New Mexico Human Servies Department Behavioral Health Services

2024 Policy and Billing Manual

Contents

Section 1

Overview and Purpose

The Behavioral Health Policy & Billing Manual (BH Manual) was developed by the Human Services Department's (HSD) Medical Assistance Division (MAD), Behavioral Health Services Division (BHSD), and the Children, Youth and Families Department (CYFD) to document policies and processes for providers delivering behavioral health services in New Mexico's Medicaid program. The information in the BH Manual reflects operational policies developed by HSD, MAD, BHSD, and CYFD and requirements in New Mexico's Administrative Code (NMAC), specifically, Section 8.321.2 Specialized Behavioral Health Services and Section 7.20.11 Certification Requirements for Child and Adolescent Mental Health Services. The BH Manual also provides supplemental information for the Medicaid managed care organizations (MCOs).

The BH Manual is issued and maintained by HSD. The provisions of the BH Manual reflect the general operating policies and essential procedures specific to behavioral health services, are not all inclusive, and may be amended or revoked at any time by HSD. If there is a conflict between the BH Manual and the NMAC rules, the NMAC rules take precedence. The BH Manual will be updated as needed and HSD reserves the right to change, modify, or supersede any of these policies and procedures at any time.

It is the responsibility of all providers and entities affiliated with the New Mexico Medicaid program to be familiar with the BH Manual and any amendments. Providers and entities should refer to the Behavioral Health Fee Schedule for detailed payment information, referring and rendering provider requirements, and information on billing units found here, Behavioral Health Fee Schedule (rtsclients.com).

Definitions of terms pertaining to this manual can be found here.

Section 2

Care Delivery Principles

This section describes the following care delivery principle topics:

1. Trauma informed care
2. Recovery and resiliency
3. Nondiscrimination
4. Cultural competency
5. Quality

Providers should be cognizant of these principles in providing services.

Trauma Informed Care

Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Behavioral health providers should be aware of the pervasive, adverse impact of trauma commonly found with persons who are experiencing mental health and/or substance use disorders. The entire system of care is therefore designed to be trauma informed to create a healing environment that utilizes evidenced-based best practices in the treatment process from intake to discharge. It is also critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) concept of a trauma informed approach, a program, organization, or system that is trauma informed:

1. Realizes the widespread impact of trauma and understands potential paths for recovery.
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices.
4. Seeks to actively resist re-traumatization.

A trauma informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing (described below). A trauma informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting or sector specific. All areas below cite examples, but are not limited to those examples:

1. **Safety**. No chairs in the center of a waiting room only along walls, not asking clients to sit with their backs toward any entryways, practicing and modeling consent with touch and space, and respecting the wishes of people who need more space or no touch.

2. **Trustworthiness and Transparency**. Communicating exactly what will happen next at every step of service, clearly explaining services (i.e., who, why, when, where and how), keeping to any agreements made, not being late, and following through. Do not assume that as a provider you will be treated as trustworthy; demonstrate behavior that earns the trust of your clients.

3. **Peer Support**. Having peers as part of your staff teams and allowing them to be accessible to clients; provide appropriate and healthy support for peers.

4. **Collaboration and Mutuality**. Seeking the input of all parties involved; no unilateral decision making about the direction of a case; "nothing about us without us;" treating others with high level of respect, compassion, and dignity while assuming the positive intention of all people.

5. **Empowerment, Voice, and Choice**. Finding and fostering the individual strengths of all people and leveraging them, creating and holding space for people to communicate their opinions, ideas and hopes, and then following up with opportunities for choice in any given situation.

6. **Cultural, Historical, and Gender Issues**. Practicing cultural awareness and curiosity while understanding that there are events that have occurred that profoundly changed a culture. Historical trauma can include genocide, slavery, forced relocation, and destruction of cultural practices, among other things. Many of these things are still occurring today; it is critical to welcome dialogue and opinions on these experiences. It is not trauma informed to speak for a culture that you do not identify as being a part of; nor is it trauma informed to call out a member of your community to be a spokesperson for a particular culture or historical event. Recognize that there are gender disparities that affect all aspects of our work, including limiting gender to a binary, birth definition. Gender and sexuality are part of individual human identity and are sometimes not recognized within our patrionormative and heteronormative culture. This can have a very traumatic effect on clients and staff. Trauma informed work includes awareness of the spectrum of identity and creating brave and courageous space for people to be fully themselves.

