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**(15)** Requirements for health care providers who prescribe, distribute or dispense opioid analgesics:

**(a)** A health care provider who prescribes, distributes or dispenses an opioid analgesic for the first time to a patient shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist.

**(b)** For a patient to whom an opioid analgesic has previously been prescribed, distributed or dispensed by the health care provider, the health care provider shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist on the first occasion that the health care provider prescribes, distributes or dispenses an opioid analgesic each calendar year.

**(c)** A health care provider who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply. The prescription for the opioid antagonist shall be accompanied by written information regarding the temporary effects of the opioid antagonist and techniques for administering the opioid antagonist. That written information shall contain a warning that a person administering the opioid antagonist should call 911 immediately after administering the opioid antagonist.

**C. Identified population:**

**(1)** An eligible recipient is treated for opioid dependency only after the agency's physician determines and documents that:

**(a)** the recipient meets the definition of opioid use disorder using generally accepted medical criteria, such as those contained in the current version of the DSM;

**(b)** the recipient has received an initial medical examination as required by 7.32.8.19 NMAC, *Opioid Treatment Program Admissions*;

**(c)** if the recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting OTP services unless the recipient receives a waiver of this requirement from the agency's physician because the recipient:

**(i)** was released from a penal institution within the last six months;

**(ii)** is pregnant, as confirmed by the agency's physician;

**(iii)** was treated for opioid use disorder within the last 24 months;

**(iv)** is under the age of 18; has had two documented unsuccessful attempts at short-term opioid treatment withdrawal procedures of drug-free treatment within a 12 month period, and has informed consent for treatment provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority; or

**(v)** meets any other requirements specified in 7.32.8 NMAC, *Opioid Treatment Program* regarding waivers, consent, and waiting periods.

**D. Covered services:**

**(1)** Withdrawal treatment and medically supervised dose reduction.

**(2)** A biopsychosocial assessment will be conducted by a licensed behavioral health professional or a LADAC under the supervision of an independently licensed clinician, as defined by the NM RLD within 14 days of admission.

**(3)** A comprehensive, patient centered, individualized treatment plan shall be conducted within 30 days of admission and be documented in the patient record.

**(4)** Each OTP will ensure that adequate medical, psychosocial counseling, mental health, vocational, educational and other services identified in the initial and ongoing treatment plans are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.

**(5)** Drug screening: A recipient in comprehensive maintenance treatment receives one random urine drug detection test per month; short-term opioid treatment withdrawal procedure patients receive at least one initial drug abuse test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee. Samples that are sent out for confirmatory testing (by internal or external laboratories) are billed separately by the laboratory.

**E. Non-covered services:** Blood samples collected and sent to an outside laboratory.

**F. Reimbursement:**

**(1)** The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine dipstick testing conducted within the agency.

**(2)** Other services performed by the agency as listed below are reimbursed separately and are required by (42 CFR Part 8.12 (f)), or its successor.

**(a)** A narcotic replacement or agonist drug item other than methadone that is administered or dispensed;

**(b)** Behavioral health prevention and education services to affect knowledge, attitude, or behavior can be rendered by a licensed substance abuse associate or certified peer support worker in addition to independently licensed practitioners;

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

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

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

**(f)** Medically necessary services provided beyond those required by (42 CFR Part 8.12 (f)), to address the medical issues of the eligible recipient; 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, [~~or~~] tribal 638 facility or any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations §438.14(a), MAD considers the bundled OTP services to be outside the IHS all-inclusive rate and is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC. Non-bundled services may be billed at the office of management and budget (OMB) rate.

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

[8.321.2.30 NMAC - Rp, 8.321.2.30 NMAC, 8/10/2021]

**8.321.2.31 PARTIAL HOSPITALIZATION SERVICES:** To help an eligible recipient receive the level of services needed, MAD pays for partial hospitalization services furnished by an acute care or freestanding psychiatric hospital. Partial Hospitalization Programs (PHP) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinical services. They are designed to stabilize deteriorating conditions or avert inpatient admissions, or can be a step-down strategy for individuals with SMI, SUD or SED who have required inpatient admission. The environment is highly structured, is time-limited and outcome oriented for recipients experiencing acute symptoms or exacerbating clinical conditions that impede their ability to function on a day-to-day basis. Program objectives focus on ensuring important community tdies and closely resemble the real-life experiences of the recipients served.

**A. Eligible providers and practitioners:** In addition to the requirements found in Subsections A and B of 8.321.2.9 NMAC, an eligible provider includes a facility joint commission accredited, and licensed and certified by DOH or the comparable agency in another state.

