Behavioral Health Policy and Billing Manual

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Contents

Adult Accredited Residential Treatment Center for Substance Use Disorder (Adult AARTC)

Overview/Purpose

Adult Accredited Residential Treatment Centers (AARTC) provide residential or inpatient treatment for substance use disorder (SUD). Admission criteria and treatment at each level of care is based on ASAM's six dimensions. The State has organized ASAM level of care programming into three tiers. Each tier is tied to a separate reimbursement level and is organized as follows:

Tier	ASAM Level	ASAM Level of Care Description
Tier 1	3.1	Clinically Managed Low-Intensity Residential Services
Tier 2	3.2-WM	Clinically Managed Residential Withdrawal Management
	3.3	Clinically Managed Population-Specific High-Intensity Residential Services
	3.5	Clinically Managed High-Intensity Residential Services
Tier 3	3.7	Medically Monitored Intensive Inpatient Services
	3.7-WM	Medically Monitored Inpatient Withdrawal Management

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to AARTCs are below.

AARTCs must be accredited as an adult facility by the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). AARTCs must be certified through an application process by the Behavioral Health Services Division (BHSD). The BHSD application for agency certification is found on www.nmrecovery.org. Initial approval from BHSD will result in a two-year certification. As part of the initial approval process, a site visit will be required. Re-certification to operate as an AARTC will occur every two years thereafter and will also include a site-visit. A life and safety inspection may be performed by the HCA division of health improvement, as part of the certification process and ongoing re-certification. At its discretion, BHSD can conduct a site visit on the certified AARTC at any time. AARTCs are also required to communicate with BHSD to establish agency-specific reimbursement rates for each tier. Please reach out to aartc@nmrecovery.org for further questions.

Eligible Providers

General provider enrollment information can be found here.

AARTCs must be accredited and certified to provide the ASAM levels of care being delivered at the facility. Providers must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient. Providers must provide medication for opioid use disorder (MOUD).

Eligible Members

General member eligibility information can be found here.

Medicaid members must meet the ASAM criteria for admission for the level of care placement.

Covered and Non-covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to AARTCs are below.

Members must be placed in the level of care appropriate to the most acute problem identified in the assessment process. The Medicaid member assessed for a specific ASAM level of care can only be admitted to a facility that has been accredited and enrolled in the same ASAM level of care. The level of service and level of care is determined by the progress and outcomes of treatment, rather than a predetermined length of stay. Resolution of a Medicaid member's problems and priorities identified in the assessment process results in a transfer to a different level of care, referral to a different type of treatment, or treatment discharge. The following information describes services for ASAM levels 3.1, 3.2-WM, 3.3, 3.5, 3.7, and 3.7-WM.

ASAM Level 3.1: Clinically Managed Low-Intensity Residential Services

ASAM Level 3.1 AARTC facilities provides a minimum of five hours of low-intensity SUD treatment per week to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services include:

- Individual, group, and family therapy.
- Medication management.
- Psychoeducation.

Services focus on improving the Medicaid member's readiness to change (Dimension 4 or the most current version of ASAM) and/or functioning and coping skills (Dimensions 5 or the most current version of ASAM and 6). Services 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 Level 3.1 AARTCs provides the stability to prevent or minimize relapse or continued use and problem potential (Dimension 5 or the most current version of ASAM). The residential component is also 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. Interpersonal and group living skills are promoted by community or house meetings of residents and staff.

ASAM Level 3.2-WM: Clinically Managed Residential Withdrawal Management

ASAM Level 3.2-WM AARTC facilities provide 24-hour supervision, observation, and support for Medicaid members who are intoxicated or experiencing withdrawal. This level of care is characterized by its emphasis on peer and social support rather than medical and nursing care.

The Medicaid member 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) 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 individual 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 3.3: Clinically Managed Population-Specific High-Intensity Residential Services

ASAM Level 3.3 AARTC facilities 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. ASAM Level 3.3 programming is appropriate for Medicaid members for whom 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. Cognitive limitations make it unlikely that the Medicaid member could benefit from other levels or residential care.

If the Medicaid member has a temporary condition, they can be transferred to another level of care if they are no longer cognitively impaired. If the Medicaid member has a chronic condition (e.g., chronic brain syndrome, an older adult who has age and substance-related cognitive limitations, traumatic brain injury, or developmental disabilities) they continue to receive treatment in the ASAM Level 3.3 AARTC.

ASAM Level 3.5: Clinically Managed High-Intensity Residential Services

ASAM Level 3.5 AARTC facilities assist Medicaid members whose use of substances requires a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. 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. Instead, a person's treatment and recovery process are integrated into a flexible continuum of services.

Individuals in Level 3.5 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.

ASAM Level 3.7: Medically Monitored Intensive Inpatient Services

ASAM Level 3.7 AARTC facilities provide medically monitored, intensive inpatient services delivered by medical and nursing professionals. Medically monitored services 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.

Evaluation and monitoring services are provided 24-hours a day under the direction of a physician or clinical nurse practitioner. The physician or clinical nurse practitioner is available by phone 24-hours a day and 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 Medicaid members and to obtain and interpret information regarding the individual's needs.

ASAM Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management

ASAM Level 3.7-WM AARTC facilities provide medically monitored inpatient withdrawal management services. Services include a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the Medicaid member's understanding of substance use disorder, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. This level of care requires 24-hour hour nursing care and physician visits as needed for severe withdrawal.

A Medicaid member remains in a level 3.7-WM program until: 1) Withdrawal signs and symptoms are sufficiently resolved so that it can be managed at a less intensive level of

care; 2) 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 3) The individual 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.

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. Services are monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed. Protocols must be in place in case an individual's condition deteriorates and appears to need intensive inpatient withdrawal management interventions. Facilities must also arrange for appropriate laboratory and toxicology tests.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding AARTCs services is below.

Prior authorization is not required for up to five days for eligible Medicaid members who meet ASAM level three criteria to facilitate immediate admission and treatment to the appropriate level of care. During that five-day period, the AARTC must notify HCA about the admission, furnish medical necessity based on ASAM placement criteria, and obtain concurrent authorization if continued care is necessary from MAD or its designee, or the relevant MCO. Concurrent authorization for continued care is required prior to moving to a different level of care than the one the Medicaid member was originally admitted to. For out-of-state AARTCs, prior authorization is required prior to placement. Prior authorization for withdrawal management (ASAM Levels 3.2-WM and 3.7-WM) is not required.

For admission to a withdrawal management level of care (3.2-WM and 3.7-WM), the Medicaid member must have withdrawal signs and symptoms that are sufficiently severe to require 24-hour structure and support. The assessment for Level 3.2-WM and 3.7-WM includes the following:

- A substance use focused history which is reviewed with an MD/CNP/PA during the admission process.
- A physical exam by an MD/CNP/PA within 24-hours of admission and appropriate laboratory and toxicology tests.
- Sufficient biopsychosocial screening to determine the level of care.
- A treatment plan including problem identification in ASAM dimensions 2–6.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be

found here. Specific billing and claims requirements related to AARTCs are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

AARTCs should follow the billing guidance below for the respective tiers and levels of care. For all levels of care, the following also applies:

1. CCSS may also be billed for discharge planning and transitions.
2. 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. Agencies should use procedure code H0047 to bill for room and board. This funding is only available for AARTCs who are billing Medicaid fee-for-service and is not reimbursed by Medicaid managed care.
3. AARTCs use procedure code H0001 for an ASAM level of care assessment.

Tier	Billing Instructions
Tier 1 ASAM Level 3.1	1. Prior authorization is not required for an in state AARTC until five days from admission. 2. Out of State AARTC require prior authorization prior to placement 3. Prior authorization must occur prior to moving to a different level of care than the original admission. 4. Enter ordering or referring provider in attending provider field. 5. Agencies bill on a UB claim form with revenue code 1003 and procedure code H0019.
Tier 2 ASAM Level 3.2-WM ASAM Level 3.3 ASAM Level 3.5	1. Prior authorization is not required for an in state 3.3 and 3.5 AATRC until five days from admission. 2. Out of State AARTC require prior authorization prior to placement 3. 3.2-WM does not require prior authorization. 4. Prior authorization must occur prior to moving to a different level of care than the original admission. 5. Enter ordering or referring provider in attending provider field. 6. Agencies bill on a UB claim form with revenue code 1003 and procedure code H0018. 7. For 3.2-WM, agencies should add revenue code 0229 and HCPCS code H0010 for WM tracking purposes.
Tier 3 ASAM Level 3.7 ASAM Level 3.7-WM	1. Prior authorization is not required for an in state 3.7 AATRC until five days from admission. 2. Out of State AARTC require prior authorization prior to placement 3. 3.7-WM does not require prior authorization.

Tier	Billing Instructions
	4. Prior authorization must occur prior to moving to a different level of care than the original admission. 5. Enter ordering or referring provider in attending provider field. 6. Agencies bill on a UB claim form with revenue code 1003 and procedure code H0017. 7. For 3.7-WM, agencies should add revenue code 0229 and procedure code H0010 for WM tracking purposes.

Adult Accredited Residential Treatment Center (Adult AARTC) for Mental Health

Overview/Purpose

Adult Accredited Residential Treatment Centers (AARTC) provide residential or inpatient treatment for serious mental illness (SMI). Admission criteria and treatment at each level of care is based on ASAM's six dimensions. The State has organized LOCUS level of care programming into three tiers. Each tier is tied to a separate reimbursement level and is organized as follows:

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to AARTCs are below.

AARTCs must be accredited as an adult facility by the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). AARTCs must be certified through an application process by the Behavioral Health Services Division (BHSD). The BHSD application for agency certification is found on www.nmrecovery.org. Initial approval from BHSD will result in a two-year certification. As part of the initial approval process, a site visit will be required. Recertification to operate as an AARTC will occur every two years thereafter and will also include a sit visit. A life and safety inspection may be performed by HCA's Division of Health Improvement, as part of the certification process and ongoing recertification. At its discretion, BHSD can conduct a site visit on the certified AARTC at any time. AARTCs are also required to communicate with BHSD to establish agency-specific reimbursement rates for each tier. Please reach out to aartc@nmrecovery.org for further questions.

Providers must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

Eligible Providers

General provider enrollment information can be found here.

AARTCs must be accredited and certified to provide the LOCUS level of care 5 being delivered at the facility. Providers must provide Medication Assisted Treatment (MAT) or refer eligible recipients for medication assisted treatment (MAT) for SUD, if appropriate; to include access to buprenorphine and methadone, if appropriate and desired by the recipient.

Programs may not exclude recipients from receiving AARTC services on the basis of receiving or desiring to receive MAT services for SUD as indicated.

Eligible Members

General member eligibility information can be found here.

Medicaid members must meet the LOCUS criteria for admission for the level of care placement.

Covered and Non-covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to AARTCs are below.

Members must be placed in the level of care appropriate to the most acute problem identified in the assessment process. The Medicaid member assessed for a specific LOCUS level of care can only be admitted to a facility that has been accredited and enrolled in the same LOCUS level of care. The level of service and level of care is determined by the progress and outcomes of treatment, rather than a predetermined length of stay. Resolution of a Medicaid member's problems and priorities identified in the assessment process results in a transfer to a different level of care, referral to a different type of treatment, or treatment discharge. The following information describes services for LOCUS tiers 5c, 5b, and 5a.

Tier 5C: Moderate Intensity Long Term Residential Treatment Programs

This type of residential treatment facility has capacity to treat persons who are suffering from long term and persistent disabilities that require extended rehabilitation and skill building in order to develop capacity for community living. This category would include long term nursing and rehabilitation facilities. These facilities will provide intensive treatment as described for all Level 5 programs and the length of stay will vary from two months to a year.

Tier 5C Criteria

1. Meets criteria for LOCUS Level 5 (Medically Monitored Residential Services)

   AND

2. Meets at least one of the following specific criteria:

   - I.4d Clear and chronic compromise of ability to care adequately for oneself or to be adequately aware of environment.
   - II.3e Chronic and severe deficits in interpersonal skills, ability to engage in socially constructive activities and ability to maintain even minimal responsibilities.

- III.4a Chronic medical conditions exist which may require intensive medical monitoring.
- III.4b Chronic medical conditions exist which are seriously exacerbated by concurrent psychiatric or addiction problems which cannot be controlled outside a structured setting.
- III.4d Substance use is uncontrolled outside a structured setting and seriously destabilizes psychiatric disorder.
- V.4a–b Minimal past response to treatment and inability to maintain any gains achieved outside an intensive and highly structured setting.
- V.5a–b Symptoms are persistent despite extensive and intensive treatment exposure.
- VI.5a–d Chronic inability to understand disability, recovery, responsibility or to relate to other individuals.

Tier 5B: Moderate Intensity Intermediate Stay Residential Treatment Programs

This type of residential treatment facility has capacity to treat persons who are in need of rehabilitation and skill building following stabilization of a crisis situation or to prevent precipitous deterioration in functioning. It would provide an intensive treatment environment as described for all Level 5 programs. These programs are sometimes referred to as short-term residential rehabilitation facilities and length of stay usually does not exceed 60 days.

Tier 5B Criteria

1. Meets criteria for LOCUS Level 5 (Medically Monitored Residential Services)

   AND

2. Meets at least one of the following specific criteria:

   - I.3a–c Client may experience some ideation or have some history related to harm of self or others, but the current risk of engaging is such behaviors is relatively low.
   - II.3f Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting (Medically Managed Res. Rx).
   - II.4a Significant disturbance in interpersonal skills and interactions.
   - II.4e Serious impairment in expected role functioning at work, school, or home.
   - III.3d&f Co-occurring substance use and mental health disorders are both active and interact to seriously impede ability to enter recovery.
   - III.3e Substance use temporarily arrested in a highly structured or protected setting, but recovery is not initiated.

- III.4a–c Acute or unstable medical conditions exist which may require intensive medical monitoring, and which may be adversely affected by coexisting substance use or mental health issues.
- IV-A.3a–g Ongoing difficulties with life circumstances exceeding ability to cope and enter recovery process.
- IV-B.3.e Difficulty developing relationship with or using available sources of support.
- V.3a–c Previous treatment, particularly in less intensive levels of care, have not been successful.
- VI.3a–e Agrees to participate in intensive residential treatment, whether coerced or voluntarily, despite limited understanding of illness, desire to change, ability to accept responsibility, or to engage with caregivers or programs.

Tier 5A: Intensive-Short Term Residential Services

This type of residential treatment facility has capacity to treat persons who are stepping down from acute inpatient care or people who are in crisis but who do not require the security of a locked facility. These services are capable of providing intense treatment programming (as described for all Level 5 services) and they are sometimes referred to as subacute or respite care. Length of stay usually would not exceed 7–10 days.

Tier 5A Criteria

1. Meets criteria for LOCUS Level 5 (Medically Monitored Residential Services)

   AND

2. Meets at least one of the following specific criteria:
   - I.4a Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so.
   - I.4b History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
   - III.3a Intoxication with potential to develop a physiologic withdrawal syndrome, which may require significant medical monitoring.
   - III.3d Episodic substance use impacting the severity of the risk of harm or functional impairment.
   - IV-A.4a-g Recent or sudden exposure to traumatic event or circumstances impacting functional status.
   - IV-B.4a-d Recent deterioration in supportive structures impacting functional capacity.

- V.3b Past episodes of treatment have provided little or no benefit.
- V.4a Repeated past inpatient admissions with limited benefit.
- VI.3b Has limited desire or commitment to change.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding AARTCs services is below.

Prior authorization is not required for up to five days for eligible Medicaid members who meet LOCUS Level 5 criteria to facilitate immediate admission and treatment to the appropriate level of care. During that five-day period, the AARTC must notify HSD about the admission, furnish medical necessity based on ASAM placement criteria, and obtain concurrent authorization if continued care is necessary from MAD or its designee, or the relevant MCO. Concurrent authorization for continued care is required prior to moving to a different level of care than the one the Medicaid member was originally admitted to. For out-of-state AARTCs, prior authorization is required prior to placement. Prior authorization for Intensive-short term residential services (LOCUS Level 5a subacute or respite care) is not required.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General information on fraud and abuse can be found here. Specific billing and claims requirements related to AARTCs are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

AARTCs should follow the billing guidance below for the respective tiers and levels of care. For all levels of care, the following also applies:

1. CCSS may also be billed for discharge planning and transitions.
2. 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. Agencies should use procedure code H0047 to bill for room and board. This funding is only available for AARTCs who are billing Medicaid fee-for-service and is not reimbursed by Medicaid managed care.
3. AARTCs use procedure code ****** for a LOCUS level of care assessment.

Applied Behavior Analysis (ABA)

Overview/Purpose

New Mexico's Medical Assistance Division (MAD) pays for medically necessary, empirically supported, applied behavior analysis (ABA) services for Medicaid eligible members who are diagnosed with autism spectrum disorder (ASD) or at-risk of ASD. ABA services are delivered in a comprehensive three-stage approach, consisting of evaluation, assessment, and treatment. ABA services may be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, developmentally disabled waiver services, etc.).

Definitions of terms pertaining to this manual can be found here.

Eligible Members

General member eligibility information can be found here.

ABA is a covered benefit for Medicaid eligible members over 12 months of age who are either at-risk for ASD or are diagnosed with ASD. The criteria for "at-risk for ASD" and "diagnosed with ASD" is described below. ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program for Medicaid members between the ages of 12-months and 21 years of age.

- **At-Risk for ASD:** A Medicaid eligible member is considered "at-risk" for ASD and therefore eligible for time-limited ABA services, if they do not meet full criteria for ASD based on the latest version of the diagnostic statistical manual (DSM) or international classification of diseases (ICD). To be considered "at-risk," the Medicaid eligible member must:
  - Be between 12 and 36 months of age.
  - Present with developmental differences and delays as measured by standardized assessments.
  - Demonstrate some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior).
  - Present with at least one genetic risk factor (e.g., genetic risk due to having an older sibling with a well-documented ASD diagnosis; eligible member has a diagnosis of Fragile X syndrome).
- **Diagnosed with ASD:** A Medicaid eligible member is considered "diagnosed with ASD" when they have a documented medical diagnosis of ASD based on the latest version of the DSM or the ICD at any time in their life.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to ABA are below.

ABA treatment is intended to develop adaptive behaviors (e.g., social, communication skills), and reduce maladaptive behaviors (e.g., self-injury, property destruction) to enhance healthy, successful functioning and prevent deterioration and regression for individuals with ASD or who are at-risk of ASD. Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number of behavioral targets, specific aspects of those behaviors, and the Medicaid eligible member's response to treatment protocols help determine which model is most appropriate (focused ABA treatment, or comprehensive ABA treatment).

This section summarizes the general ABA treatment models, screening for ABA services, the three stages of ABA treatment (including covered services and steps), and non-covered ABA services.

ABA Treatment Models

There are two general treatment ABA treatment models: 1) focused ABA treatment; and 2) comprehensive ABA treatment. A focused ABA treatment model is appropriate for members who either need treatment only to develop a limited number of key functional skills or have such risky problem behavior that its treatment should be the priority. Focused ABA treatment generally ranges from 10–25 hours per week of direct treatment (plus direct and indirect supervision and caregiver training). However, certain programs for severe destructive behavior may require more than 25 hours per week of direct therapy (e.g., day treatment or inpatient program for severe self-injurious behavior).

A comprehensive ABA treatment model is provided when there are multiple targets across most or all developmental domains that are affected by the Medicaid eligible member's ASD. Treatment often involves an intensity level of 30-40 hours of 1:1 direct treatment to the client per week. In some cases, direct treatment hours increase gradually, are maintained at maximum intensity for a period and are then systematically decreased in preparation for focused approach. In other cases, treatment may begin at maximum levels.

For an individual who meets the "at-risk for ASD" criteria, comprehensive ABA services are available from age 12 months up to three years of age. For EPSDT-aged Medicaid members, the overarching goal of comprehensive treatment is to close the gap between the individual's level of functioning and that of typical peers. For adult Medicaid members, the goal of comprehensive treatment is to: 1) treat multiple domains across many different environments, particularly if there are severe or high-risk behaviors; 2) ensure continuity of care and generalization across environments/providers; and 3) improve participation in routines to maintain good health (e.g., dental/medical exams) and independent living.

Screening

ASD and “at-risk for ASD” screening occurs before Stage 1 services are rendered. ASD and “at-risk for” ASD screening can be completed by a variety of practitioners, including:

- Primary care provider
- Licensed health care practitioner (e.g., speech-language pathologist, occupational therapist)
- Medicaid enrolled behavioral health practitioner who is a LPCC, LISW/LCSW, psychologist, CNP or CNS, LMHC, or LMSW who also has qualifications to render a Level 2 screening
- Department of Health (DOH) Family Infant Toddler (FIT) Program Service Coordinator, if the Medicaid eligible member is concurrently being evaluated for or receiving FIT services
- School-based health or educational professional involved in the Medicaid eligible member’s special education eligibility determination process

Screening tools may include Level 1 screener (e.g., Modified Checklist for Autism in Toddlers, Revised with Follow-Up; M-CHATR/F™ or Social Communication Questionnaire; SCQ) or Level 2 screener (e.g., the 7 Screening Tool for Autism in Toddlers™; STAT™). Use of Level 2 screening tools is encouraged, but not required. Providers are also encouraged to gather additional information through another clinical assessment mechanism whenever the Level 1 screener result is inconsistent with other clinical data. If the screening results are positive, the referring practitioner may then refer the individual to an autism evaluation provider (AEP) for ABA Stage 1 services.

Three Stages of Treatment

ABA covered services are provided in three stages and are continued until the Medicaid eligible member no longer meets the ABA service criteria. This may happen when the results of a comprehensive diagnostic evaluation (CDE), targeted evaluation, integrated service plan (ISP), or treatment plan is updated and placement in a higher, more intensive, or more restrictive level of care is recommended instead of ABA services.

A Medicaid member is discharged from ABA when: 1) symptoms related to ASD have been remediated; 2) symptoms related to ASD no longer cause clinically significant impairment, resulting in functional limitations that constitute a barrier to quality of life; 3) Symptoms no longer interfere significantly with home, community, and age-appropriate activities.

Stage 1

In Stage 1, a Medicaid member is referred to an autism evaluation provider (AEP) after screening positive for ASD. The AEP conducts a comprehensive diagnostic evaluation (CDE) or targeted evaluation to confirm the presence of and diagnosis of ASD, develops the Integrated Service Plan (ISP), recommends ABA Stage 2 services, and refers the Medicaid member to an approved ABA provider agency.

A targeted evaluation is used when the Medicaid eligible member has an ASD diagnosis and presents with behaviors that are changed from the last CDE. An ASD risk evaluation (also referred to as “targeted risk evaluation”) is used for Medicaid eligible members who meet the “at-risk for ASD” criteria. For an eligible Medicaid member who has an existing ASD diagnosis, diagnostic re-evaluation is not necessary, but the development of an ISP and the determination of the medical necessity for ABA services are required.

A Medicaid eligible member with a diagnosis of ASD may be referred for ABA Stage 2 and Stage 3 services by providers other than AEPs. This process is referred to as the “grace exception.” MAD recognizes ASD diagnosis by a licensed provider whose scope of practice allows them to render a diagnosis of ASD.

For Medicaid eligible members who have previously been diagnosed with ASD, the CDE or targeted risk evaluation must be scheduled prior to accessing ABA Stage 2 and approved Stage 3 services.

Stage 2
In Stage 2, a behavior or functional analytic assessment is completed, an ABA service model is determined, and a treatment plan development is developed. The family, eligible Medicaid member (as appropriate for age and developmental level), and the ABA practitioner work collaboratively to make a final determination on the clinically appropriate ABA service model, with consultative input from the AEP as needed. A behavior or functional analytic assessment addressing needs associated with skill acquisition is conducted, and an individualized ABA treatment plan (as appropriate for the ABA service model) is developed by the supervising BA.

The BA is responsible for completing all of the following services:

- The Medicaid member’s assessment
- Selection and measurement of goals
- Treatment plan

Stage 3
In Stage 3, the Medicaid member receives treatment according to the treatment plan. ABA Stage 3 services require prior authorization and may vary in terms of intensity, frequency and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. All Stage 3 services require clinical management. If a BAA or a BT is implementing the treatment plan, the BAA or BT requires frequent, ongoing case supervision from his or her BA or supervising BAA. The Behavior Analyst Certification Board (BACB®) requires at least 5% of service hours provided to be supervised.

MAD recognizes for Stage 3 ABA treatment to be effective, it must be generalized across all-natural environments. MAD supports the delivery of ABA Stage 3 in all the following natural environments:

- Home
- School
- Clinics, hospitals, outpatient services (physical and behavioral health)
- Childcare centers
- Alternative living arrangements (such as but not limited to assisted or supportive living/housing, residential or institutional location such as ARTC/RTC/Group/TFC, nursing facilities)
- Respite care
- Day habilitation
- Vocational or other educational classes
- Community-based settings (e.g. stores, places of recreational or socialization)
- Place of work

MAD allows additional units of services and prior authorization easements in order to keep an adult Medicaid member in their home and community (described in the table below). Additional service allowances are intended to recognize the length of time an adult Medicaid eligible member may access ABA services, the number of changes an adult will encounter in the course of their lives, and as many adults are entering into ABA services for the first time with patterns of behaviors learned over time.

Adult ABA Tiers		
Tier	**Description**	**Hours authorized for a combination of codes 97153, 97154, and 97158** ****The service codes for 97155, 97156, 97157 and T1026 UD are not included in the maximum number of hours.*
Tier 1	Maintenance for adult Medicaid members who require ABA services in reduced amounts to assist the eligible member to maintain their positive behaviors that continue to be stabilized due to continued ABA services or gains made in Adult ABA Tier Two or Three services. Adult ABA Tier One services support an eligible member to reduce utilization of Tier Two and Three services.	Maximum of 10 to 15 hours per week for combined service codes.
Tier 2	Intervention Services For adult Medicaid members experiencing life events that disrupt their normal life qualify for Adult ABA Tier Two services. Tier Two is appropriate for an adult Medicaid member who has	Maximum of 20 to 30 hours per week for up to six weeks without prior authorization.

Adult ABA Tiers		
Tier	**Description**	**Hours authorized for a combination of codes 97153, 97154, and 97158** ****The service codes for 97155, 97156, 97157 and T1026 UD are not included in the maximum number of hours.*
	skill deficits across multiple domains and requires a higher dosage of treatment to ensure continuity across multiple settings, caregivers, etc. to improve treatment outcomes. Events include and are not limited to: • Illness of self or caregiver resulting in the eligible individual's adaptive coping responses becoming maladaptive. • Multiple service settings and multiple staff or caregivers, such as an eligible individual who is residing in a residential setting, has day habilitation, and interactions with parents. • Movement from current living situation to a new living situation, thus disrupting their patterns of daily resulting in the eligible individual's adaptive coping responses becoming maladaptive. • Addition of new services that introduce new expectations or new staff that disrupt their patterns of daily living resulting in the eligible individual's adaptive coping responses becoming maladaptive.	
Tier 3	High-Risk Intervention Services For adult Medicaid eligible members experiencing destructive or self-injurious behavior, or behavior injurious to others, resulting in the eligible individual's adaptive coping responses becoming maladaptive such as the eligible individual possibility accessing emergency room services, inpatient services, or incarceration. Accessing adult ABA 3 Tier 3 services does not necessarily require the Medicaid eligible member to first access adult ABA Tier 2 services. After Adult ABA Tier 3 services, a Medicaid eligible member under most situations will enter Adult ABA Tier 2 services.	Maximum of 30 to 40 hours per week for up to eight weeks without prior authorization.

Non-Covered Services

The following are non-covered ABA services:

- Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA treatment plan.
- Activities that are not based on the principles and application of ABA.
- Activities that take place in school settings and have the potential to supplant educational services.
- Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the practitioner has expertise in the provision of ABA.
- Activities which are better characterized as staff training certification or licensure or certification supervision requirements, rather than ABA case supervision.

Eligible Providers

General provider enrollment information can be found here. General information on requirements for out-of-state and border area providers can be found here.

All ABA providers are required to successfully complete a criminal background and registry check. Each provider also has specific MAD Medicaid provider enrollment requirements.

ABA services are rendered by a number of providers and practitioners, including but not limited to:

- **Autism Evaluation Provider (AEP):** The AEP completes the Comprehensive Diagnostic Evaluation (CDE), ASD risk evaluation, or targeted evaluation and develops the Integrated Service Plan (ISP) for a Medicaid eligible member.
- **Behavioral Analyst (BA) Candidate:** A non-certified BCBA who has: 1) attained their master's degree from an accredited university which the Behavior Analyst Certification Board (BACB) recognizes towards earning a Board-Certified Behavior Analyst (BCBA) certificate; and 2) completed the BACB's BCBA coursework requirements and have completed at least 50% of defined practical experience in ABA. The BA Candidate must complete the remainder of the BACB's requirements and hold their BCBA within one year of the first date of service. If the candidate fails to hold the BCBA certificate within this timeframe, they must stop rendering ABA stage 2 & 3 services until they hold a BCBA. At that time, they must submit a new attestation. They must complete the BACB's Professional and Ethical Compliance Code for Behavior Analysts. All changes will be reported in their certification status in-between renewals immediately to their agency and to the MAD ABA Manager and each HCA-contracted MCOs. The Candidate has also successfully completed the New Mexico criminal background registry check prior to rendering ABA services and is in compliance with the New Mexico Administration Code (NMAC) rules and any subsequent supplements or policy and billing manuals to render ABA Stage 2 (Assessments) and ABA Stage 3 (Intervention Services).

- **Behavior Analyst (BA):** BAs must be: 1) a board-certified behavior analyst (BCBA® or BCBA-D®) by the Behavior Analyst Certification Board (BACB®); or 2) a psychologist who is certified by the American Board of Professional Psychology in behavior and cognitive psychology and who has ABA as part of their certification. BAs may render the behavior analytic assessment, service model determination, and treatment plan development and Stage 3 services-implementation of an ABA treatment plan. A "Mentored BA" is a BA who has been certified less than three years and is supervised by a BA with at least three years of BA supervision experience.
- **Behavior Analyst Assistant (BAA):** BAAs must be a board-certified assistant behavior analyst (BCaBA®) by the BACB®. BAAs may assist their supervising BA in rendering: 1) The behavior or functional analytic assessment, service model determination, and ABA treatment plan development in Stage 2; and 2) Services implemented in the ABA treatment plans in Stage 2, when the supervising provider determines that the BAA has the skills and knowledge to render such services.
- **Behavioral Technician (BT):** BTs are supervised by a BA. BTs may assist in ABA Stage 2 and Stage 3 interventions and services.
- **Board Certified Autism Technician® (BCAT®)**: A practitioner who is certified by the Behavioral Intervention Certification Council. The BCAT is included in the term BT. A BCAT is supervised by a BA, and if approved, a BAA.
- **Applied Behavior Analysis Technician (ABAT)**: A practitioner who is certified by the Qualified Applied Behavior Analysis Credentialing Board (QABA). The ABAT is included in the term BT. A ABAT is supervised by a BA, and if approved, a BAA.
- **Board Certified Registered Behavior Technician (RBT):** A practitioner who is certified by the BACB. The RBT renders ABA Stage 2 and 3 services under the supervision of a BA or, if approved, a Supervising BAA. A RBT is included in the term BT.
- **Stage 3 ABA Specialty Care Provider:** ABA specialty care services provide different areas of specialization of ABA Stage 3 services (e.g., aggression or self-injury). The specialty care provider must be a BCBA, BCBA-D or a Qualifying Psychologist. A qualifying psychologist must possess and maintain their license and a BCBA or BCBA-D must possess and maintain BACB certification. Specialty Care Providers must also submit an attestation to demonstrate they have skills, training, and clinical experience to oversee and render ABA services to highly complex eligible individual who require specialized ABA services. This attestation can be found at the following link: https://www.hsd.state.nm.us/wp-content/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Billing%20Instructions/Specialty-Care-Practitioner-Attestation-20201.pdf**.**

Instructions for Residential Facility or Institutional Setting

A Medicaid eligible member who meets the criteria for ABA services and is in a residential treatment center, accredited residential treatment center, or a group home may receive ABA services to the extent that the residential provider is able to provide the services. In cases

where the residential facility or institution is not an ABA provider for Stage 2 and Stage 3 services, the facility/institution is required to locate an ABA provider and develop an agreement allowing that provider to provide Stage 2 and Stage 3 services at the facility/institution. Reimbursement for ABA Stage 2 and three services is made to the MAD enrolled ABA provider, not the residential facility.

A Medicaid member in a treatment foster care (TFC) placement, is not considered to be in a residential facility and they may receive ABA services outside of the TFC agency.

Instructions for ABA Telehealth Providers
The BICC, BACB, and New Mexico Regulation and Licensing Department (RLD) psychologist's practice board allows and supports the use of telehealth to deliver ABA services and the HCA does not require in-state ABA providers to have a telemedicine license. However, if the AEP is an out-of-state provider, the New Mexico Medical Board does require this practitioner to obtain a telemedicine license (or a full New Mexico medical license).

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding ABA services is below.

