BEHAVIORAL HEALTH SERVICES
SPECIALIZED BEHAVIORAL HEALTH PROVIDER ENROLLMENT AND REIMBURSEMENT
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TITLE 8 SOCIAL SERVICES
CHAPTER 321 BEHAVIORAL HEALTH SERVICES
PART 2 SPECIALIZED BEHAVIORAL HEALTH PROVIDER ENROLLMENT AND REIMBURSEMENT

8.321.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.321.2.1 NMAC - N, 1-1-14]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC - N, 1-1-14]

8.321.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.321.2.3 NMAC - N, 1-1-14]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC - N, 1-1-14]

8.321.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - N, 1-1-14]

8.321.2.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.321.2.6 NMAC - N, 1-1-14]

8.321.2.7 DEFINITIONS: [RESERVED]

8.321.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.321.2.8 NMAC - N, 1-1-14]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by the HSD medical assistance division (MAD). Upon approval of a New Mexico MAD provider participation agreement (PPA) or a MAD electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency, and for a. Services must be in compliance with the statutes, rules and regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.3.

C. Each specialized behavioral health services may have specific noncovered services. The following are the noncovered services for all specialized behavioral health services:

(1) hypnotherapy;
(2) biofeedback;
(3) conditions that do not meet the standard of medical necessity as defined in MAD rules;
(4) treatment for personality disorders;
(5) treatment provided for adults 21 years and older in alcohol or drug rehabilitation units;
(6) educational or vocational services related to traditional academic subjects or vocational training;
(7) experimental or investigational procedures, technologies or non-drug therapies and related services;
(8) activity therapy, group activities and other services which are primarily recreational or divisional in nature;
(9) electroconvulsive therapy;
(10) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside his or her scope of practice;
(11) treatment of intellectual disabilities alone;
(12) services not considered medically necessary for the condition of the MAP eligible recipient; and
(13) services for which prior authorization is required but was not obtained;
(14) milieu therapy.

D. All behavioral health services must meet with the current MAD definition of medical necessity found in the MAD New Mexico Administrative Code (NMAC) rules.

E. Performance of a behavior health service cannot be delegated to a provider or practitioner not licensed for independent practice except as furnished within the limits of MAD benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local statutes, laws and rules. A behavioral health professional service must be provided directly to the MAP eligible recipient by the licensed behavioral health professional listed in Section 9, Subsections B, H, I and J of this rule or where specifically allowed in a MAD rule. When a service is performed by supervised master's level provider, nurse, bachelor's level and another health professional not listed in Section 9, Subsections H-J, that service cannot be billed by the licensed supervisor even though the services may have been furnished under his or her direction. All specialized behavioral health services are reimbursed as follows, except when instructed within a particular specialized service's reimbursement section.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a behavioral health provider for covered services at the lesser of the following:

(a) the provider's billed charge; or
(b) the MAD fee schedule for the specific service or procedure.

(2) Reimbursement to a provider for covered services is made at the lesser of the following:

(a) the provider's billed charge; or
(b) the MAD fee schedule for the specific service or procedure for the provider:
(i) The provider's billed charge must be its usual and customary charge for services.
(ii) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(3) Reimbursement is made for an Indian health services (IHS) agency or a federal qualified health center (FQHC) by following its federal guidelines and special provisions and as detailed in 8.310.12 NMAC.

F. All specialized behavioral health services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made, see 8.302.5 NMAC. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper 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. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specialized behavioral health service may have additional prior authorization requirements listed in the service's prior authorization section.

G. General MAD treatment plan requirements for specialized behavioral health services: A MAD treatment plan and all supporting documentation must be available for review by HSD or its authorized agency in

the MAP eligible recipient's file. Specific treatment plan elements may be required for a specialized behavioral health service listed in that service section's the treatment plan subsection. MAD makes available on its website comprehensive treatment plan requirements and requires a provider to use the applicable treatment plan requirements for services he or she renders. At the least, following must be contained in the treatment plan and documents used in the development of the treatment plan:

(1) statement of the nature of the specific problem and specific needs of the MAP eligible recipient;

(2) description of the functional level and symptom status of the MAP eligible recipient, including the following:

(a) mental status assessment;
(b) intellectual function assessment;
(c) psychological assessment;
(d) social assessment which includes community support, housing and legal status;
(e) medical assessment;
(f) physical assessment;
(g) substance abuse assessment; and
(h) activities of daily living assessment;

(3) description of the MAP eligible recipient's intermediate and long-range goals and approaches for the least restrictive conditions necessary to achieve the purposes of treatment with a projected timetable for each goal attainment;

(4) statement of the duration, frequency, and rationale for services included in the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(5) specific staff responsibilities, proposed staff involvement and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient;

(6) criteria for discontinuation of services and the projected date for discontinuation of services; and

(7) plan is regularly and periodically reviewed to determine effectiveness of treatment and is modified as indicated.

H. The following independent providers are eligible to be reimbursed for providing behavioral health professional services:

(1) a physician licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry, to include the groups they form;

(2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as clinical psychologist by the New Mexico regulations and licensing department's (RLD) board of psychologist examiners, to include the groups they form;

(3) an independent social worker (LISW) licensed by RLD's board of social work examiners, to include the groups they form;

(4) a professional clinical mental health counselor (LPCC) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(5) a marriage and family therapist (LMFT) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(6) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by RLD's board of nursing and is certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as his or her certification permits.

I. The following agencies are eligible to be reimbursed for providing behavioral health professional services:

(1) a community mental health center (CMHC)
(2) a federally qualified health clinic (FQHC;
(3) an Indian health services (IHS) hospital and clinic;
(4) a PL 93-638 tribally operated hospitals and clinics;
(5) children, youth and families department CYFD;
(6) a hospital and its outpatient facility; and
(7) a core service agency (CSA).

J. When providing services supervised and billed by an agency listed above in Subsection I of this Section, the following practitioner's outpatient services may be reimbursed when the services are within his or her legal scope of practice (see Section 9, Subsection B of this rule):

(1) a masters level social worker (LMSW) licensed by RLD's board of social work examiners;

(2) a professional mental health counselors (LPC) licensed by RLD's counseling and therapy practice board;

(3) a mental health counselor (LMHC) licensed by RLD's counseling and therapy practice board;

(4) a psychologist associates licensed by the RLD's psychologist examiners board;

(5) a professional art therapists (LPAT) licensed by RLD's counseling and therapy practice board;

(6) a registered mental health counselors RMHC;

(7) an alcohol and drug abuse counselor (LADAC) licensed by RLD's counseling and therapy practice board; and

(8) A MAP eligible recipient under 21 years of age may be identified through a tot to teen healthcheck, self referral, referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns. If the MAP eligible recipient requires extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of the MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

[8.321.2.9 NMAC - N, 1-1-14]

8.321.2.10 OUTPATENT BEHAVIORAL HEALTH PROFESSIONAL SERVICES:

A. Psychological, counseling and social work: These services mean diagnostic or active treatments with the intent to reasonably improve a MAP eligible recipient's physical, social, emotional and behavioral health condition. Services are provided to a MAP eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling and social work services are performed by licensed or equivalent psychological, counseling and social work staff acting within their scope of practice (see Section 9 subsections B, H-J or this rule). These services include but are not limited to testing and evaluation that appraise cognitive, emotional and social functioning and self concept. Therapy and treatment includes the planning, managing and providing a program of psychological services to the MAP eligible recipient with diagnosed behavioral health condition and may include consultation with his or her family and other professional staff.

B. An assessment or evaluation must be conducted at least annually or upon approval more frequently if indicated by the MAP eligible recipient's condition or applicable federal or state statute, regulation, rule or law. The assessment must be signed by the practitioner operating within his or her scope of licensure (see Section 9, Subsection B of this rule). Based on the MAP eligible recipient's annual assessment, the MAP eligible recipient's 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.

[8.321.2.10 NMAC - N, 1-1-14]

8.321.2.11 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): To help a New Mexico MAP eligible recipient receive necessary services, MAD pays for covered CCSS. This culturally sensitive service coordinates and provides services and resources to a MAP eligible recipient and his or her family necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the MAP eligible recipient's community, as well as strengths that may aid the MAP eligible recipient and family in the recovery or resiliency process.

A. **Definitions:**

(1) Comprehensive community support services (CCSS) are delivered through a MAD approved core service agency. The purpose of CCSS is to surround the MAP eligible recipient and as appropriate, his or her family with the services and resources necessary to promote resiliency. Community support activities address goals specifically in the following areas independent living, learning, working, socializing, and recreational. Support services consist of a variety of interventions, primarily face-to-face and in community locations that address barriers that impede the developing independent functioning in the community.

(2) CSA is enrolled and designated by MAD to provide CCSS services as well as other services to a MAP eligible recipient.

(3) A certified family specialist is an approved provider who is certified as a family specialist through an approved state of New Mexico certification program.

(4) A peer support worker is a certified peer specialist through an approved state of New Mexico certification program.

B. **Eligible providers:** In addition to the requirements of Section 9, Subsections A and B of this rule, in order to be eligible to be reimbursed for providing CCSS services, an agency must be: a FQHC; an IHS hospital or clinic; a PL 93-638 tribally operated hospital or clinic; or be a MAD enrolled CSA. If a CSA renders CCSS to a MAP eligible recipient ages 18 through 20, the CSA must have CCSS certification or a license from either CYFD or the department of health (DOH), as appropriate.

(1) Community support workers (CSW) (not a peer or family specialist), must possess the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the CSW must have:

(a) the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS.

(b) a bachelor's degree in a human service field from an accredited university and one year of relevant experience with the target population; or

(c) an associate's degree and a minimum of two years of experience working with the target population; or,

(d) a high school graduation or general educational development (GED) test and a minimum of three years of experience working with the target population; or

(e) a New Mexico peer or family specialist certification and have completed 20 hours of documented training or continuing education, as identified in the CCSS service definition.

(2) CCSS agency supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the supervisory staff must hold:

(a) a bachelor's degree in a human services field from an accredited university or college; and

(b) have four years of relevant experience in the delivery of case management or community support services with the target population; and

(c) have at least one year of demonstrated supervisory experience; and

(d) completed 20 hours of documented training or continuing education, as identified in the New Mexico behavioral health collaborative CCSS service definition.

(3) CSA clinical supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the clinical supervisory staff must:

(a) be a licensed independent practitioner as detailed in Section 9 Subsection B and H of this rule; and

(b) have one year of documented supervisory training.

(4) Certified peer worker (CPW) must:

(a) be 18 years of age or older; and

(b) have a high school diploma or GED; and

(c) be self-identified as a current or former consumer of mental health or substance abuse services;

(d) have at least two years of mental health or substance abuse recovery; and

(e) be a current New Mexico CPW.

(5) Certified family specialist (CFS) must:

(a) be 18 years of age or older; and

(b) have a high school diploma or GED; and

(c) have personal experience navigating any of the child and family-serving systems, advocating for family members who are involved with the child and family behavioral health systems; and must also have an understanding of how these systems operate in New Mexico;

(d) be a current New Mexico CFS; and

(e) must be well-grounded in his or her symptom self-management if the family specialist is a current or former consumer of behavioral health services.

(6) MAD covers CCSS when there is a medical necessity based on the MAP eligible recipient's condition.

(7) CCSS activities are goal-directed and provided as part of the approved treatment plan.

(8) CCSS includes supporting a MAP eligible recipient and his or her family in crisis situations and providing individual interventions to develop or enhance a MAP eligible recipient's ability to make informed and independent choices.

C. **Covered services:** The purpose of CCSS is to surround a MAP eligible recipient and his or her family with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. CCSS consist of a variety of interventions, with at a minimum 60 percent face-to-face and in vivo (where the MAP eligible recipient is located). that address barriers that impede the development of skills necessary for independent functioning in the community.

