

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



DRAFT

2021

Table of Contents

Section One: Introduction & General Principles

	<u>Page</u>
1.1 Purpose of this Manual	6
1.2 Severe Emotional Disturbances (SED)	6
1.3 Serious Mental Illness (SMI).....	6
1.4 Substance Use Disorder (SUD)	7
1.5 Diagnostic Classification of Mental Health and Developmental Disorders for Infancy and Early Childhood (DC:0-5).....	9
1.6 Trauma Informed Care (TIC).....	11
1.7 Recovery and Resiliency.....	13
1.8 Nondiscrimination Policy and Cultural Competency.....	15
1.9 Clinical Supervision.....	16
1.10 Supervisory Certification	18
1.11 Quality	20
1.12 Mental Health Parity and Addiction Equity Act of 2008	22
1.13 Critical Incidents	24
1.14 Telemedicine/Telehealth	27
1.15 Billing for Behavioral Health	31

Section Two: Screening, Assessment, Medication and Therapies

2.1 Definitions for Evaluations & Assessments.....	35
2.2 SMI/SED and Moderate SUD Assessment Policy	36
2.3 Integrated Care and Interdisciplinary Teaming.....	37
2.4 Treat First Clinical Model.....	41
2.5 The Comprehensive Assessment.....	44
2.6 ASAM Assessment for Substance Use Disorders	47

2.7	Crisis and Safety Planning	49
2.8	Treatment Plan.....	50
2.9	Psychiatric Evaluations, Assessments, Counseling, Therapy, Peer Support, Activity Therapy, and Medication Management	51
2.10	Behavioral Health Pharmacology	54
2.11	Screens	59
2.12	Early SUD Intervention (ASAM Level 0.5)	60
2.13	Outpatient SUD Services (ASAM Level 1 and 1-WM)	63

Section Three: Special Outpatient Services for Adults and Children

3.1	Applied Behavioral Analysis (ABA)	68
3.2	Ambulatory Withdrawal Management – SUD (ASAM Level 2-WM)	69
3.3	Comprehensive Community Support Services (CCSS).....	70
3.4	Crisis Intervention Services.....	74
3.5	Crisis Triage Centers (CTC).....	77
3.6	Family Support Services (MCO members only).....	80
3.7	Family Peer Support Services (FPSS).....	81
3.8	Intensive Outpatient Program for Substance Use Disorders (ASAM 2.1).....	84
3.9	Intensive Outpatient Program for Mental Health Conditions	92
3.10	Medication Assisted Treatment for Buprenorphine (MAT)	95
3.11	Partial Hospitalization Services in Acute Care or Psychiatric Hospital	96
3.12	Peer Support Services	103
3.13	Recovery Services (MCO members only).....	105
3.14	Smoking Cessation Counseling	106

Section Four: Specialized Outpatient Services for Children and Adolescents

4.1	Behavioral Health Respite Care (MCO members only)	107
4.2	Behavior Management Skills (BMS).....	109

4.3	Day Treatment Services (DTS).....	113
4.4	Multi-systemic Therapy (MST)	116
 Section Five: Specialized Outpatient Services for Adults		
5.1	Assertive Community Treatment Services (ACT)	118
5.2	Cognitive Enhancement Therapy (CET).....	123
5.3	Opioid Treatment Program (OTP).....	125
5.4	Psychosocial Rehabilitation Services (PSR).....	149
5.5	Supportive Housing (MCO members only)	151
 Section Six: Inpatient and Residential Services for Children and Adolescents		
6.1	Accredited Residential Treatment Center (ARTC) for Youth.....	155
6.2	ASAM Level 4: Medically Managed Intensive Inpatient Services for SUD in a Hospital	171
6.3	ASAM Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management in a Hospital.....	176
6.4	Residential Treatment Center (RTC) and Group Home (GH).....	178
6.5	Treatment Foster Care	182
 Section Seven: Inpatient and Residential Services for Adults		
7.1	Adult Accredited Residential Treatment Centers for Substance Use Disorders (AARTC)	186
7.2	ASAM Level 3.1: Clinically Managed Low-Intensity Adult Accredited Residential Treatment Center for SUD (Tier 1)	191
7.3	ASAM Level 3.2-WM: Clinically Managed Residential Withdrawal Management (Tier 2) ...	195
7.4	ASAM Level 3.3: Clinically Managed Population Specific High Intensity Adult Accredited Residential Services for Adults with SUD (Tier 2)	197
7.5	ASAM Level 3.5: Clinically Managed High Intensity Residential Services (Tier 2)	201
7.6	ASAM Level 3.7: Medically Monitored Intensive Inpatient Services in an Adult Accredited Residential Treatment Center (Tier 3)	206
7.7	ASAM Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management in an Adult Accredited Residential Treatment Center (Tier 3)	210

7.8	Institution for Mental Disease (IMD) in Psychiatric Hospital	...211
7.9	ASAM Level 4-WM: Medically Monitored Intensive Inpatient Withdrawal Management in a Hospital	213
7.10	ASAM Level 4: Medically Monitored Intensive Inpatient Services in a Hospital	215

Appendices

A:	Severe Emotional Disturbance (SED)
B:	Serious Mental Illness (SMI) Criteria and coding
C:	Substance Use Disorder (SUD) – Criteria and Coding
D:	Crosswalk for DC:0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) to DSM-5 and ICD-10
E:	Supervisory Certification Attestation Application Form
F:	Supervisory Certification Process Flow
G:	Supervisory Certification Roster Update Process
H:	Critical Incident Report Form
I:	Behavioral Health Provider Critical Incident Reporting Protocol
J:	Tip Sheet for Practitioners in Integrated Care Settings
K:	Interdisciplinary Teaming in Behavioral Healthcare
L:	Practice Standards for Family Teaming
M:	Highlights of the 1 st Four Encounters in the Treat First Clinical Model
N:	Treat First Approach Protocol
O:	Adult and Child Self Check-In and Session Check-Out Instruments
P:	CareLink NM Screening – Adult
Q:	CareLink NM Screening – Children
R:	Intensive Outpatient (IOP) Certification Information and Process Flow
S:	IOP Certification Tool
T:	IOP Application
U:	IOP Attestation
V:	IOP Site Visit Tools
W:	Assertive Community Treatment (ACT) General Organizational Index
X:	Dartmouth Assertive Community Treatment Scale (DACTS)
Y:	ACT Chart Review
Z:	ACT Service Audit Tool
AA:	Tool for Measurement of ACT (TMACT)
BB:	ACT Process Flow
CC:	Prudent Parenting & Prevention of Sex Trafficking
DD:	BHSD application for agency certification of an AARTC
EE:	AARTC Program Approval Process Flow

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, Specialized Behavioral Health Services, and Section 7.20.11 Certification Requirements for Child and Adolescent Mental Health Services. The BH Manual will also provide supplemental material as direction for the managed care organizations and (MCOs).

The BH Manual was developed by the Human Services Department's (HSD) 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 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>. 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 be familiar with the BH Manual and any amendments.

The reader should also refer to the Behavioral Health Fee Schedule which has 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 Substance Use Disorder (SUD):

New Mexico Medicaid has committed to the Centers for Medicare and Medicaid (CMS), both through the 1115 Centennial Care Waiver and a State Plan Amendment, to utilize the American Society of Addiction Medicine's admission and treatment criteria for addictive, substance related and co-occurring conditions. This affords the specificity needed for providers to assure they are placing the individual with a substance use diagnosis in the right level of care. It also accommodates a common language between provider and payer which facilitates understanding of the necessity of treatment in differing levels of care. Therefore, the majority of this information derives directly from *The ASAM Criteria: Treatment Criteria for Addictive Substance-Related, and Co-Occurring Condition – 3rd edition 2013*, and all footnoted references are to this publication.

A. ASAM Definition of Addiction

“Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. It is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. It often involves cycles of relapse and remission.”

(Pg 10)

B. ASAM Criteria

The ASAM Criteria describes five broad levels of care (Levels 0.5–4) with specific service and recommended provider requirements to meet those needs. These levels of care (Levels 0.5–4) span a continuum of care.

Two examples of patient flow throughout the SUD care continuum illustrate how important service coverage of the full range of care is to appropriately treating SUD. An individual with SUD may be admitted to a medically managed withdrawal management or inpatient facility with acute physical health care needs requiring medical and nursing care. Once medically stable, the individual may next need a clinically managed adult residential program for treatment services or an intensive outpatient or outpatient program that includes medication assisted treatment (MAT). Alternatively, an individual with SUD may begin treatment by receiving outpatient treatment services only to find that a more intensive level of care, such as intensive outpatient treatment, is more appropriate. Without the ability to transition to less or more intensive levels of care throughout treatment in response to changing clinical needs and treatment goals, individuals with SUD face higher risk of relapse and worse behavioral and physical health outcomes, including increased inpatient hospital utilization.

Treatment failure in a lower level of care is *not a prerequisite* for an IP program. This is not true for other chronic diseases such as diabetes or hypertension, e.g. diabetic ketoacidosis or hypertensive crisis. A “treatment failure” approach potentially puts the patient at risk because it delays a more appropriate level of treatment.

Changes to the treatment plan are based on treatment outcomes and tracked by real-time measurement. The quality of the therapeutic alliance and the degree to which hope for recovery is conveyed to the patient contribute even more to the outcome.

C. SUD Medical Necessity

The ASAM definition of medical necessity for SUD states “it must be based on biopsychosocial severity and is defined by the extent and severity of problems in 6 multidimensional assessment areas.” It is described as necessity of care, clinical necessity, or clinical appropriateness.

Biopsychosocial assessment elements:

- History of present episode
- Family history
- Developmental history
- Alcohol, tobacco, other drug use, addictive behavior history
- Personal/social history
- Legal history
- Psychiatric history
- Medical history
- Spiritual history

Review of systems:

- Mental status examination
- Physical examination
- Formulation and diagnoses
- Survey of assets, vulnerabilities, and supports
- Treatment recommendations

Length of stay is decided by tracking severity, function, and progress, not by a predetermined decision that the patient needs a certain length of stay. There is no “graduation” or “completion of a program” as this entails a focus on a fixed plan and program rather than on functional improvement as the determinant of level of care and ongoing chronic-disease management (with certain episodes of care being offered with increased intensity for a relatively brief span of time) being what is needed for most patients with a substance-related or co-occurring disorder” (p. 21).

D. References/Exhibits

Appendix C: Diagnostic Criteria and Codes for Substance Use Disorders

1.5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)

The incorporation of DC:0-5 into infant and early childhood mental health (IECMH) clinical practice is an essential component of accurately screening for, and then assessing, diagnosing, and treating specific conditions for this age group. These diagnoses are based upon accumulating evidence which shows that early adaptive experience and its disruptions and adversities have profound influences on development throughout the lifespan. In the clinical formulation the authors of DC:0-5 make two key observations:

- 1) “Assessment and diagnostic classification are guided by the awareness that all infant/young children have their own development progression and show individual differences in their motor, sensory, language, cognitive, affective, and interactive patterns, and
- 2) All infants/young children are participants in relationships. Infant/young children’s most significant relationships are usually those within the family. Families, in turn, participate in relationships within their larger communities and cultures.”

DC:0-5 goes on to say that any intervention or treatment program should be based on as complete an understanding of the infant/young child *and the infant’s/young child’s relationships* as is possible to achieve. To this end they recommend the clinician or clinical team need 3 – 5 sessions to completely evaluate the behavioral health of an infant/toddler in differing environments, i.e. parental interviewing; direct observation of caregiver-infant/young child relationship and interaction patterns; both direct observation and report about the infant’s/young child’s individual characteristics, language, cognition, social reciprocity, and affective and behavioral expression; and the nature of the infant’s/young child’s pattern of strengths and difficulties, including the level of overall adaptive capacity and functioning in the major areas of development (emotional, social-relational, language-social communication, cognitive, and movement and physical) in comparison with age and culturally expected developmental patterns.

DC:0-5 is the only diagnostic classification that has as a major component the relationship between the infant/young child and his/her caregiver. It appears at a time of unprecedented progress in neuroscience, genetics, immunology, and cell and molecular biology. The evolution of these diagnostic constructs will continue, as will the clinical practice that evolves from this knowledge. New Mexico is developing education and support for the inclusion of this practice, as well as future consideration of regulatory changes within Medicaid. Participants of this initiative, entitled “Pull Together for Zero to Five,” are the Departments of Children, Youth and Families; Human Services including MAD and BHSD; the Department of Health; the University of New Mexico Department of Psychiatry and Behavioral Sciences, and the Center for Development and Disability.

The classification system is published and copy-righted by the national organization Zero to Three, 2016. The system and other voluminous information can be accessed at <https://www.zerotothree.org/>.

The book is subdivided into five axes:

Axis I: Clinical Disorders

- Neurodevelopmental disorders
- Sensory processing disorders
- Anxiety disorders
- Mood disorders
- Obsessive compulsive and related disorders
- Sleep, Eating, and Crying disorders
- Trauma, stress and deprivation disorders
- Relationship disorders

Axis II: Relational context

Axis III: Physical Health Conditions and Considerations

Axis IV: Psychosocial stressors

Axis V: Developmental Competence

There is a cross-walk for billing purposes for DSM-V and ICD-10 which can be accessed within the appendices at:

Appendix D: DC: 0-5 – Crosswalk for Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood to DSM-5 and ICD-10

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1.6 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) 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.

1.7 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 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).

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1.8 Nondiscrimination Policy and Cultural Competency

Nondiscrimination Policy Statement

No child, youth, family, or individual shall be excluded from participation in, denied the benefits of, or subjected to discrimination in the administration or provision of BHSD programs and services, including contract services and programs, on the basis of:

race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; medical condition, including HIV/AIDS; status as a survivor of domestic violence, sexual assault, or stalking; and housing status, including homelessness; or any other non-merit factor.

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).

1.9 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 also 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 that holds a clinical Supervisory Certification, 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 Certification, or the supervision is being provided as part of the educational program of the unlicensed practitioner.

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>

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1.10 Supervisory Certification

A. Purpose

Supervisory Certification is a major component of a wider workforce development strategy for New Mexico's behavioral health service delivery system. The purpose of this certification process is for Behavioral Health Agencies (BHA 432), Opioid Treatment Programs (OTP 343), Adult Accredited Residential Treatment Centers (AARTC 216/261), and non-FQHC School Based Health Centers (321) to demonstrate that there is ongoing education, learning and oversight of clinical supervisors and non-independently licensed (NIL) practitioners, Certified Peer Support Workers, and student interns. Additionally, this certification is in place to support competent consultation and supervision. It is required in order to be eligible for reimbursement for services from Medicaid delivered by a non-independently licensed provider, CPSW, or student intern.

B. Policy

The request for certification demonstrates that the agency is in support of the state's workforce development strategy and 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, as of January 1, 2020, grandfathered agencies must apply for and be approved for certification under current regulations for specialized behavioral health services (8.321.2 NMAC) prior to MCO contracting. Approval from BHSD requires all providers to submit rosters to the MCOs for contracting their non-independently licensed clinicians, certified peer support workers, and student interns.

All rosters must be updated and submitted to BHSD every time there is a change in supervisors and/or providers, or every six (6) months if there are no earlier changes.

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. Certified peer support workers will have their own NPI number; student interns will not have an NPI but their institution of higher education must be included on the roster

NOTE: For the duration of the COVID 19 public health crisis, all BHSD staff are working off site. To avoid delays, please email all completed application materials and rosters to bilsfornil.bhsd@state.nm.us. Do not mail via the U.S. Postal Service.

Follow the instructions in the Supervisory Certification Attestation Application, (Appendix E). All items referenced in the attestation must be presented as part of the site visit or desk audit, as requested by BHSD. 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 any behavioral health code that the agency is approved to deliver and is within the scope of practice of the supervised employee.

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.

Exhibits/Appendices/Forms

Appendix E: Supervisory Certification Attestation Application Form
Appendix F: Supervisory Certification Process Flow
Appendix G: Supervisory Certification Roster Update Process

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1.11 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.

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1.12 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, sub-part 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.

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1.13 Critical Incidents

All publicly funded 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), and/or other regulating, licensing, or accrediting organizations, as necessary. Agencies licensed and certified by CYFD must report pursuant to licensing and certification regulatory requirements.

Critical incident reporting responsibilities and requirements include:

- A. Behavioral health critical incidents** 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. Behavioral health critical incidents and 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 (see link below).

- C. MCO processes for reporting of critical incidents by behavioral health service providers**

- 1) **Criteria:** The provider type 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. Sentinel events are defined within the Behavioral Health Critical Incident Protocol. This Protocol may be found at: <https://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx> The MCO will notify BHSD of all Sentinel events via email to hsd.csmbhsd@state.nm.us within twenty-four (24) hours of receipt of the Critical Incident Report.

- 2) All providers are required to report critical incidents. Only sentinel events are reported directly to the Human Services Department/Behavioral Health 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 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; also COEs 100 and 200, if they have a Nursing Facility Level of Care (NF LOC).

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/IMCE contracted behavioral health provider network.

- 3) 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: The HSD/MAD Quality Bureau is responsible for reviewing and ensuring complete follow-up has occurred. <https://nmmedicaid.portal.conduent.com/static/index.htm>
 - (iii) 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.

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: <https://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx>

- D. Critical Incident Reporting for Non-Medicaid Recipients:** For non-Medicaid recipients of behavioral health services that are paid for by state general funds/BHSD or federal funds received through the state, 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.

Agencies licensed and/or certified by CYFD to provide behavioral health for children are required to report incidents pursuant to licensing and/or certification regulatory requirements.

A link to the HSD/BHSD Critical Incident Report Form template can be found on the HSD website at: <https://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 behavioral health provider network.

- F.** Questions about CIR protocol can be sent to: bh.qualityteam@state.nm.us

Exhibits/Appendices/Forms

Appendix H: Critical Incident Report Form

Appendix I: Behavioral Health Provider Critical Incident Reporting Protocol

1.14 Telemedicine/Telehealth

A. Purpose

According to CMS, Telehealth is defined as two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. It is viewed as a cost-effective alternative to face-to-face provision of behavioral health care (see 42 CFR 410.78). It is especially useful in remote locations where travel is difficult.

According to the NM Telehealth Act, Sections 59A-46-50.3(A), 59A-22-49.3, 59A-23-7.12 , and 59A-47-45.3 , NMSA 1978:

- (1) Insurers shall treat telemedicine visits and in-person visits equally;
- (2) Your plan or member agreement not impose limitations on telemedicine visits that are not likewise imposed on in-person provider visits; and
- (3) Rates for services delivered via telemedicine not be lower than the rates for in-person services.
- (4) A health care provider does not need to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

B. SPECIAL NOTE: Telemedicine during the COVID-19 Public Health Crisis

HSD is allowing telemedicine services to be provided in all settings including member's home through the termination of the declaration of the emergency.

For the most current information and billing instructions, please visit HSD's COVID-19 Response page: <https://nmmedicaid.portal.conduent.com/static/covid.htm>

C. 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 when distance separates the patient and the health care provider (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.

Telehealth services - An interactive HIPAAA compliant telecommunication system must include both interactive audio and video and be delivered on a real-time basis at both the originating and distant sites, as in subsection M of 8.310.2 NMAC

Originating site - The location of an eligible Medicaid recipient at the time the service is furnished via an interactive telecommunications system. See subsection M of 8.310.2

Importantly, a health coverage plan may not impose originating-site restriction (e.g., home) with respect to telemedicine services. There should be no distinguishing between provided

telemedicine services to patients in rural locations or those in urban locations, (NMSA, 1978, Section 13-7-14. B)

Distant site – The location where the telemedicine provider is physically located at the time of the telemedicine service. See subsection M of 8.310.2

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 and meet HIPAA standards for privacy and security. It is important to note that during this COVID-19 pandemic the federal government has announced that it will not impose penalties for noncompliance with HIPAA rules related to good faith provision of telehealth (such as use of non-HIPAA compliant platforms like Skype or Facetime). For more details about platforms acceptable to the federal government at this time see the U.S. Department of Health and Human Services website: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

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

Under the Special Registration for Telemedicine Clarification Act of 2018, substances which are prescribed by means of the internet require the DEA to activate special registration allowing physicians and nurse practitioners to prescribed controlled substances by telemedicine without requiring an initial in-person exam. 21 USC § 801. This replaced the former Ryan Haight Act of 2008, U.S.C. § 829(e).

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.

E. Best Practice Guidelines

All efforts must be made to furnish telehealth 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), Telehealth Policy for National Rural Health Association (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>

<https://www.ruralhealthinfo.org/topics/telehealth/resources>

https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/05-11-18-NRHA-Policy-Telehealth.pdf

Use of Telemedicine While Providing Medication Assisted Treatment (MAT). HHS, 2018.
www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-dea-final-508compliant.pdf

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 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 the originating site for services provided under telemedicine at the same rate as when the services are furnished without the use of a telecommunication system.
- 3) Add modifier GT to the service indicating it was done via telemedicine
- 4) School-based services provided via telemedicine are covered.
- 5) Indian Health Services and Tribal 638s:
 - a. A telemedicine communication fee is paid for the originating site at fee schedule rates using the CMS 1500 format; not the OMB rate.
 - b. The originating clinical service fee is billed on a UB claim form at the OMB rate.
 - c. 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.
- 6) 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 on a UB claim form if for evaluation or therapy and on a CMS 1500 if for a special service and reimbursed at the encounter rate.

1.15 Billing for Behavioral Health

A. General Principles

1) Rendering providers are required on most OP claims. These may be on the header level if a single provider is the rendering provider 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.

2) 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) Follow the Medicaid national correct coding initiative, NCCI, rules that delineate which services should not be billed together on the same day. The NCCI website states: "The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims.

NCCI procedure-to-procedure (PTP) edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported."

4) The NCCI website for Medicaid is:
<https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html>

5) For Accredited Residential Treatment Centers (ARTCs) for Youth, Residential Treatment Centers (RTCs) and Group Homes, and Adult Accredited Residential Treatment Centers (AARTCs), the referring or ordering provider must be listed in the attending field.

6) 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.

B. Federally Qualified Health Center (FQHC) Billing

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 billed using the CMS 1500 format and corresponding 837-P electronic transactions, but will be reimbursed based on the provider's encounter rate unless another rate has been negotiated. They may bill for the specialized services only when they are approved to provide specific specialized behavioral health services. 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 an 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.

For a CMHC which is also a FQHC, the FQHC billing instructions apply.

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. Examples include, but are not limited to: 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 Behavioral Health or 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.

- 1) 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.
- 2) For specialized behavioral health services, if the provider chooses to use the Medicaid fee schedule rather than the FQHC rate, they may do so. They must communicate this to the MAD Benefits and Reimbursement Bureau and the MCOs so that their billing profile is correctly set up. 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.

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.

- 3) 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.

C. FQHC satellite locations that provide only behavioral health services.

Many FQHCs have satellite or extension offices that see clients specifically for behavioral health services. Based on the FQHC certification, we consider the “behavioral health only” sites to be satellite sites of the certified “medical” site and no additional enrollment is necessary in order to facilitate billing for behavioral health services.

Behavioral health services fall under the FQHC approved scope of services and thus should be billed like any other FQHC encounter by the enrolled FQHC on the **institutional claim form** using the encounter **revenue code 0919** and including the appropriate procedure code (for tracking purposes). The FQHC should not identify the satellite location on the claim form in the Servicing Facility identifier field as this will cause encounters to deny since the satellite office is not enrolled as a Medicaid provider.

Specialized behavioral health services

There are specialized behavioral health services that do not fall under the basic FQHC approved scope of services, and these require that the FQHC obtain appropriate licensure and/or certification in order to bill for specialized behavioral health services such as IOP, CCSS, MST, Day Treatment, etc. All specialized behavioral health services provided within the HRSA-approved scope of practice of the FQHC will be paid using the prospective payment system rate. Again, the satellite location does not need to be enrolled separately from the FQHC for these services.

If the satellite location has been approved for a separate Medicaid Provider ID under a specialized behavioral health provider type, those services should be billed according to the instructions for that service on the Behavioral Health Fee Schedule.

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. Telehealth originating communication fee: Q3014
 - b. Smoking cessation: 99406, 99407
 - c. Accredited Residential Treatment Centers for youth
 - d. Adult Accredited Residential Treatment Centers
 - e. Non-accredited residential treatment centers
 - f. Group homes
 - g. Treatment foster care
 - h. Partial hospitalization
 - i. 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; 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.
 - 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 Benefits and Reimbursement 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.

