




State of New Mexico
Medical Assistance Program Manual
Supplement



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TO: BEHAVIORAL HEALTH PROVIDERS and MANAGED CARE ORGANIZATIONS

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SUBJECT: MEDICAID BEHAVIORAL HEALTH UPDATES

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EFFECTIVE DATE: JANUARY 1, 2019

This supplement to existing rule offers guidance, policy updates, and explanation of new services that augment current 8.321.2 NMAC. It also addresses 8.308 NMAC, Managed Care; section 9, benefit package; subsection 19 Behavioral Health Services by identifying and clarifying outdated definitions and referencing this Supplement. It is being issued in advance of the rule promulgation of 8.321.2 NMAC so that new behavioral health services are available on January 1, 2019. There will be an opportunity to submit public comment during the rule promulgation process, which is anticipated to follow in the next several weeks.

I. Eligible Behavioral Health Agencies and Practitioners

- A. Effective January 1, 2019, the following independent providers with active licenses (not provisional or temporary) are eligible to be reimbursed directly for providing Medicaid behavioral health professional services unless otherwise restricted or limited by NMAC rules:
- (1) a physician licensed by the Board of Medical Examiners or Board of Osteopathy who is board eligible or board certified in psychiatry or primary care, to include the groups they form;
 - (2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as a clinical psychologist by the New Mexico Regulation and Licensing Department's (RLD's) Board of Psychologist Examiners, to include the groups they form;
 - (3) a licensed independent social worker (LISW) or a licensed clinical social worker (LCSW) licensed by RLD's Board of Social Work Examiners, to include the groups they form;
 - (4) a licensed professional clinical counselor (LPCC) licensed by RLD's Counseling and Therapy Practice Board, to include the groups they form;
 - (5) a licensed marriage and family therapist (LMFT) licensed by RLD's Counseling and Therapy Practice Board, to include the groups they form;
 - (6) a licensed alcohol and drug abuse counselor (LADAC) licensed by RLD's Counseling and Therapy Practice Board or a certified alcohol and drug abuse counselor (CADC) certified by the New Mexico Credentialing Board for Behavioral Health Professionals (CBBHP). Independent practice is for alcohol and drug abuse diagnoses only. The LADAC or CADC may provide therapeutic services that may include treatment of clients with co-occurring disorders or dual diagnoses in an integrated behavioral health setting in which an interdisciplinary team has developed an interdisciplinary treatment plan that is co-authorized by an independently licensed counselor or therapist. The treatment of a mental health disorder must be supervised by an independently licensed counselor or therapist; or
 - (7) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by the New Mexico Board of Nursing and certified in psychiatric nursing or family practice 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.
 - (8) an out-of-state provider rendering a service from out-of-state must meet his or her state's licensing and certification requirements which are acceptable when deemed by the Medical Assistance Division (MAD) to be substantially equivalent to the license and certification requirements of New Mexico.

- B. The following agencies are eligible to be reimbursed for providing behavioral health professional services when all conditions for providing services are met:
- (1) a community mental health center (CMHC);
 - (2) a federally qualified health center (FQHC);
 - (3) an Indian health service (IHS) hospital, clinic or FQHC;
 - (4) a PL 93-638 tribally operated hospital, clinic or FQHC;
 - (5) a children, youth and families department (CYFD) facility;
 - (6) a hospital and its outpatient facility;
 - (7) a core service agency (CSA);
 - (8) a CareLink NM health home (CLNM HH);
 - (9) a crisis triage center licensed by the department of health (DOH);
 - (10) a behavioral health agency (BHA);
 - (11) an opioid treatment program in a methadone clinic;
 - (12) a political subdivision of the state of New Mexico enrolled with Medicaid as a behavioral health agency, FQHC, CMHC or CSA;
 - (13) a crisis services community provider enrolled as a BHA, FQHC, CMHC, or CSA.
- C. A behavioral health service rendered by a licensed practitioner listed in subsection C (2) whose scope of licensure does not allow him or her to practice independently or a non-licensed practitioner listed in subsection C (3) is covered to the same extent as if rendered by a practitioner licensed for independent practice, when the supervisory requirements are met consistent with the practitioner's licensing board within his or her scope of practice and the service is provided through and billed by one of the provider's agencies listed in numbers one through nine of Subsection B and numbers 10 through 13 of Subsection B when the agency has a BHSD supervisory certificate. All services must be delivered according to the Medicaid regulation and current version of the Behavioral Health Policy and Billing Manual. If the service is an evaluation, assessment, or therapy service rendered by the practitioner and supervised by an independently licensed practitioner, the independently licensed practitioner's practice board must specifically allow him or her to supervise the non-independent practitioner.
- (1) Specialized behavioral health services, other than evaluation, assessment, or therapy services, may have specific rendering practitioner requirements which are detailed in each behavioral health services section.
 - (2) The non-independently licensed rendering practitioner with an active license which is not provisional or temporary must be one of the following:
 - (a) a licensed Master of Social Work (LMSW) licensed by RLD's Board of Social Work examiners;
 - (b) a licensed mental health counselor (LMHC) licensed by RLD's Counseling and Therapy Practice Board;
 - (c) a licensed professional mental health counselor (LPC)
 - (d) a licensed associate marriage and family therapist (LAMFT)
 - (e) a psychologist associate licensed by the RLD's Psychologist Examiners Board;
 - (f) A licensed substance abuse associate (LSAA) licensed by RLD's Counseling and Therapy Practice Board;
 - (g) a registered nurse (RN) licensed by the New Mexico Board of Nursing if a certified nurse practitioner or clinical nurse specialist or physician is supervising; or
 - (h) a licensed physician assistant certified by the state of New Mexico if supervised by a behavioral health physician or DO.

- (3) Non-licensed practitioners must be one of the following:
 - (a) a master's level behavioral health intern;
 - (b) a psychology intern;
 - (c) a pre-licensure psychology post doctorate student;
 - (d) a certified peer support worker;
 - (e) a certified family peer support worker; or
 - (f) a provisional or temporarily licensed masters level behavioral health professional.
 - (4) An independently licensed professional art therapist (LPAT) licensed by RLD's Licensing and Therapy Practice Board is not paid directly, but through an agency listed under Subsection B, a supervisory certificate is not required.
 - (5) Other licensed practitioners such as occupational therapists, pharmacists, dietitians, nutritionists, or traditional practitioners may be providers within the agencies.
 - (6) The rendering practitioner must be enrolled as a MAD provider.
- D. An eligible recipient under 21 years of age may be identified through a tot to teen health check, self-referral, referral from an agency (such as a public school, child care provider or other practitioner) when he or she is experiencing behavioral health concerns.
- E. For recipients meeting the NM state definition of serious mental illness (SMI) for adults or severe emotional disturbances (SED) for recipients under 18 years of age or a substance use disorder (SUD) for any age, a comprehensive assessment or diagnostic evaluation and service plan must be completed. (See the BH Policy and Billing Manual for specific instructions.)
- (1) Comprehensive assessment and service plan can only be billed by the agencies listed in Subsection B.
 - (2) Behavioral health service plans can be developed by individuals employed by the agency who have HIPAA training and are working under the supervision of the rendering provider who must be a NM independently licensed clinician.
 - (3) A comprehensive assessment and service plan cannot be billed if care coordination is being billed through bundled service packages such as case rates, value-based purchasing agreements, high fidelity wraparound or CareLink NM (CLNM) health homes.

II. INTERDISCIPLINARY TEAMING

- A. For outpatient, non-residential recipients, where multiple provider disciplines are required and engaged for co-occurring conditions an update to the service plan may be made using interdisciplinary teaming. MAD covers service plan updates through the participation of interdisciplinary teams.
- (1) Coverage of interdisciplinary teaming for recipients meeting the NM state definition of serious mental illness (SMI) for adults or severe emotional disturbance (SED) for recipients under 18 years of age or a moderate to severe substance use disorder (SUD) for any age:
 - (a) Purpose and frequency of team meetings:
 - (i) provides the central learning, decision-making, and service integrating elements that weave practice functions together into a coherent effort for helping a recipient meet needs and achieve life goals;

- (ii) covered team meetings resulting in service plan changes or updates are limited to an annual review, or when recipient conditions change, or at critical decision points in the recipient's progress to recovery.
- (b) The team consists of:
 - (i) a lead agency, which must be one of the agencies listed in numeral I, Subsection B. This agency has a designated and qualified team lead who prepares team members, convenes and organizes meetings, facilitates the team decision-making process, and follows up on commitments made;
 - (ii) a participating provider is a MAD enrolled provider that is either already treating the recipient or is new to the case and has the expertise pertinent to the needs of the individual. This provider may practice within the same agency but in a differing discipline, or outside of the lead agency;
 - (iii) other participating providers not enrolled with MAD, other subject matter experts, and relevant family and natural supports may be part of the team, but are not reimbursed through MAD; and
 - (iv) the recipient, who is the subject of this service plan update, must be a participating member of every team meeting.
- (c) Reimbursement:
 - (i) only the team lead, and two other MAD enrolled participating providers or agencies may bill for the interdisciplinary team update. When more than three MAD enrolled providers are engaged within the session, the team decides who will bill based on the level of effort or change within their own discipline.
 - (ii) when the team lead and only one other provider meets to update the service plan, the definition of teaming is not met, and the service plan update may not be billed using the interdisciplinary teaming codes.
 - (iii) the six elements of teaming may be performed by using a variety of media (with the person's knowledge and consent) e.g., texting members to update them on an emergent event; using email communications to ask or answer questions; sharing assessments, plans and reports; conducting conference calls via telephone; using skype conferences; and, conducting face-to-face meetings with the person present when key decisions are made. Only the last element, that is, conducting the final face-to-face meeting with the recipient present when key decisions that result in the updates to the service plan, is a billable event.
 - (iv) when the service plan updates to the original plan, that was developed within the comprehensive assessment, are developed using the interdisciplinary teaming model described in the BH Policy and Billing Manual, service codes specific for interdisciplinary teaming may be billed. If the teaming model is not used, only the standard codes for updating the service plan can be billed. An update to the service plan using a teaming method approach and an update to the service plan not using the teaming method approach, cannot both be billed.

- (v) billing instructions are found in the BH Policy and Billing Manual.
- (2) For recipients with non-SMI/SED conditions with behavioral health diagnoses and other co-occurring conditions, and for whom multiple provider disciplines are engaged, MAD covers service plan development and one subsequent update per year for an interdisciplinary team.
- (a) The team consists of:
 - (i) a lead MAD enrolled provider that has primary responsibility for coordinating the interdisciplinary team, convenes and organizes meetings, facilitates the team decision-making process, and follows up on commitments made;
 - (ii) a participating MAD enrolled provider from a different discipline;
 - (iii) other participating providers not enrolled with MAD, other subject matter experts, and relevant family and natural supports may be part of the team, but are not reimbursed through MAD; and
 - (iv) the recipient, who is the subject of this service plan development and update, must be a participating member of each team meeting.
 - (b) Reimbursement:
 - (i) only the team lead and one other MAD enrolled participating provider may bill for a single session. When more than two MAD enrolled providers are engaged with the session, the team decides who will bill based on the level of effort or change within their own discipline;
 - (ii) this service plan development and subsequent update to the original plan can only be billed twice within one year.

B. Billing Instructions

There are two types and directions for billing which are only covered for outpatient services and must include the patient: 1) for serious emotional disturbance (SED), severe mental illness SMI, substance use disorder (SUD) and co-occurring conditions; and 2) all other BH diagnoses with other co-occurring diagnoses.

- (1) For recipients with SMI, SED, and SUD conditions and any other co-occurring diagnoses requiring multiple provider disciplines to be working together, conferences are billable when a critical juncture or change in status requires the treatment plan to be changed:
 - (a) The lead agency
 - (i) may only be one of the 11 listed here: CMHC, FQHC, IHS, Tribal 638, CYFD, hospital OP, CSA, CTC, BHA, OTP, or a governmental agency;
 - (ii) bill **G0175, U1** for conference of 30-89 minutes (less than 30 minutes is not billable);
 - (iii) bill **G0175, U1, 2 units** for conference 90 minutes or more
 - (b) The participating agency
 - (i) any agency or provider type
 - (ii) one practitioner attending for 30-89 minutes: **G0175, U2**
 - (iii) multiple practitioners from same agency attending for 30-89 minutes: **G0175, U3**

- (iv) one practitioner for 90 minutes or more: **G0175, U2, 2 units**
- (v) multiple practitioners from same agency for 90 minutes or more: **G0175, U3, 2 units**
- (c) Only three agencies may bill for a single session; if more than three attend the group decides, based on level of change for their discipline, which will bill.
- (2) For recipients with any BH diagnosis requiring multiple provider disciplines to be working together.
 - (a) The lead agency
 - (i) any provider type;
 - (ii) for a 30-minute conference, bill **S0220, U1**
 - (iii) for a conference of 60 minutes or more, bill **S0221, U1**
 - (b) The participating agency
 - (i) any provider type;
 - (ii) for a 30-minute conference, bill **S0220, U2**
 - (iii) for a 60 minute or greater conference bill **S0221, U2**
 - (c) Only two agencies or providers may bill for the same session.

III. TREAT FIRST CLINICAL MODEL

- A. Currently, no-show rates at many sites are between 40-60% and are usually because the client's need (i.e., their reason for requesting services) was not addressed at the first visit. The Treat First Approach emphasizes the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a quick response for any urgent matters when a new person presents with a problem and requests help from the agency. See the BH Policy and Billing Manual for a detailed description of this clinical model.

The use of the Treat First Clinical Model may be billed with a provisional diagnosis for up to four encounters. After four encounters, if continuing treatment is required, a diagnostic evaluation must be performed, and subsequent reimbursement is based on the diagnosis and resulting service and treatment plan.

One exception to the four encounter limit is for individuals at an ASAM 0.5 clinical level requiring only group participation. In these cases, a provisional diagnosis may be utilized until other clinical treatment is requested. This level of care often builds awareness of other needs.

- B. Billing Instructions
 - (1) OP therapy and all special services can be initiated and billed before a diagnostic evaluation has been completed. This may not be completed until the fourth therapy session.
 - (2) All claims will contain a provisional diagnosis. This shall include all appropriate ICD 10 classified external causes of morbidity (V, X, and Y diagnosis codes), factors influencing health status (Z diagnosis codes), and signs/symptoms and abnormal lab values (R diagnosis codes).
 - (3) All claims will bill with the appropriate CPT or HCPCS code until the final diagnosis has been established.
 - (4) CCSS can be billed upon an initial intake, if needed, and before a SMI/SED diagnosis has been determined. A provisional diagnosis, which may not be a SMI or SED diagnosis, will be utilized for billing purposes.

- (5) If a crisis intervention is required, H2011 will be billed and considered outside of the four visits.
- (6) A FQHC, IHS or Tribal 638 facility may bill more than one encounter or OMB rate on the same day for completely different services such as a behavioral health visit.
- (7) Providers should no longer use the HE modifier, which was previously required.

IV. ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) FOR ADULTS WITH SUBSTANCE USE DISORDERS: To help an eligible recipient 21 years of age and older, who has been diagnosed as having a substance use disorder (SUD), and the need for ARTC has been identified in the eligible recipient's diagnostic evaluation as meeting criteria of the American Society of Addiction Medicine (ASAM) level of care three for whom a less restrictive setting is not appropriate, MAD pays for services furnished to him or her by an ARTC accredited by the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council On Accreditation (COA). The effective date will be January 1, 2019, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS). ASAM criteria can be accessed in the BH Policy and Billing Manual, or The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions by the American Society of Addiction Medicine, Third Edition, 2013.

A. Eligible facilities:

- (1) To be eligible to be reimbursed for providing ARTC services to an eligible recipient, an ARTC facility:
 - (a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;
 - (b) must be enrolled as a MAD provider;
 - (c) must have written policies and procedures specifying ASAM level of care three criteria as the basis for accepting eligible recipients into the sub-level treatment program;
 - (d) must meet ASAM treatment service requirements for the ASAM level of care three recipients it admits into each sub-level of care;
 - (e) must provide medication assisted treatment (MAT) for SUD, as indicated; and
 - (f) all practitioners must be trained in ASAM principles and levels of care.
- (2) An out-of-state or MAD border ARTC must have JC, CARF or COA accreditation, use ASAM level three criteria for accepting recipients, and be licensed in its own state as an ARTC residential treatment facility.

