State of New Mexico
Medical Assistance Program Manual

Supplement

HUMAN SERVICES DEPARTMENT

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TO: BEHAVIORAL HEALTH PROVIDERS

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ATTACHMENT: Specialized Behavior Health Services Billing Instructions

This supplement provides billing instructions for several Medicaid specialized behavior health services. An earlier supplement was directed specifically to residential treatment centers and treatment foster care providers. It can be found on the Human Services Department (HSD) website at:
http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Provider%20Packets/Billing%20Instructions%20ARTC%2C%20RTC%2C%20TFC%2014-03.pdf

Providers are required to adhere to the instructions in this supplement. It is also important for providers to be aware of any specific billing requirements that a managed care organization may have when billing a managed care organization.

I. Taxonomy for Specialized Behavioral Health Services

Often, behavioral health agencies and clinics have more than one provider entity. This may create problems when the National Provider Identifier (NPI) is the same for all the lines of business the provider may have. Please review the following information to help facilitate claims payment:

1. When a claim is submitted to Xerox because the recipient is in the fee-for-service Medicaid program, it is still necessary that BHSD and MAD know what specific facility or clinic is billing for the service. Recognizing a specific provider is a federal requirement when a certification, license, or other approval for a provider is for a specific location rather than for an individual person.

   However, in developing the NPI, Centers for Medicare and Medicaid Services (CMS) specifically elected not to include any information within the NPI number that would indicate different locations of a provider under the same NPI. Therefore, Medicaid programs must have a way to identify the specific provider and location in the payment systems.

2. A list of taxonomies has been developed for behavioral health entities to be placed on the claim so provider information can be located within the payment systems. The taxonomies are included in the list of services attached to these billing instructions. An earlier list was sent to Behavioral Health Residential and Treatment Foster Care (TFC) providers.

3. The taxonomy code may not be the one that was identified by the provider when applying for an NPI, but that is not an issue. There is no requirement that the taxonomy on a claim be limited to the taxonomy associated with the NPI at the time provider requests an NPI number.

4. The taxonomy requirements stated are for filing claims with Xerox. Each MCO may have its own varying requirements for taxonomy.

   An alternative for the provider is to obtain a different NPI for different businesses, locations, or service areas which is generally what physical health providers under Medicaid have done. For example, each hospital location in a hospital network will have a distinct NPI number and possibly other NPIs for specialized areas such as home health agencies associated with the hospital.

   If you choose to obtain different NPI's for submitting claims for different provider entities, please notify all the payers so their records can be changed.

5. If a service requires authorization from the Medicaid Third Party Assessor, (TPA), in order for the claim to be paid, the provider number must be given to the TPA at the time of the authorization request, and must match the provider who is submitting the claim.

To request Prior Authorization a provider may contact:
The Molina Healthcare Provider line at 505.348.0311 (Local)
or 866.916.3250 (Toll Free) Monday – Friday 8am -5pm.

The TPA will authorize the services for the procedure codes with a span of dates and provide the prior authorization number to the provider. The provider number is located by Xerox by using the combination of NPI and taxonomy on the claim. This provider number must match the provider number under which the authorization was given by the TPA.

A proper match exists when the provider does one of the following:

a. The provider gives the correct Medicaid Provider ID to the TPA when the request is made and then places the correct NPI and taxonomy on the claim (as described in the attachment). This is the recommended method.

b. The provider gives the correct NPI and taxonomy to the TPA when the request is made and then places the correct NPI and taxonomy on the claim.

The service and dates of service on the claim must be the same as authorized by the TPA.

It is also essential the provider not combine two different authorizations on the same claim line. The span of dates on the claim cannot cross two different TPA authorizations.

On March 1, 2015, the Medicaid Third Party Assessor, (TPA) will change to Qualis. Additional information will be sent to providers on this transition. Qualis will be expecting the providers to request prior authorizations under their Medicaid provider ID number.

II. Program Rules

Providers must adhere to the Medicaid program rules. The following chapters of the rules are particularly important.

300 – General information
301 – General benefit information
302 – General provider policies
310 – General benefit description

These rules and others can be found at:
http://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx

Also very important is the rule 8.321.2 NMAC Specialized Behavioral Health Provider Enrollment and Reimbursement specifically for special behavioral health providers and services found at:

http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20321/8_321_2%20Revised.pdf

Services provided must always meet the criteria specified in the New Mexico Behavioral Health Collaborative Service Definitions found at:
http://www.bhc.state.nm.us/BHServices/ServiceDefinition.html

III. CMHC's Providing Comprehensive Community Support Services (CCSS)

The current rule on CCSS in NMAC 8.321.2.14 A. eligible providers, does not state that CCSS can be performed by a licensed CMHC. MAD and BHSD recognize that a licensed CMHC can still provide CCSS services while the clarification to this rule is in the process of being made. Therefore, on the attachment which includes billing information, it is noted that a licensed CMHC can bill for CCSS services.

IV. Billing for Services Rendered by Individuals Who Must Be Supervised

Except under limited circumstances, evaluations and therapy can only be billed by independently licensed practitioners qualified to perform the services, consistent with the scope of the independent practitioner's license and as allowed by program rules.
For example, a psychologist in a private or group practice cannot have an independent or non-independent practitioner actually provide the services and then bill as if the psychologist had actually performed the services.

However, special provisions apply when the billing provider is one of the following agencies:

1. A Community mental health center (CMHC)
2. A Federally Qualified Health Center (FQHC);
3. An Indian Health Services (IHS) hospital and clinic;
4. A PL 93-638 tribally operated hospital and clinic;
5. The Children, Youth and Families Department (CYFD);
6. A hospital and its outpatient facility; or
7. A Core Service Agency (CSA).