Trauma-specific intervention programs generally recognize the following:

- The survivors need to be respected, informed, connected, and hopeful.
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety.
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and clients.

Recovery and Resiliency

The process of recovery is highly personal and individualized. Its definition is reflective of what challenges each person has overcome so that challenge no longer impedes that person's quality of life. Recovery is characterized by continual growth and improvement in one's health and wellness, social and spiritual connection, and renewed purpose. A person's recovery is a reflection of their strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person, the person in their community, and is supported by peers, friends, and family members.

Recovery may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. These recovery support services are culturally and linguistically appropriate to facilitate individuals and families to work toward recovery from mental and/or substance use problems and/or trauma. They incorporate a full range of social, legal, and other

services that facilitate recovery, wellness, and linkage to, and coordination among service providers and other supports including their families. This approach has been shown to improve quality of life for people seeking recovery.

Recovery support services also include access to evidence-based practices such as supported employment, supported education, supportive housing, assertive community treatment, disease management, and peer-operated services. Recovery support services may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support services. These services, provided by professionals and peers, are delivered through a variety of community and faith-based groups, treatment providers, schools, and other specialized services.

SAMHSA has delineated four major dimensions that support a life in recovery:

1. **Health.** Overcoming or managing one's disease(s) or symptoms. For example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem, and for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
2. **Home.** Having a stable and safe place to live.
3. **Purpose.** Conducting meaningful daily activities, such as working, school volunteerism, family caretaking, or creative endeavors; and having the independence, income, and resources to participate in society.
4. **Community.** Having relationships and social networks that provide support, friendship, love, and hope.

Resiliency is the ability to "bounce back" from adverse, traumatic, or highly stressful experiences. Resilience is the positive and protective response that many individuals cultivate to move past negative effects of a traumatic experience. Though there might not be specific evidence informed approaches to teach resiliency, a focus on strategically timed, culturally relevant, comprehensive programs across multiple settings that are of sufficient length and depth to address the magnitude of the problem, can maximize outcomes. Additionally, because the effects of interventions might be delayed, unexpected, or indirect, it is important to consider more complex models of change and monitor outcome over time, in multiple domains and at multiple system levels. Such comprehensive prevention approaches acknowledge the multiplicity of risks and the cumulative trauma that many children and adults face and emphasize the importance of promoting competence and building protection across multiple domains in order to achieve a positive outcome. (retrieved from: apa.org, 2018).

Nondiscrimination Policy

It is HSD's policy that no child, youth, family, or individual shall be excluded from participation in, denied the benefits of, or subjected to discrimination in the administration or provision of programs and services, including contract services and programs on the basis of:

- Race, ethnicity, creed, or color
- Age
- Religion
- Sex, gender, gender identity, gender expression, or sexual orientation

- Marital status, partnership, familial, or parental status
- Pregnancy and breastfeeding or nursing
- Disability
- Genetic information
- Intersex traits
- Citizenship, immigration status, national origin, or ancestry
- Tribal affiliation
- Language
- Political affiliation
- Military or veteran status
- Medical condition, including HIV/AIDS
- Status as a survivor of domestic violence, sexual assault, or stalking
- Housing status, including homelessness
- Any other non-merit factor

Cultural Competency

Culturally competent health care is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families (Goode, 2002). Practices are designed and implemented to match the unique needs of individuals, children, families, organizations and communities served. Culturally competent systems of care are driven by client preferred choice, not by culturally blind or culture-free interventions. Culturally competent practice also includes a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care. Services and support are delivered in the preferred language and/or mode of delivery of the population served; and written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the population. Culturally competent interpretation and translation services comply with all relevant federal, state, and local mandates governing language access; and clients receive high quality, culturally appropriate care (Goode, 2002).

Quality

The vision of continuous quality programing supports ongoing, customer-focused, data-driven, and outcome-based approaches to service delivery that is mindful of the community served and the need for improving access throughout the State. Behavioral health service systems shall be anchored in the belief of resiliency and recovery.

