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 Health Care Authority (HCA).
[8.321.2.1 NMAC - Rp, 8.321.2.1 NMAC, 12/10/2024]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC - Rp, 8.321.2.2 NMAC, 12/10/2024]

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, 12/10/2024]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC - Rp, 8.321.2.4 NMAC, 12/10/2024]

8.321.2.5 EFFECTIVE DATE: December 10, 2024, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - Rp, 8.321.2.5 NMAC, 12/10/2024]

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, 12/10/2024]

8.321.2.7 DEFINITIONS: [**RESERVED**]

8.321.2.8 MISSION STATEMENT: We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.321.2.8 NMAC - Rp, 8.321.2.8 NMAC, 12/10/2024]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico (NM) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by the HCA medical assistance division (MAD). Upon approval of a NM 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 HCA or its authorized agents, including NM administrative code (NMAC) program rules, program policy manuals, billing instructions, supplements, utilization review (UR) instructions, and other pertinent materials is available on the HCA 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 HCA 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 their 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 are eligible to be reimbursed directly for providing MAD covered 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 NM 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 NM credentialing board for behavioral health professionals (CBBHP). Independent practice is for alcohol and substance use 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 NM 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 their certification permits; or

(8) a licensed professional art therapist (LPAT) licensed by RLD's counseling and therapy practice board, and certified for independent practice by the art therapy credentials board (ATCB);

(9) an occupational therapist licensed by the RLD board of examiners for occupational therapy; who is facilitating occupational performance and managing an individual's mental health functioning and performance in accordance with the NM occupational therapy act; or

(10) an out-of-state provider rendering a service from out-of-state must meet their state's licensing and certification requirements which are acceptable when deemed by MAD to be substantially equivalent to the license.

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) to the extent not covered by Paragraphs (3) and (4) of Subsection D of 8.321.2.9 NMAC above, an "Indian health care provider (IHCP)" defined in 42 code of federal regulations §438.14(a).

(6) a children, youth and families department (CYFD) facility;

(7) a hospital and its outpatient facility;

(8) a core service agency (CSA);

(9) a CareLink NM health home (CLNM HH);

(10) a crisis triage center licensed by the department of health (DOH);

(11) a behavioral health agency (BHA);

(12) an opioid treatment program in a methadone clinic;

(13) a political subdivision of the state of NM;

(14) a crisis services community provider as a BHA; and

(15) a school based health center.

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 them 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 their scope of practice and the service is provided through and billed by one of the provider agencies listed in numbers Paragraphs (1) through (15) of Subsection D of 8.321.2.9 NMAC. All services must be delivered according to the medicaid regulation and current version of the BH policy and billing manual. If the service is an evaluation, assessment, or therapy service rendere d by the practitioner and supervised by an independently licensed practitioner, the independently licensed practitioner's practice board must specifically allow them 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 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 NM 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 NM if supervised by a behavioral health physician or DO licensed by RLD's examiner board.

(3) Non-licensed practitioners working under RLD board approved supervisor, 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;

(f) a certified youth peer support specialist;

(g) a community support worker (CSW);

(h) a community health worker (CHW);

(i) a tribal community health representative (TCHR); or

(j) a provisional or temporarily licensed master's level behavioral health professional.

(4) 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, childcare provider, or other practitioner) when they are 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 8.302.1 NMAC;

(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 their 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 the definition of medical necessity found in 8.302.1 NMAC. Performance of a MAD covered behavioral health service cannot be delegated to a provider or practitioner not licensed for independent practice except as specified within this rule, within their 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, themselves, as a rendering provider, bill for a service for which they were 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), any other "Indian health care provider (IHCP)" as defined in 42 Code of Federal Regulations §438.14(a), 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 HCA 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 HCA, 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 8.321.2.15, 8.321.2.19 and 8.321.2.35 NMAC and in the 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 HCA 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 treatment plan must be completed (see the BH policy and billing manual for specific instructions).

(1) A comprehensive assessment and treatment plan can only be billed by the agencies listed in Subsection D of 8.321.2.9 NMAC.

(2) Behavioral health treatment plans can be developed by individuals employed by the agency who have Health Insurance Portability and Accountability Act (HIPAA) training, are working within their

scope of practice, and are working under the supervision of the rendering provider who must be a RLD board approved supervisor.

(3) A comprehensive assessment and treatment 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. MAD covers treatment plans, and updates, created with interdisciplinary teams for out-patient recipients meeting the NM state definition for SMI, SED, or SUD in which multiple provider disciplines are engaged to address co-occurring conditions, or other social determinants of health.

(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 treatment 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 treatment 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 treatment plan, the definition of teaming is not met and the treatment 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 conducting the final face-to-face meeting with the recipient present when key decisions are made that result in the updates to the treatment plan, is a billable event.

(d) when updates to the treatment 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 treatment plan can be billed. An update to the treatment plan using a teaming method approach and an update to the treatment 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 treatment 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 treatment 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 treatment 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.

N. All specialized behavioral health services should be delivered in the least restrictive setting. Least restrictive settings will differ between services and facilities and are generally defined as a physical setting which places the least restraint on the client's freedom of movement and opportunity for independence and enables an individual to function with as much choice and self-direction as safely appropriate. In addition, access to or receipt of one service may not be contingent on requiring an individual to obtain or utilize any other service; for example, a housing service may not require a treatment component, nor may an outpatient treatment service require participation in housing. Multiple services may be encouraged, under appropriate circumstances, but may not be required.

O. Site visits must be conducted for specialized behavioral health services. Site visit requirements are outlined in the BH policy and billing manual.

[8.321.2.9 NMAC - Rp, 8.321.2.9 NMAC, 12/10/2024]

8.321.2.10 ADULT ACCREDITED RESIDENTIAL TREATMENT CENTER (AARTC) FOR ADULTS WITH SUBSTANCE USE DISORDERS: To help an eligible recipient 18 years of age and older, who has been diagnosed as having a SUD, and the need for AARTC 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 them by an AARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

A. Eligible facilities:

(1) To be eligible to be reimbursed for providing AARTC services to an eligible recipient, an AARTC facility:

(a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;

(b) must be certified through an application process with the behavioral health services division (BHSD) which includes site visits. Site visit requirements are outlined in the BH policy and billing manual;

(c) must have written policies and procedures specifying ASAM level of care three criteria as the basis for accepting eligible recipients into the sub-level treatment program;

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

(e) must provide medication assisted treatment (MAT) for opioid use disorder (OUD), as indicated. See 8.321.2.28 NMAC for MAT requirements. An AARTC may coordinate with another agency for provision of MAT services when they are not provided by the AARTC; an AARTC may not exclude recipients from receiving AARTC services on the basis of receiving MAT services;

(f) all licensed practitioners shall be trained in ASAM principles and levels of care. The ASAM training must comprehensively cover the expected treatment expectations of the ASAM level 3 sub-level treatment programs;

(g) prior to the initial hire and every three years thereafter employees must pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16- 12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs;

(h) must maintain appropriate drug permit required, issued by the state board of pharmacy, as applicable;

(i) must maintain appropriate food service permit required, issued by the New Mexico environmental department (NMED), as applicable; and

(j) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) An out-of-state or MAD enrolled border AARTC must have JC, CARF or COA accreditation, use ASAM level three criteria for accepting recipients, and be licensed in its own state as an AARTC residential treatment facility.

B. Coverage criteria:

(1) Treatment must be provided under the direction of an independently licensed clinician or 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 plan rendered by the AARTC 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 AARTC 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 their 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. Length of stay is determined by medical necessity. The differing sub-levels of ASAM level 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. Cognitive impairments can be due to aging, traumatic brain injury, acute but lasting injury, or illness.

(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, emergency medical technicians with documentation of three hours of annual training in SUD, 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 SUD, 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 the recipient 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's length of stay is typically 3 - 5 days, after which transfer to another level of care is indicated.

(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, emergency medical technicians with documentation of three hours of annual training in SUD, 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 SUD, 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 they 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: AARTCs 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 facility must provide 24-hour care with trained staff.

