of 30 days or less, as a method of bringing the individual to a drug-free state.

State Opiate Treatment Authority (SOTA) - the single state agency for substance abuse designated by the governor or another appropriate official designated by the governor to exercise authority within the state for governing treatment of opiate addiction with an opioid drug. In New Mexico it is the Human Services Department, Behavioral Health Services Division.

Take-home medication - one or more doses of an opioid treatment medication dispensed to a patient for use off the premises. [7.32.8.7 NMAC - N, 11-30-05]

O. Application for Approval to Operate an Opioid Treatment Program

- 1) Interested applicants apply for approval to operate an opioid treatment program using the application provided by the State Opioid Treatment Authority (SOTA). This application shall be in addition to the application to Drug Enforcement Administration, SAMHSA/CSAT, New Mexico Board of Pharmacy, local government, and additional governing bodies.
- 2) The SOTA shall approve or deny the application within 60 working days of submission, unless the SOTA and applicant mutually agree to extend the application review period.
- 3) The SOTA may require the applicant to provide additional written or verbal information in order to reach its decision. Such further information shall be considered an integral part of the application and may extend the application review period.
- 4) Preference will be given to providers who are able to service Medicaid members.
- 5) Approval to operate shall be for the duration of up to three years.
- 6) The SOTA shall not grant approval to operate an OTP to any program sponsor who has been convicted of any crime related to controlled substances laws or any felony within the last five years. No person who has been convicted of any felony in the last five years shall be employed by the OTP in any capacity that gives that person access to controlled medications.
- 7) The SOTA shall not grant approval to any entity that poses a risk to the health and safety of the public based on a history of nonadherence with state and federal regulations as verified by the Drug Enforcement Association (DEA), New Mexico State Board of Pharmacy, Food and Drug Administration, SAMSHA approved accreditation bodies, or the state licensure agency in any state in which the program sponsor currently operates. Any existing OTP with the same owner and/or program sponsor on a corrective action plan is considered non-adherent and will not be granted approval to operate a new OTP until adherence is achieved.

- 8) The SOTA will review and consider documented history of law enforcement involvement with respect to other OTPs currently operated by the program sponsor or by any corporation, LLC or partnership with whom the program sponsor has been associated in the past five years.
- 9) As a condition of approval to operate an OTP, the OTP must maintain or obtain accreditation with a SAMHSA/CSAT-approved nationally recognized accreditation body, (e.g., CARF, TJC or COA.) In the event that such accreditation lapses, or approval of an application for accreditation becomes doubtful, or continued accreditation is subject to any formal or alleged finding of need for improvement, the OTP program will notify the SOTA within two business days of such event. The OTP program will furnish the SOTA with all information related to its accreditation status, or the status of its application for accreditation, upon request.
- 10) The application for approval shall be accompanied by a needs assessment, specifying the proposed geographical area to be served, estimated number of patients anticipated, and such other information that may assist the SOTA in review of the application. The SOTA shall take into consideration in making its decision the need for an OTP in a given geographic area and the impact on the community.
- 11) The SOTA shall perform on-site inspection of the proposed OTP facility as part of the review and approval process.
- 12) Change of ownership of an approved opioid treatment program is not transferable; the new ownership must institute an application for approval as a new program, in accordance with these regulations.

P. Supervisory Certification

See Supervisory Certification section of BH Policy and Billing Manual. This certification is optional for OTPs if they wish to employ non-independently licensed providers to render additional billable services.

Q. Exhibits/Appendices/Forms

Appendix ZS: OTP Regulations Crosswalk
Appendix ZT: OTP Clinic & Personnel Check List
Appendix ZU: OTP Counselor Questionnaire
Appendix ZV: OTP Personnel site review form
Appendix ZW: OTP Patient Record Audit Form

R. Resources

Hazelden Betty Ford Foundation (2014) Heroin and prescription painkillers: A toolkit for community action. Center City, MN: Hazelden Publishing.

SAMHSA Medication Assisted Treatment
<https://www.samhsa.gov/medication-assisted-treatment>

SAMHSA OTP Certification:

<https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs>

SAMHSA TIP 63 Medications for Opioid Use Disorder

<https://www.store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorders-Full-Documents-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC>

SAMHSA Trauma Informed Approach

<https://www.samhsa.gov/nctic/trauma-interventions>

SAMHSA Treatments for Substance Use Disorders

<https://www.samhsa.gov/treatment/substance-use-disorders>

SAMHSA TIP 52 Clinical Supervision

<https://store.samhsa.gov/product/TIP-52-Clinical-Supervision-and-Professional-Development-of-the-Substance-Abuse-Counselor/SMA14-4435>

Seppala, M. D. & Larson, B. (2015) Integrating the twelve steps with medication assisted treatment for Opioid Use Disorder. Center City, MN: Hazelden Publishing.

