

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

8.321.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.321.2.1 NMAC - Rp, 8.321.2.1 NMAC, 1/1/2020]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC - Rp, 8.321.2.2 NMAC, 1/1/2020]

8.321.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq., NMSA 1978.
[8.321.2.3 NMAC - Rp, 8.321.2.3 NMAC, 1/1/2020]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC - Rp, 8.321.2.4 NMAC, 1/1/2020]

8.321.2.5 EFFECTIVE DATE: January 1, 2020, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - Rp, 8.321.2.5 NMAC, 1/1/2020]

8.321.2.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.321.2.6 NMAC - Rp, 8.321.2.6 NMAC, 1/1/2020]

8.321.2.7 DEFINITIONS: [RESERVED]

8.321.2.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.321.2.8 NMAC - Rp, 8.321.2.8 NMAC, 1/1/2020]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

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

B. Services must be provided within the licensure for each facility and scope of practice for each provider and supervising or rendering practitioner. Services must be in compliance with the statutes, rules and

regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.2 NMAC and 8.310.3 NMAC.

C. The following independent providers with active licenses (not provisional or temporary) are eligible to be reimbursed directly for providing MAD 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, 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) 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 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 MAD to be substantially equivalent to the license and certification requirements of New Mexico.

D. 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; and
- (13) a crisis services community provider as a BHA.

E. A behavioral health service rendered by a licensed practitioner listed in Paragraph (2) of Subsection E of 8.321.2.9 NMAC whose scope of licensure does not allow him or her to practice independently or a non-licensed practitioner listed in Paragraph (3) of Subsection E of 8.321.2.9 NMAC 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 D of 8.321.2.9 NMAC and numbers 10 through 13 of Subsection D of 8.321.2.9 NMAC when the agency has a behavioral health services division (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 of 8.321.2.9 NMAC.

(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) licensed by RLD's examiner board;
- (d) a licensed associate marriage and family therapist (LAMFT) licensed by RLD's examiner board;
- (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 will be eligible for reimbursement aligned with each tier level of designated scope of practice determined by the board;
- (g) a registered nurse (RN) licensed by the New Mexico board of nursing under the supervision of a certified nurse practitioner, clinical nurse specialist or physician; or
- (h) a licensed physician assistant certified by the state of New Mexico if supervised by a behavioral health physician or DO licensed by RLD's examiner board.

(3) Non-licensed practitioners must be one of the following:

- (a) a master's level behavioral health intern;
- (b) a psychology intern including psychology practicum students, pre-doctoral internship;
- (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 D of 8.321.2.9 NMAC. A supervisory certificate is not required.

(5) The rendering practitioner must be enrolled as a MAD provider.

F. 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.

G. Either as a separate service or a component of a treatment plan or a bundled service, the following services are not MAD covered benefits:

- (1) hypnotherapy;
- (2) biofeedback;
- (3) conditions that do not meet the standard of medical necessity as defined in NMAC MAD rules;
- (4) educational or vocational services related to traditional academic subjects or vocational training;
- (5) experimental or investigational procedures, technologies or non-drug therapies and related services;
- (6) activity therapy, group activities and other services which are primarily recreational or diversional in nature;
- (7) electroconvulsive therapy;
- (8) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside his or her scope of practice;
- (9) treatment of intellectual disabilities alone;
- (10) services not considered medically necessary for the condition of the eligible recipient;

- (11) services for which prior authorization is required but was not obtained; and
- (12) milieu therapy.

H. All behavioral health services must meet with the current MAD definition of medical necessity found in 8.302.1 NMAC. Performance of a MAD behavioral health service cannot be delegated to a provider or practitioner not licensed for independent practice except as specified within this rule, within his or her practice board's scope and practice and in accordance with applicable federal, state, and local statutes, laws and rules. When a service is performed by a supervised practitioner, the supervision of the service cannot be billed separately or additionally. Other than agencies as allowed in Subsections D and E of 8.321.2.9 NMAC, a behavioral health provider cannot himself or herself as a rendering provider bill for a service for which he or she was providing supervision and the service was in part or wholly performed by a different individual. Behavioral health services are reimbursed as follows, except when otherwise described within a particular specialized service's reimbursement section.

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

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

(2) Reimbursement is made for an Indian health service (IHS) agency, a PL 93-638 tribal health facility, a federally qualified health center (FQHC), rural health clinic, or hospital-based rural health clinic by following its federal guidelines and special provisions as detailed in 8.310.4 and 8.310.12 NMAC.

I. All behavioral health services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after service is furnished but before a payment is made, or after the payment is made; see 8.310.2 NMAC. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's and practitioner's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specialized behavioral health service may have additional prior authorization requirements listed in that service's prior authorization subsection. All prior authorization procedures must follow federal parity law.

J. For an eligible recipient to access behavioral health services, a practitioner must complete a diagnostic evaluation, progress and treatment notes and teaming notes, if indicated. Exceptions to this whereby a treatment or set of treatments may be performed before a diagnostic evaluation has been done, utilizing a provisional diagnosis based on screening results are outlined in 8.321.2.14, 8.321.2.18 and 8.321.2.34 NMAC and in the behavioral health (BH) policy and billing manual. For a limited set of treatments, (i.e. four or less), no treatment plan is required. All documentation must be signed, dated and placed in the eligible recipient's file. All documentation must be made available for review by HSD or its designees in the eligible recipient's file (see the BH policy and billing manual for specific instructions).

K. 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 D of 8.321.2.9 NMAC.

(2) Behavioral health service plans can be developed by individuals employed by the agency who have Health Insurance Portability and Accountability Act (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.

