State of New Mexico
Medical Assistance Program Manual

Supplement

HEALTH CARE AUTHORITY

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TO: MEDICAID PROVIDERS

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THROUGH: KRESTA OPPERMAN, ACTING BUREAU CHIEF, BENEFITS AND REIMBURSEMENT BUREAU

SUBJECT: IMPLEMENTATION OF MOBILE CRISIS INTERVENTION SERVICES AND MOBILE RESPONSE AND STABILIZATION

The New Mexico Health Care Authority, Medical Assistance Division (HCA/MAD) is issuing this Supplement to provide billing and reimbursement guidance for mobile crisis intervention services and children's mobile response and stabilization (MRSS) services effective July 1, 2024. This guidance is being issued in advance of a rule promulgation of 8.321.2 NMAC and is effective immediately.

This Supplement, 24-14, replaces Supplement 24-03.

Mobile Crisis Intervention Services

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

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

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

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

Children's Mobile Response and Stabilization Services

Children's MRSS is a child, youth, and family specific behavioral health crisis intervention and prevention service. It provides immediate, in-person response, screening and triage to de-escalate crises that are defined by the child, youth, family or caregivers. MRSS provides ongoing stabilization services and support, follow up, navigation and access to community supports across the system of care to prevent future crises or out of home placement. MRSS services are conducted through a cultural, linguistic, and developmentally appropriate, trauma-responsive framework.

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

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

MCT/MRSS Staffing Requirements

Mobile crisis intervention services are furnished by a multidisciplinary team that includes at least two members. The team includes at least one behavioral health care professional able to conduct a clinical assessment within their permitted scope of practice under state law and who may be available via telehealth. Additional team members may include:

a. A licensed Mental Health Therapist;
b. Certified Peer Support Specialist;
c. Certified Family Peer Support Worker;
d. Certified Youth Peer Support Worker
e. Community Support Worker;
f. Community Health Worker;
g. Community Health Representative;
h. Certified Prevention Specialist;
i. Registered Nurse;
j. Emergency Medical Service provider;
k. Licensed Alcohol and Drug Abuse Counselor (LADAC) or Certified Alcohol and Drug Addiction Consultant (CADAC);
l. Non- independently licensed behavioral health professional;
m. Emergency Medical Technician;
n. Licensed Practical Nurse; and
o. Other certified and/or credentialed individuals.

MCT Specific Requirements

The MCT shall have a full-time clinical director who is an RLD board- approved clinical supervisor and/or a part-time medical director which may include a physician, psychiatrist, or advanced practice registered nurse. The MCT shall ensure that, prior to providing direct care of recipients, all individuals having direct contact with recipients shall have all applicable background checks and receive 25 hours of required training. Annually all individuals having direct contact with recipients must receive at least 20 hours of crisis related continuing education.

MRSS Specific Requirements

A range of staffing models that include both licensed and non-licensed staff can be used to develop a MRSS team. When not on the scene, a clinical supervisor must be available remotely to provide clinical consultation to the MRSS team. MRSS teams shall have a clinical supervisor who is an independently licensed, RLD board-approved clinical supervisor.

MRSS providers shall ensure that MRSS staff complete required training which includes:

a. 30 hours of required MRSS training
b. CPR and de-escalation training
c. Any HCA/MAD required provider trainings.

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

Eligible Providers

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

a. Federally Qualified Health Center;
b. Community Mental Health Center;
c. Hospital or affiliated clinic;
d. an IHS hospital or clinic;
e. Crisis Triage Center;
f. PL 93-638 tribally operated hospital or clinic;
g. a MAD designated CareLink NM Health Home;
h. Behavioral Health Agency;
i. Core Service Agency

Following approval by BHSD or MRSS respectively providers must update their NM Medicaid provider enrollment to reflect provider specialty 149 (MCT) or 139 (MRSS).

MCT/MRSS Dispatch

Use of state approved tools will be used for dispatch protocols for crisis response services. MCT/MRSS may be dispatched by 988 Lifeline call centers, by the agency operating the MCT or MRSS, or by local law enforcement or public safety systems, as outlined in a memorandum of understanding (MOU). MOUs must be provide to the state, or its designee, as requested. MCTs and MRSS responders cannot refuse a request for dispatch unless safety considerations warrant involvement of public safety. In those cases, MCT and MRSS providers must establish standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, imminent risk of harm). Policies must appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history). In the case of simultaneous requests for dispatch, MCT and MRSS providers must use a triage system to prioritize acuity.

Telehealth is allowable, however in vivo MCT and MRSS response is preferred. MCT and MRSS providers

can use telehealth to ensure rapid response and clinical decision-making to ensure the crisis is resolved safely.

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

Billing and Reimbursement

Claims for reimbursement should be submitted on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC.