E. Behavioral Health Fee Schedule:

To view the current fee schedule, which includes information about varying reimbursement rates for different providers, please follow the link below:

<https://www.hsd.state.nm.us/providers/fee-schedules.aspx>

Directions:

- 1) Go to bottom of page and check “agree” to the policies
- 2) Click submit
- 3) Select Behavioral Health (BH) Fee Schedule (the actual title of the document may vary as updates are made)

Section Two: Screening, Assessment, Medication and Therapies

2.1 Definitions for Evaluations & Assessments

A. Comprehensive assessment (HCPCS H2000): A multidisciplinary assessment completed for all recipients with a serious mental illness, severe emotional disturbance, or moderate to severe substance use disorder. It does not include a diagnosis, but results in a service plan which delineates all services needed, and is included in the reimbursement.

B. Psychiatric Diagnostic Evaluation (90791 or 90792 with medical component): Includes diagnostic assessment or reassessment

C. Mental Health Assessment by a non-physician (H0031): This assessment does not yield a diagnosis, and so can be used by non-independent practitioners, co-signed by an independent practitioner for a recipient who does not have SMI or SED or moderate to severe SUD.

D. ASAM based assessment for substance use disorders (H0002): To be used to place patients with a SUD in the appropriate level of care. This assessment is done *in addition* to the comprehensive assessment.

E. Service plan: A plan for all needed services that is developed with the recipient and participating family/significant others, and clinicians. It is included in the reimbursement for either a comprehensive assessment or mental health assessment.

F. Service Plan update (T1007): Is utilized for updates to the service plan that was originally developed with the comprehensive assessment. It is billed and reimbursed separately whenever a significant change in status requires the care team to collaborate and update. It is *not* reimbursed for updates to the Mental Health Assessment by a non-physician (H0031).

G. Treatment plan: A plan for the specific activities included in a specialized behavioral health service. Often components of it are specific to the specialized service. It is included in the billing for the specialized service and is not billed or reimbursed separately.

2.2 SMI/SED and moderate to severe SUD Mental Health Assessment Policy

A. Policy

For all chronic diseases categorized under serious mental illness for adults, and severe emotional disturbance for children and adolescents, and all ages with a moderate to severe substance use disorder, an annual mental health assessment and service plan must be completed.

B. Billing instructions

- 1) Utilize 90791 or 90792 for a diagnostic assessment, or
- 2) H2000 for a comprehensive multidisciplinary assessment without the diagnostic component.

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2.3 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 (up to three) to bill for a meeting of the team where the individual 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.

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.

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. When the recipient is a child, the parent or caretaker is involved along with the child. If it is determined that resultant discussion may have a negative clinical impact on the child, the child may be excused from the meeting. Any meeting at which the individual is absent when their needs and services are discussed is an *agency staffing*.

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 video 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. Interdisciplinary team members may have the same specialty license but need to bring different areas of expertise to the discussion.

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

Appendix K: "Interdisciplinary Teaming in Behavioral Health Care"

Appendix L: 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 one of the 11 types 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) one practitioner attending for 30-89 minutes: G0175, U2
 - (iii) multiple practitioners from same agency attending for 30-89 minutes: G0175, U3
 - (iv) one 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. There must be three (3) providers in attendance to bill this code, and only 3 agencies may bill for a single session; if more than 3 attend the group decides which will bill.
- 2) For recipients with any BH diagnosis requiring multiple provider disciplines 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
 - (iv) any provider type;
 - (v) for a 30-minute conference, bill S0220, U2
 - (vi) for a 60 minute or greater conference bill S0221, U2

c. There must be at least two providers in attendance to bill this code, and only two agencies or providers may bill for the same session. If more than 2 attend the group decides which will bill.

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2.4 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.

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.

More information about Treat First, including how to become a Treat First provider, can be found at: www.treatfirst.org

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, if needed, after 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 M.

Tip sheets are provided in Appendix N 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 M: Highlights of the 1st Four Encounters in the Treat First Clinical Model

Appendix N: Treat First Approach Protocol

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

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 after the fourth 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.

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2.5 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 psychiatric 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
 - a. Assesses preliminary risk conditions and health needs;
 - b. 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;
 - c. Must be conducted face-to-face or through telemedicine;
 - d. 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.
 - e. 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 (CANS) assessment may also be indicated; however, the Comprehensive Assessment is still required.
 - f. 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:

- a. Requires active participation from the individual, identified family, caregivers, and team members;

- b. Requires consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, and other participants involved in the individual's care;
 - c. Identifies additional health recommended screenings;
 - d. Addresses long-term and physical, behavioral, and social health needs;
 - e. 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;
 - f. Specifies treatment and wellness supports that bridge behavioral health and primary care;
 - g. 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;
 - h. 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;
 - i. Is shared with members and their providers; and
 - j. 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:
- a. Significant change in level of care, health status, or change in recovery;
 - b. No significant change over a period of time in which change should have occurred;
 - c. 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, found in Appendix P for the adult version, and Appendix Q 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 P: Comprehensive Assessment & Service Plan - Adult Form

Appendix Q: 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
- 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 Benefits and Reimbursement Bureau.

2.6 The ASAM Assessment for Substance Use Disorders

A. Six Dimensions of Multidimensional Assessment

All six dimensions must be explored for a comprehensive SUD assessment in order to diagnose and determine service needs and appropriate placement within the levels of care. The assessment is coupled with a risk/severity rating as well as a “needs” profile. For less severe instances of substance use, appropriate screening may suffice.

The six dimensions are:

- 1) Acute intoxication and/or withdrawal potential: Exploring an individual’s past and current experiences of substance use and withdrawal. If withdrawal symptoms are currently present, consultation with a physical health provider is recommended. (see page 44 of the ASAM Criteria)
- 2) Biomedical conditions and complications: Exploring an individual’s health history and current physical condition. This entails assessing the need for physical health services (Page 45 of the ASAM Criteria).
- 3) Emotional, behavioral, or cognitive conditions and complications: Exploring an individual’s thoughts, emotions, and mental health issues. This entails differentiation of those symptoms which are part of addiction from those which may be attributed to other health conditions such as trauma-related issues, cognitive conditions and developmental disorders. This category also encompasses the risk assessment and is categorized into the following domains:
 - Dangerousness/lethality
 - Interference with addiction or mental health recovery efforts
 - Social functioning
 - Ability for self-care
 - Course of illness (see page 47 of the ASAM Criteria)
- 4) Readiness to change: Exploring an individual’s readiness and interest in changing. An adolescent assessment cannot rely on adult assessment methodologies, but must be augmented by developmentally appropriate, adolescent specific elements. The earlier stages of readiness to change such as precontemplation should be thoroughly addressed. This element is often coupled with a prevalence of co-occurring disorders, polydrug involvement, and the challenges of habilitation as opposed to rehabilitation. Often skills such as effective communication, impulse control, prosocial behavior, and interpersonal interactions have not yet been learned and therefore do not constitute rehabilitation, but skills that must be learned anew. (see page 49 of the ASAM Criteria)
- 5) Relapse, continued use, or continued problem potential: Assesses the need for relapse prevention services. If the person has not achieved a period of recovery from which to relapse, this dimension assesses the potential for continued use for SUD. (see page 51)
- 6) Recovery/living environment assesses the need for individualized family or significant other support and services. It also assesses the need for housing, financial, vocation, education, legal, transportation, or childcare services. (see page 52 of the ASAM Criteria)

A credentialed counselor or clinician, a certified addiction registered nurse, a psychologist, or a physician may gather diagnostic and multidimensional assessment data, however interpretation must be within the assessor’s scope of practice. Consultation with the interdisciplinary team is required

whenever the assessor is outside of his/her scope of practice and expertise. For example, a counselor can gather a history of recent substance use and past history of withdrawal but would need nursing or medical consultation to determine the severity of withdrawal and the matched level of withdrawal management.

B. Determination of Risk and 3 Components of Imminent Danger

Risk is:

- 1) Multidimensional and biopsychosocial
- 2) Relates to patient's history
- 3) Is expressed in current status, answering the question, "how acute unstable, and active is the patient's current clinical presentation?"
- 4) Involves a degree of change from baseline or premorbid functioning

Three components of imminent danger:

- 1) A strong probability that certain behaviors (such as continued alcohol, other drug use or addictive behavior relapse) will occur
- 2) The likelihood that such behaviors will present a significant risk of serious adverse consequences to the individual and/or others
- 3) The likelihood that such adverse events will occur in the very near future, within hours and days, rather than weeks or months

Imminent danger in an OP and residential levels of care:

If an individual has problems in dimensions 4 & 5 that require twenty-four (24) hour supervision and treatment interventions (such as boundary setting) the patient needs placement in a residential program that offers clinical staff and services 24 hrs/day in order to respond to imminent danger

Imminent danger in IP setting:

If there is significant severity in dimensions 1, 2, and/or 3, her or his imminent danger will usually require services in an IP setting rather than a residential level. "High probability of significant risk in the near future" in any of the 6 dimensions. Dimensions 1, 2, or 3 requires medical and/or nursing interventions, and 4, 5, or 6 need clinical rather than medical and/or nursing interventions. (See page 55)

C. Billing Instructions

- 1) Bill HCPCS H0002 on a CMS 1500 claim form
- 2) Enter the rendering clinician's provider ID

2.7 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.

2.8 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 for individual services are considered part of the service being performed and are not billable as individual services.

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2.9 Psychiatric Evaluations, Assessments, Counseling, Therapy, Peer Support, Activity Therapy, and Medication Management

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 nurse specialists:

When the above clinicians are in private practice or group private practice, their reimbursement is calculated at 90% of the reimbursement for physicians; if providing services within an agency, and there is a graduated fee schedule determined by provider type, please see the Medicaid Fee Schedule.
- 3) For all services listed below:
 - a. If service is delivered after regular business hours or 5 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; or 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
 - a. Code depends on time spent with patient
 - b. 90836 and 90838 are add on codes to be used with an E & M code
- 7) +90863 for pharmacological management is an add on code when performed with psychotherapy
- 8) Psychotherapy for crisis: Use CPT code 90839 for first 60 minutes & 90840 for an add on 30-minute increment
Original code: 1 unit; add on code 1 unit
- 9) Cognitive Enhancement Therapy: Use CPT code G0515
Unit = 15 minutes
- 10) Family therapy: Use CPT codes 90846 - 90847
Unit = 1 hour
For functional family therapy EBP use modifier HK on CPT code 90847
- 11) Group therapy: Use CPT codes 90849 and 90853
Bill for each member in group
- 12) Prolonged service billing:
 - a) CPT codes 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) CPT codes 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) CPT codes 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 minutes to 1 hr & 14 min)	99354 Unit of 1
75 - 104 minutes (1 hr 15 minutes to 1 hr 44 min)	99354 Unit of 1 and 99355 Unit of 1
105 minutes or more (1 hr 45 minutes 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.

- 13) 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 worker; 115 certified family peer support worker; 117 certified correctional peer support worker
- 14) 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) Activity therapy service is not recreational but does include nationally accredited adventure based or experiential based therapies.
 - d) Per session; 1 unit
 - e) Use modifier HQ for groups
- 15) Inpatient and ED consultation – telehealth: must identify both rendering & referring practitioner on claim
 - a) Add modifier GT to HCPCS code
 - b) 15 minutes - G0406
 - c) 25 minutes - G0407
 - d) 35 minutes - G0408
- 16) Comprehensive med service - H2010
 - a) 15 minutes unit
 - b) Includes medication assessment, administration, monitoring and recipient education
- 17) Comprehensive Multidisciplinary Assessment – H2000
 - a) For SMI, SED, SUD
 - b) Billable by the 13 agency types only
- 18) Assessment for non-SMI/SED/SUD – H0031
- 19) ASAM assessment for placement in level of care for recipients with SUD – H0002

2.10 Behavioral Health Pharmacology

A. Prior Authorization

- 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) No prior authorization is required 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.
- 3) No prior authorization is required for extended release naltrexone IM.

B. Availability of Medically Necessary Drug Items

An MCO Preferred Drug List (PDL) cannot be used to remove recipient access to a 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. 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; opioid addiction is a chronic disease as is diabetes and high blood pressure and is treatable.

D. Medicaid Drug Utilization Review (DUR) Provisions of the SUPPORT Act

In response to the federal amendment of Section 1902(a) of the Social Security Act (42 U.S.C. 1396a) and the national opioid crisis, the New Mexico Human Services Department (HSD), Medical Assistance Division (MAD) is implementing provisions required by Section 1004 of the “Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act,” also known as the “SUPPORT for Patients and Communities Act” (SUPPORT Act).

Effective October 1, 2019, the New Mexico Medicaid program is required to have the following provisions implemented in both the fee-for-service (FFS) and Centennial Care programs:

Specifically, managed care and fee for service organizations will have implemented the following provisions by October 1, 2019:

- 1) Opioid claims review. A real-time prospective drug utilization review of the sort defined in section 1927(g)(2)(A) of the Social Security Act, for each prescription that identifies potential problems at point of sale to engage both patients and prescribers about possible opioid abuse and overdose risk prior to the prescription being dispensed to the patients;
- 2) An automated claim review process as a retrospective drug utilization review of the sort defined in section 1927(g)(2)(B) of the Social Security Act, that provides for additional examination of claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care;
- 3) Both the prospective and the retrospective drug utilization review will be consistent with medical practice patterns in New Mexico to help meet the health care needs of the Medicaid patient population in the state. The Centers for Medicare & Medicaid Services encourages states to utilize, for example, the 2016 Centers for Disease Control and Prevention Guideline for primary care practitioners on prescribing opioids in outpatient settings for chronic pain.
- 4) Claims Review Requirements
 - a) Safety Edits Including Early, Duplicate, and Quantity Limits: Limitations in both prospective and retrospective drug utilization review should include restrictions on duplicate fills, early fills, and drug quantity limitations.
 - b) Maximum Daily Morphine Milligram Equivalents Safety Edits: Both the prospective and retrospective drug utilization review safety edits must include a morphine milligram equivalents threshold amount such as the level that is recommended in the 2016 Centers for Disease Control Guideline.

c) Concurrent Utilization Alerts: Both the prospective and retrospective drug utilization review safety edits must be able to provide alerts for concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics, as well as potential complications resulting from other medications concurrently being prescribed with opioids.

d) Care Coordination: All safety edits will activate Care Coordination for the deliberate organization of patient care activities between all participants involved in the patient's care to facilitate the appropriate delivery of health care services.

5) Exemptions

The drug review and utilization requirements under this subsection shall not apply with respect to an individual who is receiving hospice or palliative care or treatment for cancer; or is a resident of a long-term care facility, a facility described in section 1905(d) of the Social Security Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

6) Opioid Therapy Edits

Opioid pharmacy claims that exceed the maximum morphine milligram equivalents per day, as determined by the state, will be flagged and may be denied. If the prescriber deems that it is medically necessary for the recipient to exceed the maximum morphine milligram equivalents per day limit, the prescriber must complete the *Drug Prior Authorization Request* form and fax the completed signed form requesting to increase the maximum prescribed morphine milligram equivalents limit to the prior authorization unit of the recipient's assigned benefit plan for clinical review. If a recipient presents a new prescription to the pharmacy that exceeds a previously approved morphine milligram equivalents limit, this is considered an additional request requiring the prescriber to again submit for prior authorization. Subsequent requests by a prescriber to increase a morphine milligram equivalents limit will require the prescriber to submit a new request.

When the pharmacist cannot reach a prescriber or when the prior authorization departments are closed, the pharmacist, using his/her professional judgement, may deem the filling of the prescription for these edits to be an "emergency." In these emergency cases, the pharmacist must document "Emergency Prescription" in writing on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and can override the pharmacy claim at point-of-sale by contacting the health plan's pharmacy help desk.

State Medicaid plans fee for service and managed care organizations will offer education and training to all providers on new opioid provisions to help minimize workflow disruption and to ensure that beneficiaries have continuity of care. Prior authorization may be necessary to avoid abrupt opioid withdrawal for patients that need to taper off high doses of opioids to minimize potential symptoms of withdrawal and manage their treatment regimen, while encouraging pain treatment using non-pharmacologic therapies and non-opioid medications when appropriate.

7) Program to Monitor Antipsychotic Medications for Children

The managed care organizations shall develop and implement a program to monitor and manage the appropriate use of antipsychotic medications for children and submit quarterly to the Human Services Department any information as may be required on activities carried out under a monitoring program for individuals not more than the age of 18 years, specifically for children in foster care.

8) Fraud and Abuse Identification

The Managed Care Organizations shall develop and implement a process that identifies potential fraud or abuse of controlled substances by individuals, health care providers prescribing drugs to individuals, and pharmacies dispensing drugs to individuals.

9) Drug Utilization Review Activities and Requirements

Beginning not later than October 1, 2019, each Managed Care Organization will comply with the applicable provisions of section 438.3(s)(2) of title 42, Code of Federal Regulations, section 483.3(s)(4) of such title, and section 483.3(s)(5) of such title, as such provisions were in effect on March 31, 2018."

a. Prospective DUR includes screening for potential drug therapy problems due to:

- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

b. Retrospective DUR:

Through Medicaid drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care

10) The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage/duration
- Clinical abuse/misuse

11) Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act

Summary: <https://www.congress.gov/bill/115th-congress/house-bill/6>

Text: <https://www.congress.gov/bill/115th-congress/house-bill/6/text#toc-HA3B1D9BB0B5F45B0BCF9A81C0707A4AB>

On October 15, 2019 the Managed Care Organizations attested that all components of the SUPPORT for Patients and Communities Act had been implemented.

SUPPORT Act reporting requirements have been incorporated into the Pharmacy Report #44.

Managed Care Organization Requirements

In addition to implementing the SUPPORT Act requirements described above by October 1, 2019, and ensuring that the claims of Medicaid eligible individuals who are excluded from the requirements will be exempted from the claims review requirements, each Centennial Care MCO 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.

2.11 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; use provisional diagnosis, Z13.9, encounter for screening, unspecified

G0443 – Brief intervention; use a provisional diagnosis

Note: These codes are not to be used for SBIRT; there are separate codes for SBIRT found in the physical health fee schedule

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2.12 Early SUD Intervention (ASAM Level 0.5)

A. Definition of Service

Professional services targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed SUD are provided in Level 0.5. These early intervention services including individual or group counseling, and motivational interventions seek to identify substance-related risk factors to help individuals recognize the potentially harmful consequences of high-risk behaviors.

Length of service may vary from 15 to 60 minutes provided once or over several brief motivational sessions, to several weeks of services provided in programs. Provider types include credentialed and/or licensed BH professionals including addiction counselors, social workers, peer support workers, or health educators. SBIRT activities are often provided by generalist health care professionals, peer support workers or addiction counselors who are knowledgeable about substance use and addictive disorders, motivational counseling, and the personal consequences of high-risk behavior.

The goal of the individual, group, or family counseling and SBIRT services is to educate individuals about the risks of substance use and help them avoid such behavior. SBIRT services aim to intervene early, linking individuals with SUDs to appropriate treatment programs.

B. Admission Criteria - Adult

- 1) Meets one of the specifications in Dimensions 4, 5, or 6
- 2) Any identifiable problems in Dimensions 1, 2, or 3 are stable or are being addressed through appropriate outpatient medical or mental health services
- 3) The Six Dimensions:
 - I. *Acute intoxication and/or withdrawal potential:* (see SUD WM section below)
 - II. *Biomedical conditions and complications:* If any, are stable or being actively addressed and thus will not interfere with therapeutic interventions.
 - III. *Emotional, Behavioral, or cognitive conditions and complications:* if any, are being addressed through appropriate mental health services, and thus will not interfere with therapeutic interventions.
 - IV. *Readiness to change:* Expresses willingness to gain an understanding of how his/her current addictive behavior and/or use of alcohol and/or other drugs may be harmful or impair his/her ability to meet responsibilities and achieve personal goals.
 - V. *Relapse, continued use, or continued problem potential:* Meets either (a) **or** (b):
 - (a) Does not understand the need to alter his/her current behavior or pattern of use to prevent harm that may be related to such use or behavior; **OR**
 - (b) Needs to acquire specific skills needed to change his/her current pattern of use or behavior

VI. *Living environment*: Characterized by at least (a) or (b) or (c) or (d):

- (a) His/her social support system is composed primarily of persons whose substance use or addictive behavior patterns prevent them from meeting social, work, school, or family obligations;
- (b) His/her family member(s) currently is/are addictively using alcohol or other drugs (or have done so in the past), thereby heightening the individual's risk for a substance use disorder;
- (c) His/her significant other expresses values concerning addictive behavior and/or alcohol or other drug use that create serious conflicts for the individual;
- (d) His/her significant other condones or encourages high-risk addictive behavior and/or use of alcohol or other drugs.

C. Admission Criteria - Adolescent

- 1) Meets at least one of the specifications in Dimensions 4, 5, or 6.
- 2) Any identifiable problems in Dimensions 1,2, or 3 are stable or are being addressed through appropriate outpatient medical or mental health services.
- 3) The Six Dimensions:
 - I. *Acute intoxication and/or withdrawal potential*: No signs of acute or subacute withdrawal, or risk of acute withdrawal.
 - II. *Biomedical conditions and complications*: If any, are stable or are being actively addressed, and thus will not interfere with therapeutic interventions.
 - III. *Emotional, Behavioral, or cognitive conditions and complications*: If any, are being addressed through appropriate mental health services, and thus will not interfere with therapeutic interventions.
 - IV. *Readiness to change*: Expresses willingness to gain an understanding of how his/her current addictive behavior and/or use of alcohol and/or other drugs may be harmful or impair his/her ability to meet responsibilities and achieve personal goals. Could also include those who are ambivalent about exploring how their current behavior or use of alcohol and other drugs may be harmful or impairing, or those whose motivation is to achieve some goal other than the modification of their substance use behaviors (e.g. having their driving privileges restored).
- V. *Relapse, continued use, or continued problem potential*: (a) **or** (b):
 - (a) Does not understand the need to alter his/her current behavior or pattern of use to prevent harm that may be related to such use or behavior;

(b) Needs to acquire specific skills needed to change his/her current pattern of use or behavior.

VI. *Living environment:* Meets (a) **or** (b) **or** (c) **or** (d):

- (a) His/her social support system is composed primarily of persons whose substance use or addictive behavior patterns prevent him/her from meeting social, work, school, or family obligations;
- (b) His/her family members currently are addictively using alcohol or other drugs or have done so in the past, thereby heightening the adolescent's risk for a substance use disorder;
- (c) A significant member of the adolescent's support system expresses values concerning addictive behavior and /or alcohol or other drug use that create serious conflict for the individual;
- (d) A significant member of the adolescent's support system condones or encourages high-risk addictive behavior and/or use of alcohol or other drugs.

D. Billing Instructions

See billing instructions from Outpatient Therapy sections of this manual.

2.13 Outpatient SUD Services (ASAM Levels 1 and 1-WM)

A. Definition of Service

Level 1 is appropriate in many situations as an initial level of care for patients with less severe disorders; for those who are in early stages of change; as a “step down” from more intensive services; or for those who are stable and for whom ongoing monitoring or disease management is appropriate. Adult services for Level 1 programs are provided less than 9 hours weekly, and adolescents’ services are provided less than 6 hours weekly. Individuals recommended for more intensive levels of care may receive more intensive services.

Credentialed and/or licensed treatment professionals, including counselors, social workers, psychologists, and physicians (whether addiction-credentialed or generalist) deliver outpatient services, including medication assisted treatment, medication oversight and disease management services.

Outpatient services are designed to help patients achieve changes in alcohol and/or drug use and addictive behaviors and often address issues that have the potential to undermine the patient’s ability to cope with life tasks without the addictive use of alcohol, other drugs, or both.

Medicaid covered services in this category include individual and group counseling, interdisciplinary teaming, motivational enhancement, family therapy, educational groups, occupational and activity therapy, psychotherapy, comprehensive medication services, medication assisted treatment, cognitive enhancement therapy (if co-occurring mental health), comprehensive community support services, OP crisis intervention and stabilization, the opioid treatment program, and for MCO members only family support services and recovery support services.

Level 1 – WM (withdrawal management) with extended on-site monitoring is an organized outpatient service, which may be delivered in an office setting, a crisis center, or a medical or behavioral health treatment facility. It depends on a support system of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems when encountered. There must be an ability to conduct or arrange for appropriate laboratory and toxicology testing, and 24-hour access to emergency medical services if indicated.

B. Admission Criteria – Adult

- 1) The patient who is appropriately admitted to Level 1 is assessed as meeting specifications in **all** of the following six dimensions.
- 2) The Six Dimensions:
 - I. *Acute intoxication and/or withdrawal potential: Biomedical conditions and complications:* No signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a level 1 setting. (See WM section below)
 - II. *Biomedical conditions and complications:* If any, characterized by biomedical conditions or problems that are sufficiently stable to permit participation in outpatient treatment. Examples include uncomplicated pregnancy or asymptomatic HIV disease.