S. Billing Instructions

All listed services must only be rendered by practitioners working within their respective scopes of practice and MAD regulation. A supervisory certificate, issued through BHSD, is required for the use of non-independent practitioners:

- 1) **HCPCS H0020:** The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine testing conducted within the agency.
 - a. For an IHS or Tribal 638 clinic, MAD considers the bundled OTP services to be reimbursed at the OMB rate unless otherwise negotiated with the facility.
 - b. For a FQHC, MAD considers the bundled OTP services to be billed at the FQHC encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
- 2) The quantity of service billed in a single day can include, in addition to the drug items administered that day, the number of take-home medications dispensed that day.
- 3) Guest dosing can be reimbursed at Medicaid-enrolled agencies. Arrangements must be confirmed prior to sending the patient to the receiving clinic.
- 4) A narcotic replacement or agonist drug item other than methadone that is administered or dispensed: Codes: **J0571, J0572, J0573, J0574, J0575.**
- 5) An eligible recipient's initial medical examination when rendered by a MAD approved medical provider - **H0001.**

- 6) **H2000** - comprehensive interdisciplinary assessment including initial service plan development under the direction/supervision of an independently licensed practitioner.
- 7) **H0031** - mental health assessment by non-physician including initial service plan development (cannot be billed if billing H2000).
- 8) **90791 - 90702** – psychiatric diagnostic evaluations.
- 9) **T1007** - Service plan updates following the comprehensive interdisciplinary assessment and service plan.
- 10) One hour/month of individual HIV/SUD counseling – **H0025**, or H0025 with modifier HQ if delivered in a group setting. One hour is a federal requirement; either individual or group counseling is acceptable.
- 11) Outpatient therapy other than the substance abuse and HIV counseling required by 2 CFR Part 8.12 (f) is reimbursable when rendered by a MAD approved independently licensed provider, or a licensed non-independent provider under the supervision of an independent.
Codes:
 - a. **90832 - 90838** - psychotherapy services
 - b. **90839 - 90840** - psychotherapy for crisis
 - c. **90846 - 90847** - family psychotherapy
 - d. **90849 - 90853** - group therapies
 - e. **+90863** - pharmacologic management if combined with psychotherapy
 - f. **+90785** - Interactive complexity
- 12) Medically necessary services provided beyond those required by CFR 42 Part 8.12 (f), to address the medical issues of the eligible recipient; **99201 - 99205**: Evaluation and management services for a new patient, and **99213 - 99215** for an established patient.
- 13) Full medical examination, prenatal care and gender specific services for a pregnant recipient. **99201 - 99205**: Evaluation and management services for a new patient, and **99213 - 99215** for an established patient.
- 14) Other miscellaneous services:
 - a. **36415** - routine venipuncture
 - b. **81025** - urine pregnancy test
 - c. **86580** - skin test; tuberculosis, intradermal
 - d. **G0480** through **G0483** drug tests
 - e. **80307** - drug screening
 - f. **93000** and **93005** - EKG screening
 - g. **Q3014** - telehealth technical fee for originating site
- 15) Other special services performed by the agency as listed below are reimbursed when documented in the plan of care:

- a. **H0033** - oral medication administration, direct observation (for buprenorphine induction)
- b. **H2010** - comprehensive medication services, per 15 min (for buprenorphine administration)
- c. **H2011 U2** - crisis intervention service in clinic, per 15 min
- d. **H2011 U3** - crisis intervention, mobile, if having a mobile crisis team
- e. **H2011 U4** - crisis stabilization, if having a 24-hour OP crisis stabilization service
- f. **H0015** – intensive outpatient program for substance use disorders, if HSD approved
- g. **H2030** – recovery services (for MCO members only)
- h. **S5110** – family support services (for MCO members only)

5.4 Psychosocial Rehabilitation Services (PSR)

A. Purpose

The purpose of Psychosocial Rehabilitation Services (PSR) is to provide an array of services offered through a group modality in a clubhouse or classroom setting to help an individual to capitalize on personal strengths; to develop coping strategies and skills to deal with deficits; and to develop a supportive environment in which to function as independently as possible. Psychosocial rehabilitation intervention is intended to be a transitional level of care based on the individual's recovery and resiliency goals.

B. The Clubhouse Model

If choosing to do PSR through a Clubhouse, this is defined as a dynamic program of support and opportunities for people with severe mental illnesses or co-occurring disorders. Clubhouses are places where people can belong as contributing adults, rather than passing their time as patients who need to be treated. Clubhouse restorative activities focus on their strengths and abilities, not their illness. For the Clubhouse member it is:

- A right to a place to come;
- A right to meaningful relationships;
- A right to meaningful work; and
- A right to a place to return.

The following applies to all Clubhouses.

- 1) Clubhouse membership is voluntary and without time limits.
- 2) The Clubhouse membership is open to anyone with a history of mental illness unless that person poses a significant and current threat to the general safety of the Clubhouse community.
- 3) Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.
- 4) All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.
- 5) Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.
- 6) Members have a right to immediate re-entry into the Clubhouse community after any length of absence unless their return poses a threat to the Clubhouse community.
- 7) The Clubhouse provides an effective outreach to engage members who would otherwise become isolated in the community or hospitalized.

C. Documentation Requirements

In addition to the standard client record documentation requirements for all services, the following is required for PSR:

- 1) PSR Service must be identified and justified in the individual's service plan or a referral from another treatment plan or referring practitioner.
- 2) Recipients shall participate in PSR services for those activities that are identified in the treatment or service plan and are tied directly to the recipient's recovery and resiliency plan/goals.