When the service is provided in one of these settings, the service may be provided by a licensed practitioner whose license does not include practicing independently when the service is within the scope of the practitioners license and all clinical supervision requirements under the law are met. The supervisory requirements include those required under state law, by licensing boards, and Medical Assistance Division and Behavioral Health Service Division guidelines. The supervisor of the service must meet all requirements related to supervision including having a license for which the scope includes the ability to supervise and for which the scope includes the service being supervised.

Also, for Behavior Health Agencies, Medicaid FFS provider type 432, the Department is continuing to allow the Behavioral Health Agency providers recognized by OPTUM under the OPTUM Supervisory Protocol to bill for non-independently licensed practitioner's services when all requirements described above related to supervision are met.

The Department is currently developing criteria under which other Behavioral Health Agencies not yet on the Supervisory Protocol list, can qualify to bill for the services of non-independent practitioners and will notify providers when those requirements are available.

When the program rules or service definitions for specific behavioral health services indicate that the services may be performed by a specific level of practitioner or individual, that individual or practitioner may render the service when all requirements for supervision are met.

Providers specifically certified for specific services may bill for the services as allowed by the certification, providing all requirements by the certifying agency are met. For example, if a provider is certified for Day Treatment, then practitioners rendering the Day Treatment services must meet the requirements of the certifying agency for staffing and supervisory requirements.

Otherwise, only when specifically allowed by program rules and program service definitions, is a provider able to bill for the service of a non-independently licensed practitioner.

The payment level for a supervised serviced, that is an independent practitioner supervising a non-independent practitioner is at the fee schedule amount in the column "Master's Level for Independent and Non-Independent Licensure Types.
The fee schedule is found at:
http://www.hsd.state.nm.us/providers/fee-schedules.aspx

It is necessary to scroll to the bottom of the page and click the "agree" button, then click submit, then locate the BH fee schedule on the page that appears on the screen.

V. USE OF THE U7 MODIFIER:

The above special provisions for CSAs, CMHCs, and for BHAs under the supervisory protocol will require changes in how services are billed.

In order to meet federal requirements, MAD will soon start enrolling non-independent providers so that they may be properly identified on a claim as a rendering provider. More information will shortly be forthcoming on that project within the next few weeks.

Until that time, as indicated in the attached information on specialized services, the supervisor of the non-independent provider who is supervising the service must be indicated as the rendering provider if the individual cannot currently be enrolled.

In order to properly communicate on the claim that the rendering provider is really a supervising provider, the claim must include modifier U7, which means the NPI listed in the rendering provider field is to be interpreted as the supervisor of the rendering provider.

This use of the U7 modifier will also be used for the same purpose by managed care organizations.

Identifying a rendering non-independent provider on a claim.

If a non-independent provider is allowed to render a service under supervision, but the rendering non-independent cannot currently be enrolled through the Medical Assistance Division, the supervisor who is supervising the service must be indicated as the rendering provider, using a U7 modifier on the procedure, to note the supervision.

The U7 modifier cannot be used in this way on a claim if:

- the non-independent provider is not qualified to provide the service
- the service is outside the scope of practice of the non-independent provider
- the service is outside the scope of practice of the non-independent provider
- any of the standards for clinical supervision are not met

Note that a managed care organization, working with BHSD, is able to allow more flexibility regarding supervision of services than the Fee-for-Service program rules may allow. However, the provider is responsible for being able to document that proper authorization for flexibility in supervision has been obtained from the MCO.

Enrolling providers through the Medical Assistance Division

Historically, MAD has not enrolled most non-independent BH providers in the Medicaid system. However, MAD is changing their processes to allow non-independent BH providers to enroll using the MAD/Xerox portal. Providers will be notified when this enrollment can begin, and the date by which all non-independent providers must be enrolled through MAD. Even when enrolling through MAD, a provider may elect to only participate in managed care

It will be necessary for non-independent providers to complete their enrollment through MAD in order to participate even in just managed care, because the process will register the providers NPI number in the Medicaid system so that the practitioner rendering the service can be identified.

The Centers for Medicare and Medicaid Services (CMS) are now requiring virtually all levels of practitioners rendering services to Medicaid recipients to be identifiable on claims.

More information will soon be forthcoming on how non-independent BH providers can enroll as a provider for Medicaid and MCOs.

Independent providers should already be enrolled through MAD. If not, go to the following website:

https://nmmedicaid.acs-inc.com/webportal/enrollOnline

VI. Recognition of Evaluation and Management Services Provided in Hospitals and Nursing Facilities and as Provided by Psychologists with Prescription Authority

A new Behavioral Health Fee Schedule can be found at the HSD website at:
http://www.hsd.state.nm.us/providers/fee-schedules.aspx

It is necessary to click on the acceptance button at the bottom of the page to go to the fee schedules.
Changes include recognizing evaluation and management codes for services rendered in a nursing facility and in a hospital for providers for whom these codes did not previously have fee schedule information. Because this coverage is a technical correction these prices are effective retroactive to January 1, 2014.

Also a new column has been added that shows fees for services provided by psychologists with prescription authority which includes the recognition of many evaluation and management codes. This is consistent with the training that a psychologist receives regarding management of medications and providing a level of examination and decision making as part of their qualifying for prescribing privileges.

VII. Specialized Behavioral Health Services

Attached is billing and program information related to many specialized behavioral health services. Please note and follow the requirements as indicated.

Note these instructions do not apply to IHS or Tribal 638 facilities or FQHC providers. Information will be provided for their use separately. Also, for recipients enrolled in managed care organizations (MCOs), please follow the specific instructions from each MCO for billing for services to their members.