B. Coverage criteria:

- (1) Referrals from an independent practitioner are required.
- (2) Treatment must be provided under the direction of an independently licensed clinician/practitioner as defined by ASAM criteria level three for the sub-level of treatment being rendered.
- (3) Treatment shall be based on the eligible recipient's individualized treatment plans rendered by the ARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation.
- (4) The following services shall be performed by the ARTC agency to receive reimbursement from MAD:
 - (a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

- (b) provision of regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to ASAM guidelines for level three, residential care, and the specific sub-level of care for which that client meets admission criteria;
 - (c) facilitation of age-appropriate life skills development;
 - (d) assistance to the eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;
 - (e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and
 - (f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable.
- (5) Admission and treatment criteria based on the sub-levels of ASAM level three criteria must be met. The differing sub-levels of ASAM three are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals. The defining characteristic of level three ASAM criteria is that they serve recipients who need safe and stable living environments to develop their recovery skills. They are transferred to lower levels of care when they have established sufficient skills to safely continue treatment without the immediate risk of relapse, continued use, or other continued problems, and are no longer in imminent danger of harm to themselves or others.
- (6) Levels of care without withdrawal management:
- (a) clinically managed low-intensity residential services as specified in ASAM level of care 3.1 are covered for recipients whose condition meets the criteria for ASAM 3.1:
 - (i) is often a step down from a higher level of care and prepares the recipient for transition to the community and outpatient services;
 - (ii) requires a minimum of five hours per week of recovery skills development.
 - (b) clinically managed population-specific high-intensity residential services as specified in ASAM levels of care 3.3 and 3.5 are covered for recipients whose condition meets the criteria of ASAM level 3.3 or 3.5:
 - (i) level 3.3 meets the needs of recipients with cognitive difficulties needing more specialized individualized services. The cognitive impairments can be due to aging, traumatic brain injury, acute but lasting injury, or illness. These recipients need a slower pace and lower intensity of services.
 - (ii) level 3.5 offers a higher intensity of service not requiring medical monitoring.
 - (c) medically monitored intensive inpatient services as specified in ASAM level of care 3.7 are covered for recipients whose condition meets the criteria for ASAM level 3.7:
 - (i) 3.7 level is an organized service delivered by medical and nursing professionals which provides 24-hour evaluation and monitoring services under the direction of a physician or clinical nurse practitioner who is available by phone 24-hours a day.
 - (ii) nursing staff is on-site 24-hours a day.

- (iii) other interdisciplinary staff of trained clinicians may include counselors, social workers, and psychologists available to assess and treat the recipient and to obtain and interpret information regarding recipient needs.
- (7) Withdrawal management (WM) levels of care:
- (a) clinically managed residential withdrawal management services as specified in ASAM level of care 3.2WM for recipients whose condition meets the criteria for ASAM 3.2WM:
 - (i) managed by behavioral health professionals, with protocols in place should a patient's condition deteriorate and appear to need medical or nursing interventions;
 - (ii) ability to arrange for appropriate laboratory and toxicology tests;
 - (iii) a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment;
 - (iv) the recipient remains in a level 3.2 withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated; and
 - (v) 3.2WM typically lasts for no more than 30 days.
 - (b) medically monitored residential withdrawal management services as specified in ASAM level of care 3.7WM for recipients whose condition meets the criteria for ASAM 3.7WM:
 - (i) services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician;
 - (ii) monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions;
 - (iii) ability to arrange for appropriate laboratory and toxicology tests;
 - (iv) a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment; and
 - (v) the recipient remains in a level 3.7 withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated.
 - (vi) 3.7WM typically last for no more than seven days.

- C. Non-covered services: MAD does not cover the following specific services billed in conjunction with ARTC services to an eligible recipient:
- (1) comprehensive community support services (CCSS), except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;
 - (2) services for which prior approval was not requested and approved;
 - (3) services furnished to ineligible individuals;
 - (4) formal educational and vocational services which relate to traditional academic subjects or vocational training;
 - (5) activity therapy, group activities, and other services primarily recreational or diversional in nature; and
 - (6) Room and board.
- D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient and in accordance with ASAM and accreditation standards. The interdisciplinary team must review the treatment plan at least every 15 days.
- E. Prior authorization: Prior authorization is not required for up to five days for eligible recipients meeting ASAM level three criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five-day period, the provider must furnish notification of the admission and if the provider believes that continued care beyond the initial five days is medically necessary, prior authorization must be obtained from MAD or its designee. For out-of-state ARTCs prior authorization is required prior to admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Follow up auditing is done by the accrediting agency per their standards.
- F. Reimbursement: An ARTC agency must submit claims for reimbursement on the UB-04 form or its successor. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.
- (1) MAD reimbursement covers 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.
 - (2) Services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services. These services are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.
 - (3) MAD does not cover room and board.
- G. Billing Instructions
- (1) ASAM levels 3.7 and 3.7WM placement criteria for medically monitored short term residential addiction program - typically 3-7 days
 - (a) UB: revenue code 1003
 - (b) HCPCS: H0011
 - (2) Clinically monitored, medium to high intensity level of care for sub-acute detoxification and/or residential addiction program. ASAM 3.2WM, 3.2, 3.3, 3.5 placement criteria - typically, 30 days.
 - (a) UB: revenue code 1003

- (b) HCPCS: H0010
- (3) Clinically monitored, low intensity level of care long-term residential (non-medical, nonacute care in a residential treatment program). ASAM 3.1 placement criteria - typically longer than 30 days.
 - (a) UB: revenue code 1003
 - (b) HCPCS: H0017
- (4) Enter ordering or referring provider in attending provider field

V. ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) FOR YOUTH

To help an eligible recipient under 21 years of age when the need for ARTC has been identified in the eligible recipient's tot to teen health check screen (EPSDT) program (42 CFR section 441.57) or other diagnostic evaluation, and for whom a less restrictive setting is not appropriate, MAD pays for services furnished to him or her by an ARTC accredited by the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA).

A. Eligible facilities:

- (1) To be eligible to be reimbursed for providing ARTC services to an eligible recipient, an ARTC facility:
 - (a) must provide a copy of its JC, COA, or CARF accreditation as a children's residential treatment facility;
 - (b) must provide a copy of its CYFD ARTC facility license and certification;
 - (c) must be enrolled as a MAD provider; and
 - (d) must have written utilization review (UR) plans in effect which provide for review of the eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245;
- (2) If the ARTC is operated by IHS or by a federally recognized tribal government, the youth-based facility must meet CYFD ARTC licensing requirements but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, CYFD will provide MAD copies of its facility findings and recommendations. MAD will work with the facility to address recommendations. Details related to findings and recommendations for an IHS or federally recognized tribal government's ARTC are detailed in the BH Policy and Billing Manual; and
- (3) In lieu of New Mexico CYFD licensure, an out-of-state or MAD border ARTC facility must have JC, COA or CARF accreditation and be licensed in its own state as an ARTC residential treatment facility.

B. Billing Instructions

- (1) UB: 1001 revenue code for psychiatric
- (2) UB: 1002 revenue code for substance use
- (3) Referring or ordering provider in attending provider field

VI. APPLIED BEHAVIOR ANALYSIS (ABA): MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) services for eligible recipients 12 months up to 21 years of age who have a well-documented medical diagnosis of autism spectrum disorder (ASD). If the eligible recipient is attending high school, coverage continues until the age of 22 for individuals covered under the Alternative Benefit Plan (ABP). It also covers eligible recipients 12 months up to three years of age who have well-documented risk for the development of ASD. As part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment, ABA services may be provided in

coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, etc.). ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57).

A. Coverage Criteria:

- (1) Confirmation of the presence or risk of ASD must occur through an approved autism evaluation provider (AEP) through a comprehensive diagnostic evaluation (CDE) used to determine the presence of ASD with a diagnosis of ASD. A targeted evaluation is used when the eligible recipient who has a full diagnosis of ASD presents with behaviors that are changed from the last CDE. An ASD risk evaluation is used when an eligible recipient meets the at-risk criteria found in Subsection C.
- (2) An integrated service plan (ISP) must be developed by the AEP together with a referral to an approved ABA provider (AP) agency (stage one).
- (3) The AP agency completes a behavior or functional analytic assessment. The assessment results determine if a focused or comprehensive model is selected and a treatment plan is completed (stage two).
- (4) ABA stage two and three services are then rendered by a Behavior Analyst Certification Board (BACB) approved behavior analyst (BA), a board certified assistant behavior analyst (BCaBA) or a behavior technician (BT), in accordance with the treatment plan (stage three). A BCaBA is referred to in this supplement as a behavior analyst assistant (BAA).

B. Eligible providers: ABA services are rendered by several providers and practitioners: an AEP; a behavior analyst (BA) and a behavior technician (BT) through an ABA provider (AP); and an ABA specialty care provider. Each ABA provider and practitioner has corresponding enrollment requirements and renders unique services according to his or her provider type and specialty. All providers must successfully complete a criminal background registry check.

- (1) Stage 1: Autism Evaluation Provider (AEP): Completes the CDE, ASD risk evaluation or targeted evaluation and develops the ISP for an eligible recipient
- (2) Behavior Analyst (BA): a BA who is a board certified behavior analyst (BCBA® or BCBA-D®) by the Behavior Analyst Certification Board (BACB®) or a psychologist who is certified by the American Board of Professional Psychology in behavior and cognitive psychology and who was tested in the ABA part of his or her certification may render ABA stage two-behavior analytic assessment; service model determination; treatment plan development; and stage three services-implementation of an ABA treatment plan. MAD refers to this practitioner in rule and on the fee schedule as a BA.
- (3) Stage two and three BAA: A BAA who is a board certified assistant behavior analyst (BCaBA®) by the BACB® may assist his or her supervising BA in rendering an ABA stage two-behavior or functional analytic assessment; service model determination; ABA treatment plan development; and stage three services implementation of the ABA treatment plans when the BAA's supervising BA determines he or she has the skills and knowledge to render such services. This is determined in the contract the BAA has agreed to with his or her supervising BA.
- (4) Stage three Behavioral Technician (BT): A BT, under supervision of a BA, may assist stage two and implement stage three ABA treatment plan interventions and services.

- (5) Stage three ABA specialty care provider eligibility requirements: practitioners who are enrolled as BAs must provide additional documentation that demonstrates the practitioner has the skills, training and clinical experience to oversee and render ABA services to highly complex eligible recipients who require specialized ABA services.
- (6) Additional provider types: To avoid a delay in receiving stage two services, a recipient may be referred for ABA services with a diagnosis of ASD by other medical provider types. While the practitioners listed below may not meet the requirements to be approved as AEPs and therefore are not considered AEPs, until further notice MAD is recognizing the diagnosis of ASD of a recipient by the following provider types to expedite a recipient's access to ABA stage two services:
 - (a) A New Mexico regulation and licensing department (RLD) licensed psychologist.
 - (b) A New Mexico board of nursing licensed:
 - (i) psychiatric clinical nurse specialist;
 - (ii) certified nurse practitioner with a specialty of pediatrics or psychiatry.
 - (c) A New Mexico MD or DO board licensed:
 - (i) psychiatrist who is board certified in child and adolescent;
 - (ii) pediatrician.

C. Identified population: The admission criteria are separated into two types: at-risk for ASD and diagnosed with ASD.

- (1) At-risk for ASD: an eligible recipient may be considered 'at-risk' for ASD and therefore eligible for time-limited ABA services, if he or she does not meet full criteria for ASD per the latest version of the diagnostic statistical manual (DSM) or international classification of diseases (ICD). To be qualified for the ABA criteria of at-risk, the eligible recipient must meet all the following requirements:
 - (a) is between 12 and 36 months of age;
 - (b) presents with developmental differences and delays as measured by standardized assessments;
 - (c) demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior);
 - (d) presents with at least one genetic risk factor (e.g., genetic risk due to having an older sibling with a well-documented ASD diagnosis; eligible recipient has a diagnosis of Fragile X syndrome).
- (2) Diagnosed with ASD: an eligible recipient 12 months up to 21 years of age who has a documented medical diagnosis of ASD according to the latest version of the DSM or the ICD is eligible for ABA services if he or she presents with a CDE or targeted evaluation.

D. Covered services:

- (1) Stage one: An eligible recipient 12 months up to 21 years of age is referred to an AEP after screening positive for ASD. The AEP conducts a diagnostic evaluation (CDE or targeted evaluation), develops the ISP, and recommends ABA stage 2 services. For an eligible recipient who has an existing ASD diagnosis, diagnostic re-evaluation is not necessary, but the development of an ISP and the determination of the medical necessity for ABA services are required.

- (2) Stage two BA: For all eligible recipients, stage two services include a behavior or functional analytic assessment, ABA service model determination, and treatment plan development. The family, eligible recipient (as appropriate for age and developmental level), and the AP's supervising BA work collaboratively to make a final determination regarding the clinically appropriate ABA service model, with consultative input from the AEP as needed. A behavior or functional analytic assessment addressing needs associated with both skill acquisition and behavior reduction is conducted, and an individualized ABA treatment plan, as appropriate for the ABA service model, is developed by the supervising BA. The BA is responsible for completing the following services:
 - (a) the recipient's assessment;
 - (b) selection and measurement of goals; and
 - (c) treatment plan formulation and documentation.
- (3) Stage three – treatment: Most ABA stage three services require prior authorization and may vary in terms of intensity, frequency and duration, the complexity and range of treatment goals, and the extent of direct treatment provided.
- (4) Stage three - clinical management and case supervision: All stage three services require clinical management. If a BAA or a BT is implementing the treatment plan, the BAA or BT requires frequent, ongoing case supervision from his or her BA or supervising BAA. The BH Policy and Billing Manual provides a detailed description of the requirements for rendering clinical management and case supervision.
- (5) Stage three - ABA specialty care services: Specialty care services require prior authorization. In cases where the needs of the eligible recipient exceed the expertise of the AP and the logistical or practical ability of the AP to fully support the eligible recipient MAD covers the eligible recipient for a referral to a MAD enrolled ABA SCP.
- (6) If the eligible recipient is in a residential facility that either specializes in or has as part of its treatment modalities MAD ABA services, and the residential facility is not an AP for ABA stage two and three services, and the eligible recipient has a MAD recognized CDE or targeted evaluation which recommends ABA stage two services, the residential facility is responsible to locate a MAD enrolled ABA stage two and three AP and develop an agreement allowing the AP to render stage two and three services at the residential facility. Reimbursement for ABA stage two and three services is made to the MAD enrolled AP, not the residential facility.
- (7) For an eligible recipient who meets the criteria for ABA services and who is in a treatment foster care (TFC) placement, he or she is not considered to be in a residential facility and may receive ABA services outside of the TFC agency. An eligible recipient who meets the criteria for ABA services who is in a residential treatment center, accredited residential treatment center, or a group home may receive ABA services to the extent that the residential provider is unable to provide the services.
- (8) See the BH Policy and Billing Manual for specific instructions concerning stages one through three services.

E. Prior authorization - general information stage three services:

- (1) Prior authorization to continue ABA stage three services must be secured every six months. At each six-month authorization point, a UR contractor will assess, with input from the family and AP's BA, whether changes are needed in the

eligible recipient's ISP and if immediate changes are warranted to preserve the health and wellbeing of the eligible recipient.

- (2) To secure the initial and ongoing prior authorization for stage three services, the AP must submit the prior authorization request, specifically noting:
 - (a) CDE or targeted evaluation and the ISP from the AEP (developed in stage one) along with the ABA treatment plan (developed in stage two);
 - (b) the requested treatment model (focused or comprehensive), maximum hours of service requested per week;
 - (c) the number of hours of case supervision requested per week, if more than two hours of supervision per 10 hours of intervention is requested. The BH Policy and Billing Manual provides detailed requirements for case supervision;
 - (d) the number of hours of clinical management requested per week, if more than two hours of clinical management per 10 hours of intervention is requested;
 - (e) the need for collaboration with an ABA specialty care provider, if such a need has been identified through initial assessment and treatment planning; after services have begun, the AP agency may refer the eligible recipient to a SCP for a focused behavior or functional analytic assessment focusing on the specific care needs of the eligible recipient. The SCP will then request a prior authorization for specialty care services to the eligible recipient's UR contractor.
- (3) The request must document hours allocated to other services (e.g., early intervention through FIT, physical therapy, speech and language therapy) that are in the eligible recipient's ISP for the eligible recipient's UR to determine if the requested intensity (i.e., hours per week) is feasible and appropriate.
- (4) When an eligible recipient's behavior exceeds the expertise of the AP and logistical or practical ability of the AP to fully support him or her, MAD allows the AP to refer the eligible recipient to his or her UR contractor for prior authorization to allow an ABA specialty care provider to intervene. The UR contractor will approve a prior authorization to the ABA specialty care provider to complete a targeted assessment including a functional assessment, and provide the primary AP, or him/her self, with individualized interventions to address the behavioral or medical concerns upon which the referral is based.
- (5) Services may continue until the eligible recipient no longer meets service criteria for ABA services or ages out of eligibility for comprehensive ABA services as described in BH Policy and Billing Manual.
- (6) See the BH Policy and Billing Manual for specific instructions on prior authorizations.

F. Non-covered services:

- (1) When the eligible recipient's comprehensive or targeted diagnostic evaluation or the ISP and treatment plan updates recommend placement in a higher, more intensive, or more restrictive level of care (LOC) and no longer recommends ABA services;
- (2) The eligible recipient has reached the maximum age range for ABA services;
- (3) Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA treatment plan;
- (4) Activities that are not based on the principles and application of applied behavior analysis;

- (5) Activities that take place in school settings and have the potential to supplant educational services;
- (6) Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the practitioner has expertise in the provision of ABA; and
- (7) Activities which are better characterized as staff training, certification or licensure or certification supervision requirements, rather than ABA case supervision.