Prior authorization is required for ABA stage 2 and 3 services. Prior Authorization is the period of time in which ABA stage 2 and 3 services are approved, so long as the Medicaid member has an ASD diagnosis and continues to demonstrate medical necessity for services. The prior authorization period for a Medicaid eligible member between the age of 12 months and eight years is three years, and six years for those who are age eight and older.

After a Medicaid eligible member has ABA service, prior authorization is required before Stage 3 services are rendered, and every six months thereafter. To secure the initial and ongoing prior authorization for Stage 3 services, the ABA provider must submit the prior authorization request to the HCA's utilization review contractor, with the information listed below. Changes to the ISP may be executed prior to the biannual review of prior authorization to preserve the health and wellbeing of the individual receiving ABA services.

- The CDE/targeted evaluation and the Integrated Service Plan (ISP) developed in Stage 1 and the ABA treatment plan developed in Stage 2.
- The ABA treatment model, including the maximum hours of services requested per week.
- The number of case supervision hours requested per week, if more than two hours of supervision per 10 hours of intervention is requested.
- The number of clinical management hours requested per week, if more than two hours of clinical management per 10 hours of intervention is requested.
- ABA specialty care, if that need has been identified for the treatment plan. After services have begun, the AP agency may refer the eligible Medicaid member to a SCP for a

focused behavior or functional analytic assessment focusing on the specific care needs of the eligible individual. The SCP will then request a prior authorization for specialty care services to the State contracted utilization review entity.

- Hours allocated to other services in the ISP (e.g., early intervention through FIT, physical therapy, speech and language therapy) so the State contracted utilization review entity can determine if the requested intensity (i.e., hours per week) is feasible and appropriate.

In cases when a Medicaid eligible member's behavior exceeds the expertise of the ABA provider, or logistical/practical ability of the ABA provider to fully support the member, the ABA provider must refer the member to an ABA specialty care provider to intervene. The State contracted utilization review entity will approve a prior authorization to the ABA specialty care provider to complete a targeted assessment, including a functional assessment, and provide the primary ABA provider with, or to implement by the Medicaid eligible member, individualized interventions to address the behavioral concerns for which the referral is based on medical documentation.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to ABA are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Providers should reference the appropriate codes, code limits, and service authorization requirements below for ABA specific services.

ABA Stage 1 Services			
Service	**Procedure Code**	**Unit Limits (one unit is 60 minutes)**	**Billing/Service Description**
Comprehensive Diagnostic Evaluation (CDE)	T1026 TG	One unit per day	• Partial billing for each unit (25% of one unit for 8-22 minutes; 50% for 23-37 minutes; 75% for 38-52 minutes; 100% for 53-67 minutes). • A ISP must be completed after a CDE. • Do not bill concurrently for a ISP update.
Targeted/Risk Evaluation	T1026 HK	Five 60-minute units for each evaluation	• An EPSDT member must have a CDE prior to completing a Targeted/Risk Evaluation. • An ISP must be completed after the Targeted/Risk Evaluation. • Do not bill concurrently for a CDE or ISP update.

ABA Stage 1 Services			
Service	**Procedure Code**	**Unit Limits (one unit is 60 minutes)**	**Billing/Service Description**
Integrated Service Plan (ISP)	T1026 TG/HI	Three units	• Completed after a CDE and/or a Targeted/Risk Evaluation. • ABA Stage 2 and 3 services may be billed while the ISP is being completed. • Do not bill concurrently for ISP update.
ISP Update	T1026 HK/HI	Two units	• ISP is updated when a Medicaid member needs no longer aligns with their current ISP and the AEP determines that a new CDE and/or Targeted/Risk Evaluation is not medically warranted. • ABA Stage 2 and 3 services may be billed while the ISP update is being completed. • Do not bill concurrently for CDE, Targeted/Risk Evaluation, or ISP.

ABA Stage 2 and 3 Assessment and Treatment Planning				
Service	**Procedure Code**	**Unit Limits Per Day (one unit is 15 minutes)**	**Billing Provider**	**Billing/Service Description**
Behavior Identification Assessment	97151	General limit of eight units with several exceptions. Total units may not exceed 25 units in one day (five hours total).	• BA • Mentored BA	• Must be completed annually or more frequently, as appropriate. • Administered by a qualified health professional. • Face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations. • Non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.

ABA Stage 2 and 3 Assessment and Treatment Planning				
Service	**Procedure Code**	**Unit Limits Per Day (one unit is 15 minutes)**	**Billing Provider**	**Billing/Service Description**
				• All ABA Stage 3 services continue as prior authorized. • Do not bill concurrently with 0373T.
Behavior Identification Supporting Assessment	97152	General limit of eight units with several exceptions. Total units may not exceed 32 units in one day (eight hours total).	• BA • Mentored BA	• A Behavior Identification Assessment must be in process to bill the Supporting Assessment. • Administered by one technician under the direction of QHP. • Face-to-face with the patient. • Do not bill concurrently with 0373T.
	0362T	General limit of eight units with several exceptions. Total units May not exceed 32 units in one day (eight hours total).	• Specialty Care Practitioner	• A Behavior Identification Assessment must be in process to bill the Supporting Assessment. • Administered by more than one technician. • Face-to-face with one patient, requiring four components: 1) QHP on site; 2) assistance of two or more technicians; 3) patient with destructive behavior; and 4) environment customized to patient behavior.
Adaptive Behavior Treatment by Protocol	97153: Individual 97154: Group			• Administered by technician under the direction of a QHP. • Face-to-face with one patient for individual service or two or more patients for group service.

ABA Stage 2 and 3 Assessment and Treatment Planning				
Service	**Procedure Code**	**Unit Limits Per Day (one unit is 15 minutes)**	**Billing Provider**	**Billing/Service Description**
	0373T code requires prior authorization		• Specialty Care Practitioner	• Administered by more than one technician. • Face-to-face with one patient, requiring four components: 1) QHP on site; 2) assistance of two or more technicians; 3) patient with destructive behavior; and 4) environment customized to patient behavior. • Do not bill concurrently with 97151, 97152, T1026 UD.
Adaptive Behavior Treatment with Protocol Modification	97155: Individual 97158: Group	At least four 15-minute units (one hour) of 97155 must be rendered for every eighty 15-minute units or 20 hours of combined 97153, 97154 and 97156. Higher limits for ABA adult tiers (please reference ABA Adult Tiers under “Covered/ Non-Covered” Section).	• BA • Mentored BA • Supervising BAA	• Administered by QHP, which may include simultaneous direction of technician. • Face-to-face with one patient or two or more patients for group service.
Family Adaptive Behavior	97156: One Family 97157: Two or more Families		• BA • Mentored BA • Supervising BAA	• Administered by QHP (with or without patient present). • Face-to-face with guardian(s)/caregiver(s).

ABA Stage 2 and 3 Assessment and Treatment Planning				
Service	**Procedure Code**	**Unit Limits Per Day (one unit is 15 minutes)**	**Billing Provider**	**Billing/Service Description**
Treatment Guidance				
ABA Stage 3 Clinical Management and Indirect/Direct Case Supervision	T1026 UD		• BA • Mentored BA • Supervising BAA	T1026 UD may be billed concurrently with: • 97153 • 97154 • 97155 (without telemedicine) • 97156 (rendered by a BA to a Mentored BA/BAA) • 97157 (rendered by a BA to a Mentored BA) • 97158 (rendered by a BA to a Mentored BA) Do not bill concurrently with 0373T.

ASAM Level 1 and 1-WM (Outpatient SUD Services)

Overview/Purpose

ASAM Level 1 is a low-intensity SUD treatment program that is provided in an outpatient setting and provides flexibility to meet treatment needs of Medicaid members at different stages of treatment. ASAM Level 1-WM without 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.

Definitions of terms pertaining to this manual can be found here.

Eligible Providers

General provider enrollment information can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to ASAM Level 1 are below.

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.

ASAM Level 1-WM without 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.

Eligible Members

General member eligibility information can be found here.

ASAM Level 1 is appropriate in many situations as an initial level of care for Medicaid members:

- With less severe disorders for those who are in early stages of change.
- As a "step down" from more intensive services.
- For those who are stable and for whom ongoing monitoring or disease management is appropriate.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to ASAM Level 1 are below.

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, outpatient crisis intervention and stabilization, the opioid treatment program, and for MCO members only family support services and recovery support services.

Adult services for ASAM Level 1 programs are provided less than nine hours weekly, and adolescents' services are provided less than six hours weekly. Individuals recommended for more intensive levels of care may receive more intensive services.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding ASAM Level 1 is below.

Prior authorization for ASAM Level 1 is not required. The ASAM admission criteria adolescents and adults are described in the table below.

ASAM Level 1 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
Dimension 1: Acute intoxication and/or withdrawal potential	No signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a Level 1 setting and: 1. Is not experiencing acute or subacute withdrawal from alcohol or other drugs, and is not at risk of acute withdrawal; **or** 2. If experiencing very mild withdrawal, the symptoms consist of no more than lingering but improving sleep disturbance.	No signs or symptoms of withdrawal, or his/her withdrawal needs can be safely managed in a Level 1 setting.
Dimension 2: Biomedical	Biomedical conditions and problems, if any, are sufficiently stable to permit participation in outpatient treatment.	If any, characterized by biomedical conditions or problems that are sufficiently stable to permit participation in outpatient treatment. Examples

ASAM Level 1 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
conditions and complications		include uncomplicated pregnancy or asymptomatic HIV disease.
Dimension 3: Emotional, behavioral, or cognitive conditions and complications	All of the following are true: 1. Dangerousness/lethality: Assessed as not posing a risk of harm to self or others. They have adequate impulse control to deal with any thoughts of harm to self or others. 2. Interference with recovery efforts: The adolescents' emotional concerns relate to negative consequences and effects of substance use, and he/she is able to view them as part of 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. 3. 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). 4. Ability for self-care: Has adequate resources and skills to cope with	<u>All Programs</u> The individual meets (1) or (2) and both (3) and (4): 1. 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 treatment issues. 2. 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. 3. The individual's mental status does not preclude their ability to 1) understand the information presented and 2) participate in treatment planning and the treatment process. 4. They are assessed as not posing a risk of harm to self or others and is not vulnerable to victimization by another. **Co-Occurring Programs** In addition to the criteria for all programs, the patient's status in

ASAM Level 1 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
	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. 5. 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.	Dimension 3 is characterized by either (1), or all of (2) and (3) and (4): 1. Severe and chronic mental illness that impairs their ability to follow through consistently with mental health appointments and psychotropic medication with the ability to access services such as assertive community treatment and intensive case management or supportive living designed to help them remain engaged in treatment. 2. Severe and chronic mental disorder or other emotional, behavioral, or cognitive problems, or substance induced disorder. 3. Mental health functioning has impaired ability to: understand information presented, participate in treatment planning and the treatment process. Mental health management is required to stabilize mood, cognition, and behavior. 4. Assessed as not posing risk of harm to self or others and is not vulnerable to victimization by another.
Dimension 4: Readiness to change	The individual meets (1) **and one** of (2), (3), **or** (4): 1. Expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan. 2. Acknowledges that he/she has a substance-related or other addictive disorder and/or mental health problem and wants help to change. 3. 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. 4. May not recognize that they have 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.	
Dimension 5: Relapse, continued	Able to achieve or maintain abstinence and related recovery goals. Or is able to achieve awareness of a substance or	**All Programs**

ASAM Level 1 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
use, or continued problem potential	other addiction problem and related motivational enhancement goals only with support and scheduled therapeutic contact.	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.
Dimension 6: Recovery environment	The adolescent's status is characterized by (1), **or** (2), **or** (3): 1. 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). 2. Does not have an adequate primary or social support system, but he/she has demonstrated motivation and	**All Programs** The patient's status is characterized by (1), **or** (2), **or** (3): 1. 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). 2. Does not have an adequate primary or social support system, but he or

ASAM Level 1 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
	willingness to obtain such a support system. 3. Family, guardian, or significant others are supportive but require professional interventions to improve the adolescents chance of treatment success and recovery.	she has demonstrated motivation and willingness to obtain such a support system. 3. 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 criteria for all programs, the patient's status in Dimension 6 is characterized by (1), **or** (2), **or** (3): 1. 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. 2. 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. 3. 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

ASAM Level 1 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
		stabilizing both the substance use or other addictive disorder and mental disorders.

Billing and Claims Requirements

General billing and claims requirements can be found here. Specific billing and claims requirements related to ASAM Level 1 are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies bill the appropriate procedure code for the service being provided and should reference the codes described in the Behavioral Health Professional Services for Screenings, Evaluations, Assessments, and Therapies Manual. [PLACEHOLDER FOR BEHAVIORAL HEALTH PROFESSIONAL SERVICES FOR SCREENINGS, EVALUATIONS, ASSESSMENTS, AND THERAPIES MANUAL].
2. When billing for ASAM Level 1-WM, providers should also use procedure code H0014 for withdrawal management tracking purposes.

ASAM Level 2-WM (Ambulatory Withdrawal Management with Extended On-Site Monitoring)

Overview/Purpose

ASAM Level 2-WM (Ambulatory Withdrawal Management with Extended On-Site Monitoring) are outpatient treatment services that provide for safe withdrawal in an ambulatory setting. ASAM Level 2-WM is provided 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.

Definitions of terms pertaining to this manual can be found here.

Eligible Providers

General provider enrollment information can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to ASAM Level 2-WM are below.

ASAM Level 2-WM services may be delivered in an office setting, a general health care or behavioral health care facility, or a substance use disorder treatment facility. Services are monitored by a physician or nurse practitioner, who does not need to be on-site, but must be available to evaluate and confirm that withdrawal management in this less supervised setting is safe.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for ASAM Level 2-WM services are those who have been assessed for medical necessity.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to ASAM Level 2-WM are below.

Covered services 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.

The Medicaid member continues in ASAM Level 2-WM services until:

- Withdrawal signs and symptoms are sufficiently resolved;

- 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
- The patient is unable to complete withdrawal management at level 2-WM, despite an adequate trial, indicating a need for more intensive services.

Authorization

General prior authorization and utilization review information can be found here. ASAM Level 2-WM does not require prior authorization.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to ASAM Level 2-WM are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Providers use the procedure code from the outpatient service the person is receiving (e.g., crisis intervention services).
2. Providers should also use procedure code H0014 for withdrawal management tracking purposes.

ASAM Level 4 (Medically Managed Intensive Inpatient Services)

Overview/Purpose

ASAM Level 4 services (Medically Managed Intensive Inpatient Services) are delivered in an acute care inpatient setting and intended for individuals whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. ASAM Level 4 services are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the Medicaid member. ASAM Level 4 offers specialty substance use disorder 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.

Definitions of terms pertaining to this manual can be found here.

Eligible Providers

General provider enrollment information can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to ASAM Level 4 are below.

Joint Commission (JC) certified psychiatric hospitals and State Department of Health Institution for Mental Diseases (IMDs) are eligible to provide ASAM Level 4 programming.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for ASAM Level 4 services are adolescents and adults who have been assessed for medical necessity.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to ASAM Level 4 are below.

Placement in an ASAM 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 (see admission criteria in the table below). A referral from an independent practitioner or a transfer from the emergency department is required, and the physician in the hospital or IMD must accept the patient.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding ASAM Level 4 services is below.

Prior authorization for ASAM Level 4 placement is required. The ASAM admission criteria adolescents and adults are described in the table below.

ASAM Level 4 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
Dimension 1: Acute intoxication and/or withdrawal potential	Characterized by one of the following: 1. 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. 2. 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. 3. Drug overdose or intoxication has compromised the adolescent's mental status, cardiac function, or other vital signs or functions. 4. 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).	The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical conditions; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.
Dimension 2: Biomedical conditions and complications	Characterized by one of the following: 1. Biomedical complications of the addictive disorder require medical management and skilled nursing care.	Characterized by one of the following: 1. Biomedical complications of the addictive disorder require medical management and skilled nursing care.

ASAM Level 4 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
	2. A concurrent biomedical illness or pregnancy requires stabilization and daily medical management, with daily primary nursing interventions. 3. 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. 4. The adolescent's alcohol, tobacco, and/or other drug use is gravely complicating or exacerbating a previously diagnosed medical condition. 5. Changes in medical status, such as significant worsening of a medical condition, make abstinence imperative. 6. Significant improvement in a previously unstable medical condition allows the adolescent to respond to treatment. 7. Has other biomedical problems that require twenty-four (24) hour observation and evaluation.	2. A concurrent biomedical illness or pregnancy requires stabilization and daily medical management, with daily primary nursing interventions. 3. 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. 4. Is experiencing recurrent or multiple seizures. 5. Is experiencing a disulfiram-alcohol reaction. 6. Has life-threatening symptoms (such as stupor or convulsions) that are related to use of alcohol, tobacco, and/or other drugs. 7. Patient's alcohol, tobacco, and/or other drug use is gravely complicating or exacerbating a previously diagnosed medical condition. 8. Changes in the patient's medical status, such as significant worsening of a medical condition, make abstinence imperative. 9. Significant improvement in a previously unstable medical condition allows the patient to respond to treatment. 10. Has another biomedical problem that requires twenty-four (24) hour observation and evaluation.
Dimension 3: Emotional, Behavioral, or cognitive conditions and complications	Characterized by one of the following: 1. 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. 2. Interference with Recovery Efforts: Is unable to focus on recovery	Characterized by one of the following: 1. Emotional, behavioral, or cognitive complications of the patient's addictive disorder require psychiatric management and skilled nursing care. 2. A concurrent emotional, behavioral, or cognitive illness requires stabilization, daily psychiatric management, and primary nursing interventions.

ASAM Level 4 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
	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). 3. 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). 4. 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). 5. 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.	3. Uncontrolled behavior poses an imminent danger to self or others. 4. Mental confusion or fluctuating orientation poses an imminent danger to self or others (for example, severe self-care problems, violence, or suicide). 5. A concurrent serious emotional, behavioral, or cognitive disorder complicates treatment and requires a differential diagnosis and treatment. 6. Extreme depression poses an imminent risk to his/her safety. 7. 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. 8. Continued alcohol, tobacco, and/or drug use is causing grave complications or exacerbation of a previously diagnosed psychiatric, emotional, or behavioral condition. 9. Is experiencing altered mental status, with or without delirium, as manifested by 1) disorientation to self, 2) alcoholic hallucinosis, or 3) toxic psychosis.
Dimension 4: Readiness to change	Only those who meet criteria in Dimensions 1, 2, or 3 are appropriately placed in an ASAM Level 4 program. Problems in Dimension 4 alone are not sufficient for placement.	
Dimension 5: Relapse, continued use, or continued problem potential	Only those who meet criteria in Dimensions 1, 2, or 3 are appropriately placed in an ASAM Level 4 program. Problems in Dimension 5 alone are not sufficient for placement.	

ASAM Level 4 Admission Criteria		
ASAM Dimension	**Adolescents**	**Adults**
Dimension 6: Recovery environment	Only those who meet criteria in Dimensions 1, 2, or 3 are appropriately placed in an ASAM Level 4 program. Problems in Dimension 6 alone are not sufficient for placement.	

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to ASAM Level 4 services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Facilities bill all services on a UB claim form using a per diem bundled daily rate (depending on bed type) and accompanying professional services.
2. Eligible SUD IMDs bill revenue code 0116 for a private room or revenue code 0126 for a semi-private room.
3. Eligible acute care hospitals bill using per diem revenue codes or DRG codes for medical detox:

Revenue Code	Description
0116	Room and Board — Private room crisis
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

DRG Code	Description
895	Alcohol/Drug Use Disorder treatment with rehabilitation therapy

DRG Code	Description
	***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.
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

4. Facilities billing with per diem revenue codes should add revenue code 0229 and procedure code H0009 for withdrawal management tracking purposes.
5. Procedure codes for professional services for medical detoxification (withdrawal management) must be linked with relevant ICD code for substance use withdrawal. Professional service procedure codes include:
    A. Initial hospital Care: CPT codes 9922x series
    B. Subsequent hospital care: CPT codes 9923x series
    C. Discharge Day management: CPT codes 99238, 99239
6. CCSS may also be billed for discharge planning and transition purposes.

ASAM Level 4-WM (Medically Managed Intensive Inpatient Withdrawal Management in a Hospital)

Overview/Purpose

ASAM Level 4-WM (Medically Managed Intensive Inpatient Withdrawal Management in a Hospital) is an organized service delivered by medical and nursing professionals that provides 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. ASAM Level 4-WM is appropriate for individuals whose withdrawal symptoms are severe enough to require primary medical and nursing services. Although ASAM Level 4-WM is specifically designed for acute medical withdrawal management, the Medicaid member is also assessed for any treatment priorities identified in ASAM Dimensions 2–6 (https://www.asam.org/asam-criteria/about-the-asam-criteria).

Definitions of terms pertaining to this manual can be found here.

Eligible Providers

General provider enrollment information can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to ASAM Level 4-WM are below.

ASAM Level 4-WM programming is provided in an inpatient acute care hospital and 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.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for ASAM Level 4-WM services are those who have been assessed for medical necessity.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to ASAM Level 4-WM are below.

Therapies offered include individualized biomedical, emotional, behavioral, and substance use disorder treatment. Medicaid members must be assessed for ASAM Level 4-WM. At the time of admission, the following must occur:

- Admission approval by a physician.
- A comprehensive nursing assessment.

- A comprehensive history and physical examination performed within 12 hours of admission with appropriate laboratory and toxicology tests.
- A substance use focused history.
- Sufficient biopsychosocial screening to determine placement.

Treatment planning, including discharge/transfer planning, begins after ASAM Level 4-WM has been identified. Treatment planning focuses on problem identification in ASAM Dimensions 2–6 and includes referral arrangements, as needed. The interdisciplinary provider team must assess the Medicaid member's progress with withdrawal management and any treatment changes daily.

The Medicaid member continues in an ASAM Level 4-WM program until withdrawal signs and symptoms are sufficiently resolved until they can be safely managed at a less intensive level of care.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding ASAM Level 4-WM is below.

Prior authorization for ASAM Level 4-WM placement is required and must be approved by a physician.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to ASAM Level 4-WM are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Inpatient acute hospitals use the following revenue codes for billing:
    A. For Medicaid members age 22–64, use revenue code 0116 for a private room or 0126 for a semi-private room.
    B. For Medicaid members age 65 and older, use revenue code 0114 for a private room or 0124 for a semi-private room.
2. Revenue code 0229 and procedure code H0009 should be added to claims for withdrawal management tracking purposes.
3. CCSS may also be billed for discharge planning and transition.

Assertive Community Treatment (ACT)

Overview/Purpose

Assertive Community Treatment (ACT) is a voluntary psychiatric, comprehensive case management, and psychosocial intervention program that offers individualized treatment 24 hours a day, seven days a week by an transdisciplinary team. The ACT therapy model is based on empirical data and evidence treatment plan for the Medicaid member. Specialized therapeutic and rehabilitative interventions falling within the fidelity of the ACT model are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services. ACT services can be traditional ACT, Forensic, or Coordinated Specialty Care (CSC) services.

The primary goals of ACT treatment are 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.
- Meet basic needs and enhance quality of life.
- Improve functioning in adult social and employment roles and activities.
- Increase community tenure.
- Lessen the family's burden of providing care.

In addition, the primary goals of Coordinated Specialty Care (CSC) are to engage individuals with first episode psychosis and their natural supports, and to provide psycho education, supported education, supported employment, and access to evidenced based medication treatments.

For additional information and State ACT forms, please contact act@nmrecovery.org. Relevant forms, application and information can be found at www.nmrecovery.org.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to ACT are below.

General Requirements

An ACT agency must demonstrate compliance with State requirements on administrative, financial, clinical, quality improvement, and information services infrastructure standards

established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. Agency compliance will be reviewed as part of the application process.

Agency Application Process

Agencies interested in providing ACT services should do the following:

1. Attend the State approved ACT training.
2. Communicate the agency's interest in providing ACT services with BHSD by submitting questions to act@nmrecovery.org.
3. Review the Implementation Manual and Startup Guide.
4. Determine if the agency has the ability to build a multi-disciplinary team with a staff to member ratio of 1:10.
5. Build agency Policy and Procedure for the implementation and oversight of the service.
6. Submit an ACT application through www.nmrecovery.org.

The agency must have an HCA ACT approval letter prior to rendering ACT services to Medicaid member. The approval letter will authorize an agency also delivering CSC services. Any adaptations to the ACT model require an approved variance from BHSD.

Staff Training, Education, and Experience

Each ACT team staff member must be successfully and currently certified or trained according to ACT fidelity model standards. Training standards focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices and ACT fidelity model.

Staff and providers must have the following competencies, professional qualifications, and experience:

- Crisis assessment and intervention.
- Symptom assessment and management.
- Individual counseling and psychotherapy.
- Prescription, administration, monitoring and documentation of medications.
- Substance use disorder (SUD) treatment.
- Services related to work and activities of daily living.
- Support services or direct assistance to ensure that the Medicaid member obtains the basic necessities of daily life; and coordination, support and consultation to the individual's family and other major supports.

Eligible Providers

General provider enrollment information can be found here.

An ACT agency must be approved by HCA prior to rendering ACT services. ACT services are provided by an interdisciplinary team of 10 to 12 staff who work interchangeably to provide the treatment, rehabilitation, and support services to help Medicaid members live successfully in the community. The team is more than a consortium of mental health specialists — it includes collaborative assessment and treatment planning for each Medicaid member, cross-training of team members, daily team meetings, and use of an open office format to promote team communication and team approach to each Medicaid member's care and services.

Each ACT team must have sufficient numbers of qualified staff to provide treatment, rehabilitation, crisis and support services 24 hours a day, seven days a week. The staff to member ratio must consider the clinical severity of members, rural/urban barriers in the service region, and fidelity to the ACT model being used. BHSD may consider smaller interdisciplinary teams based on clinical severity and rural/urban barriers in the service region, but approval of smaller team composition is required.

A Medicaid member is considered a part of the ACT team for decisions impacting their ACT services. Each ACT team must include the following providers/staff:

- A team leader who is an independently licensed behavioral health practitioner (LPCC, LMFT, LISW, LCSW, LPAT, psychologist).
- Medical Director/Prescriber(s).
- Either a 1) Board certified/board eligible psychiatrist; 2) State licensed psychiatric certified nurse practitioner or psychiatric clinical nurse specialist; 3) Prescribing psychologist under the supervision or consultation of an MD; or 4) Two licensed nurses, one of whom is an RN.
- A MAD recognized licensed behavioral health professional.
- A MAD recognized licensed behavioral health practitioner with expertise in SUD.
- An employment specialist.
- A State certified peer support worker (CPSW) through the approved New Mexico certification program or certified family peer support worker (CFPSW).
- Administrative staff.

Eligible Members

General member eligibility information can be found here.

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 appropriate for some people who experience significant disability from other disorders and who have not been helped by traditional mental health services. A co-occurring diagnosis of SUD should not exclude a Medicaid member from ACT services.

Medicaid members eligible for ACT services include those who:

- Are age 18 and older, have been diagnosed with a Serious Mental Illness (SMI), and have a psychiatric disorder that has included significant behavioral health services, repeated hospitalizations, and/or incarcerations due to mental illness. These types of psychiatric disorders severely impede activities of daily living and may include schizophrenia, schizoaffective disorder, bipolar disorder, or psychotic depression; or
- Age 15–30 who are within the first two years of their first episode of psychosis.

Coordinated Specialty Care (CSC) Target Population

The CSC model is indicated for young adults, ages 15 to 35, who are experiencing a first episode of psychosis 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).

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to ACT are below.

ACT services are available 24 hours a day, seven days a week and include an array of services that reflect a Medicaid member's need. Ideally, 90% of services are delivered as community-based, non-office-based outreach services (in vivo), and are recovery oriented. Mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations. The agency must coordinate its ACT services with local hospitals, local crisis units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies. The ACT team will assist the Medicaid member to access other appropriate services in the community that are not funded by MAD.

Treatment plan and supports must be developed at admission and must be reviewed and updated every six months. The treatment plan must indicate interactions with Medicaid members. ACT services cover four levels of interaction with Medicaid members:

1. **Face-to-face encounters.** Face-to-face encounters are ideally approximately 60% of all ACT team activities with approximately 90% of ACT encounters occurring outside of the ACT agency's office (in vivo).

2. **Collateral encounters.** This includes encounters with an individual's family, household, or "significant others." Significant others regularly interact with the Medicaid member and are directly affected by or have the capability of affecting the individual's condition and are identified in the treatment 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 a Medicaid member in locating housing). Collateral encounters are limited to 40% of all ACT team activities.

3. **Assertive outreach.** Assertive outreach involves the ACT team having knowledge of what is happening with the Medicaid member, the relationships that the individual has within the community, and intervening early if a difficulty arises. This type of outreach is key to ACT and works to avoid "discharging the individual for lack of engagement or no-shows." Instead, this service involves intensive efforts to locate and engage with the patient. For homeless individuals, or individuals who may leave their home, assertive outreach is a key to success. This is done on behalf of the client and is generally limited to 5% of total service time per month.

4. **Group encounters.** Group encounters include basic living skills development, psychosocial skills training, peer groups, or wellness and recovery groups.

CSC Model

CSC is an evidence based multidisciplinary intervention for young adults experiencing early stages of psychosis. CSC 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. CSC can be provided by ACT Teams that have been trained and approved by BHSD and CYFD to deliver this model of care. CSC services are provided for a minimum of 24 months

The primary goals of CSC are to reduce the duration of untreated psychosis (DUP) through community awareness and rapid access to services. It is intended to increase functioning, involvement in employment or education, and improve quality of life. It is also intended to reduce inpatient psychiatric hospitalizations/ER visits and clinical symptoms or the impact of clinical symptoms.

The ACT team providing CSC is responsible for following the CSC evidence-based fidelity model guidelines as approved by BHSD and CYFD. This includes:

- Creating a treatment plan and supports which is developed through shared decision making with the Medicaid member. The treatment plan must be reviewed and updated every six months.

- Maintaining a low staff to patient ratio.

- 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.
- Please see CSC audit tool for further details.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding ACT services is below.

ACT services do not require prior authorization. ACT services that include CSC must be provided for a minimum of 24 months.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to ACT services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies use the procedure code H0039 for each 15-minute unit. Modifiers are required to indicate the type of intervention:
    A. U1 = face-to-face
    B. U2 = collateral encounter
    C. U3 = assertive outreach
    D. U4 = group
2. The following services may not be billed in conjunction with ACT, except for medically necessary medications and hospitalization:
    A. Other psychiatric mental health nursing
    B. Therapeutic, non-intensive outpatient SUD
    C. Crisis services, except for medically necessary medications and hospitalizations

Behavior Management Services (BMS)

Overview/Purpose

Behavior Management Services (BMS) are intended to provide highly-supportive and structured therapeutic behavioral interventions to maintain a Medicaid member in their home or community. BMS is not provided as a stand-alone service, but instead as part of an integrated plan of services.

BMS are individualized, trauma-informed care which provides skill development through a treatment plan. The treatment plan is designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. BMS assists in reducing or preventing inpatient hospitalizations and out-of-home residential placement of the Medicaid member. BMS includes teaching, training, and coaching activities designed to assist Medicaid members in acquiring, enhancing, and maintaining the skills needed to function successfully within their home and community settings.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to BMS are below.

Each agency is responsible for establishing written policies and procedures that specify how applicable certification requirements are met, including those described for Child and Adolescent Mental Health Services (7.20.11 NMAC [cyfd.org]). Agencies must ensure 24-hour availability of appropriate staff or have ability to develop and implement a crisis/safety plan, which may include referral to respond to the Medicaid member's crisis situations. A BMS specialist staff-to-member ratio of 1:1 is required at all times.

Eligible Providers

General provider enrollment information can be found here.

An agency must be certified by CYFD to provide BMS services. An independently licensed Clinical Director must provide clinical supervision of all certified BMS services. Clinical supervision may be direct, or may occur through a Clinical Supervisor who is directly supervised by the Clinical Director. All Clinical Supervisors must be board-approved through the Regulation and Licensing Department (RLD).

For program management, BMS specialists must be supervised 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 of experience working with children, adolescents and families. If a supervisor with these 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, in addition to four years of experience working with seriously emotionally disturbed (SED) or neurobiological disordered children and adolescents.

Supervision must be provided for a minimum of two hours per month, depending upon the complexity of the needs presented by Medicaid members and the supervisory needs of the BMS specialist. All clinical supervision/consultation must be documented with the theme, date, length of time of supervision, and signatures of those participating.

The Clinical Director or Clinical Supervisor must ensure the following:

- A clinical assessment of the Medicaid member is completed upon admission into BMS. The clinical assessment identifies the need for BMS as medically necessary to prevent inpatient hospitalizations or out-of-home residential placement of the Medicaid member.
- The BMS worker receives documented supervision for a minimum of two hours per month. Supervision requirements are dependent on the complexity of the needs presented by Medicaid members and the supervisory needs of the BMS worker.

Eligible Members

General member eligibility information can be found here.