In order for New Mexicans to succeed and lead healthier lives, agencies and providers are encouraged to have continuous quality improvement core values that positively impact the individual in service, the community, and other stakeholders. These core values are:

- **Customer-focused, recovery-oriented, with an emphasis on clinical excellence.** Services that promote and preserve well-being and expand choices to support person-centered goals that are culturally and linguistically appropriate. Expecting clinical excellence that improves quality of care, expands services and access to services, and achieves outcomes that are recovery oriented, with an emphasis and support to train clinical staff in evidence-based approaches and interventions.
- **Communication with compassion and respect.** A commitment to compassionate, respectful communication that provides appropriate, consistent, and accurate information through active listening, sharing ideas, cooperative problem-solving, tact, and courtesy, while valuing all contributions.
- **Improvement, innovation, and integrity**. A commitment to implementing innovative processes that are continually reviewed and improved, while understanding that incremental changes do make an impact, and that there are always ways to make things better. All operations are conducted in an honest, fiscally responsible, ethical manner with dedication to quality that meets and exceeds customer expectations.
- **Staff development.** A commitment to providing a work environment that fosters teamwork, mutual support, learning and development, recognition, and effective leadership while recognizing that effective programs require the involvement of a prepared and informed staff at all levels.
- **Inclusive and diverse partnerships.** A commitment to focusing on common goals through collaboration, teamwork, and consensus-building while sustaining the development of strong, positive, long-term relationships between staff and stakeholders. These partnerships are diverse, creative, supportive, and are always focused on supporting our quality improvement mission.
- **Data driven.** A commitment to the creation of successful processes and informed decisions that use data to inform practice and quality improvement policy.

It is the State's mission to improve access to quality behavioral health care for New Mexicans and to reduce barriers that prevent access. Goals to support those missions and the overall vision for quality improvement include, but are not limited to:

- Prevention.
- Early intervention.
- Exceeding the expectations of clients and their families in meeting their behavioral health needs as they define them.
- Ensuring access to services that provide appropriate evidence-based treatment and promising practice-based evidence while promoting and supporting recovery.
- Services that are culturally and linguistically appropriate.
- Effectively and efficiently managing state, federal, and other resources.
- Facilitating linkages, consensus building, and collaboration among State agencies, clients and their families, and other public policy makers.
- Actively seeking and implementing client, provider, and other stakeholder involvement in the design and delivery of behavioral health-related services.
- Strengthening integration between behavioral and other health services.

- Increasing health care innovation and best practice implementation.

Section 3

Substance Use Disorder

New Mexico Medicaid has committed to the Centers for Medicare and Medicaid (CMS), both through the 1115 Centennial Care Waiver and the Medicaid State Plan, to utilize the American Society of Addiction Medicine's (ASAM) admission and treatment criteria for addictive, substance related and co-occurring conditions. This affords the specificity needed for providers to assure they are placing the individual with a substance use diagnosis in the right level of care. It also accommodates a common language between provider and payer which facilitates understanding of the necessity of treatment in differing levels of care. Therefore, the majority of this information derives directly from the third edition of *ASAM Criteria*.

ASAM Criteria

ASAM Criteria describes five broad levels of care (Levels 0.5–4) with specific service and recommended provider requirements to meet those needs. These levels of care (Levels 0.5–4) span a continuum of care. Appendix C describes diagnostic criteria and substance use disorder (SUD) codes. [placeholder for Appendix C]

Two examples of patient flow throughout the SUD care continuum illustrate how important service coverage of the full range of care is to appropriately treat SUD. An individual with SUD may be admitted to a medically managed withdrawal management or inpatient facility with acute physical health care needs requiring medical and nursing care. Once medically stable, the individual may next need a clinically managed adult residential program for treatment services or an intensive outpatient or outpatient program that includes medication assisted treatment (MAT). Alternatively, an individual with SUD may begin treatment by receiving outpatient treatment services only to find that a more intensive level of care, such as intensive outpatient treatment, is more appropriate. Without the ability to transition to less or more intensive levels of care throughout treatment in response to changing clinical needs and treatment goals, individuals with SUD face higher risk of relapse and worse behavioral and physical health outcomes, including increased inpatient hospital utilization.

Treatment failure in a lower level of care is not a prerequisite for an IP program. This is not true for other chronic diseases such as diabetes or hypertension, e.g., diabetic ketoacidosis or hypertensive crisis. A "treatment failure" approach potentially puts the patient at risk because it delays a more appropriate level of treatment.