D. Non-covered services: AARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered 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 AARTC 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 AARTCs 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 AARTC 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 - Rp, 8.321.2.10 NMAC, 12/10/2024]

8.321.2.11 ADULT ACCREDITED RESIDENTIAL TREATMENT CENTER (AARTC) FOR ADULTS WITH SERIOUS MENTAL HEALTH CONDITIONS: To help an eligible recipient 18 years of age and older, who has been diagnosed as having a serious mental health condition, and the need for AARTC has been identified in the eligible recipient's diagnostic evaluation as meeting criteria of the level of care utilization system (LOCUS) for psychiatric and SUD services level of care five for whom a less restrictive setting is not appropriate. MAD pays for services furnished to them by an AARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

A. Eligible facilities:

(1) To be eligible to receive reimbursement for providing AARTC services to an eligible recipient, an AARTC facility:

(a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;

(b) must be certified through an application process with BHSD which includes site visits. Site visit requirements are outlined in the BH policy and billing manual;

(c) must have written policies and procedures specifying utilization of the LOCUS evaluation parameters for assessment of service needs and ensuring that based on the dimensional rating scale, clients meet LOCUS level 5 criteria as the basis for accepting eligible recipients into the treatment program;

(d) must meet LOCUS level five service definitions for the care environment, clinical services, support services, and crisis stabilization and prevention services;

(e) must assess for and treat co-occurring SUDs;

(f) must provide or refer eligible recipients for MAT for SUD, if appropriate; to include access to buprenorphine and methadone, if appropriate and desired by the recipient. Programs may not exclude recipients from receiving AARTC services on the basis of receiving or desiring to receive MAT services.

(g) must train all clinicians or practitioners in the LOCUS for psychiatric and SUD services. The LOCUS training must be conducted by a LOCUS approved trainer and must be comprehensive in covering the evaluation parameters for assessment of service needs and level of care definitions for LOCUS level 5 services;

(h) prior to the initial hire and every three years thereafter employees must pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16- 12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs;

(i) must maintain appropriate drug permit required, issued by the state board of pharmacy, as applicable;

(j) must maintain appropriate food service permit required, issued by the NMED, as applicable; and

(k) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) An out-of-state or MAD enrolled border AARTC must have JC, CARF or COA accreditation, use LOCUS level five criteria for accepting recipients, and be licensed in its own state as an AARTC residential treatment facility.

B. Coverage criteria:

(1) Treatment must be provided under the direction of an independently licensed clinician/practitioner and the program must have sufficient staffing to meet the LOCUS level five clinical capabilities description.

(2) Treatment shall be based on the eligible recipient's individualized treatment plan rendered by the AARTC 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 AARTC 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 LOCUS level five service descriptions the care environment, clinical services, support services, and crisis stabilization and prevention services;

(c) facilitation of age-appropriate life skills development;

(d) assistance to the eligible recipient in their 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 LOCUS level five criteria based on the dimensional evaluation of service needs. Length of stay duration is determined by medical necessity and ongoing LOCUS level five criteria and symptomology. The LOCUS levels of care are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of psychiatric, medical, and nursing professionals. The defining characteristic of LOCUS level five is that it serves recipients who need a medically monitored residential setting for stabilization and treatment. Recipients are transferred to lower levels of care when they have established sufficient skills to safely continue treatment at a lower level of care.

(5) Sub-levels of level five level of care:

(a) moderate intensity long term residential treatment services as specified in LOCUS level of care 5c are covered for recipients whose condition meets the criteria for LOCUS Level 5c and who are experiencing long term and persistent disabilities that require extended rehabilitation and skill building to develop capacity for community living:

(b) moderate intensity intermediate stay residential treatment programs as specified in LOCUS levels of care 5b are covered for recipients whose condition meets the criteria of LOCUS level 5c and who need rehabilitation and skill building following stabilization of a crisis or to prevent precipitous deterioration in functioning.

(c) intensive short term residential services as specified in LOCUS level of care 5a are covered for recipients whose condition meets the criteria for LOCUS level 5a and who are stepping down from acute inpatient care or people who are in crisis but who do not require the security of a locked facility.

C. Covered services: AARTCs treating all recipients meeting LOCUS level five criteria. MAD covers residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A LOCUS level five AARTC facility must provide 24-hour care with trained staff.

D. Non-covered services: AARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered 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 AARTC 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 LOCUS 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 LOCUS level 5 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 AARTCs 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 AARTC 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.

[8.321.2.11 NMAC - N, 8.321.2.11 NMAC, 12/10/2024]

8.321.2.12 ACCREDITED RESIDENTIAL TREATMENT CENTER FOR YOUTH (ARTC): 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 them by an ARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA). A determination must be made that the eligible recipient needs the level of care (LOC) for services furnished in an ARTC. This determination must have considered all environments which are least restrictive, including but not limited to outpatient therapy, intensive outpatient, day treatment services, group home services.

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 per 7.20.12 NMAC and certification per 7.20.11 NMAC;

(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; and

(d) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) If the ARTC is operated by IHS or by a federally recognized tribal government, the youth based facility must meet CYFD ARTC licensing and certification 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 NM CYFD licensure, an out-of-state or MAD enrolled 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 enrolled 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. Avoiding acute psychiatric hospitalization or further deterioration are also reasonable expectations of treatment.

(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 plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the 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 their 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 covered 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, their parent, legal guardian and others in whose care they 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 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 NM border (Mexico excluded) are at the fee schedule unless a separate rate is negotiated.

[8.321.2.12 NMAC - Rp, 8.321.2.11 NMAC, 12/10/2024]

8.321.2.13 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 including but not limited to family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication

management, and developmental disability waiver services. ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57) for recipients under the age of 21. 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 8.321.2.13 NMAC.

(2) An integrated service plan (ISP) must be developed by the AEP together with a referral to an approved ABA provider agency (stage one).

(3) The ABA provider 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 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 providers and practitioners who meet the qualification requirements: an AEP; a behavior analyst (BA) and a behavior technician (BT) through an ABA provider agency; and an ABA specialty care provider. Each ABA provider and practitioner has corresponding enrollment requirements and renders services according to their provider type and specialty. All providers must successfully complete a criminal background registry check. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(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 their 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.

(3) Stage two and three BAA: A BAA who is a board certified assistant behavior analyst (BCaBA®) by the BACB® may assist their 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 they have the skills and knowledge to render such services. This is determined in the contract the BAA has agreed to with their 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 and three services, a recipient may be referred for ABA services with a presumptive diagnosis of ASD by a licensed practitioner whose scope of practice allows them to render a diagnosis of ASD. This diagnosis must have been received within three years of referral to stage two or three services.

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 if they do 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 including but not limited to 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 such as having an older sibling with a well-documented ASD diagnosis or 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 they present 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 two 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 ABA provider'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 case supervision from their 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 ABA provider and the logistical or practical ability of the ABA provider 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 ABA services, and the residential facility is not an ABA provider for ABA stage two and three services, and the eligible recipient has a 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 ABA provider and develop an agreement allowing the ABA provider 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 ABA provider, 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, they are 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, a UR contractor will assess, with input from the family and ABA provider's BA, whether changes are needed in the eligible recipient's ISP or treatment plan. Additionally, the family or ABA provider may request ISP modifications prior to the UR contractor's six month authorization 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 ABA provider must submit the prior authorization request, specifically noting:

(a) the CDE or targeted evaluation and the ISP from the AEP along with the ABA treatment plan;

(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 ABA provider 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 from the UR contractor.

(3) The request must document hours allocated to other services including but not limited to early intervention through FIT, physical therapy, speech and language therapy that are in the eligible recipient's ISP in order for the UR contractor to determine if the requested intensity is feasible and appropriate.

(4) When an eligible recipient's behavior exceeds the expertise of the ABA provider and logistical or practical ability of the ABA provider to fully support them, MAD allows the ABA provider to request prior authorization for ABA specialty care services.

(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.

[8.321.2.13 NMAC - Rp, 8.321.2.12 NMAC, 12/10/2024]

8.321.2.14 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help an eligible recipient with medically necessary services MAD pays for covered assertive community treatment services (ACT). See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

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 8.321.2.14 NMAC for the required composition. A lower number of team member

compositions may be considered by BHSD. The waiver request is 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 use disorder 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 a sufficient number 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 licensed behavioral health professional;

(e) at least one MAD enrolled licensed behavioral health practitioner with expertise in substance use disorders;

(f) at least one employment specialist;

(g) at least one NM certified peer support worker (CPSW) through the approved state of NM 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 their ACT services.

(7) The agency must have a HCA ACT approval letter to render ACT services to an eligible recipient. The approval letter will authorize an agency also delivering CSC model.

(8) Any adaptations to the model require an approved variance from BHSD.

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 their condition and are identified in the treatment 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 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 SUD shall not exclude an eligible recipient from ACT services.

D. Covered services: ACT is a voluntary medical, comprehensive case management and psychosocial intervention program. See the BH policy and billing manual for a complete service description.