D. Additional Resources

- Clubhouse International
<https://clubhouse-intl.org/>
- Psychosocial Rehabilitation Association of New Mexico (PSRANM)
<http://www.psrnm.com>
- Psychiatric Rehabilitation Association (PRA)
<https://www.psychrehabassociation.org/>
- Code of Ethics for psychiatric rehabilitation practitioners
https://www.psychrehabassociation.org/sites/default/files/images/CPRP-Code_of_Ethics_REV.pdf
- Evidence-Based Practices Web Guide
<https://www.samhsa.gov/ebp-web-guide/adult-ebps>

E. Billing Instructions

- 1) **H2017:** 15 min unit
- 2) Utilize agency provider ID and NPI in rendering fields
- 3) FQHC: UB claim form; revenue code 0919 for encounter rate
- 4) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 5) For FQHC, IHS, and Tribal 638: if preferring to utilize CMS 1500 and fee schedule rates, please contact MAD Policy Bureau.

5.5 Supportive Housing

Effective date is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and will not be implemented until such time.

A. Definition

Supportive Housing is defined as decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy and is linked to voluntary and flexible support and services designed to ensure successful tenancy and address other needs. The basic principles of supportive housing include:

- Support services are offered to promote independent living and help consumers find, get, and keep housing.
- Support services are client-driven, individually tailored, flexible and are primarily provided in vivo, e.g. in the consumer's home.
- Neither support service compliance nor following treatment plans is a condition of accessing housing or maintaining tenancy.
- Supportive housing consumers have all the rights and responsibilities of tenancy.
- Housing is not subject to time limitations other than lease requirements.
- Leases are renewable if compliance with standard lease terms and property rules is maintained.
- Ongoing, regular communication must occur between service providers, property managers, and tenants to ensure that tenants remain successfully housed by resolving any difficulties and preventing eviction.

B. Supportive Housing Programs

The Behavioral Health Services Division of the HSD administers a range of supportive housing programs for people with disabilities, including the Linkages Permanent Supportive Housing Program, Special Needs Housing Program/Local Lead Agencies, Crisis Housing, Move-in Assistance and Eviction Prevention, and Oxford House. For additional information, contact BHSD's Supportive Housing Coordinator, Lisa Howley, at 505-476-9209.

C. Documentation Requirements

In addition to the standard client record documentation requirements for all services, Supportive Housing documentation must ensure non-duplication of services for billing purposes.

D. Resources

Strategic Plan for Supportive Housing in New Mexico, 2018-2023.

http://newmexico.networkofcare.org/content/client/1446/NMStrategicHousingPlan2018-2023_Jan2018FINAL.pdf

E. Billing Instructions

- 1) **H0044**, per month for reimbursement;
- 2) On a monthly basis, bill all of the following services which were rendered within that month along with the reimbursement code for the purpose of utilization tracking. These codes will not be reimbursed as the services are included in the H0044 monthly reimbursement. Identify both rendering provider and date of each service.

Pre Tenancy		
Screening and identifying preference and barriers related to successful tenancy;	G9005	U1
Developing an individual housing support plan and crisis plan;	G9005	U2
Assisting participants with finding and applying for housing;	G9005	U3
Ensuring that the living environment is safe and read for move-in;	G9005	U4
Tenancy orientation and move-in assistance	G9005	U5
Landlord advocacy;	G9005	U6
Assisting participants with securing necessary household supplies	G9005	U7
Tenancy Support		
Early identification of issues including member behaviors	G9005	U8
Coaching to the Medicaid member about relationships with neighbors and landlords and tenancy compliance;	G9005	U9
Education about tenant’s responsibilities and rights;	G9005	UA
Supports to assist participants in resolving tenancy issues;	G9005	UB
Regular review and updates to housing support plan and crisis plan;	G9005	UC
Assist participants in linking to other community resources that may support individuals in maintaining housing	G9005	UD

SECTION SIX: INPATIENT AND RESIDENTIAL SERVICES FOR CHILDREN AND ADOLESCENTS

6.1 Accredited Residential Treatment Center (ARTC)

These instructions apply in conjunction with applicable legislation, laws, codes, and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

A. Definition

Accredited Residential Treatment Centers are residential treatment service programs accredited by one of the national accrediting agencies. Individualized, trauma informed services are provided to children/adolescents in need of psychosocial rehabilitation/psychotherapeutic intervention and 24-hour therapeutic group living to meet their severe behavioral, psychological, neurobiological, or emotional problems and needs.

In addition to service-specific supervision, assessment, physical examination, medical history, and infection control requirements, each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable Certification Requirements are met. Services are client-driven, evidence-based best practices based on outcomes.