Changes to the treatment plan are based on treatment outcomes and tracked by real-time measurement. The quality of the therapeutic alliance and the degree to which hope for recovery is conveyed to the patient contribute even more to the outcome.

SUD Medical Necessity

ASAM describes medical necessity for SUD treatment as being "based on biopsychosocial severity and is defined by the extent and severity of problems in 6 multidimensional assessment areas."

A biopsychosocial assessment includes review of the following elements in an individual's life:

- Present episode history

- Family history
- Developmental history
- Alcohol, tobacco, other drug use, addictive behavior history
- Personal/social history
- Legal history
- Psychiatric history
- Medical history
- Spiritual history

The review of systems include:

- Mental status examination
- Physical examination
- Formulation and diagnoses
- Survey of assets, vulnerabilities, and supports
- Treatment recommendations

Length of a SUD treatment stay is decided by tracking severity, function, and progress, not by a predetermined decision that the patient needs a certain length of stay. There is no “graduation” or “completion of a program” as this entails a focus on a fixed plan and program rather than on functional improvement as the determinant of level of care and ongoing chronic-disease management (with certain episodes of care being offered with increased intensity for a relatively brief span of time) being what is needed for most patients with a substance-related or co-occurring disorder.”

Section 4

DC:0-5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

Originally published in 1994, ZERO TO THREE's Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3) was the first developmentally based system for diagnosing mental health and developmental disorders of infants and toddlers (i.e., 0 to 3). The revised DC:0–3, published in 2005 (DC:0–3R) drew on empirical research and clinical practice that had occurred worldwide since the 1994 publication and extended the depth and criteria of the original DC:0–3. DC:0–5 captures new findings relevant to diagnosis in young children and addresses unresolved issues in the field since DC:0–3R was published in 2005.

DC:0–5 is designed to help mental health and other professionals:

- Recognize mental health and developmental challenges in infants and young children, through 5 years old;
- Understand that relationships and psychosocial stressors contribute to mental health and developmental disorders and incorporate contextual factors into the diagnostic process;
- Use diagnostic criteria effectively for classification, case formulation, and intervention; and
- Facilitate research on mental health disorders in infants and young children.

DC:0–5 enhances the professional's ability to prevent, diagnose, and treat mental health problems in the earliest years by identifying and describing disorders not addressed in other classification systems and by pointing the way to effective intervention approaches. Individuals across disciplines - mental health clinicians, counselors, physicians, nurses, early interventionists, social workers, and researchers - will find DC:0–5 to be an essential guide to evaluation and treatment planning with infants, young children, and their families in a wide range of settings.

In 2021, a "2.0 version" was released with some edits to the previous version. The "2.0 version" includes clarifying language throughout the manual and numerical codes to help facilitate the inclusion of DC:0-5 disorders in health care delivery and electronic medical records. Discrete numerical coding provides consistency among various disorder lists and can prevent misunderstanding when translating diagnoses into other languages.

The system and other information can be found at https://www.zerotothree.org/. The DC:0-5 is subdivided into five axes, listed below. Appendix D describes a crosswalk of diagnoses found in the DC:0-5 to DSM-V and ICD-10. [placeholder for link to Appendix D]

Axis	Description
Axis I	Clinical Disorders Neurodevelopmental disorders Sensory processing disorders Anxiety disorders Mood disorders Obsessive compulsive and related disorders Sleep, Eating, and Crying disorders Trauma, stress and deprivation disorders Relationship disorders
Axis II	Relational context
Axis III	Physical Health Conditions and Considerations
Axis IV	Psychosocial stressors
Axis V	Developmental Competence

Section 5

Supervision Requirements

This section describes clinical supervision and supervisory certification requirements.

Clinical Supervision

Clinical supervision instructs, models, and encourages self-reflection of the supervisee's acquisition of clinical practice and administrative skills through observation, evaluation, feedback, and mutual problem solving. However, there may be opportunities in which the clinical supervisor chooses to give professional direction based on experience, expertise, and/or ethical or safety concerns. Clinical supervision is delivered within the supervisor's professional practice and ethical standards.