E. Non-covered services: ACT services are subject to the limitations and coverage restrictions that exist for other MAD covered 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 use disorder treatment or crisis services when billed in conjunction with ACT services to an eligible recipient, except for medically necessary medications and hospitalizations. Psychosocial rehabilitation and intensive outpatient services can be billed concurrently if indicated in treatment plan 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.

[8.321.2.14 NMAC - Rp, 8.321.2.13 NMAC, 12/10/2024]

8.321.2.15 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 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 use condition. Services are provided to an eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling, and social work services are performed by licensed psychological, counseling, and social work practitioners acting within their scope of practice and licensure (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, ICD, or DC:0-5 behavioral health diagnosis and may include therapy with their family, parent or caretaker, and consultation with their 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 their scope of licensure (see Subsection B of 8.321.2.9 NMAC). A non-independently licensed behavioral health practitioner must have an independently licensed RLD board approved supervisor review and sign the assessment with a diagnosis. Based on the eligible recipient's current assessment, their treatment file must document the extent to which their 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 their 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 treatment plans.
[8.321.2.15 NMAC - Rp, 8.321.2.14 NMAC, 12/10/2024]

8.321.2.16 BEHAVIORAL HEALTH RESPITE CARE (Managed Care Organization (MCO)): As part of the managed care comprehensive service system, behavioral health 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. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible practitioners:

(1) Supervisor:

(a) bachelor's degree and three years' experience working with the target population;

(b) 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;

(c) access to on call crisis support available 24-hours a day; and

(d) supervision by RLD board approved clinical supervisors must be in accordance with their respective licensing board regulations.

(2) Respite care staff:

(a) minimum three years' experience working with the target population;

(b) pass all criminal records and background checks for all persons residing in the home over 18;

(c) possess a valid driver's license, vehicle registration and insurance, if transporting member;

(d) CPR and first aid; and

(e) 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 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 NM 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.

[8.321.2.16 NMAC - Rp, 8.321.2.15 NMAC, 12/10/2024]

8.321.2.17 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 their 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 them in acquiring, enhancing, and maintaining the life, social and behavioral skills needed to function successfully within their 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 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 per 7.20.11 NMAC. 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 their 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 their 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 treatment 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 their 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 and service section of the IEP.

D. Non-covered services: BMS services are subject to the limitations and coverage restrictions which exist for other MAD covered 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 treatment plan (IFTP).

(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.

[8.321.2.17 NMAC - Rp, 8.321.2.16 NMAC, 12/10/2024]

8.321.2.18 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 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 enrolled provider after demonstrating that the agency meets all the requirements of CET program services and supervision. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) 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.

(2) 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.

(3) 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 covered 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 enrolled 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.

[8.321.2.18 NMAC - Rp, 8.321.2.17 NMAC, 12/10/2024]

8.321.2.19 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): To help a NM 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 their 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) See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements. To provide CCSS services, a provider must receive CCSS training through the state or state approved trainer. The children, youth and families department (CYFD) will provide background checks for CCSS direct service and clinical staff for child/youth CCSS programs.

(2) 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 valid certification in good standing from the NM credentialing board as a certified peer support worker (CPSW), a certified family peer support worker (CFPSW) or a certified youth peer support specialist (CYPSS); and

(b) minimum staff qualifications for certified peer support workers:

(i) must hold a valid certification in good standing from the NM credentialing board for behavioral health professionals; and

(ii) meet all qualifications defined in 8.321.2.42 NMAC.

(b) 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.

(c) minimum staff qualifications for the clinical supervisor:

(i) must be RLD board approved clinical supervisor;

(ii) provide documented clinical supervision on a regular basis to the CSW, CPSW, CFPSW, and CYPSS; and

(iii) obtain a continuing education unit (CEU) training certificate related to providing clinical supervision of non-clinical staff.

(3) The clinical supervisor and the CCSS program supervisor may be the same individual.

(4) 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; and

(c) description of the service provided with reference to the CCSS treatment plan and related goals.

B. Coverage criteria:

(1) CCSS must be identified in the treatment plan for an individual. When identifying a need for this service, if the provider agency is using the "treat frst" 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) adult accredited residential treatment center (AARTC);

(c) residential treatment center (RTC);

(d) group home service;

(e) inpatient hospitalization; or

(f) treatment foster care (TFC).

C. Covered services: The purpose of CCSS is to provide an eligible recipient and their 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 treatment 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 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 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 their recovery and resiliency process; and

(3) Recipients with a moderate to severe SUD according to the current DSMV or its successor; and

(4) Recipients with a co-occurring disorder 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 covered 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.

[8.321.2.19 NMAC - Rp, 8.321.2.18 NMAC, 12/10/2024]

8.321.2.20 CRISIS INTERVENTION SERVICES: MAD pays for a continuum of community-based crisis intervention services which are immediate, and designed to ameliorate, prevent, or minimize a crisis episode or to prevent inpatient psychiatric hospitalization, medical detoxification, emergency department use, multiple system involvement or incarceration. Services are provided to eligible recipients who are unable to use their current coping strategies and need immediate support. Crisis intervention services include telephone crisis services; face-to-face crisis triage and intervention; mobile crisis services; and crisis stabilization services.

A. Coverage criteria:

(1) Telephone crisis services:

(a) agencies providing telephone crisis services must develop policy and procedures regarding telephone crisis services which must be made available to MAD or is designee upon request;

(b) assurance that a backup crisis telephone system is available if the toll-free number is not accessible;

(c) assurance that calls are answered by a person trained in crisis response as described in the BH policy and billing manual;

(d) processes to screen calls, evaluate crisis situation, provide referral to mobile crisis team (MCT) or mobile response and stabilization services (MRSS) when appropriate, and provide counseling and consultation to crisis callers are documented and implemented;

(e) 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;

(f) provision of a toll-free number, such as 988, and the agency's number to active clients and their support; and

(g) documentation of 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. This may include a referral to MCT or MRSS when appropriate. (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; and

(iv) develop or update the crisis and safety plans.

(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:

(a) mobile crisis services provide rapid response, individual assessment, and evaluation and treatment of mental health crisis to individuals experiencing a mental health crisis or SUD crisis. A crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow mobile crisis services:

(i) are provided in two models: MCT and MRSS. MRSS is a child, youth and family specific crisis intervention and prevention service. In order to be eligible to provide services MCT and MRSS teams must be approved though the application process outlined in the BH policy and billing manual;

(ii) must be provided by a multidisciplinary team of at least two behavioral health professionals or paraprofessionals, as defined in 8.321.2.9 NMAC, that includes at minimum a RLD board approved clinical supervisor who must be available to provide real-time clinical assessment and clinical support in-person or via telehealth at any time during the initial response;

(iii) must be available where the individual is experiencing a mental health, or SUD, crisis and may not be restricted to a specific location and in the least restrictive environment available;

(iv) must be available 24 hours a day, seven days a week and 365 days per year and may not be restricted to select days or times;

(v) must be person and family centered as well as culturally, linguistically, and developmentally appropriate;

(vi) may be provided prior to an intake evaluation for mental health services; and

(vii) may not be provided in a hospital or other facility setting.

(b) at a minimum, mobile crisis services including initial response of conducting immediate crisis screening an assessment, mobile crisis stabilization and de-escalation, and coordination with and referral to health social and other services as needed to effect symptom reduction, harm reduction or to safely transition an individual in acute crisis to the appropriate environment for continued stabilization. MCT and MRSS teams must:

(i) be trained in trauma-informed care, de-escalation strategies, and harm reduction;

(ii) be able to respond in a timely manner;

(iii) have the ability to provide screening and assessment, stabilization and de-escalation, and coordination and referral to services as appropriate;

(iv) ensure language access for individuals with limited-English proficiency, those who are deaf or hard of hearing, and comply with all applicable requirements under the Americans with Disabilities Act, Rehabilitation Act, and Civil Rights Act;

(v) maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations for the purpose of coordination and referral to services; and

(vi) be able to administer naloxone.

(c) MCTs and MRSS may connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation only in situations that warrant transition to other locations or higher levels of care. Services may also include telephone follow-up or intervention services for up to 72 hours after the initial mobile response. Follow-up may include additional intervention and de-escalation services as well as referral to care as appropriate.