G. Reimbursement: A revised ABA fee schedule will be posted by MAD soon.

VII. ASSERTIVE COMMUNITY TREATMENT SERVICES (ACT): MAD pays for covered assertive community treatment services (ACT).

A. Eligible providers:

- (1) 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.
- (2) An ACT agency providing coordinated specialty care for an individual with first episode psychosis must provide services consistent with the coordinated specialty care (CSC) model.
- (3) ACT services must be provided by an agency designated team of 10 to 12 members; see number (6) of Subsection A for the required composition. Lower number of team member compositions may be considered by BHSD for a waiver request dependent on the nature of the clinical severity and rural vs. urban environment pending BHSD approval. 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 the eligible recipient obtains the basic necessities of daily life; and coordination, support and consultation to the eligible recipient's family and other major supports. The agency must coordinate its ACT services with local hospitals, local crisis units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.
- (4) Each ACT team staff member must be successfully and currently certified or trained according to ACT fidelity model standards. The training standards focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices and ACT fidelity model. Each ACT team shall have sufficient numbers of qualified staff to provide treatment, rehabilitation, crisis and support services 24-hours a day, seven days a week.
- (5) Each ACT team shall have a staff-to-eligible recipient ratio of 1:10 or lower dependent on the nature of the team based on clinical severity and rural vs. urban environment pending BHSD approval.
- (6) Each ACT team must comply with all specific licensing requirements for ACT staff team members as appropriate, and must include:

- (a) one team leader who is an independently licensed behavioral health practitioner (LPCC, LMFT, LISW, LCSW, LPAT, psychologist)
 - (b) Medical Director/prescriber;
 - (i) board certified or board eligible psychiatrist; or
 - (ii) NM licensed psychiatric certified nurse practitioner; or
 - (iii) NM licensed psychiatric clinical nurse specialist; or
 - (iv) Prescribing psychologist under the supervision or consultation of an MD; or
 - (c) two licensed nurses, one of whom shall be a RN;
 - (d) at least one other MAD recognized independently licensed behavioral health professional;
 - (e) at least one MAD recognized licensed behavioral health practitioner with expertise in substance use disorders;
 - (f) at least one employment specialist;
 - (g) at least one New Mexico certified peer support worker (CPSW) through the approved state of New Mexico certification program; or certified family peer support worker (CFPSW);
 - (h) one administrative staff person; and
 - (i) the eligible recipient shall be considered a part of the team for decisions impacting his or her ACT services.
- (7) The agency must have a HSD ACT approval letter to render ACT services to an eligible recipient. The approval letter will authorize an agency also delivering CSC services.

B. Coverage criteria:

- (1) MAD covers medically necessary ACT services required by the condition of the eligible recipient.
- (2) The ACT program provides four levels of interaction with the participating individuals:
 - (a) Face-to-face encounters.
 - (b) Collateral encounters designated as members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting his or her condition and are identified in the service plan as having a role in treatment.
 - (c) Assertive outreach defined as the ACT team having knowledge of what is happening with an individual. This occurs in either locating the individual or acting quickly and decisively when action is called for, while increasing client independence. This is done on behalf of the client and can comprise only five percent per individual of total service time per month.
 - (d) Group encounters defined by the following types:
 - (i) Basic living skills development;
 - (ii) Psychosocial skills training;
 - (iii) Peer groups; or
 - (iv) Wellness and recovery groups.
- (3) The ACT therapy model is based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan for the eligible recipient. Specialized therapeutic and rehabilitative interventions falling within the fidelity of the ACT model are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe

problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services.

- C. Identified population:
- (1) ACT services are provided to an eligible recipient aged 18 and older whose diagnosis or diagnoses meet the criteria of serious mental illness (SMI) with a special emphasis on depression with psychosis including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression for individuals who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services and who have experienced repeated hospitalizations or incarcerations due to mental illness.
 - (2) ACT services can also be provided to eligible individuals 15 to 30 years of age who are within the first two years of their first episode of psychosis.
 - (3) A co-occurring diagnosis of substance abuse shall not exclude an eligible recipient from ACT services.
- D. Covered services:
ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the principles covered in the BH Policy and Billing Manual.
- E. Non-covered services: MAD does not cover other psychiatric, mental health nursing, therapeutic, non-intensive outpatient substance abuse or crisis services when billed in conjunction with ACT services to an eligible recipient, except for medically necessary medications and hospitalizations. Psychosocial rehabilitation services can be billed for a six-month period for transitioning levels of care but must be identified as a component of the treatment plan.
- F. Billing Instructions: ACT agencies submit claims for reimbursement on the CMS1500 claim form or its successor.
- (1) H0039: 15 min unit
 - (2) Modifier required:
 - (a) U1 = face-to-face
 - (b) U2 = collateral encounter
 - (c) U3 = assertive outreach
 - (d) U4 = group
 - (3) Utilize agency provider ID and NPI in rendering fields

VIII. BEHAVIORAL HEALTH PROFESSIONAL SERVICES FOR SCREENINGS, EVALUATIONS, ASSESSMENTS, and THERAPY

- A. Validated screenings are covered for high risk conditions to provide prevention or early intervention. Brief interventions and preventive services may be billed with a provisional diagnosis.
- B. Psychological, counseling and social work: These services are diagnostic or active treatments with the intent to reasonably improve an eligible recipient's physical, social, emotional and behavioral health or substance use condition. Services are provided to an eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling and social work services are performed by

licensed psychological, counseling and social work practitioners acting within their scope of practice and licensure. These services include, but are not limited to assessments that appraise cognitive, emotional and social functioning and self-concept. Therapy includes planning, managing and providing a program of psychological services to the eligible recipient meeting a current DSM or ICD behavioral health diagnosis and may include consultation with his or her family and other professional staff.

- C. An assessment as described in the BH Policy and Billing Manual, must be signed by the practitioner operating within his or her scope of licensure. A non-independently licensed behavioral health practitioner must have an independently licensed behavioral health practitioner review and sign the assessment with a diagnosis. Based on the eligible recipient's current assessment, his or her 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.
- D. Outpatient therapy services (individual, family and group) includes planning, managing, and providing a program of psychological services to the eligible recipient with a diagnosed behavioral health disorder, and may include consultation with his or her family and other professional staff with or without the eligible recipient present when the service is on behalf of the recipient. See the BH Policy and Billing Manual for detailed requirements of service plans and treatment plans.
- E. Activity Therapy includes, but is not limited to, art therapy, sand-box, and other modalities when identified as a need in a comprehensive assessment and treatment plan. It is only covered for agencies listed in numeral I, sub-section B.
- F. Billing Instructions:
 - (1) Always enter the rendering provider when billing;
 - (2) Validated screening for G0444 for behavioral health, except for SBIRT which has its own codes. Does not require a diagnosis.
 - (3) Brief intervention – G0443; use a provisional diagnosis.
 - (4) For all services listed below:
 - (a) If service is delivered after regular business hours or 10 pm, whichever is earlier, or for days for which the provider would otherwise be closed, add modifier UH;
 - b) If service is delivered on weekends or holidays, add modifier TV, or for any holiday for which the provider would be closed, add modifier TV.
 - (5) Psychiatric diagnostic evaluation: Use CPT code 90791
 - (6) Psychiatric evaluation w medical service: Use CPT code 90792
 - (7) Individual therapy & counseling: Use CPT codes 90832 – 90838, and +90863; code depends on time spent with patient
 - (8) Psychotherapy for crisis: Use CPT code 90839 for first 60 minutes & 90840 for add on 30-minute increments. Original code: 1 unit; add on code 4 units;
 - (9) Family therapy: Use CPT codes 90846 – 90847
 - (a) Unit = 1 hour
 - (b) For functional family therapy EBP use modifier HK on CPT code 90847
 - (10) Group therapy: Use CPT codes 90849 and 90853
 - (11) Prolonged service billing:
 - (a) 99354 – 99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a

- given date providing prolonged service in the office or other outpatient setting, even if the time spent on that date is not continuous. These codes are reported separately from the original Evaluation and Management (E/M) or psychotherapy session. Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.
- (b) 99356 – 99357 are used to report the total duration of time spent by a physician or other qualified health care professional in an inpatient or nursing facility on delivering face-to-face service at the bedside and time spent on the patient’s floor or unit on a given date providing prolonged service, even if the time spent on that date is not continuous.
 - (c) 99354 or 99356 are used to report the first hour of prolonged service on a given date, depending on the place of service. They are to be listed separately from the original E/M or treatment code. 99355 or 99357 are used to report each additional 30 minutes. Either code may also be used to report the final 15-30 minutes on a given date. Prolonged service of less than 15 minutes beyond the first hour or beyond the final 30 minutes is not reported separately.
 - (d) Any prolonged service of less than 30 minutes total on the same day beyond the original session is not reported; it is considered included in the original session.
- (12) Peer Support Services – individual or group: use HCPCS H0038
 - (a) Unit is for 15 minutes with a maximum of 12 units
 - (b) Use modifier HQ for group setting
 - (c) Providers: 430, specialties 114 certified peer support worker; 115 certified family peer support worker; 117 correctional peer support worker
 - (13) Activity therapy – use HCPCS G0176
 - (a) Provider type: billable by the 13 agency types listed in numeral I, subsection B only
 - (b) Rendering provider by those qualified by scope of practice or agency policy
 - (c) Per session; 1 unit
 - (d) Use modifier HQ for groups
 - (14) Inpatient and ED consultation – telehealth: must identify both rendering & referring
 - (a) 15 minutes - G0406
 - (b) 25 min - G0407
 - (c) 35 min - G0408
 - (15) Comprehensive med service - H2010
 - (a) 15 min unit
 - (b) Includes medication assessment, administration, monitoring and recipient education
 - (c) May be billed by RNs, LPNs, and PAs under respective supervision

IX. BEHAVIORAL HEALTH RESPITE CARE (Managed Care/Centennial Care enrollees only): As part of centennial care’s comprehensive service system, behavioral health (BH) respite service is for short-term direct care and supervision of the eligible recipient to afford the parent(s) or caregiver a respite for their care of the recipient and takes place in the recipient’s home or another setting.

A. Eligible providers and practitioners:

- (1) Provider types:
 - (a) Treatment foster care home;
 - (b) Core service agency;
 - (c) Behavioral health agency.
- (2) Practitioners:
 - (a) Supervisor:
 - (i) bachelor's degree and three years' experience working with the target population;
 - (ii) supervision activities include a minimum of two hours per month individual supervision covering administrative and case specific issues, and two additional hours per month of continuing education in behavioral health respite care issues, or annualized respite provider training;
 - (iii) access to on call crisis support available 24-hours a day;
 - (iv) supervision by licensed practitioners must be in accordance with their respective licensing board regulations.
 - (b) Respite care staff:
 - (i) minimum three years' experience working with the target population;
 - (ii) pass all criminal records and background checks for all persons residing in the home over 18;
 - (iii) possess a valid driver's license, vehicle registration and insurance, if transporting member;
 - (iv) CPR and first aid; and
 - (v) documentation of behavioral health orientation, training and supervision as defined in the BH Policy and Billing Manual.

B. Coverage criteria: The provider agency will assess the situation and, with the caregiver, recommend the appropriate setting for respite. BH respite services may include a range of activities to meet the social, emotional and physical needs identified through the service or treatment plan and documented in the treatment record. These services may be provided for a few hours during the day or for longer periods of time involving overnight stays. BH respite, while usually planned, can also be provided in an emergency or unplanned basis.

C. Identified population:

- (1) Members up to 21 years of age diagnosed with a severe emotional disturbance (SED), as defined by the state of New Mexico who reside with the same primary caregivers daily; or
- (2) Youth in protective services custody whose placement may be at risk whether or not they are diagnosed with SED.

D. Non-covered services:

- (1) 30 days or 720 hours per year are covered without prior authorization, at which time prior authorization must be acquired for additional respite care;
- (2) May not be billed in conjunction with the following Medicaid services:
 - (a) treatment foster care;
 - (b) group home;
 - (c) residential services;
 - (d) inpatient treatment.

- (3) Non-enrolled siblings of a child receiving BH respite services are not eligible for BH respite benefits; and
- (4) Cost of room and board are not included as part of respite care.

E. Billing Instructions:

- (1) MCO coverage only
- (2) Provider types that can bill are CSA (446), BHA (432), or TFC (218)
- (3) HCPCS code T1005 in 15 min units
- (4) Annual limit of 720 hours or 30 days. If needing more, request to MCO with medical necessity.
- (5) FQHC & IHS/Tribal 638 bill as contracted with MCO(s)

X. BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: MAD pays for behavior management services (BMS) as part of the EPSDT program for enrolled clients up to age 21 when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation. BMS services are designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the eligible recipient in his or her home or community. BMS assists in reducing or preventing inpatient hospitalizations or out-of-home residential placement of the 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 eligible recipient's comprehensive behavioral health treatment or service plan. BMS is not provided as a stand-alone service but delivered as part of an integrated plan of services to maintain eligible recipients in their communities as an alternative to out-of-home services.

A. Eligible providers:

- (1) An agency must be certified by CYFD to provide BMS services.
- (2) The agency must be enrolled as a MAD provider.

B. Coverage criteria: MAD reimburses for behavior management services specified in the eligible recipient's individualized treatment plan which are designed to improve his or her performance in targeted behaviors, reduce emotional and behavioral episodic events, increase social skills and enhance behavioral skills through a regimen of positive intervention and reinforcement.

- (1) Implementation of the eligible recipient's BMS treatment plan, which includes crisis planning, must be based on a clinical assessment that includes identification of skills deficits that will benefit from an integrated program of therapeutic services. A detailed description of required elements of the assessment and treatment plan are found in the BH Policy and Billing Manual.
- (2) 24-hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the eligible recipient's crisis situations.
- (3) Supervision of behavioral management staff by an independent level practitioner is required for this service. Policies governing supervisory responsibilities are detailed in the BH Policy and Billing Manual. The supervisor must ensure that:
 - (a) a clinical assessment of the eligible recipient is completed upon admission into BMS. The clinical assessment identifies the need for BMS as medically necessary to prevent inpatient hospitalizations or out-of-home residential placement of the eligible recipient;

- (b) the assessment is signed by the recipient or his or her parent or legal guardian; and
 - (c) the BMS worker receives documented supervision for a minimum of two hours per month dependent on the complexity of the needs presented by recipients and the supervisory needs of the BMS worker.
- (4) An eligible recipient's treatment plan must be reviewed at least every 30 calendar days after implementation of the comprehensive service plan. The BMS worker, in partnership with the client and family as well as all other relevant treatment team members such as school personnel, juvenile probation officer (JPO), and guardian ad litem (GAL), shall discuss progress made over time relating to the BMS service goals. If the BMS treatment team assesses the recipient's lack of progress over the last 30 days, the treatment plan will be amended as agreed upon during the treatment team meeting. Revised BMS treatment plans will be reviewed and approved by the BMS supervisor, which must be documented in the recipient's file.
- C. Identified population: In order to receive BMS services, an eligible recipient must be under the age of 21 years, be diagnosed with a behavioral health condition and:
- (1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;
 - (2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or
 - (3) require behavior management support following an institutional or other out-of-home placement as a transition to maintain the eligible recipient in his or her home and community.
 - (4) either the need for BMS is NOT listed on an individualized education plan (IEP), or IT IS listed in the supplementary aid & service section of the IEP.
- D. Non-covered services: MAD does not cover the following specific services billed in conjunction with BMS services:
- (1) activities which are not designed to accomplish the goals in the BMS treatment plan;
 - (2) services provided in residential treatment facilities; and
 - (3) services provided in lieu of services that should be provided as part of the eligible recipient's individual educational plan (IEP) or individual family service plan (IFSP).
 - (4) BMS is not a reimbursable service through the Medicaid school-based service program.
- E. Billing Instructions: Claims are submitted on a CMS-1500 claim form or its successor;
- (1) H2014: 15 min units
 - (2) Practitioners: 430, specialty 113 (BMS worker)
 - (3) Utilize agency NPI in rendering field

XI. COGNITIVE ENHANCEMENT THERAPY (CET)

CET services provide treatment service for an eligible recipient 18 years of age or older with cognitive impairment associated with the following serious mental illnesses: schizophrenia, bipolar disorder, major depression, recurrent schizoaffective disorder, or autism spectrum disorder. CET uses an evidence-based model to help eligible recipients with these conditions improve their processing speed, cognition, and

social cognition. Any CET program must be approved by BHSD and ensure that treatment is delivered with fidelity to the evidence-based model.