BMS is a covered service for Medicaid members under the age of 21 who have been diagnosed with a behavioral health condition and meet the following criteria:

- Are at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;
- Need behavior management intervention to avoid inpatient hospitalizations or residential treatment;
- Require behavior management support following an institutional or other out-of-home placement as a transition to maintain the Medicaid member in their home and community; or
- Either the need for BMS is NOT listed on an individualized education plan (IEP), or it is listed in the supplementary aid and service section of the IEP.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to BMS are below.

BMS services are delivered to Medicaid members 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 Medicaid member in the least restrictive environment possible.

BMS services must be documented in the BMS **Treatment Plan**. The BMS **Treatment Plan** is developed following an initial screening and comprehensive **multidisciplinary** assessment **and/or psychiatric diagnostic evaluation**.

BMS Skill Development Services

BMS services include skills development, which are designed to develop, restore, or maintain skills and behaviors that result in improved function or prevent deterioration of function. BMS skill development services are delivered through an individualized behavior management skills development designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. BMS skills development services focus on acquisition of skills and improvement of the client and/or family's performance related to targeted behaviors.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding BMS is below.

BMS does not require prior authorization but is subject to medical necessity. The need for BMS must be identified in a Tot-to-Teen health check screen or other diagnostic evaluation.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to BMS are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

- Provider types that can bill BMS are BMS workers (430, specialty 113).
- Providers use HCPCS code H2014 for each 15-minute unit.
- BMS may not be billed in conjunction with 1) activities which are not designed to accomplish the objectives in the BMS treatment plan; 2) services provided in residential treatment facilities; and 3) services provided in lieu of services that should be provided as part of the eligible member's IEP or treatment plan. BMS is not a reimbursable service through the Medicaid school-based service program.
- Services provided in lieu of services that should be provided as part of the eligible member's IEP or IFSP.
- BMS is **not** a reimbursable service through the Medicaid school-based service program.

Behavioral Health Professional Services for Screenings, Evaluations, Assessments, and Therapy

Overview/Purpose

Validated screenings for high-risk conditions are a covered service in order to provide prevention or early intervention. Psychological, counseling, and social work services include diagnostic or active treatments with the intent to reasonably improve an eligible Medicaid member's physical, social, emotional, and behavioral health or substance use condition. Services are provided to an eligible Medicaid member whose condition or functioning can be expected to improve with interventions.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to related to screenings, evaluations, assessments, and therapies are below.

An assessment must be signed by the practitioner operating within his or her scope of licensure. A non-independently licensed behavioral health practitioner must have an independently licensed behavioral health practitioner review and sign the assessment with a diagnosis.

Screening instruments and results must be reviewed by a practitioner identified as a behavioral health provider according to the New Mexico Administrative Code and enrolled as New Mexico Medicaid Provider. Screening results must be included in the clinical documentation. All screening must be conducted in coordination with programs combining screening with adequate support systems in place to improve clinical outcomes.

Eligible Providers

General provider enrollment information can be found here.

Psychological, counseling, and social work services are performed by licensed psychological, counseling, and social work practitioners acting within their scope of practice and licensure.

Eligible Members

General member eligibility information can be found here.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to screenings, evaluations, assessments, and therapies are below.

Services include, but are not limited to assessments that appraise cognitive, emotional and social functioning, and self-concept. Therapy includes planning, managing, and providing a program of psychological services to the eligible Medicaid member meeting a current DSM, ICD, or DC:0-5 behavioral health diagnosis and may include therapy with her or his family or parent/caretaker, and consultation with his or her family and other professional staff. Based on the Medicaid member's Assessment, their treatment file must document the extent to which his or her treatment goals are being met and whether changes in direction or emphasis of the treatment are needed.

Outpatient therapy services can include individual, family, and group sessions. Services include planning, managing, and providing a program of psychological services to the eligible Medicaid member with a diagnosed behavioral health disorder. Outpatient therapy services may include consultation with the Medicaid member's family and other professional staff with or without the individual present when the service is on behalf of the individual.

Authorization

General prior authorization and utilization review information can be found here.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to screenings, evaluations, assessments, and therapies are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

- The rendering provider should be documented as appropriate in the claim.
- When services are provided by a psychiatric certified nurse practitioner or psychiatric clinical nurse specialist in a private or group practice, reimbursement is 90% of the comparable reimbursement for physicians. When services are provided by a psychiatric certified nurse practitioner or psychiatric clinical nurse specialist in an agency, there is a graduated fee schedule determined by provider type.
- Modifiers should be used if services are delivered after regular operating hours. If services are delivered after regular business hours, add modifier "UH." If services are delivered on weekends or holidays, add modifier "TV."
- Brief interventions or the use of the Treat First Clinical Model may be billed with a provisional diagnosis for up to four visits. After four visits, if continuing treatment is required, a diagnostic evaluation or comprehensive multidisciplinary assessment must be

performed, and subsequent reimbursement is based on the diagnosis and resulting treatment plan. [placeholder for link to Treat First Model]

Procedure Code	Procedure Code Description	Billing Guidance (as applicable)
90791	Psychiatric Diagnostic Evaluation	
90792	Psychiatric Diagnostic Evaluation with a Medical Service	
90832–90838	Individual Therapy and Counseling	Appropriate code depends on the amount of time of counseling session. Codes 90836 and 90838 are add-on codes to be used with an E&M code.
90836	Pharmacological Management	Code should be used as an add-on code when performed with psychotherapy.
90839	Psychotherapy for crisis (first 60 minutes)	
90840	Psychotherapy for crisis (for each additional 30-minute increment)	
G0515	Cognitive Enhancement Therapy (15-minute unit)	
90846–90847	Family Therapy (One-hour unit)	
90847 HK	Functional Family Therapy	
90849 and 90853	Group Therapy (GT)	Bill each member in the group.
H0038	Individual Peer Support Services (15-minute unit)	A maximum of 12 units may be billed. Providers who can bill include Provider Type 430 with the following provider specialty codes: 114 (certified peer support worker), 115 (certified family peer support worker), 117 (certified correctional peer support worker). Use H0038 HQ for Group Peer Support Services.
G0176	Activity Therapy	Activity Therapy is not recreational but does include nationally accredited adventure-based or

Procedure Code	Procedure Code Description	Billing Guidance (as applicable)
		experiential-based therapies. Rendering provider is listed by those qualified by scope of practice or agency provider. Use G0176 HQ for Group Activity Therapy.
G0406	Inpatient and Emergency Department Consultation (15-minute unit)	Add modifier GT for telehealth. Claim must identify both rendering and rendering practitioner.
G0407	Inpatient and Emergency Department Consultation (25-minute unit)	Add modifier GT for telehealth. Claim must identify both rendering and rendering practitioner.
G0408	Inpatient and Emergency Department Consultation (35-minute unit)	Add modifier GT for telehealth. Claim must identify both rendering and rendering practitioner.
H2010	Comprehensive Medication Administration/Management (15-minute unit)	Includes medication assessment, administration, monitoring, and education.
H2000	Comprehensive Multidisciplinary Assessment	Use for assessments of Medicaid members with SMI, SED, and moderate to severe SUD. Billable by 13 agency types only.
H0031	Mental Health Assessment by non-physician	Use for assessment non-SMI/SED/mild SUD Medicaid members.
H0002	ASAM Assessment for Placement in a Level of Care	To be used with an eligible recipient with a substance use disorder (SUD). Must include documentation of ASAM six dimensions, and level of care recommendation. Can be billed concurrently with an assessment.
G0444	Behavioral Health Screening	Use provisional diagnosis for encounter (Z13.9, unspecified). Screenings should occur at intake and annually. Screenings score must be included in clinical documentation and be reviewed by a licensed provider. Screens must include validated instruments to assess for substance use and mental health symptoms including

Procedure Code	Procedure Code Description	Billing Guidance (as applicable)
		risk of suicide. This code should not be used for SBIRT. There are separate codes for SBIRT found in the physical health fee schedule.
G0443	Brief Intervention	Use a provisional diagnosis. This code should not be used for SBIRT. There are separate codes for SBIRT found in the physical health fee schedule.

Prolonged Service Billing Instructions

The following guidance should be used for prolonged services. These codes can be reported by all licensed clinicians delivering psychotherapy within their scope of practice.

CPT codes 99415–99416 are used to report the total amount of face-to-face time spent with the patient and/or family/caregiver by clinical staff in the office or other outpatient setting, on a given date of service even if the time 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.

- CPT codes 99417–99418 are used to report prolonged inpatient or observation and management service (s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, even if the time spent on that date is not continuous.
- CPT codes 99415–99416 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. CPT codes 99417 or 99418 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.
- 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	99415 (bill one unit)

Total Duration of Prolonged Services	Code(s)
75–104 minutes	99415 (bill one unit) and 99416 (bill one unit)
105 minutes or more	99415 (bill one unit) and 99416 (bill two more units for each additional 30 minutes)

Behavioral Health Respite Care (Managed Care Benefit Only)

Overview/Purpose

Behavioral Health Respite Care (BH Respite Care) is short-term direct care and supervision of the Medicaid member in order to afford the parent(s) or caregiver a respite from the Medicaid member's care. BH Respite Care takes place in the Medicaid member's home or care setting.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to BH Respite Care are below.

This section describes staff qualifications for providers and supervisors of BH Respite Care. Clinical services and supervision by licensed practitioners must be in accordance with their respective licensing board regulations. All Clinical Supervisors must be board-approved through the RLD.

BH Respite Care providers must have:

- A minimum three years' experience working with the target population.
- Completed State and national criminal record and background check for all persons residing in the home over 18.
- A valid driver's license, vehicle registration, and insurance, if providing transport to the Medicaid member.
- Certification in CPR and first aid.
- Documentation proving completion of required behavioral health orientation, which includes training on member rights, HIPAA and member confidentiality, behavioral health signs and symptoms, substance use signs and symptoms, managing safety and stability, protecting member and family dignity and choice, 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 Medicaid member.
- Commitment to access ongoing in-service training, supervision, administrative contact, and clinical support with the BH Respite Care supervisor.

BH Respite Care program supervisors must have:

- A bachelor's degree and three years' experience working with the target population.
- Complete State and national criminal records and background checks.
- Documentation proving completion of supervision requirements, including:
  - A minimum of two hours per month of individual supervision covering administrative and case specific issues; and
  - A minimum of two hours per month of continuing education in behavioral health respite care issues, or annualized respite provider training.
- Access to on call crisis support available 24 hours a day.

Eligible Providers

General provider enrollment information can be found here. General provider enrollment information describes licensing and certification requirements for each agency.

Agencies eligible to provide BH Respite Care services include:

- Treatment Foster Care (TFC) Agencies utilizing licensed TFC Homes
- Core Service Agencies (CSA)
- Behavioral Health Agencies (BHA)

Eligible Members

General member eligibility information can be found here.

Members eligible for BH Respite Care include:

- Medicaid members enrolled in managed care who up to the age of 21 who are 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 a severe emotional disturbance (SED).

Non-enrolled siblings of a child receiving BH Respite Care services are not eligible for BH Respite Care benefits.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to BH Respite Care are below.

The provider agency will assess the Medicaid member's situation and, with the caregiver, recommend the appropriate setting for respite. BH Respite Care services may include a range of activities to meet the social, emotional, and physical needs identified in the service or treatment plan, and documented in the treatment record. Services may be provided for a few hours during the day or for longer periods of time for overnight stays. BH Respite Care, while usually planned, can also be provided in an emergency or unplanned basis. Room and board are not included as part of BH Respite Care.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding BH Respite Care is below.

Providers should follow the prior authorization processes developed by each MCO. Prior authorization is required for additional BH Respite Care after services have been provided for 30 days or 720 hours in a one-year period.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to BH Respite Care are below.

1. Agencies that may bill the managed care plan for BH Respite Care are CSA (446), BHA (432), or TFC (218).
2. Agencies use procedure code T1005 for each 15-minute unit of BH Respite Care.
3. BH Respite Care services may not be billed in conjunction with treatment foster care, group home, residential services, or inpatient treatment.
4. FQHC and IHS/Tribal 638 bill as contracted with MCOs.

Cognitive Enhancement Therapy (CET)

Overview/Purpose

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. Contact BHSD at ... for more information.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to CET services are below.

An agency providing CET services must complete a training program approved by BHSD such as CET Cleveland or CET Training, LLC. The agency must hold an approval letter from BHSD certifying that staff have participated in training or have arranged to participate in training and have supervision by an approved trainer prior to providing CET services.

An agency providing CET services must have two practitioners who have been certified in the evidence-based practice for every “CET cohort of Medicaid members.” The size of each Medicaid member cohort must follow the evidence-based practice model in use. For providers who have not yet received certification, weekly participation in hourly fidelity monitoring sessions with a certified CET trainer is required.

Eligible Provider

General provider enrollment information can be found here.

CET is designed to be implemented in agency and center-based treatment settings. Services may only be delivered through a MAD-approved agency after demonstrating that the agency meets all the requirements of CET program services and supervision.

Neurocognitive training and social-cognitive group sessions are provided by independently licensed behavioral health clinicians, non-independently licensed behavioral health clinicians,

registered nurses, or CSWs who have at least two years of 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.

Eligible Members

General member eligibility information can be found here.

CET services are available to Medicaid members who are 18 years of age and older with cognitive impairment associated with schizophrenia, bipolar disorder, recurrent major depression, schizoaffective disorder, or autism spectrum disorder.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to CET are below.

CET services include:

- Initial and final standardized assessments to quantify social-cognitive impairment, processing speed, cognitive style.
- Treatment planning.
- Weekly social cognition groups with enrollment according to model fidelity.
- Weekly computer skills groups with enrollment according to model fidelity.
- Weekly individual face-to-face coaching sessions to clarify questions and to work on homework assignments.

The duration of the CET intervention is based on model fidelity, but is generally provided over an 18-month period. The first three months of CET includes weekly one-hour sessions of computer-assisted neurocognitive attention training conducted with pairs of Medicaid members. As CET 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 neurocognitive attention training, Medicaid members begin attending weekly 1.5-hour social-cognitive group sessions weekly. There are a total of 45 social-cognitive group sessions in the program. 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.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding CET services is below.

CET does not require prior authorization, but is subject to medical necessity. CET services are not covered during an acute inpatient stay.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General information on fraud and abuse can be found here. Specific billing and claims requirements related to CET are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies that can bill for CET services include: CMHC, FQHC, IHS, Tribal 638, CSA, CLNM HH, and BHA.

2. Core CET services are reimbursed through a bundled rate. Medications and other mental health therapies are billed and reimbursed separately from the bundled rate.

3. Agencies use procedure code G0515 for each 15-minute unit (bundled rate).

4. Agencies that are actively participating in approved training and supervision can bill for services delivered while completing supervision requirements.

Comprehensive Multidisciplinary Assessment and Treatment Planning

Overview/Purpose

The Comprehensive Multidisciplinary Assessment can be completed for Medicaid members with a serious mental illness (SMI), severe emotional disturbance (SED), or moderate to severe substance use disorder (SUD). The Treatment Plan documents all needed services and is developed collaboratively with the Medicaid member participating as well as family/significant others, and other involved clinicians. Reimbursement for the Comprehensive Multidisciplinary Assessment must include the development of a Treatment Plan and crisis/safety/relapse prevention plan.

The following information describes the specific requirements and billing information for the Comprehensive Multidisciplinary Assessment, the Treatment Plan, and crisis/safety planning.

Definitions of terms pertaining to this manual can be found here.

Eligible Providers

General provider responsibilities and requirements can be found here. General provider enrollment information can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Comprehensive Assessments are below.

Independently licensed behavioral health practitioners may conduct the comprehensive multidisciplinary assessment and initial treatment plan. Non-independently licensed LMHCs, LMSWs, LAMFTs, LPCs, psychology interns, and postdoctoral students may conduct the comprehensive assessment and initial treatment plan under the supervision of a board approved clinical supervisor. RNs may contribute to the assessment and initial treatment plan to the extent of forming clinical impressions and according to scope of practice.

Eligible Members

General member eligibility information can be found here.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to the Comprehensive Assessment is below.

The Comprehensive Multidisciplinary Assessment can be used for Medicaid members with SMI, SED, and moderate to severe SUD to determine individual needs related to physical and behavioral health, long-term care, social and community support resources and natural and family supports. This information must be collected in a structured format using the New

Mexico Comprehensive Multidisciplinary Assessment templates. The collection of information and data is used to guide and shape the initial treatment plan and can be used to highlight elements that need to be addressed in a treatment plan. The Comprehensive Multidisciplinary Assessment should be completed collaboratively with the individual in service and also requires collecting collateral information from other supports, natural or paid.

The Comprehensive Multidisciplinary Assessment is not a psychiatric diagnostic evaluation 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.

Treatment Plan

The Initial Treatment Plan is developed collaboratively 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 Treatment Plan is a document intended to be updated frequently to reflect identified needs and to communicate services an individual will receive. The plan must also include a crisis and safety plan and/or relapse preventions plans.

The Treatment Plan must meet the following requirements:

- Includes active participation from the individual, identified family, caregivers, and team members.
- Consultation with interdisciplinary team experts, such as primary care providers, specialists, behavioral health providers, and other participants involved in the individual's care.
- Identifies additional health recommended screenings.
- Addresses long-term and physical, behavioral, and social health needs.
- Is organized around an individual's goals, preferences, and optimal clinical outcomes, including self-management. The plan includes as many short- and long-term goals as needed.
- Specifies treatment and wellness supports that bridge behavioral health and primary care.
- Includes the individualized crisis/ safety plan collaboratively completed with member participation, listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency.
- Members with substance use disorder must have a collaboratively developed relapse prevention plan, to support the member in their recovery journey.

- Includes an individualized discharge plan that includes resource information for maintenance and progressive recovery.
- Is shared with members and their providers.
- Is updated regularly with status and plan changes.

The updates to the treatment plan, initially developed through the comprehensive multidisciplinary assessment, are billed using the HCPCS Code T1007 and updates must be completed under the following circumstances:

- Significant change in level of care, health status, or change in recovery.
- At the individual's or guardian's request.
- Every 90 days if updates have not occurred during that time.

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. 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. 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."

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

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. The Safety Plan should be started with the member at intake and be updated with the member every 90 days during treatment plan updates.

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 meet more closely 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. 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. The Crisis Plan should be started with the member at intake and be updated with the member every 90 days during treatment plan updates.

Relapse Prevention Plan

At the time of treatment plan development, the counselor will develop a Relapse Prevention Plan with the patient. The Plan must include 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 Plan must include, at a minimum:

- The patient's most likely triggers for relapse (i.e., 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.
- The Relapse Prevention Plan should be started at intake with the member and be updated with the member every 90 days during treatment plan updates.

Authorization

General prior authorization and utilization review information can be found here.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to the Comprehensive Multidisciplinary Assessment are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. For a psychiatric diagnostic assessment, use procedure code 90791 or 90792. For a comprehensive multidisciplinary assessment without a diagnostic component, use H2000. Agencies eligible to bill for the Comprehensive Assessment include:
   A. Community Mental Health Centers (CMHC)
   B. Federally Qualified Health Centers (FQHC)
   C. Indian Health Services (IHS) hospital, clinic or FQHC
   D. Tribal hospital, clinic or FQHC

E. New Mexico Children, Youth and Families Department (CYFD)

F. Hospitals and affiliated outpatient facilities

G. Core Service Agencies (CSA)

H. Licensed crisis triage centers

I. Behavioral health agencies (BHA)

J. Opioid treatment program in a methadone clinic

K. Political State subdivisions

2. Agencies use the following procedure codes for billing the Comprehensive Assessment. Reimbursement is inclusive of the Comprehensive Assessment, Treatment Plan and any crisis/safety planning activities.

   A. Use procedure code H2000 for Medicaid members with SMI, SED, or moderate to severe SUD. If the Comprehensive Assessment requires multiple encounters, agencies should bill only the last encounter once it is completed.

   B. Use procedure code H0031 for all other Medicaid members.

3. Agencies use procedure code T1007 for updates to the treatment plan. This should be utilized for updates to the treatment plan that was originally developed with the comprehensive assessment. It can also be billed for treatment plan updates for specific services. It is billed and reimbursed separately whenever a significant change in status requires the care team to collaborate and update.

4. FQHCs and IHS/638 facilities use UB claim form and revenue code 0919 for encounter or OMB rate.

Comprehensive Community Support Services (CCSS)

Overview/Purpose

Comprehensive Community Support Services (CCSS) provide individuals/families with services and resources necessary to promote recovery, rehabilitation, and resiliency. CCSS consists of a variety of face-to-face and community interventions to support independent functioning in the community. This includes skills for independent living, learning, working, socializing, and recreation. CCSS also provides assistance with identifying and coordinating services and supports identified in an individual's treatment plan, supports an individual and family in crisis situations, and provides individual interventions to develop or enhance an individual's ability to make informed and independent choices.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to CCSS are below.

This section describes staff qualifications and training requirements for CCSS agency staff. In addition to the requirements described below, CCSS direct service and clinical staff must have a CYFD provider background check.

Community Support Worker

A Community Support Worker (CSW) must have the following minimum qualifications:

- Age 18 or older; and
- Bachelor's degree in a human services field from an accredited university and have one year of relevant experience with the target population; or
- Associate degree and a minimum of two years of experience working with the target population; or
- Associate degree in approved curriculum in behavioral health coaching (no experience is necessary); or
- High school diploma or equivalent and a minimum of three years of experience working with the target population; or
- Completed certification from the State's designated credentialing board-a certified peer support worker (CPSW) or as a certified family peer support worker (CFPSW), or a certified youth peer support specialist (CYPSS).

CSW staff must also complete 20 hours of initial training within the first 90 days of employment, and 20 hours of education every subsequent year. Training and education topics include:

- Clinical and psychosocial needs of the target population
- Managing side effects of psychiatric medication and communicating with your clinician
- Principles of states of change
- Principles of motivational interviewing
- Crisis management
- Principles of recovery, resiliency, and empowerment
- Cultural considerations
- Ethics and professionalism
- Enhancing interpersonal supports
- Mental Health/Developmental Disabilities Code
- Children's Code
- Client/family-centered practice
- Treatment and discharge planning with an emphasis on recovery and crisis planning
- Psychiatric Advance Directive
- Strategies for engagement in services

CCSS Program Supervisor and Clinical Supervisor

The CCSS Program Supervisor and RLD board-approved Clinical Supervisor can be the same individual, but minimum qualifications vary for each position. Supervisors must complete must also complete 20 hours of initial training within the first 90 days of employment, and 20 hours of education every subsequent year.

A CCSS Program Supervisor must have the following minimum qualifications:

- A bachelor's degree in a human services field from an accredited university;
- Four years relevant experience in the delivery of case management or CCSS with the target population; and
- One year demonstrated supervisory experience.

Eligible Provider

General provider enrollment information can be found here.

Providers must be approved by BHSD, prior to rendering CCSS services. The application process for CCSS can be found at www.nmrecovery.org. An agency wishing to provide CCSS must ensure that supervisors and staff have the appropriate one-time initial training from State approved trainers. CCSS training must be provided by a State Approved Trainer, there is no train the trainer option. Clinical Supervisors must be trained prior to other CSW's being trained. Once the approval is complete and the attestation is received, BHSD will return a letter to the agency allowing for the provision of CCSS and identifying the agency as having the specialty service 107. This approval letter is necessary to complete the Medicaid and provider enrollment processes. BHSD will work with the agency to schedule a site visit within the first year of approval. Ongoing review and participation in technical assistance is available by contacting ccss@nmrecovery.org.

Eligible Members

General member eligibility information can be found here.

CCSS is a covered service for Medicaid members who are:

- Under 21 years who meets the NM State criteria for severe emotional disturbance (SED)/neurobiological/behavioral disorders;
- 21 years and older whose diagnoses meet the State criteria for SED or serious mental illness (SMI) or those who do not meet the State criteria for a SMI, but for whom time-limited CCSS would support their recovery and resiliency process; or
- Have a moderate to severe SUD or co-occurring mental health diagnosis.

A licensed provider must determine CCSS eligibility by providing a diagnosis, and documenting impairment in one of the following areas:

- Independent living
- Education and learning
- Working
- Socializing
- Recreation

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to CCSS are below.

CCSS activities include:

Development of a recovery/resiliency plan.

- Development of a psychiatric advance directive.
- 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, and use of alternatives to emergency departments and inpatient services.
- Revision of the crisis and safety plan over time based on newly identified triggers and what is known to be effective for the individual.
- Development of a relapse prevention plan.
- Individualized interventions, including:
  - Coaching in the development of interpersonal community coping and functional skills including adaptation to home, school, and work environments. This includes socialization skills, developmental issues, daily living skills, school and work readiness activities, and education in co-occurring illness.
  - Encouraging the development and eventual succession of natural supports in workplace and school environments.
  - 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.
  - Providing support and coaching to the individual to obtain and maintain stable housing.

Behavior management interventions are not considered to be CCSS and should be billed under Behavior Management Services [PLACEHOLDER FOR LINK TO BMS SECTION].

For agencies participating in the "Treat First" model," CCSS can be initiated anytime within the first four visits utilizing a Z code or a provisional diagnosis. This diagnosis does not need to meet SMI/SED criteria during the four visits of Treat First. CCSS is often initiated in the very first visit, when deemed appropriate, without a comprehensive multidisciplinary assessment or psychiatric diagnostic evaluation having been completed. After four visits, an individual must have a comprehensive multidisciplinary assessment, or a psychiatric diagnostic evaluation, and a Treatment Plan.

Individuals who 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 Treatment Plan.

The agency providing CCSS must make every effort to provide services in the community outside of clinic settings. The CSW must make every effort to engage the individual and/or the family in achieving treatment/recovery goals and provide follow-up to determine if the services accessed have adequately met the individual's needs.

In addition to the standard client record documentation requirements for all services, case notes are required identifying all activities and location of services, duration of service span (e.g., 1:07–2:19 pm), and a description of the service provided with reference to the CCSS treatment plan and related goals.

CCSS Treatment Plan

The CCSS Treatment Plan must specify natural and facilitated community supports and any other treatment interventions needed for the individual. Medicaid member goals and providers must be clearly identified in the Treatment Plan. Prior to rendering CCSS services an initial treatment plan must be developed collaboratively with the individual and must be updated every 90 days or earlier. The assessment determines the Medicaid member's readiness for change and identifies strengths and challenge areas that may affect treatment decisions toward the Medicaid member's recovery, and the family's involvement in the recovery process. It utilizes a strength-based approach to capitalize on client, family, and community assets.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding CCSS services is below.

CCSS does not require prior authorization but is subject to medical necessity requirements.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to CCSS are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies use procedure code H2015 for each 15-minute unit.
2. Modifiers are required to notate practitioner type:
    A. HO = master's level practitioner
    B. HN = bachelor's level practitioner

C. HM = less than a bachelor's or peer specialist

3. For CCSS delivered in the community add modifier CG as a second modifier.

4. A maximum 16 units may be billed per admission or discharge and may be billed concurrently with Accredited Residential Treatment Center (ARTC), Adult Accredited Residential Treatment Center (AARTC), Residential Treatment Center (RTC), Group Home Service, inpatient hospitalization, or Treatment Foster Care (TFC).

5. CCSS may be billed for purposes of discharge planning and transition for all higher levels of service, and concurrent to intensive outpatient program (IOP) if medical necessity and treatment plan indicate.

6. Transportation of a patient by clinic staff is not billable or reimbursable.

7. CCSS may not be billed in conjunction with multi-systemic therapy (MST) or assertive community treatment (ACT) services, or resource development by New Mexico Corrections Department.

Crisis Intervention Services

Crisis Intervention Services are provided to Medicaid members who are experiencing a crisis, defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow. Crisis Intervention Services include: 1) Mobile Crisis Intervention Services; 2) Telephone Crisis Services; 3) Face-to-Face Outpatient Clinic Visits; and 4) Crisis Stabilization Services. These services help ensure individuals and families experiencing a behavioral health crisis can access immediate care. The services are intended to reduce use of hospital emergency rooms for behavioral health crisis and help divert individuals who experience a behavioral health crisis from incarceration to appropriate treatment.

In addition to the requirements described below, agencies providing Crisis Intervention Services must have partnerships with first responders, judicial and social services, and have processes documenting referrals to other community-based services. Crisis Intervention Service providers must partner with 988 and the State approved crisis line. Prior to delivering any Crisis Intervention Service, all staff must have the required approved minimum training that must include, but is not limited to de-escalation techniques, trauma informed approaches, developmentally appropriate approaches to crisis intervention, patient rights, and least restrictive methods.

Providers of mobile crisis intervention services must also ensure language access for individuals with limited-English proficiency, those who are deaf or hard of hearing, and comply with all applicable requirements under the Americans with Disabilities Act, Rehabilitation Act and Civil Rights Act.

- Definitions of terms pertaining to this manual can be found here.
- General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here.
- General provider enrollment information can be found here. Specific provider responsibilities and requirements related to Crisis Intervention Services are below.
- General member eligibility information can be found here.
- General covered and non-covered services can be found here. General information on telehealth services can be found here.
- General prior authorization and utilization review information can be found here.
- General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Crisis Intervention Services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Mobile Crisis Intervention Services

Overview/Purpose

Mobile Crisis Intervention Services are intended to provide rapid response, individual assessment, and evaluation and for individuals across the lifespan experiencing a behavioral health crisis. A behavioral health crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow. Services must be available where the individual is experiencing the crisis 24 hours a day, 7 days a week, 365 days per year and not may not be restricted to select locations within any region, or particular days or times and must address co-occurring substance use disorders, including opioid use disorder, if identified. Mobile crisis intervention services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

Mobile crisis intervention services include immediate response by a mobile crisis team (MCT) or Children's Mobile Response and Stabilization Service (MRSS) team to provide screening and assessment, stabilization, de-escalation, coordination and referral to health, social, and other services as needed to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization. Services follow an integrated culturally, linguistically, and developmentally appropriate approach, are trauma informed and may be provided prior to an intake evaluation for mental health services. Mobile crisis intervention services includes telephonic follow-up for up to 72 hours after the initial mobile response, which may include, where appropriate, additional intervention and deescalation services, and coordination with and referrals to health, social, emergency services, and other services and supports, as needed. MRSS includes both immediate crisis response and ongoing stabilization and support services, as detailed in the MRSS section.

In the event the recipient of a Mobile Crisis Intervention Service has an existing provider and treatment plan, the crisis provider should coordinate with the existing provider and notify the provider of the individual's engagement with crisis services. The members' provider should work to provide continuity and support to re-establish and/or provide community-based care as soon as possible. The existing provider could advise the MCT/MRSS team to provide input, etc. However, the MCT/MRSS team should ensure the existing treatment plan is sufficient and does not need to be modified as a result of the crisis being experienced by the individual.

Children's MRSS

Children's MRSS is a child, youth, and family specific behavioral health crisis intervention and prevention service. It provides immediate in-person response, screening, and triage to de-escalate crises that are defined by the child, youth, family, or caregivers. MRSS provides ongoing stabilization services and supports, follow up, navigation, and access to community

supports across the system of care to prevent future crises or out of home placement. MRSS services are conducted through a cultural, linguistic, and developmentally appropriate, trauma responsive framework.

The initial mobile response includes activities to de-escalate a crisis, address immediate needs that intensify the crisis, gathering information from family and collateral contacts to complete the MRSS Crisis Assessment Tool (CAT), and collaborative completion of a crisis, safety or relapse prevention plan, as appropriate, with the child, youth, and their family or caregivers.

Following the initial mobile response, MRSS includes up to 56 days of stabilization services, a critical component of MRSS. To maintain care continuity, whenever possible, stabilization services are conducted by a member of the MRSS team who initially responded. The stabilization period is meant to identify deeper reasons for safety and stability events, particularly when they are re-occurrent. The MRSS stabilization process addresses the child and family's urgent and emergent needs through intensive care coordination. The MRSS eight-week stabilization process is not meant to be a limitation of the stabilization period but part of a continuum of care for stabilization, and the individual may at any time transfer to other long-term services and supports for continued care.

Provider Requirements – Mobile Crisis Intervention Services

MCTs

MCTs must comply with the crisis requirements described in 8.321.2.20 NMAC and must:

- Operate 24 hours per day, 7 days per week, and 365 days per year.
- Provide community-based crisis intervention, screening, assessment, and referrals to appropriate resources.
- Be able to administer naloxone and other harm reduction strategies, as warranted.
- Coordinate to ensure appropriate transportation to a place of safety if clinically appropriate or to a higher level of care, if required by the situation.
- Maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, county health and human services, law enforcement, Certified Community Behavioral Health Clinics, crisis care providers including 988, crisis triage centers, and managed care organizations (as applicable).
- Be certified by HCA/BHSD.