III. *Emotional, Behavioral, or cognitive conditions and complications:*

Meets (a) **or** (b) **and** both (c) **and** (d):

(a) No symptoms of a co-occurring mental disorder, or any symptoms are mild, stable, fully related to a substance use or other addictive disorder, and do not interfere with his/her ability to focus on addiction treatment issues;

(b) Psychiatric symptoms (such as anxiety, guilt, or thought disorders) are mild, mostly stable, and primarily related to either a substance use or other addictive disorder, or to a co-occurring cognitive, emotional, or behavioral condition. Mental health monitoring is needed to maintain stable mood, cognition, and behavior. For example, fluctuations in mood only recently stabilized with medication, substance-induced depression that is resolving but still significant, or a patient with schizophrenic disorder recently released from the hospital;

(c) His/her mental status does not preclude his/her ability to 1) understand the information presented and 2) participate in treatment planning and the treatment process;

(d) He/she is assessed as not posing a risk of harm to self or others and is not vulnerable to victimization by another.

IV. *Readiness to change:* Meets (a) **and one** of (b) **or** (c) **or** (d)

(a) Expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan;

(b) Acknowledges that he/she has a substance-related or other addictive disorder and/or mental health problem and wants help to change;

(c) Ambivalent about a substance-related or other addictive disorder and/or mental health condition. Requires monitoring and motivating strategies, but not a structured milieu program.

(d) May not recognize that he/she has a substance-related or other addictive disorder and/or mental health problem. For example, is more invested in avoiding a negative consequence than in the recovery effort.

V. *Relapse, continued use, or continued problem potential:*

All programs: Patient is assessed as able to achieve or maintain abstinence and related recovery goals. Or the patient is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals, only with support and scheduled therapeutic contact. This is to assist him or her in dealing with issues that include concern or ambivalence about preoccupation with alcohol, and/or other drug use; other addictive behavior; cravings to use or gamble; peer pressure; and lifestyle and attitude changes.

Co-occurring programs: In addition to the above criteria for all programs, the patient is assessed as able to achieve or maintain mental health functioning and related goals only

with support and scheduled therapeutic contact to assist him or her in dealing with issues that include impulses to harm self or others and difficulty in coping with his/her affects, impulses, or cognition.

VI. *Recovery environment:*

All Programs

The patient's status is characterized by (a) **or** (b) **or** (c)

- (a) Patient's psychosocial environment is sufficiently supportive that outpatient treatment is feasible (for example, significant others are in agreement with the recovery effort; there is a supportive work environment or legal coercion; adequate transportation to the program is available; and support meeting locations and non-alcohol/drug-centered work are near the home environment and accessible);
- (b) Does not have an adequate primary or social support system, but he or she has demonstrated motivation and willingness to obtain such a support system;
- (c) Family, guardian, or significant others are supportive but require professional interventions to improve the patient's chance of treatment success and recovery.

Co-Occurring Programs

In addition to the above criteria, the patient's status in Dimension 6 is characterized by (a) **or** (b) **or** (c)

- (a) Does not have an adequate primary or social support system and has mild impairment in his/her ability to obtain a support system. For example, mood, cognition, and impulse control fluctuate and distract from focusing on treatment tasks;
- (b) The family, guardian, or significant others require active family therapy or systems interventions to improve the patient's chances of treatment success and recovery. These may include family enmeshment issues, significant guilt or anxiety, or passivity or disengaged aloofness or neglect;
- (c) All of the following are true: 1) Patient has a severe and chronic mental disorder or an emotional, behavioral, or cognitive condition, and 2) does not have an adequate family or social support system, and 3) is chronically impaired, but not in imminent danger, and has limited ability to establish a supportive recovery environment. However, does have access to outreach and case management services that can provide structure and allow him/her to work toward stabilizing both the substance use or other addictive disorder and mental disorders.

C. Admission Criteria – Adolescent

- 1) The adolescent admitted to Level 1 is assessed as meeting specifications in **all** of the following six dimensions
- 2) The six dimensions:

I. Acute intoxication and/or withdrawal potential:

- (a) No signs or symptoms of withdrawal, **or** his/her withdrawal needs can be safely managed in a level 1 setting.
- (b) Is not experiencing acute or subacute withdrawal from alcohol or other drugs, and is not at risk of acute withdrawal; **or**
- (c) If experiencing very mild withdrawal, the symptoms consist of no more than lingering but improving sleep disturbance

II. Biomedical conditions and complications:

Biomedical conditions and problems, if any, are sufficiently stable to permit participation in outpatient treatment.

III. Emotional, Behavioral, or cognitive conditions and complications: All of the following are true:

- (a) Dangerousness/lethality: Assessed as not posing a risk of harm to self or others. He/she has adequate impulse control to deal with any thoughts of harm to self or others;
- (b) Interference with addiction recovery efforts: The adolescents' emotional concerns relate to negative consequences and effect of addiction, and he/she is able to view them as part of addiction and recovery. Emotional, behavioral, or cognitive symptoms, if present, appear to be related to substance-related problems rather than to a co-occurring psychiatric, emotional, or behavioral condition. If they are related to such a condition, appropriate additional psychiatric services are provided concurrent with the level 1 treatment. The adolescent's mental status does not preclude his/her ability to 1) understand the materials presented; and 2) participate in the treatment process;
- (c) Social functioning: Relationships or spheres of social functioning (as with family, friends, and peers at school and work) are impaired but not endangered by substance use. Is able to meet personal responsibilities and to maintain stable, meaningful relationships despite the mild symptoms experienced (such as mood swings without aggression or threats of danger, or in-school suspension for lateness but no suspensions for truancy);
- (d) Ability for self-care: Has adequate resources and skills to cope with emotional, behavioral, or cognitive problems, with some assistance. He/she has the support of a stable environment and is able to manage the activities of daily living.
- (e) Course of Illness: Has only mild signs and symptoms. Any acute problems (such as severe depression, suicidality, aggression, or dangerous delinquent behaviors) have been well stabilized, and chronic problems are not serious enough to pose a high risk of vulnerability.

IV. Readiness to change:

Meets (a) **and** one of (b) **or** (c) **or** (d)

- (a) Expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan;
- (b) Acknowledges that s/he has a substance-related or other addictive disorder and/or mental health problem and wants help to change, but is ambivalent about recovery efforts and requires monitoring and motivating strategies;
- (c) Is Ambivalent about a substance-related or other addictive disorder and/or mental health condition. s/he requires monitoring and motivating strategies to engage in treatment and progress through the stages of change, but not a structured milieu program. Is invested in avoiding negative consequences;
- (d) May not recognize that s/he has a substance-related or other addictive disorder and/or mental health problem. Is more invested in avoiding negative consequences than the recovery process;

V. *Relapse, continued use, or continued problem potential:*

Able to achieve or maintain abstinence and related recovery goals. Or is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals only with support and scheduled therapeutic contact.

VI. *Recovery environment:*

The adolescent's status is characterized by (a) **or** (b) **or** (c)

- (a) The psychosocial environment is sufficiently supportive that outpatient treatment is feasible (e.g. significant others are in agreement with the recovery effort; there is a supportive work environment or legal coercion; adequate transportation to the program is available and support meeting locations and non-alcohol/drug centered work are near the home environment and accessible);
- (b) Does not have an adequate primary or social support system, but he/she has demonstrated motivation and willingness to obtain such a support system;
- (c) Family, guardian, or significant others are supportive but require professional interventions to improve the adolescent's change of treatment success and recovery.

D. Billing Instructions

- 1) For Level 1-WM (withdrawal management)
 - (a) Bill the outpatient code from section 2.8 that is applicable to the service being provided, **AND**
 - (b) Bill H0014, ambulatory detoxification. There is no reimbursement attached to this code; it is being utilized for WM tracking purposes.

- 2) For Level 1 – outpatient services, bill the appropriate code from section 2.8

Section Three: Special Outpatient Services for Adults & Children

3.1 Applied Behavior Analysis (ABA)

Information on Applied Behavioral Analysis was not updated in time to be included in this edition of the Behavioral Health Provider Billing and Policy Manual. Full information, including service definitions, eligibility, screening and referral, evaluations, and billing instructions, will be released by the Medical Assistance Division as a Provider Supplement, and will then be included in future versions of this manual.

DRAFT

3.2 Ambulatory Withdrawal Management – SUD (ASAM Level 2-WM)

A. Definition of Service

Level 2 Ambulatory Withdrawal Management with extended on-site monitoring is an organized service which may be delivered in an office setting, a general health care or behavioral health care facility, or an addiction treatment facility by medical and nursing professionals who provide evaluation, withdrawal management, and referral services. All services are provided under physician or nurse practitioner monitored procedures or clinical protocols. The MD/CNP need not be on-site, but available to evaluate and confirm that withdrawal management in this less supervised setting is safe. Therapies include individual assessment, medication or non-medication methods of withdrawal management, patient education, non-pharmacological clinical support, involvement of family members or significant others, and discharge and transfer planning.

B. Length of Service/Continued Service and Discharge Criteria

The patient continues in Level 2-WM services until:

- 1) Withdrawal signs and symptoms are sufficiently resolved; or,
- 2) Signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of WM is indicated; or,
- 3) The patient is unable to complete withdrawal management at level 2-WM, despite an adequate trial, indicating a need for more intensive services.

C. Billing Instructions

For Level 2-WM (withdrawal management)

- 1) Bill the outpatient code from section 2.7 that is applicable to the service being provided, **AND**
- 1) Bill H0014, ambulatory detoxification. There is no reimbursement attached to this code; it is being utilized for WM tracking purposes.

3.3 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, or provisional diagnosis if using the Treat First model (see section 2.4 for more on Treat First), 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. For those agencies participating in the "Treat First" methodology, CCSS can be initiated anytime within the first four encounters utilizing a Z code in place of a diagnosis. CCSS is often initiated in the very first encounter, when deemed appropriate, without a full assessment or diagnostic evaluation having been completed.

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 initial 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. The agency must work with BHSD to schedule a site visit within the first year, ongoing reviews and participate in technical assistance as needed.

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: CMS 1500 Claim form with reimbursement at the encounter rate unless choosing fee schedule.
- 7) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 8) For FQHC, IHS, and Tribal 638: if preferring to utilize fee schedule rates, please contact MAD Benefits and Reimbursement Bureau.
- 9) Transportation of a patient by clinic staff is not billable or reimbursable.
- 10) CCSS may be billed for purposes of discharge planning and transition for all higher levels of service, and concurrent to IOP if medical necessity and service plan indicate.

3.4 Crisis Intervention Services

A. Purpose

- 1) Ensure 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 (NMCAL), or their own twenty-four (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 twenty (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 (6) hours of training must be received prior to working any crisis services; the balance of the training is received within the first twelve (12) months.
- 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 – maximum of 1 unit
 - b. Use call center billing NPI in rendering field
 - c. FQHC: UB claim form; 0919 revenue code for OMB rate
 - d. IHS/638: UB claim form; 0919 revenue code for OMB
- 2) Clinic crisis services (in person or telephonic management of complex crises):
 - a. H2011 U2 – 15 min units
 - b. Use facility NPI in rendering field
 - c. FQHC: UB claim form; 0919 revenue code for encounter 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 encounter 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
- 5) For FQHCs, UB claim form, revenue code 0919
- 6) IHS/638: UB claim form; revenue code 0919 for OMB rate

3.5 Crisis Triage Centers (CTC)

A. Purpose

- 1) Ensure 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. Policy

- 1) All CTCs shall provide emergency screening and evaluation services twenty-four (24) hours per day, seven (7) days per week.
- 2) All CTCs must be licensed by the New Mexico Department of Health as a Crisis Triage Center offering one of the following types of service:
 - a. A CTC structured for less than twenty-four (24) hour stays providing only outpatient withdrawal management or other stabilization services;
 - b. A CTC providing outpatient and residential crisis stabilization services; or
 - c. A CTC providing residential crisis stabilization services.
- 3) CTCs that provide residential/outpatient care:
 - a. The CTC shall admit twenty-four (24) hours a day, seven (7) days a week, and discharge seven (7) days a week.
 - b. Client visits last a minimum of twenty-four (24) hours and may be as long as five (5) to seven (7) days, or until the client is determined stable and ready for discharge.
- 4) CTCs that provide outpatient/non-residential care only:
 - a. Client visits begin when the client is assessed to require crisis stabilization services and last fewer than twenty-four (24) hours.

C. Living Room Model

Clinical staff run residential crisis care models have been found to provide outcomes comparable to those of hospital care for 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).

D. CTC Rates and Billing Instructions:

CTCs are reimbursed through an agency specific cost based bundled rate developed by the agency and HSD. To start the rate setting process, a new CTC should contact BHSD while pursuing licensure through DOH (or shortly after). Because the rate setting process can take several months, some providers will receive a proxy rate they can use to bill while their final rate is being developed. HSD will provide a letter with approved rates established to each provider, both for the proxy rate and the final rate. The providers will then present the letter to the MCOs to establish the individual provider rates.

Whether the final rate is higher or lower than the proxy rate, there will be no retroactive adjustment for the difference. Because the initial agency rates are developed using cost projections, CTC rates will be reviewed again after HSD has collected at least one full year of utilization and actual cost data.

The CTC must have an approved enrollment with **provider type 342** and **specialty 246** – residential/non-residential, or **specialty 247** – non-residential.

- 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 CTCs:
 - a. Bill rev code 0169, room and board if staying more than twenty-four (24) hours
 - b. Bill rev code 0513, psychiatric clinic if staying less than twenty-four (24) hours
 - c. Type of bill is 089X
 - d. No other revenue codes can be billed on the claim submitted with this combination of revenue code and type of bill 089x. A procedure code should not be billed in conjunction with revenue code 0169 or 0513.
- 3) For non-residential only (outpatient) CTCs:
 - a. Bill rev code 0513, psychiatric clinic
 - b. Type of bill is 0131
- 4) For services rendered in the non-residential only (outpatient) CTC, billed with type of bill 0131, in addition to the bundled revenue code 0513, the following revenue codes should be included as **additional informational lines**, if that specific service was rendered. The CTC may include whatever applicable procedure code that further defines any revenue code used; however, a procedure code is not necessarily required:
 - a. 0914 – Individual therapy
 - b. 0915 – group therapy

- c. 0916 – family therapy
- d. 0944 – drug rehab
- e. 0945 - alcohol rehab
- f. 0961 - psychiatric
- g. 0984 - medical social services

- 5) CCSS may also be billed for discharge planning and transition purposes.
- 6) Medical assessments (90792) and mental health intake assessments (90791) are not included in the CTC bundled rate and may be billed separately.
- 7) BHSD (State General Fund) will pay an additional \$50 per client per day of CTC services for room and board, billed through the BHSD Star system. If this code should get billed on the CTC claim received by the MCO/IMCE, it will be denied by the MCO/IMCE.
 - a. Room and board per diem (\$50 per client per day) = HCPCS H0047

3.6 Family Support Services (MCO Members Only)

A. Purpose

Family support services are community-based, face-to-face interactions with children, youth or adults and their family designed to enhance the family's strengths, capacities, and resources to promote the recipient's ability to reach the recovery and resiliency behavioral health goals they consider most important. The entire family along with other primary caregivers who are closely linked to the recipient are engaged in the plan of care.

B. 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

3.7 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 approved independent practitioner or staff who have completed a state approved course in supervision of peers within the scope of the specialty service. The approved peer supervisor must be employed with the same agency as the peer.
- 2) 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.
- 3) 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.

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) IHS and Tribal 638: UB claim form; revenue code 0919. Reimbursement at OMB rate.
- 5) For FQHC, IHS, and Tribal 638: if preferring to utilize fee schedule rates, please contact MAD Benefits and Reimbursement Bureau.

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3.8 Intensive Outpatient Program for Substance Use Disorders (IOP) (ASAM Level 2.1)

A. Definition of Service

Level 2.1 Intensive Outpatient Programs (IOP) have a goal of providing 9–19 hours of weekly structured programming for adults or 6–19 hours of weekly structured programming for adolescents. However, the amount of weekly services per individual is directly related to the goals and objectives specified in the individual’s treatment plan. In addition, NM’s rural geography sometimes prohibits this amount of programming. Programs may occur during the day or evening, on the weekend, or after school for adolescents. Level 2.1 IOP includes individual and group counseling, educational groups, psychotherapy, MAT, motivational interviewing, enhancement and engagement strategies, family therapy, or other skilled treatment services. Services are linguistically and culturally-sensitive and incorporate recovery and resiliency values into all service interventions. The 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.

At a minimum, this level of care also provides a support system including medical, psychological, psychiatric, laboratory, and toxicology services within 24 hours by telephone or within 72 hours in person. Emergency services are available at all times, and the program has direct affiliation with more or less intensive care levels and supportive housing

B. Policy

Level 2.1 IOP service requires a diagnostic evaluation and a SUD multi-dimensional assessment which identifies IOP as a need. 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.

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

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.

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

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.

C. Admission Criteria – Adults

- 1) *Direct admission* to a level 2.1 program is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) **and** in Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist), as well as in **at least one** of Dimensions 4, 5, or 6.

Transfer to a level 2.1 program is advisable for the patient who

- (a) has met the essential treatment objectives at a more intensive level of care **and**
- (b) requires the intensity of services provided at level 2.1 in at least one of Dimensions 4, 5, or 6.

A patient may also be transferred to level 2.1 from a level 1 program when the services provided at level 1 have proved insufficient to address the patient's needs or when level 1 services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he /she now meets the admission criteria.

2) The six Dimensions

I. Acute intoxication and/or withdrawal potential:

No signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a level 2.1 setting.

II. Biomedical conditions and complications:

Biomedical conditions and problems, if any, are stable or are being addressed concurrently and thus will not interfere with treatment. Examples include mild pregnancy-related hypertension, asthma, hypertension, or diabetes.

III. Emotional, Behavioral, or cognitive conditions and complications:

If any of the above conditions are present, the patient must be admitted to a co-occurring capable program, depending on the patient's level of function, stability and degree of impairment in this dimension. **One** of the following characteristics apply:

- (a) Engages in abuse of family members or significant others, and requires intensive outpatient treatment to reduce the risk of further deterioration;

(b) Is at significant risk of victimization by another. However, the risk is not severe enough to require twenty-four (24) hour supervision (e.g. has sufficient coping skills to maintain safety through attendance at treatment sessions at least 9 or more hours/week).

(c) Has a diagnosed emotional, behavioral, or cognitive disorder that requires intensive outpatient monitoring to minimize distractions from his/treatment or recovery. May have history which suggests a high potential for distraction from treatment; such a disorder requires stabilization concurrent with addiction treatment (examples are an unstable borderline personality disorder, compulsive personality disorder, unstable anxiety, or mood disorder);

IV. Readiness to change:

All programs: Patient's status is characterized by (a) **or** (b)

(a) Requires structured therapy and programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Such interventions are not feasible or are not likely to succeed in a level 1 program;

(b) Patient's perspective inhibits his/her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. (e.g. Attributes his/her alcohol or other drug and mental health problems to other persons or external events rather than to the disorder).

Co-Occurring Programs: Meets criteria for all programs (above) **and** (a) **and** one of (b) **or** (c)

(a) Is reluctant to agree to treatment and is ambivalent about his/her commitment to change a co-occurring mental health problem;

(b) Is assessed as requiring intensive services to improve his/her awareness of the need to change. Has such limited awareness of or commitment to change that he/she cannot maintain an adequate level of functioning without level 2.1 services.

(c) Follow through in treatment is so poor or inconsistent that level 1 services are not succeeding or are not feasible.

V. Relapse, continued use, or continued problem potential:

All programs: Meets (a) **or** (b)

(a) Although the patient has been an active participant at a less intensive level of care, he/she is experiencing an intensification of symptoms of SUD such as difficulty postponing immediate gratification and related drug-seeking behavior, and his /her level of functioning is deteriorating despite modification of the treatment plan;

(b) There is a high likelihood that the patient will continue to use or relapse to use of alcohol and/or other drugs or gambling without close outpatient monitoring and structured therapeutic services, as indicated by his/her lack of awareness of relapse

triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment. The patient has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is adjudged insufficient to stabilize the patient's condition so that direct admission to level 2.1 is indicated.

Co-occurring programs

Patient's status is characterized by psychiatric symptoms that pose a moderate risk of relapse to the alcohol, other drug, or other addictive or psychiatric disorder.

Such a patient has impaired recognition or understanding of-and difficulty in managing-relapse issues, and requires level 2.1 co-occurring program services to maintain an adequate level of functioning.

VI. *Recovery environment:*

All programs: Meets (a) **or** (b)

(a) Continued exposure to the patient's current school, work, or living environment will render recovery unlikely. The patient lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a level 2.1 program;

(b) Patient lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He/she also lacks the resources or skills necessary to maintain an adequate level of functioning without level 2.1 services.

Co-Occurring Programs

Patient' status is characterized by a living, working, social, and/or community environment that is not supportive of good mental functioning. The patient has insufficient resources and skills to deal with this situation.

D. Admission Criteria - Adolescent

A. *Direct admission* to a level 2.1 program is advisable for the adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) **and** Dimension 2 (if any biomedical conditions or problems exist) **and** the severity specifications in at least one of Dimensions 3, 4, 5, and 6.

Transfer to a level 2.1 program is appropriate for the adolescent who has met the objectives of treatment in a more intensive level of care **and** who requires the intensity of service provided at level 2.1 in at least **one** dimension.

An adolescent also may be transferred to level 2.1 from a level 1 program when the services provided at that level have proven insufficient to address his/her needs or when level 1 services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care for which he or she now meets criteria.

B. The 6 Dimensions;

I. Acute intoxication and/or withdrawal potential:

No experience or not at risk of acute withdrawal. At most, symptoms consist of subacute withdrawal marked by minimal symptoms that are diminishing.

Is likely to attend, engage, and participate in treatment, as evidenced by his/her meeting the following:

- (a) Able to tolerate mild subacute withdrawal symptoms;
- (b) Has made a commitment to sustain treatment and to follow treatment recommendations; and
- (c) Has external supports (family and/or court) that promote engagement in treatment.

II. Biomedical conditions and complications:

Biomedical conditions/complications, if any, are stable or are being addressed concurrently and thus will not interfere with treatment, **or**

the biomedical conditions and problems are severe enough to distract from recovery and treatment at a less intensive level of care, but will not interfere with recovery at level 2.1. The biomedical conditions and problems are being addressed concurrently by a medical treatment provider.

III. Emotional, Behavioral, or cognitive conditions and complications:

Meets at least **one** of the following:

(a) Dangerousness/lethality: Is at mild risk of behaviors endangering self, others, or property (for example, he/she has suicidal or homicidal thoughts, but no active plan), and requires frequent monitoring to assure that there is a reasonable likelihood of safety between IOP or DT sessions. However, his or her condition is not so severe as to require daily supervision.

(b) Interference with addiction recovery efforts: Recovery efforts are negatively affected by an emotional, behavioral, or cognitive problem, which causes mild interference with, and requires increased intensity to support treatment participation and/or adherence

(c) Social functioning: Symptoms are causing mild to moderate difficulty in social functioning, but not to such a degree that he/she is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work, or community.

(d) Ability for self-care: The adolescent is experiencing mild to moderate impairment in ability to manage the activities of daily living, and thus requires frequent monitoring and treatment interventions. Problems may involve poor hygiene secondary to exacerbation of a chronic mental illness, poor self-care, or lack of independent living skills in an older adolescent who is transitioning to adulthood, or in a younger adolescent who lacks adequate family supports.

(e) Course of illness: His/her history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without frequent monitoring and maintenance. Examples include medication or behavioral adherence.

IV. Readiness to change: Is characterized by (a) **or** (b)

(a) Requires structured therapy and a programmatic milieu to promote progress through the stages of change, as evidenced by behaviors such as 1) is verbally compliant, but does not demonstrate consistent behaviors; 2) is only passively involved in treatment; or 3) demonstrates variable adherence with attendance.

(b) The adolescent's perspective inhibits his/her ability to make progress through the stages of change. Has unrealistic expectations or does not recognize the need for continued assistance.

V. Relapse, continued use, or continued problem potential: Is characterized by (a) **or** (b)

(a) Although the adolescent has been an active participant at a less intensive level of care, he/she is experiencing an intensification of symptoms of the SUD and his/her level of functioning is deteriorating despite modification of the treatment plan;

(b) There is a likelihood that he/she will continue to use or relapse without close outpatient monitoring and structured therapeutic services, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment.

VI. Recovery environment: Is characterized by (a) **or** (b) **or** (c)

(a) Continued exposure to the adolescent's current school, work, or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a level 2.1 program.

(b) Lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He/she also lacks the resources or skills necessary to maintain an adequate level of functioning without level 2.1 services.