- A. Eligible providers: Services may only be delivered through a MAD approved agency after demonstrating that the agency meets all the requirements of CET program services and supervision.
- (1) The following types of agencies are eligible to be reimbursed for providing CET services once gaining a letter of approval from BHSD:
 - (a) a CMHC;
 - (b) a FQHC;
 - (c) an IHS facility;
 - (d) a PL 93-638 tribal facility;
 - (e) a CSA;
 - (f) a CLNM health home;
 - (g) a behavioral health agency with a BHSD supervisory certificate.
 - (2) CET services are provided through an integrated interdisciplinary approach by staff with expertise in the mental health condition being addressed and have received training from a state approved trainer. Staff can include independently licensed behavioral health practitioners, non-independently licensed behavioral health practitioners, RNs, or CSWs. For every CET cohort of eligible recipients, there must be two practitioners who have been certified in the evidence-based practice by a state approved trainer or training center. The agency shall retain documentation of the staff that has been trained. The size of each cohort who receives CET must conform to the EBP model in use.
 - (3) The agency must hold an approval letter issued by BHSD certifying that the staff have participated in an approved training or have arranged to participate in training and have supervision by an approved trainer prior to commencing services.
 - (4) Weekly required participation in hourly fidelity monitoring sessions with a certified CET trainer for all providers delivering CET who have not yet received certification.
- B. Covered services:
- (1) CET services include:
 - (a) weekly social cognition groups with enrollment according to model fidelity;
 - (b) weekly computer skills groups with enrollment according to model fidelity;
 - (c) weekly individual face-to-face coaching sessions to clarify questions and to work on homework assignments;
 - (d) initial and final standardized assessments to quantify social-cognitive impairment, processing speed, cognitive style; and
 - (e) individual treatment planning.
 - (2) The duration of an eligible recipient's CET intervention is based on model fidelity. Each individual participating in CET receives up to three hours of group treatment and up to one hour of individual face-to-face coaching.
- C. Identified population: CET services are provided to an eligible adult recipient 18 years of age and older with cognitive impairment associated with the following serious mental illnesses:
- (1) schizophrenia;

- (2) bipolar disorder;
- (3) major depression, recurrent;
- (4) schizoaffective disorder; or
- (5) autism spectrum disorder.

D. Non-covered services:

- (1) CET services are subject to the limitation and coverage restrictions which exist for other MAD services.
- (2) MAD does not cover the CET during an acute inpatient stay.

E. Billing Instructions:

- (1) G0515 – 15 min units
- (2) Agencies: CMHC, FQHC, IHS, Tribal 638, CSA, CLNM HH, BHA with Supervisory Certificate.
- (3) Utilize agency provider ID and NPI in rendering fields.

XII. COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): This culturally sensitive service coordinates and provides services and resources to an 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 eligible recipient's community, as well as strengths that may aid the eligible recipient and family in the recovery or resiliency process.

A. Eligible providers and practitioners:

- (1) In order to be eligible to be reimbursed for providing CCSS services, an agency must be enrolled in MAD as one of the following:
 - (a) a FQHC;
 - (b) an IHS hospital or clinic;
 - (c) a PL 93-638 tribally operated hospital or clinic;
 - (d) a MAD enrolled CSA;
 - (e) a MAD enrolled behavioral health agency with a supervisory certificate;
 - (f) a MAD designated CareLink NM health home.
- (2) To provide CCSS services, a provider must receive CCSS training through the state or UNM, and attest that they have received this training when contacting the state's fiscal agent to add the specialty service 107, CCSS to their existing enrollment in Medicaid. The Children, Youth and Families Department (CYFD) will provide background checks for CCSS direct service and clinical staff for child/youth CCSS programs.
- (3) Clinical services and supervision by licensed behavioral health practitioners must be in accord with their respective licensing board regulations:
 - (a) Minimum staff qualifications for the community support worker (CSW):
 - (i) must be at least 18 years of age; and
 - (ii) hold a bachelor's degree in a human services field from an accredited university and have one year of relevant experience with the target population; or
 - (iii) hold an associate degree and a minimum of two years of experience working with the target population; or
 - (iv) hold an associate degree in approved curriculum in behavioral health coaching; no experience necessary; or

- (v) have a high school diploma or equivalent and a minimum of three years' experience working with the target population; or
 - (vi) hold a certification from the New Mexico credentialing board for behavioral health professionals as a certified peer support worker (CPSW) or as a certified peer family specialist (CPFS).
- (b) Minimum staff qualifications for certified peer support workers (CPSW):
 - (i) must be 18 years of age or older; and
 - (ii) have a high school diploma or equivalent; and
 - (iii) be self-identified as a current or former consumer of mental health or substance abuse services, and have at least two years of mental health or substance abuse recovery; and
 - (iv) have received certification as a CPSW.
 - (c) Minimum staff qualifications for certified family support workers (CFSW):
 - (i) must be 18 years of age or older; and
 - (ii) have a high school diploma or equivalent; and
 - (iii) have personal experience navigating any of the child/family-servicing systems or advocating for family members who are involved with the child/family behavioral health systems. Must also understand how these systems operate in New Mexico; and
 - (iv) have received certification as a CFSW or CPSW with a family support specialty.
 - (d) Minimum staff qualifications for the CCSS Program Supervisor:
 - (i) must hold a bachelor's degree in a human services field from an accredited university; and
 - (ii) have four years relevant experience in the delivery of case management or CCSS with the target population; and
 - (iii) have one year demonstrated supervisory experience.
 - (e) Minimum staff qualifications for the clinical supervisor:
 - (i) must be a licensed independent practitioner (i.e. psychiatrist, psychologist, LISW, LPCC, LMFT), psychiatrically certified clinical nurse specialist or clinical nurse practitioner practicing under the scope of their NM licensure; and
 - (ii) have one year demonstrated supervisory experience; and
 - (iii) provide documented clinical supervision on a regular basis to the CSW, CPS and CFS.
- (4) Staff training requirements:
- (a) Minimum staff training requirements for a community support worker includes:
 - (i) an initial training comprised of 20 hours of documented education within the first 90 days of employment drawn from an array of areas documented in the BH Policy and Billing Manual;
 - (ii) documentation of ongoing training comprised of 20 hours is required of a CSW every year, after the first year of hire, with content of the education based upon agency assessment of staff need.
 - (b) Minimum staff training requirements for supervisors:
 - (i) the same 20 hours of documented training or continuing education as required for the CCSS community support worker;
 - (ii) an attestation of training related to providing clinical supervision of non-clinical staff.

- (5) The clinical supervisor and the CCSS program supervisor may be the same individual.
 - (6) Documentation requirements: In addition to the standard client record documentation requirements for all services, the following is required for CCSS:
 - (a) case notes identifying all activities and location of services;
 - (b) duration of service span (e.g., 1:00 p.m.-2:00 p.m.); and
 - (c) description of the service provided with reference to the CCSS treatment plan and related goals.
- B. Coverage criteria:
- (1) When identifying a need for this service, if the provider agency is utilizing the "Treat First" clinical model, they may be placed in this service for up to four encounters without having had a psychiatric diagnostic evaluation with the utilization of a provisional diagnosis for billing purposes. After four encounters, an individual must have a comprehensive needs assessment, a diagnostic evaluation, and a CCSS treatment plan. Further details related to the CCSS treatment plan can be accessed in the BH Policy and Billing Manual.
 - (2) CCSS may be concurrently delivered and billed during a transition phase either being admitted to, or discharged from:
 - (a) accredited residential treatment center (ARTC);
 - (b) residential treatment center (RTC);
 - (c) group home service;
 - (d) inpatient hospitalization;
 - (e) treatment foster care (TFC); or
 - (f) transitional living services.
- C. Covered services: The purpose of CCSS is to provide an eligible recipient and his or her family with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support services address goals specifically in the following areas of the eligible recipient's activities: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, based on coaching and addressing barriers that impeded the development of skills necessary for independent functioning in the community. Community support services also include assistance with identifying and coordinating services and supports identified in an individual's service plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.
- D. Identified population:
- (1) CCSS is provided to an eligible recipient under 21 years who meets the NM state criteria for serious emotional/neurobiological/behavioral disorders (SED); and
 - (2) CCSS is provided to an eligible recipient 21 years and older whose diagnosis or diagnoses meet the NM state criteria of serious mental illness (SMI) and for an eligible recipient with a diagnosis that does not meet the criteria for SMI, but for whom time-limited CCSS would support his or her recovery and resiliency process; and
 - (3) Recipients with a moderate to severe substance use disorder (SUD) according to the current DSM V or its successor; and
 - (4) Recipients with a co-occurring disorder (mental illness/substance use) or dually diagnosed with a primary diagnosis of mental illness.

- E. Non-covered services: CCSS is subject to the limitations and coverage restrictions which exist for other MAD services. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST), or ACT services, or resource development by New Mexico corrections department (NMCD).
- F. Billing Instructions:
 - (1) HCPCS code H2015 on a CMS-1500 claim form
 - (2) Rendering provider is required
 - (3) 15-minute unit
 - (4) Modifier is required:
 - (a) HO = masters level practitioner
 - (b) HN = bachelors level practitioner
 - (c) HM = less than a bachelors or peer specialist
 - (5) For CCSS delivered in the community add modifier CG as a second modifier

XIII. CRISIS INTERVENTION SERVICES: MAD pays for community-based crisis intervention services which are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode or to prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to eligible recipients who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods which could threaten the safety of self or others. MAD covers four types of crisis services: telephone crisis services; face-to-face crisis intervention in a clinic setting; mobile crisis services; and outpatient crisis stabilization services.

- A. Coverage criteria:
 - (1) Telephone crisis services:
 - (a) Must provide 24-hour, seven day-a-week telephone services to eligible recipients that are in crisis and to callers who represent or seek assistance for persons in a mental health crisis;
 - (b) The establishment of a toll-free number dedicated to crisis calls for the identified service area;
 - (c) Assurance that a backup crisis telephone system is available in the event that the toll-free number is not accessible;
 - (d) Assurance that calls are answered by a person trained in crisis response as described in the BH Policy and Billing Manual;
 - (e) Processes to screen calls, evaluate crisis situation, and provide counseling and consultation to crisis callers are documented and implemented;
 - (f) Assurance that face-to-face intervention services are available immediately if clinically indicated either by the telephone service or through memorandums of understanding with referral sources;
 - (g) Provision of a toll-free number to active clients and their support; and
 - (h) A crisis log documenting each phone call must be maintained and includes:
 - (i) date, time and duration of call;
 - (ii) name of individual calling;
 - (iii) responder handling call;
 - (iv) description of crisis; and
 - (v) intervention provided, (e.g. counseling, consultation, referral, etc.).
 - (2) Face-to-face clinic crisis services:

- (a) The provider shall make an immediate assessment for purposes of developing a system of triage to determine urgent or emergent needs of the person in crisis. (Note: The immediate assessment may have already been completed as part of a telephone crisis response.)
 - (b) Within the first two hours of the crisis event, the provider will initiate the following activities:
 - (i) immediately conduct the crisis assessment;
 - (ii) protect the individual (possibly others) and de-escalate the situation;
 - (iii) determine if a higher level of service or other supports are required and arrange, if applicable.
 - (c) Follow-up. Initiate telephone call or face-to-face follow up contact with individual within 24 hours of initial crisis.
- (3) Mobile crisis intervention services: When mobile crisis is provided, the response will include a two-member team capable of complying with the initial crisis requirements.
- (4) Crisis stabilization services: are outpatient services for up to 24-hour stabilization of crisis conditions which may, but do not necessarily, include ASAM level two withdrawal management, and can also serve as an alternative to the emergency department or police department. Eligible population is 14 years and older or adult only.
- B. Eligible providers and practitioners:
- (1) Telephone crisis services:
 - (a) Individual crisis workers who are covering the crisis telephone must meet the following:
 - (i) CPSW with one-year work experience with individuals with behavioral health condition;
 - (ii) Bachelor level community support worker employed by the agency with one-year work experience with individuals with a behavioral health condition;
 - (iii) RN with one-year work experience with individuals with behavioral health condition;
 - (iv) LMHC with one-year work experience with individuals with behavioral health condition;
 - (v) LMSW with one-year work experience with individuals with behavioral health condition;
 - (vi) Psychiatric physician assistant.
 - (b) Supervision by a:
 - (i) licensed independent behavioral health practitioner; or
 - (ii) behavioral health clinical nurse specialist; or
 - (iii) psychiatric certified nurse practitioner; or
 - (iv) psychiatrist.
 - (c) Training:
 - (i) 20 hours of crisis intervention training that addresses the developmental needs of the full age span of the target population by a licensed independent mental health professional with two years crisis work experience;
 - (ii) 10 hours of crisis related continuing education annually.
 - (2) Face-to-face clinic crisis services:
 - (a) core service agency (CSA);
 - (b) community mental health center (CMHC);

- (c) CareLink NM health home (CLNM HH);
 - (d) federally qualified health center (FQHC);
 - (e) IHS and tribal 638;
 - (f) hospital outpatient clinics;
 - (g) behavioral health agency with supervisory certificate (BHA);
 - (h) political subdivision of the state of NM with supervisory certificate;
 - (i) opioid treatment program within a methadone clinic with supervisory certificate;
 - (j) agencies contracted with an eligible provider agency.
- (3) Mobile crisis intervention services:
- (a) Services must be delivered by licensed behavioral health practitioners employed by a mental health or substance abuse provider organization as described above.
 - (b) One of the team members may be a certified peer support or family peer support worker.
- (4) Crisis stabilization services:
- (a) Agencies:
 - (i) core service agency (CSA);
 - (ii) community mental health center (CMHC);
 - (iii) federally qualified health center (FQHC);
 - (iv) IHS and tribal 638;
 - (v) hospital outpatient clinics;
 - (vi) behavioral health agency with supervisory certificate (BHA);
 - (vii) political subdivision of the state of NM with supervisory certificate;
 - (viii) opioid treatment program within a methadone clinic with supervisory certificate;
 - (ix) agencies contracted with an eligible provider agency.
 - (b) Staffing: must include all of the below positions and must be adequate to serve the expected population, but not less than:
 - (i) one registered nurse (RN) licensed by the NM board of nursing with experience or training in crisis triage and managing intoxication and withdrawal management, if this service is provided during all hours of operation;
 - (ii) one regulation and licensing department (RLD) master's level licensed mental health professional on-site during all hours of operation;
 - (iii) certified peer support worker on-site during all hours of operation;
 - (iv) board certified physician or certified nurse practitioner licensed by the NM board of nursing either on-site or on call; and
 - (v) at least one staff trained in Basic Cardiac Life Support (BCLS), the use of the Automated External Defibrillator (AED) equipment, and first aid shall be on duty at all times.

C. Covered services:

- (1) Telephone crisis services:
 - (a) The screening of calls, evaluation of the crisis situation and provision of counseling and consultation to the crisis callers.
 - (b) Referrals to appropriate mental health professions, where applicable.
 - (c) Maintenance of telephone crisis communication until a face-to-face response occurs, as applicable.

- (2) Face-to-face clinic crisis services:
 - (a) crisis assessment;
 - (b) other screening, as indicated by assessment;
 - (c) brief intervention or counseling;
 - (d) referral to needed resource.
- (3) Mobile crisis intervention services:
 - (a) crisis assessment;
 - (b) other screening, as indicated by assessment;
 - (c) brief intervention or counseling;
 - (d) referral to needed resource.
- (4) Crisis stabilization services:
 - (a) Ambulatory withdrawal management includes:
 - (i) evaluation, withdrawal management and referral services under a defined set of physician approved policies and clinical protocols. The physician does not have to be on-site, but available during all hours of operation;
 - (ii) clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems;
 - (iii) comprehensive medical history and physical examination of recipient at admission;
 - (iv) psychological and psychiatric consultation;
 - (v) conducting or arranging for appropriate laboratory and toxicology test;
 - (vi) assistance in accessing transportation services for recipients who lack safe transportation.
 - (b) Crisis stabilization includes but is not limited to:
 - (i) crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment;
 - (ii) screening and assessment;
 - (iii) de-escalation and stabilization;
 - (iv) brief intervention or psychological counseling;
 - (v) peer support; and
 - (vi) prescribing and administering medication, if applicable.
 - (c) Navigational services for individuals transitioning to the community include:
 - (i) prescription and medication assistance;
 - (ii) arranging for temporary or permanent housing;
 - (iii) family and natural support group planning;
 - (iv) outpatient behavioral health referrals and appointments; and
 - (v) other services determined through the assessment process.

D. Billing Instructions:

- 1) Crisis call center (telephone):
 - (a) H2011 U1 - 15 min units
 - (b) Enter rendering provider
- 2) Clinic crisis services:
 - (a) H2011 U2 - 15 min units
 - (b) Enter rendering provider
- 3) Mobile crisis team:
 - (a) H2011 U3 - 15 min units, covers transportation time and direct patient contact.