The agencies included in this Specialized Behavior Health Services supplement can also bill for evaluations and therapy for their recipients not in these specialized services when the provider rendering the service meets the program requirements. However, those services are not included in the attachment because the scope of this document is for the specialized programs.

Note that effective as of the date of this supplement, Crisis Intervention can be billed by Behavioral Health Agencies, CMHCs, and CSAs to other than a psychosocial rehabilitation recipient, providing that service is available 24 hours a day, 7 days a week.

Also, for the Intensive Outpatient Program, code T1007 U8 can be billed for developing an initial treatment plan prior to the recipient entering IOP.

The next supplement to BH providers on billing will be more related to individual practitioners and also clarify the billing of services related to smoking cessation, alcohol and substance abuse, and other services which some specialized behavior health providers are also able to bill when not already bundled into another service definition.

VIII. Billing For Services in the Schools

A service that is in the Individual Education Plan (I.E.P.) or Individual Family Service Plan (I.F.S.P.) can only be billed by a school. Even if you currently have a contract with a school for which you provide services as part of an I.E.P or I.F.S.P. that service must be billed to the Medicaid program by the school and it is the school that will be paid by Medicaid.
If a service is provided in a school, and the service is in the I.E.P. or I.F.S.P. the place of service on the claim must be reported as 03 – school.

Each provider with a contract with a school must make certain that the contract requires the school to bill for services in the I.E.P. or I.F.S.P. The school then pays the provider according to their contract for services and payment rate.

It is possible that not all services rendered by the provider to students at a school will be billable by the school to the Medicaid program, such as coordinating the services with the school or consultation with principals, school counselors, or teachers. The school's payment to the provider may include some of those services that cannot be billed by the school to Medicaid. This is a contract issue between the school and the provider.

If a service is appropriately not included in the I.E.P. or I.F.S.P. because is being performed at the school for the convenience of the student, it would be appropriate for the provider of the service to bill the Medicaid program, or to the managed care organization if the child is enrolled in a managed care organization. Coordinating the services with the school, such as coordination or consultation with principals, school counselors, or teachers, is not a billable service by the provider. School districts are able to bill and be reimbursed for certain Medicaid-related administrative activities, such as conducting Medicaid-related outreach; facilitating Medicaid eligibility determinations; coordinating transportation to Medicaid-covered services; making referrals; coordinating and monitoring Medicaid services; and engaging in medical service program planning, policy development and interagency coordination. But these services are paid to the schools as an administrative payment, not by individually billed claims.

IX. New Modifiers for Billing Individual, Family, and Group Therapy on the Same Day

The CMS National Correct Coding Initiative (NCCI) requires the Medicaid program to deny services when multiple therapies are billed on the same day, such as individual, family, and group therapy. However, the provider can use a modifier with the procedure

code on the claim to indicate that the services really did take place on the same day. When the modifier is present, the service is not denied for occurring on the same day as another therapy. The modifier 59 has been used for this purpose.

The modifier 59 is still valid for use, but effective 1/01/2015 CMS added 4 new modifiers to be used to replace modifier 59 when the new modifiers accurately describe the situation.

CMS notes that CPT instructions state that the 59 modifier should not be used when a more descriptive modifier is available. These new modifiers were added because "This modifier [59] is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases."

The new modifiers are:

XE Separate Encounter, a Service That Is Distinct Because It Occurred During a Separate Encounter

XS Separate Structure, a Service That Is Distinct Because It Was Performed On a Separate Organ/Structure

XP Separate Practitioner, a Service That Is Distinct Because It Was Performed By a Different Practitioner

XU Unusual Non-Overlapping Service, the Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of the Main Service

Specific information for behavioral health CPT code combinations that are often misinterpreted are as follows:

- Previously there was a NCCI edit for individual psychotherapy (90832, 90834, or 90837) with group therapy (90853), but it allowed payment with a 59 modifier signifying a separate procedure. This edit was discontinued altogether on 9/30/2014; therefore there is no NCCI edit for this code combination on the same day for the same patient and can be billed if the services occured at different times of the day.

- There is an edit for individual psychotherapy and family psychotherapy on the same day. Family psychotherapy (i.e., CPT codes 90846, 90847) is not separately reportable with psychotherapy CPT codes 90832-90838 since the latter codes include psychotherapy with family members. Physicians should not report psychotherapy CPT codes 90832-90838 with CPT code 90847 (family psychotherapy with patient present) for the same date of service. CPT codes 90832-90838 include all psychotherapy with family members, if present, for a single date of service. However, if individual psychotherapy and family psychotherapy are done on the same day by different practitioners or as distinct

encounters, the use of the XE or XP modifiers will by-pass the edit.

The link to the federal Medicaid NCCI edits which have been updated for 2015 is: www.medicaid.gov/Medicaid-CHIP-program-information/By-topics/data-and-systems/National-Correct-Coding-Initiative.html

We appreciate your participation as a Medicaid provider. If you have further questions on this supplement, please contact Sally Wait at (505) 476-7153 or at sallyanne.wait@state.nm.us

SPECIALIZED BEHAVIOR HEALTH SERVICES BILLING INSTRUCTIONS

1-23-2015

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1) **ACT – Assertive Community Treatment** consists of recovery oriented therapeutic interventions addressing the functional problems associated with complex and pervasive conditions of the population with a diagnosis that meets the criteria of a severe mental illness (SMI). A co-occurring diagnosis of substance abuse shall not exclude a recipient from this service.

Interventions are strength based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others while enhancing the highest level of functioning in the community.