L. For out-patient, non-residential 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, where multiple provider disciplines are required and engaged either for

co-occurring conditions, or other social determinants of health, 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, purpose and frequency of interdisciplinary team meetings:

(a) 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; and

(b) covered team meetings resulting in service plan changes or updates are limited to an annual review, when recipient conditions change, or at critical decision points in the recipient's progress to recovery.

(2) The team consists of:

(a) a lead agency, which must be one of the agencies listed in Subsection D of 8.321.2.9 NMAC. 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;

(b) a participating provider that 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;

(c) 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

(d) the recipient, who is the subject of this service plan update, must be a participating member of every teaming meeting.

(3) Reimbursement:

(a) 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.

(b) when the team lead and only one other provider meet 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.

(c) 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 telehealth platforms 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.

(d) 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.

(e) billing instructions are found in the BH policy and billing manual.

M. For recipients with behavioral health diagnoses and other co-occurring conditions, or other social determinants of health meeting medical necessity, and for whom multiple provider disciplines are engaged, MAD covers service plan development and one subsequent update per year for an interdisciplinary team.

(1) The team consists of:

(a) 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;

(b) a participating MAD enrolled provider from a different discipline;

(c) 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

(d) the recipient, who is the subject of this service plan development and update, must be a participating member of each team meeting.

(2) Reimbursement:

(a) 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;

(b) this service plan development and subsequent update to the original plan can only be billed twice within one year; and

(c) billing instructions are found in the BH policy and billing manual.
[8.321.2.9 NMAC - Rp, 8.321.2.9 NMAC, 1/1/2020]

8.321.2.10 ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) FOR ADULTS WITH SUBSTANCE USE DISORDERS: To help an eligible recipient 18 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).

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 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;

(c) must meet ASAM treatment service requirements for the ASAM level of care three recipients it admits into each sub-level of care;

(d) must provide medication assisted treatment (MAT) for SUD, as indicated; and

(e) all practitioners shall 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) 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.

(2) 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. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) 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.

(4) 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.

(5) 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; and
- (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.

(6) 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 3.2WM 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 3.7WM 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. Covered services:

(1) ARTCs treating all recipients meeting ASAM level three criteria. MAD covers residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A clinically-managed ARTC facility must provide 24-hour care with trained staff.

(2) Referrals from an independent practitioner are required.

D. Non-covered services: ARTC services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. 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; and

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

E. 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.

F. 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.

G. Reimbursement: An ARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. 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.

(4) Detailed billing instructions can be accessed in the BH policy and billing manual.

[8.321.2.10 NMAC - N, 1/1/2020]

8.321.2.11 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) In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order 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; and

(c) 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. Covered services: MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. An ARTC facility must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the eligible recipient. The ARTC will coordinate with the educational program of the recipient, if applicable.

(1) Treatment must be furnished under the direction of a MAD board eligible or certified psychiatrist.

(2) Treatment must 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. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

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

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

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

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

(c) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the eligible recipient;

(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;

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable;

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

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

C. Non-covered services: ARTC services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with ARTC services to an eligible recipient:

(1) 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; ARTC and group services are covered only for eligible recipients under 21 years of age;
- (4) formal educational and vocational services which relate to traditional academic subjects or vocation training; and
- (5) activity therapy, group activities, and other services primarily recreational or diversional in nature.

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the eligible recipient's admission to an ARTC facility. The interdisciplinary team must review the treatment plan at least every 30 calendar days. In addition to the requirements of Subsection K of 8.321.2.9 NMAC, all supporting documentation must be available for review in the eligible recipient's file. The treatment plan must also include a statement of the eligible recipient's cultural needs and provision for access to cultural practices.

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

F. Reimbursement: An ARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

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

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

(b) Services which are not covered in routine services include 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, are billed directly by the applicable providers and are governed by applicable sections of NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD covered service include services not related to medical necessity, clinical treatment, and patient care.

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

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

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

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

(4) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the New Mexico border (Mexico excluded) are at the fee schedule unless a separate rate is negotiated. [8.321.2.11 NMAC - Rp, 8.321.2.11 NMAC, 1/1/2020]

8.321.2.12 APPLIED BEHAVIOR ANALYSIS (ABA): MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) services for eligible recipients who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients 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, developmentally disabled waiver services, etc.). ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57). There is no age requirement to receive ABA services and ABA is a covered benefit for medicaid-enrolled adults.

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 and 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 of 8.321.2.12 NMAC.

(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 8.321.2 NMAC as a behavior analyst assistant (BAA).

B. Eligible providers: ABA services are rendered by a number of 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 and 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 a ABA stage two-behavior or functional analytic assessment, service model determination and ABA treatment plans 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; or
 - (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; or
 - (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); and

- (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 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 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 all of 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 specialty care practitioner (SCP).

(6) If the eligible recipient is in a residential facility or institutional setting 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 able 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 or not changes are needed in the eligible recipient's ISP or treatment plan. Additionally, the family or AP may request ISP modifications prior to the UR contractor's six-month authorization point 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) the 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; and

(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 in order 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 with, or to implement his or herself, individualized interventions to address the behavioral concerns for which the referral is based on medical documentation.

(5) Services may continue until the eligible recipient no longer meets service criteria for ABA services as described in the BH policy and billing manual.

(6) See the BH policy and billing manual for specific instructions on prior authorizations.

F. Non-covered services:

(1) 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) Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA treatment plan.

(3) Activities that are not based on the principles and application of applied behavior analysis.

(4) Activities that take place in school settings and have the potential to supplant educational services.

(5) 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.

(6) Activities which are better characterized as staff training certification or licensure or certification supervision requirements, rather than ABA case supervision.

G. Reimbursement: Billing instructions for ABA services are detailed in the BH policy and billing manual.

[8.321.2.12 NMAC - Rp, 8.321.2.10 NMAC, 1/1/2020]

8.321.2.13 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help an eligible recipient with medically necessary services 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. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(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 Paragraph (5) of Subsection A of 8.321.2.13 NMAC 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 dependent on the nature of the team based on clinical severity and rural vs. urban environment pending BHSD approval to ensure fidelity with current model.