Clinical supervision is provided to all treatment/clinical staff who are either employed or under contract by an agency or an individual provider. The Clinical Supervisor:

- Meets the standards for clinical supervision as defined by their professional practice board.
- Provides support, consultation, and oversight of the individual's treatment to include assessment of needs.
- Diagnoses/differential diagnoses, mental health, SUD and co-occurring disorders (COD).
- Provides clinical reasoning and case formulation, to include documentation, treatment planning and implementation, refining treatment goals and outcomes, selecting interventions and supports, coordination of care, and tracking and adjusting interventions.
- Continuously reviews and adjusts interventions according to an individual's status, success and challenges.
- Teaches the importance of retaining continuity throughout all documentation.
- Ensures plans, interventions, goals and supports are appropriate to diagnosis.
- Addresses the supervisee's steps to ensure an individual's active involvement at all levels also ensures the individual's voice and choice are clearly represented and documented.
- Assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the client 's continued recovery and success.
- Assures that appropriate safety, crisis management and advanced directive plans are in place at the onset of service delivery.
- Addresses ethics and ethical dilemmas, (aligned with professional practice board).

Clinical Supervisors will document the date, duration, and the content of the supervision session for their supervisee(s), which may include a professional development plan. All documents pertaining to clinical supervision will be readily available to the supervisee. Clinical Supervisors must review and sign all progress notes, treatment plans, crisis and safety plans, and assessments for all non-independently licensed and unlicensed staff.

Note that a provider or provider group, other than an agency authorized to utilize non-independent practitioners or one that holds a clinical Supervisory Certification, cannot bill for the services of a supervised practitioner except as specifically allowed as part of an educational program.

Supervisory Certification

Supervisory Certification is a major component of a wider workforce development strategy for New Mexico's behavioral health service delivery system. The purpose of this certification process is for Crisis Triage Centers (342), Behavioral Health Agencies (BHA 432), Opioid Treatment Programs (OTP 343), Adult Accredited Residential Treatment Centers (AARTC 216/261), and non-FQHC School Based Health Centers (321) to demonstrate that there is ongoing education, learning and oversight of clinical supervisors and non-independently licensed practitioners, unlicensed staff, , and student interns. Additionally, this certification is in place to support competent consultation and supervision. It is required in order to be eligible for reimbursement for services from Medicaid delivered by a non-independently licensed provider, unlicensed staff, or student intern.

The request for Supervisory Certification demonstrates that the agency is in support of the State's workforce development strategy and is in alignment with the clinical supervision requirements. As of January 1, 2020, all agencies must apply for and be approved for supervisory certification under current regulations for specialized behavioral health services (8.321.2 NMAC) prior to MCO contracting. All rosters must be updated and submitted to the MCOs at the time of the initial request for supervisory certification, and every time there is a change in supervisors and/or providers.

Behavior Health Agencies and Opioid Treatment Programs qualify for Supervisory Certification. Agencies must hold an agency NPI and Medicaid number and each rendering provider, whether independently licensed, non-independently licensed, or unlicensed must also hold their own NPI and Medicaid number. In most cases a student intern will have an NPI. In cases where the student intern does not have an NPI, the intern's institution of higher education must be included on the roster.

Supervisory Certification Application

Appendix E is the Supervisory Certification Attestation Application Form [placeholder for Appendix E]. Appendix F is the Supervisory Certification Process Flow [placeholder for Appendix F].

Applicants should visit www.nmrecovery.org and select supervisory certification to apply. All items referenced in the attestation must be presented as part of the site visit or desk audit, as requested by BHSD. BHSD reserves the right to perform a retrospective review of agencies with Supervisory Certification. These reviews may include a desk audit of policy and procedure, supervision documentation, personnel records, treatment records, as well as quality improvement records. Services approved for Supervisory Certification include any behavioral health code that the agency is approved to deliver and is within the scope of practice of the supervised employee. If there are questions or concerns about the application or process, please email bilfornil@nmrecovery.org.