- (b) 2-person team included in rate of service
- (c) Use primary BH practitioner NPI in rendering field
- 4) OP Crisis stabilization centers:
 - (a) Billed services must be mutually exclusive, i.e. only 1 service at a time with the single exception of a practitioner working directly with the recipient while the peer support worker is working with family support or navigation/referrals, on behalf of the recipient
 - (b) Immediate crisis assessment: H2011 U4 - 15 min unit
 - (c) Peer support as navigation services or face-to-face living room support: H0038 – self-help peer services - 15 min unit; max 48 units
 - (d) Family support services (MCO members only) – S5110
 - (e) Counseling: Use fee schedule codes and rates for therapy and counseling services
 - (f) Physical examination:
 - (i) For MD or CNS or CNP utilize E & M codes
 - (ii) For RN – T1001 for 30 min (nursing assessment/evaluation)
 - (g) Observation services rendered by a nurse: G0493 (Skilled services of an RN for the observation and assessment of the patient’s condition, each 15 minutes; (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment)
 - (h) Medication administration/management by an RN or PA: H2010 for 15 min; max 4 units
 - (i) Medication assisted treatment: Buprenorphine and Naloxone: J0571 oral Buprenorphine 1 mg; J0572 w/Naloxone 3 mg; J0753 w/Naloxone 6 mg; J0574 w/Naloxone 10 mg; J0574 w/Naloxone over 10 mg; and J0592 Naloxone injection (must be licensed as required by the Board of Pharmacy)
 - (j) On site laboratory services: Use fee schedule codes and rates. The provider must be CLIA-certified. Payment for Medicaid-covered lab services only.
 - (k) Collection of blood by routine venipuncture: 36415
 - (l) If the recipient is sleeping, and not under observation, the time is not billable.

XIV. CRISIS TRIAGE CENTER (CTC): MAD pays for a set of services, either outpatient only or including residential, authorized by 2014 NM HB 212 Crisis Triage Center (CTC) to eligible adults and youth 14 years of age and older, or adults only, to provide voluntary stabilization of behavioral health crises including emergency mental health evaluation and care. The effective date will be January 1, 2019, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS).

- A. Coverage criteria for CTCs which include residential care:
 - (1) The CTC shall provide emergency screening, and evaluation services 24-hours a day, seven days a week and shall admit 24-hours a day seven days a week and discharge seven days a week;
 - (2) Readiness for discharge shall be reviewed in collaboration with the recipient every day;
 - (3) An independently licensed mental health practitioner or non-independent mental health practitioner under supervision must assess each individual with the assessment focusing on the stabilization needs of the client;

- (4) The assessment must include medical and mental health history and status, the onset of the illness, the presenting circumstances, risk assessment, cognitive abilities, communication abilities, social history and history as a victim of physical abuse, sexual abuse, neglect, or other trauma as well as history as a perpetrator of physical or sexual abuse;
- (5) A licensed mental health professional must document a crisis stabilization plan to address needs identified in the assessment which must also include criteria describing evidence of stabilization and either transfer or discharge criteria;
- (6) The CTC identifies recipients at high risk of suicide or intentional self-harm, and subsequently engages these recipients through solution-focused and harm-reducing methods;
- (7) Education and program offerings are designed to meet the stabilization and transfer of recipients to a different level of care;
- (8) The Charge Nurse, in collaboration with a behavioral health practitioner, shall make the determination as to the time and manner of transfer to ensure no further deterioration of the recipient during the transfer between facilities, and shall specify the benefits expected from the transfer in the recipient's record;
- (9) The facility shall develop policies and procedures addressing risk assessment and mitigation including, but not limited to: assessments, crisis intervention plans, treatment, approaches to supporting, engaging and problem solving, staffing, levels of observation and documentation. The policies and procedures must prohibit seclusion and address physical restraint, if used, and the facility's response to clients that present with imminent risk to self or others, assaultive and other high-risk behaviors;
- (10) Use of seclusion is prohibited;
- (11) The use of physical restraint must be consistent with federal and state laws and regulation;
- (12) Physical restraint, as defined in the BH Policy and Billing Manual, shall be used only as an emergency safety intervention of last resort to ensure the physical safety of the client and others, and shall be used only after less intrusive or restrictive interventions have been determined to be ineffective;
- (13) If serving both youth and adult populations, the service areas must be separate; and
- (14) If an on-site laboratory is part of services, appropriate CLIA license must be obtained.

B. Coverage criteria for CTCs which are outpatient only:

- (1) The outpatient CTC shall provide emergency screening, and evaluation services during business hours of operation;
- (2) Steps 3 through 14 as listed in Subsection A of numeral XIV are conditions of coverage for outpatient only services.

C. Eligible providers and practitioners:

- (1) A provider agency licensed through the department of health and certified by the human services department/behavioral health services division as a crisis triage center.
- (2) Practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery.
- (3) All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers licensed outside of New Mexico, a provider's out-of-state license may be accepted in lieu of licensure in New

Mexico if the out-of-state licensure requirements are similar to those of the state of New Mexico.

- (4) For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.
- (5) The facility shall maintain sufficient staff including supervision and direct care and mental health professionals to provide for the care of non-residential clients served by the facility, based on the acuity of client needs.
- (6) The following individuals and practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery:
 - (a) An on-site administrator which can be the same person as the clinical director. The administrator is specifically assigned to crisis triage center service oversight and administrative responsibilities and:
 - (i) is experienced in acute mental health; and
 - (ii) is at least 21 years of age; and
 - (iii) holds a minimum of a bachelor's degree in the human services field; or
 - (iv) is a registered nurse (RN) licensed by the NM board of nursing with experience or training in acute mental health treatment.
 - (b) A full time clinical director that is:
 - (i) at least 21 years of age; and
 - (ii) is a licensed independent mental health practitioner or certified nurse practitioner or clinical nurse specialist with experience and training in acute mental health treatment and withdrawal management services if withdrawal management services are provided.
 - (c) A charge nurse on duty during all hours of operation under whom all services are directed, with the exception of the physician's and who is:
 - (i) at least 18 years of age; and
 - (ii) a RN licensed by the NM board of nursing with experience in acute mental health treatment and withdrawal management services if withdrawal management services are provided.
 - (d) A regulation and licensing department (RLD) master's level licensed mental health practitioner.
 - (e) Two certified peer support workers (CPSW) holding a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker.
 - (f) An on-call physician during all hours of operation who is a physician licensed to practice medicine (MD) or osteopathy (DO), or a licensed certified nurse practitioner (CNP), or a licensed clinical nurse specialist (CNS) with behavioral health experience.
 - (g) A part time psychiatric consultant or prescribing psychologist, hours determined by size of center, who is a physician (MD or DO) licensed by the board of medical examiners or board of osteopathy and is board eligible or board certified in psychiatry, or a prescribing psychologist licensed by the board of psychologist examiners. These services may be provided through telehealth.
 - (h) At least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid shall be on duty at all times.

D. Identified population:

- (1) An eligible recipient is 18 years of age and older who meets the crisis triage center admission criteria if the CTC is an adults only agency.
- (2) If serving youth, an eligible recipient is 14 years through 17 years.
- (3) Recipients may also have other co-occurring diagnoses.
- (4) The CTC shall not refuse service to any recipient who meets the agency's criteria for services, or solely based on the recipient being on a law enforcement hold or living in the community on a court ordered conditional release.

E. Covered services:

- (1) Comprehensive medical history and physical examination of recipient at admission;
- (2) Development and update of the assessment and plan as described in the BH Policy and Billing Manual;
- (3) Crisis stabilization including, but not limited to:
 - (a) Crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment;
 - (b) Screening and assessment as described in the BH Policy and Billing Manual;
 - (c) De-escalation and stabilization;
 - (d) Brief intervention and psychological counseling;
 - (e) Peer support.
- (4) Ambulatory withdrawal management based on American Society of Addiction Medicine (ASAM) 2.1 level of care includes:
 - (a) Evaluation, withdrawal management and referral services under a defined set of physician approved policies and clinical protocols;
 - (b) Clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems;
 - (c) Psychological and psychiatric consultation; and
 - (d) Other services determined through the assessment process.
- (5) Clinically or medically monitored withdrawal management in residential setting, if included, not to exceed services described in level 3.7 of the current ASAM patient placement criteria;
- (6) Prescribing and administering medication, if applicable;
- (7) Conducting or arranging for appropriate laboratory and toxicology testing;
- (8) Navigational services for individuals transitioning to the community include:
 - (a) prescription and medication assistance;
 - (b) arranging for temporary or permanent housing;
 - (c) family and natural support group planning;
 - (d) outpatient behavioral health referrals and appointments; and
 - (e) other services determined through the assessment process.
- (9) Assistance in accessing transportation services for recipients who lack safe transportation.

F. Non-covered services: Specific to crisis triage services, the following apply:

- (1) The average length of stay for a residential facility is typically three to seven days, but may be extended for medical necessity;
- (2) Acute medical alcohol detoxification that requires hospitalization as diagnosed by the agency physician or certified nurse practitioner;
- (3) Medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.

- (4) Involuntary commitments or individuals who are not voluntarily seeking treatment.
- G. Prior authorization and utilization review: All MAD services are subject to utilization review (UR) for medical necessity and program compliance. The provider agency must contact HSD or its authorized agents to request UR instructions. It is the provider agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials.
- (1) Prior authorization: Crisis triage services do not require prior authorization but are provided as approved by the crisis triage center provider agency. However, other procedures or services may require prior authorization from MAD or its designee when such services require prior authorization for other MAD eligible recipients, such as inpatient admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. It is the provider agency's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when prior authorization is necessary.
 - (2) Timing of UR: A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agency agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements.
- H. Reimbursement: Crisis triage center services are reimbursed through an agency specific cost based bundled rate relative to type of services rendered.
- (1) Bill both types, specialty 246 – residential/non-residential, and specialty 247 – non-residential on a UB claim form utilizing revenue codes
 - (2) For residential/non-residential:
 - (a) Bill rev code 0169, room and board if staying more than 24 hours
 - (b) Bill rev code 0513, psychiatric clinic if staying less than 24 hours
 - (c) Type of bill is 089X
 - (3) For non-residential (outpatient only) centers:
 - (a) bill rev code 0513, psychiatric clinic.
 - (b) Type of bill is 0131.
 - (4) For both specialty types, residential/non-residential and non-residential only bill any of these revenue codes if that specific service was rendered:
 - (a) 0905 – intensive OP - psychiatric
 - (b) 0906 – intensive OP chemical dependency
 - (c) 0914 – individual therapy
 - (d) 0915 – group therapy
 - (e) 0916 – family therapy
 - (f) 0944 – drug rehab
 - (g) 0945 - alcohol rehab
 - (h) 0961 - psychiatric
 - (i) 0984 - medical social services
 - (j) laboratory: use rev code specific to type of lab service

XV. DAY TREATMENT (DT) - MAD pays for services rendered by a day treatment provider as part of the EPSDT program for eligible recipients under 21 years of age (42 CFR section 441.57). The

need for day treatment services (DTS) must be identified through an EPSDT tot to teen health check or other diagnostic evaluation. Day treatment services include 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 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: An agency must be certified by CYFD to provide day treatment services.
- B. Coverage criteria
 - (1) 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.
 - (2) 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.
 - (3) Services must be based upon the eligible recipient's individualized treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the eligible recipients' adaptive functioning in their home and community.
 - (4) The certified DTS provider delivers adequate care and continuous supervision of the client at all times during the course of the client's DTS program participation.
 - (5) 24-hour availability of appropriate staff or implementation of crisis plan (which may include referral) to respond to the eligible recipient's crisis situation.
 - (6) Only those activities of daily living and basic life skills that are assessed as a clinical problem should be addressed in the treatment plans and deemed appropriate to be included in the eligible recipient's individualized program.
 - (7) 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 eligible recipient and his or her family as identified in the treatment plan.
- C. Identified population: MAD covers day treatment services for an eligible recipient under age 21 who:
 - (1) is diagnosed with an emotional, behavioral, and neurobiological or substance use problem;
 - (2) may be at high risk of out-of-home placement;
 - (3) requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school; and
 - (4) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services.
- D. Covered services:
 - (1) 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 parent and eligible recipient education, and skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the eligible recipient's school or

other child serving agencies are included. Other behavioral health services (e.g. outpatient counseling, ABA) may be provided in addition to the day treatment services when the goals of the service are clearly documented, utilizing a clinical model for service delivery and support.

- (2) The goal of day treatment is to maintain the eligible recipient in his or her home or community environment.
- (3) The service is designed to complement and coordinate with the eligible recipient's educational system.
- (4) Services must be identified in the treatment plan, including crisis planning, which is formulated on an ongoing basis by the treatment team. The treatment plan guides and records for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; and individualized discharge and aftercare plans. Treatment plan requirements are detailed in the BH Policy and Billing Manual.
- (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 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, multifamily, 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, as defined in the DTS treatment plan;
 - (d) family training and family outreach to assist the eligible recipient in gaining functional and behavioral skills;
 - (e) supervision of self-administered medication, as clinically indicated;
 - (f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each eligible recipient's individualized treatment plan;
 - (g) 24-hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the eligible recipient's crisis situations;
 - (h) advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the client pursuant to the treatment plan.

E. Non-covered services: 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 plan;
- (6) leisure time activities such as watching television, movies or playing computer or video games;

- (7) transportation reimbursement for the therapist who delivers services in the family's home; or
- (8) a partial hospitalization program and residential programs cannot be offered at the same time as day treatment services.

F. Prior authorization: This service does not require prior authorization.

G. Reimbursement & Billing Instructions

- (1) All services described are covered in the bundled day treatment rate;
- (2) Submit claims for reimbursement on the CMS-1500 claim form or its successor with HCPCS code H2012; 1-hour unit
- (3) Utilize agency NPI in rendering field

XVI. FAMILY SUPPORT SERVICES (FSS) (Managed Care/Centennial Care enrollees only)

Family Support Services are community-based, face-to-face interactions with children, youth or adults and their family, available to managed care members only. Family Support Services enhance the member family's strengths, capacities, and resources to promote the member's ability to reach the recovery and resiliency behavioral health goals they consider most important.

A. Eligible providers:

- (1) Family Support Services can only be delivered by:
 - (a) Core service agency;
 - (b) CareLink NM health home;
 - (c) Community mental health center;
 - (d) FQHC;
 - (e) IHS and tribal 638;
 - (f) A political subdivision of the state of New Mexico with supervisory certificate; or
 - (g) An opioid treatment program in a methadone clinic with supervisory certificate.
- (2) Family support service providers and staff shall meet standards established by the state of NM and documented in the New Mexico BH Policy and Billing Manual.
- (3) Family support service staff and supervision by licensed behavioral health practitioners must be in accordance with their respective licensing board regulations or credentialing standards for peer support workers or family peer support workers.
- (4) Minimum staff qualifications for peer support workers or family peer support workers include maintenance of credentials as a peer support worker or family peer support worker in New Mexico.
- (5) Minimum staff qualifications for the Clinical Supervisor:
 - (a) Must be a licensed independent practitioner (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, or psychiatrically certified nurse practitioner) practicing under the scope of their NM licensure;
 - (b) Have four years' relevant experience in the delivery of case management or comprehensive community support services or family support services with the target population;
 - (c) Have one year demonstrated supervisory experience; and
 - (d) Have completed both basic and supervisory training regarding family support services.

B. Identified population:

- (1) Members with parents, family members, legal guardians, and other primary caregivers who are living with or closely linked to the member and engaged in the plan of care for the member.
- (2) Members are young persons diagnosed with a severe emotional disturbance or adults diagnosed with serious mental illness as defined by the state of New Mexico.

C. Covered services:

- (1) Minimum required Family Support Services activities:
 - (a) Review of the existing social history and other relevant information with the member and family;
 - (b) Review of the existing service and treatment plans;
 - (c) Identification of the member and family functional strengths and any barriers to recovery;
 - (d) Participation in service planning and delivery with the member and family; and
 - (e) Adherence to the applicable Code of Ethics.
- (2) The specific services provided are tailored to the individual needs of the member and family according to the individual's treatment or service plan and include but are not limited to support needed to:
 - (a) Prevent members from being placed into more restrictive setting; or
 - (b) Quickly reintegrate the member to their home and local community; or
 - (c) Direct the member and family towards recovery, resiliency, restoration, enhancement and maintenance of the member's functioning; or
 - (d) Increase the family's ability to effectively interact with the member.
- (3) Family support services focus on psycho-education, problem solving, and skills building for the family to support the member and may involve support activities such as:
 - (a) Working with teams engaged with the member;
 - (b) Engaging in service planning and service delivery for the member;
 - (c) Identifying family strengths and resiliencies in order to effectively articulate those strengths and prioritize their needs;
 - (d) Navigating the community-based systems and services that impact the member's life;
 - (e) Identifying natural and community supports;
 - (f) Assisting the member and family to understand, adjust to, and manage behavioral health crises and other challenges;
 - (g) Facilitating an understanding of the options for treatment of behavioral health issues;
 - (h) Facilitating an understanding of the principles and practices of recovery and resiliency; and
 - (i) Facilitating effective access and use of the behavioral health service system to achieve recovery and resiliency.
- (4) Documentation requirements:
 - (a) Notes related to all family support service interventions to include how and to what extent the activity promoted family support in relationship to the member's recovery and resilience goals and outcomes;
 - (b) Any supporting collateral documentation.