(4) Mobile response and stabilization services (MRSS):

(a) MRSS must comply with requirements outlined in Paragraph (3) of Subsection A of 8.321.2.19 NMAC as well as the meet the following criteria:

(i) provider response and stabilization services to individuals 0-21 years of age;

(ii) provide immediate, in-person, response to de-escalate crisis or safety and stability event that is defined by the family. A safety and stability event is defined as the perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the caregiver; an unexpected or out of control event that causes pain, suffering, or instability for the family; an event occurs that could result in movement to a higher level of care or a restrictive setting; or the caregiver does not know what to do about a child's behavior; and

(iii) provide up to 56 days of stabilization service support, follow-up and navigation to reduce the likelihood of future crisis or out of home placement.

(b) MRSS aligns with the children's system of care (SOC) approach in NM. MRSS supports teams to effectively coordinate within the state's children's behavioral health service array including access to community support and resources.

(5) Crisis stabilization services: Outpatient, clinic-based, stabilization services for substance use and co-occurring disorder crises which includes ASAM level two withdrawal management. Crisis stabilization services include assessment, safety planning and coordination with appropriate resources for up to 24 hours. This service is available across the lifespan.

B. Eligible practitioners:

(1) Telephone crisis services:

(a) individual crisis workers who are covering the crisis telephone must meet the following criteria:

(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;

(vii) LADAC; or

(viii) LSAA with one year of work experience with individuals with behavioral health conditions.

(b) Supervision by a:

(i) psychiatrist; or

(ii) RLD board approved clinical supervisor.

(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) Mobile crisis intervention services for MCT and MRSS:

(a) services must be delivered by an agency designated as an MCT or MRSS through the approval process defined in the BH policy and billing manual and must be an enrolled medicaid provider. Allowable agency types are identified in Subsection D of 8.321.2.9 NMAC.

(b) services must be delivered by a minimum of a two-person team that includes at minimum a RLD board approved clinical supervisor who must be available to provide real-time clinical assessment and clinical support in-person or via telehealth;

(c) additional team members may include:

(i) a licensed mental health therapist;

(ii) certified peer support worker;

(iii) certified family peer support worker;

(iv) certified youth peer support specialist;

(v) community support worker;

(vi) community health worker;

(vii) community health representative;

(viii) certified prevention specialist;

(ix) registered nurse;

(x) emergency medical service provider;

(xi) licensed alcohol and drug abuse counselor (LADAC);

(xii) non-independently licensed behavioral health professionals as defined in 8.321.2.9 NMAC.

(xiii) emergency medical technicians;

(xiv) licensed practical nurses;

(xv) other certified or credentialed individuals;

(xvi) tribal 638 or IHS facilities may request a waiver to the staffing requirements outlined above for MRSS by submitting a staffing plan to the department as defined in the BH billing and policy manual.

(3) Crisis stabilization services: staffing must include RLD board approved clinical supervisor and:

(a) one registered nurse (RN) licensed by the NM board of nursing with experience or training in crisis triage and managing intoxication and withdrawal management when providing ASAM level two detoxification services;

(b) one regulation and licensing department (RLD) master's level licensed mental health professional on-site during all hours of operation;

(c) certified peer support worker, certified family per support worker, or certified youth peer support worker, on-site or available for on-call response during all hours of operation; and

(d) board certified physician or certified nurse practitioner licensed by the NM board of nursing either on-site or on call.

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) immediate crisis screening and assessment;

(b) other screening, as indicated by assessment;

(c) mobile crisis stabilization and de-escalation and crisis prevention activities specific to the needs of the individual;

(d) coordination with and referral to health, social, and other service as needed to effect symptom reduction harm reduction or to safely transition person in acute crisis to the appropriate environment for continued stabilization;

(e) warm hand off and coordination of transportation in situations that warrant transition to other locations; and

(f) telephonic follow-up interventions for up to 72 hours after the initial mobile response. Follow-up may include additional intervention and de-escalation services as well as referral to care as appropriate.

(4) Mobile crisis intervention services for MRSS: includes all mobile crisis intervention defined in Paragraph (3) of Subsection C of 8.321.2.19 and up to 56 days of stabilization services.

(5) 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 to support individuals in the community include assistance with:

(i) prescription and medication assistance;

(ii) arranging for temporary or permanent housing;

(iii) family or caregiver 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.

[8.321.2.20 NMAC - Rp, 8.321.2.19 NMAC, 12/10/2024]

8.321.2.21 CRISIS TRIAGE CENTER: MAD pays for a set of services, either outpatient or residential, to eligible adults and youth 14 years of age and older, to provide voluntary and involuntary stabilization of behavioral health crises including emergency mental health evaluation and care. Crisis triage centers (CTC) shall provide emergency screening and evaluation services 24-hours a day, seven days a week. Involuntary admissions are for individuals who have been determined to be a danger themselves or others and are governed by the requirements of the New Mexico mental health and developmental disabilities code, 43-1-1 through 43-1-21 NMSA 1978.

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 the supervision of RLD board-approved clinical supervisor 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: Paragraph (3) through (14) of Subsection A of 8.321.2.21 NMAC are conditions of coverage for outpatient only services.

C. Eligible providers and practitioners:

(1) A provider agency licensed through the department of health as a crisis triage center offering one of the following types of service:

(a) a CTC structured for less than 24-hour stays providing only outpatient withdrawal management or other stabilization services;

(b) a CTC providing outpatient and residential crisis stabilization services; or

(c) a CTC providing residential crisis stabilization services.

(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 NM for services performed in NM. For services performed by providers licensed outside of NM, a provider's out-of-state license may be accepted in lieu of licensure in NM if the out-of-state licensure requirements are similar to those of the state of NM.

(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, working within the scope of their licensure, 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 services provided by the physician and the licensed independent mental health practitioner, 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. This requirement may be met through access to a supervising nurse who is available via telehealth.

(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 NM credentialing board for behavioral health professionals as a certified peer support worker staffed appropriate to meet the client needs 24 hours a day seven 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.

(7) Additional staff may include an emergency medical technician (EMT) with documentation of three hours of annual training in suicide risk assessment.

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 adult 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: Services furnished by a CTC are subject to the limitations and coverage restrictions that exist for other MAD covered 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 HCA 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 and are provided as approved by the CTC provider agency. 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.

[8.321.2.21 NMAC - Rp, 8.321.2.20 NMAC, 12/10/2024]

8.321.2.22 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 per 7.20.11 NMAC 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 their 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 SUD;

(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 their 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 their 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 covered 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 8.321.2.22 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.

[8.321.2.22 NMAC - Rp, 8.321.2.21 NMAC, 12/10/2024]

8.321.2.23 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. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers:

(1) Family support service providers and staff shall meet standards established by the state of NM and documented in the BH policy and billing manual.

(2) 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.

(3) 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 NM.

(4) Minimum staff qualifications for the clinical supervisor:

(a) must be a licensed RLD board approved clinical supervisor (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 NM.

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 treatment plans;

(c) identification of the member and family functional strengths and any barriers to recovery;

(d) participation in treatment 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 treatment 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 psychoeducation, 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 treatment 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 center (ARTC);

(b) adult accredited residential treatment center (AARTC);

(c) residential treatment center services;

(d) group home services;

(e) inpatient hospitalization;

(f) partial hospitalization;
(g) treatment foster care; or
(h) crisis triage centers.

[8.321.2.23 NMAC - Rp, 8.321.2.22 NMAC, 12/10/2024]

8.321.2.24 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 up to 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 SUD refer to 8.321.2.25 NMAC. For freestanding psychiatric hospitals, if the eligible recipient who is receiving inpatient services reaches the age of 21 years, services may continue 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 NM 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 enrolled 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 their 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 their 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, their 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, their 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 covered 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 their 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 NM 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 HCA 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 HCA for the provision of managed care services to an eligible recipient.

(a) if the provider and the HCA 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 HCA to the provider participating in the medical assistance programs administered by MAD and excludes disproportionate share hospital and medical education payments.

[8.321.2.24 NMAC - Rp, 8.321.2.23 NMAC, 12/10/2024]

8.321.2.25 INSTITUTION FOR MENTAL DISEASES (IMD) FOR SUBSTANCE USE DISORDER (SUD): 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. MAD covers inpatient hospitalization in an IMD for SUD diagnoses only 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. 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 8.321.2.24 NMAC.

A. Eligible recipients: Adolescents and adults with a mental health or SUD 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.

[8.321.2.25 NMAC - Rp, 8.321.2.24 NMAC, 12/10/2024]

8.321.2.26 INTENSIVE OUTPATIENT PROGRAM (IOP) FOR SUBSTANCE USE DISORDERS (SUD): 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 through the process described in the BH policy and billing manual and target specific behaviors with individualized behavioral interventions.