(c) The family or caretakers are supportive of recovery, but family conflicts and related family dysfunction impede the adolescent's ability to learn the skills necessary to achieve and maintain abstinence

E. Continued Stay/Discharge

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 SUD 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.

F. Staff Training

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

G. 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 thirty (30) business 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 ninety (90) business 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 business 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.

H. 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.

I. Exhibits/Appendices/Forms

Appendix R:	IOP Provider Certification Information and Process Flow
Appendix S:	IOP Certification Tool
Appendix T:	IOP Application
Appendix U:	IOP Provider Attestation Form
Appendix V:	IOP Site Visit Tools

J. Billing Instructions

- 1) HCPCS H0015 – One 60 minute unit minimum; up to four 60 minute units per day
- 2) Use agency NPI in rendering field
- 3) FQHC: Use the CMS 1500 claim form with the FQHC encounter rate for reimbursement. 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 the fee schedule rates, please contact the MAD Benefits and Reimbursement Bureau.

3.9 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 has a goal of 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

The Interdepartmental Council (IDC) 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 business 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 business 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 – One 60 minute unit minimum; up to four 60 minute units per day
- 2) Use agency NPI in rendering field
- 3) FQHC: Use the CMS 1500 claim form. Reimbursement is 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.
- 4) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 5) For FQHC, IHS, and Tribal 638: if preferring to utilize fee schedule rates, please contact the MAD Benefits and Reimbursement Bureau and all applicable MCOs.

3.10 Medication Assisted Treatment for Buprenorphine (MAT)

Medication Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. There are FDA approved medications to treat alcohol use disorder, smoking and opioid use disorder. MAT treatments for opioid use disorder include methadone and buprenorphine which are regulated under the Controlled Substances Act. Please see section 5.3 for clarification of methadone maintenance treatment for opioid use disorder through Opioid Treatment Programs. For Office Based Opioid Treatment using MAT with buprenorphine, all requirements of The Drug Addiction Treatment Act of 2000 must be addressed. For guidance regarding prescribing buprenorphine via telehealth, please see Telehealth/Telemedicine section above (1.14).

A. Billing Instructions

- 1) Diagnosing, assessing, prescribing, and initial induction
 - a. Practitioners with the DATA 2000 waiver; physician, PA, 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
- 6) For FQHC, IHS, and Tribal 638: if preferring to utilize fee schedule rates contact the MAD Benefits and Reimbursement Bureau and all applicable MCOs.

3.11 Partial Hospitalization Services in Acute Care or Psychiatric Hospital

A. Definition for Partial Hospitalization for SUD – ASAM Level 2.5

Partial Hospitalization Programs (PHP) are appropriate for patients who are living with unstable medical and psychiatric conditions. Partial hospitalization programs are able to provide 20 hours or more of clinically intensive programming each week to support patients who need daily monitoring and management in a structured outpatient setting.

Partial hospitalization services are delivered by an interdisciplinary team of providers under the direction of a psychiatrist, with some cross-training to identify mental disorders and potential issues related to prescribed psychotropic drug treatment in populations with SUD. Additionally, these programs must support access to more and less intensive programs as well as supportive housing services. One major distinction from Level 2.1 is the requirement for qualified practitioners in Partial Hospitalization Programs to provide medical, psychological, psychiatric, laboratory, toxicology and emergency services.

For adolescents, partial hospitalization often occurs during school hours; such programs typically have access to educational services or they coordinate with a school system in order to assess and meet their adolescent patients' educational needs.

While there is no prescribed length of stay for Partial Hospitalization, if the necessity for continued services goes beyond 45 days, a prior authorization by the respective MCO or fee-for-service TPA is required. Conditions for this are found in the continued stay/discharge section D (below).

B. Admission Criteria – Adults with SUD

A. The adult who is appropriately placed in a level 2.5 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder, as well as the dimensional criteria for admission.

Direct admission to a level 2.5 program is advisable for the patient who meets specification in Dimension 2 (if any biomedical conditions exist) **and** in Dimension 3 (if any emotional, behavioral, or cognitive conditions exist), as well as in at least **one** of Dimensions 4, 5, or 6.

Transfer to a level 2.5 program is advisable for the patient who

- (a) has met essential treatment objectives at a more intensive level of care **and**
- (b) requires the intensity of services provided at level 2.5 in at least **one** dimension.

A patient also may be transferred to level 2.5 from a level 1 or 2.1 program when the services provided at the less intensive level have proved insufficient to address the patient's needs, or when those services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he/she now meets the admission criteria.

B. The 6 Dimensions:

I. Acute intoxication and/or withdrawal potential:

No signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a level 2.5 setting.

II. Biomedical conditions and complications:

If any conditions exist, they are not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts. Such problems require medical monitoring and/or medical management, which can be provided by a level 2.5 program.

III. Emotional, Behavioral, or cognitive conditions and complications

If any of these conditions are present, the patient must be admitted to a co-occurring capable program, depending on the patient's level of function, stability, and degree of impairment in this dimension.

The severity of the patient's problems in Dimension 3 may require partial hospitalization or a similar supportive living environment in conjunction with a level 3.1 program. Or, if the patient receives adequate support from his/her family or significant other(s), a level 2.5 program may suffice.

The patient's status in Dimension 3 is characterized by a history of mild to moderate psychiatric decompensation (marked by paranoia or mild psychotic symptoms) on discontinuation of the drug use. Such decompensation may occur and requires monitoring to permit early intervention.

The patient's meets (a) **or** (b) **or** (c)

(a) The patient evidences current inability to maintain behavioral stability over a 48-hour period as evidenced by distractibility, negative emotions, or generalized anxiety that significantly affects his or her daily functioning;

(b) The patient has a history of moderate psychiatric decompensation marked by severe, non-suicidal depression on discontinuation of the addictive drug. Such decompensation is currently observable;

(c) The patient is at mild to moderate risk of behaviors endangering self, others, or property, and is at imminent risk of relapse, with dangerous emotional, behavioral, or cognitive consequences, in the absence of level 2.5 structured services.

IV. Readiness to change: Characterized by (a) **or** (b) **and** (c) **and one** of (d) **or** (e)

(a) Requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational intervention at another level of care have failed.

(b) Patient's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinical directed motivational interventions.

(c) Has little awareness of his/her co-occurring mental disorder;

(d) Is assessed as requiring more intensive engagement, community, or case management services than are available at level 2.1 in order to maintain an adequate level of functioning;

(e) Follow through in treatment is so poor or inconsistent that level 2.1 services are not succeeding or are not feasible.

V. *Relapse, continued use, or continued problem potential:*

Characterized by (a) or (b)

(a) Although the patient has been an active participant at a less intensive level of care, he/she is experiencing an intensification of symptoms of the SUD (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his/her level of functioning is deteriorating despite modification of the treatment plan;

(b) There is a high likelihood that the patient will continue to use or relapse to use of substances or gambling without close outpatient monitoring and structured therapeutic services, as indicated by his/her lack of awareness of relapse triggers, difficulty in coping or postponing immediate gratification, or ambivalence toward treatment. Has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is adjudged insufficient to stabilize the patient's condition so that direct admission to level 2.5 is indicated.

VI. *Recovery environment:* Characterized by (a) or (b)

(a) Continued exposure to current school, work, or living environment will render recovery unlikely. Patient lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a level 2.5 program.

(b) Family members and/or significant other(s) who live with the patient are not supportive of his or her recovery goals, or are passively opposed to his/her treatment. The patient requires the intermittent structure of level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is no active opposition to, or sabotaging of, his/her recovery efforts.

Co-Occurring Conditions

Patient's status in Dimension 6 is characterized by a living, working, social environment that is not supportive of good mental functioning. The patient has such limited resources and skills to deal with this situation that treatment is not succeeding or not feasible.

C. Admission Criteria – Adolescent with SUD

1) The adolescent who is appropriately placed in a level 2.5 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder, as well as the dimensional criteria for admission.

Direct admission to a level 2.5 program is advisable for the adolescent who meets the stability specification in Dimension 1, if existing, **and** Dimension 2, if existing, **and** the severity specification in one of Dimensions 3, 4, 5, and 6.

Transfers to a level 2.5 program is appropriate for the adolescent who has met the objectives of treatment in a more intensive level of care **and** who requires the intensity of service provided at level 2.5 in at least **one** dimension.

An adolescent also may be transferred to level 2.5 from a level 1 or 2.1 program when the services provided at those levels have proven insufficient to address his/her needs or when level 1 or 2.1 services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care.

2) The 6 Dimensions:

I. Acute intoxication and/or withdrawal potential:

Is experiencing acute or subacute withdrawal, marked by mild symptoms that are diminishing. (Note: symptoms are specific to type of drug). The adolescent is likely to attend, engage, and participate in treatment, as evidenced by meeting the following criteria:

- (a) Is able to tolerate mild withdrawal symptoms
- (b) Has made a commitment to sustain treatment and to follow treatment recommendations
- (c) Has external supports (as from family and/or court) that promote treatment engagement.

II. Biomedical conditions and complications:

Biomedical conditions are severe enough to distract from recovery and treatment at a less intensive level of care, but will not interfere with recovery at level 2.5. Such problems require medical monitoring and/or medical management which can be provided by a level 2.5 program either directly or through an arrangement with another treatment provider.

III. Emotional, Behavioral, or cognitive conditions and complications:

Characterized by at least **one** of the following:

(a) **Dangerousness/lethality:** Is at mild risk of behaviors endangering self, others, or property (for example, he/she has suicidal or homicidal thoughts, but no active plan), and requires frequent monitoring to assure that there is a reasonable likelihood of safety between PHP sessions. However, his/her condition is not so severe as to require twenty-four (24)-hour supervision.

(b) **Interference with addiction recovery efforts:** Recovery efforts are negatively affected by an emotional, behavioral, or cognitive problem, which causes moderate interference with, and requires increased intensity to support, treatment participation and/or adherence.

(c) **Social functioning:** Symptoms are causing mild to moderate difficulty in social functioning, but not to such a degree that the adolescent is unable to manage the activities

of daily living or to fulfill responsibilities at home, school, work, or community. Alternatively, the adolescent may be transitioning back to the community as a step down from an institutionalized setting.

(d) **Ability for self-care:** Is experiencing moderate impairment in ability to manage the activities of daily living, and thus requires near-daily monitoring and treatment interventions. Problems may involve disorganization and inability to manage the demands of daily self-scheduling, a progressive pattern of promiscuous or unprotected sexual contacts, or poor vocational or prevocational skills that require habilitation and training provided in the program.

(e) **Course of illness:** History and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without daily or near-daily monitoring and maintenance. For example, signs of imminent relapse may indicate a need for near-daily monitoring of an adolescent with attention deficit hyperactivity disorder and a history of disorganization that becomes unmanageable in school with substance use; or an initial lapse indicates a need for near-daily monitoring in an adolescent whose conduct disorder worsens dangerously within the context of progressive use.

IV. *Readiness to change:* Characterized by (a) **or** (b)

(a) Requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed.

(b) Adolescent's perspective and lack of impulse control inhibit his/her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. For example, has unrealistic expectations that his/her alcohol, other drug, or mental health problem will resolve quickly, with little or no effort, or experiences frequent impulses to harm him/herself.

V. *Relapse, continued use, or continued problem potential:*
Characterized by (a) **or** (b)

(a) Is at high risk of relapse or continued use without almost daily outpatient monitoring and structured therapeutic services as indicated, for example, by susceptibility to relapse triggers, a pattern of frequent or progressive lapses, inability to overcome the momentum of a pattern of habitual use, etc. Also, treatment at a less intensive level of care has been attempted or given serious consideration and been judged insufficient to stabilize the adolescent's condition.

(b) Demonstrates impaired recognition and understanding of relapse or continued use issues. Has such poor skills in coping with and interrupting substance use problems, and avoiding or limiting relapse, that the near-daily structure afforded by a level 2.5 program is needed to prevent or arrest significant deterioration in function.

VI. *Recovery environment:* Characterized by (a) **or** (b) **or** (c)

(a) Continued exposure to current school, work, or living environment will render recovery unlikely. He/she lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a level 2.5 program.

(b) Family members and/or significant other(s) who live with the adolescent are not supportive of his/her recovery goals, or are passively opposed to his/her treatment. The adolescent requires the intermittent structure of level 2.5 and relief from the home environment in order to remain focused on recovery, but may live at home because there is no active opposition to, or sabotaging o, his/her recovery efforts;

(c) Lacks social contacts, or has high-risk social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He/she also has insufficient or severely limited resources or skills necessary to maintain an adequate level of functioning without the services of a level 2.5 program, but is capable of maintaining an adequate level of functioning between sessions.

May need out-of-home placement in addition to level 2.5 services if his or her present environment is supportive of recovery but does not provide sufficient addiction-specific support to foster and sustain recovery goals.

D. Continued Stay/Discharge Criteria and Prior Authorization (adults and adolescents)

If it is determined by the treatment team that the PHP stay should be extended beyond 45 days because of clinical necessity, a prior-authorization from the payer must be obtained. Prior authorization is not required until such time. Request for authorization for continued stay must state evidence of the need for the acute, intense, structured combination of services provided by the PHP, and must address the continuing serious nature of the patient's psychiatric/SUD condition requiring active treatment in a PHP and include expectations for imminent improvement. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement. The request for authorization must also specify that a lower level of outpatient services would not be advised, and why, and the patient may otherwise require inpatient psychiatric care in the absence of continued stay in the PHP. The request describes:

- 1) The patient's response to the therapeutic interventions provided by the PHP;
- 2) The patient's psychiatric or behavioral or addictive symptoms that continue to place the patient at risk of hospitalization; and
- 3) Treatment goals for coordination of services to facilitate discharge from the PHP.

E. Billing Instructions

- 1) Facility billing
 - a. Bill on a UB; revenue code 0912
 - b. HCPCS code S0201 per diem, regardless of number of 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. CPT/HCPCS code 97530 – occupational therapy; therapeutic activities, each 15 minutes
 - b. CPT/HCPCS code G0410 – Group psychotherapy other than with a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
 - c. CPT/HCPCS code G0411 – Interactive group psychotherapy in a partial hospitalization setting, approximately 45 to 50 minutes
 - d. CPT/HCPCS code 90832 – 90838 – Individual Psychotherapy
 - e. Evaluation and management services, utilize E & M codes with fee schedule reimbursement
 - f. CPT/HCPCS code 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) CCSS may also be billed for discharge planning and transition purposes

3.12 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;
- 3) All peer support services are delivered under the supervision of an approved independent practitioner or staff who have completed a state approved course in supervision of peers within the scope of the specialty service. The approved peer supervisor must be employed with the same agency as the peer.

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 forty (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) CPT/HCPCS code 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.

3.13 Recovery Services (MCO Members 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- minute units
- 2) Rendering provider required
- 3) H0038; (Peer Support) 15- minute units
- 4) FQHC: UB Claim form; revenue code 0919 for encounter fee
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate

3.14 Smoking Cessation Counseling

Smoking cessation: MAD covers tobacco cessation services for all Medicaid recipients. Note that the current NMAC 8.310.2.12.R still reads that the service is only available to pregnant eligible recipients and eligible recipients under the age of 21, but MAD has issued Letter of Direction (LOD) #34 and made changes to the MCO contracts to expand coverage; revisions to the NMAC are pending at the time of this manual.

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.
- 4) Rendering providers can include all licensed and certified MAD practitioners.

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) CPT/HCPCS code 99406: 3 – 10 minutes
- 2) CPT/HCPCS code 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 (MCO Members Only)

A. Definition

Behavioral health (BH) respite service is for short-term direct care and supervision of the eligible recipient in order to afford the parent(s) or caregiver a respite for their care of the recipient and takes place in the recipient's home or another setting. The provider agency will assess the situation and, with the caregiver, recommend the appropriate setting for respite. BH respite services may include a range of activities to meet the social, emotional and physical needs identified through the service or treatment plan, and documented in the treatment record. These services may be provided for a few hours during the day or for longer periods of time involving overnight stays. BH respite, while usually planned, can also be provided in an emergency or unplanned basis. Target population for BH respite services include managed care members up to 21 years of age diagnosed with a severe emotional disturbance (SED), as defined by the state of New Mexico who reside with the same primary caregivers on a daily basis; or Youth in protective services custody whose placement may be at risk whether or not they are diagnosed with SED.

B. Eligible Providers

Eligible providers and practitioners include:

- 1) Treatment foster care homes
- 2) Core Service Agencies
- 3) Behavioral Health Agencies

C. Staff Qualifications, Orientation, Training and Supervision (HSD Respite Supplement 17-01)

- 1) BH Respite Care staff qualifications include:
 - a. Have a minimum three years-experience working with the target population;
 - b. pass all required state and national criminal records and background checks for all persons residing in the home over 18;
 - c. possess a valid driver's license, vehicle registration and insurance, if transporting member;
 - d. CPR and first aid; and
 - e. documentation of all required behavioral health orientation, training and supervision.
- 2) BH Respite Practitioners qualifications and supervision requirements include:
Supervisor:
 - a. must have bachelor's degree and three years' experience working with the target population;
 - b. pass all required state and national criminal records and background checks;

- c. documented supervision activities include a minimum of two hours per month individual supervision covering administrative and case specific issues; and two additional hours per month of continuing education in behavioral health respite care issues, or annualized respite provider training;
 - d. access to on call crisis support available twenty-four (24) hours a day; and
 - e. both clinical services and supervision by licensed practitioners must be in accordance with their respective licensing board regulations.
- 3) Behavioral Health Respite Staff Orientation, Training and Supervision requirements include:
- a. Member rights;
 - b. HIPAA and Client Confidentiality;
 - c. Behavioral health signs and symptoms;
 - d. Substance abuse signs and symptoms;
 - e. Managing safety and stability;
 - f. Protecting client and family's dignity and choice;
 - g. Have documented access to regular in-service training, supervision, administrative contact and clinical support with the BH Respite Supervisor; and
 - h. Receive additional training and supervision including:
behavioral management techniques; stages of child and adolescent development; crisis identification and referral resources; and other target population-specific information necessary to continue to promote the health, safety and personal dignity of the client and meet their service goals and of the member;

D. 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) 30 days or 720 hours per year at which time prior authorization must be acquired for additional respite care;
- 5) May not be billed in conjunction with the following Medicaid services:
 - a. treatment foster care;
 - b. group home;
 - c. residential services;
 - d. inpatient treatment.
- 6) Non-enrolled siblings of a child receiving BH respite services are not eligible for BH respite benefits; and
- 7) Cost of room and board are not included as part of respite care.
- 8) FQHC & IHS/Tribal 638 bill as contracted with MCOs

4.2 Behavior Management Skills (BMS)

A. Definition

Behavior Management Skills 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. Eligible clients are under the age of 21 years of age who are in need of these medically necessary services as identified in an EPSDT screen or other diagnostic evaluation (42 CFR Section 441.57). 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. BMS services are not provided as a stand-alone service, but delivered as part of an integrated plan of services to maintain clients in their communities as an alternative to out-of-home services. BMS specialist staff-to-client ratio of 1:1 is mandated at all times. 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. Eligible Providers

An agency must be certified by CYFD to provide BMS services.

C. Policy

- 1) Initial Screening:
 - 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
 - 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**
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;
 - d. Is reviewed every 30 days and revised as necessary; and
 - e. 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**
- 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
 - 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

D. Related Policies

- 1) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC
- 2) Health Facility Sanctions and Civil Monetary Penalties, 7.18 NMAC
- 3) New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997)
- 4) Governing Background Checks and Employment History Verification, 8.8.3 NMAC
- 5) Specialized Behavioral Health Provider, Behavior Management Skills Development Services, 8.321.2.16 NMAC
- 6) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.2.11 and 8.321.2.27 NMAC

E Billing Instructions

- 1) Services provided in lieu of services that should be provided as part of the eligible recipient's individual educational plan (IEP) or individual family service plan (IFSP)
- 2) BMS is **not** a reimbursable service through the Medicaid school-based service program
- 3) H2014: 15- minute units
- 4) Practitioners: 430, specialty 113 (BMS worker)
- 5) Utilize agency NPI in rendering field
- 6) FQHC: CMS 1500 claim form with encounter rate reimbursement
- 7) For FQHC, if preferring to utilize fee schedule rates, please contact MAD Benefits and Reimbursement Bureau and applicable MCOs.

4.3 Day Treatment Services (DTS)

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, as defined in an agency written agreement with the public-school district or licensed, private school so that appropriate education services are provided to clients in the day treatment services program. Day treatment services must be provided in a school setting or other community setting; however, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered. 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. Procedures

The structured program of care is scheduled for a minimum of four (4) hours per day, two to five days per week based on the acuity and the clinical needs of the client and family. Twenty four (24)-hour availability of appropriate staff or implementation of crisis plan (which may include referral) to respond to the client's crisis situation.

Day Treatment Services' Clinical Director is responsible for provision of clinical oversight of the services, as well as to provide supervision, support and consultation to all agency direct service staff. All direct service staff receive documented clinical supervision for a minimum of two (2) hours per month from the Clinical Supervisor.

C. 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 NMAC
- 5) Specialized Behavioral Health Provider Day Treatment, 8.321.2.21 NMAC

D. Day Treatment Services Treatment Plan

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. Services must be identified in the treatment plan, including crisis planning, which is

formulated on an ongoing basis by the treatment team. twenty-four (24) hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the client's crisis situations. The treatment plan guides and records for each client individualized therapeutic goals and objectives, individualized therapeutic services provided, and individualized discharge and aftercare plans.

- 1) Initial Treatment Plan
 - a. Developed and documented within seventy-two (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; and
 - i. Documents individuals responsible for implementing each action specified in the discharge plan.

E. Billing Instructions

- 1) H2012: 1-hour unit
- 2) Utilize agency NPI in rendering field
- 3) FQHC: CMS 1500 claim form with encounter rate for reimbursement
- 4) IHS/638 Tribal Agency: UB claim form; revenue code 0919 for OMB rate
- 5) FQHC, IHS and Tribal 638: if preferring to utilize fee schedule rates, please contact MAD Benefits and Reimbursement Bureau
- 6) CCSS may also be billed for discharge planning and transition purposes.

4.4 Multi-Systemic Therapy (MST)

A. Definition

MST provides intensive home, family and community-based treatment for youth from 10 to 18 years of age who are at risk of out-of-home placement or are returning home from an out-of-home placement. They meet the criteria for a severe emotional disturbance, or are involved in or at serious risk of involvement with the juvenile justice system; have antisocial, aggressive, violent, or substance-abusing behaviors. There is an assigned team, under supervision, for each recipient.

MST is a culturally sensitive service and is primarily provided in the youth's home, but may include intervention at the youth's school and other community settings. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need.

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 minutes
- 3) Provider types: BHA, CMHC, CSA, FQHC, Tribal 638, IHS
- 4) Utilize agency NPI in rendering field
- 5) FQHC: CMS 1500 claim form with encounter rate for reimbursement. 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 the fee schedule rates, please contact MAD Benefits and Reimbursement 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. ACT services can be traditional ACT, Forensic or Coordinated Specialty Care (CSC) services.

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 twenty four (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.

Coordinated Specialty Care (CSC) can also be provided through ACT Teams that have been trained and approved by BHSD and CYFD to deliver this model of care. CSC is an evidence based multidisciplinary intervention for young adults experiencing early stages of psychosis and provides intensive wrap-around services from a specially trained team including (but not limited to) pharmacotherapy, individual and group psychotherapy, client and family psychoeducation, peer support, supported employment and education, and comprehensive community support services or case management. Community education and outreach is also an integral part of the CSC model.

The primary goals of CSC are:

- 1) Reduce the duration of untreated psychosis (DUP) through:
 - a. Community awareness
 - b. Rapid access to services
- 2) Increase functioning and improve quality of life
- 3) Increase involvement in employment or education
- 4) Reduce clinical symptoms or the impact of clinical symptoms
- 5) Reduce inpatient psychiatric hospitalizations or ER visits

CSC is provided on the following principles:

- 1) The service is recovery oriented;
- 2) The service is individualized to meet each client's needs;
- 3) The service is engagement focused;
- 4) The service is community based to the extent possible;
- 5) The service is provided by a multidisciplinary CSC team that have been approved by BHSD and CYFD
- 6) The CSC team is responsible for following the CSC evidence-based fidelity model guidelines as approved by BHSD and CYFD which include:
 - a. Creating an individualized treatment plan and supports are developed through shared decision making with the client and must be reviewed and updated every six months
 - b. Maintaining a low staff to patient ratio;

- c. Providing continuity of care during and after a psychiatric crisis, including facilitation of rapid use of crisis services, if needed as support needs increase or decrease.
- d. services are provided for a minimum of 24 months

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.