**(1)** The program team must include:

**(a)** registered nurse;

**(b)** a clinical supervisor that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician; and

**(c)** licensed behavioral health practitioners.

**(2)** The team may also include:

**(a)** physician assistants;

**(b)** certified peer support workers;

**(c)** certified family peer support workers;

**(d)** licensed practical nurses;

**(e)** mental health technicians.

**B. Coverage criteria:** MAD covers only those services which meet the following criteria:

**(1)** Services that are ordered by a psychiatrist or licensed Ph.D.

**(2)** Partial hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services are essentially of the same nature and intensity, including medical and nursing services, as would be provided in an inpatient setting, except that the recipient is in the program less than 24-hours a day, and it is a time-limited program.

**(3)** A history and physical (H&P) must be conducted within 24 hours of admission. If the eligible recipient is a direct admission from an acute or psychiatric hospital setting, the program may elect to obtain the H&P in lieu of completing a new H&P. In this instance, the program physician's signature indicates the review and acceptance of the document. The H&P may be conducted by a clinical nurse specialist, a clinical nurse practitioner, a physician assistant or a physician.

**(4)** An interdisciplinary biopsychosocial assessment within seven days of admission including alcohol and drug screening. A full substance abuse evaluation is required if alcohol and drug screening indicates the need. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment.

**(5)** Services are furnished under an individualized written treatment plan established within seven days of initiation of service by the psychiatrist, together with the program's team of professionals, and in consultation with recipients, parents, legal guardian(s) or others who participate in the recipient's care. The plan must state the type, amount, frequency and projected duration of the services to be furnished, and indicate the diagnosis and anticipated goals. The treatment plan must be reviewed and updated by the interdisciplinary team every 15 days.

**(6)** Documentation must be sufficient to demonstrate that coverage criteria are met, including:

**(a)** Daily documentation of treatment interventions which are outcome focused and based on the comprehensive assessment, treatment goals, culture, expectations, and needs as identified by the recipient, family or other caregivers.

**(b)** Supervision and periodic evaluation of the recipient, either individually or in a group, by the psychiatrist or psychologist to assess the course of treatment. At a minimum, this periodic evaluation of services at intervals indicated by the condition of the recipient must be documented in the recipient's record.

**(c)** Medical justification for any activity therapies, recipient education programs and psychosocial programs.

**(7)** Treatment must be reasonably expected to improve the eligible recipient's condition or designed to reduce or control the eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the eligible recipient's level of functions. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.

**(8)** For recipients in elementary and secondary school, educational services must be coordinated with the recipient's school system.

**C. Identified population:**

**(1)** Recipients admitted to a PHP shall be under the care of a psychiatrist who certifies the need for partial hospitalization. The recipient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a SMI, SED or moderate to severe SUD which severely interferes with multiple areas of daily life, including social, vocational or educational functioning. Such dysfunction generally is of an acute nature;

**(2)** Recipients must have an adequate support system to sustain/maintain his or herself outside the PHP;

**(3)** Recipients 19 and over with a serious mental illness including substance use who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment; or

**(4)** Recipients five to 18 with severe emotional disturbances including substance use disorders who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment.

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

**(1)** regularly scheduled structured counseling and therapy sessions for an eligible recipient, his or her family, group or multifamily group based on individualized needs furnished by licensed behavioral health professionals, and, as specified in the treatment plan;

**(2)** educational and skills building groups furnished by the program team to promote recovery;

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

**(4)** drugs and biologicals that cannot be self-administered and are furnished for therapeutic management;

**(5)** assistance to the recipient in self-administration of medication in compliance with state policies and procedures;

**(6)** appropriate staff available on a 24-hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the recipient make referrals as necessary, and provide follow-up;

**(7)** consultation with other professionals or allied caregivers regarding a specific recipient;

**(8)** coordination of all non-medical services, including transportation needed to accomplish a treatment objective;

**(9)** therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients; and

**(10)** discharge planning and referrals as necessary to community resources, supports, and providers in order to promote a recipient's return to a higher level of functioning in the least restrictive environment.

**E. Non-covered services:** Partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services with partial hospitalization:

**(1)** meals;

**(2)** transportation by the partial hospitalization provider;

**(3)** group activities or other services which are primarily recreational or diversional in nature;

**(4)** a program that only monitors the management of medication for recipients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a partial hospitalization program;

**(5)** actively homicidal or suicidal ideation that would not be safely managed in a PHP;

**(6)** formal educational and vocational services related to traditional academic subjects or vocational training; non-formal education services can be covered if they are part of an active treatment plan for the eligible recipient; see 42 CFR Section 441.13(b); or

**(7)** services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

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

**(1)** the recipient's response to the therapeutic interventions provided by the PHP;

**(2)** the recipient's psychiatric symptoms that continue to place the recipient at risk of hospitalization; and

**(3)** treatment goals for coordination of services to facilitate discharge from the PHP. See Subsection F of 8.321.2.9 NMAC for MAD general prior authorization requirements.