(1) CCSS activities include:

(a) assistance to the MAP eligible recipient in the development and coordination of his or her treatment plan including a recovery or resiliency management plan, a crisis management plan, and, when requested, his or her advanced directives related to the MAP eligible recipient's behavioral health care;

(b) assessment support and intervention in crisis situations, including the development and use of crisis plans that recognize the early signs of crisis or relapse, use of natural supports, alternatives to the utilization of emergency departments and inpatient services.

(2) Individualized interventions, with the following objectives:

(a) services and resources coordination to assist the MAP eligible recipient in gaining access to necessary rehabilitative, medical and other services;

(b) assistance in the development of interpersonal and community coping and functional skills (e.g., adaptation to home, school and work environments), including:

(i) socialization skills;
(ii) developmental issues;
(iii) daily living skills;
(iv) school and work readiness activities; and
(v) education on co-occurring illness;

(c) encouraging the development of natural supports in workplace and school environments;

(d) assisting in learning symptom monitoring and illness self-management skills (e.g. symptom management), relapse prevention skills, knowledge of medication and side effects, and motivational and skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms that interfere with the MAP eligible recipient's daily living and to support him or her in maintaining employment and school tenure;

(e) assisting the MAP eligible recipient in obtaining and maintaining stable housing; and

(f) any necessary follow-up to determine if the services accessed have adequately met the MAP eligible recipient's needs.

(3) The majority (60 percent or more) of non facility-based CCSS provided must be face-to-face and in vivo (where the MAP eligible recipient is located). The CSW must monitor and follow-up to determine if the services accessed have adequately met the MAP eligible recipient's specific treatment needs.

(4) The CSW will make every effort to engage the MAP eligible recipient and his or her family in achieving the member's treatment or recovery goals.

(5) When the service is provided by a CPS or CFS, the above functions and interventions should be performed with a special emphasis on recovery values and process, such as:

(a) empowering the MAP eligible recipient to have hope for, and participate in, his or her own recovery;

(b) helping the MAP eligible recipient to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;

(c) helping the MAP eligible recipient to identify and achieve his or her personalized recovery goals; and

(d) promoting the MAP eligible recipient's responsibility related to illness self-management.

(6) Limited CCSS services may be provided by a CSA during discharge planning while a MAP eligible recipient is receiving the following services:

(a) accredited residential treatment (ARTC);
(b) residential treatment (RTC);
(c) group home service;
(d) impatient hospitalization; and
(e) treatment foster care (TFC I and II).

D. **MAP eligible recipients:**

(1) CCSS is provided to a MAP eligible recipient 21 years and under who meets the criteria for or is diagnosed as either or both (a) at risk of or experiencing serious emotional disturbances (SED); (b) has a chronic substance abuse disorder.

(2) MAD covers CCSS for a MAP eligible recipient 21 years and older diagnosed with a severe mental illness (SMI). A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from CCSS.

E. **Noncovered services:** CCSS are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.310.2 NMAC for a detailed description of MAD general noncovered services and Section 9 Subsection C of this rule for all noncovered MAD behavioral health services or activities. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST) or ACT services.

F. Reimbursement: CCSS agencies must submit claims for reimbursement on the HCFA/CMS claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives direction on how to access MAD NMAC rules, instructions for documentation, billing, and claims processing. General reimbursement instructions are found in this rule under Section 9 Subsection D. For IHS and a tribal 638 facility, MAD does not consider CCSS services to be outside the IHS all inclusive rate and CCSS is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

[8.321.2.11 NMAC - N, 1-1-14]

8.321.2.12 INTENSIVE OUTPATIENT PROGRAM SERVICES: To help a MAP eligible recipient receive medically necessary services, MAD pays for intensive outpatient program (IOP) services. IOP services provide a time-limited, multi-faceted approach to treatment service for a MAP eligible recipient who requires structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be delivered through a MAD approved agency, as specified in this section.

A. Eligible providers: See Section 9 Subsection A of this rule for MAD general provider requirements.

(1) Specific to IOP, the following types of agencies are eligible to be reimbursed for providing IOP services when they have a research-based model meeting the requirements of this Section Subsection C of this rule:

(a) a CMHC
(b) a RHC;
(c) a FQHC;
(d) an IHS facility;
(e) a PL.93-638 tribal 638 facility;
(f) a MAD CSA; and
(g) an agency approved by MAD after demonstrating that the agency meets all the requirements of IOP program services and supervision requirements. Such a MAD approved IOP agency is allowed to have services rendered by non-independent practitioners as listed in Section 9 Subsection J of this rule.

(2) Each IOP program must have a clinical supervisor. The clinical supervisor may also serve as the IOP program supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) be licensed as a MAD approved independent practitioner; see Section 9 Subsection H of this rule;
(b) two years relevant experience with an IOP program;
(c) one year demonstrated supervisory experience; and
(d) expertise in both mental health and substance abuse treatment.

(3) The IOP agency is required to develop and implement a program evaluation system.

(4) The agency must maintain the appropriate state facility licensure if offering medication treatment or medication replacement services.

(5) The agency must hold a MAD IOP approval letter and be enrolled by MAD to render IOP services to a MAP eligible recipient. A MAD IOP agency will be provisionally approved for a specified timeframe to render IOP services to a MAP eligible recipient. During this provisional approved time, MAD or its designee will determine if the IOP agency meets MAD IOP requirements and if so, the agency will receive an approval letter for IOP full enrollment.

B. **Coverage criteria:** The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be culturally-sensitive and incorporate recovery and resiliency values into all service interventions. Treatment services should address co-occurring mental health disorders, as well as substance use disorders, when indicated. The IOP services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MAD enrolled behavioral health providers, with the intent that the IOP service shall not exclude a MAP eligible recipient with co-occurring disorder.

C. **Covered services:**

(1) MAD covers services and procedures that are medically necessary for the evaluation, assessment, diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. See Section 9 of Subsection C of this rule for general behavioral health provider requirements. Also see 8.310.2 NMAC.

(2) IOP core services include:

(a) individual therapy;

(b) group therapy (group membership may not exceed 15 in number); and

(c) psycho-education for the MAP eligible recipient and his or her family.

(3) A MAP eligible recipient youth or transition-age young adult is defined for this service as 17 years of age and under. This population should engage in IOP treatment in an environment separate from recipients 18 years of age and older who are receiving IOP services.

(4) Co-occurring mental health and substance use disorders: IOP must accommodate the needs of the MAP eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated multi-disciplinary approach or coordinated, concurrent services with MAD behavioral health providers. Medication management services are available to oversee the use of psychotropic medications.

(5) Duration: The duration of a MAP eligible recipient's IOP intervention is typically three to six months. The amount of weekly services per MAP eligible recipient is directly related to the goals and objectives specified in his or her treatment or service plan.

(6) IOP services must be rendered through one of the following research-based models:

(a) matrix model adult treatment model;

(b) matrix model adolescent treatment model;

(c) Minnesota treatment model;

(d) integrated dual disorder treatment; or

(e) other researched-based models than those identified in (a)-(d) above must be approved by MAD or its designee.

(7) IOP services not provided in accordance with the conditions for coverage as specified in this rule are not a MAD covered service and are subject to recoupment.

D. **IOP eligible recipients:**

(1) IOP services are provided to a MAP eligible recipient, 13 through 17 years of age diagnosed with substance abuse disorder or with co-occurring disorder (SED and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

(2) IOP services are provided to a MAP eligible recipient 18 years of age and over diagnosed with substance abuse disorder or with a co-occurring disorder (SMI and substance abuse) or that meets the ASAM patient placement criteria for level two (II) - intensive outpatient treatment.

(3) Before engaging in an IOP program, the MAP eligible recipient must have a treatment file containing:

(a) one diagnostic evaluation; and

(2) one individualized treatment or service plan that includes IOP as an intervention.

E. **Noncovered services:** IOP services are subject to the limitations and coverage restrictions which exist for other MAD services see Section 9, Subsection C of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, and transitional living services;

(3) ACT;

(4) partial hospitalization;

(5) outpatient therapies (individual, family and group therapy may be billed only if there are clinical issues beyond the scope of IOP services);

(6) multi-systemic therapy (MST);

(7) activity therapy; or

(8) psychosocial rehabilitation (PSR) group services.

F. Reimbursement: See Section 9 Subsection E of this rule for MAD behavioral health general reimbursement requirements and Subsection F for general prior authorization requirements. Specifically for IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

[8.321.2.12 NMAC - N, 1-1-14]

8.321.2.13 MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION: MAD provides coverage for medication assisted treatment for opioid addiction (MAT) to a MAP eligible recipient through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment Programs.

A. **Eligible providers:** An opioid treatment center agency is public or private facility operating a federally certified program to dispense methadone, other narcotic replacement, or narcotic agonist drug items, as part of a detoxification treatment or maintenance treatment as defined in 42 CFR Part 8 Certification of Opioid Treatment Programs. In addition to the requirements found in Section 9 Subsections A and B of this rule, the following are requirements of an opioid treatment facility.

(1) The agency must maintain documentation supporting the medical necessity of MAT services in the MAP eligible recipient's medical record per the requirements in 42 CFR Part 8, Certification of Opioid Treatment Programs.

(2) A MAT agency must provide the following:

(a) its DEA certification to operate an opioid treatment program (OTP);

(b) a copy of substance abuse and mental health services administration (SAMHSA), center for substance abuse treatment (CSAT) approval to operate an OTP;

(c) a copy of accreditation by the joint committee (JC) or a copy of the commission on accreditation of rehabilitation facilities (CARF) accreditation;

(d) its HSD behavioral health services division (BHSD) approval letter as a methadone provider.

B. **Covered services:** MAT services use a drug or biological that is recognized in the treatment of substance use disorder and provided as a component of a comprehensive treatment program. MAT is also a benefit as a conjunctive treatment regimen for a MAP eligible recipient who is addicted to a substance that can be abused and who meets the DSM-IV-TR and subsequent editions' criteria for a substance use disorder diagnosis.

C. **MAT eligible recipients:**

(1) The agency must ensure through its internal policies and procedures that a MAP eligible recipient is treated for opioid dependency only after the agency's physician determines and documents that:

(a) the MAP eligible recipient meets the definition of opioid dependence using generally accepted medical criteria, such as those contained in DSM-IV-TR and subsequent editions;

(b) the MAP eligible recipient has received an initial medical examination as required by 7.32.8.19 NMAC, *Opioid Treatment Program Admissions*;

(c) if the MAP eligible recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting MAT services unless the MAP eligible recipient receives a waiver of this requirement from the agency's physician because the MAP eligible recipient:

(i) was released from a penal institution within the last six months;

(ii) is pregnant, as confirmed by the agency's physician;

(iii) was treated for opioid dependence within the last 24 months; and

(iv) meets any other requirements specified in 7.32.8 NMAC, *Opioid Treatment Program* regarding waivers, consent, and waiting periods.

(2) The agency must ensure that a MAP eligible recipient requesting long-term or short-term opioid withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period be assessed by the agency's medical director or physician to determine if other forms of treatment may be more appropriate.

D. **Noncovered services:** MAT services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services.

E. **Reimbursement:** See Section 9 Subsection E of this rule for MAD general reimbursement requirements. Specifically:

(1) the MAT agency, except an IHS or a 638 tribal facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor; see 8.302.2 NMAC and 8.310.12 NMAC for IHS reimbursement details;

(2) the coverage of services provided to a MAP eligible recipient can be greater than the services required under 42 CFR Part 8 or its successor, *Certification of Opioid Treatment Programs*. MAD recognizes it is beneficial to the MAP eligible recipient to receive necessary comprehensive medical and behavioral health services when they can be rendered by the MAT agency at the same time as MAT services.

(a) The reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, other narcotic replacement or agonist drug items, and substance abuse and HIV counseling as well as other services performed by the agency, unless otherwise described as separately reimbursed are required by 42 CFR Part 8.12 (f), or its successor.