Target population for CSC teams: The CSC model is indicated for young adults ages 15-35 who are experiencing a first episode of psychosis (FEP) with onset of positive symptoms that meet threshold criteria for diagnosis of a psychotic disorder within the previous 12 months. Eligible psychotic disorders may be affective (e.g. bipolar disorder) or non-affective (e.g. schizophrenia).

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 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 W:	ACT General Organizational Index
Appendix X:	Dartmouth Assertive Community Treatment Scale (DACTS)
Appendix Y:	ACT Chart Review
Appendix Z:	ACT Service Audit Tool
Appendix AA:	Tool for Measurement of ACT (TMACT)
Appendix BB:	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: CMS 1500 claim form with encounter rate for reimbursement.
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate
- 6) For FQHC, IHS, and Tribal 638: if preferring to utilize fee schedule rates, please contact MAD Benefits and Reimbursement 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 schizophrenia, bipolar disorder, recurrent major depression, schizoaffective disorder or autism spectrum disorder who are stabilized and maintained on medications and do not have active substance use disorders. 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 serious mental illness. 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 independently licensed behavioral health clinicians, non-independently licensed behavioral health clinicians, registered nurses, 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- minutes units
- 2) Agencies: CMHC, FQHC, IHS, Tribal 638, CSA, CLNM HH, BHA with Supervisory Certificate.
- 3) Utilize rendering provider ID and NPI in rendering fields.
- 4) FQHC: UB claim form; revenue code 0919 with encounter rate reimbursement.
- 5) IHS/638: UB claim form; revenue code 0919 for OMB rate unless otherwise negotiated with the facility.

For FQHC, IHS, and Tribal 638: if preferring to utilize fee schedule rates, please contact MAD Benefits and Reimbursement 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.

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; and
 - (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 the Pharmacy Monitoring Program (PMP) has been queried before initiating methadone, and thereafter every three months. 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; and
 - (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.
- i. Emergency medical technicians (EMTs) with documentation of three (3) hours of annual training in substance use disorder, under appropriate supervision.

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.

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 levels of frequency, 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.
- 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, OTPs 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.
 - k. Poly-substance use
- 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 four (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 underlying 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 underlying 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 2.1, 2.4, 2.5, and 2.7 of this Manual for a complete description of the Assessments and 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 twenty-four (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 NMRLD), 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 twenty-four (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, 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.

A program sponsor shall ensure that the whole quantity of secured take-home medication is placed and secured in a locking container (i.e. box) before a patient exits the program with the medication.

- 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 above (1.11).

Additionally, OTPs must submit a quarterly report to the SOTA about Narcan distribution and Fentanyl prevalence. OTPs must keep records about all incidents that occur in the facility and what their resolutions are.

L. Telemedicine

See telemedicine policy in the BH Policy and Billing Manual.

M. Related Policies

- 1) NMAC 8.321.2 Specialized Behavioral Health Services
- 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.

Diversion - 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:

- has been accredited through appropriate national procedures as a health professional;
- fulfills the national requirements on training and experience for prescribing procedures;
- 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;
- 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. 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.

- 8) 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.
- 9) 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.
- 10) The SOTA shall perform on-site inspection of the proposed OTP facility as part of the review and approval process.
- 11) 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 (above) of this manual. This certification is optional for OTPs if they wish to employ non-independently licensed providers to render additional billable services.

Q. 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-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC>

SAMHSA Trauma Informed Approach <https://www.samhsa.gov/ntic/trauma-interventions>

SAMHSA Treatments for Substance Use Disorders <https://www.samhsa.gov/treatment/substance-use-disorders>

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

R. 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 - 90792 – psychiatric diagnostic evaluations.
- 9) T1007 - Service plan updates following the comprehensive interdisciplinary assessment and service plan.

- 10) One (1) hour/month of individual HIV/SUD counseling – H0025, or H0025 with modifier HQ if delivered in a group setting. One (1) 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:
 - H0033 - oral medication administration, direct observation (for buprenorphine induction)
 - a. H2010 - comprehensive medication services, per 15-minutes (for buprenorphine administration)
 - b. H2011 U2 - crisis intervention service in clinic, per 15 minutes
 - c. H2011 U3 - crisis intervention, mobile, if having a mobile crisis team
 - d. H2011 U4 - crisis stabilization, if having a twenty-four (24)-hour OP crisis stabilization service
 - e. H0015 – intensive outpatient program for substance use disorders, if HSD approved
 - f. H2030 – recovery services (for MCO members only)
 - g. S5110 – family support services (for MCO members only)

S. OTPs and Medicare

In December, 2019, the Centers for Medicare and Medicaid Services (CMS) announced that Medicare will become the primary payer for dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) who currently receive OTP services through Medicaid. This includes medication-assisted treatment (MAT), toxicology testing, and counseling. The New Mexico Medicaid program stopped paying for these services for dually eligible beneficiaries as October 1, 2020. However, Medicaid MCOs are expected to pay the Medicaid coinsurance/deductible for OTP services once the claim has crossed over from Medicare.

Only OTP providers enrolled with Medicare can submit claims for payment or receive a denial of payment from Medicare. The link below can guide OTP providers to begin the Medicare enrollment process if they have not already done so:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OTP-enrollment-factsheet-MLN6325432.pdf>

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

5.5 Supportive Housing – Peer Delivered Pre-Tenancy and Tenancy Services (MCO Members Only)

A. Purpose

The aim of supportive housing services is to assist members in acquiring, retaining, and maintaining stable housing, making it more conducive for members to participate in ongoing treatment of their illness and improve the management of their mental and physical health issues. Supportive housing services do not include tenancy assistance in the form of rent or subsidized housing; instead they expand the availability of basic housing supports.

B. Definitions

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:

- a) Support services are offered to promote independent living and help consumers find, get, and keep housing.
- b) Support services are client-driven, individually tailored, flexible, and primarily provided in vivo, e.g. in the consumer's home.
- c) Neither support service compliance nor following treatment plans is a condition of accessing housing or maintaining tenancy.
- d) Supportive housing consumers have all the rights and responsibilities of tenancy.
- e) Housing is not subject to time limitations other than lease requirements.
- f) Leases are renewable if compliance with standard lease terms and property rules is maintained.
- g) 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.

Homeless or precariously housed

- a) People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided for up to 90 days and were in shelter or a place not meant for human habitation prior to entering that institution.
- b) People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled-up situation, within 14 days and lack resources or support networks to remain in housing. Specific documentation may be required for this category.
- c) Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. This category applies to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barrier to employment.

Extremely Low Income

- a) 30% Area Median Income or Less, per the U.S Department of Housing Urban Development (HUD) guidelines

C. Policy

The state will use its existing program infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program to render Peer Delivered Pre-Tenancy and Tenancy Services. Linkages providers will be expected to utilize peers for service delivery. This approach builds upon a successful statewide supportive housing model; expands the peer workforce; and improves the engagement, service delivery, and outcomes for individuals with Serious Mental Illness.

1) Eligible Providers:

- a) Any clinic, office, or agency providing permanent supportive housing under the Human Services Department's Linkages program, administered by the Behavioral Services Division.
- b) Behavioral health practitioners employed or contracted with such facilities including:
 - i. Behavioral health professional licensed in the state of New Mexico; and
 - ii. Certified Peer Support Workers or Certified Family Peer Support Workers.

2) Coverage criteria:

- a) Enrollment in the Linkages permanent supportive housing program;
- b) An assessment documenting serious mental illness;
- c) An assessment for mental illness and co-occurring substance use disorders.

3) Eligible recipients:

Individuals must have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria for Serious Mental Illness (SMI), specified. The criterion includes co-occurring substance use disorders. In addition to a diagnosis, the criteria require a Functional Impairment. Adults whose eligible diagnosis has resulted in functional impairment, which substantially interferes with, or limits, one or more major life activities shall be included in the target population.

4) Target Criteria: Includes services that are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the end goal of maintaining individual recipients' personal health and welfare.

- a) Homeless or precariously housed;
- b) Disabled with a serious mental illness (SMI);
- c) Extremely low-income level, 30% area median income, per HUD.

5) Covered services:

- a) Pre-tenancy services, including:

1. Screening and identifying preferences and barriers related to successful tenancy;
 2. Developing an individual housing support plan and housing crisis plan;
 3. Assisting participants with finding and applying for housing;
 4. Ensuring that the living environment is safe and ready for move-in;
 5. Tenancy orientation and move-in assistance;
 6. Assistance in securing necessary household supplies; and
 7. Landlord relationship building and communication.
- b) Tenancy support services, including:
1. Early identification of issues undermining housing stability, including member behaviors;
 2. Coaching the Medicaid member about relationships with neighbors, landlords and tenancy compliance;
 3. Education about tenant responsibilities and rights;
 4. Supports to assist participants in resolving tenancy issues;
 5. Regular review and updates to housing support plan and housing crisis plan; and
 6. Assist participants in linking to other community resources that may support individuals in maintaining housing.

6) Duration:

The PSH-TSS benefit is available to an eligible member for the duration of the member's enrollment in a Linkages program, ceasing when the client leaves the program.

D. 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.

E. Resources

Strategic Plan for Supportive Housing in New Mexico, 2018-2023.
http://newmexico.networkofcare.org/content/client/1446/NMStrategicHousingPlan2018-2023_Jan2018FINAL.pdf

F. 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.
- 3) Place rendering provider in the rendering field

Pre Tenancy		
Screening and identifying preference and barriers related to successful tenancy	H0043	U1
Developing an individual housing support plan and crisis plan	H0043	U2
Assisting participants with finding and applying for housing	H0043	U3
Ensuring that the living environment is safe and ready for move-in	H0043	U4
Tenancy orientation and move-in assistance	H0043	U5
Landlord advocacy	H0043	U6
Assisting participants with securing necessary household supplies	H0043	U7
Tenancy Support		
Early identification of issues including member behaviors	H0043	U8
Coaching to the Medicaid member about relationships with neighbors and landlords and tenancy compliance	H0043	U9
Education about tenant's responsibilities and rights	H0043	UA
Supports to assist participants in resolving tenancy issues	H0043	UB
Regular review and updates to housing support plan and crisis plan	H0043	UC
Assist participants in linking to other community resources that may support individuals in maintaining housing	H0043	UD

SECTION SIX: INPATIENT AND RESIDENTIAL SERVICES FOR CHILDREN AND ADOLESCENTS

6.1 Accredited Residential Treatment Center (ARTC) for Youth

A. Definition

Accredited Residential Treatment Centers are residential treatment service programs accredited by the Joint Commission (JC), the Commission on Accreditation of rehabilitation facilities (CARF) or the Council on Accreditation (COA) for provision of medically necessary services for the diagnosis and treatment of an eligible recipient's condition, which has been identified in an EPSDT screen (42 CFR section 441.57) or other diagnostic evaluation and for whom a less restrictive setting is not appropriate. Individualized, trauma informed services are provided to children/adolescents in need of an interdisciplinary psychotherapeutic treatment program on a twenty-four (24)- hour basis to meet their severe behavioral, psychological, neurobiological, or emotional problems and needs. Accredited Residential Treatment Centers services must be furnished under the direction of a Medicaid eligible or certified psychiatrist. Treatment must be designed to reduce or control symptoms or maintain levels of functioning and avoid hospitalization or further deterioration.

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) Accredited Residential Treatment Centers provide services, care, and supervision at all times, including the maintenance of a minimum staff-to-child ratio of one to five during the day and evening shifts and one awake staff to ten clients during the night shift. Additional staff is provided and documented on the facility's schedule based upon client acuity or other conditions.
- 2) An Accredited Residential Treatment Center (ARTC) must maintain current facility ARTC licensure and certification issued by CYFD Licensing and Certification Authority Bureau (LCA) and provide the LCA a copy of its most recent accreditation report and any corresponding quality improvement plan.
- 3) In lieu of New Mexico CYFD licensure, an out-of-state or MAD border ARTC facility must have JC, COA, or CARF accreditation and must be licensed by its own state as an ARTC residential treatment facility.
- 4) If the ARTC is operated by IHS or by a federally recognized tribal government, the facility must meet the minimum Medicaid standards, which are evaluated by CYFD Licensing and Certification Authority Bureau (LCA). Any ARTC operated by IHS or federally recognized tribal government is not required to be licensed or certified by CYFD, but must comply with reviews performed by CYFD of the minimum Medicaid standards.

- 5) An ASAM based assessment must be conducted for all admissions. If there is no history or reported current substance use the remainder of the assessment need not be executed. If there is substance use, admission criteria specific to each ASAM level must be utilized for both prior authorization purposes, and development of the treatment plan. The following is the ASAM Level 3 definition and sub-divisions with associated admission criteria.

ASAM Level 3 – General Definition

All ASAM level 3 programs serve individuals who, because of specific functional limitations, need safe and stable living environments and twenty-four (24) hour care. This is needed to develop, practice, and/or demonstrate the recovery skills necessary so that patients do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care.

The sublevels within level 3 exist on a continuum ranging from the least intensive residential services to the most intensive medically monitored inpatient services. The differing levels are reflective of the functional limitations of the patients and the services provided to respond to those limitations. All level 3 sublevels have twenty-four (24)-hour staff, but level 3.1 is qualitatively different in that it is a twenty-four (24)-hour supportive living environment whereas the other sublevels are twenty-four (24)-hour treatment settings.

Before any ARTC services are furnished to an eligible recipient, prior authorization is required.

ASAM Level 3.1: Clinically Managed Low-Intensity in an ARTC

A. Definition of Service

Level 3.1 programs offer at least 5 hours per week of low-intensity treatment of SUD. Treatment such as individual, group, and family therapy; medication management; and psychoeducation is included. These services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies.

The treatment services are focused on improving the individual's readiness to change (Dimension 4) and or functioning and coping skills in Dimensions 5 and 6. They promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. Mutual/self-help meetings are available on-site, or accessible in the local community.

The residential component of care provides the stability to prevent or minimize relapse or continued use and problem potential (Dimension 5). Interpersonal and group living skills are promoted through the use of community or house meetings of residents and staff.

The residential component of Level 3.1 is sometimes combined with an Intensive Outpatient Program (IOP) if available, for individuals whose living situation or recovery

environments are incompatible with their recovery goals, and if they meet the dimensional admission criteria of IOP.

B. Admission Criteria for Adolescents

Meets diagnostic criteria for a moderate or severe substance use and/or addictive disorder and specifications in at least **two** of the six dimensions

The Six Dimensions:

I. Acute intoxication and/or withdrawal potential:

The adolescent's status is characterized by problems with intoxication or withdrawal (if any) that are being managed through concurrent placement at another level of care for withdrawal management (typically Level 1, Level 2.1, or Level 2.5). If residential placement in a level 3.1 program is being used to support withdrawal management at a non-residential level of care, then the adolescent is considered to have met specification in Dimension 1.

II. Biomedical conditions and complications:

Is characterized by **one** of the following:

(a) Biomedical conditions distract from recovery efforts and require limited residential supervision to ensure their adequate treatment or to provide support to overcome the distraction. Adequate nursing or medical monitoring can be provided through an arrangement with another provider. The adolescent is capable of self-administering any prescribed medications or procedures, with available supervision;

(b) Continued substance use would place the adolescent at risk of serious damage to his/her physical health because of a biomedical condition (such as pregnancy) or an imminently dangerous pattern of high-risk use. Adequate nursing or medical monitoring for biomedical conditions can be provided through an arrangement with another provider. The adolescent is capable of self-administering any prescribed medication or procedures, with available supervision.

III. Emotional, Behavioral, or cognitive conditions and complications:

Characterized by at least **one** of the following (requiring twenty-four (24)-hour supervision):

(a) Dangerousness/lethality: Is at risk of dangerous consequences because of the lack of a stable living environment (for example, exposure to the elements, risk of assault, risk of prostitution, and the like). He/she needs a stable residential setting for protection.

(b) Interference with addiction Recovery Efforts: Needs a stable living environment to promote a sustained focus on recovery tasks

(c) Social functioning: Emotional, behavioral, or cognitive problems result in moderate impairment in social functioning. He/she needs limited twenty-four (24) hour supervision, which can be provided by program staff or in combination with a level 1 or level 2 program. May involve protection from antisocial peer influences in a motivated adolescent, reinforcement of improving behavior self-management techniques, support of increasingly independent function such as school or work.

(d) Ability for self-care: Has moderate impairment in his/her ability to manage the activities of daily living and needs limited twenty-four (24)-hour supervision, which can be provided by program staff or through coordination with a level 1 or level 2 program.

(e) Course of illness: History and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without twenty-four (24)-hour supervision;

(f) The adolescent's emotional, behavioral, or cognitive condition suggests the need for low-intensity and/or longer-term reinforcement and practice of recovery skills in a controlled environment.

IV. Readiness to change:

Characterized by at least **one** of the following:

(a) Acknowledges the existence of a psychiatric condition and/or substance use problem. He/she recognizes specific negative consequences and dysfunctional behaviors and their effect on his/her desire to change. Is sufficiently ready to change and cooperative enough to respond to treatment at level 3.1.

(b) Is assessed as appropriately placed at level 1 or 2 and is receiving level 3.1 services concurrently. May be at an early stage of readiness to change and thus in need of engagement and motivational strategies;

(c) Requires a twenty-four (24)-hour structured milieu to promote treatment progress and recovery because motivating interventions have failed in the past and such interventions are assessed as not likely to succeed in an outpatient setting;

(d) The adolescent's perspective impairs his/her ability to make behavior changes without the support of a structured environment. For example, attributes his/her alcohol, other drug, or mental health problem to other persons or external events, rather than to a substance use or mental disorder. Interventions are assessed as not likely to succeed in an outpatient setting.

V. Relapse, continued use, or continued problem potential:

Characterized by at least **one** of the following:

(a) Demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning. Is in imminent danger of relapse, with dangerous emotional, behavioral, or cognitive consequences, and needs twenty-four (24) hour structure to apply recovery and coping skills.

(b) Understands his/her addiction and/or mental disorder but is at risk of relapse in a less structured level of care because he/she is unable to consistently address either or both;

(c) Needs staff support to maintain engagement in his/her recovery program while transitioning to life in the community;

(d) Is at high risk of substance use, addictive behavior, or deteriorated mental functioning, with dangerous emotional, behavioral, or cognitive consequences, in the absence of close twenty-four (24)-hour structure support (as evidenced by lack of awareness of relapse triggers, difficulty in postponing immediate gratification or ambivalence toward or low interest in treatment), and these issues are being addressed concurrently in a level 2 program.

VI. *Recovery environment:*

Characterized by at least **one** of the following:

(a) Has been living in an environment in which there is a high risk of neglect, or initiation or repetition of physical, sexual, or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential secure placement;

(b) Has a family or other household member who has an active substance use disorder, or substance use is endemic in his/her home environment or broader social network, so that recovery goals are assessed as unachievable without residential secure placement;

(c) The adolescent's home environment or social network is too chaotic or ineffective to support or sustain treatment goals, so that recovery is assessed as unachievable without residential support.

(d) Logistical impediments preclude participation in treatment at a less intensive level of care.

ASAM Level 3.2WM – Clinically Managed Residential Withdrawal Management

A. Definition of Service

An organized service that is delivered by trained staff who provide twenty-four (24)-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. It is characterized by its emphasis on peer and social support rather than medical and nursing care.

B. Admission Criteria:

The withdrawal signs and symptoms are sufficiently severe to require twenty-four (24)-hour structure and support; however, the full resources of a level 3.7 WM are not required. Elements of the assessment include:

- 1) An addiction focused history which is reviewed with an MD/CNP/PA during the admission process;
- 2) A physical exam by an MD/CNP/PA;
- 3) Sufficient biopsychosocial screening to determine the level of care; and
- 4) An individualized treatment plan including problem identification in Dimensions 2 through 6

C. Length of Service/Continued Service and Discharge Criteria

The adolescent continues in a level 3.2-WM withdrawal management program until a) the withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or b) The patient's 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; or c) The patient is unable to complete withdrawal management at level 3.2-WM, despite an adequate trial and needs to transfer to a more intensive level of care or the addition of other clinical services such as intensive counseling.

ASAM Level 3.5 – Clinically Managed Medium Intensity Residential Treatment

A. Definition of Service:

Level 3.5 assists individuals whose addiction is currently so out of control that they need a twenty-four (24)-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Their multidimensional needs are of such severity that they cannot safely be treated in less intensive levels of care.

The adolescent who is appropriately placed in Level 3.5 care typically has impaired functioning across a broad range of psychosocial domains. These impairments may be expressed as disruptive behaviors, delinquency and juvenile justice involvement, educational difficulties, family conflicts and chaotic home situation, development immaturity, and psychological problems. Particularly suited to 3.5 treatments are the entrenched patterns of maladaptive behavior, extremes of temperament, and developmental or cognitive abnormalities related to mental health symptoms or disorders.

B. Admission Criteria

The adolescent placed in a level 3.5 program meets the diagnostic criteria for a substance use and/or addictive disorder of moderate to high severity, as well as the dimensional criteria for admission, i.e. at least **two** of Dimensions 1 through 6.

The Six Dimensions:

I. Acute intoxication and/or withdrawal potential:

Is at risk of or experiencing acute or subacute intoxication or withdrawal, with mild to moderate symptoms. Needs secure placement and increased treatment intensity (without frequent access to medical or nursing services) to support engagement in treatment, ability to tolerate withdrawal, and prevention of immediate continued use. Alternatively, the adolescent has a history of failure in treatment at the same or a less intensive level of care.

Problems with intoxication or withdrawal are manageable at this level of care.

II. Biomedical conditions and complications:

Characterized by **one** of the following:

(a) Biomedical conditions distract from recovery efforts and require residential supervision to ensure their adequate treatment, or they require medium-intensity residential treatment to provide support to overcome the distraction. Adequate nursing or medical monitoring can be provided through an arrangement with another provider. The adolescent is capable of self-administering any prescribed medication or procedure, with available supervision.

(b) Continued substance use would place the adolescent at risk of serious damage to his/her physical health because of a biomedical condition or an imminently dangerous pattern of high-risk (such as continued use of shared injection apparatus). Adequate nursing or medical monitoring for biomedical conditions can be provided through an arrangement with another provider. The adolescent is capable of self-administering any prescribed medication or procedures, with available supervision.

III. Emotional, Behavioral, or cognitive conditions and complications:

Characterized by at least one of the following (requiring twenty-four (24)-hour supervision and a medium-intensity therapeutic milieu):

(a) **Dangerousness/lethality:** Is at moderate but stable risk of imminent harm to self or others, and needs medium-intensity twenty-four (24)-hour monitoring and/or treatment for protection and safety. However, he/she does not require access to medical or nursing services.

(b) **Interference with addiction recovery efforts:** Recovery efforts are negatively affected by his/her emotional, behavioral, or cognitive problems in significant and distracting way. He/she requires twenty-four (24)-hour structured therapy and/or a programmatic milieu to promote sustained focus on recovery tasks because of active symptoms.

(c) **Social functioning:** Has significant impairments, with moderate to severe symptoms (such as poor impulse control, disorganization, etc.). These seriously impair his/her ability to function in family, social, school, or work settings, and cannot be managed at a less intensive level of care. This might involve, for example, a recent history of high-risk runaway behavior, inability to resist antisocial peer influences, a need for consistent boundaries unavailable in the home environment, or inability to sustain school attendance, and the like.

(d) **Ability for self-care:** Has moderate impairment in his/her ability to manage the activities of daily living and thus requires twenty-four (24)-hour supervision and staff assistance, which can be provided in the program. Impairments may involve a need for intensive modeling and reinforcement of personal grooming and hygiene, a pattern of continuing indiscriminate or unprotected sexual contacts in an adolescent with a history of sexually transmitted disease, moderate dilapidation and self-neglect in the context of advanced alcohol or drug dependence, a need for intensive teaching of personal safety techniques in an adolescent who has suffered physical or sexual assault, and the like.

(e) **Course of illness:** History and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without twenty-four (24)-hour supervision and a medium-intensity structured programmatic milieu. These may involve an adolescent whose substance use has been associated with a dangerous pattern of criminal or delinquent behaviors and who needs monitoring to assess safety and the likelihood of successful treatment on an outpatient basis before being returned to the community following release from a juvenile justice setting, or an adolescent with a recent lapse or relapse, whose history suggests that this is likely to result in disruptive behavior that will impede participation in treatment at a less intensive level of care, and the like.