(6) Each ACT team must comply with 8.321.2.9 NMAC for 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, or other allied medical professionals may be used in place of one nurse;

(d) at least one other MAD recognized independently licensed behavioral health professional, see Subsection C of 8.321.2.9 NMAC;

(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 psychiatric disorders, 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 basis of principles covered in the BH policy and billing manual.

E. Non-covered services: ACT services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for MAD general non-covered behavioral health 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. Reimbursement: ACT agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 for MAD general reimbursement requirements. [8.321.2.13 NMAC - Rp 8.321.2.12 NMAC, 1/1/2020]

8.321.2.14 BEHAVIORAL HEALTH PROFESSIONAL SERVICES FOR SCREENINGS, EVALUATIONS, ASSESSMENTS AND THERAPY: MAD covers validated screenings for high risk conditions in order to provide prevention or early intervention. Brief interventions or 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. See the BH policy and billing manual for a description of the treat first clinical model.

A. 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 abuse 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 (see Subsections B through E of 8.321.2.9 NMAC). 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.

B. 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 (see Subsection B of 8.321.2.9 NMAC). 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. See Subsection K of 8.321.2.9 NMAC for detailed description of the required eligible recipient file documentation.

C. 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.

[8.321.2.14 NMAC - Rp, 8.321.2.22 NMAC, 1/1/2020]

8.321.2.15 BEHAVIORAL HEALTH RESPITE CARE (Managed Care Organization (MCO 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 in order 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; and
- (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; and
- (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 on a daily basis; 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 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.
- [8.321.2.15 NMAC - N, 1/1/2020]

8.321.2.16 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: To help an eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD pays for behavior management services (BMS) as part of the EPSDT program and when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation (see 42 CFR Section 441.57). 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: An agency must be certified by CYFD to provide BMS services. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

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 (8.321.2.9 NMAC). 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, 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: BMS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

- (1) activities which are not designed to accomplish the objectives 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. Reimbursement: A BMS agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC.

[8.321.2.16 NMAC - Rp 8.321.2.13 NMAC, 1/1/2020]

8.321.2.17 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 the behavioral health services division (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; and
- (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 evidence-based practice (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. See Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services.

(2) MAD does not cover the CET during an acute inpatient stay.

E. Reimbursement: See subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement.

(1) For CET services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

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

(3) CET services furnished by a CET team member are billed by and reimbursed to a MAD CET agency whether the team member is under contract with or employed by the CET agency.

(4) CET services not provided in accordance with the conditions for coverage as specified in 8.321.2.9 NMAC are not a MAD covered service and are subject to recoupments.

(5) Billing instructions for CET services are detailed in the BH policy and billing manual. [8.321.2.17 NMAC - N, 1/1/2020]

8.321.2.18 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): To help a New Mexico eligible recipient receive medically necessary services, MAD pays for covered 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 addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing CCSS services, an agency must be:

(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; or

(g) a CMHC.

(2) To provide CCSS services, a provider must receive CCSS training through the state or state approved trainer 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's degree and a minimum of two years of experience working with the target population; or
 - (iv) hold an associate's 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 of 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 have an understanding of 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) A maximum of 16 units per each admission or discharge may be billed concurrently with:
- (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 severe emotional disturbance (SED)/neurobiological/behavioral disorders; 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. See 8.310.2 NMAC for a detailed description of MAD general non-covered services and Subsection G of 8.321.2.9 NMAC for all non-covered MAD behavioral health services or activities. 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. Reimbursement: CCSS agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information. General reimbursement instructions are found in this rule under Subsection H of 8.321.2.9 NMAC. Billing instructions for CCSS are found in the BH policy and billing manual.

[8.321.2.18 NMAC - Rp, 8.321.2.14 NMAC, 1/1/2020]

8.321.2.19 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 if 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 include:
 - (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 described in 8.321.2.19 NMAC.
- (4) **Crisis stabilization services:** 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.

B. Eligible providers and practitioners:

- (1) **Telephone crisis services (Independently licensed BH practitioner):**
 - (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; or
 - (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; and

- (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;

and

- (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; and

- (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 or available for on-call response 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; and
 - (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; and
 - (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. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to crisis intervention services.
[8.321.2.19 NMAC - N, 1/1/2020]

8.321.2.20 CRISIS TRIAGE CENTER: 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, 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 of trauma;

(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, the appropriate clinical laboratory improvement amendments (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; and

(2) Paragraph (3) through (14) of Subsection A of 8.321.2.20 NMAC 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 residential and 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) Certified peer support workers (CPSW) holding a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker staffed appropriate to meet the client needs 24 hours a day 7 days a week.
- (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 as described in 8.310.3 NMAC.
- (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 as described in 8.321.2 NMAC, or a prescribing psychologist licensed by the board of psychologist examiners or psychiatric certified nurse practitioner as licensed by the board of nursing. 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 (non-residential) 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 when available 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: are subject to the limitations and coverage restrictions that exist for other MAD services. See 8.310.2 and 8.321.2 NMAC for general non-covered services. Specific to crisis triage services, the following apply:

- (1) Acute medical alcohol detoxification that requires hospitalization as diagnosed by the agency physician or certified nurse practitioner.
- (2) Medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.

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. Billing details are provided in the BH policy and billing manual.

[8.321.2.20 NMAC - N, 1/1/2020]

8.321.2.21 DAY TREATMENT: MAD pays for services provided 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 in addition to meeting the general provider enrollment requirements in Subsections A and B of 8.321.2.9 NMAC.