(b) The following additional MAD reimbursements will be made for the specific drug item if separately reimbursed service payable to the MAT agency:

(i) a narcotic replacement or agonist drug item other than methadone is administered or dispensed;

(ii) outpatient therapy other than the substance abuse and HIV counseling required by 42 CFR Part 8.12 (f) is reimbursable when rendered by a MAD approved independently licensed provider that meets Section 9 Subsection H of this rule requirements;

(iii) a MAP eligible recipient's initial medical examination when rendered by a MAD approved medical provider who meets 8.310.2 and 8.310.3 NMAC requirements;

(iv) laboratory services provided by a certified laboratory facility when billed by the offsite laboratory, see 8.310.2 and 8.310.3 NMAC;

(v) full medical examination, prenatal care and gender specific services for a pregnant MAP eligible recipient. If she is referred to a provider outside the agency, payment is made to the provider of the service; and

(vi) medically necessary services provided beyond those required by CFR 42 CFR Part 8.12 (f), to address the medical issues of the MAP eligible recipient; see 8.310.2 and 8.310.3 NMAC;

(c) the quantity of service billed for administering or dispensing for each day cannot exceed the combined total of the drug items administered that day plus the number of drug items dispensed on that day.

(d) for an IHS and a tribal 638 facility, MAD does not consider MAT services to be outside the IHS all inclusive rate and CCSS is therefore reimbursed at the MAT fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC.

(3) Claims billed for MAT services must include the MAP eligible recipient's substance use disorder diagnosis.

[8.321.2.13 NMAC - N, 1-1-14]

8.321.2.14 SMOKING CESSATION COUNSELING: See 8.310.2 NMAC for a detailed description of tobacco cessation services and approved behavioral health providers.

[8.321.2.14 NMAC - N, 1-1-14]

8.321.2.15 APPLIED BEHAVIOR ANALYSIS: MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) for MAP eligible recipients under 21 years of age who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for MAP eligible recipients under 3 years of age who has a well-documented risk for the development of ASD. ABA is provided to a MAP eligible recipient by MAD as part of a three-stage comprehensive approach to assessment and treatment which stipulates that ABA be provided in conjunction with other medically necessary services (e.g., occupational therapy, speech language therapy, medication management, etc.). Following a referral to an approved autism assessment provider (AAP) to confirm the presence of, or risk for, ASD (stage one), a behavior analytic assessment is conducted and a behavior analytic treatment plan is developed, as appropriate for the selected service model (stage two). Then, behavior analytic services are rendered by an approved behavior analytic provider in accordance with the MAP eligible reicpient's treatment plan (stage three). See MAD billing instructions for detailed and specific requirements for this

service. A MAD provider must completely comply with all MAD NMAC rules and billing instructions to be eligible for reimbursement of this service.
[8.321.2.15 NMAC - N, 1-1-14]

8.321.2.16 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: To help a MAP eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD furnishes these services as part of the EPSDT program [42 CFR Section 441.57]. MAD pays for medically necessary health behavior management skills development services (BMS) which are services designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the MAP eligible recipient in his or her home or community. The need for BMS must be identified by a diagnostic evaluation specific to the MAP eligible recipient by the appropriately licensed MAD behavioral health provider; see Section 9 of this rule. BMS services assist in preventing inpatient hospitalizations or out-o-home residential placement of the MAP eligible recipient through use of teaching, training and coaching activities designed to assist him or her in acquiring, enhancing and maintaining the life, social and behavioral skills needed to function successfully within his or her home and community settings. BMS is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the MAP eligible recipient's treatment or service plan.

A. Eligible providers:

(1) Upon approval of a MAD PPA, an agency must meet the following requirements to be eligible for reimbursed for providing BMS services:

(a) CYFD certified as a BMS provider; and

(b) employs or contracts with behavior management specialists who work under the supervision of a licensed practitioner employed by a certified BMS agency.

(2) See Section 9 Subsections A and B of this rule for MAD general provider requirements.

B. Covered services: MAD reimburses for services specified in the MAP eligible recipient's individualized treatment plan which are designed to improve his or her performance in targeted behaviors, reduces emotional and behavioral excess, increases social skills and enhances behavioral skills through a regimen of positive intervention and reinforcement.

(1) The following tasks must be identified in the MAP eligible recipient's BMS treatment plan which is performed by a behavior management specialist:

(a) implementation of his or her BMS treatment or service plan based on a relevant clinical assessment as part of a comprehensive treatment plan covering an integrated program of therapeutic services as applicable. The behavior management plan must identify all targeted behaviors that are to be addressed by the behavior management specialist. The behavior management plan should include, when appropriate, a goal of working with the foster, adoptive or natural family of the MAP eligible recipient in order to assist with the achievement and maintenance of behavior management skills;

(b) the behavior management plan must identify the behavior management specialist who is responsible for implementation of the behavior management plan specific to the MAP eligible recipient, including but not limited to:

(i) assistance in achieving and maintaining appropriate behavior management skills through teaching, training and coaching activities;

(ii) working with a foster, adoptive or the MAP eligible recipient's family to help him or her achieve and maintain appropriate behavior management skills; and

(iii) maintaining case notes and documentation of tasks as required by the agency and the standards under which it operate; and

(iv) tasks (a) through (d) are included in the payment rate and cannot be billed separately.

(2) Supervision of behavioral management staff by an independent level practitioner is required for this service; see Section 9 of this rule. The BMS supervisor shall ensure that an assessment(within the past 12 months) of the MAP eligible recipient has been completed and identifies the need for BMS and is signed by the him or her.

(3) An agency certified for BMS services must:

(a) develop a BMS treatment plan, based on a relevant clinical assessment, as part of a comprehensive treatment plan covering an integrated program of therapeutic services as applicable;

(b) identify all targeted behaviors that are to be addressed by the behavior management specialist;

(c) ongoing assessment of the MAP eligible recipient's progress in behavioral management skills by the BMS supervisor; and

(e) offer 24-hour availability of appropriate staff to respond to the MAP eligible recipient's crisis situations.

C. MAP eligible recipients: A MAP eligible recipient must meet the MAD or its designee's established LOC for BMS services and be under the age of 21 years and:

(1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community; or

(2) needing behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) requiring behavior management support following an institutional or other out-of-home placement as a transition to maintain the MAP eligible recipient in his or her home and community.

D. Noncovered services: BMS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

(1) activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the BMS treatment plan;

(2) services provided in a residential treatment care; and

(3) as services provided in lieu of services that should be provided as part of the MAP eligible recipient's individual Educational Plan (IEP).

E. BMS treatment plan: If the MAP eligible recipient is receiving other behavioral health services in addition to BMS, a treatment plan must be developed by a team of professionals in consultation with MAP eligible recipient, his or her parent, legal guardian, and his or her primary care provider (PCP) prior to service delivery or within 14 calendar days of initiation of services.

(1) The BMS treatment or service plan must be included, when appropriate, in a comprehensive treatment plan which covers an integrated program of therapeutic services.

(2) The team must review the MAP eligible recipient's treatment plan at least every 30 calendar days.

(3) The treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file; and

(4) There must be individualized criteria for release of the MAP eligible recipient to a less restrictive setting for treatment, an individualized discharge plan, the criteria for discharge and the projected date of his or her discharge.

F. The BMS treatment or service plan must identify all targeted behaviors that are to be addressed by the behavior management specialist. The BMS treatment plan should include, when appropriate, a goal of working with the foster, adoptive or natural family of the MAP eligible recipient in order to assist with the achievement and maintenance of behavior management skills. The BMS treatment plan must identify the use of a behavior management specialist who is responsible for implementation of the MAP eligible recipient's BMS treatment or service plan through teaching, training and coaching skills.

G. Reimbursement: A BMS agency must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and 8.302.2 NMAC. For IHS and a tribal 638 facility MAD does not consider BMS services to be outside the IHS all inclusive rate and BMS is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC.

[8.321.2.16 NMAC - N, 1-1-14]

8.321.2.17 COUNSELING, EVALUTION AND THERAPY IN A SCHOOL-BASED SETTING: MAD pays for medically necessary services billed to a MAP eligible recipient under 21 years of age when the services are part of his or her individualized education plan (IEP) or individualized family service plan (IFSP) for the treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.

A. Upon approval of the provider's MAD PPA, a local education agencies (LEA), regional educational cooperative (REC), and another state-funded educational agencies (SFEA) that meet specified requirements are eligible to be reimbursed for furnishing services to a MAP eligible recipient. The LEA, REC, or other SFEA must develop a collaborative plan with the community. Requirements for such plans will be described in MAD written guidelines and available on its website. The rendering practitioners listed detailed below must be

employed by or under contract with the LEA, REC, or other SFEA when furnishing treatment to a MAP eligible recipient. A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HSD or MAD regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

(1) Social work practitioners who meet one of the following requirements are eligible to receive reimbursement thru the provider for services to a MAP eligible recipient:

(a) is licensed by RLD's as a LISW and a MAD enrolled provider; or

(b) is licensed by RLD as either a LMSW or a licensed bachelor social worker (LBSW), and supervised by a New Mexico licensed Ph.D., Psy.D., Ed.D., or LISW who is a MAD enrolled provider; and

(c) services provided by licensed LBSW or licensed LMSW must be within the scope of his or her practice board respectively, supervised and periodically evaluated in accordance with his or her practice board requirements.

(i) Supervision must adhere to the requirements of the practitioner's applicable licensing board.

(ii) A MAP eligible recipient receiving services from a LBSW or a LMSW must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) or a LISW who is enrolled as a MAD provider. If the MAP eligible recipient has a current diagnosis from another independently licensed practitioner as detailed in Section 9 of this rule, that diagnosis will be accepted. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and

(d) meets licensure requirements of PED.

(2) Psychologists meeting one of the following requirements are eligible to receive reimbursement thru the provider for services to a MAP eligible recipient:

(a) psychologists (Ph.D., Psy.D., or Ed.D.) licensed by the New Mexico psychologist examiners board and meeting licensure requirements of the public education department; or

(b) master's level practitioners licensed by the New Mexico psychologist examiners board as psychologist associates or licensed by PED as school psychologists and supervised by a psychiatrist or a Ph.D., Psy.D., or Ed.D. who is licensed as a psychologist by the New Mexico psychologist examiners board, enrolled as a MAD provider, and meets licensure requirements of PED.

(3) Physicians and psychiatrists licensed by the board of medical examiners and meet licensure requirements of PED are eligible for reimburse by the provider for services to a MAP eligible recipient.

(4) Case managers who meet one of the following requirements:

(a) bachelor's degree in one of the following: social work, counseling, psychology or a related health or social services field from an accredited institution and having one year experience serving medically-at-risk children or adolescents, and must be a MAD enrolled case manager with the appropriate provider type and specialty; or

(b) a licensed registered (RN) or practical nurse (LPN) or

(c) an individual with a bachelor's degree in another field and two years of direct experience in serving medically-at-risk children or adolescents.

(5) LPC, and LMHC licensed by RLD and meeting licensure requirements of PED. A LMHC and LPC must be supervised by a MAD enrolled licensed LPCC, LMFT, licensed psychologist, or licensed psychiatrist. A LMSW and LBSW must be supervised by a MAD enrolled LPCC, or a Ph.D., Psy.D., or Ed.D. and meet the licensure requirements of PED.

(6) A MAD enrolled LISW, LMFT and LPPC practitioner may render services when licensed by RLD and meet licensure requirements of PED:

(7) The following practitioners may render services when supervision is provided by 8.320.6.10 B (6)(a) or 8.320.6.10.B(10): a licensed LMHC or a licensed LPC. Services provided by licensed LMHC, and a LPC must be within the scope of their practice respectively and supervised and periodically evaluated in accordance with their practice board requirements. Supervision must adhere to the requirements of the practitioner's applicable licensing board.