IV. *Readiness to change:*

Characterized by at least **one** of the following:

(a) Because of the intensity and chronicity of the addictive disorder or the adolescent's mental health problems, he/she has limited insight into and little awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment, and thus has limited readiness to change;

(b) Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the adolescent has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health, or life problems and his/her impaired coping skills and level of functioning, often blaming others for his/her addiction problems;

(c) Demonstrates passive or active opposition to addressing the severity of his o/her mental health problem or addiction, or does not recognize the need for treatment. Such continued substance use or inability to follow through with mental health treatment poses a danger of harm to self or others. However, assessment indicates that treatment interventions available at level 3.5 may increase the patient's degree of readiness to change;

(d) Requires structured therapy and a twenty-four (24)- hour programmatic milieu to promote treatment progress and recover, because motivational interventions have not succeeded at less intensive levels of care and such interventions are assessed as not likely to succeed at a less intensive level of care;

(e) The adolescent's perspective impairs his or her ability to make behavior changes without repeated, structured, clinically directed motivational interventions, which will enable him/her to develop insight into the role he/she plays in substance use and/or mental condition, and empower him/her to make behavioral changes, which can only delivered in a twenty-four (24)-hour milieu;

(f) Despite recognition of a substance use or addictive behavior problem and understanding of the relationship between his/her substance use, addiction, and life problems, the patient expresses little to no interest in changing. Because of the intensity or chronicity of the adolescent's addictive disorder and high-risk criminogenic needs, he/she is in imminent danger of continued substance use or addictive behavior. This poses imminent serious life consequences (i.e. imminent risk to public safety or imminent abuse or neglect of children) and/or a continued pattern of risk of harm to others (i.e. extensive pattern of assaults, burglaries) while under the influence of substances;

(g) Attributes his/her alcohol, drug, addictive, or mental health problem to other persons or external events, rather than to a substance use or addictive or mental disorder. Requires clinical, directed motivation interventions that will enable him/her to develop insight into the role he/she plays in the health condition, and empower him/her to make behavioral changes. Interventions are determined to not be feasible or unlikely to succeed at a less intensive level of care.

V. *Relapse, continued use, or continued problem potential*

Characterized by at least **one** of the following:

(a) Does not recognize relapse triggers and lacks insight into the benefits of continuing care, and is therefore not committed to treatment. Continued substance use poses an imminent danger of harm to self or others in the absence of twenty-four (24)-hour monitoring and structured support;

(b) The adolescent's psychiatric condition is stabilizing. However, despite his/her best efforts, is unable to control her/his use of alcohol, other drugs, and/or antisocial behaviors, with attendant probability of harm to self or others. Has limited ability to interrupt the relapse process or continued use, or to use peer supports when at risk for relapse to her/his addiction or mental disorder.

Continued substance use poses an imminent danger of harm to self or other in the absence of twenty-four (24)-hour monitoring and structured support;

(c) Is experiencing psychiatric or addiction symptoms such as drug craving, insufficient ability to postpone immediate gratification, and other drug-seeking behaviors. The situation poses an imminent danger of harm to self or others in the absence of close twenty-four (24) hour monitoring and structured support. The introduction of psychopharmacologic support is indicated to decrease psychiatric or addictive symptoms, such as cravings, that will enable the patient to delay immediate gratification and reinforce positive recovery behaviors;

(d) Is in imminent danger of relapse or continued use, with dangerous emotional, behavioral, or cognitive consequences, as a result of a crisis situation;

(e) Despite recent, active participation in treatment at a less intensive level of care, the adolescent continues to use alcohol or other drugs, or to deteriorate psychiatrically, with imminent serious consequences, and is at high risk of continued substance use or mental deterioration in the absence of close twenty-four (24) hour monitoring and structured treatment;

(f) Demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. This poses imminent risk of harm to self or others. The imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment. Requires twenty-four (24) hour monitoring and structure to assist in the initiation and application of recovery and coping skills.

VI. *Recovery environment:*

Status is characterized by at least **one** of the following:

(a) Adolescent has been living in an environment that is characterized by a high risk of neglect; initiation or repetition of physical, sexual, or severe emotional abuse; such that the patient is assessed as being unable to achieve or maintain recovery without residential treatment;

(b) Has a family or other household member who has an active substance use disorder, or substance use is endemic in his/her home environment or broader social network, so that recovery goals are assessed as unachievable without residential treatment;

(c) The adolescent's home environment or social network is too chaotic or ineffective to support or sustain treatment goals, so that recovery is assessed as unachievable without residential treatment. For example, the adolescent's family reinforces antisocial norms and values, or the family cannot sustain treatment engagement or school attendance, or the family is experiencing significant social isolation or withdrawal.

(d) Logistical impediments such as distance from a treatment facility, mobility limitation, lack of transportation, and the like, preclude participation in treatment at a less intensive level of care.

ASAM Level 3.7 – Medically Monitored Intensive Inpatient Services in an ARTC

A. Definition of Service:

Level 3.7 programs provide a planned and structured regimen of twenty-four (24) hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a separate, more intensive unit of a freestanding level 3.5 residential facility. They function under a defined set of policies, procedures, and clinical protocols and are appropriate for patients whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program. The services are designed to meet the needs of patients who have functional limitations in Dimensions 1, 2, and/or 3.

“For adolescents, problems in Dimension 3 are the most common reason for admission to Level 3.7 programs. Such problems include co-occurring psychiatric disorders or symptoms such as hypomania, severe lability, mood dysregulation, disorganization or impulsiveness, or aggressive behaviors. Treatment at Level 3.7 often is necessary simply to orient the adolescent to the structure of daily life, according to other organizing principles than “getting high” and “being high”. Initial abstinence through confinement in a Level 3.7 program provides many adolescents who have addiction syndromes with a much-needed reintroduction to their own patterns of emotional and cognitive experience without a nearly constant cloud of intoxication.” (ASAM Criteria, p. 265)

B. Adolescent Admission Criteria

The adolescent who is placed in a level 3.7 program meets the diagnostic criteria for a moderate or severe substance use or addictive disorder **and** meets specifications in **two** of the six dimensions, at least **one** of which is in Dimension 1, 2, or 3.

The Six Dimensions:

I. Acute intoxication and/or withdrawal potential:

Experiencing or at risk of acute or subacute intoxication or withdrawal, with moderate to severe signs and symptoms. Meets twenty-four (24) hour treatment services, including the availability of active medical and nursing monitoring to manage withdrawal, support engagement in treatment, and prevent immediate continued use. Alternatively, has a history of failure in treatment at the same or a less intensive level of care. Problems with intoxication or withdrawal are manageable at this level of care. Withdrawal rating scale tables and flow sheets are used as needed. *Note: See page 277 for withdrawal symptoms specific to type of substance.*

II. Biomedical conditions and complications:

Characterized by **one** of the following:

- (a) The interaction of the adolescent's biomedical condition and continued alcohol and/or other drug use places the adolescent at significant risk of serious damage to physical health or concomitant biomedical conditions;
- (b) A current biomedical condition requires twenty-four (24) hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital.

III. Emotional, Behavioral, or cognitive conditions and complications

Characterized by at least one of the following (requiring twenty-four (24) hour supervision and a high-intensity therapeutic milieu, with access to nursing and medical monitoring and treatment).

(a) Dangerousness/lethality: Is at moderate (and possibly unpredictable risk of imminent harm to self or others and needs twenty-four (24) hour monitoring and/or treatment in a high-intensity programmatic milieu and/or enforced secure placement for safety.

(b) Interference with addiction recovery efforts: Recovery efforts are negatively affected by his/her emotional, behavioral, or cognitive problems in significant and distracting ways. He/she requires twenty-four (24) hour structured therapy and/or a high-intensity programmatic milieu to stabilize unstable emotional or behavioral problems (as through ongoing medical or nursing evaluation, behavior modification, titration of medication, and the like).

(c) Social Functioning: Has significant impairments, with severe symptoms which seriously impair his/her ability to function in family, social, school, or work settings and which cannot be managed at a less intensive level of care. These might involve a recent history of aggressive or severely disruptive behavior, severe inability to manage peer conflict, a recurrent or chronic pattern of runaway behavior requiring enforced confinement, and the like.

(d) Ability for self-care: Has a significant lack of personal resources and moderate to severe impairment in ability to manage the activities of daily living. He/she thus needs twenty-four (24) hour supervision and significant staff assistance, including access to nursing or medical services. The impairments may involve progressive and severe dilapidation and self-neglect in the context of advanced substance use disorder, the need for observation after eating to prevent self-induced vomiting, the need for intensive reinforcement of medication adherence, the need for intensive modeling of adequate self-care during pregnancy, the need for intensive training for self-care in a cognitively impaired patient, and the like.

(e) Course of illness: History and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without twenty-four (24) hour supervision and a high-intensity structure programmatic milieu, with access to nursing or medical monitoring or treatment. Examples include the requirement for a secure placement or enforced abstinence for reinstatement or titration of a pharmacological treatment regimen; substance use that has been associated with a dangerous pattern of aggressive/violent behaviors and a person who needs monitoring to assess safety and likelihood of outpatient treatment success before returning to the community following release from a juvenile justice setting; or requirement for intensive monitoring or

treatment because ongoing substance use prevents adequate or safe treatment or diagnostic clarification for an emotional, behavioral, or cognitive condition that may or may not be substance-induced; or an adolescent whose history suggests rapid escalation of dangerousness/lethality when using alcohol or drugs and who is in relapse or at imminent risk of relapse.

IV. Readiness to change:

At least **one** of the following:

- (a) Despite experiencing serious consequences or effects of the addictive disorder and/behavioral health problem, does not accept or relate the addictive disorder to the severity of the presenting problem;
- (b) Is in need of intensive motivating strategies, activities, and processes available only in a twenty-four (24) hour structured, medically monitored setting;
- (c) Needs ongoing twenty-four (24) hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medication and a recovery program.

V. Relapse, continued use, or continued problem potential;

Characterized by at least **one** of the following:

- (a) Is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his/her addictive or mental disorder. This situation poses a serious risk of harm to self or others in the absence of twenty-four (24) hour monitoring and structured support;
- (b) Experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of twenty-four (24) hour monitoring and structured support found in a medically monitored setting (for example, not taking life-sustaining medications; or has severe and chronic problems with impulse control that requires stabilization through high-intensity medical and nursing interventions; or he/she has issues with intoxication or withdrawal that require stabilization in a medically monitored setting; or there is a likelihood of self-medication of recurrent symptoms of a mood disorder, which require stabilization in a medically monitored setting). Treatment at a less intensive level of care has been attempted or given serious consideration.
- (c) The modality or intensity of treatment protocols to address relapse require that the patient receive care in a level 3.7 program (such as initiating or restarting medications for medical or psychiatric conditions, an acute stress disorder, or the processing of a traumatic event; to safely and effectively initiate antagonist or agonist therapy).

VI. Recovery environment:

Characterized by **one** of the following:

- (a) Has been living in an environment in which supports that might otherwise have enabled treatment at a less intensive level of care are unavailable. For example, the

family undermines the adolescent's treatment, or is unable to sustain treatment attendance at a less intensive level of care, or family members have active substance use disorders and/or facilitate access to alcohol or other drugs, or the home environment is dangerously chaotic or abusive, or the family is unable to adequately supervise medications, or the family is unable to adequately implement a needed behavior management plan. Level 3.7 care thus is needed to effect a change in the home environment so as to establish a successful transition to a less intensive level of care.

(b) Logistical impediments (such as distance from a treatment facility, mobility limitation, lack of transportation, and the like) preclude participation in treatment at a less intensive level of care, and level 3.7 is necessary to establish a successful transition to a less intensive level of care.

ASAM Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management in an ARTC

A. Definition of Service

ASAM 3.7-WM Medically monitored inpatient withdrawal management services as specified in *The ASAM Criteria*; requires twenty-four (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 twenty-four (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.

B. Admission Criteria

Elements of the assessment for 3.7-WM are:

- 1) An addiction focused history
- 2) A physical examination by a physician, physician assistant, or nurse practitioner within 24 hours of admission and appropriate laboratory and toxicology tests.
- 3) Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6; and
- 4) An individualized treatment plan, including problem identification in Dimensions 2 through 6.

C. Length of Service/Continued Service and Discharge Criteria

The adolescent continues in a level 3.7-WM withdrawal management program until a) the withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or b) The adolescent's 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; or c) The adolescent is unable to complete withdrawal management at level 3.7-WM, despite an adequate trial and needs to transfer to a more intensive level of care or the addition of other clinical services such as intensive counseling.

D. ARTC Procedures

- 1) For an ARTC operated by IHS or by a federally recognized tribal government, 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.
- 2) 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.
- 3) 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.

E. 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, Accredited Residential Treatment Center (ARTC) for Youth 8.321.2.11 NMAC

F. Billing Instructions

- 1) Prior authorization is required for initial admission

- 2) If moving between ASAM levels of care for SUD, discharge from the first level and re-admit into the next level, with notification to the appropriate MCO if patient is a MCO member
- 3) UB claim form; revenue code 1001 is to be used for ARTC psychological services, and revenue code 1002 is to be used for ARTC chemical dependency services
- 4) For withdrawal management, 3.2WM add revenue code 0229 and HCPCS H0010 for non-reimbursable tracking purposes
- 5) For withdrawal management, 3.7WM add revenue code 0229 and HCPCS H0011 for non-reimbursable tracking purposes
- 6) Referring or ordering provider in attending provider field
- 7) CCSS may be billed for discharge planning and transition purposes

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6.2 ASAM Level 4 – Medically Managed Intensive Inpatient Services for SUD in a Hospital

A. Definition of Service:

Level 4, medically managed intensive inpatient services is an organized service delivered in an acute care inpatient setting. It is for patients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. These services are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the patient. Level 4 offers specialty addiction services and the full resources of a general acute care or psychiatric hospital. Although treatment is specific to substance use and other addictive disorders, the skills of the interdisciplinary team allow the joint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed.

Prior Authorization is required.

B. Admission Criteria:

Placement in a level 4 program requires the diagnostic criteria for a substance use or substance-induced disorder, and the required dimensional criteria in **at least one** of dimension 1, or 2, or 3. A referral from an independent practitioner or a transfer from the Emergency Department is required, and the physician in the hospital must accept the patient.

The six dimensions:

I. Acute intoxication and/or withdrawal potential:

- a. The adolescent is experiencing acute withdrawal, with severe signs or symptoms, and is at risk for complications that require twenty-four (24) hour intensive medical services. Such complications may involve delirium, hallucinosis, seizures, high morbidity medical complications, pregnancy, severe agitation, psychosis, unremitting suicide risk, and the like; or
- b. There is recent (within 24 hours) serious head trauma or loss of consciousness, with chronic mental status or neurological changes, resulting in the need to closely observe the adolescent at least hourly; or
- c. Drug overdose or intoxication has compromised the adolescent's mental status, cardiac function, or other vital signs or functions; or
- d. Has a significant acute biomedical disorder that poses substantial risk of serious or life-threatening consequences during withdrawal (such as significant hypertension or esophageal varices).

II. Biomedical conditions and complications:

Characterized by at least **one** of the following:

- (a) Biomedical complications of the addictive disorder require medical management and skilled nursing care; or
- (b) A concurrent biomedical illness or pregnancy requires stabilization and daily medical management, with daily primary nursing interventions; or
- (c) Has a concurrent biomedical condition (including pregnancy) in which continued alcohol or other drug use presents an imminent danger to life or severe danger to health; or
- (d) The adolescent's alcohol, tobacco, and/or other drug use is gravely complicating or exacerbating a previously diagnosed medical condition; or
- (e) Changes in medical status, such as significant worsening of a medical condition, make abstinence imperative; or
- (f) Significant improvement in a previously unstable medical condition allows the adolescent to respond to addiction treatment; or
- (g) Has other biomedical problems that require twenty-four (24) hour observation and evaluation.

III. Emotional, Behavioral, or cognitive conditions and complications

Characterized by at least **one** of the following:

- a. **Dangerousness/Lethality:** Presents an imminent risk of suicidal, homicidal, or other violent behavior, or is at risk of a psychosis with unpredictable, disorganized, or agitated behavior that endangers self or others. May require a locked unit.
- b. **Interference with Addiction Recovery Efforts:** Is unable to focus on recovery tasks because of unstable, overwhelming psychiatric problems (e.g. a patient with schizophrenia who has gravely regressed to a lower level of functioning, or bipolar youth who is manic, or a juvenile diabetic whose uncontrolled glucose levels are causing his or her confusion).
- c. **Social Functioning:** Is unable to cope with family, school, work, or friends, or has severely impaired ability to function in family, social, work, or school settings because of an overwhelming mental health problem (such as a thought disorder or severe mood lability that places the patient at risk).
- d. **Ability for Self-Care:** Has insufficient resources and skills to maintain an adequate level of functioning and requires daily medical and nursing care (for example, an adolescent with head injury, mental retardation, severe depression, eating disorder, and severe cachexia).
- e. **Course of Illness:** History and present situation suggest that, in the absence of medical management, the adolescent's emotional, behavioral, or cognitive condition will become unstable. The unfolding course of the adolescent's illness, with ensuing changes in symptoms or mental status, is likely to lead to imminently dangerous consequences.

IV. Readiness to change:

Only a patient who meets criteria in Dimensions 1,2 or 3 is appropriately placed in a level 4 program. Problems in dimension 4 alone are not sufficient for placement at level 4.

V. *Relapse, continued use, or continued problem potential:*

Only a patient who meets criteria in Dimensions 1,2 or 3 is appropriately placed in a level 4 program. Problems in dimension 5 alone are not sufficient for placement at level 4.

VI. *Recovery environment:*

Only a patient who meets criteria in Dimensions 1,2 or 3 is appropriately placed in a level 4 program. Problems in dimension 6 alone are not sufficient for placement at level 4.

C. Continued Stay Criteria for the Present Level of Care:

- 1) Is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the current level of care is assessed as necessary to permit the adolescent to continue to work toward his/her treatment goals; **or**
- 2) Is not yet making progress but has the capacity to resolve his/her problems. Is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; **and/or**
- 3) New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care.

D. Transfer/discharge Criteria

- 1) Has achieved the goals articulated in his/her individualized treatment plan, thus resolving the problems that justified admission to the present level of care. Continuing the chronic disease management of the condition at a less intensive level of care is indicated; **or**
- 2) Has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (either more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated; **or**
- 3) Has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his/her ability to resolve his/her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated; **or**
- 4) Has experienced an intensification of his/her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.
AND each of the six dimensions:
- 5) The Six Dimensions

I. Acute intoxication and/or withdrawal potential:

Patient's intoxication or withdrawal problem has improved sufficiently to allow monitoring or withdrawal management services to be provided at a less intensive level of care. **Or** the condition has worsened to a point at which more intensive monitoring or withdrawal management services are required.

II. Biomedical conditions and complications:

Patient's physical health has improved sufficiently to allow biomedical services to be provided effectively at a less intensive level of care. **Or** the patient's condition has worsened to a point at which more intensive biomedical serves are necessary.

III. Emotional, Behavioral, or cognitive conditions and complications:

Functioning has improved sufficiently to allow interventions or services to be provided effectively at a less intensive level of care. **Or** the patient's condition has worsened to a point at which more intensive services are necessary.

IV. Readiness to change:

Patient's stage of readiness to change has improved sufficiently to allow interventions or strategies to be provided effectively at a less intensive level of care. **Or** has demonstrated sustained lack of interest in changing; or a lack of progress to such a degree that further interventions at the present level of care will be ineffective and/or decrease the patient's willingness to engage in treatment. Transfer to another level of care will permit the use of different strategies to engage the patient in treatment and enhance his/her readiness to change.

V. Relapse, continued use, or continued problem potential:

Coping skills have improved sufficiently that strategies to prevent relapse or continued use can be provided effectively at a less intensive level of care. **Or** has demonstrated a regression or lack of progress so significant that further interventions at the present level of care will not enhance her/his ability to prevent relapse or continued use, and/or will decrease the patient's willingness to engage in treatment. Transfer to another level of service will allow different strategies to be employed to engage the patient in treatment and enhance his/her ability to prevent relapse or continued use.

VI. Recovery environment:

Patient's environment and/or ability to cope with it have improved sufficiently to allow interventions or services to be provided effectively at a less intensive level of care. **Or** the patient's recovery environment and/or ability to cope with it have worsened to such a degree that the patient requires transfer to another level of care, where different interventions or strategies can be provided

E. Billing Instructions

- 1) 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.
- 2) Bill all services on a UB claim form utilizing a bundled daily rate
- 3) IMD for SUD

- a. rev code 0116 for private room
 - b. rev code 0126 for semi-private room
- 4) Acute care hospital facility fees for medical detoxification:
- a. Can bill per diem vs DRG depending on contract with MCO
 - b. Per Diem reimbursement is based on bed type with the following rev codes for withdrawal management:

Rev Code	Description
0116	Room and Board – Private room
0126	Room and Board – Semi Private (Two Beds) Detoxification
136	Room and Board – Semi Private (Three or Four Beds) Detoxification
156	Room and Board - Ward
250	Pharmacy
260	IV therapy
270	Medical/ Surgical Supplies and Devices
300	Laboratory
320	Radiology - Diagnostic
450	Emergency Room
730	EKG
740	EEG

- c. Add revenue code 0229 and HCPCS code H0009 for WM tracking purposes.
- d. Diagnostic related group (DRG) codes for withdrawal management:

895: Alcohol/ Drug Use Disorder treatment with rehabilitation therapy
 896: Alcohol/ Drug Use Disorder treatment without rehabilitation therapy with major complications or comorbidities
 896: Alcohol/ Drug Use Disorder treatment without rehabilitation therapy without major complications or comorbidities

Rehabilitation services can include: individual or psychotherapy using modalities such as CBT, MI, family therapy, etc., and Medication Assisted Treatment for ongoing care to include initiation of buprenorphine, acamprosate, naloxone, Antabuse, etc.

- 5) Professional services for medical detoxification (withdrawal management):
 Initial hospital Care: CPT codes 9922x series
 Subsequent hospital care: CPT codes 9923x series
 Discharge Day management: CPT codes 99238, 99239
 Must be linked with relevant ICD code for substance use withdrawal
- 6) CCSS may also be billed for discharge planning and transition purposes

6.3 ASAM Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management in a Hospital

A. Definition of Service

Level 4-WM is an organized service delivered by medical and nursing professionals that provides twenty-four (24) hour medically directed evaluation and withdrawal management in an acute care inpatient setting. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing services. 24-hour observation, monitoring, and treatment are available. Although level 4-WM is specifically designed for acute medical withdrawal management, the patient is also assessed for any treatment priorities identified in Dimensions 2 through 6. It is staffed by physicians who are available 24 hours a day as members of an interdisciplinary team, and hourly or more frequent nurse monitoring is available. Therapies offered include individualized biomedical, emotional, behavioral, and addiction treatment.

B. Admission Criteria

The assessment for placement and treatment plan include:

- 1) A comprehensive nursing assessment performed at admission;
- 2) Approval of the admission by a physician;
- 3) A comprehensive history and physical examination performed within 12 hours of admission, accompanied by appropriate laboratory and toxicology tests;
- 4) An addiction-focused history;
- 5) Sufficient biopsychosocial screening to determine placement;
- 6) Discharge/transfer planning beginning at admission;
- 7) Referral arrangements, as needed;
- 8) An individualized treatment plan including problem identification in Dimensions 2 through 6; and
- 9) Daily assessment of patient progress through withdrawal management and any treatment changes.

C. Length of Service/Continued Service and Discharge Criteria

The patient continues in a level 4-WM program until withdrawal signs and symptoms are sufficiently resolved that s/he can be safely managed at a less intensive level of care.

D. Billing Instructions:

- 1) Prior authorization is required

- 2) Bill revenue code 0114 for a private room, and 0124 for a semi-private room
- 3) Add revenue code 0229 and HCPCS code H0009 for WM tracking purposes.
- 4) CCSS may also be billed for discharge planning and transition purposes

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6.4 Residential Treatment Centers (RTC) and Group Homes (GH)

A. Definition

Residential Treatment Services provide individualized, trauma informed twenty-four (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. Residential and Group Home Treatment Services are designed for clients to develop skills necessary for successful reintegration into his or her family or transition into his or her community. Residential Treatment Center (RTC) and Group Home (GH) services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. The RTC or GH provides regularly scheduled individual, family, and group counseling and therapy sessions at the level of frequency documented individually in each client's treatment plan. RTC and GH services are part of the EPSDT program (42 CFR 441.57)

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) RTC and GH services are provided under the clinical oversight of its licensed Clinical Director who is responsible for provision of clinical supervision, support and consultation to all agency staff. The RTC or GH Clinical Director and Supervisor must have a minimum of two years of experience with clinical practice with children, adolescents and families. The RTC or GH Clinical Director must be a separate clinician than the RTC or GH therapists.
- 2) Staffing ratios for:
 - a. The RTC are 1 clinician to 6 recipients during day hours, and 1 clinician to 12 recipients at night; and
 - b. The GH are 1 clinician to 8 recipients during day hours, and 1 clinician to 12 recipients at night.
 - c. Staff-to-client ratio must be appropriate to the level of care and needs of the clients, and additional staff must be provided if the clinical needs of the client population are high.