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 abuse 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: Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

- (1) educational programs;
- (2) pre-vocational training;
- (3) vocational training which is related to specific employment opportunities, work skills or work settings;
- (4) any service not identified in the treatment plan;
- (5) recreation activities not related to the treatment 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: See Subsection J of 8.321.2.9 NMAC for general behavioral health services prior authorization requirements. This service does not require prior authorization.

G. Reimbursement:

- (1) All services described in Subsection D of 8.321.2.21 NMAC are covered in the bundled day treatment rate;
- (2) Day treatment providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how to access documentation, billing and claims processing information.
[8.321.2.21 NMAC - Rp, 8.321.2.15 NMAC, 1/1/2020]

8.321.2.22 FAMILY SUPPORT SERVICES (FSS) (MCO reimbursed 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 includes 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. Reimbursement: To help an eligible MCO member receive medically necessary services, the centennial care MCOs pay for family support services.
[8.321.2.22 NMAC - N, 1/1/2020]

8.321.2.23 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS AND PSYCHIATRIC UNITS OF ACUTE CARE HOSPITALS: To assist the eligible recipient in receiving necessary mental health services, 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 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. 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 stays in an IMD that include a substance use disorder (SUD) refer to 8.321.2.24 NMAC, *Institution for Mental Diseases (IMD)*. However, for freestanding psychiatric hospitals, if the eligible recipient who is receiving inpatient services reaches the age of 21 years, services may until one of the following conditions is reached: until the date the eligible recipient no longer requires the services, or 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. 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.

A. Eligible providers: A MAD eligible provider must be licensed and certified by the New Mexico DOH (or the comparable agency if in another state), comply with 42 CFR 456.201 through 456.245; and be accredited by at least one of the following:

- (1) the joint commission (JC);
- (2) the council on accreditation of services for families and children (COA);
- (3) the commission on accreditation of rehabilitation facilities (CARF); or
- (4) another accrediting organization recognized by MAD as having comparable standards;

and

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

B. Covered services: MAD covers inpatient psychiatric hospital services which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the eligible recipient.

(1) These services must be furnished by eligible providers within the scope and practice of his or her profession (see 8.321.2.9 NMAC) and in accordance with federal regulations; see (42 CFR 441.156);

(2) Services must be furnished under the direction of a physician;

(3) In the case of an eligible recipient under 21 years of age these services:

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

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

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

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

(b) at the time of admission, a psychiatrist who is board prepared, board eligible, or board certified in child or adolescent psychiatry, is not accessible in the community in which the facility is located;

(c) there is another facility which has a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, but the facility, is not available or is inaccessible to the community in which the facility is located; and

(d) the admission is for stabilization only and a transfer arrangement to the care of a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, is made as soon

as possible with the understanding that if the eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer in accordance with professional standards.

(5) A freestanding hospital must provide the following components to an eligible recipient to receive reimbursement:

- (a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;
- (b) a treatment plan and all supporting documentation must be available for review in the eligible recipient's file;
- (c) regularly scheduled structured behavioral health therapy sessions for the eligible recipient, group, family, or a multifamily group based on individualized needs, as specified in the eligible recipient's treatment plan;
- (d) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school, attendance and money management;
- (e) assistance to an eligible recipient in his or her self administration of medication in compliance with state regulations, policies and procedures;
- (f) appropriate staff available on a 24-hour basis to respond to crisis situations; determine the severity of the situation; stabilize the eligible recipient by providing support; make referrals, as necessary; and provide follow-up;
- (g) a consultation with other professionals or allied caregivers regarding a specific eligible recipient;
- (h) non-medical transportation services needed to accomplish treatment objectives;
- (i) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of the eligible recipient; and
- (j) plans for discharge must begin upon admittance to the facility and be included in the eligible recipient's treatment plan. If the eligible recipient will receive services in the community or in the custody of CYFD, the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the eligible recipient, his or her family, and school and community.

(6) MAD covers "awaiting placement days" when the MAD UR contractor determines that an eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the eligible recipient requires a residential placement which cannot be immediately located. Those days during which the eligible recipient is awaiting placement to the step-down placement are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the average payment for accredited residential treatment centers plus five percent. A separate claim form must be submitted for awaiting placement days.

(7) A treatment plan must be developed by a team of professionals in consultation with an eligible recipient, his or her parent, legal guardian or others in whose care the eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days. See the BH policy and billing manual for a description of the treatment team and plan.

C. Non-covered services: Services furnished in a freestanding psychiatric hospital are subject to the limitations and coverage restrictions which exist for other MAD services; see Subsection G of 8.321.2.9 NMAC for MAD general non-covered services. MAD does not cover the following specific services for an eligible recipient in a freestanding psychiatric hospital in the following situations:

- (1) conditions defined only by Z codes in the current version of the international classification of diseases (ICD) or the current version of DSM;
- (2) services in freestanding psychiatric hospital for an eligible recipient 22 years of age through 64, except as allowed in 8.321.2 NMAC;
- (3) services furnished after the determination by MAD or its designee has been made that the eligible recipient no longer needs hospital care;
- (4) formal educational or vocational services, other than those covered in Subsection B of 8.321.2.9 NMAC, related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active treatment plan for an eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b); or
- (5) drugs classified as "ineffective" by the food and drug administration (FDA) drug evaluation.

D. Prior authorization and utilization review: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.310.2 and 8.310.3 NMAC.

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

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

(3) A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration; see 8.350.2 NMAC.

E. Reimbursement: A freestanding psychiatric hospital service provider must submit claims for reimbursement on the UB-04 claim form or its successor; see 8.302.2 NMAC. Once enrolled, providers receive instructions on how to access documentation, billing, and claims processing information.