Section 6

Critical Incidents Reporting Requirements

All publicly funded agencies in New Mexico providing behavioral health services are required to report critical incidents within 24 hours of knowledge of the occurrence. The critical incident(s) should be reported to the member's MCO, and/or Adult Protective Services (APS) or Child Protective Services (CPS), and/or other regulating, licensing, or accrediting organizations, as necessary. Agencies licensed and certified by CYFD must report pursuant to licensing and certification regulatory requirements. Health Facilities that are licensed through the Department of Health (DOH) are required by the NMAC 7.1.13 to report all incidents of Abuse, Neglect and Exploitation, injuries of unknown origin and death where abuse or neglect may be suspected.

Behavioral health critical incidents involving members with the following Qualifying Medicaid categories of eligibility (COE) 001, 003, 004, 081, 083, 084, 090, 091, 092, 093, and 094, and COEs 100 and 200, if they have a Nursing Facility Level of Care (NF LOC) must be reported on the HSD Critical Incident Reporting System. Reportable incidents include abuse; neglect; exploitation; death; environmental hazard; missing/elopement; law enforcement; and emergency services. The HSD Critical Incident Reporting System can be accessed at the following link: https://criticalincident.hsd.state.nm.us/.

For Fee-for-Service (FFS) Medicaid recipients and non-Medicaid recipients of behavioral health services that are paid for by State general funds/BHSD or federal funds received through the state, the behavioral health provider agency shall fax the critical incident to BHSD at (505) 476-9272 using the approved HSD/BHSD template found at CIReport_Form-PDF.pdf (state.nm.us). BHSD is responsible for reviewing or providing follow-up on these incidents. Only sentinel events are reported directly to the Human Services Department/Behavioral Health Services Division. Sentinel events are defined within the Behavioral Health Critical Incident Protocol placeholder for link to Appendix I]. Refer to the Critical Incident Reporting Protocol for additional information and reporting resources. Questions about Critical Incident Protocol can be sent to bh.qualityteam@state.nm.us.

Critical incidents involving behavioral health services for members enrolled in managed care with a non-qualifying COE must be reported to the member's MCO on the Centennial Care Behavioral Health Critical Incident form for any known, alleged or suspected events of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents. The MCOs have a process and designate one fax line to receive critical incident reports from behavioral health providers for Medicaid eligible members. The MCO is responsible for reviewing and ensuring complete follow up has occurred regarding all submitted behavioral health critical incidents reported by or on behalf of their members, including APS and CPS.

Section 7

MCO Behavioral Health Parity Requirements

MCOs are required to provide mental health and SUD services in all benefit classifications (e.g., inpatient, outpatient, emergency care, and prescription drugs). MCOs are required to cooperate with HSD to establish and demonstrate ongoing compliance with 42 CFR Part 438, sub-part K regarding parity. If requested by HSD, the MCO will conduct an analysis to determine compliance with 42 CFR Part 438, subpart K regarding parity and provide the results of the analysis to the State.

The following summaries MCO behavioral health parity requirements:

- The MCO may not apply Aggregate Lifetime or Annual Dollar Limits (AL/ADLs) to mental health and SUD services (see 42 CFR 438.905, eCFR :: 42 CFR Part 438 -- Managed Care).
- The MCO must follow State policy regarding co-payment requirements, including the populations subject to a co-payment, the amount of the co-payment, populations and services exempt from co-payments, as well as the out-of-pocket maximum.
- Quantitative Treatment Limits and Exceptions Process to be applied to Behavioral Respite Services (T1005):
  - Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caretaker. Additional hours may be requested if an eligible recipient's health and safety needs exceed the specified limit.
  - For children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 days. Additional hours may be requested if an eligible recipient's health and safety needs exceed the specified limit.
- MCOs may impose a non-quantitative treatment limitation (NQTL) for mental health or SUD services in any classification (e.g., inpatient, outpatient, emergency care, or prescription drugs). NQTLs include, but are not limited to: medical management standards; standards for provider participation, including reimbursement rates; fail-first policies; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, other criteria that limit the scope or duration of services; and standards for providing access to non-participating providers.

Section 8

Billing and Claims

This section describes general billing requirements specific to behavioral health services. Specific billing and claims requirements related to each specific behavioral health service are found in the respective service manual. General billing and claims requirements can be found here.

The Behavioral Health Fee Schedule can be found at the following link: Behavioral Health Fee Schedule (rtsclients.com).