(a) A MAP eligible recipient receiving services from a LMHC or LPC must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) who is enrolled as a MAD provider. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and is this

(b) A MAP eligible recipient receiving services from an LBSW or an LMSW must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) or a LISW who is enrolled as a

MAD provider. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and meets licensure requirements of PED.

(8) A MAD enrolled CNS licensed by RLD and meeting licensure requirements of PED.

B. **MAP eligible recipients:** MAD covers medically necessary treatment to a MAP eligible recipient under 21 years of age who has a MAD-reimbursable service identified in his or her IEP or IFSP.

C. **Documentation requirements:**

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to MAP eligible recipient who is currently receiving MAD services or have received MAD services in the past. Payment for services billed to MAD that are not substantiated in the MAP eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of creation or until ongoing audit issues are resolved, whichever is longer. See Section 8.302.1.

(2) For services covered under this rule, complete copies of the IEPs or IFSPs, with the individualized treatment plan (ITP) portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

(3) Provider written documentation must include:

(a) present level of performance; and

(b) description of actual service delivered or rendered; and

(c) billing information recorded in units of time.

K. **Record availability:** The provider must, on request, promptly furnish to HSD, the secretary of the department of health and human services, or the state medicaid fraud control unit any information under documentation requirements, stated above, including MAP eligible recipient and employee records and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims.

L. **Covered services:** For services in subsections A-F, a provider must first develop and then update the MAP eligible recipient's present level of performance for each IEP cycle. For these services, MAD requires the following elements be included in the provider's notes:

(1) specific activity provided to the MAP eligible recipient for each date of service billed;

(2) description of the level of engagement and ability of the MAP eligible recipient for each date of service billed;

(3) outcomes of session on the impact on the MAP eligible recipient's exceptionality for each date of service billed.

M. MAD covers the following services when medically necessary and billed by specified providers in school settings:

(1) For services covered under this rule, complete copies of the IEPs or IFSPs, with the individualized treatment plan (ITP) portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

(2) Provider written documentation must include:

(a) present level of performance; and

(b) description of actual service delivered or rendered; and

(c) billing information recorded in units of time.

[8.321.2.17 NMAC - N, 1-1-14]

8.321.2.18 DAY TREATMENT: To help a MAP eligible recipient under 21 years of age receive services, MAD pays for services furnished by a day treatment provider as part of the EPSDT program [42 CFR section 441.57]. The need for day treatment services must be identified by an independent, qualified health care practitioner through an EPSDT tot-to-teen healthcheck or other diagnostic evaluations or assessments. Day treatment services include counseling (individual, group, and family), MAP eligible recipient and parent education, skill and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented utilizing a clinical model for service delivery and support.

A. Eligible providers: Upon authorization of a MAD PPA, an agency which is licensed by DOH as a limited diagnostic and treatment center and meets the certification standards established by MAD or its designee, is eligible to be reimbursed for furnishing day treatment services. A day treatment program located in a public school setting holds a DOH waiver in lieu of being a licensed limited diagnostic and treatment center as the school already is a state licensed facility. Direct services must be furnished by licensed clinical professionals or under their

supervision, as described in the DOH certification criteria. In addition to the general provider enrollment requirements in Section 9, subsection A and B, a day treatment provider must provide a copy of its approval letter as a CSA.

B. MAP eligible recipients: Day treatment services are designed to transition a MAP eligible recipient who is discharging from a residential treatment service that requires intensive therapeutic interventions to facilitate either or both family reunification and the MAP eligible recipient's emancipation in a least restrictive environment. A MAP eligible recipient has the freedom to receive services from the eligible BMS provider of his or her choice. MAD covers day treatment services for a MAP eligible recipient under age 21 who:

(1) has emotional, behavioral, and neurobiological or substance abuse problems;

(2) may be at high risk of out-of-home placement;

(3) may have a severe emotional disturbance (SED);

(4) requires a structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school;

(5) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services; and

(6) is able to benefit from this LOC.

C. Covered services:

(1) Behavioral health day treatment services are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include counseling (individual, group, and family), parent and MAP eligible recipient education, skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented, utilizing a clinical model for service delivery and support.

(2) The goal of day treatment is to maintain the MAP eligible recipient in his or her home or community environment.

(3) Day treatment services must be provided in a school setting or other community setting. However, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered. Programming is designed to complement and coordinate with the MAP eligible recipient's educational system.

(4) Services must be based upon the MAP eligible recipient's individualized BMS treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the MAP eligible recipient's adaptive functioning.

(5) The following services must be furnished by a day treatment service agency to receive reimbursement from MAD:

(a) the assessment and diagnosis of the social, emotional, physical and psychological needs of the MAP eligible recipient and his or her family for treatment planning ensuring that evaluations already performed are not unnecessarily repeated;

(b) development of individualized treatment and discharge plans and ongoing reevaluation of these plans;

(c) regularly scheduled individual, family, multi-family, group or specialized group sessions focusing on the attainment of skills, such as managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention (if applicable);

(d) family sessions and family outreach by the agency is encouraged;

(e) supervision of self-administered medication, as clinically indicated;

(f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each MAP eligible recipient's individualized treatment plan;

(g) availability of appropriate staff to provide crisis intervention during program hours;

(h) day treatment services are provided at a minimum of four hours of structured programming per day, two to five days per week based on acuity and clinical needs of the MAP eligible recipient and his or her family; and

(i) payment for performance of these services is included in the day treatment reimbursement rate.

(6) Only those activities of daily living and basic life skills that are assessed as being a clinical problem should be addressed in the treatment plan and deemed appropriate to be included in the MAP eligible recipient's individualized program.

(7) A family who is unable to attend the regularly scheduled sessions at the day treatment facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the day treatment agency.

D. Noncovered services: Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 subsection C of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

(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 issues;

(6) leisure time activities such as watching television, movies or playing computer games;

(7) transportation reimbursement for the therapist who delivers services in the family's home; and

(8) a partial hospitalization program and all residential programs cannot be offered at the same time as day treatment services.

E. Prior authorization: See Section 9 Subsection F of this rule for the general behavioral health services prior authorization requirements.

F. Treatment plan: Development of a treatment plan, a discharge plan and the regular reevaluation of these plans is required. Services must be based upon the MAP eligible recipient's individualized treatment plan goals and should include interventions with significant member of his or her family, which are designed to enhance adaptive functioning. The initial treatment plan must be developed and approved by the utilization review designee prior to the delivery of services. The initial treatment plan must include documentation of prior treatment interventions and their efficacy, the MAP eligible recipient's family involvement in the current treatment process, and the presenting clinical problems and targeted treatment behaviors. A statement addressing the therapeutic appropriateness of this level of care must be included in the initial documentation. The comprehensive treatment plan must be developed within 14 calendar days of the initiation of services by a team of professionals in consultation with the MAP eligible recipient, his or her family and others involved in his or her care.

(1) The team must review and modify the treatment plan at least every 30 calendar days or more often when indicated based on the changing clinical needs.

(2) The following must be contained in the assessment process or clinical information obtained and used in the development of the treatment plan: the functional level of the MAP eligible recipient's mental status; intellectual function; physical, psychological, vocational and social evaluations; medication status.

(3) The treatment plan must be based on the clinical needs identified in the assessments.

(4) Identified clinical needs must be addressed by specific therapeutic interventions. There must be documentation by the designated staff responsible for those interventions. Documentation should focus on measurable outcomes of the treatment goals and objectives.

(5) The comprehensive treatment plan and all supporting documentation must be available for review in the record. The following should be included in the record:

(a) the provider must document the rationale day treatment is the least restrictive environment for the MAP eligible recipient's clinical needs;

(b) description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

(c) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provision for review and modification of the plan;

(d) for the purpose of comprehensive coordination of services, the program must specify in the comprehensive treatment plan each of the following areas of care which may be delivered by other services providers: medication orders; restorative and rehabilitative services such as occupational therapy, physical therapy or speech therapy; psychiatric and psychology services; social services; diet; special procedures recommended for the health and safety of the MAP eligible recipient; and

(e) aftercare and discharge plans, a projected discharge date will be criteria for discontinuation of services.

G. Reimbursement: Day treatment providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement

requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how access documentation, billing and claims processing information. For IHS and a tribal 638 facility MAD does not consider day treatment services to be outside the IHS all inclusive rate and day treatment is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.
[8.321.2.18 NMAC - N, 1-1-14]

8.321.2.19 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: MAD pays for medically necessary health services furnished to a MAP eligible recipient under 21 years of age. To assist the MAP eligible recipient receive necessary mental health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program [42 CFR Section 441.57]. If the MAP eligible recipient is receiving services immediately before he or she reaches the age of 21 years, services may continue based on the following conditions: (1) up to the date the MAP eligible recipient no longer requires the services, or (2) the date the MAP eligible recipient reaches the age of 22 years, whichever comes first. The need for inpatient psychiatric care in freestanding psychiatric hospital must be identified in the MAP eligible recipient's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers: An MAD eligible provider must be accredited by at least one of the following:

(1) the joint commission (JO) (formerly known as joint commission on accreditation of healthcare organizations); or

(2) the council on accreditation of services for families and children (COA); or

(3) the commission on accreditation of rehabilitation facilities (CARF); or

(4) another accrediting organization recognized by MAD as having comparable standards; and

(5) be licensed and certified by the New Mexico department of health (DOH) or the comparable agency if in another state; and

(6) have a written utilization review (UR) plan in effect which provides for the review of a MAP eligible recipient's need for the facility's services that meet federal requirements; see 42 CFR Sections 456.201 through 456.245; and

(7) be an approved MAD provider before it furnishes services; see 42 CFR Sections 456.201 through 456.245.

B. Covered services: MAD covers those inpatient psychiatric hospital services furnished in freestanding psychiatric hospitals which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the MAP eligible recipient. These services must be furnished by eligible providers within the scope and practice of their profession (see Section 9 of this rule) and in accordance with federal regulations; see 42 CFR Section 441 Subpart D. Services must be furnished under the direction of a physician.

(1) In the case of MAP eligible recipient under 21 years of age these services:

(a) must be furnished under the direction of a board prepared, board eligible, board certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist;

(b) the psychiatrist must conduct an evaluation of the MAP eligible recipient, in person, within 24 hours of admission.

(2) In the case of MAP eligible recipients under 12 years of age, the psychiatrist must be board prepared, board eligible, board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for a MAP eligible recipient under age 12 and a MAP eligible recipient under 21 years of age can be waived when all of the following conditions are met:

(a) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;

(b) at the time of admission, a board prepared/board eligible/board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located;

(c) another facility which is able to furnish a board prepared/board eligible/board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(d) the admission is for stabilization only and transfer arrangement to the care of a board prepared/board eligible/board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible under the understanding that if the MAP eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the MAP eligible recipient is stable for transfer, in accordance with professional standards.

(3) The following services must be furnished by freestanding hospitals to receive reimbursement from MAD:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) regularly scheduled structured counseling and therapy sessions for MAP eligible recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;

(c) 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;

(d) assistance to a MAP eligible recipient in self- administration of medication in compliance with state policies and procedures;

(e) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize MAP eligible recipient by providing support, make referrals, as necessary, and provide follow-up;

(f) a consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(g) non-medical transportation services needed to accomplish treatment objectives; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

E. payment for performance of these required services is included in the hospital's reimbursement rate.

C. Noncovered services: Services furnished in freestanding psychiatric hospitals are subject to the limitations and coverage restrictions which exist for other MAD services; see 8.310.2 NMAC for MAD general noncovered services. MAD does not cover the following specific services for a MAP eligible recipient in freestanding psychiatric hospitals:

(1) conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM);

(2) services in freestanding psychiatric hospital for MAP eligible recipient 21 years of age or older;

(3) services furnished after the determination by MAD or its designee has been made that the MAP eligible recipient no longer needs hospital care;

(4) formal educational or vocational services related to traditional academic subjects or vocational training. MAD only covers non-formal education services if they are part of an active treatment plan for a MAP eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b);

(5) drugs classified as "ineffective" by the FDA drug evaluation.