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

**(1)** Freestanding psychiatric hospitals are reimbursed at an interim percentage rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles cost methodology, MAD reduces the medicare allowable costs by three percent. For partial hospitalization services that are not cost settled, such as general acute

care hospitals, payments are made at the outpatient hospital prospective levels, when applicable, on the procedure codes (see Subsection E of 8.311.2.15 NMAC).

**(2)** The payment rate is at a per diem representing 8 hours, which is billed fractions of .25, .5, or .75 units to represent 2, 4, or 6 hours when applicable.

**(3)** Any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

**(4)** Services performed by a physician or Ph.D. psychologist are billed separately as a professional service. Other services performed by employees or contractors to the facility are included in the per diem rate which may be billed separately are:

**(a)** performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

**(b)** physical examination and any resultant medical treatments, while ensuring that a physical examination already performed is not repeated;

**(c)** any medically necessary occupational or physical therapy; and

**(d)** other professional services not rendered as part of the program.

[8.321.2.31 NMAC - Rp & Rn, 8.321.2.31 NMAC, 8/10/2021]

**8.321.2.32 PSYCHOSOCIAL REHABILITATION SERVICES:** To help an adult eligible recipient (18 years and older) who met the criteria of SMI, MAD pays for psychosocial rehabilitation services (PSR). PSR is an array of services offered in a group setting through a clubhouse or a classroom and is designed to help an individual to capitalize on personal strengths, to develop coping strategies and skills to deal with deficits, and to develop a supportive environment in which to function as independently as possible. Psychosocial rehabilitation intervention is intended to be a transitional level of care based on the individual's recovery and resiliency goals. 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.

**(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 which comply with DOH licensing standards and are medically necessary to meet the individual needs of the eligible recipient, as delineated in his or her service plan and treatment plan. Medical necessity is based upon the eligible recipient's level of functioning as affected by his or her SMI. The PSR services are limited to goals which are individually designed to accommodate the level of the

eligible recipient's functioning and which reduce the disability and restore the recipient to his or her best possible level of functioning.

**(2)** These services must be provided in a facility-based setting, either in a clubhouse model or a structured classroom.

**(3)** PSR services must be identified and justified in the individual's treatment or service plan. Recipients shall participate in PSR services for those activities that are identified in the treatment or service plan and are tied directly to the recipient's recovery and resiliency plan/goals.

**(4)** Specific service needs (e.g., household management, nutrition, hygiene, money management, parenting skills, etc.) must be identified in the individual's treatment or service plan.

**C. Identified population:**

**(1)** An eligible recipient 18 years or older meeting the criteria for SMI and for whom the medical necessity for PSR services was determined.

**(2)** Adults diagnosed with co-occurring SMI and substance use disorders and for whom the medical necessity for PSR services was determined.

**(3)** A resident in an institution for mental illness is not eligible for this service**.**

**D. Covered services:** The psychosocial intervention (PSI) program must include the following major components: basic living skills development; psychosocial skills training; therapeutic socialization; and individual empowerment.

**(1)** Basic living skills development activities address the following areas, including but not limited to:

- **(a)** basic household management;
- **(b)** basic nutrition, health, and personal care including hygiene;
- **(c)** personal safety;
- **(d)** time management skills;
- **(e)** money management skills;
- **(f)** how to access and utilize transportation;
- **(g)** awareness of community resources and support in their use;
- **(h)** child care/parenting skills;
- **(i)** work or employment skill-building; and
- **(j)** how to access housing resources.

**(2)** Psychosocial skills training activities address the following areas:

- **(a)** self-management;
- **(b)** cognitive functioning;
- **(c)** social/communication; and
- **(d)** problem-solving skills.

**(3)** Therapeutic socialization activities address the following areas:

- **(a)** understanding the importance of healthy leisure time;
- **(b)** accessing community recreational facilities and resources;
- **(c)** physical health and fitness needs;
- **(d)** social and recreational skills and opportunities; and
- **(e)** harm reduction and relapse prevention strategies (for individuals with co-occurring disorders).

**(4)** Individual empowerment activities address the following areas:

- **(a)** choice;
- **(b)** self-advocacy;
- **(c)** self-management; and
- **(d)** community integration.

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

**F. Prior authorization:** 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 service and treatment plans; and

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.

**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.