(1) Reimbursement rates for New Mexico freestanding psychiatric hospital are based on the Tax Equity and Fiscal Responsibility Act (TEFRA) provisions and principles of reimbursement; see 8.311.3 NMAC. Covered inpatient services provided in a freestanding psychiatric hospital will be reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles.

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

(3) Reimbursement rates for services furnished by a psychiatrist and licensed Ph.D. psychologist in a freestanding psychiatric hospital are contained in 8.311.3 NMAC. Services furnished by a psychiatrist and psychologist in a freestanding psychiatric hospital cannot be included as inpatient psychiatric hospital charges.

(4) When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the MAD coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

(5) The provider agrees to be paid by a MCO at any amount mutually-agreed upon between the provider and MCO when the provider enters into contracts with MCO contracting with HSD for the provision of managed care services to an eligible recipient.

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

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

[8.321.2.23 NMAC - Rp, 8.321.2.16 NMAC, 1/1/2020]

8.321.2.24 INSTITUTION FOR MENTAL DISEASES (IMD) FOR SUBSTANCE ABUSE: 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 only without the 15-day limitation with criteria for medical necessity and based on ASAM admission criteria. The coverage may also include co-occurring behavioral health disorders with the primary SUD. If an MCO covers stays in an IMD for eligible recipients as an in lieu of service, the stay cannot exceed 15 days. 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 8.321.2.23 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals and Psychiatric Units of Acute Care Hospitals*.

A. Eligible recipients: Adolescents and adults with a mental health or substance use disorder or co-occurring mental health and SUD.

B. Covered services: Withdrawal management (detoxification) and rehabilitation.

C. Prior authorization is required. Utilize the substance abuse and mental health services administration (SAMHSA) admission criteria for medical necessity.

D. Reimbursement: An IMD is reimbursed according to the provisions in Subsection E of 8.321.2.23 NMAC.

[8.321.2.24 NMAC - N, 1/1/2020]

8.321.2.25 INTENSIVE OUTPATIENT PROGRAM FOR SUBSTANCE USE DISORDERS (IOP):

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.

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 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 PL 93-638 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 non-independent practitioners under the direction of the IOP supervisor including LMSW, LMHC, LADAC, CADAC, LSAA, and a master's level psych 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; see Subsection C of 8.321.2.9 NMAC;
- (b) have two years relevant experience with an IOP program or approved exception by the interdepartmental council;
- (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. 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. A list of pre-approved EBP is available through the council, as are the criteria for having another model approved. They are also listed in the BH policy and billing manual.

(2) Treatment services must address co-occurring mental health disorders, as well as substance use disorders, when indicated.

C. Covered services:

(1) IOP core services include:

- (a) individual substance use disorder related 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) Co-occurring mental health and substance use disorders: The IOP agency must accommodate the needs of an eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated interdisciplinary team and through coordinated, concurrent services with MAD behavioral health providers.

(3) 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.

(4) 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.

(5) Other mental health therapies: outpatient therapies may be rendered in addition to the IOP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services which are outside the scope of the IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services in addition to IOP therapies, and a statement from the IOP agency that to postpone such therapy until the completion of the eligible recipient's IOP services is not in the best interest of the eligible recipient. Such documentation includes, but is not limited to: current assessment, a co-occurring diagnosis, and the inclusion in service plan for outpatient therapy services. An IOP agency may:

(a) render these services when it is enrolled as a provider covered under Subsection D of 8.321.2.9 NMAC with practitioners listed in Subsections C and E of 8.321.2.9 NMAC whose scope of practice specifically allows for mental health therapy services; or

(b) refer the eligible recipient to another provider if the IOP agency does not have such practitioners available; the IOP agency may continue the eligible recipient's IOP services coordinating with the new provider.

D. 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 in detention or incarceration. See eligibility rules 8.200.410.17 NMAC.

(2) IOP services are provided to an eligible recipient of a transitional age 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 service plan that includes IOP as an intervention.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD services see Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

services);

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

- (3) ACT;

- (4) partial hospitalization;

- (5) outpatient therapies which do not meet Subsection C of 8.321.2.9 NMAC;

- (6) multi-systemic therapy (MST);

- (7) activity therapy; or

- (8) psychosocial rehabilitation (PSR) group services.

F. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement requirements.

- (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 8.321.2 NMAC are not MAD covered services and are subject to recoupment.
[8.321.2.25 NMAC - Rp, 8.321.2.17 NMAC, 1/1/2020]

8.321.2.26 INTENSIVE OUTPATIENT PROGRAM FOR MENTAL HEALTH CONDITIONS (IOP):

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

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.

- (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 LMSW, LMHC, a master's level psych associates, RNs or registered dieticians.

- (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; see Subsection C of 8.321.2.9 NMAC;

- (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 (EBP) models 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. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved. They are also listed 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 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; or diagnosis for which the IOP is approved; and

(b) one individualized service plan that includes IOP as an intervention.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD services see Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

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

(3) ACT;

(4) partial hospitalization;

(5) outpatient therapies which do not meet Subsection C of 8.321.2.9 NMAC;

(6) multi-systemic therapy (MST);

(7) activity therapy; or

(8) psychosocial rehabilitation (PSR) group services.

F. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general 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. Medications 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 the rule are not a MAD covered service and are subject to recoupment.
[8.321.2.26 NMAC - N, 1/1/2020]

8.321.2.27 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) 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 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 behavioral health practitioners licensed for counseling or therapy.
- (5) Practitioners for skills and education include certified peer support workers or certified family peer support workers to provide skill-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;
- (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. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to MAT.
[8.321.2.27 NMAC - Rp, 8.321.2.18 NMAC, 1/1/2020]

8.321.2.28 MULTI-SYSTEMIC THERAPY (MST): To help an eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter his or her home and community, MAD pays for MST services as part of EPSDT program (42 CFR 441.57). MAD covers medically necessary MST services required by the condition of the eligible recipient. MST provides intensive home, family and community-based treatment for an eligible recipient 10 to 18 years of age who is at risk of out-of-home placement or is returning home from an out-of-home placement. The need for MST services must be identified in the eligible recipient's tot to teen health check screen or another diagnostic evaluation.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST Inc licensure, or any of its approved subsidiaries. MST Inc is a national organization located in Mt. Pleasant, South Carolina, and is deemed by MAD to be the primary authority on licensure of New Mexico MST programs.