The service is based on the ACT therapy model with a team of 10 to 12 members educated in the model, and must be available 24 hours/7 days with at least 90% of services delivered as community-based outreach. Collateral encounter & assertive outreach together can comprise no more than 40% of the total activities. ACT service approval is contingent upon a satisfactory on-site audit conducted by HSD Behavioral Health Services Division (BHSD).

MAD does not cover other psychiatric residential or therapeutic services, substance abuse or crisis services when billed during the time period the recipient is under the ACT service model or in conjunction with ACT services except for medically necessary medications and hospitalizations.

A provider must have a letter from HSD/MAD approving them as a Medicaid ACT provider.

Refer to the program rule 8.321.2.12 NMAC

ACT – Assertive Community Treatment

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Behavioral Health Agencies (enrolled by MAD as a BHA provider type 432)	251S00000X	H0039 (Assertive community treatment face to face per 15 min.) Modifiers	No prior authorization is required. ACT is limited to recipients 18 years of age and older.
Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433)	261QM0801X	U1 – Face to Face U2 – Collateral Encounter U3 – Assertive Outreach	Bill on a CMS 1500 form.
Core Service Agency (enrolled by MAD as a CSA provider type 446)	261QR0800X	A rendering provider is required. See note 1, regarding identifying a rendering non-independent provider.	

2) BMS – Behavior Management Skills Development Services

BMS services provide highly supportive and structured therapeutic behavioral interventions to maintain the recipient in his or her home or community. It is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the treatment plan.

BMS providers must be certified by CYFD.

Refer to the program rule 8.321.2.13 NMAC

BMS – Behavior Management Skills Development Services

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Behavioral Health Agencies (enrolled by MAD as a BHA provider type 432) Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433) Core Service Agency (enrolled by MAD as a CSA provider type 446)	251S00000X 261QM0801X 261QR0800X	H2014 BMS Skills training & development per 15 min. A maximum of 24 15-minute units per day is allowed. A rendering provider is not required though it is prefer-ab le to identify a rendering provider. Include the rendering provider on the claim when the rendering provider is enrolled either as a Medicaid or Managed Care - only provider. See note 1, regarding identifying a rendering non-independent provider. See note 2, below, regarding identifying rendering providers	No prior authorization is required. Limited to recipients under the age of 21 who are at risk for out-of-home residential placement, or transitional support after residential placement. Not available for a recipient in a residential treatment facility (ARTC, RTC, group home) or inpatient facility. Supervision of BMS staff by an independent level practitioner is required. Bill using the CMS 1500 format.

3) CCSS – Comprehensive Community Support Service

Is a culturally sensitive service that coordinates and provides services and resources to a recipient and family necessary to promote recovery, rehabilitation and resiliency in order to promote independent living. It requires a minimum of 60% face to face and in vivo service that addresses barriers that impede the development of skills necessary for independent functioning in the community.

The following staff, i.e. community support workers, supervisory staff, and CSA clinical supervisory staff must possess the education, skills, abilities and experience to perform the activities comprising the full spectrum of CCSS. In addition, the clinical supervisor must be a licensed independent practitioner. Other staff includes certified peer support workers, and certified family specialists.

A provider must be certified for CCSS. CYFD certifies providers for CCSS for recipients under 21; DOH certifies providers for recipients over 21; and services for recipients 18-20 years may be certified by either CYFD or DOH.

CCSS can be billed only when the eligible recipient meets the criteria for the targeted population:

- A child at risk of/or experiencing Serious Emotional/Neurobiological/Behavioral disorders,
- An adult with Severe Mental Illness,
- Individuals with chronic drug abuse, or
- Individuals with a co-occurring disorder (mental illness/substance abuse) and/or dually diagnosed with a primary diagnosis of mental illness

A diagnosis of mental illness in and of itself would not qualify the individual for CCSS

Refer to the program rule 8.321.2.14 NMAC

CCSS – Comprehensive Community Support Service

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433)	261QM0801X	H2015 The procedure code must be appended with the modifier that identifies the level of practitioner:	No prior authorization is required. Limited CCSS services may be provided during discharge planning from an ARTC, RTC, group home, IP hospitalization or Treatment Foster Care I or II.
Core Service Agency (enrolled by MAD as a CSA provider type 446)	261QR0800X	Modifiers HO – Masters (or Higher) HN – Bachelors Level HM – Less than a Bachelors or peer specialist A rendering provider is required. Include the rendering provider on the claim when the rendering provider is enrolled either as a Medicaid or	May not be provided in conjunction with MST, ACT, ARTC, RTC, group home, inpatient facility, partial hospitalization, or treatment foster care. Bill using the CMS 1500 format. In addition to the CCSS codes, a CCSS provider is also allowed to bill for a comprehensive multi-disciplinary assessment for establishing the treatment plan under CCSS. The code is H0031 U8.

		Managed Care -only provider. If the rendering provider is not enrolled at the time of service, indicate the supervising provider and use a U7 modifier with the procedure code ..	

4) CRISIS INTERVENTION (OTHER THAN AS A PSR SERVICE)

Community-based crisis intervention services are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode and/or to prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to adults, adolescents, and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods. These services are characterized by the need for highly coordinated services across a range of service systems that are available on a 24 hour, 7 day a week basis. Services can be provided by a mobile team or by a crisis program in a facility or clinic. Crisis intervention services include: crisis prevention, primary assessment, secondary evaluation, acute crisis services and support services.