Eligible Providers – Mobile Crisis Intervention

MCTs must be certified by HCA/BHSD. MRSS providers must be certified by CYFD/BHS. In addition to this certification the agency must be enrolled as one of the following provider agency types:

- Federally Qualified Health Center (FQHC)
- Community Mental Health Center
- Hospital or Affiliated Clinic
- IHS Hospital or Clinic
- Crisis Triage Center
- PL 93-638 Tribally Operated Hospital or Clinic
- MAD designated CareLink NM Health Home
- Behavioral Health Agency
- Core Service Agency

Mobile crisis intervention services are furnished by a multidisciplinary team that includes at least two members. The team includes at least one behavioral health care professional able to conduct a clinical assessment within their permitted scope of practice under State law and who may be available via telehealth. It is strongly recommended that Certified Family Peer Support Workers, Certified Youth Peer Support Workers, or Certified Peer Support Workers are included in the MRSS team whenever possible. Additional team members may include:

- Licensed Mental Health Therapist
- Certified Peer Support Specialist
- Certified Family Peer Support Worker
- Certified Youth Peer Support Worker
- Community Support Worker
- Community Health Worker
- Community Health Representative
- Certified Prevention Specialist
- Registered Nurse
- Emergency Medical Service Provider
- Licensed Alcohol and Drug Abuse Counselor or Certified Alcohol and Drug Addiction Consultant
- Non-Independently Licensed Behavioral Health Professional
- Emergency Medical Technician

- Licensed Practical Nurse
- Other certified and/or credentialed individuals

MCTs

The MCT must have a full-time clinical director who is an RLD board-approved clinical supervisor and/or a part-time medical director which may include a physician, psychiatrist, or advanced practice registered nurse.

The MCT must also ensure that prior to providing direct care to recipients, all individuals having direct contact with recipient shall have all applicable background checks and receive 25 hours of required training. Annually, all individuals having direct contact with recipients must receive at least 20 hours of crisis related continuing education.

Tribal 638 or Indian Health Service (IHS) facilities may request waivers to the staffing requirements outlined above for MCTs by submitting a staffing plan to the HCA/BHSD.

MRSS

A range of staffing models that include both licensed and non-licensed staff can be used to develop an MRSS team.

MRSS teams may include both licensed and non-licensed staff and must have a Clinical Supervisor who is an independently licensed, RLD board-approved Clinical Supervisor. It is strongly recommended that Certified Family Peer Support Workers, Certified Youth Peer Support Workers, or Certified Peer Support Workers are included in the MRSS team whenever possible. MRSS providers shall ensure MRSS staff complete required training which includes:

- 30 hours of required MRSS training
- CPR and de-escalation training provided through the behavioral health agency
- Any HCA/MAD required trainings

Tribal 638 or IHS facilities may request waivers to the staffing requirements outlined above for MRSS teams by submitting a staffing plan to the Children, Youth and Families Department Behavioral Health Services (CYFD/BHS).

MCT/MRSS Dispatch

Use of State approved tools will be used for dispatch protocols for crisis response services. MCT/MRSS may be dispatched by 988 Lifeline call centers, by the agency operating the MCT or MRSS, or by local law enforcement as outlined in a memorandum of understanding. MCTs and MRSS responders cannot refuse a request for dispatch unless safety considerations warrant involvement of public safety. In those cases, MCT and MRSS providers must establish standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, imminent risk of harm). Policies must appropriately balance a willingness to help

those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history). In the case of simultaneous requests for dispatch, MCT and MRSS providers must use a triage system to prioritize acuity.

Telehealth is allowable, however in vivo MCT and MRSS response is preferred. MCT and MRSS providers can use telehealth to ensure rapid response and clinical decision-making to ensure the crisis is resolved safely.

MCT and MRSS dispatch practices on Tribal lands may differ from MCT dispatch protocol off Tribal lands.

Eligible Members – Mobile Crisis Intervention

Members eligible for Mobile Crisis Intervention Services include all Medicaid eligible individuals. Members eligible for MRSS include children and youth up to age 21 and their families/caregivers.

Covered and Non-Covered Services – Mobile Crisis Intervention

At a minimum, mobile crisis intervention services include:

- Initial response of conducting immediate crisis screening and assessment.
- Mobile crisis stabilization and de-escalation.
- Coordination with and referral to health social and other services as needed to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization.
- Telephonic follow-up within 72 hours of the initial response.
- Up to 56 days of ongoing stabilization and care coordination services for MRSS recipients.

Crisis providers cannot bill a mobile crisis unit code (H2011), mobile crisis per diem (S9485) and/or MRSS stabilization (S9482) rate on the same day.

Crisis providers cannot bill a mobile crisis per diem (S9485) and a telephonic follow-up call (H0030) on the same day.

Evidence-based practice (EBP) teams such as Assertive Community Treatment (ACT), Dialectical Behavioral Therapy (DBT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) should provide initial crisis services for their caseload and not bill for mobile crisis intervention services and stabilization services separately. If MCT/MRSS teams are dispatched to a member receiving ACT, DBT, MST, or FFT the MCT/MRSS team can bill for the crisis response, as applicable, until the EBP team relieves them.

MRSS stabilization should not be billed when a child or youth is under the care of a DBT, MST, FFT, HFW, or other existing care team.

Authorization – Mobile Crisis Intervention

Mobile Crisis Intervention Services are crisis services by nature and are not subject to prior approval. Mobile Crisis Intervention (e.g., H2011, S9485) is authorized for no more than 72 hours per episode. Authorization for Telephonic Follow-up (H0030) is not required if it follows a Mobile Crisis Intervention service. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode. Activities beyond the 72-hour period for MCT must have prior authorization by the State or its designee.

MRSS stabilization services are authorized for no more than eight weeks. For children or youth in need of regular care beyond 72 hours who have been seen by an MRSS crisis team, use of MRSS stabilization services will be determined in conjunction with the caregiver and are based on risk factors identified in the MRSS CAT screening including, but not limited to, housing and economic stability, potential for harm to self or others, substance use or behavioral health challenges, school behavioral and attendance challenges. The goal of stabilization should be to stabilize the child or youth in the home and school, to address immediate de-stabilizing economic factors and address immediate family needs and transition the youth to a longer-term community behavioral health service or support as appropriate.

Billing and Claims Requirements – Mobile Crisis Intervention

Face-to-face contacts with youth and adults and relevant family and kinship network members and collateral contacts are billable. The rates set include costs for the following:

- Direct contacts with individuals and relevant family, caregivers, and kinship network members.
- Direct contacts with clinically relevant collateral contacts such as teachers, school administrators, social workers, probation officers and some social network contracts when clinically indicated.
- Indirect contacts, such as phones calls, with both individuals, caregivers, and relevant family and kinship network members, and collateral contacts.
- Costs of certification, training and data documentation as well as the time spent performing these tasks.
- Face-to-face contacts with individuals, caregivers, and relevant family and kinship network members and collateral contacts.

The following activities **may not be billed:**

1. Mobile crisis intervention services are subject to the coverage limitations that exist for other HCA/MAD covered behavioral health services. See Subsection G of 8.321.2.9 NMAC for general HCA/MAD behavioral health non-covered services or activities. HCA/MAD does not cover the following services billed in conjunction with mobile crisis intervention services to an eligible recipient:
   A. Services past the initial crisis response for individuals receiving ACT, DBT, MST, FFT and HFW.
   B. Inpatient services (can be billed on same day if the recipient requires transfer, however the same provider may not bill for both MCT/MRSS and inpatient services on the same day).
   C. Residential services.

2. Contacts that are not medically necessary.

3. Time spent doing, attending, or participating in recreational activities.

4. Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.

5. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

6. Respite care.

7. ***Client Transportation:*** Rates include staff travel to and from the site of the crisis. If the staff is traveling back to the office, the individual may ride with the staff member. However, there is no adaptive or secure transportation costs included in the mobile crisis rate. If adaptive or secure transportation for the individual or family is needed, then those additional medical transportation costs for service needs are not considered part of Crisis Services and may be covered by the transportation service through the State Plan. Services provided in the car are considered Transportation and time may not be billed for Crisis.

8. Covered services that have not been rendered.

9. Services not in compliance with the crisis service definition within the Behavioral Health Billing and Policy Manual or licensure standards.

10. Services provided to children, spouse, parents, or siblings of the eligible member under treatment or others in the eligible member’s life to address problems not directly related to the eligible member’s issues and not listed on the eligible member’s crisis participant-directed care coordination plan.

11. Services provided that are not within the provider's scope of practice.

12. Any art, movement, dance, or drama therapies.

13. Anything not included in the approved crisis service description.

14. Services that do not follow the requirements outlined in the provider contract, service manual, or licensure standards.

15. Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, service manual, or licensure standards will not be reimbursed.

Mobile crisis and stabilization will use the following procedure codes and modifiers:

Service	Procedure Code	Modifier(s)	MRSS Modifier	Unit
Mobile Crisis Intervention Services – Per Diem for Response Over 4 Hours in Duration				
Mobile Crisis – Licensed Response	S9485	HO	HA	Per Encounter
Mobile Crisis – Non-Licensed Response	S9485		HA	Per Encounter
Mobile Crisis – Licensed Response with Peer	S9485	HT	HA	Per Encounter
Team Response with Telehealth in Hub	S9485	GT	HA	Per Encounter
Mobile Crisis Intervention Services – For Responses 4 Hours or Less in Duration				
Licensed Response – Crisis Licensed & Crisis Level 1 Non-Licensed	H2011	HO	HA	15 minutes Max units: 16

Service	Procedure Code	Modifier(s)	MRSS Modifier	Unit
Non-Licensed Response – Crisis Level 2 Non-Licensed & Crisis Peer/Youth & Family Support	H2011		HA	15 minutes Max units: 16
Licensed Response – Crisis Licensed & Crisis Peer/Youth & Family Support	H2011	HT	HA	15 minutes Max units: 16
Team Response with Telehealth	H2011	GT	HA	15 minutes Max units: 16
Telephonic				
Mobile Crisis Follow-Up – Telephone	H0030	HA		15 minutes
Stabilization Services – For Individuals age 21 and under				
Stabilization Services – Licensed & Peer	S9482	HA, HT		15 minutes
Stabilization Services – Licensed & Non-Licensed	S9482	HA, HT		15 minutes
Stabilization Services – Non-Licensed Only	S9482	HA		15 minutes
Stabilization Services – Licensed Only	S9482	HA, HO		15 minutes

Telephone Crisis Services

Overview/Purpose

Telephone Crisis Services involve screening of calls, evaluation of the crisis situation, provision of counseling and consultation to the crisis callers, referrals to appropriate mental health professionals, and relevant crisis services, and maintenance of crisis communication until a face-to-face response occurs.

Eligible Providers and Provider Requirements – Telephone Crisis Services

Telephone Crisis Services are provided by independently licensed behavioral health practitioners and may include the following staff with the respective qualifications:

- CPSW with one year work experience with individuals with a behavioral health condition(s).
- Bachelor's level community support worker employed by the agency with one year work experience with individuals with a behavioral health condition(s).
- RN with one year work experience with individuals with a behavioral health condition(s).
- Licensed Mental Health Counselor (LMHC) with one year work experience with individuals with a behavioral health condition(s).
- Licensed Master Social Worker (LMSW) with one year work experience with individuals with a behavioral health condition(s).
- Psychiatric physician assistant.
- LADAC; or
- LSAA with one year of work experience with individuals with behavioral health conditions

A licensed independent behavioral health practitioner, that is a RLD board approved Clinical Supervisor or a Psychiatrist may fill the supervisor role.

Telephone Crisis Services must be provided to Medicaid members who are in crisis and to callers who represent or seek assistance for persons in a behavioral health crisis. The agency providing Telephone Crisis Services must establish a toll-free number dedicated to crisis calls for the identified service area and establish a backup crisis telephone system. Calls must be answered by a person trained in crisis response who must document the name of the caller, call center staff, a description of the crisis, intervention provided (e.g., counseling, consultation, referral, etc.), and the date, time, and call duration. The call center must also have processes to screen calls, evaluate the crisis situation, provide counseling and consultation to crisis callers, provide referrals to Mobile Crisis Intervention Services when appropriate, and assurances that face-to-face intervention services are available immediately if clinically indicated either by the telephone service or through formalized agreements with referral sources. When clinically indicated, telephone crisis services must ensure appropriate referrals through the New Mexico Crisis System of Care, including 988, Mobile Crisis Intervention Services, Crisis Triage Centers, etc. Developing or updating the crisis and safety plan is required and needs to be provided to the Medicaid eligible individual (refer to crisis, safety and relapse prevention planning section) during the next face to face session, as appropriate.

Telephone Crisis Service staff are required to complete 20 hours of crisis intervention training that addresses the developmental needs of the full age span of the target population. Training must be provided by a licensed independent mental health professional with two years crisis work experience. Staff are required to complete 10 hours of crisis-related continuing education annually.

Billing and Claims Requirements – Telephone Crisis Services

Telephone Crisis services are billed with procedure code H2011 U1 for each 15-minute unit, with a maximum of 40 units.

Face-to-Face Outpatient Clinic Services

Overview/Purpose

Face-to-Face Outpatient Clinic Crisis Services involves crisis assessment, other screening indicated by the assessment, brief intervention or counseling, and referral to needed resource.

Face-to-Face Outpatient Clinic Services involve a behavioral health provider making an immediate assessment to determine urgent or emergent needs of the person in crisis, which may include a referral to other Crisis Services, or other services as appropriate. The immediate assessment may have already been completed as part of a telephone crisis response. Within the first two hours of the crisis event, the provider will conduct the crisis assessment, stabilize the individual (possibly others), de-escalate the situation, and determine if a higher level of service or other supports are required. Providers will initiate a telephone call or face-to-face follow up contact with an individual in crisis within 24 hours of the initial crisis. Developing or updating the crisis and safety plan is required and needs to be provided to the Medicaid eligible individual (refer to crisis, safety and relapse prevention planning section).

Billing and Claims Requirements – Face-to-Face Outpatient Clinic Services

Clinic Crisis Services are billed using procedure code H2011 U2 for each 15-minute unit.

Crisis Stabilization Services

Overview/Purpose

Crisis Stabilization Services are available for Medicaid members age 14 years and older and involve ambulatory withdrawal management, up to 24 hours crisis stabilization, and navigational services for individuals transitioning to the community.

Eligible Providers and Provider Requirements – Crisis Stabilization Services

Crisis Stabilization Services staff team must include the following:

- A licensed RN with experience or training in crisis triage and managing intoxication and withdrawal management, if this service is provided during all hours of in operation.
- A RLD master's level licensed mental health professional on-site during all hours of operation.

- A certified peer support worker, certified family peer support worker, or certified youth peer support worker on-site or available for on-call response during all hours of operation.
- A board-certified physician or certified, licensed nurse practitioner on-site or on call.

At least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid must be on duty at all times.

Covered and Non-Covered Services – Crisis Stabilization Services

Crisis Stabilization Services include:

- ***Ambulatory withdrawal management*** includes evaluation, withdrawal management, and referral services under a defined set of physician approved policies and clinical protocols. At the time of admission, a comprehensive medical history and physical examination is completed. A psychological and psychiatric consultation is also completed, in addition to appropriate laboratory and toxicology tests. Medicaid members who lack safe transportation are also provided assistance in accessing transportation services. The physician does not have to be on-site, but available during all hours of operation. Clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems is also required.
- ***Crisis stabilization*** includes but is not limited to crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment, screening and assessment, de-escalation and stabilization, brief intervention or psychological counseling, peer support, prescribing and administering medication, if applicable.
- ***Navigational services for individuals transitioning to the community*** includes prescription and medication assistance, arranging for temporary or permanent housing, family and natural support group planning, outpatient behavioral health referrals and appointments, other services determined through the assessment process.

Billing and Claims Requirements – Crisis Stabilization Services

Crisis Stabilization Services must be mutually exclusive (i.e., only one service at a time, with the single exception of a practitioner working directly with the Medicaid member while the peer support worker is working with family support or navigation/referrals, on behalf of the Medicaid member).

The following table outlines Crisis Stabilization services and procedure codes.

Service Description	Procedure Code
Immediate crisis assessment	H2011 U4 for each 15-minute unit
Peer support as navigation services or face-to-face living room support.	H0038 for each 15-minute unit (maximum of 48 units)
Family support services (MCO members only)	S5110
Physical examination	MD, CNS, or CNPs use E & M codes

Service Description	Procedure Code
	RNs use code T1001 for each 30-minute unit (nursing assessment/evaluation)
Observation services rendered by a nurse – skilled services of an RN for the observation and assessment of the patient's condition	G0493 for each 15-minute unit
Medication administration/management by an RN	H2010 for each 15-minute unit (maximum of four units)
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 J0592 Naloxone injection
Collection of blood by routine venipuncture	36415
On-site laboratory services	Use fee schedule codes and rates. The provider must be CLIA-certified. Payment for Medicaid-covered lab services only

Crisis Triage Center (CTC)

Overview/Purpose

Crisis Triage Center (CTC) services ensure individuals and families experiencing a behavioral health crisis can access immediate care. The services are intended to reduce use of hospital emergency rooms for behavioral health crisis and help divert individuals who experience a behavioral health crisis from incarceration to appropriate treatment. CTCs provide voluntary and involuntary stabilization of behavioral health crisis including mental health evaluation and care. Involuntary admissions are allowed only for individuals who have been determined to be a danger to themselves or others and are governed by the requirements of the New Mexico Mental Health and Developmental Disabilities Code, NMSA 1978 43-1-1 through 43-1-21.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to CTC staffing and facilities are below.

Staffing Requirements

CTC agencies must maintain sufficient staff including supervision and direct care and mental health professionals to provide for the care of residential and non-residential clients served by the facility, based on the acuity of client needs. The CTC agency must contract with or employ the following staff:

- **On-site Administrator**. The Administrator is specifically assigned to crisis triage center service oversight and administrative responsibilities. The Administrator must be at least 21 years of age and either: 1) Hold a bachelor's degree in the human services field, have experience in acute mental health; or 2) Is a licensed RN with experience or training in acute mental health treatment. The Administrator may be the same individual as the Clinical Director.
- **Full-time Clinical Director**. The Director must be at least 21 years of age and a licensed independent mental health practitioner, certified nurse practitioner (CNP), or clinical nurse specialist (CNS) with experience and training in acute mental health treatment and withdrawal management services, if withdrawal management services are provided.
- **Registered Nurse.** The Registered Nurse must be on duty during all hours of operation under whom all services are directed, with the exception of services provided by the physician and the licensed independent mental health practitioner. This requirement may be met through access to a supervising nurse who is available via telehealth. The Registered Nurse must be at least 18 years of age, a licensed RN, and have experience

in acute mental health treatment and withdrawal management service if withdrawal management services are provided.

- RLD master's level licensed mental health practitioner.
- **Certified Peer Support Workers (CPSW)**. CPSWs must be certified by the State as behavioral health professionals and meet comprehensive client needs.
- **On-call Physician**. The On-call Physician must be either: 1) A licensed MD or DO; or 2) A licensed CNP, or CNS with behavioral health experience. This individual must be on-call during all hours of operation.
- **Part-time Psychiatric Consultant or Prescribing Psychologist**. The Part-time Psychiatric Consultant or Prescribing Psychologist must either be either: 1) A licensed MD or DO; or 2) A licensed prescribing psychologist or psychiatric CNP. These services may be provided through telehealth. Part-time hours are determined by size of CTC.
- **One staff member trained in specific emergency services.** This individual must be on duty at all times and must be trained in basic cardiac life support (BCLS) and the use of the automated external defibrillator (AED) equipment.

Additional staff may include an emergency medical technician (EMT) with documentation of three hours of annual training in suicide risk assessment.

Outpatient and Residential CTC Facility Requirements

The following requirements apply to both outpatient and residential CTC facilities:

- An independently licensed mental health practitioner or non-independent mental health practitioner under supervision must assess each individual with the assessment focusing on the stabilization needs of the client. The assessment must include medical and mental health history and status, the onset of the illness, the presenting circumstances, risk assessment, cognitive abilities, communication abilities, social history and history of trauma. The CTC must identify Medicaid members at high-risk of suicide or intentional self-harm, and subsequently engage these Medicaid members through solution-focused and harm-reducing methods.
- A licensed mental health professional must document a crisis stabilization plan to address needs identified in the assessment which must also include criteria describing evidence of stabilization and either transfer or discharge criteria. The crisis stabilization plan should be developed in collaboration with the individual, signed by all parties, and provided to the individual. Education and program offerings must be designed to meet the stabilization and transfer of Medicaid members to a different level of care.
- For transfers between facilities, the registered nurse, in collaboration with a behavioral health practitioner, must determine the time and manner of transfer to ensure no further deterioration of the Medicaid member. The registered nurse must also specify the benefits expected from the transfer in the Medicaid member’s record.

- The CTC must develop policies and procedures addressing risk assessment and mitigation including, but not limited to assessments, crisis intervention plans, treatment, approaches to supporting, engaging and problem solving, staffing, levels of observation and documentation, and clinical supervision. The policies and procedures must prohibit seclusion and address physical restraint, if used, and the facility's response to clients that present with imminent risk to self or others, assaultive and other high-risk behaviors.
- Use of seclusion is prohibited. The use of physical restraint must be consistent with federal and State laws and regulation. Physical restraint must only be used only as an emergency safety intervention of last resort to ensure the physical safety of the client and others and must be used only after less intrusive or restrictive interventions have been determined to be ineffective.
- If serving both youth and adult populations, the service areas must be physically separate. If possible, in different wings or units.
- If an on-site laboratory is part of services, the appropriate clinical laboratory improvement amendments (CLIA) license is required.
- For residential CTCs, emergency screening and evaluation services must be available 24 hours per day, seven days per week.
- Readiness for discharge must be reviewed in collaboration with the Medicaid member every day.

Eligible Providers

General provider enrollment information can be found here.

All CTCs must be licensed by the State as a Crisis Triage Center offering one of the following types of service:

- A CTC structured for less than 24-hour stays providing only outpatient withdrawal management or other stabilization services.
- A CTC providing outpatient and residential crisis stabilization services.
- A CTC providing residential crisis stabilization services.

CTC agency practitioners must be contracted or employed by an agency and licensed by the State. For services performed by providers licensed outside of New Mexico, a provider's out-of-state license may be accepted in lieu of licensure in New Mexico if the out-of-state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

Eligible Members

General member eligibility information can be found here.

CTC services are covered for Medicaid members who are:

- 18 years of age and older and meet the CTC admission criteria if the CTC is an adults-only agency; or
- 14–17 years of age if the CTC is a youth agency.

Medicaid members may also have other co-occurring diagnoses. CTCs may not refuse service to any Medicaid members who meets the agency's criteria for services, or solely based on the Medicaid member being on a law enforcement hold or living in the community on a court ordered conditional release.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to CTC services are below.

CTC services include:

- Comprehensive medical history and physical examination of Medicaid member at admission.
- An assessment and a crisis stabilization plan.
- Crisis stabilization including, but not limited to:
  - Crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment.
  - Screening and assessment
  - De-escalation and stabilization.
  - Brief intervention and psychological counseling.
  - Peer support.
- Ambulatory withdrawal management (non-residential) based on American society of addiction medicine (ASAM) 2.1 level. This includes evaluation, withdrawal management and referral services under a defined set of physician-approved policies and clinical protocols; clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems; psychological and psychiatric consultation; and other services determined through the assessment process. [PLACEHOLDER FOR LINK TO ASAM 2.1]
- Clinically or medically monitored withdrawal management in residential setting, if included, not to exceed services described in level 3.7 of the current ASAM patient placement criteria. [PLACEHOLDER FOR LINK TO ASAM 3.7]

- Prescribing and administering medication, if applicable.
- Conducting or arranging for appropriate laboratory and toxicology testing.
- Navigational services for individuals transitioning to the community when available include:
  - Prescription and medication assistance.
  - Arranging for temporary or permanent housing.
  - Family and natural support group planning.
  - Outpatient behavioral health referrals and appointments.
  - Other services determined through the assessment process.
- Assistance in accessing transportation services for Medicaid members who lack safe transportation.

A CTC does not include acute medical alcohol detoxification that requires hospitalization and medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.

For residential CTCs, Medicaid member visits must be at least 24 hours and may be as long as 14 days, or until the Medicaid member is determined stable and ready for discharge.

For outpatient/non-residential CTCs, services last less than 24 hours. CTC services begin when the Medicaid member is assessed to require crisis stabilization services.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding CTC services is below.

A CTC does not require prior authorization but is subject to utilization review (UR) for medical necessity and program compliance. The provider agency must contact HCA or its authorized agents to request UR instructions. It is the agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD preferred provider agreement, a provider agency agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements.

While CTC services do not require prior authorization, other procedures or services may require prior authorization from MAD or its designee (e.g., inpatient admission). Services for which prior authorization was obtained remain subject to UR at any point in the payment process, including after payment has been made. It is the agency's responsibility to contact

MAD or its designee and review documents and instructions available from MAD or its designee to determine when prior authorization is necessary.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to CTC are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

CTCs are reimbursed through an agency specific cost-based bundled rate developed by the agency and HCA. To start the rate setting process, a new CTC should contact ctc@nmrecovery.org 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. HCA 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 HCA 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.

Billing Instructions

1. Bill both types, specialty 246 (residential/non-residential) and specialty 247 (nonresidential), on a UB claim form utilizing revenue codes.

2. For residential/non-residential CTCs:

   A. Bill specialty 246 (residential/non-residential) on UB claim form using revenue codes specified below.

   B. Bill revenue code 0169, room and board if staying more than 24 hours.

   C. Bill revenue code 0513, psychiatric clinic if staying less than 24 hours.

   D. Type of bill is 089X.

   E. 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.

   F. 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. Room and board per diem ($50 per client per day) = HCPCS H0047.

3. For non-residential only (outpatient) CTCs:
   A. Bill specialty 247 (non-residential) on UB claim form using revenue codes specified below.
   B. Bill revenue code 0513, psychiatric clinic.
   C. 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 rates and may be billed separately.

Day Treatment Services (DTS)

Overview/Purpose

Day Treatment Services (DTS) are individualized, trauma informed care provided in a school or other community setting (facility licensed by LCA, see NMAC 7.20.11.7 AO, 7.20.11 NMAC) and are distinct from partial hospitalization services provided in a psychiatric hospital. The goal of DTS is to maintain the Medicaid member in their home or community environment. DTS are intended to complement and coordinate with the Medicaid member's educational system. There must be a distinct separation between DTS services in staffing, program description, and physical space from other behavioral health services offered.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to DTS are below.

Each agency must be certified by the State Children, Youth, and Families Department (CYFD) and providers must complete background and verification requirements. Each certified service agency is responsible for establishing written policies and procedures that specify how applicable certification requirements are met for DTS providers.

The DTS Clinical Director (or RLD board-approved Clinical Supervisor) is responsible for clinical oversight of the services and for providing supervision, support, and consultation for agency direct service staff. All direct service staff receive documented clinical supervision for a minimum of two hours per month from the Clinical Director (or Clinical Supervisor).

Eligible Provider

General provider enrollment information can be found here. An agency must be certified by CYFD to provide DTS.

Eligible Members

General member eligibility information can be found here.

DTS is a covered service for Medicaid members under the age of 21 who meet the following criteria:

- Emotional, behavioral, and neurobiological or substance use disorder diagnosis;
- May be at high risk of out-of-home placement;
- Requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school; and

- Has been determined to meet the criteria established by MAD or its designee for admission to DTS.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to DTS are below.

DTS are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include parent and Medicaid member education, and skills and socialization training that focus on the amelioration of functional and behavioral deficits. This includes intensive coordination and linkage with the Medicaid member's school or other child serving agencies. Other behavioral health services (e.g., outpatient counseling, Applied Behavioral Analysis) may be provided when the goals of the service are clearly documented and utilize a clinical model for service delivery and support.

The structured program of care is scheduled for a minimum of four hours per day, two to five days per week based on the acuity and the clinical needs of the member and family. Appropriate staff and implementation of the member's crisis plan to respond to a member's crisis situation must be available 24-hours per day. Services must be identified in the treatment plan, including crisis planning, which is formulated on an ongoing basis by the treatment team.

The following services must be furnished by a DTS agency:

- The assessment and diagnosis of the social, emotional, physical, and psychological needs of the Medicaid member and their family for treatment planning to ensure that evaluations already performed are not unnecessarily repeated.
- Development of individualized treatment and discharge plans and the ongoing reevaluation of these plans.
- Regularly scheduled individual, family, multifamily, group, or specialized group sessions focused on the attainment of skills. Skills may include managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention. Skills should be defined in the DTS treatment plan.
- Outreach to assist the Medicaid member in improving functional and behavioral skills.
- Supervision of self-administered medication, as clinically indicated.
- Therapeutic recreational activities that support clinical objectives and are identified in the Medicaid member's treatment plan.
- To respond to the eligible members crisis situations, the agency must implement a crisis plan or ensure 24-hour availability of appropriate staff. Crisis plan will define for the Member what services can be accessed 24 hours a day, seven days a week.

- Advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the Medicaid member pursuant to the treatment plan.

DTS Treatment Plan

Services must be identified in the DTS Treatment Plan, and treatment planning processes are individualized and ongoing. The process includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria. The DTS Treatment Plan guides and records for each Medicaid member their individualized therapeutic goals and objectives, therapeutic services provided, and discharge and aftercare plans.

Initial and Comprehensive Treatment Plan

The Initial Treatment Plan must be developed and documented within 72 hours of admission to the service. Individualized treatment goals and objectives are targeted in the first 14 days of treatment. The Comprehensive Treatment Plan is based on the Comprehensive Assessment and must be developed and documented within 14 days of admission to the service.

The Initial Treatment Plan and Comprehensive Treatment Plan must:

- Encourage full participation of treatment team members, including the Medicaid member and their parent(s)/legal guardian. If full participation is not possible, the plan must document reasons for nonparticipation of Medicaid member and/or family/legal guardian.
- Use language the Medicaid member and their family members can understand.
- Improve Medicaid member motivation and progress, and strengthen appropriate relationships.
- Improve Medicaid member self-determination and personal responsibility.
- Utilize Medicaid member strengths.
- Be 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.

The Initial Treatment Plan and Comprehensive Treatment Plan must also document the following in measurable terms:

- Specific behavioral changes targeted, including potential high-risk behaviors.
- Corresponding time-limited intermediate and long-range treatment goals and objectives.
- Frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures.

- Staff responsible for each intervention.
- Projected timetables for the attainment of each treatment goal.
- A statement of the nature of the specific problem(s) and needs of the member.
- A statement and rationale for the plan to achieve treatment goals.
- Specific to Medicaid member in custody of the department.
- Describe the individual's permanency plan for clients in the custody of the department.
- Provides that members 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.

Discharge Planning

Discharge Plan documents outline that the Medicaid member has achieved the objectives of the Treatment Plan. These plan documents must include:

- A projected discharge date updated as clinically indicated.
- Behavioral and other clinical criteria as conditions under which discharge will occur.
- Confirmation that the member has achieved the objectives of the Treatment Plan.
- Evaluation of high-risk behaviors or the potential for such.
- Documentation that discharge is safe and clinically appropriate for the member.
- Documentation of level of care, specific services to be delivered, and the living situation into which discharge is projected to occur.
- Establishes specific criteria for discharge to a less restrictive setting.
- Options for alternative or additional services that may better meet the Medicaid member's need.
- Documentation confirming the individual(s) responsible for implementing each action specified in the Discharge Plan.

Authorizations

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding DTS is below.

DTS does not require prior authorization but is subject to medical necessity requirements. The need for DTS must be identified through an EPSDT tot to teen health check or other diagnostic evaluation.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to DTS are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Providers must use HCPCS code H2012 for each one-hour unit of DTS.

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

3. DTS may not be billed in conjunction with: 1) educational programs; 2) pre-vocational training; 3) vocational training which is related to specific employment opportunities, work skills or work settings; 4) any service not identified in the treatment plan; 5) recreation activities not related to the treatment plan; 6) leisure time activities such as watching television, movies or playing computer or video games; 7) transportation reimbursement for the therapist who delivers services in the family's home; or (8) a partial hospitalization program and residential programs cannot be offered at the same time as day treatment services.

Dialectical Behavior Therapy (DBT)

Overview/Purpose

Dialectical Behavior Therapy (DBT) is a cognitive behavioral approach to treatment to teach individuals better management of powerful emotions, urges, and thoughts that can disrupt daily living if not addressed in a structured treatment approach. The required components of a comprehensive DBT program include individual DBT therapy, DBT skills groups, 24 hours a day, seven days a week availability for skills coaching and a clinical consultation team.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to DBT are below.

A DBT agency must meet the following requirements:

- Comply with the requirements in Subsections A and B of 8.321.2.9 NMAC (8.321.2 NMAC [state.nm.us]).
- Complete certification through DBT®-Linehan Board of Certification. This evidence-based practice includes service coordination, individual, group, and family therapy.
- Be approved through a joint letter from the HCA and CYFD. Once approved, a provider will receive an approval letter which may be used to complete the Medicaid provider enrollment process. The provider should also provide the MCOs with a copy of the approval letter to complete the contracting process.

A full-time outpatient therapist can maintain a maximum case load of 15 hours of DBT treatment on their case load. These hours include groups and individuals.

Eligible Providers

General provider enrollment information can be found here.