D. MAD covers "awaiting placement days" in freestanding psychiatric hospital when the MAD utilization review (UR) contractor determines that a MAP eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the MAP eligible recipient requires a residential level of care which cannot be immediately located. Those days during which the MAP eligible recipient is awaiting placement to the lower LOC are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for ARTC services to MAP eligible recipient classified as level III, IV, or IV+ plus five percent. A separate claim form must be submitted for awaiting placement days.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with a MAP eligible recipient, his or her parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days.

(1) The treatment team must consist of at a minimum (see CFR 42 441.156(c-d):

(a) either a:

(i) board eligible or board certified psychiatrist; or

(ii) a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(iii) a physician licensed to practice medicine; or

(iv) osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and

(v) a psychologist who has a master's degree in clinical psychology or who has been certified by the state or its licensing board;

(b) the team must also include one of the following:

(i) a psychiatric social worker; or

(ii) an occupational therapist who is licensed by the state and who has specialized training in treating a MAP eligible recipient under the age of 21 years of age with a severe emotional disturbance (SED); or

(iii) a registered nurse with specialized training or one year's experience in treating MAP eligible recipients under the age of 21 years; or

(iv) a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state's licensing board.

(2) The treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file. The following must be contained in the treatment plan or documents used in the development of the treatment plan at a minimum all the following:

(a) be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the MAP eligible recipient's situation and reflects the need for inpatient psychiatric care;

(b) be developed by a team of professionals specified in Subsection A of 8.321.2.14 NMAC in consultation with the MAP eligible recipient and, his or her parents, legal guardians, or others in whose care he or she will be released after discharge;

(c) state treatment objectives;

(d) prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;

(e) include, at the appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the MAP eligible recipient's family, school, and community upon discharge;

(f) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(g) description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

(h) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including the provision for review and modification of the plan;

(i) specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the MAP eligible recipient; and

(j) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

F. Prior authorization and utilization review: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

(1) All inpatient services for a MAP eligible recipient under 21 years of age in a freestanding psychiatric hospital, require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

(2) Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

(3) A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decision.*

G. Discharge planning: Plans for discharge must be included in the MAP eligible recipient's treatment plan. Discharge must not be delayed because post-hospital planning is neglected. If the MAP eligible recipient will receive services in the community or in the custody of the children, youth, and families department (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 MAP eligible recipient's family, school and community.

H. Reimbursement: Freestanding psychiatric hospital service providers must submit claims for reimbursement on the UB04 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services.* Once enrolled, providers receive instructions on documentation, billing, and claims processing.

(1) Reimbursement rates for New Mexico freestanding psychiatric hospitals are based on TEFRA provisions and principles of reimbursement. See 8.311.3.11 NMAC, *payment methodology for PPS-exempt hospitals and exempt units within hospitals*, and 8.311.3.14 NMAC, *determination of actual, allowable and reasonable costs,* contained in 8.311.3 NMAC, *Methods and Standards for Establishing Payment – Inpatient Hospital Services*. Covered inpatient services provided in freestanding psychiatric hospitals will be reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals.

(2) If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

(3) Reimbursement rates for services furnished by psychiatrists and licensed Ph.D. psychologists in freestanding psychiatric hospitals are contained in that provider section. See 8.310.8, *Behavioral Health Professional Services*. Services furnished by psychiatrists and psychologists in freestanding psychiatric hospitals cannot be included as inpatient psychiatric hospital charges.

(4) When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

(5) provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed upon between the provider and MCOs when the provider enters into contracts with MCOs contracting with HSD for the provision of managed care services to the MAD population.

(a) If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(b) The "applicable reimbursement rate" is defined as the rate paid by HSD to the provider participating in medicaid or other medical assistance programs administered by HSD and excludes disproportionate share hospital and medical education payments.

[8.321.2.19 NMAC - N, 1-1-14]

8.321.2.20 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS: To help a New Mexico MAP eligible recipient under 21 years of age receive the level of services needed, MAD pays for outpatient hospital and partial hospitalization services furnished in a freestanding psychiatric hospital as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57]. These services are provided upon release of an inpatient stay to address follow-up care of the MAP eligible recipient. The need for outpatient or partial hospitalization services must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers: In addition to the requirements found in Section 9, Subsection A and B of this rule, an eligible provider includes a facility accredited by the joint commission (JO); and licensed and certified by DOH or the comparable agency in another state.

B. Coverage criteria: MAD covers only those services which meet the following criteria:

(1) Services are prescribed by a psychiatrist or licensed Ph.D. psychologist and furnished under an individualized written treatment plan established by the psychiatrist or licensed Ph.D. psychologist after any necessary consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals and must be developed with the MAP eligible recipient and his or her parent or guardian. The treatment plan must be developed within 14 calendar days of admission to the partial hospitalization or outpatient program.

(2) Treatment is supervised and periodically evaluated by a psychiatrist or licensed Ph.D. psychologist to determine the extent to which treatment goals are being realized. The psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any behavioral health practitioner involved in the MAP eligible recipient's treatment. The psychiatrist or licensed Ph.D. psychologist must see the MAP eligible recipient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

(3) Treatment must be reasonably expected to improve the MAP eligible recipient's condition or designed to reduce or control the MAP eligible recipient's psychiatric symptoms to prevent relapse or

hospitalization and to improve or maintain the MAP eligible recipient's level of functioning. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.

C. Covered services and service limitations: The following services must be furnished by an provider delivering outpatient hospital or a partial hospitalization as part of the freestanding psychiatric hospital services to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

(1) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(2) regularly scheduled structured counseling and therapy sessions for a MAP eligible recipient, group, and his or her family or multifamily group based on individualized needs furnished by social workers, trained psychiatric nurses, other behavioral health professionals who are employed by the hospital, as specified in the treatment plan;

(3) 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;

(4) assistance to the MAP eligible recipient in self-administration of medication in a manner that complies with state policies and procedures;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, provide follow-up for crisis situation and schedule follow-up appointments;

(6) consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective; and

(8) consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(9) non-medical transportation services needed to accomplish the treatment objective; and

(10) discharge planning and referrals as necessary to community programs as part of the planning.

D. Noncovered services: Outpatient and partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 subsection C of this rule for all general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services under outpatient and partial hospitalization:

(1) meals and transportation;

(2) activity therapies, group activities or other services which are primarily recreational or divisional in nature;

(3) programs which provide social and recreational activities to recipients who need some supervision during the day

(4) programs which are generally community support groups in non-medical settings for a chronically mentally ill person for the purpose of social interaction;

(5) MAD does not cover the service if a MAP eligible recipient's outpatient hospital program consists entirely of social activities.

(6) formal educational and vocational services related to traditional academic subjects or vocational training. Non-formal education services can be covered if they are part of an active treatment plan for the MAP eligible recipient under the age of 21 receiving inpatient psychiatric services. See 42 CFR Section 441.13(b);

(7) hypnotherapy or biofeedback; and

(8) services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

E. Treatment plan: An individualized treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge within 14 calendar days of the MAP eligible recipient's admission. The interdisciplinary team must participate in the treatment planning at least every 30 calendar days. See Section 9, Subsection G of this rule for MAD general treatment plan requirements.

F. Prior authorization: All outpatient and partial hospitalization services furnished in freestanding psychiatric hospitals for a MAP eligible recipient under 21 years of age requires a prior authorization (PA) from MAD or its designee. See Section 9, Subsection F this rule for MAD general prior authorization requirements.

G. Reimbursement: A provider of outpatient and partial hospitalization services must submit claims for reimbursement on the UB claim form or its successor. See 8.302.2 NMAC and Section 9 Subsection E of this rule for MAD general reimbursement requirements. Specific to outpatient and partial hospitalization services:

(1) are reimbursed at an interim rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles. For those services reimbursed using the medicare allowable cost methodology, MAD reduces the medicare allowable costs by three percent. Outpatient and partial hospitalization services that are not cost settled, will be reimbursed at the provider's cost-to-charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost-to-charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration; and

(2) any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

[8.321.2.20 NMAC - N, 1-1-14]

8.321.2.21 MULTI-SYSTEMIC THERAPY (MST): To help a New Mexico a MAP eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter his or her home and community , MAD pays for MST services as part of EPSDT services [42 CFR Section 441.57]. MAD covers medically necessary MST required by the condition of the MAP eligible recipient. Multi-systemic therapy provides an intensive home, family and community-based treatment for a MAP eligible recipient and his or her family who is at risk of out-of-home placement or is returning home from an out of home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The need for MST services must be identified in the tot to teen healthcheck screen or other diagnostic evaluations. Multi-systemic therapy provides an intensive home/family and community-based treatment for MAP eligible recipients ages 10 to 18 and their families who are at risk of out of home placement or are returning home from placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions.

A. Eligible providers: In addition to the requirements of Section 9, Subsection A and B of this rule, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST licensure by MST Inc, of Mt. Pleasant, South Carolina, or any of its approved subsidiaries. (MST Inc is a national organization located in Mt. Pleasant, South Carolina, deemed by the human services department (HSD) to be the primary authority on licensure of New Mexico multi-systemic therapy programs.

(1) The MST program shall include an assigned MST team for each MAP eligible recipient. The MST team must include, at minimum:

(a) a master's level clinical supervisor who is an independently licensed behavioral health professional (see Section 9, subsection H of this rule);

(b) licensed master's and bachelor's level behavioral health staff able to provide 24 hour coverage, seven days per week (see Section, subsection J of this rule);

(c) a licensed master's level behavioral health practitioner is required to perform all therapeutic interventions; bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of his or her licensure or practice (see Section 9,subsection B of this rule);

(d) 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' experience working with the target population of children, adolescents and their families;

(e) staffing for MST services shall be comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner who is MST trained; this supervision, following the MST supervisory protocol, is provided to team members on topics directly related to the needs of MST MAP eligible recipients and their families on an ongoing basis; and

(b) one hour of local group supervision per week and one hour of telephone consultation per week with an MST systems supervisor, provided to team members on topics directly related to the needs of MST individuals and their families on an ongoing basis.

(3) All clinical staff are required to participate in and complete a prescribed five-day MST introductory training and subsequent quarterly trainings.

(4) The MST direct-service staff-to-family ratio shall not exceed 1:6.

(5) MST providers bust be licensed by MST, INC. and provide the following:

B. MAP eligible recipients:

(1) MST is provided to a MAD MAP eligible recipient 10 to 18 years of age who is diagnosed with serious emotional disturbances, involved in or at serious risk of involvement with the juvenile justice system; have antisocial, aggressive, violent, and substance-abusing behaviors; is at risk for an out-of-home placement; or is returning from an out-of-home placement where the above behaviors were the focus of treatment, and his or her family.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from the program.

C. Covered services and service limitations: MST is a culturally sensitive service, provided by an MST team, provides an intensive home, family and community-based treatment for a MAP eligible recipient and his or her family who is at risk of an out-of-home placement or is returning home from an out-of-home placement. MST services are primarily provided in the MAP eligible recipient's home, but a MST worker also intervene at the MAP eligible recipient's school and other community settings. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance abuse, delinquency and violent behavior.

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

(a) an initial assessment to identify the focus of the MST intervention;

(b) therapeutic interventions with the MAP eligible recipient and his family;

(c) case management; and

(d) crisis stabilization.

(2) MST services are conducted by a team of practitioners using a team approach. The MST team must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc. MST services shall:

(a) promote the family's capacity to monitor and manage the MAP eligible recipient's behavior;

(b) involve families and other systems, such as the school, probation officers, extended families and community connections;

(c) provide access to a variety of interventions 24 hours a day, seven days a week, by staff that will maintain contact and intervene as one organizational unit; and

(d) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc.