Use of U7 Modifier

When a new employee, including an intern, is awaiting completion of their enrollment in Medicaid and is providing services, the supervisor's name and NPI must be placed in the rendering field with a U7 modifier. The U7 modifier signifies the service was rendered by an individual under their supervision, for which the Supervisor is assuring all licensing and required certifications are in order, including initiation of Medicaid enrollment. All clinical supervisors must be approved by their respective licensing boards. Additionally, the following agency types must have an approved Supervisory Certification and Attestation from BHSD: Crisis Triage Centers, Behavioral Health Agencies, Adult Accredited Residential Treatment Centers, Opioid Treatment Programs, and Non-FQHC School-Based Health Centers. To use the U7 modifier, an enrollment application must have already been submitted to the Medical Assistance Division. Once the employee (including an intern) is successfully enrolled in Medicaid, the agency must stop utilizing the U7 modifier and start listing the employee (including an intern) as the rendering provider.

The U7 modifier can be used for interns, to the same extent as other new agency employees, until their Medicaid Enrollment is complete. Interns should register for an NPI with taxonomy **390200000X**. A Master's Level Behavioral Health intern will enroll in Medicaid with a Provider Type 445 and Specialty 254. Similarly, a Psychology intern will enroll in Medicaid with a Provider Type 445 and Specialty 255. A complete list of Provider Types and Specialties may be found at the following link: ProvTypeSpec.xlsx (live.com)

Services Provided on the Same Day and Reimbursed Separately

The following modifiers should be used to distinguish different services that should be reimbursed separately on the same day.

Modifier	Description
XE	A service that is distinct because it occurred during a separate encounter.
XP	A service that is distinct because it was performed by a separate practitioner.
XU	A service that is distinct because it does not overlap usual components of the main service.

Providers should follow the Medicaid National Correct Coding Initiative (NCCI) rules, which delineate services that should not be billed together on the same day. NCCI procedure-to-procedure (PTP) edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of

the PTP edits is to prevent improper payments when incorrect code combinations are reported. Providers can find more information on NCCI at the following link: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html.

Federally Qualified Health Center Billing

Most evaluation and treatment services are paid at the Federally Qualified Health Center (FQHC) rate, which is specific to each provider. Services are billed on a UB claim form, with the revenue code of 0919 for behavioral health claims. The specialized behavioral health services are billed using the CMS 1500 format and corresponding 837-P electronic transactions, but will be reimbursed based on the provider's encounter rate unless another rate has been negotiated. An FQHC may bill for the specialized services only when the FQHC is approved to provide specific specialized behavioral health services. Using the CMS 1500 format permits the MCO to determine the utilization of services and manage the qualifications of the provider.

The FQHC is entitled to, at a minimum, the FQHC encounter rate. However, the MCO and the FQHC may negotiate a different rate for each Specialized Behavioral Health Service. For example, the FQHC rate for Intensive Outpatient Program (IOP) services does not need to be the same as for Day Treatment. This is not applicable to Rural Health Clinics (RHCs) and Hospital Based Rural Health Clinics (HB-RHC). When an RHC or HB-RHC qualifies to render any of the Specialized Behavior Health Services, the RHC or HB-RHC obtains a separate Medicaid provider for their Specialized Behavioral Health Services and enrolls separately as a BHA, CMHC, or CSA, as appropriate. These Specialized Behavioral Health Services are not part of the core services for these types of providers and are therefore not paid at their encounter rates.

For a CMHC which is also a FQHC, the FQHC billing instructions apply.

FQHC Managed Care Billing

For managed care, it is important that the MCO edits the claims to ensure that no more than one encounter rate is paid per day unless the recipient goes to the FQHC more than once in a day with a different diagnosis or had two distinct types of visits. Examples include, but are not limited to:

1. A physical health visit and a dental visit on the same day;
2. A physical health visit and a separate behavioral health service provided by a different provider on the same day; or
3. More than one distinct Behavioral Health or Specialized Behavioral Health service which does not otherwise overlap or is prohibited from being billed in conjunction with another Specialized Behavioral Health Service.

If another entity such as a CLNM Health Home is part of the FQHC and has a separate provider number and NPI, they are billed on a CMS 1500 utilizing CPT and HCPCS codes based on either a fee schedule rate, or capitated payment.