Refer to Service definition New Mexico Interagency Behavioral Health Collaborative at

http://www.bhc.state.nm.us/pdf/H2011%20Crisis.pdf H2011 Crisis (8.2.10)

CRISIS INTERVENTION SERVICE – Non-PSR

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Behavioral Health Agencies (enrolled by MAD as a BHA provider type 432) Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433) Core Service Agency with CMHC licensure	251S00000X 261QM0801X 261QR0800X	H2011 U1 Crisis intervention, 15 min telephone (4 unit maximum) Provision of 24/7 services to consumers, families, and the consumers' support systems that are in crisis. Qualified rendering provider must be Bachelor's level with 1 year experience w mental illness and/or substance related disorders, and 20 hours of crisis training. Supervision by a licensed independent BH professional, a BH CNS or CNP, or psychiatrist. ---------- H2011 U2 Face to face crisis activities, 15 min (4 unit maximum) Conducted in facility or in vivo. A crisis assessment must be conducted immediately during the work hours of the facility by trained crisis personnel. Qualified rendering must be Masters	No prior authorization is required. If a non-independent provider is allowed to render a service, but the rendering non-independent provider cannot currently be enrolled, the supervisor who is supervising the service must be indicated as the rendering provider, using a U7 modifier on the procedure. Cannot be billed in conjunction with ACT or MST, or for recipients in IP or residential settings. Bill on a CMS 1500 form.

(enrolled by MAD as a CSA provider type 446)		Level Licensed Mental Health Professional with 1 year experience w mental illness and/or substance related disorders w 20 hours crisis training. --- H2011 U3 Crisis intervention, 15 min mobile (4 unit maximum) A 2 member team meeting the above qualifications. A rendering provider is not required though it is preferable to identify a rendering provider. provider on the claim when the rendering provider is enrolled either as a Medicaid or Managed Care -only provider. If the rendering provider is not enrolled at the time of service, indicate the supervising provider and use a U7 modifier with the procedure code. See note 1, below, regarding identifying a rendering non-independent provider.	

5) DT – Day Treatment

Is a non-residential treatment program designed for children and adolescents who have emotional, behavioral, and neurobiological or substance abuse problems and may be at high risk for out-of-home placement. DT services include parent consumer education, and skill and socialization training that focus on the amelioration of functional and behavioral deficits. It must be provided in school or other community setting and is designed to complement and coordinate with the educational system. Intensive coordination and linkage with school or other child servicing agencies is included.. Counseling services (individual, group, and family), may be billed in addition to day treatment when provided by a qualified practitioner.

The need for DT is identified through an EPSDT tot-to-teen health check or other diagnostic evaluation. It must include the assessment and diagnosis of the social, emotional, physical and psychological needs of the recipient/family.

Day Treatment providers must be certified by CYFD.

Refer to the program rule 8.321.2.15 NMAC.

DT – Day Treatment

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Behavioral Health Agencies (enrolled by MAD as a BHA provider type 432) Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433) Core Service Agency (enrolled by MAD as a CSA provider type 446)	251S00000X 261QM0801X 261QR0800X	H2012 Behavioral Health Day Treatment per hour DT services are provided at a minimum of 4 hours of structured programming per day, 2 to 5 days per week based on acuity and clinical needs. The treatment plan must be reviewed/updated every 30 days. A rendering provider is not required though it is preferable to identify a rendering provider. Include the rendering provider on the claim when the rendering provider is enrolled either as a Medicaid or Managed Care -only provider. See note 2, below, regarding identifying rendering providers.	No prior authorization is required. Limited to recipients under the age of 21. Bill using the CMS 1500 forma Day Treatment cannot be billed in conjunction with ARC, RTC, group home, inpatient facility or Treatment Foster Care, or partial hospitalization.

6) IOP – Intensive Outpatient Program

IOP is the provision of time-limited, multi-faceted services for recipients who require structure and support to achieve and sustain recovery from alcohol and/or drugs.

The recipient may be one of the following:

1. For the adolescent program the recipient is 13 through 17 years of age and is diagnosed with a substance abuse disorder, or who has a substance abuse disorder with a co-occurring behavior health disorder, or who meets the American Society of Addiction Medicine (ASAM) patient placement criteria for level two (intensive outpatient treatment). A co-occurring mental health diagnosis shall not exclude a recipient from this service.

The program is based on an evidence based IOP MAD approved model, and targets specific behaviors with individualized behavioral interventions. Services should be linguistically and culturally-sensitive and incorporate recovery/resiliency values into all service interventions. IOP services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with mental health.

Providers must have a letter from HSD/MAD approving them as an IOP Medicaid provider. It will identify whether approved for an adult or adolescent program (or both). Approval is provisional for 180 days until a satisfactory on-site audit is conducted by BHSD or CYFD.

Refer to the program rule 8.321.2.17 NMAC

IOP – Intensive Outpatient Program Services

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Behavioral Health Agencies (enrolled by MAD as a BHA provider type 432) Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433) Core Service Agency (enrolled by MAD as a CSA provider type 446)	251S00000X 261QM0801X 261QR0800X	H0015 Alcohol and drug services – intensive outpatient A rendering provider is not required though it is preferable to identify a rendering provider. Include the rendering provider on the claim when the rendering provider is enrolled either as a Medicaid or Managed Care -only provider. If the rendering provider is not enrolled at the time of service, indicate the supervising provider and use a U7 modifier with the procedure code.. Services may be provided by the following non-independently licensed practitioners when	No prior authorization is required. IOP has two programs; one is for adolescents limited to recipients 13 through 17 years of age; and the other for adults 18 years and over. Bill using the CMS 1500 format.

		supervised by an independently licensed BH practitioner. The non-independents are: LMSW, LMHC, LADAC, LSAA, and Master's Level Psych Associate. T1007 U8 Treatment Plan Development may be billed for developing the initial treatment plan prior to the recipient entering IOP. See note 1, below, regarding identifying a rendering non-independent provider. .A psychiatric evaluation must be done prior to developing the treatment plan within the previous 12 months. That evaluation does not need to have been performed by the IOP facility. If the evaluation is done by an independent practitioner at the IOP facility, the IOP provider may bill 90791 or 90792 as appropriate prior to developing the treatment plan.	