C. Treatment Plan

Non-Accredited RTC/GH Treatment Plans

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.

D. Procedures

Indian Health Service (IHS) or Federally Recognized Tribal Government RTC and GH 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.
- 4) All non-IHS and tribal RTC and GH operating in the state must maintain current licensure and certification issued by LCA.

E. 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
- 7) Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH) 8.321.2.31 NMAC

F. Billing Instructions

- 1) Prior authorization is required
- 2) RTC: UB claim form; revenue code 0190 – daily rate
- 3) GH: UB claim form; revenue code 1005 – daily rate
- 4) Units: # of days
- 5) Referring or ordering provider in attending provider field
- 6) A vacancy factor of 24 days annually for each client is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC cannot bill or be reimbursed for days when the client is absent from the facility,
- 7) CCSS may also be billed for discharge planning and transition purposes.

6.5 Treatment Foster Care (TFC)

A. 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. The family living situation is the core treatment service to which other individualized services are added based upon the client's needs. The TFC agency provides intensive support, technical assistance, and supervision of all treatment foster parents. The TFC agency provides crisis intervention on call to treatment foster parent, clients and their families on a twenty-four (24) hour, seven days a week basis including twenty-four (24) hour availability of appropriate staff to respond to the home in crisis situations. 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.

B. Policy

- 1) Treatment Foster Care placement of a client into a TFC home does not occur until after a comprehensive assessment of how the prospective TFC family can meet the client's needs and preferences, and a documented determination by the TFC agency that the prospective placement is a reasonable match for the client.
- 2) TFC families must have one parent readily accessible at all times, cannot schedule work when the client is normally at home, and is able to be physically present to meet the client's emotional, physical and behavioral needs.
- 3) In the event the TFC parents request a TFC client be removed from their home, a treatment team meeting must be held and an agreement made that a move is the best interest of the involved client. Any TFC parent(s) who demands removal of a TFC client from their home without first discussing with and obtaining consensus of the treatment team, may have their license revoked,
- 4) The TFC agency must conduct a documented private face-to-face visit with the client within the first two weeks of TFC placement and at least twice monthly thereafter by the treatment coordinator. A minimum of one weekly phone contact with the TFC parents by the treatment coordinator is required on weeks the face-to-face contacts do not occur.

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.
 - l. CCSS may also be billed for discharge planning and transition purposes

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 safest 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 Treatment Foster Care, 8.321.2.37 NMAC
- 7) Specialized Behavioral Health Provider Enrollment and Reimbursement, 8.321.2 NMAC

F. Exhibits/Appendices/Forms

Appendix CC: Prudent Parenting and Prevention of Sex Trafficking

G. Billing Instructions

- 1) Bill on a CMS 1500 claim form
- 2) Level I - S5145: unit 1 day; max units 31
- 3) Level II - S5145 (U1): unit 1 day
- 4) Prior authorization is required

SECTION SEVEN: INPATIENT AND RESIDENTIAL SERVICES FOR ADULTS

7.1 Adult Accredited Residential Treatment Centers for Substance Use Disorders (AARTC)

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). The accreditation must be for adult residential treatment.

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

Must be accredited as an adult (18 and older) residential treatment facility by the Joint Commission (JC), The Commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA) as an adult (18 and older) residential treatment facility.

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.

In New Mexico we have established three levels of reimbursement, called Tiers. For some of the Tiers more than 1 ASAM sub-level may be included so that each level is simply a point on a continuum of wellness. However, each ASAM level constitutes a separate admission requiring discharge and re-admission if transferring to another service based on ASAM placement criteria. Also, each of the ASAM sub-levels of care requires a separate prior authorization with the exception of the withdrawal management sub-levels, i.e. 3.2-WM and 3.7-WM which never require pre-authorization in order to accommodate speedy clinical intervention.

DOH licensure for AARTCs is pending. Until such time, certification from Behavioral Health Services Division (BHSD) is a requirement before enrolling in Medicaid. Also required is correspondence with BHSD related to determining the reimbursement rate for the differing levels which are specific to an agency. BHSD will conduct bi-annual site visits.

C. Exhibits/Appendices/Forms

Appendix DD: BHSD application for agency certification of an AARTC
Appendix EE: AARTC Process Flow

D. 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>

E. Prior Authorization

- 1) Prior authorization is not required for in state AARTCs until five days from admission to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if ASAM placement criteria is met and medically necessary, prior authorization for continued care must be obtained from MAD or its designee, or the relevant MCO.

For out-of-state AARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

- 2) Prior authorization must occur *prior* to moving to a different level of care than the one originally being admitted into.
- 3) Withdrawal Management (WM), no matter which level, NEVER requires prior authorization in order to facilitate immediate clinical intervention.

F. Continued Service and Transfer Discharge Criteria (for all ASAM Levels of care)

“In the process of patient assessment, certain problems and priorities are identified, the treatment of which indicates admission to a particular level of care. *The resolution of those problems and priorities determines when a patient can be transferred and treated at a different level of care, referred to a different type of treatment, or discharged from treatment.*”

Patients, especially those mandated to treatment in fixed LOS programs, often focus more on “doing time” rather than “doing treatment.” They are more focused on their discharge date than on addressing the concerns that led them to treatment initially.

The LOS and level of care is determined by the progress and outcomes of treatment, not on predetermined program lengths of stay.” (ASAM Criteria, pg. 299)

Continued Stay Criteria

- A. The patient is making progress, but has not yet achieved the goals in the treatment plan. Continued treatment at the present level of care is assessed as necessary for continued work on the treatment plan; **or**
- B. The patient is not yet making progress, but has the capacity to resolve his/her problems. Is actively working toward the goals in the treatment plan. Continued treatment at this level of care is assessed as necessary to work toward treatment goals; **or**
- C. New problems have been identified that are appropriately treated at the present level of care. The new problems require the frequency and intensity of which can only safely be delivered in the current level of care; **and**

D. The Six Dimensions:

I. *Acute intoxication and/or withdrawal potential:*

Signs and symptoms indicate the continued presence of the intoxication or withdrawal problem that required admission to the present level of care. The problem requires monitoring or withdrawal management services that can be provided effectively only at the present level of care.

II. *Biomedical conditions and complications:*

The physical health problem that required admission to the present level of care, or a new problem, requires biomedical services that can be provided effectively only at the present level of care.

III. *Emotional, Behavioral, or cognitive conditions and complications:*

The emotional, behavioral, and/or cognitive problem that required admission to the present level of care continues, or a new problem has appeared. This problem requires interventions that can be provided effectively only at the present level of care.

IV. *Readiness to change:*

Continues to demonstrate a need for engagement and motivational enhancement that can be provided effectively only at the present level of care.

V. *Relapse, continued use, or continued problem potential:*

Continues to demonstrate a problem, or has developed a new problem, that requires coping skills and strategies to prevent relapse, continued use, or continued problems. These strategies can be provided effectively only at the present level of care.

VI. *Recovery environment:*

Continues to demonstrate a problem in his/her recovery environment, or has a new problem, that requires coping skills and support system intervention. These interventions can be provided effectively only at the present level of care.

G. **Billing Instructions**

Billing instructions for each ASAM level appear in the appropriate sections below.

7.2 ASAM Level 3.1: Clinically Managed Low-Intensity Adult Accredited Residential Treatment Center for SUD (Tier I)

A. Definition of Service:

Level 3.1 programs offer at least 5 hours per week of low-intensity treatment of SUD. Treatment such as individual, group, and family therapy; medication management; and psychoeducation is included. These services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies.

The treatment services are focused on improving the individual's readiness to change (Dimension 4) and or functioning and coping skills in Dimensions 5 and 6. They promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. Mutual/self-help meetings are available on-site, or accessible in the local community.

The residential component of care provides the stability to prevent or minimize relapse or continued use and problem potential (Dimension 5). Interpersonal and group living skills are promoted through the use of community or house meetings of residents and staff.

The residential component of Level 3.1 is sometimes combined with an Intensive Outpatient Program (IOP) if available, for individuals whose living situation or recovery environments are incompatible with their recovery goals, and if they meet the dimensional admission criteria of IOP.

B. Admission Criteria:

The adult patient who is admitted to a level 3.1 program meets specification in **each** of the six dimensions. This level of care requires its own prior authorization.

- 1) Prior authorization is not required for in state AARTCs until five days from admission to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if ASAM placement criteria is met and medically necessary, prior authorization for continued care must be obtained from MAD or its designee, or the relevant MCO.

For out-of-state AARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

- 2) Prior authorization must occur *prior* to moving to a different level of care than the one originally being admitted into.

The six dimensions

I. Acute intoxication and/or withdrawal potential:

Patient has no signs or symptoms of withdrawal, or his /her withdrawal needs can be safely managed in a level 3.1 setting.

II. Biomedical conditions and complications:

Meets **one** of the following:

- (a) Biomedical problems, if any, are stable and do not require medical or nurse monitoring, and the patient is capable of self-administering any prescribed medications;
- (b) A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The problem requires medical monitoring which can be provided by the program or through an established arrangement with another provider.

III. Emotional, Behavioral, or cognitive conditions and complications;

If **any** of Dimension 3 conditions are present, the patient must be admitted to a co-occurring capable program.

Co-occurring Capable Programs

Status is characterized by (a) **and one of** (b) **or** (c) **or** (d) **or** (e)

- (a) Mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to allow participation in the therapeutic interventions provided and to benefit from treatment.
- (b) The psychiatric condition is stable, and he/she is assessed as having minimal problems in this area, as evidenced by **both** of the following: 1) the patient's thought disorder, anxiety, guilt, and/or depression may be related to substance use problems or to a stable co-occurring emotional, behavioral, or cognitive condition, with imminent likelihood of relapse with dangerous consequences outside of a structured environment., and 2) the patient is assessed as not posing a risk to self or others;
- (c) The patient's symptoms and functional limitations, when considered in the context of his or her home environment, are sufficiently severe that he/she is assessed as not likely to maintain mental stability and/or abstinence if treatment is provided in a nonresidential setting. Functional limitation may include residual psychiatric symptoms, chronic addictive disorder, history of criminality, marginal intellectual ability, limited educational achievement, poor vocational skills, inadequate anger management skills, and the sequelae of physical, sexual, or emotional trauma. These limitations may be complicated by problems in Dimensions 2 through 6.
- (d) Demonstrates an inability to maintain stable behavior over a twenty-four (24) hour period without the structure and support of a twenty-four (24) hour setting;
- (e) Patient's co-occurring psychiatric emotional, behavioral, or cognitive conditions are being addressed concurrently through appropriate psychiatric services.

IV. Readiness to change:

Status is characterized by at least **one** of the following:

- (a) Acknowledges the existence of a psychiatric condition and/or SUD. Recognizes specific negative consequences and dysfunctional behaviors and their effect on his/her desire to change. Is sufficiently ready to change and cooperative enough to respond to treatment at level 3.1.

(b) Is assessed as appropriately placed at level 1 or 2 and is receiving level 3.1 services concurrently.

(c) Requires a twenty-four (24) hour structured milieu to promote treatment progress and recovery because motivating interventions have failed in the past and such interventions are assessed as not likely to succeed in an outpatient setting;

(d) Patient's perspective impairs his/her ability to make behavior changes without the support of a structured environment.

V. *Relapse, continued use, or continued problem potential:*

Characterized by at least **one** of the following:

(a) Demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning. Is in imminent danger of relapse, with dangerous emotional, behavioral, or cognitive consequences, and needs twenty-four (24) hour structure to help apply recovery and coping skills;

(b) Understands his/her addiction and/or mental disorder but is at risk of relapse in a less structured level of care because is unable to consistently address either or both;

(c) Needs staff support to maintain engagement in his/her recovery program while transitioning to life in the community;

(d) Is at high risk of substance use, addictive behavior, or deteriorated mental functioning, with dangerous emotional, behavioral, or cognitive consequences, in the absence of close twenty-four (24) hour structured support, and these issues are being addressed concurrently in a level 2 program.

VI. *Recovery environment:*

Characterized by **one** of (a) **and** one of (b) **or** c) **or** (d) **or** (e) **or** (f)

(a) Is able to cope, for limited periods of time, outside the twenty-four (24) hour structure of a level 3.1 program in order to pursue clinical, vocational, educational, and community activities;

(b) Has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care;

(c) Lacks social contacts or has high-risk social contacts that jeopardize his/her recovery, or the patient's social network is characterized by significant social isolation and withdrawal. His/her social network includes many friends who are regular users of alcohol or other drugs or regular gamblers, leading recovery goals to be assessed as unachievable outside of a twenty-four (24) hour supportive setting;

(d) The patient's social network involves living in an environment that is so highly invested in alcohol or other drug use that the patient's recovery goals are assessed as unachievable;

(e) Continued exposure to the patient's school, work, or living environment makes recovery unlikely, and the patient has insufficient resources and skills to maintain an adequate level of functioning outside of a twenty-four (24) hour environment;

(f) Is in danger of victimization by another and thus requires twenty-four (24) hour supervision.

C. Billing Instructions:

1) Requires Prior Authorization

a. For the initial admission, prior authorization is not required for in state AARTCs until five days from admission to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if ASAM placement criteria is met and medically necessary, prior authorization for continued care must be obtained from MAD or its designee, or the relevant MCO/.

b. For out-of-state AARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

c. Prior authorization must occur *prior* to moving to a different level of care than the one originally being admitted into.

2) ASAM Level 3.1 is reimbursement Tier 1 and is the only ASAM level in this tier

3) Bill on a UB claim form with revenue code 1003 and HCPCS code H0019.

4) CCSS may also be billed for discharge planning and transition purposes.

5) BHSD (State General Fund) will pay an additional \$50 per client per day of AARTC services for room and board, billed through the BHSD Star system. This funding is only available for AARTCs who are billing Medicaid for AARTC services as specified above. If this code should get billed on the AARTC claim received by the MCO/, it will be denied by the MCO.

- Room and board per diem (\$50 per client per day) = HCPCS H0047

7.3 ASAM Level 3.2-WM: Clinically Managed Residential Withdrawal Management (Tier 2)

A. Definition of Service

An organized service that is delivered by trained staff who provide twenty-four (24) hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. It is characterized by its emphasis on peer and social support rather than medical and nursing care.

B. Admission Criteria:

The withdrawal signs and symptoms are sufficiently severe to require twenty-four (24) hour structure and support; however, the full resources of a level 3.7 WM are not required. Elements of the assessment include:

- 1) An addiction focused history which is reviewed with an MD/CNP/PA during the admission process;
- 2) A physical exam by an MD/CNP/PA;
- 3) Sufficient biopsychosocial screening to determine the level of care; and
- 4) An individualized treatment plan including problem identification in Dimensions 2 through 6

C. Length of Service/Continued Service and Discharge Criteria

The patient continues in a level 3.2-WM withdrawal management program until a) the withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or b) The patient's 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; or c) The patient is unable to complete withdrawal management at level 3.2-WM, despite an adequate trial and needs to transfer to a more intensive level of care or the addition of other clinical services such as intensive counseling.

D. Billing Instructions & Prior Authorization

- 1) No prior authorization is required to facilitate immediate clinical intervention; however if moving to another ASAM level of care, prior authorization is required.
- 2) This is 1 of 3 ASAM levels within Tier 2 reimbursement
- 3) Bill utilizing a UB claim form with revenue code 1003, HCPCS code H0018
- 4) Add revenue code 0229 and HCPCS code H0010 for WM tracking purposes.
- 5) Enter ordering or referring provider in attending provider field.
- 6) CCSS may also be billed for discharge planning and transition purposes

7) BHSD (State General Fund) will pay an additional \$50 per client per day of AARTC services for room and board, billed through the BHSD Star system. This funding is only available for AARTCs who are billing Medicaid for AARTC services as specified above. If this code should get billed on the AARTC claim received by the MCO, it will be denied by the MCO.

- Room and board per diem (\$50 per client per day) = HCPCS H0047

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7.4 ASAM Level 3.3: Clinically Managed Population-Specific High Intensity Adult Accredited Residential Treatment Services for Adults with SUD (Tier 2)

A. Definition of Service:

Level 3.3 programs provide a structured recovery environment in combination with high-intensity clinical services to meet the functional limitations of special populations of patients to support recovery from substance-related disorders. “For the typical patient in a level 3.3 program, the effects of the substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual’s life are so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Similarly, the patient’s cognitive limitations make it unlikely that he/she could benefit from other levels or residential care. If a temporary condition, when assessment indicates that such an individual no longer is cognitively impaired, he/she can be transferred to another level of care. By contrast, the individual who suffers from chronic brain syndrome, or the older adult who has age and substance-related cognitive limitations, or the individual who has experienced a traumatic brain injury, or the patient with developmental disabilities would continue to receive treatment in a level 3.3 program” (p. 234-5).

B. Admission Criteria

Meets specifications in **each** of the six dimensions

The Six Dimensions:

I. Acute intoxication and/or withdrawal potential:

No signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a level 3.3 setting.

II. Biomedical conditions and complications:

Characterized by **one** of the following:

(a) If any biomedical problems, they are stable and do not require medical or nurse monitoring, and the patient is capable of self-administering any prescribed medications;

(b) A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The problem requires medical monitoring, which can be provided by the program or through an established arrangement with another provider.

III. Emotional, Behavioral, or cognitive conditions and complications:

If any conditions are present, the patient must be admitted to a co-occurring capable program.

For those programs:

Patient’s status is characterized by (a) **and one of (b) or (c) or (d)**:

(a) Mental status is assessed as sufficiently stable to permit the patient to participate in the therapeutic interventions;

(b) The psychiatric condition is stabilizing, but he/she is assessed as in need of a twenty-four (24) hour structured environment, as evidenced by **one** of the following: 1) depression or other emotional, behavioral, or cognitive conditions significantly interfere with activities of daily living and recovery; or 2) the patient exhibits violent or disruptive behavior when intoxicated and is assessed as posing a danger to self or others; or 3) the patient exhibits stress behaviors related to recent or threatened losses in work, family, or social arenas, such that activities of daily living are significantly impaired and the patient requires a secure environment to focus on the substance use or mental health problem; or 4) concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors require continuing structured interventions;

(c) Symptoms and functional limitations, when considered in the context of his/her home environment, are assessed as sufficiently severe that the patient is not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential setting.

(d) Mild risk of behaviors endangering self, others, or property, and is in imminent danger of relapse without the twenty-four (24) hour support and structure of a level 3.3 program.

IV. Readiness to change:

Status is characterized by **one** of the following:

(a) Because of the intensity and chronicity of the addictive disorder or the patient's cognitive limitations, he/she has little awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment, and thus has limited readiness to change;

(b) Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the patient has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health, or life problems, and impaired coping skills and level of functioning;

(c) Continued substance use poses a danger of harm to self or others, and he/she demonstrates no awareness of the need to address the severity of addiction or psychiatric problem and does not recognize the need for treatment. However, assessment indicates that treatment interventions available may increase the patient's degree of readiness to change;

(d) The patient's perspective impairs his/her ability to make behavior changes without repeated, structured, clinically directed motivational interventions, delivered in a twenty-four (24) hour milieu.

V. Relapse, continued use, or continued problem potential:

Status is characterized by at least **one** of the following:

(a) Does not recognize relapse triggers and has little awareness of the need for continuing care. Because of the intensity or chronicity of the addictive disorder or mental health problem or cognitive limitations, he/she is in imminent danger of continued substance use or mental health problems with dangerous emotional, behavioral, or cognitive consequences.

(b) Is experiencing an intensification of symptoms of SUD or mental disorder, and his/her level of functioning is deteriorating despite an amendment of the treatment plan;

(c) Patient's cognitive impairment has limited his/her ability to identify and cope with relapse triggers and high-risk situations. Requires relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively in a setting that provides twenty-four (24) hour structure and support to prevent imminent dangerous consequences;

(d) Despite recent, active participation in treatment at a less intensive level of care, the patient continues to use alcohol and/or other drugs or to continue other addictive behavior or to deteriorate psychiatrically, with imminent serious consequences.

VI. Recovery environment:

Status is characterized by at least **one** of the following:

(a) Has been living in an environment with a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care;

(b) Is in significant danger of victimization and thus requires twenty-four (24) hour supervision.

(c) Patient's social network includes regular users of alcohol or other drugs, such that recovery goals are assessed as unachievable at a less intensive level of care;

(d) Patient's social network involves living with an individual who is a regular user, addicted user, or dealer of alcohol or other drugs, or the patient's living environment is so highly invested in alcohol or other drug use that his/her recovery goals are assessed as unachievable;

(e) Because of cognitive limitations, the patient is in danger of victimization by another and thus requires twenty-four (24) hour supervision;

(f) Unable to cope, for even limited periods of time, outside the twenty-four (24) hour structure of a 3.3 program. He/she needs staff monitoring to assure his/her safety and well-being.

C. Billing Instructions

1) Requires Prior Authorization

a. For the initial admission, prior authorization is not required for in state AARTCs until five days from admission to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if ASAM placement criteria is met and medically necessary, prior authorization for continued care must be obtained from MAD or its designee, or the relevant MCO.

b. For out-of-state AARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

c. Prior authorization must occur *prior* to moving to a different level of care than the one originally being admitted into.

- 2) Is one of 3 ASAM Levels within reimbursement Tier 2
- 3) Bill on a UB claim form with revenue code 1003 and HCPCS code H0018.
- 4) Enter ordering or referring provider in attending provider field.
- 5) CCSS may also be billed for discharge planning and transition purposes
- 6) BHSD (State General Fund) will pay an additional \$50 per client per day of AARTC services for room and board, billed through the BHSD Star system. This funding is only available for AARTCs who are billing Medicaid for AARTC services as specified above. If this code should get billed on the AARTC claim received by the MCO, it will be denied by the MCO.
 - Room and board per diem (\$50 per client per day) = HCPCS H0047

7.5 ASAM Level 3.5: Clinically Managed High-Intensity Adult Accredited Residential Treatment Services (Tier 2)

A. Definition of Service

Level 3.5 assists individuals whose addiction is currently so out of control that they need a twenty-four (24) hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Their multidimensional needs are of such severity that they cannot safely be treated in less intensive levels of care. They typically have multiple limitations including criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. Their mental disorders may involve serious and chronic disorders such as schizophrenia, bipolar disorders, major depression and personality disorders. They can generally be characterized as having chaotic, non-supportive, and often abusive interpersonal relationships. These limitations require comprehensive, multifaceted treatment that can address all of the patient's interrelated problems. The goals in this program are to promote abstinence from substance use, arrest other addictive and antisocial behaviors, and effect change in individual's lifestyles, attitudes, and values. It is not intended that all, or even the majority of social and psychological problems will be resolved in the 3.5 treatment stay; it is best viewed as one part of a person's treatment and recovery process integrated into a flexible continuum of services.

B. Admission Criteria

Meets the diagnostic criteria for a substance use and/or addictive disorder of moderate to high severity, as well as meeting specifications in **each** of the six dimensions.

The six Dimensions:

I. Acute intoxication and/or withdrawal potential:

Has no signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a level 3.5 setting.

II. Biomedical conditions and complications:

Status is characterized by **one** of the following:

(a) Biomedical problems, if any, are stable and do not require twenty-four (24) hour medical or nurse monitoring, and the patient is capable of self-administering any prescribed medications;

(b) A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The problem requires medical monitoring, which can be provided by the program or through an established arrangement with another provider.

III. Emotional, Behavioral, or cognitive conditions and complications:

If any of the Dimension 3 conditions are present, the patient must be admitted to a co-occurring capable program.

The patient's status in a co-occurring capable program is characterized by (a) **and one of (b) or (c) or (d) or (e) or (f)**

- (a) Patient's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit participation in the therapeutic program and to benefit from treatment;
- (b) Patient's psychiatric condition is stabilizing. However, despite best efforts, is unable to control his/her use of alcohol, tobacco, and/or other drugs and/or antisocial behaviors, with attendant probability of imminent danger. The resulting level of dysfunction is so severe that it precludes participation in a less structured and intensive level of care;
- (c) Demonstrates repeated inability to control his/her impulses to use alcohol and/or other drugs and/or to engage in antisocial behavior, and is in imminent danger of relapse, with attendant likelihood of harm to self, other, or property. The resulting level of dysfunction is of such severity that it precludes participation in treatment in the absence of the twenty-four (24) hour support and structure of a level 3.5 program.
- (d) Demonstrates antisocial behavior patterns (as evidenced by criminal activity) that have led or could lead to significant criminal justice problems, lack of concern for others, and extreme lack of regard for authority, and which prevents movement toward positive change and precludes participation in a less structured and intensive level of care;
- (e) Has significant functional deficits, which are likely to respond to staff interventions. These symptoms and deficits, when considered in the context of his/her home environment, are sufficiently severe that the patient is not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential setting. The functional deficits are of a pervasive nature, requiring treatment that is primarily habilitative in focus; they do not require medical monitoring or management. They may include residual psychiatric symptoms, chronic addictive disorder, history of criminality, marginal intellectual ability, limited educational achievement, poor vocational skills, inadequate anger management skills, poor impulse control, and the sequelae of physical, sexual, or emotional trauma. These deficits may be complicated by problems in Dimensions 2 through 6.
- (f) Patient's concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors provide opportunities to promote continuous boundary setting interventions.