A. Eligible providers: Services must be delivered through an agency approved through the application process described in the BH policy and billing manual. Prior to medicaid enrollment the agency must demonstrate that the agency meets all the requirements of IOP program services and supervision. See Subsection A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) IOP services are provided through an integrated interdisciplinary approach including staff expertise in both SUD and mental health treatment. This team may have services rendered by non-independently licensed and non-licensed practitioners within their scope of practice and under the direction of the IOP RLD board approved clinical supervisor. See Subsection E of 8.321.2.9 NMAC for non-independent and non-licensed practitioners and Subsection C of 8.321.2.9 NMAC for independently licensed professionals eligible to conduct IOP clinical supervision.

(2) Each IOP program must have an independently licensed RLD board approved clinical supervisor. Both clinical services and supervision by independently licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) have two or more years of relevant experience with an IOP program or approved exception by submitting a request through the process described in the BH policy and billing manual; and

(b) have expertise in both mental health and substance use disorder treatment.

(3) The IOP agency is required to develop and implement a program outcome evaluation system which may include consumer satisfaction surveys, retention into service rates, drop-out rates, re-admittance or relapse and lapse rates, incarceration or hospitalization data, or readily identifiable information and data specific to the IOP.

(4) The agency must maintain the appropriate state facility licensure and abide by all applicable state and federal regulations if offering medication for opioid use disorder.

(5) The agency must hold an IOP approval letter as described in the BH policy and billing manual 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. As described in the BH policy and billing manual an IOP will receive provisional approval to begin rendering IOP services prior to receiving full approval.

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 through the process described in the BH policy and billing manual. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved.

(2) Treatment services must address co-occurring substance used and mental health disorders. Care coordination should be available to ensure integrated care for medical conditions either by referral or internally.

C. Covered services:

(1) IOP core services must include:

(a) individual SUD related therapy;

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

(c) psychoeducation for the eligible recipient and their family or significant other.

(2) Co-occurring mental health and SUD: 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 behavioral health providers.

(3) Medication management services must accessible either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of SUD.

(4) The amount and intensity of an eligible recipient's IOP intervention is typically three to six months and between 9-19 hours for adults or 6-19 hours for adolescents per week. The amount of weekly services per eligible recipient is directly related to the goals specified in their IOP treatment plan and the IOP EBP in use. Recipients must meet ASAM 2.1 level of care placement criteria and have been diagnosed with a moderate or severe SUD to be eligible to receive SUD IOP services.

(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. Such documentation includes, but is not limited to current assessment, a co-occurring diagnosis, and inclusion in the treatment 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 a substance use disorder or with co-occurring disorders (mental illness and SUD) and 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. Adolescents who turn 18 years old while in an IOP program may remain until appropriate discharge. 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 program of which the age range has been determined by the agency, and that have been diagnosed with substance use disorder or with co-occurring disorders (mental illness and substance use) 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 use disorders or co-occurring disorders (mental illness and substance use) that meet the American society of addiction medicine's (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment of have been mandated by the local judicial system as an option of least restrictive level of care.

(4) Prior to engaging in an IOP program, the eligible recipient must have a treatment file containing:

(a) a diagnostic evaluation with a diagnosis of a moderate or severe SUD;

(b) an individualized IOP treatment plan that includes IOP and the EBP as the intervention; and

(c) both a crisis and safety plan developed with the recipient. The treatment, crisis, and safety plans must be regularly updated in collaboration with the recipient.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD covered 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) partial hospitalization;

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

(5) activity therapy.

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 daily rate. Medication assisted treatment and other mental health therapies are billed and reimbursed separately from the daily 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.

[8.321.2.26 NMAC - Rp, 8.321.2.25 NMAC, 12/10/2024]

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

A. Eligible providers: Services must be delivered through a MAD enrolled agency. IOP agencies must complete the application process as outlined in the BH policy and billing manual. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) 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-independently licensed and non-licensed practitioners under the direction of a RLD board approved clinical supervisor. See Subsection E of 8.321.2.9 NMAC for non-independent and non-licensed practitioners and Subsection C of 8.321.2.9 NMAC for independently licensed professionals eligible to conduct IOP clinical supervision.

(2) Each IOP program must have an independently licensed board approved 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) have two years or more relevant experience; and

(b) have one or more years demonstrated clinical supervisory experience.

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

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

(5) The agency must hold an IOP 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. As described in the BH policy and billing manual an IOP will receive provisional approval to begin rendering IOP services prior to receiving full approval.

B. Coverage criteria:

(1) An IOP is based on research and applies 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 through the process described in the BH policy and billing manual. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved.

(2) Treatment services must address a primary SMI or SED and co-occurring SUD when indicated. Care coordination should be available to ensure integrated care for medical conditions either by referral or internally.

C. Covered services:

(1) IOP core services must include:

(a) individual therapy;

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

(c) psychoeducation for the eligible recipient and their family or significant other.

(2) Co-occurring mental health and SUD. 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 behavioral health providers.

(3) Medication management services must be accessible either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of SUD.

(4) The duration and intensity of an eligible recipient's IOP intervention is typically three to six months and between 9-19 hours for adults or 6-19 hours for adolescents per week. The amount of weekly services per eligible recipient is directly related to the goals specified in their IOP treatment plan and the IOP EBP in use. Recipients must meet SMI/SED criteria and have a diagnosis to be eligible to receive MH IOP services.

(5) Other mental health therapies: outpatient therapies may be rendered in addition to the IP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services which are outside the scope of IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services. Such documentation includes, but is not limited to current assessment, a co-occurring diagnosis, and the inclusion of a 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 Subsection 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 must coordinate the recipients transfer to the new provider.

D. Identified population:

(1) IOP services are provided to an eligible recipient, 11 through 17 years of age diagnosed with a SED or have been mandated by the local judicial system as an option of least restrictive level of care. Adolescents who turn 18 years old while in an IOP program may remain until appropriate discharge.

(2) IOP services are provided to an eligible recipient of a transitional age program of which the age range has been determined by the agency, and is diagnosed with substance use disorder or with co-occurring disorders (mental illness and substance use) or that meet the ASAM patient placement criteria for level 2.1 - intensive outpatient treatment, or have been mandated by the local judicial system as an option or least restrictive level of care.

(3) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with a SMI; or have been mandated by local judicial system as an option of least restrictive level of care.

(4) Prior to engaging in an IOP program, the eligible recipient must have a treatment file containing:

(a) a diagnostic evaluation with a diagnosis of serious mental illness or severe emotional disturbance; or diagnosis for which the IOP is approved;

(b) an individualized IOP treatment plan that includes IOP and the EBP as the intervention; and

(c) both a crisis and safety plan developed with the recipient. The treatment, crisis, and safety plans must be regularly updated in collaboration with the recipient.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD covered 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, transitional living services);

(3) partial hospitalization;

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

(5) activity therapy.

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 daily rate. Medications and other mental health therapies are billed and reimbursed separately from the daily 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.

[8.321.2.27 NMAC - Rp, 8.321.2.26 NMAC, 12/10/2024]

8.321.2.28 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), the Comprehensive Addiction and Recovery Act of 2016 (CARA), and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act). Services include, but are not limited to, medication for opioid use disorder (excluding methadone) to an eligible recipient for medically managed withdrawal form opioids or medication for opioid use disorder. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Any clinic, office, or hospital staffed by required practitioners.

(2) Practitioners for diagnosing, assessing, and prescribing include:

(a) a physician or DO licensed in the state of NM and has completed drug enforcement agency (DEA) approved training and has the federal waiver to prescribe buprenorphine;

(b) an advanced practice registered nurse that has completed DEA approved training; or

(c) a physician assistant licensed in the state of NM 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 NM; or

(b) a physician assistant licensed in the state of NM.

(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, which may be conducted either in person or via telehealth, by the prescribing practitioner to determine whether the recipient has an opioid use 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 use disorders;

(4) providing psychoeducation related to all available treatment options, prior to starting treatment; and

(5) a treatment 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.

[8.321.2.28 NMAC - Rp, 8.321.2.27 NMAC, 12/10/2024]

8.321.2.29 MULTI-SYSTEMIC THERAPY (MST) and MST PROBLEM SEXUAL BEHAVIOR (MST-PSB): To help an eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter their home and community, MAD pays for MST and MST-PSB 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. MST is an intensive family and community, evidence-based treatment for youth who are at risk of out-of-home placement or are returning home from out-of-home placement. MST addresses the multiple causes of serious antisocial behavior across key systems within which youth are embedded. MST-PSB focuses on aspects of a youth's ecology that are functionally related to the problem sexual behavior. Unless otherwise described below the acronym MST may be interpreted to include both MST and MST-PSB. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient. The acronym MST used throughout this section includes both MST and MST-PSB unless otherwise specified.