(3) The duration of MST intervention is typically three to six months. Weekly interventions may range from three to 20 hours a week, less as a MAP eligible recipient nears discharge.

D. Noncovered services: MST services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9, Subsection C of this rule for general noncovered specialized behavioral health services.

E. Reimbursement: MST agencies must submit claims for reimbursement on the HCFA/CMS form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements; see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility MAD does not consider MST services to be outside the IHS all inclusive rate and MST is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

[8.321.2.21 NMAC - N, 1-1-14]

8.321.2.22 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES: MAD covers those medically necessary services for a MAP eligible recipient under 21 years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A LOC determination must indicate that the MAP eligible recipient needs the LOC that is furnished in a RTC or group home. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic

environment. MAD pays for services furnished in a RTC or group home as part of EPSDT services [42 CFR Section 441.57]. The need for RTC and group home services must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers: In addition to the requirements of Section 9, Subsection A and B of this rule, in order to be eligible to be reimbursed for providing RTC or group home services to a MAP eligible recipient must meet the following requirements.

(1) An RTC and group home must be certified by CYFD. If the provider is certified by CYFD as a RTC, that certification will suffice if all other CYFD group home certification requirements are met.

(2) If the RTC or group home is operated by the Indian health service (IHS) or by a federally recognized tribal government, the facility must meet CYFD certifying requirements but is not required to be certified by CYFD. In lieu of receiving a certificate, CYFD will provide MAD copies of its facility review and recommendations.

(3) Residential Treatment Centers that are not TJC certified must provide

(a) copy of CYFD certification;
(b) fiscal year-end date;
(c) proof of malpractice, professional liability or medical liability insurance;
(d) federal tax identification letter;
(e) completed w-9; and
(f) NM gross receipt (CRS) number documentation (if services are provided in NM).

B. Covered services: MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient.

(1) performance of necessary evaluations and psychological testing of the MAP eligible recipient for the development of his or her treatment plan, while ensuring that evaluations already performed are not repeated;

(2) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the MAP eligible recipient's treatment plan;

(3) 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 to the MAP eligible recipient;

(4) assistance to the MAP eligible recipient in the self-administration of medication in compliance with state statute, regulation and rules;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, making referrals, as necessary, and provide follow-up;

(6) consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective; and

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the MAP eligible recipient.

C. Noncovered services: RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to a MAP eligible recipient:

(1) Comprehensive Community Support Services (CCSS) except by the CCSS agency when discharge planning from the facility.

(2) services not considered medically necessary for the condition of the MAP eligible recipient, as determined by MAD or its designee;

(3) room and board;

(4) services for which prior approval was not obtained; and

(5) services furnished after the a MAD or its designee determination that the recipient no longer meets the LOC for RTC or group home care.

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released

after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a RTC or group home. The interdisciplinary team must review the treatment plan at least every 30 calendar days. In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(1) the treatment plan must meet the requirements provided in the General section of these Specialized Behavioral Health rule,

(2) the interdisciplinary team must review the treatment plan at least every 14 days

E. Prior authorization: Before any RTC or group home services is furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: An RTC or group home provider must submit claims for reimbursement on the HCFA/CMS form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements; see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. Specific to RTC and group home reimbursement the provider must submit claims for reimbursement on the long term care turn around document or its successor. For IHS and a tribal 638 facility MAD does not consider RTC services to be outside the IHS all inclusive rate and RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

(1) The fee schedule is based on actual cost data submitted by the RTC or group home provider. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The fee schedule reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include:

(i) direct services furnished by psychiatrists or licensed Ph.D. psychologists. These services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) other MAD services that a MAP eligible recipient might require, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable section of the MAD NMAC Rules Manual.

(c) Services which are not covered in the routine rate and are not a MAD-covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home provider cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

(3) The fee schedule will be updated annually each July 1st, based on the state salary increase passed by the New Mexico legislature. MAD or its designee will conduct an in depth review of cost report information every 3 years to see if adjustments, beside the yearly update, are indicated. The next such review and possible adjustment to the fee schedule will take place prior to the determination of the fee schedule for July 1, 1997.

(4) A provider must submit annual cost reports in a form prescribed by MAD. Cost reports are due 90 calendar days after the close of the provider's fiscal year end.

(a) If a provider cannot meet this due date, they can request a 30 calendar day extension for submission. This request must be made in writing and received by MAD prior to the original due date.

(b) Failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all MAD payments until such time as the cost report is received.

[8.321.2.22 NMAC - N, 1-1-14]

8.321.2.23 ACCREDITED RESIDENTIAL TREATMENT CENTER SERVICES: To help a MAP eligible recipient under 21 years of age who has been diagnosed as having a severe emotional disturbance (SED), or a chemical dependency, and for whom a less restrictive setting is not appropriate, MAD pays for services furnished to him or her by a residential treatment center accredited by the joint commission (JO) as part of EPSDT services.

The need for accredited residential treatment center services (ARTC) must be identified in the tot to teen healthcheck screen or other diagnostic evaluation.

A. eligible providers:

(1) In addition to the requirements of Section 9 Subsection A and B of this rule, in order to be eligible to be reimbursed for providing ARTC services to a MAP eligible recipient, an ARTC agency:

(a) must provide a copy of its joint council (JC) CARF accreditation as a children's residential treatment facility;

(b) must provide a copy of its CYFD ARTC facility license;

(c) must have written utilization review (UR) plans in effect which provide for review of the MAP eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245.

(d) fiscal year-end date

(e) proof of malpractice, professional liability or medical liability insurance;

(f) federal tax identification letter;

(g) completed w-9; and

(h) NM gross receipt (CRS) number documentation (if services are provided in NM).

(2) If the ARTC is operated by the Indian health service (IHS) or by a federally recognized tribal government, the facility must meet CYFD ARTC licensing requirements but is not required to be licensed by CYFD. In lieu of receiving a license, CYFD will provide MAD copies of its facility review and recommendations.

(3) In lieu of New Mexico CYFD licensure, an out-of-state or MAD border ARTC facility it must be JC accreditation and be licensed in its own state as an ARTC facility.

B. Covered services**:** MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. An ARTC facility must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient.

(1) Treatment must be furnished under the direction of a physician or the MAP eligible recipient's primary care provider.

(2) Treatment must be based on the MAP eligible recipient's individualized treatment plan rendered by the ARTC facility providers, within the scope and practice of their profession as defined by state law. See Section 9, Subsection B of this rule for general behavioral health professional requirements.

(3) Treatment must be reasonably expected to improve the MAP eligible recipient's condition. The treatment must be designed to reduce or control symptoms or maintain levels of functioning and avoid hospitalization or further deterioration are acceptable expectations of improvement.

(4) The following services must be performed by the ARTC provider to receive MAD reimbursement:

(a) performance of necessary evaluations and psychological testing and development of the MAP eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the MAP eligible recipient's treatment plan;

(c) 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 to the MAP eligible recipient;

(d) assistance to the MAP eligible recipient in the self-administration of medication in compliance with state statute, regulation and rules;

(e) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient, making referrals, as necessary, and provide follow-up to the MAP eligible recipient;

(f) consultation with other professionals or allied care givers regarding the MAP eligible recipient;

(g) non-medical transportation services needed to accomplish the treatment objective; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the MAP eligible recipient.

C. **NONCOVERED SERVICES:** ARTC services are subject to the limitations and coverage restrictions that exist for other MAD services. See section 9 Subsection C of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with ARTC services to a MAP eligible recipient:

(1) Comprehensive Community Support Services (CCSS) except when provided by a CCSS agency in discharge planning fron the facility.

(2) services for which prior approval was not requested

(3) services furnished to ineligible individuals; residential treatment center services are covered only for recipients under 21 years of age;

(4) formal educational and services which relate to traditional academic subjects or vocational training.

(5) experimental or investigational procedures and services which relate to traditional academic subjects or vocational training

(6) drugs classified as "ineffective" by the FDA drug evaluation; and

(7) activity therapy, group activities, and other services primarily recreational or divisional in nature.

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to an JC ARTC facility. The interdisciplinary team must review the treatment plan at least every 30 calendar days. In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) the treatment plan must meet the requirements provided in the General section of these Specialized Behavioral Health rule,

(b) For residential treatment services the treatment plan must also include a statement of the client's cultural needs and procision for access to cultural practices

(c) the interdisciplinary team must review the treatment plan at least every 14 days.

E. Prior authorization: Before any ARTC services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: An ARTC provider must submit claims for reimbursement on the HCFA/CMS form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements; see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. Specific to ARTC reimbursement the provider must submit claims for reimbursement on the long term care turn around document or its successor.

(1) The fee schedule is based on actual cost data submitted by the ARTC provider. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The fee schedule reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include:

(i) direct services furnished by psychiatrists or licensed Ph.D. psychologists. These services can be billed directly by the provider; see 8.310.3; and

(ii) other MAD services that a MAP eligible recipient might require, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable section of the MAD NMAC rules manual.

(c) Services which are not covered in the routine rate and are not a MAD-covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, an ARTC provider cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

(3) The fee schedule will be updated annually each July 1st, based on the state salary increase passed by the New Mexico legislature. MAD or its designee will conduct an in depth review of cost report information every 3 years to see if adjustments, beside the yearly update, are indicated. The next such review and possible adjustment to the fee schedule will take place prior to the determination of the fee schedule for July 1, 1997.

(4) Providers must submit annual cost reports in a form prescribed by MAD. Cost reports are due 90 calendar days after the close of the provider's fiscal year end.

(a) If a provider cannot meet this due date, they can request a 30 calendar day extension for submission. This request must be made in writing and received by MAD prior to the original due date.

(b) Failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all MAD payments until such time as the cost report is received.

(5) For IHS and a tribal 638 facility MAD does not consider ARTC services to be outside the IHS all inclusive rate and ARTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

(6) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the New Mexico border (Mexico excluded) are 70 percent of billed charges or a negotiated rate.
[8.321.2.23 NMAC - N, 1-1-14]

8.321.2.24 TREATMENT FOSTER CARE: MAD pays for behavioral health services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level I (TFC I) and meets this level of care (LOC) as part of the EPSDT services [42 CFR Section 441.57]. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into the community. Treatment Foster Care provides therapeutic services to children or adolescents who are experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a treatment foster care setting. The need for TFC I services must be identified in the tot to teen healthcheck or other diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers: In addition to the requirements of Section 9, Subsection A and B of this rule, in order to be eligible to be reimbursed for providing TFC I services to a MAP eligible recipient, the agency must be certified as provider of TFC I by CYFD.

B. Covered services: The family living experience is the core treatment service to which other individualized services can be added.

(1) A treatment foster parent is either employed or contracted by the TFC I agency and receive appropriate training and supervision by the Treatment Foster Care agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when a recipient is normally at home and is able to be physically present to meet the client's emotional and behavioral needs. The treatment foster parent responsibilities include:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on their observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan;

(c) recording information and documentation of activities, as required by the TFC I agency and the standards under which it operates;

(d) helping the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals; and

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan.

(g) work with all appropriate and available community-based resources to secure services for and to advocate for recipient.

(2) The following services must be furnished by a CYFD certified TFC I agency. Payment for performance of these services is included in the TFC I agency's reimbursement rate:

(a) Facilitation, monitoring and documenting of treatment of foster parents initial and ongoing training;

(b) providing support, assistance and training to the treatment foster parents

(c) assessment pre placement and placement to determine the recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC and assessment of family interactions and stress;

(e) treatment planning (as defined in the general section of the Specialized Behavioral Health Rules);

(f) regularly scheduled contact with the recipient and treatment foster parents and assistance to the treatment foster parents;

(g) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group setting for the MAP eligible recipient;

(h) Ensuring 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 MAP eligible recipient;

(i) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations; and

(j) when a return to the MAP eligible recipient's family is planned, assessment of the family's strengths, needs and the development of a family service plan.