The following Mental Health Practitioners who are licensed in the State of New Mexico to diagnose and treat behavioral health acting within the scope of all applicable state laws and their professional license may provide DBT if certification is obtained from DBT® Linehan Board of Certification:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)

- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Alcohol & Drug Abuse Counselors (LADACs)
- Advanced Practice Registered Nurses (APRN) (must be a nurse practitioner specialist in Adult Psychiatric and Mental Health, and Family Psychiatric and Mental Health or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

DBT agencies must be able to provide 24 hours a day, seven days a week availability for skills coaching. DBT Therapists must be independently licensed and certified but may work with and provide supervision of master's or bachelor's level staff if they are a board-approved clinical supervisor with the RLD. Master's and bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population (individuals with mental health disorders). There is no age restriction for DBT.

Unlicensed staff may not provide DBT therapy — they may only provide service coordination and group therapy in conjunction with a trained, certified, independently licensed DBT therapist. An active DBT team requires DBT certification of at least two certified treatment providers working collaboratively with one another using the DBT services as defined by the DBT Services program selected by the State. When the second provider is not within the same agency, only one agency would bill.

- **Definition of a DBT Therapist:** An independently licensed mental health provider in the State of New Mexico certified by the DBT Linehan Board.
- **Definition of a DBT Trainee:** A professional meeting the eligible provider requirements above who is in the process of obtaining their DBT®-Linehan Board of Certification or who is a trainee registered with the NM Regulation and Licensing Department for one of the licenses listed above recognized by the State of New Mexico who is working to obtain their license and DBT® Linehan Board of Certification. This individual is not able to provide individual DBT but may provide service coordination and group therapy in conjunction with a trained licensed DBT Therapist. The DBT Trainee is a master's level independently licensed therapist who is not yet DBT Certified but that individual is not permitted to bill for individual DBT therapy. This individual may bill for a non-EBP therapy until they are DBT certified.
- **Definition of a Care Manager:** An individual who does not meet the requirements of a "DBT Therapist" or a "DBT Trainee" and is either: 1) Assisting a DBT Therapist (not a trainee) with a DBT group; or 2) Assisting a DBT Therapist with the service coordination of a client including: adjustments to intake, assessment, case assignment / caseload, scheduling, providing navigation and linking services for the client to other Medicaid services. A Care Manager must have a degree in social work, counseling, psychology, or

a related human services field and must have at least three years of experience working with the target population, that is, children/adolescents, their families, and adults.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for DBT services include individuals who have a mental health and/or substance use disorder. There are no age restrictions for DBT services.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to DBT are below.

DBT services are comprehensive of all other behavioral health services, with the exception of psychological evaluation or assessment and medication management. These services may be provided and billed separately for a member receiving DBT services. The required components of a comprehensive DBT program include individual DBT therapy, DBT skills groups, 24 hours a day, seven days a week availability for skills coaching, and a clinical consultation team.

All services provided while a person is a resident of an Institution for Mental Disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by Medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

The following services shall be excluded from Medicaid coverage and reimbursement of DBT:

- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services provided at a worksite, which are job-oriented and not directly related to the treatment of the member's needs.
- These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.
- Residential services, including therapeutic foster care and RTC services.
- BH services by licensed and unlicensed individuals, other than medication management and assessment.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding DBT services is below.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to DBT are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. DBT providers (Provider Specialty Type 138) bill the following procedure codes with modifiers for each 15-minute increment:
    A. DBT Therapist: H2019 HO
    B. DBT Trainee: H2019 HN
    C. DBT Care Manager: H2019
    D. DBT Group Therapy (2:2): H2019 HQ, UN
    E. DBT Group Therapy (2:3; Group of 3 or 4 individuals): H2019 HQ, UP
    F. DBP Group Therapy (2:5; Group of 5 to 9 individuals): H2019 HQ, UR
    G. DBT Group Therapy (2:10; Group of 10 or more individuals): H2019, HQ, US
2. **DBT specific group therapy**: Group therapy must be performed and led by a DBT certified therapist and must include either a DBT Trainee or DBT Care Manager. The provider team only bills once for each attendee, and is billed by the independently licensed, certified DBT Therapist.
3. Phone coaching, which does not involve face-to-face occurrences, are available 24 hours per day, including weekends and holidays. DBT phone coaching is billable. If face-to-face intervention is needed during a phone coaching call, the local mental health emergency hotline or the local emergency room will be utilized. DBT 24/7 should be billed by the DBT therapist for the actual time spent using individual therapy rates. If a DBT trainee or Care Manager is helping with phone coverage through coaching (not therapy), they would bill for the individual rates.
4. DBT may not be billed in conjunction with other outpatient therapy codes.
5. Typical sessions during which there is both a child-delivered portion of the session and a parent-delivered portion of the session may be billed with the patient present, as long as the entirety of the service is provided to, or directed exclusively toward the treatment of, the Medicaid-eligible child or youth. If the parent could benefit from DBT themselves, the parent would need to be assessed and receive DBT as part of their treatment plan.

6. If there is a parent-directed session for which the child is not present, the parent-directed session must be directed exclusively toward the treatment of the Medicaid-eligible child or youth. If the parent could benefit from DBT themselves, the parent would need to be assessed and receive DBT as part of their treatment plan.

7. Collateral contacts billable to Medicaid should involve contacts with parents or guardians, and relevant natural supports using the appropriate procedure code (using HCPCS H2019 with the applicable modifier) as stated above. All contacts must be based on goals from the individual's treatment plan.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child/adult-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child/adult serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is NOT billable through Medicaid. Services may be provided by these child/adult-serving systems; however, the services provided must be funded through the agency providing the service.

Eye Movement Desensitization and Reprocessing (EMDR)

Overview/Purpose

Eye Movement Desensitization and Reprocessing (EMDR) is an evidence-based psychotherapy that treats trauma-related symptoms. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to EMDR are below.

An EMDR agency must meet the following requirements:

- Comply with the requirements in Subsections A and B of 8.321.2.39 NMAC (8.321.2 NMAC [state.nm.us]).
- Complete certification through the EMDRIA (EMDR International Association). EMDRIA sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met (see www.emdria.org). EMDRIA establishes two levels of training for practitioners in EMDR therapy: 1) EMDRIA Approved Basic Training; and 2) EMDR Certification. The standard level of training, which allows a practitioner to provide EMDR therapy, is EMDRIA Approved Basic Training. For the purposes of providing EMDR therapy under New Mexico Medicaid, either level is acceptable.
- Be approved through a joint letter from the HCA and CYFD. Once approved, a provider will receive an approval letter which may be used to complete the Medicaid provider enrollment process. The provider should also provide the MCO with a copy of the approval letter to complete the contracting process.

Eligible Providers

General provider enrollment information can be found here.

The following Mental Health Practitioners who are licensed in the State of New Mexico to diagnose and treat behavioral health acting within the scope of all applicable state laws and

their professional license may provide EMDR services if certification is obtained from EMDRIA:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Advanced Practice Registered Nurses (APRN) (must be a nurse practitioner specialist in Adult Psychiatric and Mental Health, and Family Psychiatric and Mental Health or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice).

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for EMDR services include individuals who have a mental health and or co-occurring disorder. There are no age restrictions for EMDR services.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here.

All services provided while a person is a resident of an Institution for Mental Disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by Medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

The following services shall be excluded from Medicaid coverage and reimbursement of EMDR:

- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services provided at a worksite, which are job-oriented and not directly related to the treatment of the member's needs.
- These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.

- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.
- Limitations and exclusions for outpatient individual therapy (90832–90837), group (90853) and family therapy (90846 and 900847) apply as otherwise listed in New Mexico guidance.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding EMDR services is below.

EMDR does not require prior authorization but is subject to medical necessity.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to EMDR are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. EMDR providers (Provider Specialty Type 137) use the following procedure codes with modifiers:
    A. 30-minute EMDR session (Psychotherapy with Patient Present): 90832, U3
    B. 45-minute EMDR session (Psychotherapy with Patient Present): 90834, U3
    C. 60-minute EMDR session (Psychotherapy with Patient Present): 90837, U3
    D. 50-minute EMDR session (Family Psychotherapy without Patient Present): 90846, U3
    E. 50-minute EMDR session: 90847, U1 (Family Psychotherapy with Patient Present): 90847, U3
2. Only direct staff face-to-face time with the child-or-family may be billed. EMDR is a face-to-face intervention with the individual and caregiver present. However, the child receiving treatment does not need to be present for all contacts.
3. Typical sessions during which there is both a child-delivered portion of the session, and a parent-delivered portion of the session, may be billed as 90832, 90834, or 90837 (or their successors — Psychotherapy, with patient present), as long as:
    A. The client is present for all or the majority (greater than 50%) of the time billed; and
    B. The entirety of the service is provided to, or directed exclusively toward the treatment of, the Medicaid-eligible child, youth, or adult.

4. If there is a parent-directed session for which the child is not present for the majority of the time, the appropriate procedure code must be billed (e.g., 90846 or its successor – Family Psychotherapy without Patient Present).

    A. The parent-directed session must be directed exclusively toward the treatment of the Medicaid-eligible child, or youth.

5. Collateral contacts billable to Medicaid should involve contacts with parents or guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's treatment plan. Phone contacts are not billable. **NOTE:** The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services, and foster care programs. Coordination with these child serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid. Services may be provided by these child-serving systems; however, the services provided must be funded through the agency providing the service.

Functional Family Therapy (FFT)

Overview/Purpose

Functional Family Therapy (FFT) is an evidence-based, short-term, and intensive family-based treatment. FFT program goals are to:

1. Integrate families' voices in all phases of treatment.
2. Develop and grow in innovative, collaborative, dynamic, and evidence-based practices (EBP).
3. Practice evidence-based programs in evidence-based ways to maintain model fidelity.
4. Evolve the model in a way that is responsive to the needs of families, communities, and agencies.
5. Provide innovative, real-time cloud-based technology and training for predictability and outcomes.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to FFT are below.

An FFT agency must meet the following requirements:

- Comply with requirements in Subsections A and B of 8.321.2.9 NMAC (8.321.2 NMAC [state.nm.us]).
- Engage in training, consultation, and oversight by either FFT, LLC or FFT Partners.

Eligible Providers

General provider enrollment information can be found here.

An FFT team includes, at a minimum, an FFT-certified board-approved Clinical Supervisor and at least two FFT-certified treatment providers working collaboratively with one another using the FFT services as defined by the international FFT Services program provided by the State. Program staff must include, at a minimum, licensed master's and/or bachelor's level staff.

An agency must hold a copy FFT certification, or any of its approved subsidiaries, and meet the State licensure and provider enrollment requirements for each FFT team. An active FFT team requires FFT certification of a Clinical Supervisor and at least two FFT certified

treatment providers working collaboratively with one another using the FFT services as defined by the State. Providers must be engaged in training, consultation, and oversight by either of the following training entities: FFT LLC or FFT Partners.

Staffing for FFT services must be comprised of no more than one-quarter bachelor's level staff and, at minimum, three-quarters licensed master's level staff. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population. Bachelor's level staff may provide non-clinical components of FFT treatment. Exceptions to these requirements must be approved through the official FFT training organization.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for FFT include youth between the ages of 11 to 18 who meet the criteria of ~~a~~ serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to FFT are below.

FFT has a wide range of clinical applications and has been effectively integrated into a wide array of multi-ethnic, multicultural contexts. FFT is listed with the highest rating by the Title IV-E Prevention Services Clearinghouse.

FFT is an intervention that consists of 12 to 20 family sessions over the course of three to eight months. FFT interventions occur in three primary phases (engagement/motivation, behavior change, and generalization), each with measurable process goals and family skills that are the targets of intervention. Each phase has specific goals and practitioner skills associated with it. The specificity of the model allows for monitoring of treatment, training, and practitioner model adherence in ways that are not possible with other less specific treatment interventions.

FFT can be conducted in clinic settings as an outpatient therapy or a home-based model. Services are available in-home, at school, and in other community settings including a federally qualified health center (FQHC), an Indian Health Service (IHS) facility and a PL 93-638 tribally-operated facility.

All services provided while a person is a resident of an Institution for Mental Disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by Medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

The following services shall be excluded from Medicaid coverage and reimbursement of FFT:

- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services provided at a worksite, which are job-oriented and not directly related to the treatment of the member's needs.
- These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding FFT services is below.

FFT does not require prior authorization but is subject to medical necessity.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to FFT are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. FFT providers (Provider Specialty Type 135) bill the following procedure codes with modifiers for each 15-minute increment:
    A. FFT Master's Level Team: H2019 HK, HO
    B. FFT Master's Level Team, Rural: H2019 HK, HO, TN
    C. FFT Bachelor's Level Team: H2019 HK, HN
    D. FFT Bachelor's Level Team, Rural: H2019 HK, HN, TN
2. FFT may be billed for direct staff face-to-face time with the child/youth, family, or other collateral contacts. Only direct staff face-to-face time with the child or family or other collateral contacts may be billed. Collateral contacts include probation programs, public guardianship programs, special education programs, child welfare/child protective evidence-based practices in coordination with other child-serving systems. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid if meeting a requirement of another primary program. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. FFT may be billed in conjunction with:

    A. Medication management and assessment.

    B. Another behavioral health service (e.g., individual therapy, psychosocial rehabilitation or Comprehensive Community Support Services) so long as the following conditions are met:

        i. The youth have a high level of need such that a combination of both family-focused and individually focused services is needed to meet the youth's required level of treatment intensity.

        ii. There is a clear treatment plan or Plan of Care indicating distinct goals or objectives being addressed by both the FFT service and by the concurrent service.

        iii. The services are delivered in coordination of each other to ensure no overlap or contradiction in treatment.

4. The child/youth receiving treatment does not need to be present for all contacts. Contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

5. FFT may not be billed in conjunction with Residential services (e.g., RTC).

6. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly.

7. Medicaid may not reimburse for children in the custody of the New Mexico Juvenile Justice system post-adjudication who reside in detention facilities, public institutions or secure care, and are inmates of a public institution. If the child is in Juvenile Justice custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the FFT, except for the oversight of restorative measures, which is a juvenile justice function; and

8. Medicaid does not pay when the vocational supports provided via FFT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available unless the child is not eligible for vocational rehabilitation.

High-Fidelity Wraparound

Overview/Purpose

New Mexico High-Fidelity Wraparound (HFW) provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Individuals eligible for HFW are at-risk or have a history of using services and resources that are restrictive and out of their communities and have experience with multiple systems.

Provider Requirements

An approved HFW provider must:

- Comply with requirements for HFW in the NMAC (8.321.2.41); and
- Engage in training and coaching for HFW, according to the NM HFW model.

Eligible Providers

A provider must follow the application process listed on (link). Approved providers will be issued an approval letter which will be used to complete enrollment in New Mexico Medicaid and for contracting with MCOs. Approval as a HFW provider will be for the length of three years, at which point they must be approval through a continuation application.

Approved HFW providers must maintain staffing requirements, which includes:

- Certified Wraparound Facilitator (Passing a Wraparound Facilitator exam offered by the State's designated credentialing board.)
- Wraparound Supervisor-Coach
- Program Director or Administrator
- Clinical Director
- Family Peer Support Worker

Eligible Members

HFW Eligibility Criteria: HFW is not a clinical service and as such does not require identification in a service plan or clinical assessment for referral. A person is eligible to receive HFW if they meet the following criteria:

- Children or youth who have a current or historical designation of severe emotional disturbance (SED); and

- Functional Impairment in two or more domains identified by the Child and Adolescent Needs and Strengths (CANS) tool; and
- Have current or historical involvement in two or more systems such as special education, behavioral health, child welfare or juvenile justice, or at risk for such involvement in the case of children aged 0 to 5; and
- At-risk or in an out of home placement.

The purpose of HFW is to provide intensive care coordination to eligible recipients through the HFW model. A HFW provider is expected to conduct Wraparound through a No Reject and No Eject premise.

- “No Reject” means that the provider must accept all referrals and conduct vetting for eligibility. A provider will not discriminate against nor use any policy or practice that has the effect of discriminating against an individual on the basis of health status, mental status or need for services and supports.
- “No Eject” means that the provider must persevere to provide High-Fidelity Wraparound to youth and families, regardless of changes in levels of care, the type of needs, or reluctance to engage, as described in the HFW Transition Protocol within the NM — HFW PMPIG.
- Prematurely discharging youth and families from Wraparound, for reasons other than exclusionary criteria, such as age and eligibility is not part of the NM-HFW Discharge protocol.

Covered and Non-Covered Services

HFW provides intensive care coordination, using the HFW model, across services, levels of care, systems, community stakeholders and support systems. HFW includes four phases: 1) Engagement; 2) Planning; 3) Adapting/Refining; and 5) Transition.

Billing and Claims Requirements

1. New Mexico HFW is paid in a per member per month (PMPM) basis.
2. PMPM payment for HFW services to an approved provider will be as follows:
    A. The facility NPI may be used in the rendering provider field as well as in the billing provider field.
    B. The member must meet the HFW eligibility criteria.
    C. No additional code will need to be billed in conjunction to the G9003 code.
    D. FQHC: Use the CMS 1500 claim form using the HCPCS code listed below for reimbursement.

E. For FQHC, IHS, and Tribal 638: if preferring to utilize the fee schedule rates, the provider may contact the MAD Benefits and Reimbursement Bureau.

G9003	COORDINATED CARE FEE, RISK, ADJUSTED HIGH, INITIAL	1	CMS-1500	$1995.41

The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Integrated Care and Interdisciplinary Teaming

Overview/Purpose

Integrated Care and Interdisciplinary Teaming ("Interdisciplinary Teaming") is a set of case-level learning, reasoning, and decision processes that involves applicable service providers and the Medicaid member working together collectively to achieve treatment goals. Examples of applicable service providers include physical health, behavioral health and community support providers. 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. Shared decision-making is a key component of Interdisciplinary Teaming and involves the member and service providers working together to make decisions and select the right care for the member that balances risks and expected outcomes with the member's preferences and values.

An interdisciplinary team meeting includes the Medicaid member, as well as an interdisciplinary team of health professionals, and may include representatives of community agencies and family members. The purpose of the meeting is to plan and coordinate activities of the member's care, particularly when a change in condition has occurred, and the result is a treatment plan update. This face-to-face session becomes a billable event.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Interdisciplinary Teaming are below.

The Lead Agency, Participating Agencies, and any other team members attending the interdisciplinary team meeting, must be identified in the member's treatment record. Written or electronic signatures from a representative from each participating agency and from providers participating in the meeting the must be documented with the date and time. The lead agency may use teaming within the agency or across multiple agencies. For example, a lead agency may have multiple practitioners working with the individual (CSW, LMSW, LPCC). The agency may bill for interdisciplinary teaming within their agency.

Meeting documentation must also include progress toward the Medicaid member's 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.

Eligible Providers

General provider enrollment information can be found here.

A Lead Agency is a MAD enrolled agency that has current responsibility for the Medicaid member. 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.

A Participating Agency is 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.

Eligible Members

General member eligibility information can be found here.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Interdisciplinary Teaming are below.

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. There are six elements of Interdisciplinary Teaming that are intended to support ongoing group-based processes:

- **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.
- **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.
- **Collaboration:** Operation of shared decision-making processes used to identify needs, set goals, formulate courses of action, implement supports and services, and evaluate results.
- **Consensus:** Negotiated agreements necessary for achieving common purpose and unity of effort among members of a person's team.
- **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.
- **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.

With the member's knowledge and consent, these interdisciplinary teaming elements may be performed through various communication modalities (e.g., texting members to update them on an emergent event, using email communications to ask or answer questions, sharing assessments/plans/reports, telephone or video conference calls).

Interdisciplinary Teaming is only a billable event when key decisions are made in a face-to-face meeting the Medicaid member and the providers. The face-to-face requirement may be waived when it is determined that face-to-face attendance would have a negative clinical impact. This determination must be documented in the members treatment plan/record. Any meeting at which the individual or their representative is absent when their needs and services are discussed is an agency staffing.

Authorization

General prior authorization and utilization review information can be found here.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Interdisciplinary Teaming are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

There are two different processes for Interdisciplinary Teaming billing, which are only covered for outpatient services:

- For serious emotional disturbance (SED), severe mental illness (SMI), substance use disorder (SUD), co-morbid physical health conditions and co-occurring conditions.
- All other BH diagnoses and co-morbid physical health conditions with other co-occurring diagnoses.

	Procedure Code	Billing Guidance
Integrated Care and Interdisciplinary Teaming for Medicaid Members with an SMI, SED, SUD and Co-occurring Conditions. There must be at least three providers in attendance to bill these codes, and only three agencies may bill for a single session. If more than three providers attend the meeting, the group decides which provider will bill.		
Lead Agency Agencies eligible to bill are CMHC, FQHC, IHS, Tribal 638, CYFD, hospital OP, CSA, CTC, BHA, OTP, or a governmental agency.	G0175 U1	• Bill one unit for conference lasting 30–89 minutes • Bill two units for conference lasting 90 minutes or longer
Participating Agency	G0175 U2	• Bill one unit for one practitioner attending for 30–89 minutes

	Procedure Code	Billing Guidance
Any agency or provider type can bill.		• Bill two units for one practitioner attending for 90 minutes or more
	G0175 U3	• Bill one unit for multiple practitioners from the same agency attending for 30–89 minutes • Bill two units for multiple practitioners from the same agency attending for 90 minutes or more
Integrated Care and Interdisciplinary Teaming for Medicaid Members with a qualifying behavioral health condition. There must be at least two providers in attendance to bill these codes and only two agencies or providers may bill for the same session. If more than two providers attend the meeting, the group decides which provider will bill.		
Lead Agency Any provider type can bill.	S0220 U1	• Bill one unit for conference lasting 30 minutes
	S0221 U1	• Bill one unit for conference lasting 60 minutes or longer
Participating Agency Any provider type can bill.	S0220 U2	• Bill one unit for conference lasting 30 minutes
	S0221 U2	• Bill one unit for conference lasting 60 minutes or longer

Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals and Psychiatric Units of Acute Care Hospitals

Overview/Purpose

Inpatient psychiatric care provides 24-hour care that is highly structured and focuses on rapid stabilization, treatment planning, and discharge planning. Inpatient psychiatric care is provided in a freestanding psychiatric hospital or psychiatric units of acute care hospitals. There are no age restrictions for Medicaid members receiving care in psychiatric unit of an acute care hospital. There are, however, age restrictions for care in a freestanding psychiatric hospital.

Inpatient psychiatric care furnished in freestanding psychiatric hospitals is part of the early and periodic screening, diagnosis and treatment (EPSDT) program and may be subject to age limitations depending on whether the facility is considered to be an “institution for mental disease (IMD).” A freestanding psychiatric hospital with more than 16 beds is considered an IMD and subject to the federal Medicaid IMD exclusion that prohibits Medicaid payment for inpatient stays for eligible Medicaid members aged 22–64 years. A managed care organization making payment to an IMD as an “in lieu of service” may pay for stays that do not exceed 15 days.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Inpatient Psychiatric Care are below.

Inpatient Psychiatric Care must be furnished under the direction of a physician and by eligible providers within the scope and practice of their profession. Appropriate staff must be available on a 24-hour basis to respond to crisis situations.

If psychiatric care is provided to a Medicaid member under 21 years of age, services must be provided under the direction of a board-prepared, board-eligible, board-certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible Medicaid member, in person within 24 hours of admission.

If psychiatric care is provided to a Medicaid member under 12 years of age, services must be provided under the direction of a board-prepared, board-eligible, or board-certified psychiatrist in child or adolescent psychiatry. The requirement for a child or adolescent psychiatrist may be waived if:

- The need for admission is urgent or emergent and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes; or
- At the time of admission, a psychiatrist who is board prepared, board eligible, or board certified in child or adolescent psychiatry, is not accessible in the community in which the facility is located; or
- There is another facility which has a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, but the facility, is not available or is inaccessible to the community in which the facility is located; and
- The admission is for stabilization only and a transfer arrangement to the care of a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, is made as soon as possible with the understanding that if the eligible Medicaid member needs transfer to another facility, the actual transfer will occur as soon as they are stable for transfer in accordance with professional standards.

Other provider requirements include:

- IMD must carry out intensive pre-discharge planning and include community-based providers in care transitions.
- IMD must assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.
- IMD must contact beneficiaries and community- based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge.
- If the discharging IMD is registered in OpenBeds, they will be required to utilize that system to make and follow up on behavioral health referrals. If not registered in OpenBeds, the IMD must conduct follow up through phone, email or other secure communication means.
- IMD facility staff will coordinate with CCBHCs and housing service providers who have SSI/SSDI Outreach, Access, and Recovery (SOAR) workers and connect them with FFS beneficiaries who are experiencing, or are at risk of, homelessness. If a SOAR worker is not available, coordination will be conducted between facility and housing service provider to ensure a Vulnerability Index - Service Prioritization Decision Assistance Tool (VISPDAT) assessment is completed to ensure beneficiary is entered into the Homelessness Management Information System (HMIS) which is used across the state by numerous agencies. The VISPDAT is a survey administered to both individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons; training is offered to social service agency workers, housing service providers and any other provider who is interested in becoming trained to conduct assessments. The effectiveness of these coordination efforts will be assessed through annual site visits to IMDs.
- IMDs must screen individuals for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions

- IMD must facilitate access to treatment for those conditions which cannot be treated at that facility through on-site staff, by either connecting beneficiaries to telemedicine and/or through partnerships with local physical health providers.

Eligible Providers

General provider enrollment information can be found here.

Freestanding Psychiatric Hospitals and Psychiatric Units of Acute Care Hospitals must be licensed and certified by the New Mexico Department of Health, or the comparable agency if in another state. Facilities must be an approved MAD provider and accredited by the Joint Commission (JC), the Council on Accreditation of Services for Families and Children (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or another accrediting organization recognized by MAD as having comparable standards.

Eligible Members

General member eligibility information can be found here.

Medicaid members must meet medical necessity for inpatient psychiatric care. Depending on the facility that the Medicaid member is receiving care in, there may be age restrictions. For care provided in a freestanding psychiatric hospital that is an IMD, Medicaid members must be under the age of 21. If a Medicaid member is receiving care in an IMD and turns 21, that individual may continue to receive care until the date that individual turns 22 or the individual no longer requires services, whichever occurs first. There are no age restrictions for Medicaid members receiving inpatient care in an inpatient psychiatric unit of a general acute care hospital.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Inpatient Psychiatric Care are below.

Within 72 hours of admission, a treatment plan must be developed by a team of professionals in consultation with an eligible Medicaid member, their parent, legal guardian or others in whose care the eligible Medicaid member will be released after discharge. The treatment plan must be reviewed with the interdisciplinary team at least every five calendar days.

Plans for discharge must also begin upon admittance to the facility and be included in the Medicaid member's treatment plan. If the Medicaid member will receive services in the community or in the custody of CYFD, the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the eligible Medicaid member, their family, school, and community.

Inpatient psychiatric care includes the following:

- Evaluations and psychological testing for the development of the treatment plan. Evaluations that have already performed should not repeated.
- Treatment planning. All supporting documentation must be available for review in the eligible Medicaid member's file.
- Regularly scheduled structured behavioral health therapy sessions for the eligible Medicaid member, group, family, or a multifamily group based on individualized needs, as specified in the treatment plan.
- Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management.
- Assistance to an eligible Medicaid member in self-administration of medication.
- Response to crisis situations to determine situation severity, stabilization.
- Referrals and follow-up as necessary.
- Consultation with other professionals or allied caregivers.
- Non-medical transportation services needed to accomplish treatment objectives.
- Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Inpatient Psychiatric Care services is below.

Inpatient psychiatric care requires prior authorization. For Medicaid member's receiving care in a freestanding psychiatric hospital in an IMD, the need for inpatient care must be identified in the eligible Medicaid member's tot-to-teen health check screen or another diagnostic evaluation furnished through a health check referral.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Inpatient Psychiatric Care services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Facilities use the following revenue codes for per diem reimbursements:
    A. Freestanding psychiatric hospital

B. Psychiatric units of acute care hospitals

2. Inpatient psychiatric care cannot be billed in conjunction with conditions defined only by Z codes or formal educational or vocational services related to traditional academic subjects or vocational training.

3. Inpatient days when an eligible Medicaid member is awaiting placement to a step-down level of care, or “awaiting placement days,” are reimbursable. Hospitals are reimbursed at the average comparable rate for Accredited Residential Treatment Centers (ARTCs) for “awaiting placement days.” A separate claim form must be submitted for awaiting placement days.

Intensive Outpatient Program for Mental Health Conditions (Mental Health IOP)

Overview/Purpose

An Intensive Outpatient Program (IOP) for Mental Health provides a time-limited, multi-faceted approach to treatment for those with a serious mental illness (SMI) or serious emotional disturbance (SED) including an eating disorder or borderline personality disorder, who require structure and support to achieve and sustain recovery. Mental Health IOP must use a research and evidence-based model approved by the State IOP Interdepartmental Council (IDC) and target specific behaviors with individualized behavioral interventions. Mental Health IOP services include a combination of individual, group, and family work.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Mental Health IOP are below.

This section describes agency approval for Mental Health IOP and staff training requirements. In addition to the requirements described below, the agency is required to develop and implement a program outcome evaluation system.

Agency Application Process

The Interdepartmental Council (IDC) — composed of the New Mexico Medical Assistance Division (MAD), Behavioral Health Services Division (BHSD), and the Children, Youth and Families Department (CYFD) Behavioral Health Services (BHS) division — oversee IOP services and manages the Mental Health IOP agency application process. The Mental Health IOP agency application process consists of the following steps:

- An agency communicates interest in developing Mental Health IOP by submitting an application through www.nmrecovery.org. Questions can be directed to iop@nmrecovery.org.
- The evidenced-based practice selected for the MH IOP program needs to be approved through the IDC.
- The application must identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population.
- Once the agency submits the application, the IDC reviews the materials. The review will be completed within 30 business days, and if qualified, the agency is issued a provisional approval. A provisional approval results in a letter granting provisional status to the

agency with the understanding the service will be initiated within 90 business days. If the application is not approved, the agency will be asked to submit additional information.

- After the provisional approval, the agency contacts Medicaid provider enrollment to add specialty 108 to the provider profile and, as applicable, contacts all MCOs to add the program to their contract.

On the first day that services are delivered, the agency notifies BHSD staff and the IDC schedules a site visit 180 days from the notice. Agencies with multiple sites may have more than one site reviewed. To notify BHSD staff, please contact iop@nmrecovery.org.

After the site visit, the agency will receive notice of corrective action or become fully approved for the service. The IDC may make annual site reviews, if necessary.

Staff Training

Mental Health IOP staff must complete training in following topics:

- Trauma informed care.
- Culture and linguistics relevant to the population being served.
- Recovery and resiliency.
- Consistency with national best practice guidelines for chosen clinical model.
- Evidence-based, or evidence informed practices.

Supervisory and administrative staff must also complete fidelity monitoring and quality management training.

Eligible Providers

General provider enrollment information can be found here.

Services may only be delivered through an IDC-approved agency, composed of a Mental Health IOP team of providers. Each Mental Health IOP program must have a RLD board-approved Clinical Supervisor. A Mental Health IOP Clinical Supervisor must be a State licensed, independent mental health practitioner with two years relevant experience in providing the evidence-based model and have one-year supervisory experience. The Mental Health IOP agency may have services rendered by non-independent practitioners under the direction of the Mental Health IOP Clinical Supervisor including LMSW, LMHC, master's level behavioral health interns, master's level psych associates, RNs, or registered dieticians. The agency must maintain the appropriate State facility licensure if offering medication treatment.

Eligible Members

General member eligibility information can be found here.

Mental Health IOP is a covered service for Medicaid members who are:

- Age 11–17 diagnosed with a SED; or
- Age 18 and older diagnosed with SMI.

Prior to starting Mental Health IOP services, the Medicaid member must have a treatment file containing a diagnostic evaluation of an SED or SMI that includes Mental Health IOP as an intervention. Mental Health IOP programs cannot exclude Medicaid members with co-occurring disorders unless the presence of these conditions increases the acuity of the Medicaid member to such a degree that a higher level of care is required.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Mental Health IOP are below.

Mental Health IOP services are based on research and evidence-based practice (EBP) models that target specific behaviors with individualized behavioral interventions. Treatment follows the agency's Mental Health IOP model and must maintain fidelity to the model.

All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved by the IOP IDC. A list of pre-approved EBPs is available from the IDC, as are the criteria for having another model approved. Treatment services must address co-occurring disorders when indicated. The interdisciplinary team uses one treatment plan to direct coordinated, individualized care for all persons enrolled in the IOP, including referrals to other services outside of IOP.

Mental Health IOP services include:

- Assessment.
- Treatment plan, prior to the start of MH IOP services, as well as updates which must occur every 90 days.
- Discharge/transition services planning that begins at intake and is updated regularly throughout the course of treatment. If discharge planning includes other outpatient services, referrals must be made before the Medicaid member is discharged from the program.
- Individual, group therapy, and family therapy or multi-family therapy. Group therapy must consist of less than 15 individuals.
- Individual mental health and/or substance use disorder related therapy.
- Psychoeducation, illness management, and recovery skills for the individual and family.