D. Non-covered services: This service may be billed only during the transition phases from these services:

- (a) Accredited residential treatment;
- (b) Residential treatment services;
- (c) Group home services;
- (d) Inpatient hospitalization;
- (e) Partial hospitalization;
- (f) Treatment foster care;
- (g) Transitional living services;
- (h) Crisis triage centers.

E. Billing Instructions:

- (1) HCPCS code S5110, 15 min units; max 32 units; rendering provider required

XVII. INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS AND PSYCHIATRIC UNITS OF ACUTE CARE HOSPITALS

MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program (42 CFR 441.57). A freestanding psychiatric hospital (an inpatient facility that is not a unit in a general acute care hospital), with more than 16 beds is considered to be an institution for mental disease (IMD) subject to the federal Medicaid IMD exclusion that prohibits Medicaid payment for inpatient stays for eligible recipients aged 22 through 64 years. Coverage of stays in a freestanding psychiatric hospital that is considered an IMD are covered only for eligible recipients under age 21 and over age 64. However, for freestanding psychiatric hospitals, if the eligible recipient receiving inpatient services reaches the age of 21 years, services may continue until one of the following conditions is reached: 1) until the date the eligible recipient no longer requires the services, or 2) until the date the eligible recipient reaches the age of 22 years, whichever occurs first. The need for inpatient psychiatric care in a freestanding psychiatric hospital must be identified in the eligible recipient's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral. For recipients over 65, the need must be documented in a psychiatric evaluation, and referral made.

A managed care organization making payment to an IMD as an in lieu of service may pay for stays that do not exceed 15 days for ages 21 - 65.

Inpatient stays for eligible recipients in an inpatient psychiatric unit of a general acute care hospital are also covered. As these institutions are not considered to be IMDs, there are no age exclusions for their services.

For stays in an IMD that include a substance use disorder (SUD) refer to numeral XVIII, *Institution for Mental Diseases (IMD)*.

XVIII. INSTITUTION FOR MENTAL DISEASES (IMD) FOR SUBSTANCE USE DISORDERS

An IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating substance use disorders (SUD) that is not part of a certified general acute care hospital. The federal Medicaid IMD exclusion generally prohibits payment to these providers for recipients aged 22 through 64. Contingent upon approval of a New Mexico state plan amendment and 1115 waiver, MAD covers inpatient hospitalization in an IMD for SUD diagnoses without the 15-day limitation with criteria for medical necessity and based on ASAM 3.7 and 4.0 admission criteria. The coverage may also include co-occurring behavioral health disorders with the primary SUD. For other approved IMD stays for eligible recipients under age 21 or over age 64, the number of days is determined by medical necessity as the age restriction for IMDs does not apply to ages under 21 or over 65. Also

refer to numeral XVII *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals and Psychiatric Units of Acute Care Hospitals.*

- A. Eligible recipients: Adolescents and adults with a substance use disorder or co-occurring mental health and SUD.
- B. Covered services: Withdrawal management (detoxification) and rehabilitation including treatment for any co-occurring mental health conditions.
- C. Prior authorization is required. Utilize SAMHSA admission criteria 3.7 WM and 4.0 for medical necessity.
- D. Reimbursement:
 - (1) Joint Commission (JC) certified psychiatric hospitals and DOH IMDs are reimbursed on an adjusted cost-based amount for fee-for-service recipients. MCOs reimburse based on a negotiated rate.
 - (2) IMDs are reimbursed for services only; room and board are not reimbursable
 - (3) Bill all services on a UB claim form utilizing a bundled daily rate
 - (4) IMD for SUD
 - (a) rev code 0116 for private room
 - (b) rev code 0126 for semi-private room
 - (5) IMD for mental illness for recipients over 65
 - (a) rev code 0114 for private room
 - (b) rev code 0124 for semi-private room

IXX. INTENSIVE OUTPATIENT PROGRAM (IOP) FOR SUBSTANCE USE DISORDERS

MAD pays for time-limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved by the IOP Interdepartmental Council and target specific behaviors with individualized behavioral interventions. For detailed instructions please see the BH Policy and Billing Manual.

- A. Eligible providers: Services may only be delivered through a MAD approved agency after demonstrating that the agency meets all the requirements of IOP program services and supervision.
 - (1) The following types of agencies that are enrolled with MAD are eligible to be reimbursed for providing IOP services once gaining approval by the Interdepartmental Council:
 - (a) a CMHC;
 - (b) a FQHC;
 - (c) an IHS facility;
 - (d) a PL93-638 tribal facility;
 - (e) a MAD CSA;
 - (f) a CLNM health home;
 - (g) a behavioral health agency with a BHSD supervisory certificate; or
 - (h) an opioid treatment program in a methadone clinic with a BHSD supervisory certificate.
 - (2) IOP services are provided through an integrated interdisciplinary approach including staff expertise in both addiction and mental health treatment. This team may have services rendered by independent practitioners such as Licensed

Alcohol & Drug Abuse Counselors, Certified Alcohol and Drug Abuse Counselors as well as non-independent practitioners under the direction of the IOP supervisor including Licensed Master Level Social Workers, Licensed Mental Health Counselors, Licensed Substance Abuse Associates, and Licensed Psychologist Associates.

- (3) Each IOP program must have a clinical 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;
 - (b) have two years relevant experience with an IOP program;
 - (c) have one year demonstrated supervisory experience; and
 - (d) have expertise in both mental health and substance abuse treatment.
- (4) The IOP agency is required to develop and implement a program outcome evaluation system.
- (5) The agency must maintain the appropriate state facility licensure if offering medication treatment or medication replacement services.
- (6) The agency must hold an IOP Interdepartmental Council approval letter and be enrolled by MAD to render IOP services to an eligible recipient. In the application process each IOP must identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population. A MAD IOP agency will be provisionally approved for a specified timeframe to render IOP services to an eligible recipient. During this provisionally approved time, MAD or its designee will determine if the IOP meets MAD IOP requirements and if so, the agency will receive an approval letter for IOP full enrollment.

B. Identified population:

- (1) IOP services are provided to an eligible recipient 11 through 17 years of age diagnosed with substance abuse disorder or with co-occurring disorders (mental illness and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment; or have been mandated by the local judicial system as an option of least restrictive level of care. Services are not covered if the recipient is defined as an inmate in accordance with 8.200.410.17 NMAC.
- (2) IOP services are provided to an eligible recipient of a transitional age, i.e. moving from adolescence to adulthood, in a transitional age program of which the age range has been determined by the agency, and that have been diagnosed with substance abuse disorder or with co-occurring disorders (mental illness and substance abuse) or that meet the American society of addiction medicine's (ASAM) patient placement criteria for level 2.1 – intensive outpatient treatment, or have been mandated by the local judicial system as an option of least restrictive level of care.
- (3) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with substance abuse disorders or co-occurring disorders (mental illness and substance abuse) that meet the American society of addiction medicine's (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment or have been mandated by the local judicial system as an option of least restrictive level of care.
- (4) Prior to engaging in a MAD IOP program, the eligible recipient must have a treatment file containing:

- (a) one diagnostic evaluation with a diagnosis of substance use disorder; and
 - (b) one individualized treatment or service plan that includes IOP as an intervention.

- C. Coverage criteria:
 - (1) An IOP is based on research and evidence-based practice models (EBP) that target specific behaviors with individualized behavioral interventions. All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved by the IOP Interdepartmental Council. The criteria for having models approved can be accessed in the BH Policy and Billing Manual.
 - (2) Treatment services must address co-occurring disorders when indicated.

- D. Covered services:
 - (1) IOP core services include:
 - (a) individual therapy;
 - (b) group therapy (group membership may not exceed 15 in number); and
 - (c) psycho-education for the eligible recipient and his or her family.
 - (2) Medication management services are available either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of substance use disorders.
 - (3) The duration of an eligible recipient's IOP intervention is typically three to six months. The amount of weekly services per eligible recipient is directly related to the goals specified in his or her IOP treatment plan and the IOP EBP in use.
 - (4) Treatment services must address co-occurring disorders when indicated.

- E. Reimbursement
 - (1) For IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.
 - (2) Core IOP services are reimbursed through a bundled rate. Medication assisted treatment and other mental health therapies are billed and reimbursed separately from the bundled rate.
 - (3) 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.
 - (4) IOP services not provided in accordance with the conditions for coverage as specified in this supplement and in NMAC are not a MAD covered service and are subject to recoupment.

- F. Billing Instructions:
 - (1) HCPCS H0015 – 1-hour unit
 - (2) Use agency NPI in rendering field

XX. INTENSIVE OUTPATIENT PROGRAM (IOP) FOR MENTAL HEALTH CONDITIONS
MAD pays for IOP services which provide a time-limited, multi-faceted approach to treatment for an eligible recipient with a SMI or SED including an eating disorder or borderline personality disorder who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved by the IOP Interdepartmental Council and target specific behaviors with individualized behavioral interventions.

A. Eligible providers: Services may only be delivered through an Interdepartmental Council approved agency after demonstrating that the agency meets all the requirements of IOP program services and supervision. Processes for approval can be accessed in the BH Policy and Billing Manual.

- (1) The following types of agencies are eligible to be reimbursed for providing IOP services once gaining approval by HSD and CYFD:
 - (a) a CMHC;
 - (b) a FQHC;
 - (c) an IHS facility;
 - (d) a PL 93-638 tribal facility;
 - (e) a MAD CSA;
 - (f) a CLNM health home;
 - (g) a behavioral health agency with a BHSD supervisory certificate.
- (2) IOP services are provided through an integrated interdisciplinary approach by staff with expertise in the mental health condition being addressed. This team may have services rendered by non-independent practitioners under the direction of the IOP supervisor including Licensed Masters Social Worker, Licensed Mental Health Counselor, a master's level Psychologist Associate, a Registered nurse, Registered Dietitians, or other practitioners as dictated by the evidence-based practice in use.
- (3) Each IOP program must have a clinical 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 of the following requirements:
 - (a) be licensed as a MAD approved independent practitioner;
 - (b) have two years relevant experience in providing the evidence-based model to be delivered; and
 - (c) have one year demonstrated supervisory experience.
- (4) The IOP agency is required to develop and implement a program outcome evaluation system.
- (5) The agency must maintain the appropriate state facility licensure if offering medication treatment.
- (6) The agency must hold an IOP Interdepartmental Council approval letter and be enrolled by MAD to render IOP services to an eligible recipient. In the application process each IOP must identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population. A MAD IOP agency will be provisionally approved for a specified timeframe to render IOP services to an eligible recipient. During this provisionally approved time, MAD or its designee will determine if the IOP meets MAD IOP requirements and if so, the agency will receive an approval letter for IOP full enrollment.

B. Coverage criteria:

- (1) An IOP is based on research and evidence-based practice models (EBP) that target specific behaviors with individualized behavioral interventions. All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved by the IOP Interdepartmental Council. The criteria for having models approved can be accessed in the BH Policy and Billing Manual.
- (2) Treatment services must address co-occurring disorders when indicated.

- C. Covered services:
- (1) IOP core services include:
 - (a) individual therapy;
 - (b) group therapy (group membership may not exceed 15 in number); and
 - (c) psycho-education for the eligible recipient and his or her family.
 - (2) Medication management services are available either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of substance use disorders.
 - (3) The duration of an eligible recipient's IOP intervention is typically three to six months. The amount of weekly services per eligible recipient is directly related to the goals specified in his or her IOP treatment plan and the IOP EBP in use.
 - (4) Treatment services must address co-occurring disorders when indicated.
- D. Identified population:
- (1) IOP services are provided to an eligible recipient, 11 through 17 years of age diagnosed with a SED;
 - (2) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with a SMI;
 - (3) Prior to engaging in a MAD IOP program, the eligible recipient must have a treatment file containing:
 - (a) one diagnostic evaluation with a diagnosis of serious mental illness or severe emotional disturbance; and
 - (b) one individualized service plan that includes IOP as an intervention.
- E. Non-covered services: MAD does not cover the following specific services billed in conjunction with IOP services:
- (1) acute inpatient;
 - (2) ACT;
 - (3) partial hospitalization;
 - (4) multi-systemic therapy (MST); or
 - (5) psychosocial rehabilitation (PSR) group services.
- F. Reimbursement & Billing Instructions:
- (1) Submit claims on the CMS-1500 claim form or its successor
 - (2) Core IOP services are reimbursed through a bundled rate with HCPCS H0015. Medications and other mental health or SUD therapies are billed and reimbursed separately from the bundled rate.
 - (3) 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.

XXI. MEDICATION ASSISTED TREATMENT (MAT): BUPRENORPHINE TREATMENT FOR OPIOID USE DISORDER

MAD pays for coverage for medication assisted treatment (MAT) for opioid use disorder to an eligible recipient as defined in the Drug Addiction Treatment Act of 2000 (DATA 2000) and subsequent Comprehensive Addiction and Recovery Act (CARA) 114-198. Services include, but are not limited to, the administration of opioid replacement medication (excluding methadone; please see Section XXII below) to an eligible recipient for detoxification from opioids or maintenance treatment.

- A. Eligible providers and practitioners:

- (1) Any clinic, office, or hospital staffed by required practitioners;
- (2) Practitioners for diagnosing, assessment, and prescribing include:
 - (a) a physician or DO licensed in the state of New Mexico that has board certification in addiction medicine or addiction psychiatry or has completed special training and has the federal Data 2000 waiver to prescribe buprenorphine;
 - (b) a certified nurse practitioner that has completed 24 hours of required training and has a DATA 2000 waiver; or
 - (c) a physician assistant licensed in the state of New Mexico and has the federal Data 2000 waiver to prescribe buprenorphine.
- (3) Practitioners for administration and education:
 - (a) a registered nurse licensed in the state of New Mexico; or
 - (b) a physician assistant licensed in the state of New Mexico.
- (4) Practitioners for counseling and education may include:
 - (a) behavioral health practitioners licensed for counseling or therapy;
- (5) Practitioners for skills and education include:
 - (a) certified peer support workers or certified family peer support workers to provide skills-building, recovery and resiliency support.

B. Coverage criteria:

- (1) an assessment and diagnosis by the prescribing practitioner as to whether the recipient has an opioid abuse diagnosis and their readiness for change must be conducted prior to starting treatment;
- (2) an assessment for concurrent medical or behavioral health illnesses;
- (3) an assessment for co-occurring substance abuse disorders;
- (4) educating the recipient as to differing treatment options prior to starting treatment; and
- (5) a service plan that prescribes either in house counseling or therapy, or referral to outside services, as indicated.

C. Eligible recipients: Individuals with an opioid use disorder diagnosis defined by DSM 5 or ICD 10.

D. Covered services:

- (1) history and physical if a current one is not available;
- (2) comprehensive assessment and treatment plan;
- (3) induction phase of opioid treatment;
- (4) administration of medication and concurrent education;
- (5) subsequent evaluation and management visits;
- (6) development and maintenance of medical record log of opioid replacement medication prescriptions;
- (7) development and maintenance of required records regarding inventory, storage and destruction of controlled medications if dispensing from office;
- (8) initiation and tracking of controlled substance agreements with eligible recipients;
- (9) regular monitoring and documentation of NM prescription monitoring program results;
- (10) urine drug screens;
- (11) recovery services (MCO members only);
- (12) family support services (MCO members only).

E. Billing Instructions:

- (1) Diagnosing, assessing, prescribing, and initial induction
 - (a) Practitioners with the DATA 2000 waiver; physicians, CNS, and CNP
 - (b) Use E & M codes for history & physical
 - (c) Induction: H0033
- (2) Medication Administration (after initial induction)
 - (a) Practitioners: RN (317) or PA (305) under supervision of an M.D. or CNP
 - (b) H2010
- (3) Subsequent MD/CNP/PA visits: use E & M codes

XXII. OPIOID TREATMENT PROGRAM (OTP): MAD pays for coverage for medication assisted treatment for opioid addiction to an eligible recipient through an opioid treatment center as defined in (42 CFR Part 8), certification of opioid treatment programs (OTP). Services include, but are not limited to, the administration of methadone (opioid replacement medication) to an individual for detoxification from opioids and maintenance treatment. The administration/supervision must be delivered in conjunction with the overall treatment based upon a treatment plan, which must include counseling/therapy, case review, drug testing, and medication monitoring. Please see the BH Policy and Billing Manual for detailed description of required services and policies.

A. Eligible providers and practitioners:

- (1) Provider requirements:
 - (a) Accreditation with a substance abuse and mental health services administration (SAMHSA)/CSAT approved nationally recognized accreditation body, (e.g., Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission (JC) or council on accreditation of services for families and children (COA).
 - (b) Behavioral health services division (BHSD) approval. As a condition of approval to operate an OTP, the OTP must maintain above accreditation. In the event that such accreditation lapses, or approval of an application for accreditation becomes doubtful, or continued accreditation is subject to any formal or alleged finding of need for improvement, the OTP program will notify the BHSD within two business days of such event. The OTP program will furnish the BHSD with all information related to its accreditation status, or the status of its application for accreditation, upon request.
 - (c) The BHSD shall grant approval or provisional approval to operate pending accreditation, provided that all other requirements of these regulations are met.
- (2) Staffing requirements:
 - (a) Both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations. Provider staff members must be culturally competent;
 - (b) Programs must be staffed by:
 - (i) medical director (MD licensed to practice in the state of New Mexico or a DO licensed to practice in the State of New Mexico);
 - (ii) clinical supervisor must be one of the following: licensed psychologist, or licensed independent social worker; or certified

- nurse practitioner in psychiatric nursing; or licensed professional clinical mental health counselor; or licensed marriage and family therapist;
- (iii) licensed behavioral health practitioner; registered nurse; or licensed practical nurse; and
 - (iv) full time or part time pharmacist.