7) **MAT – Medication Assisted Treatment for Opioid Addiction** provided in an Opioid Treatment Center as defined in 42 CFR.

Services include but are not limited to the administration or dispensing methadone or other narcotic replacement or agonist drug items. The administration and supervision must be delivered in conjunction with counseling, therapy, case review, and medication monitoring.

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

Refer to the program rule 8.321.2.18 NMAC

MAT – Medication Assisted Treatment for Opioid Addiction

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Methadone Clinic (enrolled by MAD as provider type 343) Methadone Clinics must have: a) DEA certification to operate an Opioid treatment program (OTP); b) Substance abuse and mental health services administration (SAMHSA) approval to operate an OTP; c) The Joint Commission (TJC) formerly JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation; and d) HSD Behavioral Health Services Division approval letter as a methadone provider.	261QM2800X	H0001 – Initial medical exam; done by a methadone clinic program physician. A rendering provider is required. H0020 – Administration & dispensing of narcotic replacement drug A rendering provider is not required. If other than methadone is used, the code for the drug may be billed additionally using the appropriate CPT or HCPC code.	No prior authorization required. Eligible recipients must have been addicted for over 12 months or have a waiver. The agency must maintain documentation supporting the medical necessity of MAT services in the recipient's medical record. Bill using the CMS1500 format. Services not considered included within the administration and dispensing code may be billed additionally when the rendering provider and the service meet all program requirements for coverage.

8) MST – Multi-systemic Therapy

MST is provided to a MAP eligible recipient 10 through 17 years of age who has a diagnosis that meets the criteria for a Severe Emotional Disturbance (SED); 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 his or her treatment. A co-occurring diagnosis of substance abuse shall not exclude a recipient from the program.

The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. It is delivered through a team approach, and must include: 1) an initial assessment to ID the focus of interventions; 2) therapeutic interventions with recipient and family; 3) case management; and 4) crisis stabilization.

Services can be delivered in homes, schools, homeless shelters, or street locations. There is 24 hour, seven day coverage by staff with a typical duration of 3 to 6 months with 13 to 20 hours per week.

Clinical supervision must be provided by an independently licensed master's level BH practitioner who is MST trained. The MST team must include 1) the above supervisor, 2) a licensed masters level BH staff able to provide 24/7 coverage; 3) a licensed master's level BH practitioner required to perform all therapeutic interventions; and 4) a bachelors level BH practitioner with degrees in social work, counseling, psychology or related field that is limited to performing functions defined within his/her scope of practice. (The bachelor's level category can comprise no more than 1/3 of all staffing).

MST providers must be licensed by MST, Inc. Documentation must be provided to MAD and the specialty 131 MST must be assigned by MAD.

Refer to the program rule 8.321.2.19 NMAC. Refer to MST service definitions and other requirements at http://www.bhc.state.nm.us/BHServices/ServiceDefinition.html

MST – Multi-systemic Therapy

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Behavioral Health Agencies (enrolled by MAD as a BHA provider type 432)	251S00000X	H2033 - Multi-systemic therapy for juveniles per 15 minutes.	No prior authorization is required.
Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433)	261QM0801X	The procedure code must be appended with the modifier that identifies the level of practitioner: HO - Masters (or higher) Level	Limited to recipients 10 through 17 years of age. Bill using the CMS 1500 format.
Core Service Agency (enrolled by MAD as a CSA provider type 446)	261QR0800X	HN – Bachelors Level A rendering provider is required. If a non-independent provider is allowed to render a service, but the rendering non-independent	

		provider cannot currently be enrolled, the supervisor who is supervising the service must be indicated as the rendering provider, using a U7 modifier on the procedure. See note 1, below, regarding identifying a rendering non-independent provider.	

9) PSR - Psychosocial Rehabilitation Program

PSR services are for adults 21 years and older who are not a resident in an institution for mental illness who have a diagnosis that meets the criteria for Serious Mental Illness (SMI). Ages 18 through 20 may also receive if they met the SED criteria prior to age 18. PSR is limited to goal oriented services designed to accommodate the level of the recipient's functioning and reduce the disability restoring his/her best possible level of functioning.

PSR is intended to be a transitional level of care based on the individual's recovery and resiliency goals. Services are designed to help an individual to capitalize on personal strengths, to develop coping strategies and skills to deal with deficits, and to develop a supportive environment in which to function as independently as possible.

Included in PSR services are: (1) Crisis Services; (2) Psychosocial Intervention – Group or Integrated Classroom; (3) Therapeutic intervention; (4) Assessment and Initial Treatment Plan, (5) Specialized Consultation; (6) Periodic Treatment Plan Reviews; and (7) Medication Management/Monitoring.

(1) CRISIS SERVICES: Include, at a minimum, twenty-four (24) hour telephone crisis services, initial face-to-face crisis intervention and follow-up crisis support services designed to ameliorate or minimize precipitating stress. Services are provided to adults and their families or support systems who have suffered a breakdown of their normal strategies or resources and, who exhibit acute problems of disturbed thoughts, behaviors, or moods. The services provide rapid response to crisis situations which threaten the safety of the individual and others.

H2011 Crisis Intervention per 15 min, (maximum of 4 units) with one of the following modifiers: U1, telephone, U2, face to face, U3, mobile crisis.

(2) **PSR PSYCHOSOCIAL REHAB SERVICES Group or Classroom (formerly known as PSR Intervention):** Includes an array of services designed to help an individual capitalize on his personal strengths, develop coping strategies and to develop a supportive environment in which to function as independently as possible. This array must include, at a minimum: Basic Living Skills, Psychosocial Skills Training and Therapeutic Socialization.