- Medication management services — either provided by the Mental Health IOP agency or by referral — to oversee the use of psychotropic medications and medication assisted treatment of substance use disorders.

The amount of weekly services per eligible Medicaid member is directly related to the goals specified in his or her IOP treatment plan and the IOP EBP in use. Adolescent IOP has a goal of at least six hours per week and adult IOP has a goal of at least nine hours per week. If an individual is consistently requiring more than 18 hours/week, the level of care should be reviewed.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Mental Health IOP is below.

Mental health IOP does not require prior authorization but is subject to medical necessity.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Mental Health IOP are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies use procedure code S9480 (Mental Health). Daily Rate=One (1) unit per day. To be eligible for the daily rate, a minimum of three (3) hours of service must be provided.
2. IOP services must be documented in the individual's plan of care. A clinician may determine that fewer than 3 hours of service in a day (with at least 1.5 hours of service) is appropriate for youth. When this is the case the modifier HA should be added to the claim with HCPCS code S9480.
3. Mental Health IOP services may not be billed in conjunction with Acute Inpatient, Residential Treatment Services (i.e., ARTC, RTC, group home, and transitional living services), Partial Hospitalization, Multi-Systemic Therapy (MST), and Activity Therapy.

Intensive Outpatient Program for Substance Use Disorders (SUD IOP)

Overview/Purpose

Intensive Outpatient Programs for Substance Use Disorders (SUD IOP) provides a time-limited, multi-faceted approach to treatment for those with a moderate to severe SUD or co-occurring moderate to severe SUD and mental health diagnoses who require structure and support to achieve and sustain recovery. A SUD IOP requires a diagnostic evaluation and an ASAM Level of Care assessment that identifies IOP as a recommended level of care.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to SUD IOP are below.

In addition to the requirements described below, the agency is required to develop and implement a program outcome evaluation system and maintain records of SUD IOP training on the chosen model.

Agency Application Process

The IDC — composed of the New Mexico Medical Assistance Division (MAD), Behavioral Health Services Division (BHSD), and the CYFD BHS — oversees IOP services and manages the SUD IOP agency application process. The SUD IOP agency application process consists of the following steps:

- An agency communicates interest in developing SUD IOP by submitting an application through www.nmrecovery.org. Questions can be directed to iop@nmrecovery.org.
- The application must identify if it is a youth program, an adult program, a transitional age program, or multiple programs.
- Once the agency submits the application, the IDC reviews the materials. The review will be completed within 30 business days, and if qualified, the agency is issued a provisional approval. A provisional approval results in a letter granting provisional approval to the agency with the understanding the service will be initiated within 90 business days. If the application is not approved, the agency will be asked to submit additional information, which may include a request to re-submit a new application.
- After the provisional approval, the agency contacts Medicaid provider enrollment to add specialty 108 to the provider profile. As applicable, contact all MCOs to add the program to their contract.

- On the first day that services are delivered, the agency notifies BHSD staff and the IDC schedules a site visit 180 days from the notice. Agencies with multiple sites may have more than one site reviewed. To notify BHSD staff, please contact iop@nmrecovery.org.The IDC schedules a site visit 180 days from the notice. Agencies with multiple sites may have more than one site reviewed. After the site visit, the agency will receive notice of corrective action or become fully approved for the service. The IDC may make annual site reviews, if necessary and reserves the right to revoke IOP status.

Process for Approving New EBP Models

This section describes agency approval for SUD IOP and care models not identified by the Interdepartmental Council (IDC). If an agency wishes to provide an IOP which differs from the model described in hours of treatment, clinical programming and support they must receive approval by the IDC prior to being implemented. New proposed models must reflect how care is trauma informed, culturally and linguistically relevant to the population being served, recovery and resiliency oriented, consistent with national best practice guidelines, evidence-based (or evidence informed), and includes EBP fidelity monitoring and continuous quality improvement/management.

The approval process consists of the following steps:

- The agency submits a request to iop@nmrecovery.org explaining why the existing models will not work for service delivery and outlines alternative evidence-based practice (EBP) or evidence informed model.
- The IDC reviews the model and request. This includes discussions between the agency and the IDC.
- If the model is deemed appropriate, the IDC will send a letter of approval to the agency. If it is not deemed appropriate, the IDC and agency will remain in dialogue until an appropriate level, revision, or middle ground has been established.

Eligible Providers

General provider enrollment information can be found here.

Services may only be delivered through an IDC-approved agency, composed of a SUD IOP team of providers, with staff who have expertise in both substance use disorder and mental health treatment. Each SUD IOP program must have a RLD board-approved Clinical Supervisor with the following qualifications:

- Be licensed as a MAD approved independent practitioner.
- Have two years relevant experience with an IOP program or approved exception by the IDC.
- Have one year demonstrated supervisory experience.

- Have expertise in both mental health and substance use disorder treatment.

The SUD IOP agency may have services rendered by non-independent practitioners under the direction of the Clinical Supervisor including LMSW, LMHC, LPC, LADAC, LSAA, master's level behavioral health interns and master's level psych associates. The agency must maintain the appropriate State facility licensure if offering medication treatment.

Eligible Members

General member eligibility information can be found here.

SUD IOP is a covered service for Medicaid members who are age 11 and older and;

- Have been diagnosed with a moderate to severe SUD or with co-occurring disorders (mental illness and moderate to severe SUD); and
- Meet the American society of addiction medicine (ASAM) patient placement criteria for Level 2.1; or
- Have been mandated by the local judicial system as an option of least restrictive level of care. Services are not covered if the Medicaid member is in detention or incarceration.

Individuals aged 11–17 qualify for an adolescent program, those individuals who are in a transitional age qualify for a transitional program, and individuals aged 18 and older qualify for an adult program.

Prior to starting SUD IOP services, the Medicaid member must have a treatment file containing a diagnostic evaluation which includes a diagnosis of a moderate to severe SUD and a treatment plan that includes SUD IOP and the EBP as an intervention, a crisis and safety plan, a relapse prevention plan, and a discharge/transition plan. Ongoing updates to these plans should occur regularly throughout the course of treatment.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to SUD IOP are below.

SUD IOP services are based on research and EBP models that target specific behaviors with individualized behavioral interventions. Treatment follows the agency's SUD IOP model and must maintain fidelity to the model.

All EBP model services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. Treatment services must address co-occurring mental health disorders, as well as SUD, when indicated. The interdisciplinary team uses one treatment 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.

SUD IOP services include:

- Assessment.
- Initial Treatment plan prior to being admitted into an ASAM Level 3.1 level of care, updates for which must occur every 90 days.
- Discharge/transition services planning that begins at intake and is continually monitored and updated. If discharge planning includes other outpatient services, referrals must be made before the Medicaid member is discharged from the program.
- Individual, group therapy, family therapy, or multi-family therapy. Group therapy must consist of less than 15 individuals.
- Psychoeducation, illness management, and recovery skills for the individual and family.
- Outpatient mental health therapies must be provided when the Medicaid member's co-occurring disorder requires treatment services which are outside the scope of the core IOP therapeutic services. The Medicaid member's file must document the medical necessity of receiving outpatient therapy services in addition to IOP therapies. The documentation must include the current assessment, a co-occurring diagnosis, and the inclusion in the treatment plan for outpatient mental health therapy services. Medication management services — either provided by the IOP agency or by referral — to oversee the use of psychotropic medications and medication assisted treatment of substance use disorders, must also be available, and can be billed using the appropriate CPT codes.

An IOP agency may render outpatient mental health services so long as its providers have a scope of practice to provide such services. The agency may also refer Medicaid members to another provider if the agency does not have such providers available.

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 a direct affiliation with more or less intensive care levels and supportive housing.

The duration of an eligible Medicaid member's IOP intervention is typically three to six months. After six months, the agency must demonstrate ongoing treatment needs through medical necessity. The amount of weekly services per Medicaid member is directly related to the goals specified in the individuals IOP treatment plan and the IOP EBP in use. Adolescent IOP has a minimum of 6–19 hours per week and adult IOP has a minimum of 9–19 hours per week. Programs may occur during the day or evening, on the weekend, or after school for adolescents.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding SUD IOP services is below.

Prior authorization is not required for SUD IOP. Medical necessity is required, after six months of treatment. The agency must demonstrate through treatment plan updates and ongoing documentation that the service is appropriate and continues to meet SUD medical necessity.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to SUD IOP are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies use procedure code H0015. Daily rate = one (1) unit per day. To be eligible for the daily rate, a minimum of three (3) hours of service must be provided.
2. Individual counseling for a diagnosis not treated in the IOP can be rendered on the same day as IOP. For example, if a client is in IOP for Alcohol Use Disorder and they need treatment for PTSD then a client could engage in IOP and individual work provided with different primary diagnoses on the billing forms.
3. SUD IOP services may not be billed in conjunction with Acute Inpatient, Residential Treatment Services (i.e., ARTC, RTC, group home, and transitional living services), Partial Hospitalization, Multi-Systemic Therapy (MST), and Activity Therapy.

Medication for Opioid Use Disorder (MOUD)

Overview/Purpose

MOUD (previously described as Medication Assisted Treatment or MAT for OUD) is the use of FDA-approved medications in the treatment of individuals diagnosed with opioid use disorder. MOUD may be delivered in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of opioid use disorder. This section describes coverage of MOUD using buprenorphine in Office Based Opioid Treatment (OBOT). Methadone for treatment of opioid use disorder can only be provided by a federally certified OTP. Methadone cannot be prescribed in an office-based setting to treat opioid use disorder.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to MAT are below.

Compliance with all applicable components of the Drug Addiction Treatment Act is required for Office Based Opioid Treatment using MAT with buprenorphine.

Eligible Providers

General provider enrollment information can be found here.

Any clinic, office, or hospital staffed by required practitioners may provide MOUD services. Providers eligible to diagnose, assess, and prescribe MOUD include:

- Physicians or DOs licensed in the State who have: 1) Board certification in addiction medicine or addiction psychiatry; or 2) Completed special training.
- Certified nurse practitioners who have completed 24 hours of required training.
- Physician assistants who are licensed in the State.

Other eligible providers to support MOUD services include:

- State licensed RNs or physician assistants may administer and educate on MOUD.
- Behavioral health practitioners licensed for counseling or therapy may provide opioid use disorder counseling and education.
- Certified peer support workers or certified family peer support workers may provide skill-building and education.

Eligible Members

General member eligibility information can be found here.

Medicaid members with an opioid use disorder diagnosis defined by DSM 5 or ICD 10 are eligible to receive MOUD services.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to MAT are below.

Prior to receiving MOUD Services, the following must occur:

- The prescribing provider must diagnose the Medicaid member with an opioid use disorder and complete an assessment (including readiness for change). The assessment must also review concurrent medical or behavioral health illnesses and co-occurring substance use disorder (SUD). The assessment and diagnosis can be conducted either in-person or via audio or audio/visual telehealth connection.
- Medicaid member education on different treatment options.
- A treatment plan that prescribes either in-house counseling or therapy, or referral to outside services.

Covered MOUD services include:

- A history and physical.
- Comprehensive assessment and treatment plan.
- Induction phase of opioid treatment.
- Administration of medication and concurrent education.
- Subsequent evaluation and management visits.
- Development and maintenance of medical record log of medication for opioid use disorder prescriptions.
- Development and maintenance of required records regarding inventory, storage and destruction of controlled medications if dispensing from office.
- Initiation and tracking of controlled substance agreements with eligible Medicaid members.
- Regular monitoring and documentation of New Mexico prescription monitoring program results.
- Urine drug screens.

- Recovery services (MCO members only).
- Family support services (MCO members only).

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding MOUD is below.

Prior authorization is not required for MOUD, but the Medicaid member must meet medical necessity.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to MOUD are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Diagnosis, Assessment, Prescribing, and Initial Induction

1. Providers eligible to bill for diagnosing, assessment, prescribing, and induction include physicians, physician assistants (PAs), clinical nurse specialists (CNS), and certified nurse practitioners (CNPs).
2. For the history and physical, use evaluation and management (E&M) codes. Also use E&M codes for subsequent physician, CNP, and PA visits.
3. For MOUD induction, use procedure code H0033.

Medication Administration (after initial induction)

1. Providers eligible to bill for medication administration include RNs (317) or PAs (305) under supervision of an MD or CNP.
2. Providers should use procedure code H2010 to bill.

Multi-Systemic Therapy (MST)

Overview/Purpose

Multi-Systemic Therapy (MST) is an intensive family and community, evidence-based treatment for youth rendered by a MST team, to provide intensive home, family, and community-based treatment for the family of an eligible Medicaid member who is at risk of out-of-home placement or is returning home from an out of home placement. MST 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. MST-PSB 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 behavior.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to MST services are below.

An MST agency must meet the following requirements:

- Comply with requirements in Subsections A and B of 8.321.2.9 NMAC (8.321.2 NMAC [state.nm.us]).
- Hold a copy of MST Services LLC licensure, or any of its approved subsidiaries. Any team providing MST-PSB must have a specific national certification from MST Services, LLC for MST-PSB.

Providers who are enrolled with specialty type 131 as of September 1, 2023 are not required to receive CYFD approval to continue services but should complete the CYFD approval process prior to their next Turn Around Document (TAD).

The MST program includes an assigned MST team for each eligible member. The MST team must have the ability to deliver services in various environments including home, school, homeless shelter, and street location. The MST team must include at a minimum two-thirds licensed master’s level staff and not exceed more than one-third bachelor’s level staff, unless a formal exception has been granted by MST Services, LLC. The MST team must include at a minimum the following staff with the respective qualifications. Any exceptions related to provider experience requirements must be approved through MST Services, LLC.

- A RLD board-approved clinical supervisor who is a master's level independently licensed mental health professional or a master's level licensed behavioral health professional working in an agency with access to an independently licensed supervisor supporting the team.
- MST-trained behavioral health staff able to provide 24-hour coverage, seven days a week.
- Licensed master's level behavioral health practitioner required to perform all MST interventions.
- Bachelor's level staff with a degree in social work, counseling, psychology, or a related human service field and a minimum of three years' experience working with the identified population of children, youth, and their families. A bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of their RLD practice board licensure or practice.

Clinical supervision must include at a minimum weekly supervision provided by an independently licensed master's level behavioral health practitioner who is MST trained or an MST trained master's level licensed behavioral health professional working in an agency with access to an independently licensed RLD board-approved clinical supervisor supporting the team. This supervision, in accordance with MST supervisory protocol, is provided to team members on topics directly related to the needs of the Medicaid member and their family on an ongoing basis. Weekly supervision must also include one hour of local group supervision and one hour of telephone consultation per week with the MST systems supervisor.

All clinical staff are required to complete a prescribed MST introductory training and subsequent quarterly trainings.

Eligible Providers

General provider enrollment information can be found here.

An agency must hold a copy of MST Inc. licensure, or any of its approved subsidiaries, and meet the State licensure and provider enrollment requirements. Any team providing MST-PSB must have a specific national certification from MST Services, LLC for MST-PSB.

Eligible Members

General member eligibility information can be found here.

MST is a covered service for Medicaid members aged 10-18 who:

- Meet the criteria of Serious Emotional Disturbance (SED) and are involved in or at serious risk of involvement with the juvenile justice system;
- Demonstrate antisocial, aggressive, violent, and substance-abusing behaviors;
- Are at risk for an out-of-home placement; or

- Are returning from an out-of-home placement where the above behaviors were the focus of treatment and family involvement.

NOTE: A co-occurring diagnosis of substance use disorder may not exclude Medicaid members from the MST program.

Criteria for those not eligible for MST include:

- Youth lives independently or a primary caregiver cannot be identified despite extensive efforts to locate extended family, adult friends, and other surrogate caregivers.
- Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors.
- Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.

MST-PSB is a covered service for individuals aged 10-18 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.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to MST are below.

MST services are conducted by practitioners using the MST team approach. The MST team must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. MST services:

- Promote the Medicaid member's family capacity to monitor and manage their behavior.
- Involve the Medicaid member's family and other systems, such as the school, probation officers, extended families and community connections.
- Provide access to a variety of interventions 24-hours a day, seven days a week, by staff who maintain contact and intervene as one organizational unit.
- Include structured face-to-face therapeutic interventions to provide support and guidance in all areas of the recipient's functional domains, such as adaptive, communication, psychosocial, problem solving, and behavior management.

The MST program includes an assigned MST team for each eligible member. MST services are primarily provided in the eligible recipient's home, but an MST worker may also intervene at the eligible recipient's school and other community settings. MST addresses the multiple causes of serious antisocial behavior across key systems within which youth are embedded (family, peers, school, and neighborhood).

The following services must be furnished as part of the MST service:

- An initial assessment to identify the focus of the MST intervention.
- Therapeutic interventions with the Medicaid member and their family.
- Case management.
- Crisis stabilization.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding MST services is below.

MST does not require prior authorization but is subject to medical necessity. The need for MST must be identified in the eligible Medicaid member's tot to teen health check or another diagnostic evaluation.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to MST services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. MST providers (Provider Specialty Type 131) bill the following procedure codes with modifiers for each 15-minute increment:
    A. MST Master's Level Team: H2033 HO
    B. MST Master's Level Team, Rural: H2033 HO, TN
    C. MST Bachelor's Level Team: H2033 HN
    D. MST Bachelor's Level Team, Rural: H2033 HN, TN
2. MST may be billed for direct staff face-to-face time with the child/youth, family or other collateral contacts. Only direct staff face-to-face time with the child or family or other collateral contacts may be billed. Collateral contacts include probation programs, public guardianship programs, special education programs, child welfare/child protective evidence-based practices in coordination with other child-serving systems. Coordination with these child-serving systems is considered collateral contact and may be necessary

to meet their goals of the individual but is not billable through Medicaid if meeting a requirement of another primary program. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. The child/youth receiving treatment does not need to be present for all contacts; contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care.

4. Phone contacts are not billable.

5. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly.

6. Medicaid may not reimburse for children in the custody of the New Mexico Juvenile Justice system post-adjudication who reside in detention facilities, public institutions or secure care, and are inmates of a public institution. If the child is in Juvenile Justice custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the MST, except for the oversight of restorative measures, which is a juvenile justice function.

7. Medicaid does not pay when the vocational supports provided via MST qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available unless the child is not eligible for vocational rehabilitation.

8. MST services are comprehensive of all other behavioral health services, with the exception of psychological evaluation or assessment, medication management, and high-fidelity wraparound. These services may be provided and billed separately for a member receiving MST services.

9. MST shall not be billed in conjunction with the following services:

    A. BH services by licensed and unlicensed individuals, other than medication management, assessment, and high-fidelity wraparound; and

    B. Residential services, including therapeutic foster care and RTC services.

10. Medicaid will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs). These are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

Non-Accredited Residential Treatment Centers and Group Home Services

Overview/Purpose

Non-Accredited Residential Treatment Centers (RTC) and Group Home Services (GHS) are trauma-responsive agencies that provide trauma-informed services to help individuals under the age of 21 develop skills needed for successful reintegration into their family or transitions back to their communities. Non-Accredited RTC services are provided to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential setting. Group Home Services are provided to children/ adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in residential setting.

Services are rehabilitative and provide access to necessary treatment services in a therapeutic environment. Treatment is provided in accordance with best practices and national standards. Non-Accredited RTCs and GHS provide regularly scheduled individual, family, and group therapy sessions at the level of frequency documented individually in each individual's treatment plan.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Non-Accredited RTCs and GHs are below.

Non-Accredited RTCs and GHS must be licensed and certified by the State Children, Youth, and Families Department (CYFD). Each licensed and certified service agency is responsible for establishing and following written policies and procedures that specify how applicable CYFD licensing and certification requirements are met. Facilities must also maintain compliance with State background checks and employment history verification requirements in 8.8.3 NMAC (Microsoft Word - 08.008.0003.doc [cyfd.org]).

Facilities provide services, care, and supervision at all times, including the provision of, or access to, medical services on a 24-hour basis. Facilities must also maintain a staff-to-Medicaid member ratio appropriate to the level of care and needs of the Medicaid members. Non-Accredited RTCs must maintain staff to Medicaid member ratio of 1:6 during daytime hours and a ratio of 1:12 during night hours. GHS must maintain staff to Medicaid member ratios of 1:8 during the day and 1:12 at night. Additional staff must be available if the clinical needs of the facility population is high. Providers must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual

for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

Special Considerations for IHS and Tribal Facilities

If the Non-Accredited RTC or GHS is operated by the Indian Health Services (IHS) or by a federally recognized tribal government, the facility must meet CYFD RTC licensing and certification requirements but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, 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 described in NMAC Sections 7.20.11 (https://www.cyfd.nm.gov/wp-content/uploads/2022/12/7.20.11_NMAC.pdf) and 7.20.12 (https://www.srca.nm.gov/parts/title07/07.020.0012.html).

The LCA generates 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. 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. MAD then works with the facility to address recommendations.

Eligible Providers

General provider enrollment information can be found here.

A Non-Accredited RTC or GHS facility provides an interdisciplinary psychotherapeutic treatment program on a 24-hour basis. Non-Accredited RTCs and GHS services are provided under the clinical oversight of an on-site RLD Board Approved Clinical Supervisor who is responsible for provision of clinical supervision, support, and consultation to all agency staff. The Clinical Supervisor must have a minimum of two years of experience with clinical practice with children, adolescents, and families. The Clinical Supervisor must be a separate clinician than the RTC or GHS therapists.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for services are under the age of 21 and must meet a level of care determination for services at a Non-Accredited RTC or GHS. Adolescents who turn 18 years old while enrolled in the service may remain until appropriately discharged. This determination must have considered all environments that are less restrictive, meaning a supervised community placement, preferably a placement with the juvenile's parent, guardian, or relative. The Non-Accredited RTC or GHS should only be used as a last resort based on the best interest of the juvenile or for reasons of public safety.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Non-Accredited RTCs and GHS are below.

Services and all activities provided at a Non-Accredited RTC or GHS must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. Residential treatment services must be medically necessary for the diagnosis and treatment of an eligible Medicaid member's condition and are provided through a team approach. The following are covered services:

- Treatment plan/safety plan interventions and support.
- Development of an interdisciplinary treatment plan.
- Evaluations, assessments, and psychological testing to support the development of the individual's treatment plan. Assessments already performed should not be repeated.
- Regularly scheduled counseling and therapy sessions in an individual, family, or group setting.
- Therapeutic services to meet physical, social, cultural, recreational, health maintenance, and rehabilitation needs.
- Age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management.
- Assistance with self-administration of medication.
- Response to crisis situations, determination of situation severity, and stabilization of the Medicaid member.
- Referrals for emergency services or to other non-agency services, as necessary, and providing follow-up.
- Non-medical transportation services needed to accomplish the treatment objective(s).
- Planning of discharge and aftercare services to facilitate timely and appropriate post-discharge care. Discharge planning begins when the Medicaid member is admitted to residential treatment services and is updated and documented in the Medicaid member's record at every treatment plan review, or more frequently as needed. Assessments support discharge planning and successful discharges with clinically appropriate after care services.

Treatment Planning

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. A treatment plan documents all needed services and is developed in collaboration with the Medicaid member, participating family/significant others, and clinicians.

The treatment planning process includes:

- **Initial Treatment Plan.** The Initial Treatment Plan is developed and documented within 72 hours of admission to the service. The Initial Treatment Plan should be based on information available at the time and identifies individualized treatment goals and objectives that are targeted the first 14 days of treatment.
- **Comprehensive Treatment Plan.** The Comprehensive Treatment Plan is based on the comprehensive assessment and is developed and documented within 14 days of admission.

The Initial and Comprehensive Treatment Plan must meet the following requirements:

- Involve the full participation of treatment members, including the Medicaid member and their parents/legal guardian, who are involved to the maximum extent possible.
- Document reasons for nonparticipation of the Medicaid members and/or family/legal guardian.
- Conducted in a language the Medicaid member and/or family members can understand, or is explained to the Medicaid member in a language/manner that is understandable, and invites full participation.
- Designed to improve the Medicaid member's motivation and progress, and strengthen appropriate family relationships.
- Designed to improve the Medicaid member's self-determination and personal responsibility.
- Use the Medicaid member's strengths.
- Provides that Medicaid members 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.
- Document the following specific information:
  - Specific behavioral changes targeted, including potential high-risk behaviors.
  - Corresponding time-limited intermediate and long-range treatment goals and objectives.
  - Frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures.
  - Staff responsible for each intervention.

- Projected timetables for the attainment of each treatment goal.
- A statement of the nature of the specific problem(s) and needs of the Medicaid member.
- A statement and rationale for the plan for achieving treatment goals.
- The Medicaid member's permanency plan (for individuals in the custody of the CYFD).

Discharge Planning

The Discharge Plan must include the following information, which must be updated as appropriate:

- A projected discharge date, which is updated as clinically indicated.
- Description of behavioral and other clinical criteria as conditions under which discharge will occur.
- Requirement that the Medicaid member has achieved the objectives of the treatment plan.
- An evaluation of high-risk behaviors or the potential for such.
- Documentation that discharge is safe and clinically appropriate for the Medicaid member.
- Documentation of level of care, specific services to be delivered, and the living situation into which discharge is projected to occur.
- Specific criteria for discharge to a less restrictive setting.
- Options for alternative or additional services that may better meet the Medicaid member's needs.
- Documentation of individuals responsible for implementing each action specified in the discharge plan.
- Barriers to discharge.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Non-Accredited RTC and GH services is below.

Prior authorization is required before Non-Accredited RTC or GHS services are furnished to an eligible Medicaid member.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Non-Accredited RTCs sand GHs are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. The referring or ordering provider should be listed in the attending provider field.
2. Facilities bill the following revenue codes per unit (units are the total number of days):
    A. Non-Accredited RTCs use revenue code 0190.
    B. GHS use revenue code 1005.
3. A vacancy factor of 24 days annually for each Medicaid member is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a facility cannot bill or be reimbursed for days when the Medicaid member is absent.
4. CCSS may also be billed for discharge planning and transition purposes.
5. The following services cannot be billed in conjunction with Non-Accredited RTC and GHS services or activities: 1) Room and board; 2) Services for which prior approval was not obtained; or 3) Services furnished after the Medicaid member no longer meets the level of care for Non-Accredited RTC or GHS care.

Opioid Treatment Program (OTP)

Overview/Purpose

Opioid Treatment Programs (OTP) provide Medication for Opioid Use Disorder (MOUD) for persons diagnosed with opioid use disorder (previously described as Medication Assisted Treatment, or MAT for OUD). Services include, but are not limited to, the administration of methadone (opioid replacement medication) to an individual for medication assisted withdrawal from opioids and maintenance treatment. MOUD administration/supervision must be delivered in conjunction with the overall treatment based upon a treatment plan, which must include drug testing, medication monitoring, and case review and may include counseling/therapy.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to OTP services are below.

OTP agencies are required to maintain specific staffing requirements outlined below. In addition to the staffing requirements, OTP agencies are required to do the following:

- Develop and maintain policies and procedure requirements as described in the *Operations* section.
- Ensure that all treatment services are delivered within a framework that reflects shared patient-provider decision making and incorporates harm reduction principles.
- Make good faith efforts to determine that a patient seeking admission is not receiving opioid dependency treatment medication from any other source. To support this effort, and as a condition of State approval, the OTP agency 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 receiving medication from more than one OTP. OTPs are required to upload their patient data each day to the central registry. OTP agencies must confirm that patients are not receiving treatment from any other OTP within a 50-mile radius of its location, by contacting any such other program, or by using the central registry.
- Identify the potential patient capacity based on the number of providers who are qualified and available to administer and monitor treatment (doctors, nurses, counselors, certified 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 a plan for maintaining service provision while continuing to admit new patients.

- Establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system must comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records.
- Submit a quarterly report to the SOTA to include numbers of nasal naloxone kits distributed and fentanyl prevalence (based upon patient drug test results).
- OTPs must keep records about all incidents that occur in the facility, to include Critical Incident Reports, and the resolution of those incidents.
- Participate in quarterly meetings with the SOTA as a way to maintain open communication and dissemination of information.

OTP Agency Staffing Requirements

Agencies providing OTP must be staffed with the following positions. Specific responsibilities, requirements, staffing ratios, and other information for each position is described below.

- A Medical Director (may be MD or health care practitioner with prescribing authority)
- A Program Physician/Health Care Practitioner with prescribing authority (may also be the Medical Director)
- A Program Director
- RLD board-approved Clinical Supervisors
- RN(s) or LPN(s)
- A part or full-time Pharmacist
- Counselors
- LSAAs and Peer Support Workers

Medical Director

The Medical Director is responsible for ensuring that the OTP agency is operating as an interdisciplinary team, where providers with differing expertise are monitoring and managing the treatment plan and service delivery. The Medical Director is also responsible for the following specific requirements:

- All patient admission criteria, including ensuring patients admitted to the OTP have a complete physical examination and that the results are documented in the patient's record.
- Making appropriate referrals for necessary services not provided by the OTP agency.
- Signing or countersigning and dating of all medical orders as required by federal or State law.

- Ensuring that each patient's dose of treatment medication is appropriate for the patient's needs.
- 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 use disorder.
- Developing and written medical protocols.
- Ensuring that all medical protocols are reviewed and approved by appropriate program officials on an annual basis.
- Determining which medical functions may be delegated to other staff and documenting these responsibilities in the protocols.
- Ensuring that individuals seeking admission to the OTP meet federal criteria for admissions.
- Establishing clinical standards for the following:
  - Treatment medication for a patient at the time of admission.
  - Titration of a patient on treatment medication.
  - Tapering of a patient off of a treatment medication.

Program Prescriber

The Program Physician, or health care practitioner with prescribing authority, must be licensed in New Mexico and work under the supervision of the Medical Director (if not the Medical Director). The Program Physician, or health care practitioner with prescribing authority, must be physically present at the OTP facility for at least ten hours per week for 500 patients. The maximum physician/health care practitioner with prescribing authority to patient ratio in an OTP facility is 1:1,000.

Program Director

A Program Director must have at least a bachelor’s degree in a related field, a minimum of three years of work experience providing services to individuals with substance use disorder (SUD), and a minimum of 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:

- Day-to-day operations of the OTP.
- Delivery of treatment services.
- Supervision of OTP staff.

- Managing all functions delegated by the Medical Director.

Clinical Supervisors

Clinical Supervisors must be approved by their respective State Boards as Regulation and Licensing Department (RLD) board-approved Supervisors. Clinical behavioral health supervisors may include licensed psychologist (to supervise other psychologists), licensed independent social worker, licensed professional clinical counselor, or licensed marriage and family therapist. Clinical physical health supervisors of RNs/LPNs may include certified nurse practitioners, clinical nurse specialists, or physicians.

Clinical Supervisors must have a minimum of one year documented supervisory experience and a minimum of two years documented experience in clinical practice with the population for whom clinical supervision is being provided. Clinical Supervision must be provided to all treatment staff a minimum of four 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.

RN(s)/LPN(s)

The RN(s)/LPN(s) must have experience treating SUD, maintain appropriate State licenses to perform delegated and assigned nursing functions, and supervise medication administration to patients. An RN/LPN may administer opioid treatment medication only when: 1) 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. The maximum RN/LPN to patient ratio in an OTP facility is 1:200.

Pharmacist

The pharmacist may be full or part-time and must be licensed.

Counselors

Counselors must be licensed and have at least at master’s level education or LADACs. Counselors must have training or experience to contribute to the individuals treatment plan and monitor patient progress toward identifying treatment goals. The OTP agency must have a sufficient number of SUD counselors to ensure patient access to counselors, to implement treatment plans, and to provide unscheduled treatment or counseling sessions.

Counselors will provide individual therapy that addresses underlying issues related to SUD. They may also provide treatment related to co-occurring disorders. If an OTP 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.

a. LSAAs and Certified Peer Support Workers

LSAAs and Certified Peer Support Workers provide education, behavioral change, and recovery and resiliency support.

OTP Operations

OTP Application

Agencies apply for approval to operate an OTP using the application provided by the SOTA. The SOTA application is in addition to the application to Drug Enforcement Agency (DEA), SAMHSA/CSAT, New Mexico Board of Pharmacy, local government, and additional governing bodies. The SOTA will approve or deny the application within 60 working days of submission, unless the SOTA and applicant mutually agree to extend the application review period. Approval to operate an OTP is granted for up to three years and preference will be given to providers who are able to service Medicaid members. Change in ownership of an OTP is not transferable. New ownership must submit another application for approval as a new program.

The application should include a needs assessment, specifying the proposed geographical area to be served, estimated number of patients anticipated, and other information. This information will be considered in making its decision the need for an OTP in a given geographic area and the impact on the community. The SOTA will perform on-site inspection of the proposed OTP facility as part of the review and approval process. 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 should notify the SOTA within two business days of such event.

Applicants who have been convicted of any crime related to controlled substances laws or any felony within the last five years are ineligible to apply. The SOTA will also 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. 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. 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 will not be granted approval. 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.