B. Coverage criteria:

- (1) A physician licensed to practice in New Mexico is designated to serve as medical director and to have authority over all medical aspects of opioid treatment.
- (2) The OTP shall formally designate a program sponsor who shall agree on behalf of the OTP to adhere to all federal and state requirements and regulations regarding the use of opioid agonist treatment medications in the treatment of opioid addiction which may be promulgated in the future.
- (3) The OTP shall be open for patients every day of the week with an option for closure for federal and state holidays, and Sundays, and be closed only as allowed in advance in writing by CSAT and the state opioid treatment authority. Clinic hours should be conducive to the number of patients served and the comprehensive range of services needed.
- (4) Written policies and procedures outlined in the BH Policy and Billing Manual are developed, implemented, compiled, and maintained at the OTP.
- (5) OTP programs will not deny a reasonable request for transfer.
- (6) The OTP will maintain criteria for determining the amount and frequency of counseling that is provided to a patient.
- (7) Referral or transfer of recipients to a suitable alternative treatment program. Because of the risks of relapse following detoxification, patients must be offered a relapse prevention program that includes counseling, naloxone and opioid replacement therapy.
- (8) Provision of unscheduled treatment or counseling to patients.
- (9) Established substance abuse counselor caseloads based on the intensity and duration of counseling required by each patient. Counseling can be provided in person or via telehealth. Counselor to patient ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity. The ratio for one full time counselor shall not exceed 50 patients.
- (10) Preparedness planning: the program has a list of all patients and the patients' dosage requirements available and accessible to program on call staff members.
- (11) Patient records: The OTP program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records.
- (12) Diversion control: a written plan is developed, implemented, and complied with to prevent diversion of opioid treatment medication from its intended purpose to illicit purposes. This plan shall assign specific responsibility to licensed and administrative staff for carrying out the diversion control measures and functions described in the plan. The program shall develop and implement a policy and procedure providing for the reporting of theft or division of medication to the relevant regulatory agencies, and law enforcement authorities.
- (13) Prescription drug monitoring program (PDMP): a written plan is developed, implemented, and complied with to ensure that all OTP physicians and other health care providers, as permitted, are registered to use the New Mexico PDMP.

The PDMP should be checked quarterly through the course of each patient's treatment.

- (14) HIV/AIDS and hepatitis testing and education are available to patients either at the provider or through referral, including treatment, peer group or support group and to social services either at the provider or through referral to a community group.

C. Identified population:

- (1) An eligible recipient is treated for opioid dependency only after the agency's physician determines and documents that:
- (a) the recipient meets the definition of opioid use disorder using generally accepted medical criteria, such as those contained in the current version of the DSM;
 - (b) the recipient has received an initial medical examination as required by 7.32.8.19 NMAC, *opioid treatment program admissions*;
 - (c) if the recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting OTP services unless the recipient receives a waiver of this requirement from the agency's physician because the 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 use disorder within the last 24 months;
 - (iv) is under the age of 18; has had two documented unsuccessful attempts at short-term opioid treatment withdrawal procedures of drug-free treatment within a 12-month period, and has informed consent for treatment provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority; or
 - (v) meets any other requirements specified in 7.32.8 NMAC, *opioid treatment program* regarding waivers, consent, and waiting periods.

D. Covered services:

- (1) Withdrawal treatment and medically supervised dose reduction.
- (2) A biopsychosocial assessment will be conducted by a licensed behavioral health professional or a LADAC under the supervision of an independently licensed clinician, as defined by the NM RLD within 14 days of admission.
- (3) A comprehensive, patient centered, individualized treatment plan shall be conducted within 30 days of admission and be documented in the patient record.
- (4) Each OTP will ensure that adequate medical, psychosocial counseling, mental health, vocational, educational and other services identified in the initial and ongoing treatment plans are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.
- (5) Drug screening: A recipient in comprehensive maintenance treatment receives one random urine drug detection test per month; short-term opioid treatment withdrawal procedure patients receive at least one initial drug abuse test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee. Samples that are sent out for confirmatory testing (by internal or external laboratories) are billed separately by the laboratory.

- E. Non-covered services: Blood samples collected and sent to an outside laboratory.
- F. Reimbursement:
- (1) The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine dipstick testing conducted within the agency.
 - (2) Other services performed by the agency as listed below are reimbursed separately and are required by (42 CFR Part 8.12 (f)), or its successor.
 - (a) A narcotic replacement or agonist drug item other than methadone that is administered or dispensed;
 - (b) Mandatory one hour per month of counseling for substance abuse and HIV required by 42 CFR Part 8.12 (f);
 - (c) Outpatient therapy other than the substance abuse and HIV counseling Referenced in (b) is reimbursable when rendered by a MAD approved independently licensed provider or non-independently licensed provider under supervision;
 - (d) An eligible recipient's initial medical examination when rendered by a MAD approved medical provider;
 - (e) Full medical examination, prenatal care and gender specific services for a pregnant recipient; if she is referred to a provider outside the agency, payment is made to the provider of the service;
 - (f) Medically necessary services provided beyond those required by (42 CFR Part 8.12 (f)), to address the medical issues of the eligible recipient;
 - (g) The quantity of service billed in a single day can include, in addition to the drug items administered that day, the number of take-home medications dispensed that day; and
 - (h) Guest dosing can be reimbursed at Medicaid-enrolled agencies per 7.32.8 NMAC. Arrangements must be confirmed prior to sending the patient to the receiving clinic.
- G. Billing Instructions:
- (1) All listed services must only be rendered by practitioners working within their respective scopes of practice and MAD regulation. A supervisory certificate, issued through BHSD, is required for the use of non-independent practitioners.
 - (2) HCPCS H0020: The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine dipstick testing conducted within the agency.
 - (a) For an IHS or Tribal 638 clinic, MAD considers the bundled OTP services to be reimbursed at the OMB rate unless otherwise negotiated with the facility.
 - (b) For a FQHC, MAD considers the bundled OTP services to be billed at the FQHC encounter rate. For Managed Care, payment is made at the higher of the encounter rate, the fee schedule amount, or a negotiated rate.
 - (3) The quantity of service billed in a single day can include, in addition to the drug items administered that day, the number of take-home medications dispensed that day.
 - (4) Guest dosing can be reimbursed at Medicaid-enrolled agencies. Arrangements must be confirmed prior to sending the patient to the receiving clinic.

- (5) A narcotic replacement or agonist drug item other than methadone that is administered or dispensed: Codes: J0571, J0572, J0573, J0574, J0575.
- (6) An eligible recipient's initial medical examination when rendered by a MAD approved medical provider - H0001.
- (7) H2000 - comprehensive interdisciplinary assessment including initial service plan development under the direction/supervision of an independently licensed practitioner.
- (8) H0031 - mental health assessment by non-physician including initial service plan development (cannot be billed if billing H2000).
- (9) 90791 - 90702 - psychiatric diagnostic evaluations.
- (10) T1007 - Service plan updates following the comprehensive interdisciplinary assessment and service plan.
- (11) H0025 - One hour/month of individual HIV/SUD counseling, or H0025 modifier HQ if delivered in a group setting. One hour is a federal requirement; either individual or group counseling are acceptable.
- (12) Outpatient therapy other than the substance abuse and HIV counseling required by 2 CFR Part 8.12 (f) is reimbursable when rendered by a MAD approved independently licensed provider, or a licensed non-independent provider under the supervision of an independent.
 - (a) 90832 - 90838 - psychotherapy services
 - (b) 90839 - 90840 - psychotherapy for crisis
 - (c) 90846 - 90847 - family psychotherapy
 - (d) 90849 - 90853 - group therapies
 - (e) +90863 - pharmacologic management if combined with psychotherapy
 - (f) +90785 - Interactive complexity
- (13) Medically necessary services provided beyond those required by CFR 42 Part 8.12 (f), to address the medical issues of the eligible recipient; 99201 - 99205: Evaluation and management services for a new patient, and 99213 - 99215 for an established patient.
- (14) Full medical examination, prenatal care and gender specific services for a pregnant recipient. 99201 - 99205: Evaluation and management services for a new patient, and 99213 - 99215 for an established patient.
- (15) Other miscellaneous services:
 - (a) 36415 - blood collection by routine venipuncture
 - (b) 81025 - urine pregnancy test
 - (c) 86580 - skin test; tuberculosis, intradermal
 - (d) G0480 through G0483 drug tests
 - (e) 80307 - drug screening
 - (f) 93000 and 93005 - EKG screening
 - (g) Q3014 - telehealth technical fee for originating site
- (16) Other special services performed by the agency as listed below are reimbursed when documented in the plan of care:
 - (a) H0033 - oral medication administration, direct observation (for buprenorphine induction)
 - (b) H2010 - comprehensive medication services, per 15 min (for buprenorphine administration)
 - (c) H2011 U2 - crisis intervention service in clinic, per 15 min
 - (d) H2011 U3 - crisis intervention, mobile, if having a mobile crisis team
 - (e) H2011 U4 - crisis stabilization, if having a 24-hour OP crisis stabilization service

- (f) H0015 -- intensive outpatient program for substance use disorders, if HSD approved
- (g) H2030 -- recovery services (for MCO members only)
- (h) S5110 -- family support services (for MCO members only)

XXIII. PARTIAL HOSPITALIZATION SERVICES IN AN ACUTE CARE OR FREESTANDING PSYCHIATRIC HOSPITAL

Partial Hospitalization Programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinical services. They are designed to stabilize deteriorating conditions or avert inpatient admissions or can be a step-down strategy for individuals with SMI, SUD or SED who have required inpatient admission. The environment is highly structured, is time-limited and outcome oriented for recipients experiencing acute symptoms or exacerbating clinical conditions that impede their ability to function on a day-to-day basis. Program objectives focus on ensuring important community ties and closely resemble the real-life experiences of the recipients served.

- A. Eligible providers and practitioners: An eligible provider includes a facility Joint Commission accredited, and licensed and certified by DOH or the comparable agency in another state.
 - (1) The program team must include:
 - (a) registered nurse;
 - (b) clinical supervisor for the adult population that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician;
 - (c) clinical supervisor for the child/adolescent population that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician;
 - (d) licensed behavioral health practitioners.
 - (2) The team may also include:
 - (a) physician assistants;
 - (b) certified peer support workers;
 - (c) certified family peer support workers;
 - (d) licensed practical nurses;
 - (e) mental health technicians.
- B. Coverage criteria: MAD covers only those services which meet the following criteria:
 - (1) Services that are ordered by a psychiatrist or licensed Ph.D.
 - (2) Partial hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services are essentially of the same nature and intensity, including medical and nursing services, as would be provided in an inpatient setting, except that the recipient is in the program less than 24-hours a day, and it is a time-limited program.
 - (3) A history and physical (H&P) must be conducted within 24 hours of admission. If the eligible recipient is a direct admission from an acute or psychiatric hospital setting, the program may elect to obtain the H&P in lieu of completing a new H&P. In this instance, the program physician's signature indicates the review and acceptance of the document. The H&P may be conducted by a clinical nurse specialist, a clinical nurse practitioner, a physician assistant or a physician.
 - (4) An interdisciplinary biopsychosocial assessment within seven days of admission including alcohol and drug screening. A full substance abuse evaluation is

required if alcohol and drug screening indicate the need. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment.

- (5) Services are furnished under an individualized written treatment plan established within seven days of initiation of service by the psychiatrist, together with the program's team of professionals, and in consultation with recipients, parents, legal guardian(s) or others who participate in the recipient's care. The plan must state the type, amount, frequency and projected duration of the services to be furnished and indicate the diagnosis and anticipated goals. The treatment plan must be reviewed and updated by the interdisciplinary team every 15 days.
- (6) Documentation must be sufficient to demonstrate that coverage criteria are met, including:
 - (a) Daily documentation of treatment interventions which are outcome focused and based on the comprehensive assessment, treatment goals, culture, expectations, and needs as identified by the recipient, family or other caregivers.
 - (b) Supervision and periodic evaluation of the recipient, either individually or in a group, by the psychiatrist or psychologist to assess the course of treatment. At a minimum, this periodic evaluation of services at intervals indicated by the condition of the recipient must be documented in the recipient's record.
 - (c) Medical justification for any activity therapies, recipient education programs and psychosocial programs.
- (7) Treatment must be reasonably expected to improve the eligible recipient's condition or designed to reduce or control the eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the eligible recipient's level of functions. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.
- (8) For recipients in elementary and secondary school, educational services must be coordinated with the recipient's school system.

C. Identified population:

- (1) Recipients admitted to a PHP shall be under the care of a psychiatrist who certifies the need for partial hospitalization. The recipient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a SMI, SED or moderate to severe SUD which severely interferes with multiple areas of daily life, including social, vocational or educational functioning. Such dysfunction generally is of an acute nature;
- (2) Recipients must have an adequate support system to sustain/maintain his or herself outside the PHP;
- (3) Recipients 19 and over with a serious mental illness including substance use who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment; or
- (4) Recipients age five to 18 with severe emotional disturbances including substance use disorders who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment.

D. Covered services and service limitations: A program of services must be furnished by a MAD enrolled provider delivering partial hospitalization to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

- (1) regularly scheduled structured counseling and therapy sessions for an eligible recipient; his or her family, group or multifamily group, based on individualized needs furnished by licensed behavioral health professionals, and, as specified in the treatment plan;
- (2) educational and skills building groups furnished by the program team to promote recovery;
- (3) 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) drugs and biologicals that cannot be self-administered and are furnished for therapeutic management;
- (5) assistance to the recipient in self-administration of medication in compliance with state policies and procedures;
- (6) appropriate staff available on a 24-hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the recipient, make referrals as necessary, and provide follow-up;
- (7) consultation with other professionals or allied caregivers regarding a specific recipient;
- (8) coordination of all non-medical services, including transportation needed to accomplish a treatment objective;
- (9) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients; and
- (10) discharge planning and referrals as necessary to community resources, supports, and providers in order to promote a recipient's return to a higher level of functioning in the least restrictive environment.

E. Non-covered services: MAD does not cover the following specific services with partial hospitalization:

- (1) meals;
- (2) transportation by the partial hospitalization provider;
- (3) group activities or other services which are primarily recreational or diversional in nature;
- (4) a program that only monitors the management of medication for recipients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a partial hospitalization program;
- (5) actively homicidal or suicidal ideation that would not be safely managed in a PHP;
- (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 eligible recipient; see (42 CFR Section 441.13(b)); or
- (7) services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

F. Prior authorization: Prior authorization is not required for this service unless the length of stay exceeds 45 days, at which time continued stay must be prior authorized (PA) from MAD or its UR contractor; or applicable centennial care MCO. Request for authorization for continued stay must state evidence of the need for the acute, intense, structured combination of services provided by a PHP, and must address the continuing serious nature of the recipient's psychiatric condition requiring active treatment in a PHP and include expectations for imminent improvement. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement. The request for authorization must also specify that a lower level of outpatient services would not be advised, and why, and that the recipient may otherwise require inpatient psychiatric care in the absence of continued stay in the PHP. The request describes:

- (1) the recipient's response to the therapeutic interventions provided by the PHP;
- (2) the recipient's psychiatric symptoms that continue to place the recipient at risk of hospitalization; and
- (3) treatment goals for coordination of services to facilitate discharge from the PHP.

G. Reimbursement and Billing Instructions

(1) Freestanding psychiatric hospitals are reimbursed at an interim percentage rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (Medicare) principles cost methodology. MAD reduces the Medicare allowable costs by three percent. For partial hospitalization services that are not cost settled, such as general acute care hospitals, payments are made at the outpatient hospital prospective levels, when applicable, on the procedure codes.

(2) Facility billing

- (a) Bill on a UB; revenue code 0912
- (b) HCPCS code S0201 per diem. However, the rate for S0201 represents 8 hours of partial hospitalization. If the recipient is in the partial hospitalization program for less than 8 hours, the quantity of service must be billed in the units of 0.25 (2 hours); 0.5 (4 hours), or 0.75 (6 hours). If the recipient is in the partial hospitalization program for more than 8 hours in one day, the units may be increased as 1.25 (10 hours); 1.5 (12 hours); 1.75 (14 hours); or 2 (16 hours).

- (i) Includes all hospital staff that are required for the PH program: independently licensed supervisor, registered nurse, non-independent behavioral health practitioner;
- (ii) Includes optional staff such as licensed practical nurse, physician assistant, peer support worker, and medical technician.