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 and meet the state licensure and provider enrollment requirements for each MST team. Additionally, the agency must complete the application process as described in the behavioral health billing and policy manual. All clinical staff are required to complete a prescribed five-day MST introductory training and subsequent quarterly trainings. Any staff person providing MST-PSB must have completed the MST-PSB specific training and be on a specially trained team with national certification from MST Services, LLC for MST-PSB.

(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 their 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. Bachelor's level staff may provide the non-clinical components of treatment including treatment planning, skill-building, and family psychoeducation but not family therapy; 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 unless an exception is granted by MST Services, LLC.

(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 their 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 their 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-using 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 their treatment and their family's involvement.

MST for youth with problem sexual behaviors (MST-PSB) is a clinician adaptation of MST that has been specifically designed and developed to treat youth for problematic sexual behavior.

(2) A co-occurring diagnosis of SUD 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 provided in the community. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance use, delinquency, and violent behavior. MST service components include treatment planning; restoration of social skills which is available 24-hours a day, seven days a week; and family therapy and psychoeducation.

(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 their 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 their 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;

(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; and

(e) services provided to family members or other supports must be for the direct benefit of the medicaid recipient.

(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 covered 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.

[8.321.2.29 NMAC - Rp, 8.321.2.28 NMAC, 12/10/2024]

8.321.2.30 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 their family or transition into their 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. This determination must have considered all environments which are least restrictive, meaning a supervised community placement, preferably a placement with the juvenile's parent, guardian or relative. A facility or conditions of treatment that is a residential or institutional placement should only be utilized as a last resort based on the best interest of the juvenile or for reasons of public safety. 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 7.20.11 NMAC;

(2) a group home must be certified per 7.20.11 NMAC and licensed per 7.20.12 NMAC 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.

(4) RTCs and group homes must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

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 their 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 their 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 treatment 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 covered 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: A treatment 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 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 and any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations Section 438.14(a), 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

(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 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. [8.321.2.30 NMAC - Rp, 8.321.2.29 NMAC, 12/10/2024]

8.321.2.31 OPIOID TREATMENT PROGRAM (OTP): MAD pays for coverage for medication assisted treatment for opioid use disorder 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 to an individual for medically managed withdrawal from opioids and maintenance treatment. The administration/supervision must be delivered in conjunction with the overall treatment based upon a treatment plan that reflects shared decision making between the patient and health care practitioner or counselor, to include availability of counseling as well as, case review, drug testing, and medication monitoring. Availability of counseling is a required OTP service however access to medication for an enrolled recipient is not contingent upon receipt of counseling services. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Provider requirements:

(a) Accreditation with a substance use 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 NM or a DO licensed to practice in the State of NM);

(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.

(c) Programs may also be staffed by:

(i) licensed substance abuse associate (LSAA); and

(ii) certified peer support worker (CPSW).

B. Coverage criteria:

(1) A physician licensed to practice in NM 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 use disorder 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 medically managed withdrawal from medication or other opioids, patients must be offered a relapse prevention program that includes, but is not limited to, counseling, naloxone, and medication for opioid use disorder.

(8) Provision of unscheduled treatment or counseling to patients.

(9) Established 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 division of medication to the relevant regulatory agencies, and law enforcement authorities.

(13) Prescription monitoring program (PMP): 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 NM PMP. The PMP should be checked quarterly through the course of each patient's treatment.

(14) HIV/AIDS, hepatitis, and other sexually transmitted infection (STI) 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 practitioners who prescribe, distribute or dispense opioid analgesics:

(a) A health care practitioner 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 practitioner, the health care practitioner 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 practitioner prescribes, distributes or dispenses an opioid analgesic each calendar year.

(c) A health care practitioner 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 medical director or licensed practitioner 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 which may be conducted either in-person or via telehealth; and

(c) informed consent for treatment must be provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority if the recipient is under the age of 18. Consent may be provided electronically.

(2) OTPs must maintain current policies and procedures that reflect the special needs and priority for treatment of recipients with opioid use disorder who are pregnant. Evidence-based treatment protocols for pregnant patients, such as a split dosing regimen, may be instituted after assessment by an OTP practitioner. Prenatal care and other sex-specific services, including reproductive health services for pregnant and postpartum patients must be provided, and documented, by either the OTP or by referral to an appropriate healthcare practitioner.

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, reflecting shared decision making between the patient and the licensed practitioner, 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 use 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.

(6) Initiation of the following mandatory laboratory tests:

(a) a mantoux skin test;

(b) a test for syphilis;

(c) hepatitis screening in accordance with the most current CDC guidelines; and

(d) a laboratory drug detection test for at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines, and other substances as may be appropriate, based upon patient history and prevailing patterns of availability.

(7) Medication units:

(a) interested applicants shall submit to the BHSD for approval to add a medication unit to their existing registration:

(i) a written letter of intent that demonstrates how this service will increase access to methadone in rural communities and avoid duplication with other OTP services;

(ii) standard operating procedure;

(iii) approval from the drug enforcement administration;

(iv) approval from the NM board of pharmacy; and

(v) application to SAMHSA/CSAT following BHSD approval.

(b) BHSD shall approve or deny the application within 30 working days of submission, unless the BHSD and applicant mutually agree to extend the application review period.

(c) BHSD may require the applicant to provide additional written or verbal information in order to reach its decision. Such further information shall be considered an integral part of the application and may extend the application review period.

(d) the following services may be provided where space allows for quality patient care in mobile medication units, assuming compliance with all applicable federal, state, and local law:

(i) administering and dispensing medications for opioid use disorder treatment;

(ii) collecting samples for drug testing or analysis;

(iii) dispensing of take-home medications;

(iv) in units that provide appropriate privacy and adequate space, intake/initial psychosocial and appropriate medical assessments (with a full physical examination to be completed or provided within 14-days of admission);

(v) initiating methadone or buprenorphine after an appropriate medical assessment has been performed;

(vi) in units that provide appropriate privacy and have adequate space, other OTP services, such as counseling, may be provided directly or when permissible through use of telehealth services.

(e) any required services not provided in mobile and non-mobile medication units must be conducted at the OTP, including medical, counseling, vocational, educational, and other assessment, and treatment services (42 CFR 8.12(f)(1)).

(8) Take home medication: active OTP recipients, regardless of the length of time in treatment, may receive take home doses for days during which the clinic is closed including one weekend day as well as state and federal holidays. Beyond the standing approval to allow take home doses when the clinic is closed OTP decisions on dispensing medication for opioid use disorder (MOUD) to recipients for unsupervised use shall be determined by an appropriately licensed OTP medical practitioner or the medical director.

(a) the OTP medical practitioner or medical director shall consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

(i) absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

(ii) regularity of attendance for supervised medication administration;

(iii) absence of serious behavioral problems that endanger the patient, the public or others;

(iv) absence of known recent diversion activity;

(v) whether take-home medication can be safely transported and stored; and

(vi) any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

(b) the program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:

(i) criteria for determining when a patient is ready to receive take-home medication;

(ii) criteria for when a patient's take-home medication is increased or decreased;

(iii) a requirement that take-home medication be dispensed according to federal and state law;

(iv) a requirement that the program medical director review a patient's take-home medication regimen at intervals of no less than 90 days and adjust the patient's dosage, as needed;

(v) procedures for safe handling and secure storage of take-home medication in a patient's home; and

(vi) criteria and duration of allowing a physician to prescribe a split medication regimen.

(c) during the first 14 days of treatment, the take-home supply is limited to seven days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to seven days, but decisions must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(d) from 15 days of treatment, the take-home supply is limited to 14 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 14 days, but this determination must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(e) from 31 days of treatment, the take-home supply to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 28 days, but this determination must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(f) a program sponsor shall ensure that a patient receiving take-home medication receives:

(i) take home medication in a child-proof container: and

(ii) written and verbal information regarding the recipient's responsibility in the protection and security of take-home mediation.

(g) the rationale underlying the decision to provide or withdraw unsupervised doses of methadone must be documented in the patient's clinical record.