B. Policy

- 1) CYFD Licensing and Certification Authority Bureau (LCA) performs reviews of IHS facilities and programs which fall under LCA survey reviews. The focus of the LCA reviews includes assessment of the IHS program's adherence to MAD minimum standards.
- 2) LCA will generate a detailed, written report in draft, then in final form to MAD which may, in part, be used to communicate with the IHS/Tribal 638 programs, and to evaluate qualification of the continued reimbursement to the IHS/Tribal 638 program.
- 3) If an IHS facility or program does not meet minimum standards, LCA will include recommendations for meeting the minimum standards in their report to MAD.
- 4) In instances where an IHS program review indicates serious issues involving health, safety and/or quality of care, an initial verbal report to MAD will be followed by a written report. Based on the acuity and/or seriousness of the issue, LCA will include recommended "next actions" in its written report.

C. Billing Instructions

- 1) UB: **1001** revenue code for psychiatric
- 2) UB: **1002** revenue code for substance use
- 3) Referring or ordering provider in attending provider field

6.2 Residential Treatment Center (RTC)

A. Definition

These instructions apply in conjunction with applicable legislation, laws, and codes, and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

Residential Treatment Services provide individualized, trauma informed 24-hour active residential psychotherapeutic intervention/therapeutic care to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, to meet their developmental, psychological, social, and emotional needs.

Each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable Certification Requirements are met. Services are client-driven, evidence-based best practices based on outcomes.

B. Treatment Plan

Non-Accredited RTC and Group Home Treatment Plans (7.20.11.7 and 7.20.11.23 NMAC).

The treatment planning process is individualized and ongoing, and includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.

- 1) Initial Treatment Plan
 - a. Developed and documented within 72 hours of admission to the service;
 - b. Individualized treatment goals and objectives are targeted the first 14 days of treatment.

- 2) Comprehensive Treatment Plan
 - a. Developed and documented within 14 days of admission to the service;
 - b. Based on the comprehensive assessment, developed within 14 days of admission.

- 3) Initial and Comprehensive Treatment Plan Requirements
 - a. Involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible;
 - b. Reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record;
 - c. Conducted in a language the client and/or family members can understand, or is explained to the client in language that invites full participation;
 - d. Designed to improve the client's motivation and progress, and strengthen appropriate family relationships;
 - e. Designed to improve the client's self-determination and personal responsibility;
 - f. Utilizes the client's strengths;

- g. Is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable him/her to conduct treatment planning;
 - h. Treatment plans meet the provisions of the Children’s Code, NMSA 1978, Sections 32A-6-10, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children’s Code;
 - i. Documents in measurable terms:
 - (i) Specific behavioral changes targeted, including potential high-risk behaviors;
 - (ii) Corresponding time-limited intermediate and long-range treatment goals and objectives;
 - (iii) Frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures;
 - (iv) Staff responsible for each intervention;
 - (v) Projected timetables for the attainment of each treatment goal;
 - (vi) A statement of the nature of the specific problem(s) and needs of the client;
 - (vii) A statement and rationale for the plan for achieving treatment goals;
 - (viii) Specifies and incorporates the client’s permanency plan, for clients in the custody of the department; and
 - (ix) Provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised to ensure their safety and that of others.
- 4) Discharge Planning Requirements
- a. Establishes a projected discharge date, which is updated as clinically indicated;
 - b. Describes behavioral and other clinical criteria as conditions under which discharge will occur;
 - c. Requires that the client has achieved the objectives of the treatment plan;
 - d. Evaluates high risk behaviors or the potential for such;
 - e. Documents that discharge is safe and clinically appropriate for the client;
 - f. Documents level of care, specific services to be delivered, and the living situation into which discharge is projected to occur;
 - g. Establishes specific criteria for discharge to a less restrictive setting;
 - h. Explores options for alternative or additional services that may better meet the client’s needs;
 - i. Documents individuals responsible for implementing each action specified in the discharge plan;
 - j. Identifies barriers to discharge; and
 - k. Revises plan as indicated.

C. Policy

Indian Health Service (IHS) or Federally Recognized Tribal Government ARTC Findings and Recommendations

- 1) CYFD Licensing and Certification Authority Bureau (LCA) performs reviews of IHS facilities and programs which fall under LCA survey reviews. The focus of the LCA reviews includes assessment of the IHS program's adherence to MAD minimum standards.
- 2) LCA will generate a detailed, written report in draft, then in final form to MAD which may in part be used to communicate with the IHS/Tribal 638 program, and to evaluate qualification of the continued reimbursement to the IHS/Tribal 638 program.
- 3) If an IHS facility or program does not meet minimum standards, LCA will include recommendations for meeting the minimum standards in their report to MAD. In instances where an IHS program review indicates serious issues involving health, safety and/or quality of care, an initial verbal report to MAD will be followed by a written report. Based on the acuity and/or seriousness of the issue, LCA will include recommended "next actions" in its written report.