H2017 HQ Psychosocial Rehab services per 15 min. The HQ indicates group or classroom.

(3) **PSR PSYCHOTHERAPY - INDIVIDUAL AND GROUP) (previously known as "PSR Therapeutic Intervention):** Includes interactive therapies which, when used in

conjunction with the other treatment strategies, assist persons to achieve optimum functioning in the personal and social dimensions of their lives. Therapeutic Interventions are most appropriately used to address individual emotional or cognitive problems which may be causative or exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental illness and psychosocial dysfunction.

IMPORTANT NOTE: For the codes listed below, a U8 modifier has not been previously required. However, the U8 will be used here in order to distinguish between these services when used for PSR, and when they are not under the PSR program. MCOs are being asked to make the same change for their systems.

Psychotherapy codes:
90832 U8, (30 min)
90834 U8, (45 min)
90837 U8, (60 min)
90853 U8, group psychotherapy
Use 90785 U8 as an add on code to the primary service when appropriate
(complex interactive encounter)

The above psychotherapy codes can only be billed when the following requirements are met:

- The rendering provider is a 301 (Psychiatrist), 431 (Psychologist), 316 (CNP with Psych Specialty), 443 (Psych CNS), 435 (LPCC), 436 (LMFT), or 444 (LISW).

- The supervising provider is a 301 (Psychiatrist), 431 (Psychologist), 316 (CNP with Psych Specialty), 443 (Psych CNS), 435 (LPCC), 436 (LMFT), or 444 (LISW) and the rendering provider being supervised is a Psych Assoc., LADAC, or Masters Counselors including LMHC.

  See note 1, below, regarding identifying a rendering non-independent provider.

Use code 90863 U8 for pharmacologic management when performed with individual psychotherapy services.

Use these add-on codes for psychotherapy services added to an Evaluation and Management Service:
90833 U8 (30 min)
90836 U8 (45 min)
90838 U8 (60 min)

90863 U8 and the above 3 codes are for use only by the following practitioners:

- Psychiatrist
- Psychologist w prescriptive authority
- Clinical Nurse Practitioner or Psychiatric Clinical Nurse Specialist

(4) **ASSESSMENT & INITIAL TREATMENT PLAN:** Use only for a recipient whose diagnosis indicates the recipient meets the criteria for Serious Mental Illness (SMI).

The service includes the initial assessment of the recipient's needs and resources, the development of the master treatment plan and its ongoing monitoring; and the accessing of specialized expertise to provide tests, interpretations of reports, or other required skills and abilities to enhance the decisions related to the care and treatment of the recipient. The intent of these services is to gather all relevant care-givers so that they can coordinate the care to be provided and assure that the recipient's care is individualized

and comprehensive. The code also includes the development of the initial treatment plan which is not paid separately.

The code is H0031 U8

(5) **TREATMENT PLAN PERIODIC UPDATES.** Use only for a recipient whose diagnosis meets the criteria for SMI and for whom the initial assessment above has been completed and the outcome of the assessment recommended PSR. Includes a systematic review and update of the treatment plan including all care givers, specialized expertise that is not generally part of the care giving team, and an active role of the recipient, the family and recipient's support system. These reviews assure that the specialized expertise of relevant care-givers and professionals provide the needed input for continued and effective treatment strategies. There must be an annual update of the treatment plan that corresponds to the annual assessment, though other updates are done whenever recipient status dictates.
T1007 modifier U8

(6) **SPECIALIZED CONSULTATION:** After the Assessment and Master Treatment Plan have been completed, it is recognized that there may be a need for specialized consultation during the course of an individual's treatment. Whenever those situations occur, a psychological evaluation is allowed.

IMPORTANT NOTE: For the codes listed below, a U8 modifier has not been previously required. However, they are used here in order to distinguish between these services when used for PSR, and when it is not under the PSR program. MCOs are being asked to make the same change for their systems

90791 U8, Psychiatric Diagnostic Evaluation
For use only by the following practitioners:
Psychiatrist
Psychologist
Clinical Nurse Practitioner or Psychiatric Clinical Nurse Specialist
LPCC, LISW, or LMFT

90792 U8, Psychiatric Diagnostic Evaluation with Medical Services
For use only by the following practitioners:
Psychiatrist
Psychologist w prescriptive authority
Clinical Nurse Practitioner or Psychiatric Clinical Nurse Specialist

IMPORTANT NOTE: The above codes replace the previous use of 90899, unlisted psychiatric service or procedure to bill for specialized consultation.

(7) PSR PHARMACOLOGICAL MANAGEMENT (previously known as PSR Medication Monitoring): Medication Services are goal-directed interventions which include, but are not limited to, the evaluation of the need for psychoactive medications and the subsequent assessment and management of pharmacologic treatment. Services which will improve the ability of the physician, nurse, and/or recipient and his/her support system to properly monitor and administer his/her medications are also included.

IMPORTANT NOTE: For the code listed below, a U8 modifier has not been previously required. However, it is used here in order to distinguish between this service when used for PSR vs when it is not under the PSR program, MCOs are being asked to make the same change for their systems

H2010 U8 per 15 min – Medication monitoring

H2010 U8 is for use only by the following practitioners:
Psychiatrist
Psychologist w prescriptive authority
Clinical Nurse Practitioner or Psychiatric Clinical Nurse Specialist

Reviews are performed retrospectively to determine whether services provided met the service guidelines based upon the assessment, diagnostic summary formulation and the treatment plan.