C. Noncovered service: TFC I services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 subsection C of this rule for all noncovered MAD behavioral health services or activities. MAD does not cover: (1) room and board; (2) formal educational or vocational services related to traditional academic subjects or vocational training; and (3) respite care (4) Comprehensive Community Support Services (CCSS) except when planning a discharge from the TFC placement.

D. Prior authorization: Before any TFC I services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. Treatment plan: The treatment plan must be developed by treatment team in consultation with the MAP eligible recipient, family or legal guardian, primary care provider, if applicable, and others in whose care recipient will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC I program.

(1) The treatment team must review the treatment plan every 30 calendar days.

(2) In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) statement of the nature of the specific problem and the specific needs of the recipient;

(b) description of the functional level of the recipient, including the following:

(i) substance abuse assessment;

(ii) educational assessment; and

(iii) vocational assessment.

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and the TFC I parent responsibilities, description of proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services diet, and special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge of the MAP eligible recipient.

F. Reimbursement: A TFC I agency must submit claims for reimbursement on the HCFA/CMS form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements; see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility MAD does not consider TFC services to be outside the IHS all inclusive rate and TFC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

[8.321.2.24 NMAC - N, 1-1-14]

8.321.2.25 TREATMENT FOSTER CARE II: MAD pays for behavioral health services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level II (TFC II) and meets this level of care (LOC) as part of the EPSDT services [42 CFR Section 441.57]. The therapeutic family

living experience is the core treatment service to which other individualized services can be added. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into the community. The need for TFC II services must be identified in the tot to teen healthcheck or other diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers:

(1) In addition to the requirements of Section 9, Subsection A and B of this rule, in order to be eligible to be reimbursed for providing TFC II services to a MAP eligible recipient, a TFC agency must be a certified CYFD TFC II agency.

(2) A MAP eligible recipient has the right to receive services from any MAD TFC II enrolled agency of his or her choice.

B. Covered services: TFC II is a behavioral health treatment modality provided by a specially trained parent or a family home. The TFC II agency's treatment foster parent is either employed by or contracted by the TFC II agency and training is provided by that agency. TFC II combines the normalizing influence of family-based care with individualized treatment interventions and social supports, thereby creating a therapeutic environment in the family context or maintaining and extending an existing therapeutic context established in TFC I. Through the provision of TFC II services, the child's symptoms are expected to decrease and functional level to improve or maintain so that he or she may be discharged successfully to a less restrictive setting, that best meets the MAP eligible recipient's needs. MAD covers those services included in the individualized treatment plan which are designed to help the MAP eligible recipient develop skills necessary for successful reintegration into the biological, foster or adoptive family or transition to the community. TFC II will allow for a step-down from TFC I when the MAP eligible recipient improves and no longer meets TFC II LOC. TFC II will also allow entry into the program at a lower LOC for a MAP eligible recipient who would benefit optimally from the TFC II model.

(1) Treatment foster parents is employed or contracted by the treatment foster care agency. His or her responsibilities include:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies as specified in an individualized treatment plan;

(c) recording of information and documentation of all activities required by the TFC II agency and the standards under which it operates;

(d) helping the MAP eligible recipient maintain contact with his or her family and foster the enhancement of those relationships as appropriate;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals; and

(f) through coordination, linkage and the monitoring of services, assist the MAP eligible recipient to obtain medical, educational, vocational and other necessary services to reach goals identified in the treatment plan.

(g) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan.

(h) work with all appropriate and available community-based resources to secure services for and to advocate for recipient

(2) The following services must be performed by the TFC II agency or the TFC II agency contracts for and oversees to receive MAD reimbursement:

(a) the assessment of the MAP eligible recipient and his or her biological, foster or adoptive family's strengths and needs;

(b) the development of a discharge plan that includes a strengths and needs assessment of the MAP eligible recipient's family when a return to that family is planned to include a family service plan;

(c) the development and monitoring of the MAP eligible recipient's treatment plan;

(d) the assessment of the MAP eligible recipient's progress in TFC II;

(e) the assessment of the TFC II family's interaction with the MAP eligible recipient, his or her biological, foster or adoptive family to include any identified stressors;

(f) facilitation of age-appropriate skills development in the areas of household management, nutrition, physical, behavioral and emotional health, basic life skills, social skills, time management, school and wo

work attendance, money management, independent living skills, relaxation techniques and self-care techniques for the MAP eligible recipient;

(g) ensuring the MAP eligible recipient attends regularly scheduled counseling and therapy sessions in an individual, family or group setting following his or her treatment plan; and

(h) ensuring the availability of crisis intervention, including 24-hour a day, seven day a week availability of appropriately licensed parties to respond to crisis situations.

C. Noncovered service: TFC II services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with TFC II services to a MAP eligible recipient: (1) room and board; (2) formal educational or vocational services related to traditional academic subjects or vocational training; (3) respite care; and (4) Comprehensive Community Support Services (CCSS) provided by the CCSS agency when planning discharge from the TFC placement

D. Prior authorization: Before any TFC II services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. Treatment plan: The treatment plan must be developed by treatment team in consultation with the MAP eligible recipient, family or legal guardian, primary care provider, if applicable, and others in whose care recipient will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC II program. The treatment plan must meet all requirements found in the general requirements of the Specialized Behavioral Health Provider Rule

(1) The treatment coordinator must review the treatment plan every 30 calendar days.

(2) In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) a statement of the nature of the specific problem and the specific needs and strengths of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) mental status assessment;
(ii) intellectual function assessment;
(iii) psychological assessment;
(iv) educational assessment;
(v) vocational assessment;
(vi) social assessment;
(vii) medication assessment; and
(vii) physical assessment.

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of intermediate and long-range goals with the projected timetable for their attainment;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and TFC II foster parent responsibilities and the description and frequency of the following components: (a) proposed staff involvement, (b)orders for medication(s), (c) treatments, restorative and rehabilitative services, (d) activities, therapies, social services, (e) special diet, and (f) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge and projected date of discharge of the MAP eligible recipient.

F. Reimbursement: A TFC II agency must submit claims for reimbursement on the HCFA/CMS form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements; see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.25 NMAC - N, 1-1-14]

8.321.2.26 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: To help a New Mexico MAD MAP eligible recipient under 21 years of age receive necessary behavioral health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals, as part of EPSDT

services [42 CFR Section 441.57]. MAD covers those inpatient psychiatric hospital services furnished in freestanding psychiatric hospitals which are medically necessary for the diagnosis or treatment of behavioral health conditions as required by the condition of the MAP eligible recipient. If the MAP eligible recipient is receiving services immediately before he or she reaches the age of 21 years, services may continue based on the following conditions: (1) up to the date the MAP eligible recipient no longer requires the services; or (2) the date the MAP eligible recipient reaches the age of 22 years, whichever comes first. The need for inpatient psychiatric care in freestanding psychiatric hospitals must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers: In addition to the requirements of Section 9, Subsection A and B of this rule, the provider of inpatient psychiatric care in a freestanding psychiatric hospital must meet the following requirements.

(1) An eligible provider must be accredited by at least one of the following:

(a) the joint commission (JO); or

(b) the council on accreditation of services for families and children (COA); or

(c) the commission on accreditation of rehabilitation facilities (CARF); or

(d) other accrediting organizations recognized by HSD as having comparable standards.

(2) An eligible provider must be licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH) or the comparable agency in another state.

(3) An eligible provider must have a written utilization review (UR) plan in effect which provides for review of a MAP eligible recipient's need for the center's services that meet federal requirements; see 42 CFR Sections 456.201 through 456.245.

B. Covered services: MAD covers inpatient psychiatric hospital services furnished in a freestanding psychiatric hospital which is medically necessary for the diagnosis or treatment of behavioral health conditions as required by the condition of the MAP eligible recipient. These services must be furnished by eligible providers within the scope and practice of their profession as defined by state law and in accordance with federal regulations. See 42 CFR Section 441 Subpart D. See Section 9 Subsection B for MAD general provider requirements.

(1) Services must be furnished under the direction of the MAP eligible recipient's primary care provider. In the case of a MAP eligible recipient under 21 years of age, the services must be furnished under the direction of a board prepared, board eligible, board certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist.

(2) The psychiatrist must conduct an evaluation of the MAP eligible recipient, in person, within 24 hours of admission. In the case of a MAP eligible recipient under 12 years of age, the psychiatrist must be board prepared, board eligible, board certified in child or adolescent psychiatry.

(3) The requirement for the specified psychiatrist for MAP eligible recipient under age 12 and for a MAP eligible recipient under 21 years of age can be waived when all of the following conditions are met:

(a) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;

(b) at the time of admission, a board prepared, board eligible, board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located;

(c) another facility which is able to furnish a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(d) the admission is for stabilization only and transfer arrangement to the care of a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible under the understanding that if the MAP eligible recipient requires a transfer to another facility, the actual transfer will occur as soon as the MAP eligible recipient is stable for transfer, in accordance with professional standards.

(4) The following services are included in the hospital's reimbursement rate and must be furnished by freestanding hospitals to receive MAD reimbursement:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group, or multifamily group settings based on individualized needs, as specified in the treatment plan;

(c) 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 for the MAP eligible recipient;

(d) assistance to the MAP eligible recipient in the self-administration of medication in compliance with state statute, regulation and rules;

(e) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, making referrals, as necessary, and providing follow-up;

(f) consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(g) non-medical transportation services needed to accomplish treatment objectives; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of the MAP eligible recipient.

C. Noncovered services: A freestanding psychiatric hospital is subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9, Subsection C of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services for a MAP eligible recipient in freestanding psychiatric hospital:

(1) services not considered medically necessary for the condition of the MAP eligible recipient, as determined by MAD or its designee;

(2) conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM);

(3) services for which prior authorization was not obtained;

(4) services in freestanding psychiatric hospital for MAP eligible recipient 21 years of age or older;

(5) services furnished after a MAD or its designee determined the MAP eligible recipient no longer needs hospital care;

(6) formal educational or vocational services related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active treatment plan for a MAP eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b);

(7) MAD covers "awaiting placement days" in freestanding psychiatric hospitals when the MAD or its designee's utilization review (UR) contractor determines that a MAP eligible recipient under 21 years of age no longer meets the hospitalization LOC;

(8) the actual days in which the MAP eligible recipient is awaiting placement to the lower LOC are termed awaiting placement days; and

(9) payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for psychosocial accredited residential services for MAP eligible recipients classified as level III, IV, or IV+ plus five percent; a separate claim form must be submitted for awaiting placement days.

D. Prior authorization: Before any psychiatric hospital service is furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 72 hours of the MAP eligible recipient's admission to a freestanding psychiatric hospital. The interdisciplinary team must review the treatment plan at least every five calendar days. In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(1) The treatment team must at a minimum consist of (see CFR 42 441.156(c-d):

(a) either:

(i) a board eligible or board certified psychiatrist; or

(ii) a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(iii) a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or its licensing board; and

(b) the team must also include one of the following:

(i) a psychiatric social worker; or

(ii) an occupational therapist who is licensed by the state and who has specialized training in treating a MAP eligible recipient under the age of 21 years of age with a severe emotional disturbance (SED); or

(iii) a registered nurse with specialized training or one year's experience in treating a MAP eligible recipient under the age of 21 years; or

(iv) a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state's licensing board.