D. Related Policies

- 1) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC
- 2) Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC
- 3) Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC (1996)
- 4) New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997)
- 5) Governing Background Checks and Employment History Verification, 8.8.3 NMAC
- 6) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.2 NMAC

E. Billing Instructions

- 1) UB: revenue code **0190** – daily rate
- 2) For Desert Hills Girls Treatment Unit only: revenue code **0191** – daily rate
- 3) Units: # of days
- 4) Referring or ordering provider in attending provider field

6.3 Group Home Services

A. Concurrence with Other Legislation and Regulations

These instructions apply in conjunction with applicable legislation, laws, codes, and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

B. Definition

Group Home Services are individualized, trauma informed care provided to children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, who are in need of active psychotherapeutic intervention, require a twenty-four-hour therapeutic group living setting to meet their developmental, social and emotional needs, and/or who are in transition from a higher level of care to a lower level of care. Clinical history and opinion establish that the needs of the client cannot be met in a less restrictive environment. Services are offered in a supervised, licensed facility that provides structured therapeutic group living.

Each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable Certification Requirements are met. Services are client-driven, evidence-based best practices based on outcomes.

C. Related Policies

- 1) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC
- 2) Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC
- 3) Health Facility Sanctions and Civil Monetary Penalties, 7.18 NMAC (1996)
- 4) New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997)
- 5) Governing Background Checks and Employment History Verification, 8.8.3 NMAC
- 6) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.2 NMAC

D. Billing Instructions

- 1) UB: revenue code 1005 - daily rate
- 2) Unit: # of days
- 3) Referring or ordering provider in attending provider field

6.4 Treatment Foster Care (TFC)

A. Concurrence with Other Legislation and Regulations

These instructions apply in conjunction with applicable legislation, laws, and codes, and any future amendments to such regulations or superseding regulations. They are supplemental, and subject to change with concurrent changes in the above.

B. Definition

Treatment Foster Care Services are individualized, trauma informed care provided to psychologically or emotionally disturbed and/or behaviorally disordered clients. Eligible clients are those who are at risk for failure or have failed in regular foster homes, are unable to live with their own families, or are going through a transitional period from residential care as part of the process of return to family and community. TFC clients require behavioral health services and supervision provided in a treatment foster home setting. TFC Level I and Level II provide therapeutic services to children or adolescents with complex and difficult psychiatric, psychological, neurobiological, behavioral, and psychosocial problems. TFC Level II is provided to children and adolescents who have successfully completed TFC Level I and are in the process of returning to biological family and community, or who meet other established criteria.

Each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable Certification Requirements are met. Services are client-driven, evidence-based best practices based on outcomes.

C. Treatment Plan (7.20.11.7, 7.20.11.23 and 7.20.11.29 NMAC)

An initial treatment plan must be developed within 72 hours of admission and a comprehensive treatment plan must be developed within 14 calendar days of the eligible recipient's admission to a TFC I or II program.

The treatment planning process is individualized and ongoing, and includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.

- 1) Initial Treatment Plan
 - a. Developed and documented within 72 hours of admission to the service
 - b. Individualized treatment goals and objectives are targeted the first 14 days of treatment.
- 2) Comprehensive Treatment Plan
 - a. Developed and documented within 14 days of admission to the service;
 - b. Based on the comprehensive assessment, developed within 14 days of admission.
- 3) Initial and Comprehensive Treatment Plan Requirements
 - a. Involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible;

- b. Reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record;
- c. Conducted in a language the client and/or family members can understand, or is explained to the client in language that invites full participation;
- d. Designed to improve the client's motivation and progress, and strengthen appropriate family relationships;
- e. Designed to improve the client's self-determination and personal responsibility;
- f. Utilizes the client's strengths;
- g. Is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable him/her to conduct treatment planning;
- h. Treatment plans meet the provisions of the Children's Code, NMSA 1978, Sections 32A-6-10, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children's Code;
- i. Documents in measurable terms:
 - (i) Specific behavioral changes targeted, including potential high-risk behaviors;
 - (ii) Corresponding time-limited intermediate and long-range treatment goals and objectives;
 - (iii) Frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures;
 - (iv) Staff responsible for each intervention;
 - (v) Projected timetables for the attainment of each treatment goal;
 - (vi) A statement of the nature of the specific problem(s) and needs of the client;
 - (vii) A statement and rationale for the plan for achieving treatment goals;
 - (viii) Specifies and incorporates the client's permanency plan, for clients in the custody of the department; and
 - (ix) Provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised so as to ensure their safety and that of others.

4) Discharge Planning Requirements:

- a. Establishes a projected discharge date, which is updated as clinically indicated;
- b. Describes behavioral and other clinical criteria as conditions under which discharge will occur;
- c. Requires that the client has achieved the objectives of the treatment plan;
- d. Evaluates high risk behaviors or the potential for such;
- e. Documents that discharge is safe and clinically appropriate for the client;
- f. Documents level of care, specific services to be delivered, and the living situation into which discharge is projected to occur;
- g. Establishes specific criteria for discharge to a less restrictive setting;
- h. Explores options for alternative or additional services that may better meet the client's needs;

- i. Documents individuals responsible for implementing each action specified in the discharge plan;
- j. Identifies barriers to discharge; and
- k. Revises plan as indicated.