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

(a) master's level independently licensed behavioral health professional clinical supervision; see Subsection H of 8.321.2.9 NMAC;

(b) licensed master's and bachelor's level behavioral health staff able to provide 24-hour coverage, seven days a week; see Subsection E of 8.321.2.9 NMAC;

(c) a licensed master's level behavioral health practitioner that is required to perform all MST interventions; a bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of his or her RLD practice board licensure or practice (see Subsection E of 8.321.2.9 NMAC;

(d) bachelor's level staff that has a degree in social work, counseling, psychology or a related human services field and must have at least three years' experience working with the identified population of children, adolescents and their families; and

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

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection C of 8.321.2.9 NMAC) who is MST trained; this supervision, following the MST supervisory protocol, is provided to team members on topics directly related to the needs of the eligible recipient and his or her family on an ongoing basis; and

(b) one hour of local group supervision per week and one hour of telephone consultation per week with the MST systems supervisor, provided to team members on topics directly related to the needs of the eligible recipient and his or her family on an ongoing basis.

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

B. Identified population:

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

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

C. Covered services and service limitations: MST is a culturally sensitive service, rendered by a MST team, to provide intensive home, family and community-based treatment for the family of an eligible recipient who is at risk of an out-of-home placement or is returning home from an out-of-home placement. MST services are primarily provided in the eligible recipient's home, but a MST worker may also intervene at the eligible recipient's school and other community settings. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance abuse, delinquency and violent behavior.

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

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

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

(c) case management; and

(d) crisis stabilization.

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

(a) promote the recipient's family's capacity to monitor and manage his or her behavior;

(b) involve the eligible recipient's family and other systems, such as the school, probation officers, extended families and community connections;

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

(d) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of the recipient's functional domains, such as adaptive, communication, psychosocial, problem solving, and behavior management.

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

D. Non-covered services: MST services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: MST agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the MST agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.28 NMAC - Rp, 8.321.2.19 NMAC, 1/1/2020]

8.321.2.29 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS (RTC) AND GROUP HOMES: MAD pays for medically necessary services for an eligible recipient under 21 years of age which are designed to develop skills necessary for successful reintegration into his or her family or transition into his or her community. A determination must be made that the eligible recipient needs the level of care (LOC) for services furnished in a RTC or group home. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. MAD pays for services furnished in a RTC or group home as part of EPSDT program (42 CFR 441.57). The need for RTC and group home services must be identified in the eligible recipient's tot to teen health check screen or other diagnostic evaluation furnished through a health check referral.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing RTC or group home services to an eligible recipient, an agency must meet the following requirements:

(1) a RTC must be certified by the children, youth and families department (CYFD) see 7.20.12 NMAC;

(2) a group home must be certified and licensed by CYFD;

(3) if the RTC is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD RTC licensing and certification requirements but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, CYFD provides MAD copies of its facility findings and recommendations. MAD will work with the facility to address recommendations. The BH policy and billing manual provides guidance for addressing the facility findings and recommendations.

B. Covered services: Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined. MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the eligible recipient through the provision of a 24-hour therapeutic group living environment to meet their developmental, psychological, social, and emotional needs. The following are covered services:

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

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

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the eligible recipient;

- (4) assistance to the eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;
- (5) provision of appropriate on-site staff based upon the acuity of recipient needs on a 24-hour basis to ensure adequate supervision of the recipients, and response in a proactive and timely manner. Response to crisis situations, determining the severity of the situation, stabilizing the eligible recipient by providing individualized treatment plan/safety plan interventions and support, and making referrals for emergency services or to other non-agency services, as necessary, and providing follow-up;
- (6) development of an interdisciplinary service plan; see the BH policy and billing manual;
- (7) non-medical transportation services needed to accomplish the treatment objective;
- (8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the eligible recipient;
- (9) for planning of discharge and aftercare services to facilitate timely and appropriate post discharge care regular assessments are conducted. These assessments support discharge planning and effect successful discharge with clinically appropriate after care services. This discharge planning begins when the recipient is admitted to residential treatment services and is updated and documented in the recipient record at every treatment plan review, or more frequently as needed; and
- (10) the RTC and group homes provide services, care and supervision at all times, including:
 - (a) the provision of, or access to, medical services on a 24-hour basis; and
 - (b) maintenance of a staff-to-recipient ratio appropriate to the level of care and needs of the recipients.

C. Non-covered services: RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to an eligible recipient:

- (1) Comprehensive community support services (CCSS) except by a CCSS agency when discharge planning with the eligible recipient from the RTC or group home facility;
- (2) services not considered medically necessary for the condition of the eligible recipient, as determined by MAD or its UR contractor;
- (3) room and board;
- (4) services for which prior approval was not obtained; or
- (5) services furnished after a MAD or UR contractor determination that the recipient no longer meets the LOC for RTC or group home care.

D. Treatment plan: If the eligible recipient is solely receiving RTC or group home services, a service plan is not required. If the eligible recipient is receiving other behavioral health services, then a service plan is required, see Subsection K of 8.321.2.9 NMAC and the BH policy and billing manual.