(c) Type of bill 131

(3) Professional billing: For other professional services by physician, psychiatrist, psychologist, certified nurse practitioner, clinical nurse specialist, independently licensed behavioral health practitioners, and occupational therapists, bill on a CMS 1500 claim form.

- (a) **97530** – occupational therapy; therapeutic activities, each 15 minutes

- (b) **G0410** – Group psychotherapy other than with a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
- (c) **G0411** – Interactive group psychotherapy in a partial hospitalization setting, approximately 45 to 50 minutes
- (d) **90832 – 90838** – Individual Psychotherapy
- (e) Evaluation and management services, utilize E & M codes with fee schedule reimbursement
- (f) 90870-90871 - Electroconvulsive Therapy Treatment
- (g) Bill professional services on the CMS 1500 format (837P)
- (h) Other medical services that are not related to the purpose of the partial hospitalization can be reimbursed if they are medically necessary.

XXIV. PSYCHOSOCIAL REHABILITATION SERVICES (PSR)

To help an adult eligible recipient (18 years and older) who met the criteria of SMI, MAD pays for psychosocial rehabilitation services (PSR). PSR is an array of services offered in a group setting through a clubhouse or a classroom and is 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. Psychosocial rehabilitation intervention is intended to be a transitional level of care based on the individual's recovery and resiliency goals.

A. Eligible providers and practitioners:

- (1) The following agencies are eligible to be reimbursed for furnishing PSR to an eligible recipient:
 - (a) an IHS facility that meets the licensing requirement of a CMHC but elects not to seek such enrollment; and
 - (b) a CMHC licensed by DOH
- (2) An agency which furnishes PSR services must have direct experience in successfully serving individuals with SMI.
- (3) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services.
- (4) Staffing requirements:
 - (a) Both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations.
 - (b) PSR services must meet a staff ratio guideline of 1:2 minimum and 1:10 maximum.
 - (c) In both clubhouse and classroom settings, the entire staff works as a team.
 - (d) The team must include a clinical supervisor/team lead and can include the following:
 - (i) certified peer support workers;
 - (ii) certified family support workers;
 - (iii) community support workers;
 - (iv) other HIPAA trained individuals working under the direct supervision of the clinical supervisor.
 - (e) Minimum qualifications for the clinical supervisor/team lead:
 - (i) independently licensed behavioral health professional (i.e. psychiatrist, psychologist, LISW, LPCC, LMFT, psychiatrically certified (CNS) practicing under the scope of their NM license;

- (ii) have one year of demonstrated supervisory experience;
- (iii) demonstrated knowledge and competence in the field of psychosocial; rehabilitation; and
- (iv) an attestation of training related to providing clinical supervision of non-clinical staff.

B. Coverage criteria:

- (1) MAD covers only those PSR services which comply with DOH licensing standards and are medically necessary to meet the individual needs of the eligible recipient, as delineated in his or her service plan and treatment plan. Medical necessity is based upon the eligible recipient's level of functioning as affected by his or her SMI. The PSR services are limited to goals which are individually designed to accommodate the level of the eligible recipient's functioning and which reduce the disability and restore the recipient to his or her best possible level of functioning.
- (2) These services must be provided in a facility-based setting, either in a clubhouse model or a structured classroom.
- (3) PSR services must be identified and justified in the individual's treatment or service plan. Recipients shall participate in PSR services for those activities that are identified in the treatment or service plan and are tied directly to the recipient's recovery and resiliency plan/goals.
- (4) Specific service needs (e.g., household management, nutrition, hygiene, money management, parenting skills, etc.) must be identified in the individual's treatment or service plan.

C. Identified population:

- (1) An eligible recipient 18 years or older meeting the criteria for SMI and for whom the medical necessity for PSR services was determined.
- (2) Adults diagnosed with co-occurring SMI and substance use disorders and for whom the medical necessity for PSR services was determined.
- (3) A resident in an institution for mental illness is not eligible for this service.

D. Covered services

The Psychosocial Intervention (PSI) program must include the following major components: basic living skills development; psychosocial skills training; therapeutic socialization; and individual empowerment.

- (1) Basic living skills development activities address the following areas:
 - (a) basic household management;
 - (b) basic nutrition, health, and personal care including hygiene;
 - (c) personal safety;
 - (d) time management skills;
 - (e) money management skills;
 - (f) how to access and utilize transportation;
 - (g) awareness of community resources and support in their use;
 - (h) child care/parenting skills;
 - (i) work or employment skill-building; and
 - (j) how to access housing resources.
- (2) Psychosocial Skills Training activities address the following areas:
 - (a) self-management;
 - (b) cognitive functioning;
 - (c) social/communication; and

- (d) problem-solving skills.
 - (3) Therapeutic Socialization activities address the following areas:
 - (a) understanding the importance of healthy leisure time;
 - (b) accessing community recreational facilities and resources;
 - (c) physical health and fitness needs;
 - (d) social and recreational skills and opportunities; and
 - (e) harm reduction and relapse prevention strategies (for individuals with co-occurring disorders).
 - (4) Individual Empowerment activities address the following areas:
 - (a) choice;
 - (b) self-advocacy;
 - (c) self-management; and
 - (d) community integration.
- E. Non-covered services: 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. To determine if the medical necessity for the service has been met, the following factors are considered:
 - (1) recipient assessment;
 - (2) recipient diagnostic formation;
- G. Billing Instructions: Claims for reimbursement are submitted on the CMS-1500 claim form or its successor.
 - (1) H2017: 15 min unit
 - (2) Utilize agency provider ID and NPI in rendering fields

XXV. RECOVERY SUPPORT SERVICES (Managed Care/Centennial Care enrollees only)

Recovery services are peer-to-peer support for centennial care members to develop and enhance wellness and health care practices. Recovery services promote self-responsibility through recipients learning new health care practices from a peer who has had similar life challenges and who has developed self-efficacy in using needed skills.

- A. Eligible providers and practitioners:
- (1) Provider types:
 - (a) core service agency;
 - (b) behavioral health agency;
 - (c) CLNM health homes; and
 - (d) opioid treatment program in a methadone clinic with supervisory certificate.
 - (2) Staff:
 - (a) all staff must possess a current and valid NM driver's license;
 - (b) clinical supervisor:
 - (i) licensed as an independent practitioner (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, CNP, CNS); and
 - (ii) two years relevant experience with the target population; and
 - (iii) one year demonstrated supervisory experience; and
 - (iv) expertise in both mental health and addiction treatment services;
 - (v) supervision must be conducted in accord with respective licensing board regulations.

- (c) certified peer support workers; and
 - (d) certified family specialists.
 - (3) Group ratios may not exceed 1:10.
- B. Coverage criteria: Services occur individually or with consumers who support each other to optimize learning new skills. This skill enhancement then augments the effectiveness of other treatment and recovery support initiatives.
- (1) Admissions criteria: Consumer has been unable to achieve functional use of natural and community support systems to effectively self-manage recovery and wellness.
 - (2) Continuation of services criteria: Consumer has made progress in achieving use of natural and community support systems to effectively self-manage recovery and wellness but continues to need support in developing those competencies.
 - (3) Discharge criteria: Consumer has achieved maximum use of natural and community support systems to effectively self-manage recovery and wellness.
- C. Identified population:
- (1) Children experiencing serious emotional/neurobiological/behavioral disorders;
 - (2) Adults with serious mental illness (SMI); and
 - (3) Individuals with chronic substance abuse; or individuals with a co-occurring disorder (mental illness/substance abuse) or dually diagnosed with a primary diagnosis of mental illness.
- D. Covered services:
- (1) This service will particularly focus on the individual's wellness, ongoing recovery and resiliency, relapse prevention, and chronic disease management.
 - (2) Recovery services support specific recovery goals through:
 - (a) use of strategies for maintaining the eight dimensions of wellness;
 - (b) creation of relapse prevention plans;
 - (c) learning chronic disease management methods; and
 - (d) identification of linkages to ongoing community supports.
 - (3) Activities must support the individual's recovery goals. There must be documented evidence of the individual identifying desired recovery goals and outcomes and incorporating them into a recovery services treatment plan.
 - (4) Recovery services activities include, but are not limited to:
 - (a) screening, engaging, coaching, and educating.
 - (b) emotional support that demonstrates empathy, caring, or concern to bolster the person's self-esteem and confidence.
 - (c) sharing knowledge and information or providing life skills training.
 - (d) provision of concrete assistance to help others accomplish tasks.
 - (e) facilitation of contacts with other people to promote learning of social and recreational skills, create community and acquire a sense of belonging.
 - (5) Recovery services can be delivered in an individual or group setting.
- E. Non-covered services: This service may not be billed in conjunction with:
- (1) multi-systemic therapy (MST);
 - (2) assertive community treatment (ACT);
 - (3) partial hospitalization;
 - (4) transitional living services (TLS); or
 - (5) therapeutic foster care (TFC).

- F. Billing Instructions:
- (1) HCPCS code H2030 in 15 min units
 - (2) Rendering provider required
 - (3) H0038; (Peer Support) 15 min units

XXVI. SCREENING, BRIEF INTERVENTION & REFERRAL TO TREATMENT (SBIRT)

The effective date will be January 1, 2019, or as otherwise approved by the centers for Medicare and Medicaid services (CMS).

SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with medical care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for additional treatment, the staff member will refer to behavioral health services.

A. Eligible providers and practitioners.

- (1) Providers:
 - (a) primary care offices including FQHCs, IHS and 638 tribal facilities;
 - (b) patient centered medical homes;
 - (c) urgent care centers;
 - (d) hospital outpatient facilities;
 - (e) emergency departments;
 - (f) rural health clinics;
 - (g) specialty physical health clinics; and
 - (h) school-based health centers.
- (2) Practitioners must be trained in SBIRT and may include:
 - (a) licensed nurse;
 - (b) licensed nurse practitioner or licensed nurse clinician;
 - (c) behavioral health practitioner;
 - (d) certified peer support worker;
 - (e) certified community health worker;
 - (f) licensed physician assistant;
 - (g) physician;
 - (h) medical assistant; and
 - (i) community health representative in tribal clinics.

B. Coverage Criteria:

- (1) screening shall be universal for recipients being seen in a medical setting;
- (2) referral relationships with mental health agencies and practices are in place;
- (3) utilization of approved screening tool specific to age described in the BH Policy and Billing Manual;
- (4) all participating providers and practitioners are trained in SBIRT through state approved SBIRT training entities. See details in the BH Policy and Billing Manual.

C. Identified population:

- (1) MAD recipient adolescents 11-13 years of age with parental consent
- (2) MAD recipient adolescents 14-18 years of age
- (3) MAD recipient adults 19 years and older

D. Covered services:

- (1) SBIRT screening with negative results eligible for only screening component;
- (2) SBIRT screening with positive results for alcohol, or other drugs, and co-occurring with depression, or anxiety, or trauma are eligible for:
 - (a) screening;
 - (b) brief intervention and referral to behavioral health treatment, if needed.

E: Billing Instructions:

- (1) Screening - H0049; does not require a diagnosis
- (2) Brief Intervention - H0050; use a provisional diagnosis
- (3) Practitioners: Must all be trained in SBIRT
301, 302, 305, 306, 313, 317, 411, 430, 431, 435, 436, 438, 440, 443, 444, 445

XXVII. TREATMENT FOSTER CARE I & II

MAD pays for medically necessary services furnished to an eligible recipient under 21 years of age who has an identified need for treatment foster care (TFC) and meets the TFC I or TFC II level of care (LOC) as part of the EPSDT program. MAD covers those services included in the eligible recipient's individualized treatment plan which is designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into the community. TFC I agency provides therapeutic services to an eligible recipient who is experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a TFC I setting. The TFC II agency provides therapeutic family living experiences as the core treatment service to which other individualized services can be added. The need for TFC I and II services must be identified in the tot to teen health check or other diagnostic evaluation furnished through the eligible recipient's health check referral.

A. Eligible agencies: The agency must be a CYFD certified TFC agency and be licensed as a child placement agency by CYFD protective services.

B. Coverage criteria:

- (1) The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents.
- (2) A TFC I and II parent are either employed or contracted by the TFC agency and receives appropriate training and supervision by the TFC agency.
- (3) Placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the recipient's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable match for the recipient.
- (4) An initial treatment plan must be developed within 72 hours of admission and a comprehensive treatment plan must be developed within 14 calendar days of the eligible recipient's admission to a TFC I or II program. See the BH Policy and Billing Manual for the specific requirements of a TFC treatment plan.
- (5) The treatment team must review the treatment plan every 30 calendar days.
- (6) TFC families must have one parent readily accessible at all times, cannot schedule work when the eligible recipient is normally at home, and is able to be

physically present to meet the eligible recipient's emotional and behavioral needs.

- (7) In the event the treatment foster parents request a treatment foster recipient be removed from their home, a treatment team meeting must be held, and an agreement made that a move is in the best interest of the involved recipient. Any treatment foster parent(s) who demands removal of a treatment foster recipient from his or her home without first discussing with and obtaining consensus of the treatment team, may have their license revoked.
- (8) A recipient eligible for treatment foster care services, level I or II, may change treatment foster homes only under the following circumstances:
 - (a) an effort is being made to reunite siblings; or
 - (b) a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

C. Identified population:

- (1) TFC I services are for an eligible recipient who meets the following criteria:
 - (a) is at risk for placement in a higher level of care or is returning from a higher level of care and is appropriate for a lower level of care; or
 - (b) has complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and
 - (c) requires and would optimally benefit from the behavioral health services and supervision provided in a treatment foster home setting.
- (2) TFC II services are for an eligible recipient who meets the criteria listed in C (1) and also meets one of the following criteria:
 - (a) has successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or
 - (b) requires the initiation or continuity of treatment and support of the treatment foster family to secure or maintain therapeutic gains; or
 - (c) requires this treatment modality as an appropriate entry level service from which the client will optimally benefit.
- (3) An eligible recipient has the right to receive services from any MAD TFC enrolled agency of his or her choice.

D. Covered services: The family living experience is the core treatment service to which other individualized services can be added, as appropriate to meet the recipient's needs.

- (1) The TFC parental responsibilities include, but are not limited to:
 - (a) meeting the recipient's base needs, and providing daily care and supervision;
 - (b) participating in the development of treatment plans for the recipient by providing input based on his or her observations;
 - (c) assuming the primary responsibility for implementing the in-home treatment strategies specified in the recipient's treatment plan;
 - (d) recording the recipient's information and documentation of activities, as required by the TFC agency and the standards under which it operates;
 - (e) assisting the recipient with maintaining contact with his or her family and enhancing that relationship;
 - (f) supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals;
 - (g) reunification with the recipient's family. The treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan;

- (h) assisting the recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan;
 - (i) ensuring proper and adequate supervision is provided at all times. Treatment teams determine that all out-of-home activities are appropriate for the recipient's level of need, including the need for supervision; and
 - (j) working with all appropriate and available community-based resources to secure services for and to advocate for the recipient.
- (2) The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents. The following services must be furnished by both TFC I and II agencies unless specified for either I or II. Payment for performance of these services is included in the TFC agency's reimbursement rate:
- (a) facilitation, monitoring and documenting of treatment of TFC parents initial and ongoing training;
 - (b) providing support, assistance and training to the TFC parents;
 - (c) providing assessments for pre-placement and placement to determine the eligible recipient's placement is therapeutically appropriate;
 - (d) ongoing review of the eligible recipient's progress in TFC and assessment of family interactions and stress;
 - (e) ongoing treatment planning and treatment team meetings;
 - (f) provision of individual, family or group psychotherapy to recipients as described in the treatment plan. The TFC therapist is an active treatment team member and participates fully in the treatment planning process;
 - (g) family therapy is required when client reunification with their family is the goal;
 - (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 recipient;
 - (i) providing crisis intervention on call to treatment foster parents, recipients and their families on a 24-hour, seven days a week basis including 24-hour availability of appropriate staff to respond to the home in crisis situations;
 - (j) assessing the family's strengths, needs and developing a family service plan when an eligible recipient's return to his or her family is planned;
 - (k) conducting a private face-to-face visit with the recipient within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator;
 - (l) conducting a face-to-face interview with the recipient's TFC parents within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator;
 - (m) conducting at a minimum one phone contact with the TFC I parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator;
 - (n) conducting a private face-to-face interview with the recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator;
 - (o) conducting a face-to-face interview with the recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator; and

- (p) conducting at a minimum one phone contact with the TFC II parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator.

- E. Non-covered services: Specific to TFC I and II services MAD does not cover:
 - (1) room and board;
 - (2) formal educational or vocational services related to traditional academic subjects or vocational training;
 - (3) respite care; and
 - (4) CCSS except as part of the discharge planning from either the recipient's TFC I or II placement.

- F. Prior authorization: Before any TFC service is furnished to an eligible recipient, prior authorization is required from MAD or its UR contractor. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

- G. Billing Instructions: Submit claims for reimbursement on the CMS-1500 form or its successor.
 - (1) Level I - S5145: unit 1 day; max units 31/month
 - (2) Level II - S5145 (U1): unit 1 day; max units 31/month