D. Application of the Reasonable and Prudent Parenting Standard

- 1) Protective Services Division (PSD) shall make efforts to normalize the lives of children in PSD's custody and to empower caregivers to approve a child's participation in activities, based on the caregiver's own assessment using a reasonable and prudent parent standard, without prior approval of PSD.
- 2) Foster care providers shall not require advance permission from PSD to apply the reasonable and prudent parent standard to decisions about the care of a child.
- 3) In applying the reasonable and prudent parent standard, the foster parent shall consider the following:
 - a. the desires of the child including, but not limited to, cultural identity, spiritual identity, gender identity, and sexual orientation;
 - b. the child's age, maturity and developmental level;
 - c. potential risk factors and the appropriateness of the activity;
 - d. the best interests of the child based on the foster care provider's knowledge of the child;
 - e. the importance of encouraging the child's emotional and developmental growth;
 - f. the terms of any court orders and any case plan applying to the child;
 - g. the values and preferences of the child's biological parent or parents, if appropriate;
 - h. whether the decision would bring about a permanent (e.g. tattoo) rather than a transient change to the child;
 - i. the importance of providing the child with the most safe and affirming family-like and culturally relevant living experience possible;
 - j. the legal rights and responsibilities of the child, including the youth bill of rights and responsibilities;
 - k. Americans with Disabilities Act.
- 4) Age and developmentally appropriate activities that may be the subject of decisions under the reasonable and prudent parent standard include, but are not limited to, the following:
 - a. a cultural, social, or enrichment activity or support that fosters positive identity development;
 - b. a sleepover of one or more nights;
 - c. participation in sports or social activities, including related travel;
 - d. obtaining a driver's license and conditions for driving a vehicle;
 - e. allowing the child to travel in another person's vehicle;
 - f. possession and use of a cell phone;
 - g. obtaining a job or working for pay (e.g. babysitting, yard work, etc.)
 - h. recreational activities (including, but not limited to, such activities as boating, swimming, camping, hunting, cycling, hiking, horseback riding).

- 5) Foster parents may consult with the PSD worker when uncertain or uncomfortable with a decision under their consideration.
- 6) In situations in which a child age 14 or older disagrees with a decision made under the prudent parent standard, the child shall request a review of the decision in writing. The decision shall be reviewed by a neutral three-person panel. This process does not preclude any party from seeking a court order regarding the decision.
- 7) PSD shall seek appropriate statutory change to ensure that foster parents and other substitute care providers are shielded from liability when they act in accordance with the reasonable and prudent parent standard. In the meantime, CYFD will hold harmless and defend its licensed foster care providers in situations where they have acted and made decisions in accordance with the reasonable and prudent parent standard. [8.26.2.13 NMAC - N, 9/29/15]

E. Related Policies

- 1) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC
- 2) New Mexico Children’s Code NMSA 1978 32A-1-1 et Seq. (1997)
- 3) Governing Background Checks and Employment History Verification, 8.8.3 NMAC
- 4) Licensing Requirements for Foster and Adoptive Homes, 8.26.4 NMAC
- 5) Child Placement Agency Licensing Standards, 8.26.5 NMAC
- 6) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.2 NMAC

F. Exhibits/Appendices/Forms

Appendix ZX: Prudent Parenting and Prevention of Sex Trafficking

G. Billing Instructions

- 1) Level I - **S5145**: unit 1 day; max units 31
- 2) Level II - **S5145 (U1)**: unit 1 day; max units 31

SECTION SEVEN: INPATIENT AND RESIDENTIAL SERVICES FOR ADULTS

7.1 Accredited Residential Treatment Centers for Substance Use Disorders

Effective 1/01/2019 subject to CMS approval of CC2.0 waiver and State Plan Amendment.

A. Definitions

Accreditation - a process of review through which organizations demonstrate their ability to meet regulations, requirements, and standards established by a recognized accreditation organization such as the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

ASAM - The American Society for Addiction Medicine. The differing sub-levels of ASAM 3 are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals. The defining characteristic of level 3 ASAM criteria is that they serve recipients who need safe and stable living environments to develop their recovery skills. They are transferred to lower levels of care when they have established sufficient skills to safely continue treatment without the immediate risk of relapse, continued use, or other continued problems, and are no longer in imminent danger of harm to themselves or others.

ASAM Criteria - provide a comprehensive set of guidelines for multi-dimensional assessment, treatment and service planning, placement, continued stay, and transfer/discharge of individuals who have substance use and co-occurring conditions. These guidelines provide a means for matching risk, severity, and service needs with type and intensity of services. These guidelines are detailed in *The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, Third Edition.

Clinically Managed Services - directed by non-physician addiction specialists rather than medical personnel. Clinically managed services are appropriate for individuals whose primary problems involve emotional, behavioral or cognitive concerns, readiness to change, relapse or recovery environment, and whose problems with intoxication/withdrawal and biomedical concerns, if any, are minimal or can be managed through separate arrangements for medical services.

Medically Monitored Treatment - services that are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, and other health care professionals and technical personnel, under the direction of a licensed physician.

Withdrawal Management - services previously referred to as “detoxification services” designed to assist a person’s withdrawal both physiologically and psychologically.