- The agency NPI may be used in the rendering provider field as well as the billing provider field.
- For FQHC: use the CMS 1500 claim form using the appropriate HCPCS codes at the FFS or negotiated unit rate.
- IHS/638: UB claim form; revenue code 0919 for OMB rate unless otherwise negotiated with the facility.
- For FQHC, IHS, and Tribal 638: if preferring to utilize the fee schedule rates, please contact MAD Benefits and Reimbursement Bureau.
- Mobile crisis and stabilization will use the following procedure codes and modifiers:

SERVICE	PROCEDURE CODE	MODIFIER(S)	MRSS Modifier	Units
Mobile Crisis Intervention Services – Per Diem- for responses over 4 hours in duration				
MOBILE CRISIS – – LICENSED RESPONSE	S9485	HO	HA	Per Encounter
MOBILE CRISIS — NON-LICENSED RESPONSE	S9485		HA	Per Encounter
MOBILE CRISIS –LICENSED RESPONSE WITH PEER	S9485	HT	HA	Per Encounter
TEAM RESPONSE WITH TELEHEALTH IN HUB	S9485	GT	HA	Per Encounter
Mobile Crisis Intervention Services Unit – For responses 4 hours or less in duration				
LICENSED RESPONSE – CRISIS LICENSED & CRISIS LEVEL 1 NON-LICENSED	H2011	HO	HA	15 minutes Max units: 16
NON-LICENSED RESPONSE – CRISIS LEVEL 2 NON-LICENSED & CRISIS PEER/YOUTH & FAMILY SUPPORT	H2011		HA	15 minutes Max units: 16
LICENSED RESPONSE – CRISIS LICENSED & CRISIS PEER/YOUTH & FAMILY SUPPORT	H2011	HT	HA	15 minutes Max units: 16
TEAM RESPONSE WITH TELEHEALTH	H2011	GT	HA	15 minutes Max units: 16
TELEPHONIC				
MOBILE CRISIS FOLLOW-UP - TELEPHONE	H0030		HA	15 minutes
STABILIZATION SERVICES – for individuals aged 21 and under				
STABILIZATION SERVICES – LICENSED & PEER	S9482	HA, HT		15 minutes

STABILIZATION SERVICES – LICENSED & NON-LICENSED	S9482	HA, HT		15 minutes
STABILIZATION SERVICES – NON-LICENSED ONLY	S9482	HA		15 minutes
STABILIZATION SERVICES – LICENSED ONLY	S9482	HA, HO		15 minutes

Please refer to the Behavioral Health Fee Schedule located on the HCA website for additional information. https://www.hca.nm.gov/providers/fee-schedules/.

Billing Guidance

- Crisis providers cannot bill a mobile crisis unit code (H2011), mobile crisis per diem (S9485) and/or MRSS stabilization (S9482) rate on the same day. Crisis providers cannot bill a mobile crisis per diem (S9485) and a telephonic follow-up call (H0030) in the same day.

- Mobile crisis intervention services (e.g., H2011 and S9485) by their nature are crisis services and are not subject to prior approval. Mobile crisis intervention is authorized for no more than 72 hours per episode. Mobile crisis intervention is authorized for no more than 72 hours per episode. Activities beyond the 72-hour period must have prior authorization by the State of its designee. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode.

- Authorization for Telephonic Follow-up (H0030) is not required if it follows a mobile crisis intervention service.

- MRSS stabilization is authorized for no more than 8 weeks. For children or youth in need of regular care beyond 72 hours who have been seen by an MRSS crisis team, use of MRSS stabilization services will be determined in conjunction with the caregiver and are based on risk factors identified in the MRSS CAT screening including, but not limited to, housing and economic stability, potential for harm to self or others, substance use or behavioral health challenges, school behavioral and attendance challenges. The goal of stabilization should be to stabilize the child or youth to address immediate de-stabilizing economic factors and address immediate family needs and transition the youth to a longer-term community behavioral health service or support as appropriate.

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

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

- MCT or MRSS should collaborate with ACT, DBT, MST, FFT, New Mexico High Fidelity Wraparound (HFW), or other existing care teams and ensure seamless care transition for individuals served. MRSS stabilization should not be billed when a child or youth is under the care of a DBT, MST, FFT, HFW or other existing care team.

Billable Services

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

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

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

- Mobile crisis intervention services are subject to the coverage limitations that exist for other HCA/MAD covered behavioral health services. See Subsection G of 8.321.2.9 NMAC for general HCA/MAD behavioral health non-covered services or activities. HCA/MAD does not cover the following services billed in conjunction with mobile crisis intervention services to an eligible recipient:
    - Services past the initial crisis response for individuals receiving ACT, DBT, MST, HFW and FFT
    - Inpatient services (can be billed on same day if the recipient requires transfer, however the same provider may not bill for both MCT/MRSS and inpatient services on the same day)
    - Residential services.
- Services that are primarily recreational or diversional in nature.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Client Transportation: Rates include staff travel to and from the site of the crisis. If the staff is traveling back to the office, the individual may ride with the staff member. However, there is no adaptive or secure transportation costs included in the mobile crisis rate. If adaptive or secure transportation for the individual or family is needed, then those additional medical transportation costs for service needs are not considered part of the response.
- Transportation services may be covered through the State Plan. Services provided in the car are considered Transportation and time may not be billed for Crisis.
- Covered services that have not been rendered.
- Services not in compliance with the crisis service definition within the Behavioral Health Policy and Billing Manual or licensure standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible

beneficiary's issues and not listed on the eligible beneficiary's crisis participant-directed care coordination plan.

- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved crisis service description.
- Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, Behavioral Health Policy and Billing Manual, or licensure standards will not be reimbursed.

Please contact the Medical Assistance Division at MADInfo.HCA@hca.nm.gov if you have any questions regarding this supplement.