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) behavioral health prevention and education services to affect knowledge, attitude, or behavior can be rendered by a licensed substance use disorder associate or certified peer support worker in addition to independently licensed practitioners;

(c) outpatient therapy other than substance use disorder 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;

(d) an eligible recipient's initial medical examination, which may be conducted in person or via telehealth when rendered by a MAD enrolled licensed practitioner who meets 8.310.2 and 8.310.3 NMAC requirements;

(e) full medical examination, prenatal care and gender specific services for a pregnant recipient; if they are referred to a provider outside the agency, payment is made to the provider of the service;

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

(g) the quantity of service billed in a single day can include, in addition to the drug items administered that day, the number of take-home medications dispensed that day; and

(h) guest dosing can be reimbursed at medicaid-enrolled agencies per 7.32.8 NMAC. Arrangements must be confirmed prior to sending the patient to the receiving clinic.

(3) For an IHS, tribal 638 facility or any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations Section

(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.

[8.321.2.31 NMAC - Rp, 8.321.2.30 NMAC, 12/10/2024]

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

(5) Services are furnished under an individualized 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 or psychiatric diagnostic evaluation, 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 themselves 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, their 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 covered 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 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 HCA 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 eight hours, which is billed fractions of .25, .5, or .75 units to represent two, four, or six 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.

[8.321.2.32 NMAC - Rp, 8.321.2.31 NMAC, 12/10/2024]

8.321.2.33 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. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) 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. PSR agencies must:

(a) have provided a minimum of three years of CCSS services; and

(b) be approved through the application process described in the BH policy and billing manual.

(2) 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 are medically necessary to meet the individual needs of the eligible recipient, as delineated in their treatment plan. Medical necessity is based upon the eligible recipient's level of functioning as affected by their 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 their 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 plan. Recipients shall participate in PSR services for those activities that are identified in the treatment 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 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 SUD 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 covered 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: No prior authorization is required. To determine retrospectively if the medical necessity for the service has been met, the following factors are considered:

(1) recipient assessment;
(2) recipient diagnostic formation;
(3) recipient 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.

[8.321.2.33 NMAC - Rp, 8.321.2.32 NMAC, 12/10/2024]

8.321.2.34 RECOVERY SERVICES (MCOs only): Recovery services are peer-to-peer support for managed 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. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Staffing requirements:

(1) all staff must possess a current and valid NM driver's license;
(2) clinical supervisor:

(a) licensed as a RLD board approved clinical supervisor independent practitioner (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, CNP, CNS); and

(b) two years relevant experience with the target population; and

(c) one year demonstrated supervisory experience; and

(d) expertise in both mental health and SUD treatment services; and

(e) supervision must be conducted in accord with respective licensing board regulations.

(3) certified peer support workers; and

(4) certified family specialists.

(5) 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 SMI; and

(3) Individuals with chronic SUD; or individuals with a co-occurring disorder (mental illness and SUD) 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) treatment foster care (TFC).

[8.321.2.34 NMAC - Rp, 8.321.2.33 NMAC, 12/10/2024]

8.321.2.35 SCREENING, BRIEF INTERVENTION & REFERRAL TO TREATMENT (SBIRT): 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. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Providers may include the following agency types that have completed the state approved SBIRT training:

(a) primary care offices including FQHCs, IHS 638 tribal facilities and any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations Section);

(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;

(h) school based health centers; and

(i) nursing facilities.

(2) Rendering practitioners must work in the approved agencies defined in Paragraph (1) of Subsection A of 8.321.2.36 NMAC and may include:

(a) licensed nurse trained in SBIRT;

(b) advance practice registered nurse trained in SBIRT;

(c) behavioral health practitioner at all educational levels trained in SBIRT;

(d) behavioral health interns under the supervision of a board approved clinical supervisor;

(e) certified peer support worker, certified family peer support worker, or certified youth peer support specialist trained in SBIRT;

(f) community health worker trained in SBIRT;

(g) licensed physician assistant trained in SBIRT;

(h) physician trained in SBIRT;

(i) home health agency trained in SBIRT

(j) nurse home visit EPSDT;

(k) medical assistant trained in SBIRT; and

(l) 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 a state approved SBIRT training. See details in the BH policy and billing manual.

C. Identified population:

(1) MAD recipients 11 to 17 years of age, in accordance with state laws related to adolescent consent and confidentiality.

(2) MAD recipient adolescents 18 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, with or without co-occurring 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.
[8.321.2.35 NMAC - Rp, 8.321.2.34 NMAC, 12/10/2024]

8.321.2.36 SMOKING CESSATION COUNSELING: See 8.310.2 NMAC for a detailed description of tobacco cessation services and approved behavioral health providers.
[8.321.2.36 NMAC - Rp, 8.321.2.35 NMAC, 12/10/2024]

8.321.2.37 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.

A. Eligible providers and practitioners:

(1) Any clinic, office or agency providing permanent supportive housing under the HCA linkages program administered by BHSD.

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

(a) behavioral health professional licensed in the state of NM; 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.
[8.321.2.37 NMAC - Rp, 8.321.2.36 NMAC, 12/10/2024]

8.321.2.38 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 them develop skills necessary for successful reintegration into their 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 per 7.20.11 NMAC and be licensed per 8.26.4 and 8.26.5 NMAC as a child placement agency by CYFD protective services. In lieu of NM CYFD licensure and certification, an out-of-state TFC agency must have equivalent accreditation and be licensed in its own state as a TFC agency.

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, which includes clinical rationale.

(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 their 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 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 their 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 their 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 their 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 treatment plan when an eligible recipient's return to their 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 covered 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. [8.321.2.38 NMAC - Rp, 8.321.2.37 NMAC, 12/10/2024]

8.321.2.39 THERAPEUTIC INTERVENTIONS: MAD provides coverage for therapeutic intervention services rendered to individuals with mental health disorders. The mental health services rendered shall be necessary to reduce the disability resulting from mental illness and to restore the individual to their best possible functioning level in the community. Therapeutic interventions are the following evidence-based practices delivered by qualified licensed mental health practitioners: trauma-focused cognitive behavioral therapy (TF-CBT); eye movement desensitization and reprocessing (EMDR); and dialectical behavior therapy (DBT).

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 TF-CBT, EMDR, or DBT services, an agency must be approved through the application process described in the BH policy and billing manual and hold an acceptable certification or licensure for the specific EBP identified above. The following mental health practitioners who are licensed in the state of NM to diagnose and treat behavioral health, acting within the scope of all applicable state laws and their professional license, may provide the above evidence-based practices if certification is obtained from the listed source:

(1) licensed psychologists;

(2) licensed clinical social workers (LCSWs);

(3) licensed professional clinical counselors (LPCCs);

(4) licensed marriage and family therapists (LMFTs);

(5) licensed alcohol and drug abuse counselors (LADAC); and

(6) advanced practice registered nurses (APRN) (must be a nurse practitioner specialist in adult psychiatric & mental health, and family psychiatric & mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice).

B. Additional provider requirements for DBT: DBT agencies must be able to provide 24-hours a day, seven days a week availability for skills coaching. Therapists must be independently licensed but may work with master's or bachelor's level staff with a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population that is, children or adolescents and their families. Unlicensed staff may not provide DBT therapy. Unlicensed staff may only provide service coordination and group therapy in conjunction with a trained licensed therapist. An active DBT team requires DBT certification of at least two certified treatment providers working collaboratively with one another using the DBT services as defined by the DBT services program selected by the state. DBT trainees and DBT care managers may be the second professional in a group setting where a DBT therapist is the group lead. In addition, while the DBT trainees and DBT care managers may bill for service coordination, they may not bill for DBT therapy. Only a licensed and trained DBT therapist may bill for DBT therapy.

C. Identified population: Individuals with mental health disorders. There is no age restriction for EMDR, or DBT. TF-CBT is limited to children under the age of 18 and their families. Services provided to family members or other supports are for the direct benefit of the medicaid recipient.

D. Covered services: Therapeutic interventions are services rendered to reduce disability resulting from mental illness and to restore the individual to their best possible functioning level in the community. Therapeutic interventions include:

(1) Trauma-focused cognitive behavioral therapy (TF-CBT): Is a combination of cognitive behavioral therapy, family therapy, and psychosocial education to address the effects of trauma using conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Trauma focus cognitive behavioral therapy certification program (tfcbt.org) is an acceptable certification. Any interventions involving parents and caregivers are for the direct benefit of the beneficiary.