Substance Use Disorder - according to the Diagnostic and Statistical Manual of Mental Disorders DSM-5 (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

B. Policy

Program requirements

Admission and treatment criteria for ASAM level of care 3 must be met for each recipient of services. There must be a match between the eligible recipient's specific need for services using ASAM Criteria (3.1, 3.3, 3.5, 3.7, 3.2-WM, or 3.7-WM) and the ASAM Level(s) of Care sub-level for which the facility has been accredited and enrolled. The ASAM Criteria calls for the eligible recipient to be placed in the level of care appropriate to the most acute problem as determined during the assessment process.

A brief description of ASAM Levels of Care and Sub-Levels follows:

LEVELS OF CARE

ASAM 3.1 - Clinically managed, low-intensity, residential services as specified in *The ASAM Criteria*; is often (but not always) a step down from a higher level of care; prepares the recipient for transition to the community and outpatient services; requires a minimum of 5 hours/week of recovery skills development.

ASAM 3.3 - Clinically managed medium-intensity residential services; provide a structured recovery environment in combination with medium-intensity clinical services to support recovery.

ASAM 3.5 - Clinically managed, population-specific, high-intensity residential services as specified in *The ASAM Criteria*; meets the needs of recipients with cognitive difficulties needing more specialized individualized services; offers a higher intensity of service not requiring medical monitoring.

ASAM 3.7 - Medically monitored, intensive inpatient services as specified in *The ASAM Criteria*; an organized service delivered by medical and nursing professionals which provides twenty-four-hour evaluation and monitoring services under the direction of a physician or clinical nurse practitioner who is available by phone twenty-four hours a day. Nursing staff is on-site 24 hours a day. Other interdisciplinary staff or trained clinicians may include counselors, social workers, and psychologists available to assess and treat the recipient and to obtain and interpret information regarding recipient needs.

LEVELS OF CARE - WITHDRAWAL MANAGEMENT

ASAM 3.2-WM - Clinically managed residential withdrawal management services as specified in *The ASAM Criteria*, requiring 24-hour support for moderate withdrawal; managed by behavioral health professionals, with protocols in place should a patient's condition deteriorate and appear to need medical or nursing interventions; facility has an ability to arrange for appropriate laboratory and toxicology tests; a range of cognitive, behavioral, medical, mental health, and other therapies administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. The recipient remains in a level 3.2 withdrawal management program until: withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or the recipients' signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated.

ASAM 3.7-WM Medically monitored inpatient withdrawal management services as specified in *The ASAM Criteria*; requiring 24-hour nursing care and physician visits as needed for severe withdrawal; services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician; monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions; ability to arrange for appropriate laboratory and toxicology tests; a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. The recipient remains in a level 3.7 withdrawal management program until: withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or the recipients' signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated.

C. Supporting Information

Accreditation Organizations:

Joint Commission (JC): <https://www.jointcommission.org>

The Commission on Accreditation of Rehabilitation Facilities (CARF): <http://www.carf.org>

Council on Accreditation (COA): <http://coanet.org/home/>

ASAM Resources:

ASAM Criteria: <https://www.asam.org/resources/the-asam-criteria>

Text: *The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, Third Edition

D. Prior Authorization

- 1) Prior authorization is not required for in state ARTCs up to five days for eligible recipients meeting ASAM level 3 criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, provider must furnish notification of the admission and if the provider believes that continued care beyond the initial five days is medically necessary, prior authorization for continued care must be obtained from MAD or its designee.

For out-of-state ARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

- 2) There are three reimbursable levels of ARTC for adults, and prior authorization must occur *prior* to moving to a different level than originally being admitted into.
- 3) Placement criteria for ARTC adult levels of care
 - a. Clinically managed low intensity:

- (i) ASAM level 3.1
 - Moderate or severe substance use or addictive disorder diagnosis (DSM 5 or ICD 10); **and**
 - No signs or symptoms of withdrawal or withdrawal can be safely managed in this setting; **and**
 - Has one of the following: 1) biomedical problems are stable and do not require medical or nurse monitoring; and 2) recipient is able to self-administer prescribed medications; **or**
 - A biomedical condition is not severe enough to warrant IP treatment but is sufficient to distract from treatment or recovery efforts; **and**
 - Recipient's mental status (including emotional stability and cognitive functioning) is sufficiently stable to enable participation in the therapeutic interventions provided; **and**
 - Recipients psychiatric condition is stable; **and**
 - Readiness to change as characterized in ASAM placement criteria; **and**
 - Relapse potential as characterized in ASAM criteria; **and**
 - Recovery environment as characterized in ASAM criteria.
- b. Clinically managed high intensity: ASAM level 3.2 WM, 3.3, 3.5, 3.5WM
 - (i) 3.2WM clinically managed residential withdrawal
 - Intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support;
 - (ii) 3.3 clinically managed population specific high intensity
 - Moderate or severe substance use or addictive disorder diagnosis (DSM 5 or ICD 10); **and**
 - No signs or symptoms of withdrawal or withdrawal can be safely managed in this setting; **and**
 - 1) biomedical problems are stable and do not require medical or nurse monitoring; and 2) recipient is able to self-administer prescribed medications; **or**
 - A biomedical condition is not severe enough to warrant IP treatment but is sufficient to distract from treatment or recovery efforts; **and**
 - Recipient's mental status (including emotional stability and cognitive functioning) is sufficiently stable to enable participation in the therapeutic interventions provided and to benefit from treatment; **and**
 - Psychiatric condition is stabilizing but he/she is in need of a 24-hour structured environment; **or**
 - Symptoms and functional limitations, when considered in the context of his or her home environment, are assessed as sufficiently severe that the recipient is not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential setting. (See functional limitations described in ASAM criteria) **or**