Policies and Procedures

An OTP agency must develop and maintain written policies and procedures for its services, and must include, but are not limited to the following:

- Use and/or distribution of Narcan/naloxone. OTPs will provide access to naloxone either through prescription or onsite distribution.
- Prevention of a patient from receiving OUD (opioid use disorder) treatment from more than one agency or physician concurrently.
- Plans to meet 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.
- Special needs and priority for treatment admission of patients with opioid use disorder who are pregnant. Evidence-based treatment protocols for pregnant patients, such as split dosing regimens, may be instituted after assessment by OTP practitioner. Further, prenatal care and other gender-specific services, including reproductive health services, for pregnant and postpartum patients must be provided and documented either by the OTP or by referral to appropriate health care practitioners.
- Conducting a physical examination, assessment and laboratory tests.
- Establishing SUD counselor caseloads, based on the intensity and levels of frequency, intensity, and duration of counseling agreed upon 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 levels of frequency and intensity agreed upon by patients requesting such services.
- Criteria for when the patient's blood serum levels should be tested and procedures for having the test performed.
- Processes for performing laboratory tests, such as urine drug screens or toxicological tests, including procedures for collecting specimens for testing.
- Addressing and managing a patient's concurrent use of alcohol or other drugs.
- Providing take home medication to patients, to ensure proper disposal of methadone containers. This shall include patient education about proper disposal of empty containers.
- Conducting opioid treatment withdrawal.

- 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 medically managed withdrawal, patients should be offered a relapse prevention program that includes counseling, naloxone and opioid replacement therapy.
- 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.
- 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. Transfer procedures must document the following:
  - 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.
  - 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.
  - 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.
  - The receiving clinic's physician/health care practitioner with prescribing authority will initiate an order for continuation.
  - Patients who transfer are continuing treatment. 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.
- Receiving the temporary or permanent transfer of a patient from another OTP to the receiving OTP.
- Plans to minimize adverse events such as:
  - A patient's loss of ability to function
  - Medication errors

  - Harm to a patient's family member or another individual resulting from ingesting a patient's medication
  - Sale of illegal drugs at the facility
  - Diversion of a patient's medication
  - Harassment or abuse of a patient by a staff member or another patient
  - Violence at the facility
  - Any event involving law enforcement
  - Patient death
  - Incarceration
  - Poly-substance use
- Responding to an adverse event, including the following required elements:
  - The program sponsor or director immediately investigates the adverse event and the surrounding circumstances.
  - The program sponsor or director files a Critical Incident Report (CIR), including mortality, as required and provides copy to Office of SOTA
  - The program sponsor develops and implements a plan of action to prevent a similar adverse event from occurring in the future; monitors the action taken; and takes additional action, as necessary, to prevent a similar adverse event.
  - Action taken under the plan of action is documented.
  - The documentation is maintained at the agency for at least two years after the date of the adverse event.
  - Procedures for infection control.
- Criteria for determining the amount and frequency of counseling that is offered to a patient, including the provision of unscheduled treatment or counseling to patients. A minimum of one-hour face-to-face counseling per month must be made available to patients who seek counseling services. All counseling sessions must be documented in the patient record. If additional sessions are clinically indicated based on assessment, this is justified and documented in the patient record.
- Ensuring that the facility's physical appearance is clean and orderly.
- A process for resolving patient complaints, including a provision that complaints which cannot be resolved through the agency's process may be mediated by the program director and the BHSD. The complaint process must be explained to the patient at

admission and must be posted prominently in its waiting area or other location where it will be easily seen by patients and includes the BHSD contact information.

- A process for employee continuing education that includes recovery and resiliency, trauma informed care, crisis intervention and suicide prevention.
- A written quality assurance plan.
- 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.
- Opioid treatment that is provided regardless of race, ethnicity, gender, age, or sexual orientation and is provided with consideration for a patient's individual needs, cultural background, and values.
- Unbiased language which is used in the provider's print materials, electronic media, and other training or educational materials.
- The OTP facility is compliant with the Americans with Disabilities Act (ADA).
- HIV testing and education which are available to patients either at the provider or through referral. A patient who is HIV-positive and who requests treatment for HIV or AIDS is offered treatment for HIV or AIDS either at the provider or through referral. The patient also 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.
- 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.

Specific policies and procedure for take-home medications must include:

- Criteria for determining when a patient is ready to receive take-home medication.
- Criteria for when a patient's take-home medication is increased or decreased.
- A requirement that take-home medication be dispensed or distributed only after an order from the program Medical Director or physician/health care practitioner with prescribing authority, according to federal and State law.
- A requirement that the program Medical Director, physician, or health care practitioner with prescribing authority review a patient's take-home medication regimen at intervals of no less than 90 days and adjust the patient's dosage, as needed.
- Safe handling and secure storage of take-home medication in a patient's home.

- 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).
- Criteria and duration of allowing a physician/health care practitioner with prescribing authority to prescribe a split medication regimen.

Eligible Providers

General provider enrollment information can be found here.

Agencies must be approved by the State Opiate Treatment Authority (SOTA) within BHSD prior to administering an OTP. The application process is described in the *Operations* section. BHSD will consider the operating history of the OTP agency in making its determination to grant or deny an application to a previously approved agency. For questions related to the OTP application process, contact otp@nmrecovery.org.

The New Mexico Office of SOTA will conduct regulatory site visits as basis for issuing an OTP renewal of certification to operate every three years. The regulatory site visit will require submission of an amended application, revisions to policies and procedures since the previous approval to operate was issued, and other requested documentation.

Eligible Members

General member eligibility information can be found here.

OTP services are covered for Medicaid member who have:

- Been identified by the OTP agency's physician/health care practitioner with prescribing authority as having met the definition of opioid use disorder using generally accepted medical criteria, such as those contained in the current version of the DSM; and
- Received an initial medical examination required for admissions.
- If the recipient is under the age of 18, informed consent for treatment must be provided (electronic is sufficient) by a parent, guardian, custodian or responsible adult designated by the relevant state authority.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to OTP are below.

A Medicaid member may only be enrolled in 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.

Covered OTP services include:

- Withdrawal treatment and medically supervised dose reduction.
- A biopsychosocial assessment.
- A comprehensive, patient centered, individual treatment plan. 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.
- Medical, psychosocial counseling, mental health, vocational, educational and other services identified in the initial and ongoing treatment plans must be available to patients, either by the program directly, or through formal, documented referral agreements with other providers.
- Drug screening. A Medicaid member in comprehensive maintenance treatment receives one random urine drug detection test per month; short-term opioid treatment withdrawal procedure patients receive at least one initial drug screening test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee.

Samples that are sent out for confirmatory testing (by internal or external laboratories) are billed separately by the laboratory. Blood samples collected and sent to an outside laboratory are not covered.

The following information describes specific steps for patient admission to an OTP and subsequent screening, evaluations and assessments, treatment planning, crisis planning, relapse prevention planning, the provision of additional counseling for mental health and co-occurring disorders, and polices for take-home medication.

Admissions

An individual requesting medication for opioid use disorder treatment services must be assessed by the OTP medical director or health care practitioner with prescribing authority. This assessment may be conducted in person or via telehealth platform.

A Medicaid member must provide written, voluntary, program-specific informed consent to treatment prior to being admitted into an OTP. The Medicaid member must be informed of all services available to them through the program, all policies and procedures that impact treatment, and the following specific information:

- Progression of opioid dependency and the patient’s apparent stage of opioid dependence.
- Goals and benefits of opioid dependency treatment.
- Signs and symptoms of overdose and when to seek emergency assistance.

- 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.
- Requirement of staff to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to State law.
- Requirement of staff to comply with federal confidentiality requirements.
- Drug screening and toxicological testing procedures.
- Requirements to receive take-home medication.
- 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.
- Availability of counseling for preventing exposure to and transmission of human immunodeficiency virus (HIV), sexually transmitted diseases, and blood-borne pathogens.
- 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.

The medical director or medical practitioner designee of an agency providing OTP services must complete and fully document a physical examination of a Medicaid member. The full physical examination, including test results, must be completed within 14 days of admission into the OTP, and before the individual receives a dose of opioid dependency treatment medication. The physical examination results must be documented in the patient's record. A patient re-admitted within three months after discharge does not require a repeat physical examination unless requested by the program medical director.

The physical examination must document and include:

- Review of the individual's bodily systems.
- 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.
- A history of behavioral health issues and treatment, including any diagnoses and medications.
- Laboratory tests including, a Mantoux skin test, syphilis test, hepatitis screening in accordance with the most recent CDC guidelines, and 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.

- Additional tests based on the individual's history and physical condition, such as complete blood count, EKG, chest X-ray, pap smear, screening for sickle cell disease, hepatitis B and C, and HIV.

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. Initial screening may be conducted via audio-visual telehealth platform under certain conditions (please refer to 42 CFR Part 8 final rule). The screening tools used shall be accepted as a standard appropriate screen relative to the condition. 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.

Licensed staff will then further assess the severity of disease in terms of patient response to pharmacotherapy, recovery resources, coping skills, and psychosocial morbidity and determine patient motivation and readiness for change.

Psychiatric Diagnostic Evaluation and Comprehensive Assessment

After the initial screening, a psychiatric diagnostic evaluation (procedure code 90791) may be conducted to determine any co-occurring mental health diagnoses, unless there are previously diagnosed conditions available (within the past 12 months). 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.

A comprehensive or interdisciplinary assessment is conducted by a licensed behavioral health professional within 14 days of admission and updated each year thereafter.

A comprehensive assessment (H0031) does not necessarily entail other provider types and focuses more specifically on the SUD diagnosis. The comprehensive assessment must include the date, name, signature, and professional licensing credentials of the staff completing the assessment. The comprehensive assessment must include a summary of the following information and frequency and duration of counseling services:

- Description of the patient's presenting substance use history, identification of the patient's behavioral health symptoms and the behavioral health issue or issues that require treatment.
- List of the medical services needed by the patient.
- Recommendations/referrals for further assessment or examination of the patient's needs (i.e., physical, mental health or substance use) if indicated.

- Current medications prescribed to the patient, including dosage.
- Recommendations/referrals for treatment needed by the patient, such as psychosocial counseling or mental health treatment.
- 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).

An interdisciplinary assessment (procedure code H2000) is used with Medicaid members with co- occurring mental health diagnoses and includes input from multiple provider disciplines (e.g., mental health practitioners, primary care practitioners, other community supports, etc.) and the Medicaid member 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.

Treatment Planning

A treatment plan must be signed and documented in the individual's record within 24 hours of admission. An updated treatment plan must be signed and documented in the patient record within 30 days of admission. Treatment plans should be reviewed and updated with the individual every 90 days. All components of the treatment plan must be conducted by a licensed behavioral health professional or a LADAC under the supervision of an independently licensed, when the individual presents with co-occurring conditions. The treatment plan must include the date, printed name, signature and professional licensing credential of the staff member completing the treatment plan.

The treatment plan is developed with the patient to: 1) Establish immediate treatment goals; 2) Identify specific interventions (current issues, behavioral health symptoms and issues that require treatment) and modalities and or services to be used; 3) Identify the frequency of specific interventions such as counseling (including individual and group sessions) and urine drug screens; and 4) Identify recommendations for further assessment or examination of the patient's needs. Goals are expressed in the words of the patient and are reflective of the informed choice of the person served. 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. Treatment plans should reflect shared decision making between patient and clinician and incorporate harm reduction principles.

The treatment plan must also include 1) An aftercare/discharge plan that documents patient supports and collaboration (e.g., family, community, etc.), development level and unique circumstances for the patient to continue in recovery, and concrete steps that support the patient in recovery; and 2) A detailed summary of the patient's progress or challenges toward meeting new or existing goals based upon their recent progress. Updates to the treatment plan must include documentation of progress, non-progress or decline with each stated goal and next steps. Goals and objectives should be revised, as needed. The treatment plan

should reflect shared decision making between the individual and clinician and incorporate harm reduction principles.

Crisis Plan

The crisis plan 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. The document is a patient driven plan that providers and patients can refer to when the patient is experiencing a difficult time. The crisis plan must include, at a minimum:

- Name, address, current phone number, birthdate, and gender.
- 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.
- List of service providers and whether any of them should be contacted in crisis (ROI required).
- Description of what crises look like for the patient.
- Description of what the patient finds helpful, or relieving, during times of crisis (people, places, things).
- Steps the patient can take to seek support during crisis.
- 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.
- Description of when the patient could and should reach out for support (i.e., when they know it is time to contact someone or change a behavior).
- Description of the patient’s behavior when they are in crisis (i.e., 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?).
- Description of things that the patient will not talk about during crisis.
- 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. The Plan must include 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 Plan must include, at a minimum:

- The patient's most likely triggers for relapse (i.e., 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.

Additional Counseling for Clinical Mental Health, Substance Use and Co-occurring Disorders

OTPs provide individual therapy that addresses underlying issues and treatment related to co-occurring disorders under appropriate supervision. 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. Counseling services can be billed in addition to the bundled rate that encompasses the one hour of substance use/HIV and supportive counseling.

Each patient seeking opioid treatment must be 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. The OTP must make a 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. If a patient is referred to another provider, the OTP should follow up with that provider on the results of the referral, and to coordinate its treatment with any subsequent treatment by other providers. The OTP must also 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.

Take Home Medications

The OTP Medical Director may make treatment decisions on dispensing OTP medications to a patient for unsupervised use. Please refer to specific guidelines regarding take home dosing as outlined in current NMAC.

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.

Take-home medication must be distributed in a secure locking container with written and verbal information on the patient responsibilities for protecting the security of take-home medication. Patients must also be educated about proper disposal of empty containers. The OTP may not mail opioid treatment medication to any patient, agency, facility or person.

Medication Units

Medication units are defined to include either a 'brick and mortar' location or a mobile unit, through which OTPs can provide patients with access to medication (or other services, as identified) in their home community without establishing a new clinic. Medication Units function as an extension of the home clinic so a new clinic application is not required. Requirements for application and approval for medication units (to include SAMHSA, DEA, NM Board of Pharmacy and NM SOTA) as well as description of service delivery that can be provided in a medication unit, are detailed in current NMAC (8.321.2.30).

Authorization

General prior authorization and utilization review information can be found here.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to OTP services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies approved for operating an OTP may bill for the following procedure codes for OTP and related services (see table below).
2. As of October 1, 2020, the New Mexico Medicaid program stopped reimbursing for OTP services for members dually eligible for Medicaid and Medicare. Medicare is now the primary payer of OTP services for dual-eligibles. 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.
3. For a Federally Qualified Health Center (FQHC), bundled OTP reimbursement rate is outside the FQHC all-inclusive rate and is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

Procedure Code	Description	Additional Information
H0020	The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and	The quantity of service billed in a single day can include, in addition to the drug items administered that day, the

Procedure Code	Description	Additional Information
	dispensing methadone, and urine testing conducted within the agency	number of take-home medications dispensed that day. Guest dosing can be reimbursed at Medicaid-enrolled agencies. Arrangements must be confirmed prior to sending the patient to the receiving clinic.
J0571, J0572, J0573, J0574, J0575	Reimbursable codes for a narcotic replacement or agonist drug item other than methadone that is administered or dispensed	
H0001	Initial medical examination	
H2000	Comprehensive interdisciplinary assessment including initial treatment plan	
H0031	Mental health assessment by non-physician including initial treatment plan development	Cannot be billed if billing H2000.
90791–90792	Psychiatric diagnostic evaluations	
T1007	Treatment plan updates following the comprehensive interdisciplinary assessment and treatment plan	
H0025 or H0025 with modifier HQ if delivered in a group setting	HIV/SUD counseling	One hour is a federal requirement. Either individual or group counseling is acceptable.
Outpatient Therapy		
90832–90838	Psychotherapy services	Outpatient therapy other than the substance use disorder 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.
90839–90840	Psychotherapy for crisis	
90846–90847	Family psychotherapy	
90849–90853	Group therapies	
+90863	Pharmacologic management if combined with psychotherapy	

Procedure Code	Description	Additional Information
+90785	Interactive complexity	
Medically Necessary Services		
99201–99205	Evaluation and management services for a new patient	Medically necessary services provided beyond those required to address the medical issues of the eligible Medicaid member.
99213–99215	Evaluation and management for an established patient	
99201–99205	Full medical examination, prenatal care and gender specific services for a pregnant Medicaid member	
Miscellaneous Services		
36415	Routine venipuncture	
81025	Urine pregnancy test	
86580	Skin test; tuberculosis, intradermal	
G0480–G0483	Drug tests	
80307	Drug screening	
93000 and 93005	EKG screening	
Q3014	Telehealth technical fee for originating site	
Other Special Services		
H0033	Oral medication administration, direct observation (for buprenorphine induction)	Other special services performed by the agency are reimbursed when documented in the plan of care.
H2010	Comprehensive medication services, per 15-minutes (for buprenorphine administration)	
H2011 U2	crisis intervention service in clinic, per 15 minutes	
H2011 U3	Crisis intervention, mobile, if having a mobile crisis team	
H2011 U4	Crisis stabilization, if having a twenty-four (24)-hour OP crisis stabilization service	
H0015	Intensive outpatient program for substance use disorders, if HCA approved	

Procedure Code	Description	Additional Information
	ADD IOP FOR MH CODE AND DESCRIPTION	
H2030	Recovery services (for MCO members only)	
S5110	Family support services (for MCO members only)	

Partial Hospitalization Program (PHP) Services

Overview/Purpose

Partial Hospitalization Program (PHP) services are voluntary and provide intensive psychiatric care through active treatment that utilizes a combination of clinical services provided by an interdisciplinary team. PHPs are designed to stabilize deteriorating conditions or avert inpatient admissions, or can be a step-down strategy for individuals with serious mental illness (SMI), substance use disorder (SUD), or serious emotional disturbance (SED) who have required inpatient admission. The environment is highly structured, is time-limited and outcome oriented for Medicaid members experiencing acute symptoms or exacerbating clinical conditions that impede an individual's ability to function on a day-to-day basis. Program objectives focus on ensuring important community ties and closely resemble the real-life experiences of the Medicaid members served. Partial Hospitalization Programs are able to provide 20 or more hours per week of clinically intensive programming.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to PHP services are below.

The PHP interdisciplinary team must document that coverage criteria is met. This includes:

- Daily documentation of treatment interventions.
- Supervision and periodic evaluation of the Medicaid member, either individually or in a group, by the psychiatrist or psychologist to assess the course of treatment. At a minimum, this periodic evaluation of services at intervals indicated by the condition of the Medicaid member must be documented in the individual's record.
- Medical justification for any activity therapies, Medicaid member education programs and psychosocial programs.

Eligible Provider

General provider enrollment information can be found here.

A PHP facility must be Joint Commission accredited and licensed and certified by HCA or the comparable agency in another state. The PHP interdisciplinary team must include:

- An RN.
- A RLD board-approved Clinical Supervisor who is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician.

- Licensed behavioral health practitioners.

The team may also include physician assistants, certified peer support workers, certified family peer support workers, certified youth peer support specialists, licensed practical nurses, and mental health technicians.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible for PHP require comprehensive, structured, multimodal treatment requiring medical supervision and coordination. Services are provided under a treatment plan that is updated every 15 days or more frequently if clinically indicated. Eligible Medicaid members are under the care of a psychiatrist and:

- Have an adequate support system to sustain/maintain outside the PHP; and
- Age 19 and older with an SMI including substance use who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment; or
- Age 5–18 with SED including substance use disorders who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to PHP are below.

PHP services must be ordered by a psychiatrist or licensed PhD practitioner and are essentially of the same nature and intensity (including medical and nursing services) as would be provided in an inpatient setting. However, PHP is time-limited and the Medicaid member is in the program less than 24-hours a day. PHPs 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.

Within 24 hours of admission, the PHP interdisciplinary team must conduct a history and physical (H&P). If the eligible Medicaid member is a direct admission from an acute or psychiatric hospital setting, the program may elect to obtain the H&P in lieu of completing a new H&P. In this instance, the program physician's signature indicates the review and acceptance of the document. The H&P may be conducted by a clinical nurse specialist, a clinical nurse practitioner, a physician assistant or a physician.

With seven days of admission, the PHP interdisciplinary team must:

1. Conduct an interdisciplinary biopsychosocial assessment including alcohol and drug screening;

2. Develop a treatment plan. A full substance use history and evaluation is required if alcohol and drug screening indicates the need. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment. The treatment plan must document the type, amount, frequency and projected duration of the services to be furnished and indicate the diagnosis and anticipated goals. The treatment plan must be reviewed and updated by the interdisciplinary team every 15 days; and

3. Develop an individualized crisis and safety plan and relapse prevention plan if clinically indicated. These plans should be updated throughout the course of treatment, and be provided to the member and their identified natural supports.

Treatment must be reasonably expected to improve the eligible Medicaid member's condition or designed to reduce or control the individual's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the eligible Medicaid member's level of functions. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement. For Medicaid members in elementary and secondary school, educational services must be coordinated with the individual's school system.

Covered PHP services include:

- Regularly scheduled structured counseling and therapy sessions for an eligible Medicaid member, his or her family, group or multifamily group based on individualized needs furnished by licensed behavioral health professionals, and as specified in the treatment plan.
- Educational and skills building groups furnished by the program team to promote recovery.
- Age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management.
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic management.
- Assistance in self-administration of medication in compliance with State standards.
- Response to crisis situations, including stabilization, referrals, and follow-up as necessary.
- Consultation with other professionals or allied caregivers regarding a specific Medicaid member.
- Coordination of all non-medical services, including transportation needed to accomplish a treatment objective.

- Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of Medicaid members.
- Discharge planning and referrals as necessary to community resources, supports, and providers in order to promote a Medicaid member's return to a higher level of functioning in the least restrictive environment.

PHP services do not include:

- Meals.
- Transportation by the PHP provider.
- Group activities or other services which are primarily recreational or diversional in nature.
- Formal educational and vocational services related to traditional academic subjects or vocational training and non-formal education services can be covered if they are part of a treatment plan for the eligible Medicaid member.
- Services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.
- Treatment of active suicidal or homicidal ideation that cannot be safely managed in a PHP.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding PHP services is below.

A psychiatrist or a licensed PhD must order PHP services. Prior authorization (PA) is not required for this PHP unless the length of stay exceeds 45 days, at which time continued stay PA must be obtained from MAD, its UR contractor, or applicable MCO. Continued stay PA requests must include:

- Evidence of the need for the acute, intense, structured combination of services provided by a PHP;
- Information on the continuing serious nature of the Medicaid member's psychiatric 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; and
- Information on why a lower level of outpatient services would not be advised, and why, and that the Medicaid member may otherwise require inpatient psychiatric care in the absence of continued stay in the PHP. This description must include the Medicaid member's response to the therapeutic interventions provided by the PHP, psychiatric symptoms that continue to place the individual at risk of hospitalization, and treatment goals for coordination of services to facilitate discharge from the PHP.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to PHP services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Facility Billing

1. Bill on a UB with revenue code 0912.
2. Facility per diem is billed with procedure code S0201.
3. The per diem includes all PHP required staff.
4. The type of bill is 131.

Professional Billing

1. Other medical services that are not related to PHP can be reimbursed if they are medically necessary.
2. 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 (837P).
3. CCSS may also be billed for discharge planning and transition purposes.

Procedure Code	Description
97530	Occupational therapy and therapeutic activities (15-minute unit)
G0410	Group psychotherapy other than with a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy in a partial hospitalization setting, approximately 45 to 50 minutes
90832 – 90838	Individual Psychotherapy Evaluation and management services, utilize E&M codes with fee schedule reimbursement
90870-90871	Electroconvulsive Therapy Treatment

Peer Support

Overview/Purpose

Peer Support is delivered by individuals who have common life experiences with the people they are serving and help extend the reach of treatment beyond the clinical setting into the everyday environment.

Certified Peer Support Workers (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 CPSW is an integral and highly valued member of the interdisciplinary team who provides 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.

Certified Family Peer Support Workers (CFPSW) support parents and other primary caregivers to successfully navigate the child serving behavioral health, education, juvenile justice, child welfare and other systems on behalf of their child. CFPSW support parents and caregivers to ensure that their preferences are incorporated into their children's plan of care, including behavioral health, mental health, and educational plans, and that their natural support systems are strengthened. CFPSW help families raising children and youth to gain the knowledge, skills, and confidence to effectively manage their child's needs and ultimately move to more family independence. Family peer support services furnished to a parent and/or other primary caregivers are for the direct benefit of the Medicaid beneficiary.

Certified Youth Peer Support Workers (CYPSS) offers youth a connection to a peer with demonstrated lived experience whose empathetic response and resiliency provides the additional support, validation, and encouragement necessary for young people to successfully navigate the behavioral health and other systems and engage with the community during the transition to adulthood. CYPSW work with youth in individual and group settings to increase the levels of trust, relatability, and youth voice in the relationship between youth and provider.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Peer Support are below.

The requirements and certification process for CPSWs, CFPSWs, and CYPSWs are described below.

Certified Peer Support Workers

The prerequisites for a New Mexico CPSW certification include:

- Prospective CPSWs must be 18 or older and have a high school diploma or GED or equivalent.
- Self-identify as a current or former recipient of mental health and/or substance use services.
- Have a minimum of three years in recovery.
- Refer online at nmrecovery.org (OPRE page) for policy regarding convictions.

The CPSW certification process includes:

- Following the guidelines and successfully completing the application found online at: nmrecovery.org.
- Successfully completing the Certified Peer Support Worker training offered through Office of Peer Recovery and Engagement (OPRE) and facilitated by OPRE approved credentialed trainers.
- Successfully completing 40 hours of pre-exposure at an OPRE pre-approved community-based behavioral health agency.
- Passing a CPSW exam offered by the State's designated credentialing board.
- Written attestation to abide by the New Mexico CPSW Code of Ethics.

Certified Family Peer Support Workers

The CFPSW certification process includes:

- Completing the application, training, and certification program offered through the Children, Youth and Families Department Behavioral Health Services (CYFD BHS) division.
- Completing 20 hours of initial training and 20 hours of education every subsequent year.
- Passing a CFPSW exam offered by the State's designated credentialing board.

Certified Youth Peer Support Workers

The CYPSW certification process includes:

- Completing the application, training, and certification program offered through the CYFD BHS division.
- Completing 20 hours of initial training and 20 hours of education every subsequent year.

- Passing a CYPSW exam offered by the State's designated credentialing board.

Eligible Providers

General provider enrollment information can be found here.

Certified Peer Support is delivered under the supervision of a board-approved clinical supervisor or staff who have completed a state approved course in supervision of peers within the scope of the specialty service. For Peer Support, the peer supervisor must be employed with the same agency as the peer.

Eligible Members

General member eligibility information can be found here.

Medicaid members eligible to receive Certified Peer Support Services, Certified Family Peer Support Services, or Certified Youth Peer Support Services must have a documented need for the service in their comprehensive assessment or diagnostic evaluation.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Peer Support, and Family Peer Support, and Youth Peer Support are below.

Information about the type of services that CPSWs can, or cannot, provide is available online at nmrecovery.org.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Peer Support, Family Peer Support Services, and Youth Peer Support Services is below.

Prior authorization for Peer Support, Family Peer Support Services, or Youth Peer Support Services is not required, but the need for services must be documented in the Medicaid member's comprehensive assessment or diagnostic evaluation.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Peer Support, Family Peer Support Services, and Youth Peer Support Services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

- Providers use procedure code H0038 for each 15-minute unit.
- HQ modifier is used for group services.

Psychosocial Rehabilitation Services (PSR)

Overview/Purpose

Psychosocial Rehabilitation (PSR) services provide an array of services offered through a group modality in a Clubhouse Model or classroom setting and is intended to help an individual:

- Capitalize on personal strengths.
- Develop coping strategies and skills to deal with deficits.
- Develop a supportive environment in which to function as independently as possible.

PSR is intended to be a transitional level of care based on the individual's recovery and resiliency goals.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to PSR services are below.

Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services. Clinical services and supervision by licensed practitioners must be provided in accordance with respective licensing board regulations. PSR services must meet a staff ratio sufficient to ensure that patients have reasonable and prompt access to services.

In both Clubhouse and classroom settings, the entire staff works as a team. The team must include a RLD board-approved clinical supervisor/team lead that must possess the following minimum qualifications:

- Is an independently licensed behavioral health professional (i.e., psychiatrist, psychologist, LISW, LPCC, LPAT, LMFT, psychiatrically certified CNS) practicing under the scope of their New Mexico license;
- One year of demonstrated supervisory experience;
- Demonstrated knowledge and competence in the field of psychosocial rehabilitation; and
- An attestation of training related to providing clinical supervision to non-clinical staff.

The team can also include certified peer support workers, certified family support workers, community support workers, and other HIPAA trained individuals working under the direct supervision of the clinical supervisor.

Eligible Providers

General provider enrollment information can be found here.

An agency providing PSR services must be approved by BHSD. As part of the approval process, the agency must also develop policies and procedures for implementation and oversight of the service. Eligible providers are Core Service Agencies, Community Mental Health Centers, and Certified Community Behavioral Health Clinics (CCBHC). BHSD application for agency certification is found on www.nmrecovery.org. Initial approval from BHSD will result in a three-year certification. As part of the initial approval process, a site visit will be required. Re-certification to operate a PSR program will occur every three years thereafter and will also include a site-visit. PSR Programs are subject to the HCA Division of Health Improvement life and safety processes, as part of the certification process and ongoing re-certification. At its discretion, BHSD can conduct a site visit on the PSR program at any time.

Eligible Members

General member eligibility information can be found here.

PSR is a covered service for a Medicaid member who is:

- 18 years and older;
- Meets the criteria for serious mental illness (SMI) or has been diagnosed with co-occurring SMI and substance use disorder (SUD); and
- Has been assessed for medical necessity for PSR services.

A resident in an institution for mental illness is not eligible for PSR services.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to PSR are below.

PSR services must be provided in a facility-based setting, either in a Clubhouse Model or a structured classroom. In addition to the standard client record documentation requirements for all services, PSR services must be identified and justified in the individual's treatment plan. Specific service needs (e.g., household management, nutrition, hygiene, money management, parenting skills, etc.) must also be identified in the individual's treatment plan. PSR services are limited to goals which are individually designed to accommodate the level of the Medicaid member's functioning and which reduce the disability and restore the individual to their best possible level of functioning.

PSR covered services include the following domains:

- **Basic living skills development.** Basic living skills development activities address topics such as basic household management; basic nutrition, health, and personal care including hygiene; personal safety; time management skills; money management skills; how to access and utilize transportation; awareness of community resources and support in their use; childcare/parenting skills; work or employment skill-building; and how to access housing resources.
- **Psychosocial skills training.** Psychosocial skills training activities address topics such as self-management, cognitive functioning, social/communication, and problem-solving skills.
- **Therapeutic socialization.** Therapeutic socialization activities address topics such as understanding the importance of healthy leisure time; accessing community recreational facilities and resources; physical health and fitness needs; social and recreational skills and opportunities; and harm reduction and relapse prevention strategies (for individuals with co-occurring disorders).
- **Individual empowerment.** Individual empowerment activities address topics such as choice, self-advocacy, self-management, and community integration.

The Clubhouse Model

The Clubhouse Model is a dynamic program of support and opportunities for people with SMI 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 an individual's strengths and abilities, not their illness. For the Clubhouse member it is a right to a place to come and return and to develop meaningful work and relationships.

The Clubhouse provides an effective outreach to engage members who would otherwise become isolated in the community or hospitalized. Clubhouse membership is voluntary and 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.

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. At the same time, PSR programs are encouraged to actively enhance individual empowerment to promote the full potential of each participant. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning. Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse, which are to be signed by both member and staff, and their degree of participation in the four specific PSR program domains. Only activities that are related to the four specific domains are billable.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding PSR services is below.

PSR does not require prior authorization, but Medicaid members must be assessed for medical necessity. Medical necessity is based on the Medicaid member's assessment, diagnostic information, and treatment plans.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to PSR services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies use procedure code H2017 for individual PSR, and H2017 HQ (group) for each 15-minutes unit.
2. PSR cannot be billed concurrently when the Medicaid member is a resident of an institution for the mentally ill.

Recovery Services (Managed Care Benefit Only)

Overview/Purpose

Recovery Services are highly personal and individualized and are reflective of the individual challenges each person has overcome so that it no longer impedes 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.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Recovery Services are below.

Staffing ratios for group Recovery Services must be sufficient to ensure that individuals have reasonable and prompt access to services at the required levels of frequency and intensity within the practitioner's scope of practices.

Eligible Provider

General provider enrollment information can be found here.

Recovery Services are provided by certified peer support workers, youth peer support specialist, and certified family peer support workers under the supervision of a RLD board-approved Clinical Supervisor. Clinical Supervisors must be a licensed independent practitioner (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, CNP, CNS) with two years relevant experience with the target population and one year demonstrated supervisory experience, to include required training from a state approved training/trainer on supervision of certified and credentialed providers. This training can be accessed on www.nmrecovery.org. The Clinical Supervisor must have expertise in both mental health and substance use disorder treatment services.