E. Prior authorization: Before a RTC or group home service is furnished to an eligible recipient, prior authorization is required from MAD or its UR contractor or the respective centennial care MCO. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: A RTC or group home agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility, MAD considers RTC services to be outside the IHS all inclusive rate and RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

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

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

- (b) Services which are not included in the RTC or group home rate include:
 - (i) direct services furnished by a psychiatrist or licensed Ph.D. psychologist; these services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) 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, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

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

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

(2) A vacancy factor of 24 days annually for each eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home agency cannot bill or be reimbursed for days when the eligible recipient is absent from the facility. [8.321.2.29 NMAC - Rp, 8.321.2.20 NMAC, 1/1/2020]

8.321.2.30 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.

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.
- (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 diversion 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.
- (15) Requirements for health care providers who prescribe, distribute or dispense opioid analgesics:
 - (a) A health care provider who prescribes, distributes or dispenses an opioid analgesic for the first time to a patient shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist.
 - (b) For a patient to whom an opioid analgesic has previously been prescribed, distributed or dispensed by the health care provider, the health care provider shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist on the first occasion that the health care provider prescribes, distributes or dispenses an opioid analgesic each calendar year.
 - (c) A health care provider who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply. The prescription for the opioid antagonist shall be accompanied by written information regarding the temporary effects of the opioid antagonist and techniques for administering the opioid antagonist. That written information shall contain a warning that a person administering the opioid antagonist should call 911 immediately after administering the opioid antagonist.

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) Outpatient therapy other than the substance abuse and HIV counseling required by (42 CFR Part 8.12 (f)) is reimbursable when rendered by a MAD approved independently licensed provider that meets Subsection H of 8.321.2.9 NMAC;

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

(d) 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;

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

(f) 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

(g) 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.

(3) For an IHS or tribal 638 facility, MAD considers the bundled OTP services to be outside the IHS all-inclusive rate and is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC. Non-bundled services may be billed at the office of management and budget (OMB) rate.

(4) For a FQHC, MAD considers the bundled OTP services to be outside the FQHC all-inclusive rate and is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC. Non-bundled services may be billed at the FQHC rate.

[8.321.2.30 NMAC - N, 1/1/2020]

8.321.2.31 PARTIAL HOSPITALIZATION SERVICES: To help an eligible recipient receive the level of services needed, MAD pays for partial hospitalization services furnished by an acute care or freestanding psychiatric hospital. Partial Hospitalization Programs (PHP) 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: In addition to the requirements found in Subsections A and B of 8.321.2.9 NMAC, 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) a clinical supervisor that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician; and
 - (c) 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 indicates the need. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment.
- (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 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: Partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. 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. See Subsection F of 8.321.2.9 NMAC for MAD general prior authorization requirements.

G. Reimbursement: A provider of partial hospitalization services must submit claims for reimbursement on the UB claim form or its successor. See 8.302.2 NMAC and Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements. Specific to partial hospitalization services:

- (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 (see Subsection E of 8.311.2.15 NMAC).
 - (2) The payment rate is at a per diem representing 8 hours, which is billed fractions of .25, .5, or .75 units to represent 2, 4, or 6 hours when applicable.
 - (3) Any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.
 - (4) Services performed by a physician or Ph.D. psychologist are billed separately as a professional service. Other services performed by employees or contractors to the facility are included in the per diem rate which may be billed separately are:
 - (a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;
 - (b) physical examination and any resultant medical treatments, while ensuring that a physical examination already performed is not repeated;
 - (c) any medically necessary occupational or physical therapy; and
 - (d) other professional services not rendered as part of the program.
- [8.321.2.31 NMAC - Rp & Rn, 8.321.2.21 NMAC, 1/1/2020]

8.321.2.32 PSYCHOSOCIAL REHABILITATION SERVICES: 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) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services. See Subsection A of 8.321.2.9 NMAC for MAD general provider requirements.

(3) 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 sufficient to ensure that patients have reasonable and prompt access to services.

(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; and

(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, including but not limited to:

(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 services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. Prior authorization: For PSR, reviews are retrospective. To determine if the medical necessity for the service has been met, the following factors are considered:

- (1) recipient assessment;
- (2) recipient diagnostic formation;
- (3) recipient service and treatment plans; and
- (4) compliance with 8.321.2 NMAC.

G. Reimbursement: Claims for reimbursement are submitted on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC.

[8.321.2.32 NMAC - Rp, 8.321.2.23 NMAC, 1/1/2020]

8.321.2.33 RECOVERY SERVICES (MCOs 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; and
 - (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 should be sufficient to ensure that patients have reasonable and prompt access to services at the required levels of frequency and intensity within the practitioner's scope of practices.
- 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).

[8.321.2.33 NMAC - N, 1/1/2020]

8.321.2.34 SCREENING, BRIEF INTERVENTION & REFERRAL TO TREATMENT (SBIRT) TO BE EFFECTIVE FOLLOWING CMS WAIVER APPROVAL. 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 may include:
 - (a) licensed nurse trained in SBIRT;
 - (b) licensed nurse practitioner or licensed nurse clinician trained in SBIRT;
 - (c) behavioral health practitioner trained in SBIRT;
 - (d) certified peer support worker trained in SBIRT;
 - (e) certified community health worker trained in SBIRT;
 - (f) licensed physician assistant trained in SBIRT;
 - (g) physician trained in SBIRT;
 - (h) home health agency trained in SBIRT
 - (i) nurse home visit EPSDT;
 - (j) medical assistant trained in SBIRT; and
 - (k) community health representative in tribal clinics trained in SBIRT.

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; and
 - (b) brief intervention and referral to behavioral health treatment, if needed.

E. Reimbursement:

- (1) Screening services do not require a diagnosis; brief interventions can be billed with a provisional diagnosis.
- (2) See BH policy and billing manual for coding and billing instruction.