- Has a diagnosed emotional, behavioral, or cognitive disorder that requires active management, e.g. monitoring of medications or assessment of psychiatric symptoms or behavioral management techniques; **or**
 - Assessed as at mild to moderate risk of behaviors endangering self, others, or property, e.g. has suicidal or homicidal thoughts, but lacks an active plan; **and**
 - Due to limited awareness has limited readiness to change **or**
 - Continued substance use poses a danger of harm to self or others, and demonstrates no awareness of the need to address problem, and program offers treatment interventions; **and**
 - Does not recognize relapse triggers and little awareness of the need for continuing care; **or**
 - Experiencing an intensification of symptoms of SUD; **or**
 - Cognitive impairment has limited ability to identify and cope with relapse triggers and high-risk situations; **or**
 - Despite recent, active participation in treatment at a less intensive level of care, continues to use alcohol and/or other drugs or continues other addictive behaviors to deteriorate psychiatrically, with imminent serious consequences; **and**
 - Recovery environment not conducive to recovery (see definition in ASAM criteria).
- (iii) Clinically managed high intensity 3.5
- Specific functional limitations require a safe and stable living environment in order to develop sufficient recovery skills so he or she does not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care; **or**
 - Addiction is so out of control that they need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. The multidimensional needs are of such severity that he or she cannot safely be treated in less intensive level of care.
- c. Medically monitored intensive: ASAM level 3.7 WM
- (i) Withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care including medical and nursing services, however, the full resources of an acute care general hospital are not necessary.
- (ii) See ASAM criteria for risk ratings related to each type of substance and level of care settings.

E. Billing Instructions

- 1) ASAM levels 3.7 and 3.7WM placement criteria for medically monitored short term residential addiction program - typically 3 – 7 days
 - a. UB: revenue code 1003
 - b. HCPCS: H0011

- 2) Clinically monitored, medium to high intensity level of care for sub-acute detoxification and/or residential addiction program. ASAM 3.2WM, 3.2, 3.3, 3.5 placement criteria - typically, 30 days.
 - a. UB: revenue code 1003
 - b. HCPCS: H0010

- 3) Clinically monitored, low intensity level of care long-term residential (non-medical, nonacute care in a residential treatment program). ASAM 3.1 placement criteria - typically longer than 30 days.
 - a. UB: revenue code 1003
 - b. HCPCS: H0017

- 4) Enter ordering or referring provider in attending provider field.

7.2 Institution for Mental Disease (IMD)

Effective 1/01/2019 subject to CMS approval of CC2.0 waiver and State Plan Amendment

A. Supporting Information

What is in the law?

The IMD exclusion is found in section 1905(a)(B) of the Social Security Act, which prohibits “payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases” except for “inpatient psychiatric hospital services for individuals under age 21.”

The law goes on to define “institutions for mental diseases” as any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.

The MCOs can currently reimburse for these stays for up to 15 days in any one month, however Fee for Service recipients are excluded from this coverage. Children and adolescents are covered for both MCO members and FFS recipients.

Federal authority has been requested through a 1115 waiver application that is pending to permit IMD stays for adults with a substance use disorder diagnosis for longer than 15 days. In addition, the State has submitted a State Plan Amendment to cover Fee for Service recipients as well.

B. IMD Waiver

Federal authority has been requested through a 1115 waiver application that is pending to permit IMD stays for adults with a substance use disorder diagnosis for longer than 15 days. New legislation indicates this coverage is available for up to 30 total days during a 12-month period. In addition, the State has submitted a State Plan Amendment to cover Fee for Service recipients as well as managed care enrollees.

- 1) Eligible recipients: Adolescents and adults with a substance use disorder or co-occurring mental health and SUD.
- 2) Covered services: Withdrawal management (detoxification) and rehabilitation including treatment for any co-occurring mental health conditions.
- 3) Medication assisted treatment in at least two forms must be available on-site. For opioid use disorders there must be one antagonist and one partial agonist treatment available.
- 4) Prior authorization is required. Utilize SAMHSA admission criteria 3.7 WM and 4.0 for medical necessity.

- 5) Reimbursement:
- a. Joint Commission (JC) certified psychiatric hospitals and DOH IMDs are reimbursed on an adjusted cost-based amount for fee-for-service recipients. MCOs reimburse based on a negotiated rate.
 - b. IMDs are reimbursed for services only; room and board are not reimbursable
 - c. Bill all services on a UB claim form utilizing a bundled daily rate
 - d. IMD for SUD
 - i. rev code 0116 for private room
 - ii. rev code 0126 for semi-private room
 - e. IMD for mental illness for recipients over 65
 - i. rev code 0114 for private room
 - ii. rev code 0124 for semi-private room