(2) Eye movement desensitization and reprocessing (EMDR): An evidence-based psychotherapy that treats trauma-related symptoms. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well. EMDRIA (EMDR International Association) sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met (see www.emdria.org). EMDRIA establishes two levels of training for practitioners in EMDR therapy. For the purposes of providing EMDR therapy under NM medicaid, either level (EMDRIA approved basic training, or EMDR certification) are acceptable qualifications. The standard level of training, which allows a practitioner to provide EMDR therapy, is referred to as "EMDRIA approved basic training".

(3) Dialectical behavior therapy (DBT): A cognitive behavioral approach to treatment to teach individuals better management of powerful emotions, urges, and thoughts that can disrupt daily living if not addressed in a structured treatment approach. DBT-linehan board of certification is an acceptable qualification. This evidence-based practice includes service coordination, individual, group, and family therapy. A DBT provider must include in their program individual DBT therapy, DBT skills groups, 24-hour coverage seven days per week availability for skills coaching, and a clinical consultation team.

E. Service exclusions and limitations: Therapeutic intervention services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services. All services provided while a person is a resident of an institution for mental disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations. The following activities services shall be excluded from medicaid coverage and reimbursement of these evidence-based practices:

(1) Components that are not provided to, or directed exclusively toward, the treatment of the medicaid eligible individual.

(2) Services provided at a work site, which are job-oriented and not directly related to the treatment of the member's needs.

(3) These rehabilitation services shall not duplicate any other medicaid state plan service or service otherwise available to the member at no cost.

(4) Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

F. Additional DBT service exclusions and limitations: DBT shall not be billed in conjunction with BH services by licensed and unlicensed individuals, other than medication management and psychological evaluation or assessment; and residential services, including therapeutic foster care and RTC services.

G. Reimbursement: Therapeutic intervention 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 agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.39 NMAC - N, 12/10/2024]

8.321.2.40 FUNCTIONAL FAMILY THERAPY (FFT): To help eligible recipients receive behavioral health services to MAD pays for FFT services. FFT is an evidence-based, short term and intensive family-based and manual driven treatment program that has been successful in treating a wide range of problems affecting families in a wide range of multi-ethnic, multicultural, and geographic contexts.

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 FFT services, an agency must hold a copy of FFT, LLC or FFT partners certification, or any of its approved subsidiaries and meet the state licensure and provider enrollment requirements for each FFT team. Additionally, the agency must complete the application process as described in the BH policy and billing manual. An active FFT team requires FFT certification of a clinical supervisor and at least two FFT certified treatment providers working collaboratively with one another using the FFT services as defined by the State. Providers must be engaged in training, consultation, and oversight by either of the following training entities: FFT LLC or FFT partners.

(1) The FFT program includes an assigned FFT team for each eligible recipient. The FFT 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) a licensed master's level behavioral health practitioner that is required to perform all FFT interventions; a bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of their RLD practice board licensure or practice (see Subsection E of 8.321.2.9 NMAC);

(c) 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. Bachelor's level staff may provide the non-clinical components of treatment including treatment planning, skill-building, and family psychoeducation but not family therapy; and

(d) staffing for FFT services is comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff unless an exception is granted by FFT, LLC or FFT partners.

(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 FFT trained; this supervision, following the FFT supervisory protocol, is provided to team members on topics directly related to the needs of the eligible recipient and their 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 FFT systems supervisor, provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis.

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

B. Identified population:

(1) FFT is provided to an eligible youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use. FFT is an evidence-based, short term and intensive family-based treatment. FFT program's goals are to: integrate families' voices in all phases of treatment; develop and grow in innovative, collaborative, dynamic and evidence-based practices; practice evidence-based programs in evidence-based ways to maintain model fidelity; evolve the model in a way that is responsive to the needs of families, communities, and agencies; and provide innovative, real-time cloud-based technology and training for predictability and outcomes.

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

C. Covered services and service limitations: FFT enrolls families with youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use. FFT services may be provided in both clinic-based and community-based settings. FFT service components include treatment planning; restoration of social skills which is available 24-hours a day, seven days a week; and family therapy and psychoeducation. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient.

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

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

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

(c) case management.

(2) FFT services are conducted by practitioners using the FFT team approach. The FFT team must have the ability to deliver services in various environments both clinic-based and community based.

(3) FFT interventions occur in three primary phases: engagement/motivation, behavior change, and generalization; each with measurable process goals and family skills that are the targets of intervention with the length of treatment covered based on medical necessity. Each phase has specific goals and practitioner skills associated with it. The specificity of the model allows for monitoring of treatment, training, and practitioner model adherence in ways that are not possible with other less specific treatment interventions.

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

E. Reimbursement: FFT 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 FFT agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.40 NMAC - N, 12/10/2024]

8.321.2.41 HIGH FIDELITY WRAPAROUND (HFW): An intensive care coordination service designed as a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. HFW aligns with the children's system of care (SOC) approach in NM. HFW supports teams to effectively coordinate within the state's children's behavioral health service array including access to community supports and resources. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient.

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 HFW an agency must complete the application process as described in the behavioral health billing and policy manual. HFW agencies must maintain a clinical director and program director or administrator.

(1) The HFW program includes an assigned HFW team for each eligible recipient. The HFW team includes:

(a) wraparound facilitator who has completed the requirements of the facilitator in training (FIT) track, obtained wraparound certification from the NM credentialing board for behavioral health professionals (NMCBBHP), and meets the educational requirements identified in the BH policy and billing manual;

(b) wraparound supervisor-coach who has completed the requirements of the facilitator in training (FIT) track, obtained wraparound certification from the NM credentialing board for behavioral health professionals (NMCBBHP), completed the requirements of the coach in training (CIT) track, and meets the educational requirements identified in the BH policy and billing manual; and

(c) a family peer support worker.

B. Identified population: individuals are eligible to receive HFW intensive care coordination if they meet the following criteria:

(1) children or youth with an SED diagnosis;

(2) functional impairment in two or more domains identified by the child and adolescent needs and strengths (CANS) tool;

(3) involved in two or more systems such as special education, behavioral health, protective services or juvenile justice, or (for children aged 0-5) are at risk of such involvement; and

(4) are at risk or in an out of home placement.

C. Covered services include:

(1) Intensive care coordination through dedicated full-time care coordinators working with small numbers of children and families. The care coordinator is required to follow state guidelines described in the BH policy and billing manual for care of children with SED who are eligible for HFW. Care coordinators work in partnership with representatives of key stakeholder groups, including families, agencies, providers, and community representatives to plan, implement and oversee HFW coordination plans. Intensive care coordination includes, but is not limited to:

(a) functional, needs and strengths assessment and service planning;

(b) accessing and arranging for services, resources and supports;

(c) coordinating multiple services, levels of care, resources, supports and teams;

(d) conducting safety and stability planning and response;
(e) assisting children and families in meeting basic needs;
(f) advocating for children and families;
(g) monitoring progress; and
(h) conducting a team and strengths-based approach.

(2) Treatment planning: the individualized care coordination plans are developed by engaging with the beneficiary's family or caretakers and other members of the beneficiary's community. Such plans must be family and youth-driven, team-based, collaborative, individualized, and outcomes-based. The plan of care must address youth and family needs across domains of physical and behavioral health and social services.

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

E. Reimbursement: HFW 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 HFW agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.41 NMAC - N, 12/10/2024]

8.321.2.42 PEER SUPPORT SERVICES: Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.

A. Eligible practitioners: Must be self-identified consumers who are in recovery from mental illness or substance use disorder. 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 peer support services practitioners meet the following qualifications:

(1) Certified peer support workers (CPSW) must:
(a) complete the certification program offered through BHSD;
(b) be certified by the NM credentialing board for behavioral health professionals;
(c) complete 20 hours of initial training and 20 hours of education every subsequent year;
(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and
(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

(2) Certified family peer support workers (CFPSW) must:
(a) complete the certification program offered through CYFD;
(b) be certified by the NM credentialing board for behavioral health professionals;
(c) complete 20 hours of initial training and 20 hours of education every subsequent year;
(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and
(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

(3) Certified youth peer support specialists (CYPSS) must:
(a) complete the certification program offered through CYFD;
(b) be certified by the NM credentialing board for behavioral health professionals;
(c) complete 20 hours of initial training and 20 hours of education every subsequent year;
(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and
(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

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

C. Reimbursement: peer support providers 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 peer support provider receives instructions on how to access documentation, billing, and claims processing information.
[8.321.2.42 NMAC - N, 12/10/2024]

HISTORY OF 8.321.2 NAMC:
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 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/3/2019, Repealed effective 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 7/22/2021, Repealed effective 12/1/2024.

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 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/3/2019 was replaced by 8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement effective 8/10/2021.
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