Refer to the Program rule 8.321.2.22 NMAC

See chart, below:

PSR - Psychosocial Rehabilitation Services

PROVIDERS	TAXONOMY	HCPCS PROCEDURE CODES & MODIFIERS	NOTES
Community Mental Health Center (licensed by DOH as a CMHC and enrolled by MAD as provider type 433) Core Service Agency with CMHC licensure (enrolled by MAD as a CSA provider type 446) The provider specialty for all provider types is 080	261QM0801X 261QR0800X	See above for codes The rendering provider is **only** required on the claim for the following components of PSR: • Therapeutic Intervention • Specialized Consultation • Pharmacological Management For all other PSR components a rendering provider is not required though it is preferable to identify a rendering provider. Include the rendering provider on the claim when the rendering provider is enrolled either as a Medicaid or Managed Care -only provider. If the rendering provider is not enrolled at the time of service, indicate the supervising provider and use a U7 modifier with the procedure code..	No prior authorization is required. Bill on a CMS 1500 form

10) PARTIAL HOSPITALIZATION SERVICES

As a clarification, partial hospitalization is covered as a behavioral health service under two different program provisions.

- In the fee for service program, Partial Hospitalization is covered as an EPSDT service for children (under age 21) in either an acute care hospital or a free standing psych facility hospital. A recipient 21 years and older can also be covered by either of these providers as an outpatient hospital service (rather than as an EPSDT service.)

  There is a federal exclusion that the Medicaid Fee for Service program cannot pay for an inpatient stay for a recipient 21 years of age or older in a free standing psych facility, but partial hospitalization when billed as an outpatient service is not subject to that restriction.

  Typically, a psych unit in an acute care hospital is for inpatient services only. Outpatient psychiatric services are typically billed under the acute care hospital's outpatient hospital service, and the separate NPI for an inpatient psych unit is not used. Payment is made to the acute care hospital. This is true for partial hospital also.

  The revenue code of partial hospitalization is 0912, and the type of bill is outpatient hospital 131. If the patient is actually admitted to the hospital either by spending 24 hours there as a patient or by being admitted, then the service should not be billed as partial hospitalization.

  Partial hospitalization may be paid to an acute care hospital or a free standing psych hospital.

For managed care, there is no federal exclusion covering recipients age 21 years and older in a free-standing psych for adults so free standing psych hospitalization is covered as a psych services for adults under managed care, as is partial hospitalization and outpatient services.

11) SERVICES COVERED ONLY BY MANAGED CARE ORGANIZATIONS AND NOT FEE FOR SERVICE

Because of the way the federal approval was given for the Centennial Care Program for managed care, there are several services that are not covered in the fee for service program but are covered in managed care.

HCPCS PROCEDURE CODES & MODIFIERS	PROVIDERS	TAXONOMY	NOTES
S5110 – Family Support Services per 15 minutes. Community based, face-to-face interaction with youth or adults and their family focused on the development of interactions that enhance strengths, capacities, and resources to reach the recovery and resiliency BH goals they consider most important.	Core Service Agency (enrolled by MAD as a CSA provider type 446)	261QR0800X	Can only be provided by a CSA Bill on a CMS 1500 form

H2030 – Recovery Services per 15 minutes Peer-to-peer support within a group setting to develop and optimize the strengths and skills included in an individual's service plan or recovery goals. A focus on wellness, relapse prevention, and chronic disease management.	Core Service Agency (enrolled by MAD as a CSA provider type 446)	61QR0800X	Can only be provided by a CSA. Bill on a CMS 1500 form
T1005 – BH Respite Care Services per 15 minutes Respite for the family of a youth with SED when living with the family. Provides the supervision and care of youth in a variety of settings providing an interval of rest and relief to the primary care givers.	Treatment Foster Care Provider (enrolled by MAD as a TFC provider type 218)	253J00000X	Can only be provided by Treatment Foster Care providers or home. Bill on a CMS 1500 form.

NOTES:

Note 1: Identifying a rendering non-independent provider on a claim.

If a non-independent provider is allowed to render a service under supervision, but the rendering non-independent cannot currently be enrolled through the Medical Assistance Division, the independently licensed behavioral health practitioner who is supervising the service must be indicated as the rendering provider, using a U7 modifier on the procedure, to note the supervision.

The U7 modifier cannot be used in this way on a claim if:

- the non-independent provider is not qualified to provide the service.
- the service is outside the scope of practice of the non-independent provider.
- the service is outside the scope of practice of the supervising independent BH provider.
- any of the standards for clinical supervision are not met.

Note that a managed care organization, working with BHSD, is able to allow more flexibility regarding supervision of services than the Fee-for-Service (FFS) program rules may allow. However, the provider is responsible for being able to document that proper authorization for flexibility in supervision has been obtained from the MCO.

Note 2: Enrolling providers through the Medical Assistance Division

Historically, MAD has not enrolled most non-independent BH providers in the Medicaid system. However, MAD is changing their processes to allow non-independent BH providers to enroll using the MAD/Xerox portal. Providers will be notified when this enrollment can begin, and the date by which all non-independent providers must be enrolled through MAD. Even when enrolling through MAD, a provider may elect to only participate in managed care.

It will be necessary for non-independent providers to complete their enrollment through MAD in order to participate even in just managed care, because the process will register the providers NPI number in the Medicaid system so that the practitioner rendering the service can be identified.

The Centers for Medicare and Medicaid Services (CMS) are now requiring virtually all levels of practitioners rendering services to Medicaid recipients to be identifiable on claims.

More information will soon be forthcoming on how non-independent BH providers can enroll as a provider through MAD for Medicaid FFS and/or to contract with any of the MCOs.

Independent providers should already be enrolled through MAD. If not, go to the following website:

https://nmmedicaid.acs-inc.com/webportal/enrollOnline