Eligible Members

General member eligibility information can be found here.

Recovery Services are covered for MCO members who are:

- Children experiencing serious emotional/neurobiological/behavioral disorders;
- Adults with serious mental illness (SMI); and

- Individuals with chronic substance use, those with a co-occurring disorder (mental illness/substance use), or those dually diagnosed with a primary diagnosis of mental illness.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Recovery Services are below.

Recovery Services incorporate a full range of social, legal, and other services that facilitate recovery. Services focus on the individual's wellness, ongoing recovery and resiliency, relapse prevention, and chronic disease management. Recovery Services must support the individual's recovery goals and there must be documented evidence of these goals and outcomes in the recovery services treatment plan. Recovery services support specific recovery goals through:

- Use of strategies for maintaining the eight dimensions of wellness.
- Creating relapse prevention plans.
- Learning chronic disease management methods.
- Identifying linkages to ongoing community supports.

Recovery services can be delivered in an individual or group setting, and include, but are not limited to:

- Screening, engaging, coaching, and educating.
- Emotional support that demonstrates empathy, caring, or concern to bolster the person's self-esteem and confidence.
- Sharing knowledge and information or providing life skills training.
- Provision of concrete assistance to help others accomplish tasks.
- Facilitation of contacts with other people to promote learning of social and recreational skills, creating community and acquiring a sense of belonging.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Recovery Services is below.

Prior authorization is not required for Recovery Services but must be documented in the treatment plan. Medicaid members meet admission criteria if they are unable to achieve functional use of natural and community support systems to effectively self-manage recovery and wellness. Continue stay criteria is met if the Medicaid member is making progress but

continues to need support in developing competencies. Medicaid members meet discharge criteria when maximum use of natural and community support systems to effectively self-manage recovery and wellness is achieved.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Recovery Services are below.

1. Providers use procedure code H2030 for each 15-minute unit.
2. Peer support services use procedure code H0038 each 15-minute unit.
3. Recovery Services may not be billed in conjunction with Multi-Systemic Therapy (MST), Assertive Community Treatment (ACT), Partial Hospitalization, Transitional Living Services (TLS), or Treatment Foster Care (TFC).

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

Overview/Purpose

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is used in primary care and other physical health care settings to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. This service is not available in specialized behavioral health settings. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with medical care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for additional treatment, the staff member will refer to behavioral health services.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to SBIRT are below.

Providers must have referral relationships with mental health and substance use agencies.
Providers must be trained in the New Mexico model to provide SBIRT services.
Guidance can be found at www.nmrecovery.org.

Eligible Providers

General provider enrollment information can be found here.

Facilities eligible to support the provision of SBIRT services include:

- Primary care offices including Federally Qualified Health Centers (FQHCs), Indian Health Services (IHS) 638 tribal facilities, and Indian Health Care Providers (IHCP).
- Patient centered medical homes.
- Urgent care centers.
- Hospital outpatient facilities.
- Emergency departments.
- Rural health clinics.

- Specialty physical health clinics.
- School based health centers.
- Nursing facilities.

The following providers trained in SBIRT may provide the service:

- Licensed nurse.
- Licensed nurse practitioner or licensed nurse clinician.
- Behavioral health practitioner.
- Certified peer support worker.
- Certified community health worker.
- Licensed physician assistant.
- Physician.
- Home health agency.
- Nurse home visit early and periodic screening, diagnosis and treatment (EPSDT).
- Medical assistant trained in SBIRT.
- Community health representative in tribal clinics.

Eligible Members

General member eligibility information can be found here.

Medicaid members age 11 and older are eligible to receive SBIRT services. Medicaid members between the age of 11 and 13 must have parental consent.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to SBIRT are below.

Providers must use the NM Healthy Lifestyle Questionnaire (HLQ) for adults, or other State approved instruments, or a validated screening tool which have been psychometrically tested for reliability, validity, and sensitivity and addresses substance use, depression, anxiety, and trauma. SBIRT covered services include screening for Medicaid members who have a negative screening result. Medicaid members with a positive screening result for alcohol or drugs and/or a co-occurring condition of depression, anxiety, or trauma also receive brief intervention and referral to behavioral health treatment as necessary.
The tools mentioned above can be found at www.nmrecovery.org.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding SBIRT is below.

SBIRT screening is universal for Medicaid members seen in a medical setting. No prior authorization is required. Parental consent is required for adolescents between the age of 11 and 13.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Smoking Cessation Counseling

Overview/Purpose

Smoking Cessation Counseling is an array of services (counseling and tobacco cessation drug items) intended to lower the risk of cancer and other serious health problems.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Smoking Cessation Counseling services are below.

The provider rendering Smoking Cessation Counseling must document medical necessity and that face-to-face Smoking Cessation Counseling was prescribed.

Eligible Provider

General provider enrollment information can be found here.

Smoking Cessation Counseling services must be provided by a MAD enrolled licensed provider. Smoking Cessation Counseling services may be provided by physicians, independently enrolled certified nurse practitioners (CNPs), behavioral health and dental practitioners, physician assistants or CNPs RNs or dental hygienists when under the supervision of a dentist or physician. Pharmacists who have attended at least one continuing education course on tobacco cessation, in accordance with the federal public health guidelines, may provide Smoking Cessation Counseling.

Eligible Members

General member eligibility information can be found here. All Medicaid members are eligible for Smoking Cessation Counseling.

Covered and Non-covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Smoking Cessation Counseling is below.

Treatment may include prescribing any combination of tobacco cessation products and counseling.

Covered services include:

- Assessment of tobacco use disorder including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, or assessment.
- Tobacco cessation drug items prescribed by a practitioner, including sustained release bupropion products, varenicline tartrate tablets, and prescription and over the counter (OTC) nicotine replacement drug products, such as a patch, gum, or inhaler.
- Face-to-face Smoking Cessation Counseling includes:
  - Intermediate Smoking Cessation Counseling sessions which are longer than three minutes and up to 10 minutes long; or
  - Intensive Smoking Cessation Counseling sessions which are 10 minutes or longer.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Smoking Cessation Counseling services is below.

Two Smoking Cessation Counseling attempts (or up to eight cessation counseling sessions) are allowed in any 12-month period. A cessation counseling attempt includes up to four Cessation Counseling sessions (one attempt plus up to four sessions). During the 12-month period, the provider and the eligible Medicaid members have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

Prior authorization is not required for tobacco cessation products.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General information on fraud and abuse can be found here. Specific billing and claims requirements related to Smoking Cessation Counseling are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Providers use procedure codes:

1. 99406 for Intermediate Smoking Cessation Counseling sessions (3–10 minutes of counseling).
2. 99407 for Intensive Smoking Cessation Counseling sessions (10 minutes or longer).

Supportive Housing Pre-Tenancy and Tenancy Services: Permanent Supportive Housing and Tenancy Support Services (PSH-TSS) (Managed Care Benefit Only)

Overview/Purpose

Supportive housing services 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. PSH-TSS do not include tenancy assistance in the form of rent or subsidized housing. PSH-TSS instead expands the availability of basic housing supports.

The State leverages its existing program infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program to render peer delivered PSH-TSS. Linkages with 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 SMI.

The basic principles of PSH-TSS include:

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

Definitions of terms pertaining to this manual can be found here

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to PSH-TSS are below. In addition to the standard client record documentation requirements for all services, PSH-TSS documentation must ensure non-duplication of services for billing purposes.

Eligible Provider

General provider enrollment information can be found here.

Providers eligible to deliver PSH-TSS include:

- Any clinic, office, or agency providing permanent supportive housing under HCA's Linkages Program, administered by the BHSD.
- Behavioral health practitioners licensed in the state of New Mexico, Certified Peer Support Workers, Certified Youth Peer Support Workers, or Certified Family Peer Support Workers.

Eligible Members

General member eligibility information can be found here.

In order to receive PSH-TSS, a Medicaid member must:

- Be enrolled in the State's Linkages Permanent Supportive Housing Program.
- Have an assessment documenting a SMI diagnosis with functional impairment within the prior 12 months.
- Have an assessment SMI and co-occurring SUD within the prior 12 months.

Target populations of PSH-TSS include:

- Disabled individuals with a SMI and functional impairment.
- Homeless or precariously housed. "Homeless or precariously housed" is defined as:
  - 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.
  - 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.

  - Families with children or unaccompanied youth who are unstably housed and likely to continue in that state.

- Living situations that include excessive occupancy in a unit. Excessive occupancy is occupancy in excess of the lease and/or local regulations. An Excessive Occupancy Declaration must be included with the Certificate of Eligibility. Excessive occupancy applies to those with their own lease and is different than “doubled-up situation[s]”.
- The following subcategories apply 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 barriers to employment.
  - Homeless or precariously housed families with children may be considered eligible only by an adult (18 years or older) being diagnosed with SMI (minor children with Severe Emotional Disturbance are not a qualifying situation).
  - Unaccompanied Youth must be 18 years of age and able to legally sign a Lease and diagnosed with a Severe Mental Illness.
- Extremely low-income individuals. This is defined by the U.S. Department of Housing and Urban Development (HUD) as individuals with income of “30% of area median income or less.”

Covered and Non-Covered Services

General covered services can be found here. General information on telehealth services can be found here. Specific covered services related to PSH-TSS are below.

PSH-TSS 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 personal health and welfare.

Pre-tenancy services include:

- Screening and identifying preferences and barriers related to successful tenancy.
- Developing an individual housing support plan and housing crisis plan.
- Assisting participants with finding and applying for housing.
- Ensuring that the living environment is safe and ready for move-in.
- Tenancy orientation and move-in assistance.
- Assistance in securing necessary household supplies.
- Landlord relationship building and communication.

Tenancy support services include:

- Early identification of issues undermining housing stability, including individual behaviors.
- Coaching the Medicaid member about relationships with neighbors, landlords and tenancy compliance.
- Education about tenant responsibilities and rights.
- Supports to assist participants in resolving tenancy issues.
- Regular review and updates to housing support plan and housing crisis plan.
- Assisting participants in linking to other community resources that may support individuals in maintaining housing.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding PSH-TSS services is below.

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

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to PSH-TSS are below.

1. For billing, providers should use procedure code H0044 once per month for reimbursement.
2. For utilization tracking purposes, providers should use procedure code H0043 for pre-tenancy and tenancy support services rendered during the month (see modifiers in table below). These procedure codes will not be reimbursed as the services are included in the H0044 monthly reimbursement. Identify both rendering provider and date of each service.

Procedure Code Modifier	Service Description
Pre-Tenancy Services	
U1	Screening and identifying preference and barriers related to successful tenancy
U2	Developing an individual housing support plan and crisis plan
U3	Assisting participants with finding and applying for housing
U4	Ensuring that the living environment is safe and ready for move-in
U5	Tenancy orientation and move-in assistance
U6	Landlord advocacy

Procedure Code Modifier	Service Description
U7	Assisting participants with securing necessary household supplies
Tenancy Support	
U8	Early identification of issues including individual's behaviors
U9	Coaching to the Medicaid member about relationships with neighbors and landlords and tenancy compliance
UA	Education about tenant's responsibilities and rights
UB	Supports to assist participants in resolving tenancy issues
UC	Regular review and updates to housing support plan and crisis plan
UD	Assist participants in linking to other community resources that may support individuals in maintaining housing

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Overview/Purpose

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children and youth ages 3–18 who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to TF-CBT are below.

A TF-CBT agency must meet the following requirements:

- Comply with requirements in Subsections A and B of 8.321.2.9 NMAC (8.321.2 NMAC [state.nm.us]).
- Complete certification through Trauma Focus Cognitive Behavioral Therapy Certification Program (www.tfcbt.org).
- Be approved by CYFD.

Eligible Providers

General provider enrollment information can be found here.

The following Mental Health Practitioners who are licensed in the State of New Mexico to diagnose and treat behavioral health acting within the scope of all applicable state laws and their professional license may provide TF-CBT services once certification is obtained from the Trauma Focused Cognitive Behavioral Therapy Certification Program.

- Master’s degree or above in a mental health discipline
- Permanent professional licensed in-home state, including having passed the state licensing exam in mental health discipline
- Medical Psychologists
- Licensed Psychologists

- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Advanced Practice Registered Nurses (APRN) (must be a nurse practitioner specialist in Adult Psychiatric and Mental Health, and Family Psychiatric and Mental Health or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Eligible Members

General member eligibility information can be found here.

Individuals eligible for TF-CBT services include Medicaid members ages 3-18 who have a mental health disorder and their families.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here.

All services provided while a person is a resident of an Institution for Mental Disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by Medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

The following services shall be excluded from Medicaid coverage and reimbursement of TF-CBT:

- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services provided at a worksite, which are job-oriented and not directly related to the treatment of the member's needs.
- These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding TF-CBT services is below.

TF-CBT does not require prior authorization but is subject to medical necessity.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to TF-CBT are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. TF-CBT providers (Provider Specialty Type 136) use the following procedure codes with modifiers:
    A. 30-minute TF-CBT session (Psychotherapy with Patient Present): 90832, U1
    B. 45-minute TF-CBT session (Psychotherapy with Patient Present): 90834, U1
    C. 60-minute TF-CBT session (Psychotherapy with Patient Present): 90837, U1
    D. 50-minute TF-CBT session (Family Psychotherapy without Patient Present): 90846, U1
    E. 50-minute TF-CBT session: 90847, U1 (Family Psychotherapy with Patient Present): 90847, U1
2. Only direct staff face-to-face time with the child or family may be billed. TF-CBT is a face-to-face intervention with the individual and caregiver present. However, the child receiving treatment does not need to be present for all contacts.
3. Limitations and exclusions for outpatient individual therapy (90832-90837), group (90853) and family therapy (90846 and 90847) apply as otherwise listed in New Mexico guidance.
4. Typical sessions during which there is both a child-delivered portion of the session, and a parent-delivered portion of the session, may be billed as 90832, 90834, or 90837 (or their successors — Psychotherapy, with patient present), as long as:
    A. The client is present for all or the majority (greater than 50%) of the time billed; and
    B. The entirety of the service is provided to, or directed exclusively toward the treatment of, the Medicaid-eligible child or youth.
5. If there is a parent-directed session for which the child is not present for the majority of the time, the appropriate procedure code must be billed (e.g., 90846 or its successor — Family Psychotherapy without Patient Present).
6. The parent-directed session must be directed exclusively toward the treatment of the Medicaid-eligible child or youth.

7. Collateral contacts billable to Medicaid should involve contacts with parents or guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable. **NOTE:** The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as probation and aftercare programs, public guardianship programs, special education programs, and child welfare/child protective services programs. Coordination with these child serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid. Services may be provided by these child-serving systems; however, the services provided must be funded through the agency providing the service.

Treat First Clinical Model

Overview/Purpose

Individual no-show rates at many provider sites are between 40%-60% often due to the individual's need not being addressed at the first visit. The Treat First Clinical Model ("Treat First") helps correct problems with treatment delays by: 1) emphasizing the initial clinical practice functions of establishing rapport; 2) building trust; 3) screening to detect possible urgencies; and 4) providing a quick response for any urgent matters when a new person presents with a problem and requests help from the agency. Timely and effective response to a person's request helps to achieve a more immediate formation of the therapeutic relationship, 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 visits.

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

More information about the Treat First Model, including how to become a Treat First provider, Highlights of the first four encounters, Treat First Approach in the Treat First Clinical Model, Treat First Approach Protocol, and the Adult and Child Self Check-In and Session Check-Out Instruments can be found at: www.treatfirst.org.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Treat First are below.

Treat First providers are required to have the clients complete a self-check-in and a session-check-out tool during the four visits with Medicaid members. The self check-in tool includes four questions and is intended to assess the wellbeing of the individual at the beginning of the visit and how their wellbeing may have changed from the last visit. This is repeated at each of the first four visits. The session check-out tool is also completed at the end of each of the four visits and identifies, from the client's perspective, how useful and beneficial the session has been in making progress using a rating scale. Participating agencies enter the self check-in and session check-out data into the State's designated Treat First web-based data collection program on a timely basis.

Eligible Providers

General provider enrollment information can be found here.

Participating agencies are required to have a BHSD-issued Treat First "Certificate of Acknowledgement." This certifies that the agency has 1) Completed the Treat First Participation Agreement; 2) Attested to having relevant clinical and administrative staff complete internal training on the Treat First Clinical Model; 3) Regularly participated in the Treat First Learning Community; and 4) Entered required data into the Treat First web-based data collection system in a timely manner.

Eligible Members

General member eligibility information can be found here.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Treat First are below.

The Treat First Model includes up to four visits, activities for which can be found at www.treatfirst.org. A provisional diagnosis must be documented in each of the visits. The concepts, principles, and processes used in the Treat First Approach also provide a responsive way of initiating treatment planning for Medicaid members who need continued services after four visits covered under the Treat First Model.

If an agency is using the Treat First Model, the member may receive any Medicaid eligible services for up to four visits without having had a diagnostic evaluation completed. A provisional diagnosis is used for billing purposes.

After four visits, if further treatment is needed, an individual must have an appropriate diagnostic evaluation.

Treat First practice principles include:

- Connecting with a Medicaid member 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.
- Building common purpose and unifying efforts through teamwork (when longer-term services are indicated).
- Engaging the individual in positive life-change processes.
- Understanding the individual's strengths, needs, and preferences.
- Defining the wellness and recovery goals to be achieved.
- Planning intervention strategies, supports, and services.

- Implementing plans.
- Tracking and adjusting strategies until desired outcomes are achieved.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Treat First is below.

The Treat First Model may be billed with a provisional diagnosis for up to four visits. After four visits, if continued treatment is required, an appropriate diagnostic evaluation must be performed, and subsequent reimbursement is based on the diagnosis and resulting treatment plan.

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

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to Treat First are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. All claims must contain a provisional diagnosis. This includes 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).
2. All claims must bill with the appropriate CPT or HCPCS code until the final diagnosis has been established.
3. 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 used for billing purposes.
4. If a crisis intervention is required, agencies use procedure code H2011, which will be billed and counted outside of the four visits.
5. Outpatient therapy and all special services can be initiated and billed before a diagnostic evaluation has been completed.
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.

Treatment Foster Care I and II

Overview/Purpose

Treatment Foster Care (TFC) services are individualized, trauma-informed care provided by trauma-responsive TFC agencies to Medicaid members under the age of 21 (admitted prior to their 18th birthday) who reside in a foster home setting and have psychological or emotional disturbances and/or behavior disorders. Services are provided in accordance with best practices and national standards. TFC Level I and Level II provide therapeutic services to children or adolescents with complex and difficult psychiatric, psychological, neurobiological, behavioral, and psychosocial problems.

Definitions of terms pertaining to this manual can be found here.

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to TFC are below.

The following information describes roles and responsibilities for TFC agencies, TFC parents, and the State Protective Services Division's (PSD) *Reasonable and Prudent Parenting Standard*.

TFC Agencies

TFC agencies provide therapeutic services to an eligible Medicaid member who is experiencing emotional or psychological trauma and who would optimally benefit from TFC Level 1 services and supervision. TFC agencies provide therapeutic family living experiences as the core treatment service to which other individualized services. TFC Level II services are 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.

The following services must be furnished by TFC agencies:

- Facilitation, monitoring, and documentation of Treatment Foster Parent initial and ongoing training.
- Provision of support, assistance, and training to Treatment Foster Parents.
- Provision of assessments for all placements to determine the eligible Medicaid member's therapeutic appropriateness.
- Ongoing review of the eligible Medicaid member's progress in TFC and assessment of family interactions and stress.
- Ongoing treatment planning and treatment team meetings.

- Provision of individual, family or group psychotherapy to Medicaid members as described in the treatment plan. The TFC therapist is an active treatment team member and participates fully in the treatment planning process.
- Family therapy when client reunification with their family is the goal.
- Facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques, and self-care techniques for the eligible Medicaid member.
- Crisis intervention, at all times, to Treatment Foster Parents, Medicaid members, and their families, including 24-hour availability of appropriate staff to respond to the home in crisis situations.
- Assessment of family's strengths, needs and development of a family treatment plan, when an eligible Medicaid member's return to their family is planned.
- Treatment Coordinator documentation of private face-to-face visits with Treatment Foster Parents within the first two weeks of placement for all TFC clients, and thereafter twice monthly for TFC Level 1 clients, and once monthly for TFC Level II clients.

Treatment Foster Parents

Treatment Foster Parents licensed by the TFC agency receive appropriate training and supervision by the TFC agency. A TFC family must have one parent readily accessible at all times, cannot schedule work when the Medicaid member is normally at home, and is able to be physically present to meet the child's emotional, physical, and behavioral needs. In the event the TFC family requests removal of the child from their home, a treatment team meeting must be held, and an agreement made that a move is in the best interest of the child. Any TFC family who removes the child from their home without first discussing and obtaining consensus from the treatment team may have their license revoked.

Treatment Foster Parent responsibilities include, but are not limited to:

- Meeting the Medicaid member's basic needs and providing daily care and supervision.
- Participating in the development of treatment plans for the eligible Medicaid member by providing input based on their observations.
- Assuming the primary responsibility for implementing the in-home treatment strategies specified in the eligible Medicaid member's treatment plan.
- Recording the eligible Medicaid member's information and documentation of activities, as required by the TFC agency, and the standards under which it operates.
- Assisting the eligible Medicaid member with maintaining contact, with their family, and enhancing that relationship.

- Supporting efforts specified by the treatment plan to meet the eligible Medicaid member's permanency planning goals.
- Treatment Foster Parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan.
- Assisting the eligible Medicaid member obtain medical, educational, vocational, and other services to reach goals identified in treatment plan.
- Ensuring proper and adequate supervision is provided at all times. Treatment teams determine that all out-of-home activities are appropriate for the Medicaid member's level of need, including the need for supervision, in accordance with Reasonable and Prudent Parenting Standards.
- Working with all appropriate and available community-based resources to secure services for and to advocate for the eligible Medicaid member.

Reasonable and Prudent Parenting Standard

The Reasonable and Prudent Parenting Standard and Prevention of Sex Trafficking guidance can be found at the following link: https://www.acf.hhs.gov/sites/default/files/documents/cb/im1403.pdf.

Eligible Providers

General provider enrollment information can be found here.

A TFC agency must be certified by the Licensing and Certification Authority Bureau (LCA) within the Behavioral Health Services Division of CYFD and be licensed by the Child Placement Agency within the Protective Services Division of CYFD. In lieu of New Mexico CYFD licensure and certification, an out-of-state TFC agency must have equivalent accreditation and be licensed in its own state as a TFC agency. Each certified service agency is responsible for establishing and following written policies and procedures that specify how applicable certification requirements are met. Certification requirements are described in 7.20.11 NMAC (7.20.11 NMAC [cyfd.org]).

TFC agencies and Treatment Foster Parents must follow requirements for:

- Background checks and employment history verification found in 8.8.3 NMAC (Microsoft Word - 08.008.0003.doc [cyfd.org]).
- Licensing for Foster and Adoptive Homes found in 8.26.4 NMAC (8.26.4 NMAC [cyfd.org]).
- Child Placement Agency Licensing Standards found in 8.26.5 NMAC (8.26.4 NMAC [cyfd.org]).

Eligible Members

General member eligibility information can be found here.

Eligible Medicaid members are those who are under the age of 21 (admitted prior to their eighteenth birthday) and 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.

Medicaid members eligible for TFC Level I services are those who:

- Are at risk for placement in a higher level of care or is returning from a higher level of care and is appropriate for a lower level of care or has complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and
- Require and would optimally benefit from the behavioral health services and supervision provided in a treatment foster home setting.

Medicaid members eligible for TFC Level II services are those who:

- Have successfully completed TFC Level I, as indicated by the treatment team;
- Require the initiation or continuity of treatment and support of the treatment foster family to secure or maintain therapeutic gains; or
- Require this treatment modality as an appropriate entry level service from which the Medicaid member will optimally benefit.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to TFC are below.

A Medicaid member may receive services from any TFC enrolled agency of their choice. Placement occurs upon determination that the home has been assessed as therapeutically appropriate and clinically-based. This occurs at the end of a 72-hour visitation. A comprehensive assessment is not required prior to placement, but must be completed within 15 days of admission. The match assessment determines how the prospective TFC family is able to meet the child's needs and preferences, and documents clinical rationale for the placement. A Medicaid member may change treatment foster homes in order to be reunited with siblings, or if the change in homes is clinically indicated and documented in the client's record by the treatment team.

TFC services do not cover room and board, formal educational or vocational services related to traditional academic subjects or vocational training, respite care, or CCSS except as part of the discharge planning.

The following information describes treatment and discharge planning.

Treatment Plan

A TFC agency must complete an initial treatment plan within 72 hours of admission. The treatment plan should be based on information available at the time. A comprehensive treatment plan must be developed within 14 calendar days of admission to Treatment Foster Care and is based on the comprehensive assessment. The comprehensive treatment plan must be reviewed every 30 calendar days. 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.

The initial and comprehensive treatment plan must:

- Involve the full participation of treatment team members, including the Medicaid member and their parents/legal guardian, who are involved to the maximum extent possible.
- Document reasons for nonparticipation of the Medicaid member and/or their family/legal guardian.
- Be conducted in a language/mode of communication that the Medicaid member and/or family members can understand, or is explained in a way that invites full participation.
- Be designed to improve the Medicaid member's motivation and progress and strengthen appropriate family relationships.
- Be designed to improve the Medicaid member's self-determination and personal responsibility.
- Use the Medicaid member's strengths.
- Be conducted under the direction of a person who has the authority to impact change and who possesses the experience and qualifications to enable him/her to conduct treatment planning.

The initial and comprehensive treatment plan must specifically document:

- Behavioral changes targeted, including potential high-risk behaviors.
- Corresponding time-limited intermediate and long-range treatment goals and objectives.
- Frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures.
- Staff responsible for each intervention.
- Projected timetables for the attainment of each treatment goal.
- A statement of the nature of the specific problem(s) and needs of the Medicaid member.
- A statement and rationale for the plan for achieving treatment goals.

- A permanency plan for Medicaid members in the custody of the department.
- Whether the Medicaid member has 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.

Discharge Planning

Discharge planning must include the following information and revisions are required if updates occur:

- A projected discharge date, which is updated as clinically indicated.
- Behavioral and other clinical criteria as conditions under which discharge will occur.
- Requires that the Medicaid member has achieved the objectives of the treatment plan.
- Evaluation of high-risk behaviors or the potential for such.
- Documents that discharge is safe and clinically appropriate for the Medicaid member, level of care, specific services to be delivered, and the living situation into which discharge is projected to occur.
- Specific criteria for discharge to a less restrictive setting.
- Options for alternative or additional services that may better meet the Medicaid member's needs.
- Individuals responsible for implementing each action specified in the discharge plan.
- Barriers to discharge.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding TFC services is below.

Prior authorization is required for TFC services. The need for TFC Level I and TFC Level II services must be identified in the Tot to Teen Health check or other diagnostic evaluation furnished through the eligible Medicaid member's health check referral.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to TFC services are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. Agencies bill on a CMS 1500 claim form.

2. Level I TFC agencies use procedure code S5145 for each one-day unit, with a maximum of 31 units.
3. Level II TFC agencies use procedure code S5145 (U1) for each one-day unit.
4. CCSS may also be billed for discharge planning and transition purposes.

Accredited Residential Treatment Center (ARTC for Youth)

Overview/Purpose

Accredited Residential Treatment Centers (ARTC) for Youth provide 24-hour services for individuals under the age of 21 who have severe behavioral, psychological, neurobiological, or emotional needs. Treatment is designed to reduce or control symptoms, maintain functioning, and avoid hospitalization or further deterioration.

Definitions of terms pertaining to this manual can be found here.

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

Provider Requirements

General provider responsibilities and requirements can be found here. General information on requirements for out-of-state and border area providers can be found here. Specific provider responsibilities and requirements related to Youth ARTCs are below.

ARTCs for Youth facilities must meet the following accreditation, certification, and staffing requirements:

- Accreditation as a youth facility by the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). Facilities must also develop and follow written policies and procedures identifying how certification requirements are met.

- Licensing and Certification by the CYFD Licensing and Certification Authority (LCA). As part of certification, each facility must provide a copy of its most recent accreditation report and any quality improvement plan, as applicable. For out of state facilities, the youth ARTC must be licensed in its home state, in lieu of CYFD licensing and certification. Certification requirements for Child and Adolescent Mental Health Services can be found in 7.20.11 NMAC (https://www.cyfd.nm.gov/wp-content/uploads/2022/12/Cert_Regs-_7_20_11_NMAC.pdf) and licensing requirements for Child and Adolescent Mental Health Facilities can be found in 7.20.12 NMAC.
- Compliance with State requirements on background checks and employment history verification found at 8.8.3 (https://www.cyfd.nm.gov/wp-content/uploads/2022/12/08.008.0003.pdf).
- Minimum staff-to-child ratio of 1:5 during the day and evening shifts and an “awake staff” to child ratio of 1:10 during night shifts. Additional staff may be required based on Medicaid member acuity or other conditions.

Providers must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

Special Considerations for IHS and Tribal Facilities

ARTCs for Youth operated by the Indian Health Service (IHS) or a federally-recognized tribal government must either be licensed and certified by CYFD LCA, or must comply with minimum Medicaid standards in order to receive Medicaid funding. If an IHS or a federally-recognized tribal government does not choose formal licensure and certification through CYFD, LCA will develop a written report to evaluate whether minimum Medicaid standards are met, in order for the program to receive reimbursement. In cases where the IHS program has serious health, safety, or quality of care concerns, the LCA will immediately notify MAD verbally and will follow-up with a written report.

Eligible Providers

General provider enrollment information can be found here.

ARTC for Youth facilities must be accredited, licensed, and certified prior to delivering services. Services must be provided under the direction of a Medicaid board eligible or certified psychiatrist.

Eligible Members

General member eligibility information can be found here.

Medicaid members must have a determination documenting that the individual needs the level of care for services furnished in an ARTC for Youth. This determination must have considered all environments which are least restrictive, meaning a supervised community

placement, preferably a placement with the juvenile's parent, guardian or relative. A facility or conditions of treatment that is a residential or institutional placement should only be utilized as a last resort based on the best interest of the juvenile or for reasons of public safety. The need for ARTC must be documented in the Medicaid member's tot-to-teen health check screen or other diagnostic evaluation.

Covered and Non-Covered Services

General covered and non-covered services can be found here. General information on telehealth services can be found here. Specific covered services related to Youth ARTCs are below.

ARTCs for Youth provide 24-hour interdisciplinary psychotherapy treatment, which is based on the Medicaid member's individualized treatment plan. The following information describes the treatment plan and covered services required prior to and after admissions.

Treatment Plan

Within 14 days of admission, a treatment plan must be developed by an interdisciplinary team of professionals in consultation with the eligible Medicaid member, their parent, legal guardian and others in whose care they will be released after discharge. The treatment plan must also include a statement of the Medicaid member's cultural needs and provision for access to cultural practices. The treatment plan must be reviewed as least every 30 calendar days. All supporting documents in the treatment plan must be available for review in the Medicaid member's file.

Covered Services

Covered services include:

- Evaluations, psychological testing and development of the Medicaid member's treatment plans. Facilities should not repeat evaluations that have already been performed.
- Regularly scheduled counseling and therapy sessions in an individual, family or group setting following the individual's treatment plan.
- Age-appropriate skills development on household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management.
- Assistance with self-administered medication.
- Crisis response, stabilization, and referrals as appropriate.
- Consultation with other professionals or allied caregivers regarding the needs of the Medicaid member, as applicable.
- Non-medical transportation services needed to accomplish the treatment objective.

- Therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the eligible Medicaid member.
- Coordination with the Medicaid member's educational program.

Authorization

General prior authorization and utilization review information can be found here. Specific prior authorization and utilization review information regarding Youth ARTCs is below.

ARTC for Youth admissions require prior authorizations, and services must be documented in the Medicaid member's tot to teen health check screen or other diagnostic evaluations.

Billing and Claims Requirements

General billing and claims requirements can be found here. General information on coordination of benefits can be found here. General informaiton on fraud and abuse can be found here. Specific billing and claims requirements related to ARTCs for Youth are below. The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

1. The referring or ordering provided is used in the "attending provider field."
2. ARTC for Youth facilities use UB claim form with revenue code 1001 for psychological services.
3. ARTC for Youth facilities use UB claim form with revenue code 1002 for chemical dependency services.
4. CCSS can be bill billed for discharge planning and transition purposes.
5. ARTC for Youth services cannot be billed in conjunction with the following: 1) services for which prior approval was not requested and approved; 2) Formal educational and vocational services which relate to traditional academic subjects or vocation training; or 3) Activity therapy, group activities, and other services primarily recreational or diversional in nature.
6. A vacancy factor of 24 days annually for each Medicaid member is built in for therapeutic leave and trial community placement. Agencies cannot bill for or be reimbursed for days when the Medicaid member is absent from the facility.
7. Annual cost reports must be submitted in a MAD prescribed form. Reports are due 90 days after the fiscal year end.
8. Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the New Mexico border are at the fee schedule unless a separate rate is negotiated.