(2) In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the MAP eligible recipient's situation and reflects the need for inpatient psychiatric care; and

(b) be developed by a team of professionals specified in Section 31Subsection E of this rule in consultation with the MAP eligible recipient and, his or her parent, legal guardian, or others in whose care he or she will be released after discharge;

(c) stated treatment objectives; and

(d) prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives of the MAP eligible recipient;

(e) at the appropriate time, included post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the MAP eligible recipient's family, school, and community upon discharge;

(f) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(g) description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

(h) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including the provision for review and modification of the plan for the MAP eligible recipient;

(i) specification of staff responsibilities, description of proposed staff involvement, and orders for medication, treatment, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the MAP eligible recipient; and

(j) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge of the MAP eligible recipient.

F. Discharge planning: Plans for discharge must begin upon admittance to an inpatient facility and be included in the MAP eligible recipient's treatment plan. Discharge must not be delayed because post-hospital planning is neglected. If the MAP eligible recipient 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 MAP eligible recipient's family, school and community.

G. Reimbursement: A freestanding psychiatric hospital provider must submit claims for reimbursement on the HCFA/CMS form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements. Once enrolled, the provider receives instructions on how to access documentation, billing, and claims processing information must submit claims for reimbursement on the UB04 claim form or its successor. See 8.302.2 NMAC for additional instructions.

(1) Reimbursement rates for New Mexico freestanding psychiatric hospital is based on TEFRA provisions and principles of reimbursement; see 8.311.2 NMAC. Covered inpatient services provided in a freestanding psychiatric hospital will be reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals.

(2) If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

(3) Reimbursement rates for services furnished by psychiatrists and licensed Ph.D. psychologists in freestanding psychiatric hospitals are contained in that provider section. Services furnished by psychiatrists and

psychologists in freestanding psychiatric hospitals cannot be included as inpatient psychiatric hospital charges; see 8.321.2 NMAC.
[8.321.2.26 NMAC - N, 1-1-14]

8.321.2.27 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help a MAP eligible recipient receive necessary services, MAD pays for covered assertive community treatment services (ACT) [42 CFR SS 440.40, 440.60(a) and 441.57]. ACT services are therapeutic interventions that address the functional problems associated with the most complex and pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increasing the MAP eligible recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

A. Eligible providers:

(1) An ACT provider must be legally recognized entity in the United States and qualified/ registered by the New Mexico Corporation Commission to do business in new Mexico to provide behavioral health and/or medical services.

(2) An ACT agency must demonstrate compliance with 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. See New Mexico interagency behavioral health service requirement and utilization for more specific guidance. See Section 9, Subsection A and B for MAD general provider requirements.

(3) ACT services must be provided by an agency designating a team of 10 to 12 members, (see this section's, Subsection (5) for the required composition). Each team must have a designated team leader. Practitioners on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance abuse treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that a MAP eligible recipient obtains the basic necessities of daily life; and education, support and consultation to the MAP eligible recipient's family and other major supports. The agency must coordinate its ACT services with local hospitals, local crises units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.

(4) Each ACT team staff member must be successfully and currently certified or trained according to ACT standards developed by HSD or its authorized agents. The approved training will focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, crisis and support services 24 hours a day, seven days per week.

(5) Each ACT team shall have a staff-to-MAP eligible recipient ratio in keeping with ACT evidence-based practice standards and approved by MAD or its designee.

(6) Each ACT team shall include:

(a) at least one board-certified or board-eligible psychiatrist; we could add language that specifies the role to help costs;

(b) two licensed nurses, one of whom shall be a registered nurse (RN);

(c) at least one other MAD recognized independently licensed behavioral health professional, see 8.310.3 NMAC *Professional Provider Services and Reimbursement*;

(d) at least one MAD recognized licensed substance abuse professional, see 8.310.3 NMAC *Professional Provider Services and Reimbursement*;

(e) at least one employment specialist;

(f) at least one New Mexico certified peer specialist through the approved state of New Mexico certification program.;

(g) one administrative staff person; and

(h) the MAP eligible recipient shall be considered a part of the team for decisions impacting his or her services.

(7) The agency must have a MAD ACT approval letter to render ACT services to a MAD MAP eligible recipient.

B. Coverage criteria:

(1) MAD covers medically necessary ACT services required by the condition of the MAP eligible recipient.

(2) The interventions are strength-based and focused on promoting symptom stability; increasing the MAP eligible recipient's ability to cope and relate to others; and enhancing the highest level of functioning in the community, including learning, working and recreation and making informed choices.

(3) Interventions may address adaptive skill areas such as: housing; school, work and training opportunities; daily activities; health and safety; medication support; harm reduction; money management and entitlements; promotion of the MAP eligible recipient's recovery processes; relapse prevention; and service planning and coordination.

(4) The ACT therapy model shall be based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan. Specialized therapeutic and rehabilitative interventions falling within the fidelity model of ACT are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and who have a significant history of involvement in behavioral health services. See Section 9, Subsection B of this rule for MAD general provider scope of practice and licensure requirements and Section 9, Subsection D of this rule for MAD general medical necessary requirements.

C. MAP eligible recipients:

(1) ACT services are provided to a MAP eligible recipient aged 18 and older who has a diagnosis of severe mental illness (SMI) (including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression) who have severe problems completing activities of daily living, who has a significant history of involvement in behavioral health services and who has experienced repeated hospitalizations or incarcerations due to mental illness.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient for this program.

D. Covered services:

(1) ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

(a) the service is available 24 hours a day, seven days a week;

(b) the service is provided by an interdisciplinary ACT team that includes trained personnel as defined in of Section 13, Subsection A of this rule;

(c) an individualized treatment plan and supports are developed;

(d) at least 90 percent of services are delivered as community-based, non-office-based outreach services;

(e) an array of services are provided based on the MAP eligible recipient's medical need;

(f) the service is MAP eligible recipient-directed;

(g) the service is recovery-oriented;

(h) following the ACT evidence-based model guidelines, the team maintains a low staff-to-patient ratio;

(i) mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations; and

(j) the team is not just a consortium of mental health specialists, but includes collaborative assessment and treatment planning for each MAP eligible recipient; cross-training of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each MAP eligible recipient's care and services; the team will assist the MAP eligible recipient to access other appropriate services in the community that are not funded by MAD.

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

(3) ACT services must be provided to the MAP eligible recipient by the treatment team members.

(4) ACT program provide three levels of interaction with a MAP eligible recipient:

(a) a face-to-face encounters are at least 60 percent of all ACT team activities with approximately 90 percent of ACT encounters occurring outside of the IOP agency's office;

(b) a collateral encounter where the collaterals are members of the MAP eligible recipient's family or household or significant others (e.g. landlord, criminal justice staff, and employer) who regularly interact with his or her and are directly affected by or have the capability of affecting the MAP eligible recipient's condition, and are identified in the service plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff that is assisting an ACT MAP eligible recipient in locating housing);

(c) assertive outreach consists of the ACT team being 'assertive' about knowing what is going on with a MAP eligible recipient and acting quickly and decisively when action is called for, while increasing the MAP eligible recipient's independence. The team must closely monitor the relationships that the MAP eligible recipient has within the community and intervene early if difficulty arises;

(d) collateral encounters and assertive outreach combined must not exceed 40 percent of the total ACT team activities for each MAP eligible recipient; and

(e) all of the above activities must be indicated in the MAP eligible recipient's service plan.

E. Noncovered services: ACT services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9, Subsection C of this rule for MAD general noncovered behavioral health services. No other psychiatric, mental health nursing, therapeutic, substance abuse or crisis services will be concurrently reimbursed for an ACT MAP eligible recipient, except for medically necessary medications and hospitalizations.

F. Reimbursement: ACT agencies must submit claims for reimbursement on the HCFA/CMS claim form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements. [8.321.2.27 NMAC - N, 1-1-14]

8.321.2.28 PSYCHOSOCIAL REHABILITATION SERVICES: To help a New Mexico adult MAP eligible recipient with a serious mental illness (SMI) receive a range of psychosocial services, MAD pays for psychosocial rehabilitation services (PSR). The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore his or her best possible level of functioning.

A. Eligible providers:

(1) Upon approval of the MAD PPA, the following certified department of health (DOH) psychosocial rehabilitation agency is eligible to be reimbursed for furnishing psychosocial rehabilitation services (PSR) to a MAD MAP eligible recipient:

(a) a community psychosocial center designated by the New Mexico department of health;

(b) an IHS facility;

(c) a federally qualified health center;

(d) a community mental health center (CMHC)licensed by DOH; and

(e) other agencies which meet the DOH certification criteria.

(2) An agency which furnishes PSR services must have direct experience in successfully serving individuals with severe mental illness.

(3) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services. See Section 9, Subsection A of this rule for MAD general provider requirements. A PSR agency must be licensed by DOH as a CMHC to be reimbursed for these services by MAD. A PSR agency must also have the following:

(a) copy of DOH licenses as a community mental health center;

(b) copy of its New Mexico behavioral health collaborative letter of approval as a CSA;

B. Coverage criteria: MAD covers only those PSR services which comply with DOH mental health standards as detailed in the psychiatric rehabilitation user's manual and are medically necessary to meet the individual needs of the recipient, as delineated in the treatment plan. Medical necessity is based upon the recipient's level of functioning as affected by the mental disability. The services are limited to goal oriented psychosocial rehabilitative services which are individually designed to accommodate the level of the recipient's functioning and which reduce the disability and restore the recipient to his or her best possible level of functioning.

C. Covered services: MAD covers PSR services which include a cadre of services designed to reduce symptomatology and restore basic skills necessary to function independently in a MAP eligible recipient's community. PSR services are for a MAP eligible recipient 21 years and older affected with SMI. MAD covers the

following PSR services. These services are further defined by current procedure terminology (CPT) and healthcare common procedure coding system (HCPCS) identified for PSR.

(1) Psychosocial therapy interventions designed to address the functional limitations, deficits, and behavioral excesses through capitalizing on personal strengths and developing coping strategies and supportive environments.

(2) Community-based crisis intervention which must include:

(a) the availability of appropriate staff to respond to a crisis situation on a 24-hour a day basis;

(b) determining the severity of the crisis situation;

(c) stabilizing the MAP eligible recipient,

(d) making referrals to appropriate agency(ies) and provider follow-up.

(3) Psychosocial clinical consultations by professionals to assess the MAP eligible recipient's status and develops plan of care.

(4) Therapeutic interventions designed to meet clinically determined needs through scheduled, structured sessions.

(5) Medication services that are goal-directed interventions such as the evaluation of the need for psychotropic medications and subsequent assessment and management of pharmacologic treatment.

(6) Services must be individualized for each MAP eligible recipient and identified in the treatment plan.

D. MAP eligible recipients: A MAP eligible recipient is 21 years or older diagnosed with a serious mental illness and for whom medical necessity for PSR services was determined. A resident in an institution for mental illness is not eligible for this service.

E. Noncovered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for all general noncovered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. Prior authorization: For PSR, reviews are retrospective.

(1) Retrospective review: An assessment, diagnostic summary formulation and a treatment plan determine the type of PSR services rendered to a MAP eligible recipient. An agency's staff determine medical necessity of services based upon the service guidelines included in the DOH manual for evidencing medical necessity. All plans are subject to retrospective review to determine whether services provided met the service guidelines.

(2) Reviews for crisis intervention: When crisis intervention services are required, the claim is subject to retrospective review in accordance with the definition and requirements of the service criteria listed in the users manual billing guidelines. Reviews must be submitted to the DOH.

G. Treatment plan: See Section 9 Subsection G of this rule for MAD general treatment plan requirements. The following must be contained in the treatment plan and documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review by HSD, DOH or their agents in the MAP eligible recipient's file:

H. Reimbursement: A PSR agency must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements; see 8.302.2 NMAC. For IHS and a tribal 638 facility MAD does not consider ACT services to be outside the IHS all inclusive rate and ACT is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

[8.321.2.28 NMAC - N, 1-1-14]

HISTORY OF 8.321.1 NAMC: [RESERVED]

History of Repealed Material: [Reserved]