For specialized behavioral health services, if the provider chooses to use the Medicaid fee schedule rather than the FQHC rate, they may do so. They must communicate this to the MAD Benefits and Reimbursement Bureau and the MCOs so that their billing profile is correctly set up. Those claims are billed on a CMS 1500 claim form utilizing CPT and HCPCS codes. Please see State of New Mexico Medical Assistance Program Manual Supplement 16-13 (16-13.pdf (state.nm.us)).

The MAD encounter rate includes all practitioner services unless choosing to use fee schedule rates. The encounter is billed when a practitioner sees a patient at the clinic or in a hospital or nursing facility or in the community. In addition to the revenue code, all procedure codes must be listed on the claim even though the reimbursement will be at the FQHC rate.

If seeing the patient for a behavioral health service that is for either a different specialized service or with a different provider, use the modifiers in the previous section on the CPT/HCPCS codes to signify multiple encounters.

FQHC Satellite Locations that Provide Behavioral Health Services Only

Many FQHCs have satellite or extension offices that see clients specifically for behavioral health services. Based on the FQHC certification, HSD considers the "behavioral health only" sites to be satellite sites of the certified "medical" site and no additional enrollment is necessary in order to facilitate billing for behavioral health services.

Behavioral health services fall under the FQHC approved scope of services and thus should be billed like any other FQHC encounter by the enrolled FQHC on the institutional claim form using the encounter revenue code 0919 and including the appropriate procedure code (for tracking purposes). The FQHC should not identify the satellite location on the claim form in the Servicing Facility identifier field as this will cause encounters to deny since the satellite office is not enrolled as a Medicaid provider.

There are specialized behavioral health services that do not fall under the basic FQHC approved scope of services, and these require that the FQHC obtain appropriate licensure and/or certification in order to bill for specialized behavioral health services such as IOP, CCSS, MST, Day Treatment, etc. All specialized behavioral health services provided within the HRSA-approved scope of practice of the FQHC will be paid using the prospective payment system rate. Again, the satellite location does not need to be enrolled separately from the FQHC for these services.

If the satellite location has been approved for a separate Medicaid Provider ID under a specialized behavioral health provider type, those services should be billed according to the instructions for that service on the Behavioral Health Fee Schedule.

Indian Health Services and Tribal 638 Clinics Billing

For Indian Health Services (IHS) and Tribal 638 clinics, all individual therapy, counseling, peer support, and most of the specialized services are paid at the Office of Management and Budget (OMB) rate, using the UB claim form and a revenue code for behavioral health of 0919. Some services are not paid for at the OMB rate and are instead billed on the CMS 1500 form and are paid at regular fee schedule rates. Some of those services include:

1. Telehealth originating site facility fee (Q3014);
2. Smoking cessation (99406, 99407);
3. Accredited Residential Treatment Centers for Youth;
4. Adult Accredited Residential Treatment Centers;
5. Non-Accredited Residential Treatment Centers;
6. Group Homes;

7. Treatment Foster Care;
8. Partial Hospitalization; and
9. CLNM Health Home services.

No prior authorization is required for any of the behavioral health services at IHS or Tribal 638 clinics.

If rates other than OMB rates are negotiated when applying for delivery of any of the specialized services with MAD or the MCOs, those would apply. For services not paid at the OMB rate, MCOs cannot pay less than the fee schedule rate.

Billing Options for Services Provided by Non-Tribal Providers Under a Written Care Coordination Agreement to Provide Services to American Indian or Alaska Natives (AI/AN)

The non-tribal provider may bill directly for the services at the MAD fee schedule rate. The non-tribal provider assigns its claim for payment to the tribal facility in return for payment from the facility, and the tribal facility bills Medicaid for the service. The tribal facility identifies services provided by non-IHS/tribal providers that are within the scope of covered services of the IHS/tribal facility ("IHS/tribal facility services") and can receive the facility (OMB) rate for those services. These services are billed on the UB claim form with the revenue code 0919. For services that are not classified as IHS/tribal facility services, the tribal facility bills for them on a CMS 1500 claim form with the applicable CPT or HCPCS code and is reimbursed at the fee schedule rate. The option to bill specialized services at fee schedule rates so that multiple services within the same day may be billed.

If there is interest in changing "clinic" status to FQHC status, consult with the MAD Benefits and Reimbursement Bureau. No other steps need be taken by the Tribal Health program.