IV. Readiness to change:

Characterized by at least **one** of the following:

- (a) Because of the intensity and chronicity of the addictive disorder or the patient's mental health problems, he/she has limited insight and little awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment, and thus has limited readiness to change;
- (b) Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health, or life problems and his/her impaired coping skills and level of functioning, often blaming others for his/her addiction problems;

(c) Demonstrates passive or active opposition to addressing the severity of his/her mental or addiction problem, or does not recognize the need for treatment. Such continued substance use or inability to follow through with mental health treatment poses a danger of harm to self or others. However, assessment indicates that treatment intervention available may increase the patient's degree of readiness to change;

(d) Requires structured therapy and a twenty-four (24) hour programmatic milieu to promote treatment progress and recovery, because motivational interventions have not succeeded at less intensive levels of care and such interventions are assessed as not likely to succeed at a less intensive level of care;

(e) Patient's perspective impairs his/her ability to make behavior changes without repeated, structured, clinically directed motivational interventions, which will enable him/her to develop insight into the role he/she plays in his/her substance use and/or mental condition, and empower him/her to make behavioral changes which can only be delivered in a twenty-four (24) hour milieu.

(f) Despite recognition of a substance use or addictive behavior problem and understanding of the relationship between his/her substance use, addiction, and life problems, the patient expresses little to no interest in changing. Because of the intensity or chronicity of the addictive disorder and high-risk criminogenic needs, he/she is in imminent danger of continued substance use or addictive behavior. This poses imminent serious life consequences and/or a continued pattern of risk of harm to others while under the influence of substances;

(g) Attributes his/her alcohol, drug, addictive, or mental health problem to other persons or external events, rather than to a substance use or addictive or mental disorder. Requires clinical directed motivation interventions that will enable insights into the role he/she can play to alter the health condition, and empowerment to make behavioral changes. Interventions are adjudged as not feasible or unlikely to succeed at a less intensive level of care.

V. *Relapse, continued use, or continued problem potential:*

Status is characterized by at least **one** of the following:

(a) Does not recognize relapse triggers and lacks insight into the benefits of continuing care, and is therefore not committed to treatment. Continued substance use poses an imminent danger of harm to self or others in the absence of twenty-four (24) hour monitoring and structured support;

(b) Patient's psychiatric condition is stabilizing. However, despite his/her best efforts, is unable to control his/her use of alcohol, other drugs, and/or antisocial behaviors, with attendant probability of harm to self or others. Has limited ability to interrupt the relapse process or continued use, or to use peer supports when at risk for relapse to his/her addiction or mental disorder. Continued substance use poses an imminent danger of harm to self or others in the absence of twenty-four (24) hour monitoring and structured support;

(c) Is experiencing psychiatric or addiction symptoms such as drug craving, insufficient ability to postpone immediate gratification, and other drug-seeking behaviors. This situation poses an imminent danger of harm to self or others in the absence of close twenty-four (24) hour monitoring and structured support. The introduction of psychopharmacologic support is

indicated to decrease psychiatric or addictive symptoms, such as cravings, that will enable the patient to delay immediate gratification and reinforce positive recovery behaviors;

(d) Is in imminent danger of relapse or continued use, with dangerous emotional, behavioral or cognitive consequences, as a result of a crisis situation;

(e) Despite recent, active participation in treatment at a less intensive level of care, continues to use alcohol or other drugs, or to deteriorate psychiatrically, with imminent serious consequences, and is at high risk of continued substance use or mental deterioration in the absence of close twenty-four (24) hour monitoring and structured treatment;

(f) Demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. This poses imminent risk of harm to self or others. The imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment. Requires twenty-four (24) hour monitoring and structure to assist in the initiation and application of recovery and coping skills.

VI. Recovery environment:

Status is characterized by at least **one** of the following:

(a) Patient has been living in an environment that is characterized by a moderately high risk of neglect; initiation or repetition of physical, sexual, or emotional abuse; or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care;

(b) Patient's social network includes regular users of alcohol, tobacco, and/or other drugs, such that recovery goals are assessed as unachievable at a less intensive level of care;

(c) Patient's social network is characterized by significant social isolation or withdrawal, such that recovery goals are assessed as inconsistently unachievable at a less intensive level of care;

(d) Patient's social network involves living with an individual who is a regular user, addicted user or dealer of alcohol or other drugs, or the patient's living environment is so highly invested in alcohol and/or other drug use that his/her recovery goals are assessed as unachievable;

(e) Is unable to cope, for even limited periods of time, outside of twenty-four (24) hour care. Needs staff monitoring to learn to cope with Dimension 6 problems before being transferred safely to a less intensive setting.

C. Billing Instructions

1) Requires Prior Authorization

a. For the initial admission, prior authorization is not required for in state AARTCs until five days from admission to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if ASAM placement criteria is met and medically

necessary, prior authorization for continued care must be obtained from MAD or its designee, or the relevant MCO.

b. For out-of-state AARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

c. Prior authorization must occur *prior* to moving to a different level of care than the one originally being admitted into.

- 2) Is one of 3 ASAM Levels within reimbursement Tier 2
- 3) Bill on a UB claim form with revenue code 1003 and HCPCS code H0018.
- 4) Enter ordering or referring provider in attending provider field.
- 5) CCSS may also be billed for discharge planning and transition purposes
- 6) BHSD (State General Fund) will pay an additional \$50 per client per day of AARTC services for room and board, billed through the BHSD Star system. This funding is only available for AARTCs who are billing Medicaid for AARTC services as specified above. If this code should get billed on the AARTC claim received by the MCO, it will be denied by the MCO.
 - Room and board per diem (\$50 per client per day) = HCPCS H0047

7.6 ASAM Level 3.7: Medically Monitored Intensive Inpatient Services in an Adult Accredited Residential Treatment Program for SUD (Tier 3)

A. Definition of service:

ASAM 3.7 - Medically monitored, intensive inpatient service is 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.

This medically monitored service functions under a defined set of policies, procedures, and clinical protocols in a separate more intensive unit of a residential facility. ASAM Level 3.7 is for individuals whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital. The services are designed to meet the needs of patients who have functional limitations in Dimensions 1, 2, or 3.

B. Admission Criteria:

Admission to a level 3.7 program meets specifications in **at least two** of the six dimensions, **at least one** of which is in Dimension 1, 2, or 3.

The Six Dimensions:

I. Acute intoxication and/or withdrawal potential:

Has no signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a level 3.7 setting.

II. Biomedical conditions and complications:

Is characterized by **one** of the following:

(a) The interaction of the biomedical condition and continued alcohol and/or other drug use places the patient at significant risk of serious damage to physical health or concomitant biomedical conditions;

(b) A current biomedical condition requires twenty-four (24) hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital

III. Emotional, Behavioral, or cognitive conditions and complications:

Problems in Dimension 3 are not necessary for admission to a level 3.7 program, however, if any of the Dimension 3 conditions are present, the patient must be admitted to a co-occurring capable program.

Status is characterized by at least **one** of the following:

a) Patient's psychiatric condition is unstable and presents with symptoms (which may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) that are interfering with abstinence, recovery, and stability to such a degree that the patient needs a structured twenty-four (24) hour, medically monitored environment to address recovery efforts;

(b) Exhibits stress behaviors associated with recent or threatened losses in work, family, or social domains; or there is a reemergence of feelings and memories of trauma and loss once the patient achieves abstinence, to a degree that his or her ability to manage the activities of daily living is significantly impaired. The patient thus requires a secure, medically monitored environment in which to address self-care problems and to focus on his or her substance use or behavioral health problems;

(c) Has significant functional limitations that require active psychiatric monitoring. They may include problems with activities of daily living; problems with self-care, lethality, or dangerousness; and problems with social functioning. These limitations may be complicated by problems in Dimensions 2 through 6.

(d) Is at moderate risk of behaviors endangering self, others, or property, likely to result in imminent incarceration or loss of custody of children, and/or is in imminent danger of relapse (with dangerous emotional, behavioral, or cognitive consequences) without the twenty-four (24) hour support and structure of a level 3.7 program.

(e) Is actively intoxicated, with resulting violent or disruptive behavior that poses imminent danger to self or others. Such a patient may, on further evaluation, belong in level 4-WM or an acute observational setting if assessed as not safe in a level 3.7 service;

(f) Is psychiatrically unstable or has cognitive limitations that require stabilization but not medical management

IV. Readiness to change:

Is characterized by at least **one** of the following:

(a) Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the patient does not accept or relate the addictive disorder to the severity of the presenting problem;

(b) Is in need of intensive motivating strategies, activities, and processes available only in a twenty-four (24) hour structured, medical monitored setting;

(c) Needs ongoing twenty-four (24) hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program.

V. Relapse, continued use, or continued problem potential:

Status is characterized by at least **one** of the following:

(a) Is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his/her addictive or mental disorder (such as poor impulse control, drug seeking behavior, or increasing severity of anxiety or depressive symptoms). This situation poses a serious risk of harm to self or others in the absence of twenty-four (24) hour monitoring and structured support;

(b) Is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of twenty-four (24) hour monitoring and structure support found in a medically monitored setting.

(c) The modality or intensity of treatment protocols to address relapse require that the patient receive care in a level 3.7 program (such as initiating or restarting medications for medical or psychiatric conditions, an acute stress disorder, or the processing of a traumatic event) to safely and effectively initiate antagonist therapy, or agonist therapy.

VI. *Recovery environment:*

Status is characterized by at least **one** of the following:

(a) Requires continuous medical monitoring while addressing his/her substance use and/or psychiatric symptoms because his/her current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or active substance use, such that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care.

(b) Family members or significant others living with the patient are not supportive of his/her recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts. This situation requires structured treatment services and relief from the home environment in order for the patient to focus on recovery;

(c) Is unable to cope, for even limited periods of time, outside of twenty-four (24) hour care. Needs staff monitoring to learn to cope with Dimension 6 problems before he/she can be transferred safely to a less intensive setting.

C. **Billing Instructions:**

1) Requires Prior Authorization

a. For the initial admission, prior authorization is not required for in state AARTCs until five days from admission to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if ASAM placement criteria is met and medically necessary, prior authorization for continued care must be obtained from MAD or its designee, such as the Third Party Assessor (TPA) or the relevant MCO.

b. For out-of-state AARTCs prior authorization is required prior to placement; there is no 5-day waiver of prior authorization.

c. Prior authorization must occur *prior* to moving to a different level of care than the one originally being admitted into.

- 2) Is one of 3 ASAM Levels within reimbursement Tier 3.
- 3) Bill on a UB claim form with revenue code 1003 and HCPCS code H0017.
- 4) Enter ordering or referring provider in attending provider field.
- 5) CCSS may also be billed for discharge planning and transition purposes
- 6) BHSD (State General Fund) will pay an additional \$50 per client per day of AARTC services for room and board, billed through the BHSD Star system. This funding is only available for AARTCs who are billing Medicaid for AARTC services as specified above. If this code should get billed on the ARTC claim received by the MCO, it will be denied by the MCO.
 - Room and board per diem (\$50 per client per day) = HCPCS H0047

7.7 ASAM Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management in an Adult Accredited Residential Treatment Facility (Tier 3)

A. Definition of Service

ASAM 3.7-WM Medically monitored inpatient withdrawal management services as specified in *The ASAM Criteria*; requires twenty-four (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 twenty-four (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;

B. Admission Criteria

Elements of the assessment for 3.7-WM are:

- 1) An addiction focused history
- 2) A physical examination by a physician, physician assistant, or nurse practitioner within 24 hours of admission and appropriate laboratory and toxicology tests.
- 3) Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6; and
- 4) An individualized treatment plan, including problem identification in Dimensions 2 through 6

C. Length of Service/Continued Service and Discharge Criteria

The patient continues in a level 3.7-WM withdrawal management program until a) the withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or b) The patient's 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; or c) The patient is unable to complete withdrawal management at level 3.2-WM, despite an adequate trial and needs to transfer to a more intensive level of care or the addition of other clinical services such as intensive counseling.

D. Billing Instructions & Prior Authorization

- 1) No prior authorization is required to facilitate immediate clinical intervention. However, if moving to another ASAM level of care prior authorization is required *before* the transition.

- 2) This is 1 of 2 ASAM levels within Tier 3 reimbursement
- 3) Bill utilizing a UB claim form with revenue code 1003, HCPCS code H0017.
- 4) Add revenue code 0229 and HCPCS code H0010 for WM tracking purposes.
- 5) Enter ordering or referring provider in attending provider field.
- 6) CCSS may also be billed for discharge planning and transition purposes
- 7) BHSD (State General Fund) will pay an additional \$50 per client per day of AARTC services for room and board, billed through the BHSD Star system. This funding is only available for AARTCs who are billing Medicaid for AARTC services as specified above. If this code should get billed on the AARTC claim received by the MCO, it will be denied by the MCO.
 - Room and board per diem (\$50 per client per day) = HCPCS H0047

7.8 Institution for Mental Disease (IMD) in a Psychiatric Hospital

A. Supporting Information

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.

B. 1115 Centennial Care 2.0 Waiver – IMD Section

Federal authority (CMS) has been approved through the Centennial Care 2.0 1115 waiver effective 1/01/2019. It permits IMD stays for Centennial Care MCO member and Fee for Services adults with a substance use disorder diagnosis for more than the 15 days.

Eligible recipients: Centennial Care MCO member and Fee for Service adults with a substance use disorder or co- occurring mental health and SUD.

- 1) Covered services: Withdrawal management (detoxification) and rehabilitation including treatment for any co-occurring mental health conditions.
- 2) 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.
- 3) Prior authorization is required. Utilize ASAM admission criteria 3.7 WM and 4.0 and 4-WM for medical necessity found in sections 7.9 and 7.10.

C. Billing Instructions

- 1) MCO reimburse based on a negotiated rate.
- 2) Bill all services on a UB claim form utilizing a bundled daily rate
- 3) IMD for SUD
 - a. rev code 0116 for private room
 - b. rev code 0126 for semi-private room

7.9 ASAM Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management in an Acute Care Hospital

A. Definition of Service

Level 4-WM is an organized service delivered by medical and nursing professionals that provides twenty-four (24) hour medically directed evaluation and withdrawal management in an acute care inpatient setting. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing services. 24-hour observation, monitoring, and treatment are available. Although level 4-WM is specifically designed for acute medical withdrawal management, the patient is also assessed for any treatment priorities identified in Dimensions 2 through 6. It is staffed by physicians who are available 24 hours a day as members of an interdisciplinary team, and hourly or more frequent nurse monitoring is available. Therapies offered include individualized biomedical, emotional, behavioral, and addiction treatment.

B. Admission Criteria

The assessment for placement and treatment plan include:

- 1) A comprehensive nursing assessment performed at admission;
- 2) Approval of the admission by a physician;
- 3) A comprehensive history and physical examination performed within 12 hours of admission, accompanied by appropriate laboratory and toxicology tests;
- 4) An addiction-focused history;
- 5) Sufficient biopsychosocial screening to determine placement;
- 6) Discharge/transfer planning beginning at admission;
- 7) Referral arrangements, as needed;
- 8) An individualized treatment plan including problem identification in Dimensions 2 through 6; and
- 9) Daily assessment of patient progress through withdrawal management and any treatment changes.

C. Length of Service/Continued Service and Discharge Criteria

The patient continues in a level 4-WM program until withdrawal signs and symptoms are sufficiently resolved that he/she can be safely managed at a less intensive level of care.

D. Billing Instructions:

- 1) Prior authorization is required
- 2) For a patient 22 through 64 years of age bill on a UB claim form utilizing revenue code 0116 for a private room or 0126 for a semi private room

- 3) For a patient 65 years and older, bill revenue code 0114 for a private room, and 0124 for a semi-private room
- 4) Add revenue code 0229 and HCPCS code H0009 for WM tracking purposes.
- 5) CCSS may also be billed for discharge planning and transition purposes

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7.10 ASAM Level 4 – Medically Managed Intensive Inpatient Services in an Acute Care Hospital

A. Definition of Service:

Level 4, medically managed intensive inpatient services is an organized service delivered in an acute care inpatient setting. It is for patients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. These services are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the patient. Level 4 offers specialty addiction services and the full resources of a general acute care or psychiatric hospital. Although treatment is specific to substance use and other addictive disorders, the skills of the interdisciplinary team allow the joint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed.

B. Eligible recipients:

When provided within an acute care hospital, it is not considered an IMD and is available to both fee-for-service and Centennial Care members.

C. Admission Criteria:

Prior Authorization is required.

Placement in a level 4 program requires the diagnostic criteria for a substance use or substance-induced disorder, and the required dimensional criteria in **at least one** of dimension 1, or 2, or 3. A referral from an independent practitioner is required, or transfer from an Emergency Department, and the physician in the hospital must accept the patient.

The six dimensions:

- I. *Acute intoxication and/or withdrawal potential:*
See 4 -WM withdrawal management section preceding this section
- II. *Biomedical conditions and complications:*
Characterized by at least **one** of the following:
 - (a) Biomedical complications of the addictive disorder require medical management and skilled nursing care;
 - (b) A concurrent biomedical illness or pregnancy requires stabilization and daily medical management, with daily primary nursing interventions;
 - (c) Has a concurrent biomedical condition (including pregnancy) in which continued alcohol or other drug use presents an imminent danger to life or severe danger to health;
 - (d) Is experiencing recurrent or multiple seizures;
 - (e) Is experiencing a disulfiram-alcohol reaction;

- (f) Has life-threatening symptoms (such as stupor or convulsions) that are related to use of alcohol, tobacco, and/or other drugs;
- (g) Patient's alcohol, tobacco, and/or other drug use is gravely complicating or exacerbating a previously diagnosed medical condition;
- (h) Changes in the patient's medical status, such as significant worsening of a medical condition, make abstinence imperative;
- (i) Significant improvement in a previously unstable medical condition allows the patient to respond to addiction treatment;
- (j) Has another biomedical problem that requires twenty-four (24) hour observation and evaluation

III. Emotional, Behavioral, or cognitive conditions and complications

Characterized by at least **one** of the following:

- (a) Emotional, behavioral, or cognitive complications of the patient's addictive disorder require psychiatric management and skilled nursing care;
- (b) A concurrent emotional, behavioral, or cognitive illness requires stabilization, daily psychiatric management, and primary nursing interventions;
- (c) Uncontrolled behavior poses an imminent danger to self or others;
- (d) Mental confusion or fluctuating orientation poses an imminent danger to self or others (for example, severe self-care problems, violence, or suicide);
- (e) A concurrent serious emotional, behavioral, or cognitive disorder complicates the treatment of addiction and requires differential diagnosis and treatment;
- (f) Extreme depression poses an imminent risk to his/her safety;
- (g) Impairment of thought processes or abstract thinking, limitations in his/her ability to conceptualize, and impairment in ability to manage the activities of daily living pose an imminent risk to his/ safety;
- (h) Continued alcohol, tobacco, and /or drug use is causing grave complications or exacerbation of a previously diagnosed psychiatric, emotional, or behavioral condition;
- (i) Is experiencing altered mental status, with or without delirium, as manifested by 1) disorientation to self, 2) alcoholic hallucinosis, or 3) toxic psychosis.

IV. Readiness to change:

Only a patient who meets criteria in Dimensions 1,2 or 3 is appropriately placed in a level 4 program. Problems in dimension 4 alone are not sufficient for placement at level 4.

- V. *Relapse, continued use, or continued problem potential:*
Only a patient who meets criteria in Dimensions 1,2 or 3 is appropriately placed in a level 4 program. Problems in dimension 5 alone are not sufficient for placement at level 4.
- VI. *Recovery environment:*
Only a patient who meets criteria in Dimensions 1,2 or 3 is appropriately placed in a level 4 program. Problems in dimension 6 alone are not sufficient for placement at level 4.

D. Transfer/discharge Criteria

- 1) Has achieved the goals articulated in his/her individualized treatment plan, thus resolving the problems that justified admission to the present level of care. Continuing the chronic disease management of the condition at a less intensive level of care is indicated; **or**
- 2) Has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (either more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated; **or**
- 3) Has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his/her ability to resolve his/her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated; **or**
- 4) Has experienced an intensification of his/her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care. **AND**
- 5) The Six Dimensions

I. Acute intoxication and/or withdrawal potential:

Patient's intoxication or withdrawal problem has improved sufficiently to allow monitoring or withdrawal management services to be provided at a less intensive level of care. **Or** the condition has worsened to a point at which more intensive monitoring or withdrawal management services are required.

II. Biomedical conditions and complications:

Patient's physical health has improved sufficiently to allow biomedical services to be provided effectively at a less intensive level of care. **Or** the patient's condition has worsened to a point at which more intensive biomedical serves are necessary.

III. Emotional, Behavioral, or cognitive conditions and complications:

Functioning has improved sufficiently to allow interventions or services to be provided effectively at a less intensive level of care. **Or** the patient's condition has worsened to a point at which more intensive services are necessary.

IV. Readiness to change:

Patient's stage of readiness to change has improved sufficiently to allow interventions or strategies to be provided effectively at a less intensive level of care. **Or** has demonstrated sustained lack of interest in changing; or a lack of progress to such a degree that further

interventions at the present level of care will be ineffective and/or decrease the patient’s willingness to engage in treatment. Transfer to another level of care will permit the use of different strategies to engage the patient in treatment and enhance his/her readiness to change.

V. *Relapse, continued use, or continued problem potential:*

Coping skills have improved sufficiently that strategies to prevent relapse or continued use can be provided effectively at a less intensive level of care. **Or** has demonstrated a regression or lack of progress so significant that further interventions at the present level of care will not enhance his/her ability to prevent relapse or continued use, and/or will decrease the patient’s willingness to engage in treatment. Transfer to another level of service will allow different strategies to be employed to engage the patient in treatment and enhance his/her ability to prevent relapse or continued use.

VI. *Recovery environment:*

Patient’s environment and/or ability to cope with it have improved sufficiently to allow interventions or services to be provided effectively at a less intensive level of care. **Or** the patient’s recovery environment and/or ability to cope with it have worsened to such a degree that the patient requires transfer to another level of care, where different interventions or strategies can be provided.

E. Billing Instructions:

- 1) MCOs reimburse based on a negotiated rate.
- 2) Bill all services on a UB claim form utilizing a bundled daily rate
- 3) Acute care hospital facility fees for medical detoxification:
 - a. Can bill per diem vs DRG depending on contract with MCO
 - b. Per Diem reimbursement is based on bed type with the following rev codes for withdrawal management:

Rev Code	Description
0116	Room and Board – Private room
0126	Room and Board – Semi Private (Two Beds) Detoxification
136	Room and Board – Semi Private (Three or Four Beds) Detoxification
156	Room and Board - Ward
250	Pharmacy
260	IV therapy
270	Medical/ Surgical Supplies and Devices
300	Laboratory
320	Radiology - Diagnostic
450	Emergency Room
730	EKG
740	EEG

- c. Add revenue code 0229 and HCPCS code H0009 for WM tracking purposes.

d. Diagnostic related group (DRG) codes for withdrawal management:

895: Alcohol/ Drug Use Disorder treatment with rehabilitation therapy

896: Alcohol/ Drug Use Disorder treatment without rehabilitation therapy with major complications or comorbidities

896: Alcohol/ Drug Use Disorder treatment without rehabilitation therapy without major complications or comorbidities

Rehabilitation services can include: individual or psychotherapy using modalities such as CBT, MI, family therapy, etc and Medication Assisted Treatment for ongoing care to include initiation of buprenorphine, acamprosate, naloxone, Antabuse, etc.

5) Professional services for medical detoxification (withdrawal management):

Initial hospital Care: CPT codes 9922x series

Subsequent hospital care: CPT codes 9923x series

Discharge Day management: CPT codes 99238, 99239

Must be linked with relevant ICD code for substance use withdrawal

6) CCSS may also be billed for discharge planning and transition purposes