[8.321.2.34 NMAC - N, 1/1/2020]

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

[8.321.2.35 NMAC - Rp, 8.321.2.24 NMAC, 1/1/2020]

8.321.2.36 SUPPORTIVE HOUSING PRE-TENANCY AND TENANCY SERVICES (PSH-TSS) (MCO only): MAD pays for coverage for permanent supportive housing pre-tenancy and tenancy support services (PSH-TSS) to an eligible recipient enrolled in a managed care organization to facilitate community integration and contribute to a holistic focus on improved health outcomes, to reduce the negative health impact of precarious housing and homelessness, and to reduce costly inpatient health care utilization. Services include, but are not limited to, pre-tenancy services including individual housing support and crisis planning, tenancy orientation and landlord relationship services as well as tenancy support services to identify issues that undermine housing stability and coaching, education and assistance in resolving tenancy issues for an eligible recipient who has a serious mental

illness and is enrolled in a medicaid managed care organization on, or after, July 1, 2019. The effective date will be July 1, 2019, or as otherwise approved by the centers for medicare and medicaid services (CMS).

A. Eligible providers and practitioners:

(1) Any clinic, office or agency providing permanent supportive housing under the human services department's linkages program administered by the behavioral health services division.

(2) Behavioral health practitioners employed or contracted with such facilities including:

(a) behavioral health professional licensed in the state of New Mexico; and

(b) certified peer support workers or certified family peer support workers.

B. Coverage criteria:

(1) Enrollment in the linkages permanent supportive housing program.

(2) An assessment documenting serious mental illness.

C. Eligible recipients: Individuals with serious mental illness.

D. Covered services:

(1) Pre-tenancy services, including:

(a) screening and identifying preferences and barriers related to successful tenancy;

(b) developing an individual housing support plan and housing crisis plan;

(c) ensuring that the living environment is safe and ready for move-in;

(d) tenancy orientation and move-in assistance;

(e) assistance in securing necessary household supplies; and

(f) landlord relationship building and communication.

(2) Tenancy support services, including:

(a) early identification of issues undermining housing stability, including member behaviors;

(b) coaching the member about relationships with neighbors, landlords and tenancy conditions;

(c) education about tenant responsibilities and rights;

(d) assistance and advocacy in resolving tenancy issues;

(e) regular review and updates to housing support plan and housing crisis plan; and

(f) linkages to other community resources for maintaining housing.

E. Duration: The PSH-TSS benefit is available to an eligible member for the duration of the member's enrollment in a linkages program, ceasing when the client leaves the program.

F. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to PSH-TSS. These services do not include tenancy assistance in the form of rent or subsidized housing.

[8.321.2.136 NMAC - N, 1/1/2020]

8.321.2.37 TREATMENT FOSTER CARE I and 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: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing TFC services to an eligible recipient, 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 is 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 Section 25 Subsection B of 8.321.2.9 NMAC and also meet 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 eligible 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 eligible 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 eligible recipient's treatment plan;

(d) recording the eligible recipient's information and documentation of activities, as required by the TFC agency and the standards under which it operates;

(e) assisting the eligible recipient with maintaining contact with his or her family and enhancing that relationship;

(f) supporting efforts specified by the treatment plan to meet the eligible 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 eligible 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 eligible 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 as defined in Subsection G of 8.321.2.9 NMAC 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 eligible 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 eligible 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 eligible 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 eligible 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 eligible 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 service: TFC I and II services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for all non-covered MAD behavioral health services or activities. 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 eligible 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. A TFC agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. [8.321.2.37 NMAC - Rp, 8.321.2.25 NMAC, 1/1/2020]

HISTORY OF 8.321.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.1700, EPSDT Services, filed 2/13/1980.
ISD 310.1700, EPSDT Services, filed 6/25/1980.
ISD Rule 310.1700, EPSDT Services, filed 10/22/1984.
MAD Rule 310.17, EPSDT Services, filed 5/1/1992.
MAD Rule 310.17, EPSDT Services, filed 7/14/1993.
MAD Rule 310.17, EPSDT Services, filed 11/12/1993.
MAD Rule 310.17, EPSDT Services, filed 12/17/1993.
MAD Rule 310.17, EPSDT Services, filed 3/14/1994.
MAD Rule 310.17, EPSDT Services, filed 6/15/1994.
MAD Rule 310.17, EPSDT Services, filed 11/30/1994.

History of Repealed Material:

MAC Rule 310.17, EPSDT Services, filed 11/30/1994 - Repealed effective 2/1/1995.
8.321.2 NMAC, Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals, filed 10/8/2010 - Repealed effective 1/1/2014.
8.321.3 NMAC, Accredited Residential Treatment Center Services, filed 2/17/2012 - Repeal effective 1/1/2014.
8.321.4 NMAC, Non- Accredited Residential Treatment Center Services, filed 2/17/2012 - Repeal effective 1/1/2014
8.321.5 NMAC, Outpatients and Partial Hospitalization Services in Freestanding Psychiatric Hospitals, filed 1/5/2012 - Repealed effective 1/1/2014.
8.322.2 NMAC, Treatment Foster Care, filed 2/17/2012 - Repealed effective 1/1/2014.
8.322.3 NMAC, Behavioral Management Skills Development Services, filed 10/12/2005 - Repealed effective 1/1/2014.
8.322.4 NMAC, Day Treatment, filed 10/12/2005 - Repealed effective 1/1/2014.
8.322.5 NMAC, Treatment Foster Care II, filed 2/17/2012 - Repealed effective 1/1/2014.
8.322.6 NMAC, Multi-Systemic Therapy, filed 11/16/2007 - Repealed effective 1/1/2014.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/17/2013, Repealed effective 1/1/2020.

Other History:

8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/17/2013 was replaced by 8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement effective 1/1/2020.