HUMAN SERVICES DEPARTMENT

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Letter of Direction #116

Date: **03/18/24**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**
Nick Boukas, Director, Behavioral Health Services Division

Subject: **Implementation of Mobile Crisis Intervention and Mobile Response and Stabilization Services**

Title: **Mobile Crisis Intervention and Mobile Response and Stabilization Services**

The purpose of this Letter of Direction (LOD) is to provide guidance to the Centennial Care 2.0 Managed Care Organizations (MCOs) for implementation of mobile crisis intervention and children's mobile response and stabilization services effective July 1, 2023.

Mobile Crisis Intervention Services
Mobile crisis intervention services (MCIS) are intended to provide rapid response, individual assessment, and evaluation and stabilization and treatment for individuals experiencing a behavioral health crisis. A behavioral health crisis is defined by the individual experiencing the crisis, or 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. MCIS must address co-occurring substance use disorders, including opioid use disorder, if identified. MCIS shall be available wherever the individual is experiencing a behavioral health crisis 24 hours a day, 7 days a week, 365 days per year and not restricted to select locations within any region on particular days or times. MCIS are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual, and in the least restrictive environment available. MCIS are provided in two models: mobile crisis team (MCT) and mobile response and stabilization services (MRSS).

MCIS involves all services, supports, and treatments necessary to provide a timely response, crisis interventions such as de-escalation, and crisis prevention activities specific to the needs of the individual, in a way that is person and family centered. Services follow an integrated culturally, linguistically, and developmentally appropriate approach. Services are trauma informed and may be provided prior to an intake evaluation for mental health services. Additionally, teams must 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. At a minimum, MCIS includes an initial response of conducting an immediate crisis screening and 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 and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization. Services may also include telephonic follow-up interventions for up to 72 hours after the initial mobile response. Follow-up includes, where appropriate, additional intervention and de-escalation services and coordination with and referrals to health, social, emergency management, and other services and supports as needed.

MCIS team members must be trained in trauma-informed care, de-escalation strategies, and harm reduction; be able to respond in a timely manner and, where appropriate, provide screening and assessment; stabilization and de-escalation; and coordination with, and referrals to, health, social, and other services and supports as needed. Mobile Crisis teams (MCTs) may connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation, if circumstances warrant transition to other locations.

MCTs must maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, certified community behavioral health clinics (CCBHCs), crisis respite centers, and managed care organizations, as applicable. This coordination is done while ensuring the privacy and confidentiality of individuals receiving MCIS se consistent with Federal and State requirements.

MCIS are furnished by a multidisciplinary MCT that includes at least two members. The team includes at least one behavioral health care professional able to conduct a mobile crisis screening and assessment within their permitted scope of practice under state law and who may be available via telehealth. Additional team members may include:

a. A licensed Mental Health Therapist;
b. Certified Peer Support Specialist;
c. Certified Family Peer Support Workers;
d. Certified Youth Peer Support Specialists
e. Community Support Worker;
f. Community Health Worker;
g. Community Health Representative;
h. Certified Prevention Specialist;
i. Registered Nurse;
j. Emergency Medical Service provider;
k. Licensed Alcohol and Drug Abuse Counselor (LADAC) or Certified Alcohol and Drug Addiction Consultant (CADAC);
l. Non- independently licensed behavioral health professionals;
m. Emergency Medical Technicians;
n. Licensed Practical Nurses;
o. Other certified and/or credentialed individuals.

The MCT shall have a full-time clinical director who is an independently licensed behavioral health practitioner and a medical director available part time which can include a physician, psychiatrist, or advanced practice registered nurse.

The MCT shall ensure that, within the first sixty days of providing direct care of individuals, all staff, volunteers, and contractors having direct contact with recipients shall receive 25 hours of required training. Annually all staff, volunteers, and contractors having direct contact with recipients must receive at least 20 hours of crisis related continuing education.

Tribal 638 or IHS facilities may request waivers to the staffing requirements outlined above for MCTs by submitting a staffing plan to the Behavioral Health Services Division (BHSD).

MCTs must comply with the requirements described in 8.321.2.19 NMAC and must:
a. Operate 24 hours per day, 7 days per week, and 365 days per year;
b. Provide community-based crisis intervention, screening, assessment, and referrals to appropriate

resources;
c. Be able to administer naloxone;
d. Coordinate to ensure appropriate travel to a place of safety, if clinically appropriate, or to a higher level of care are required by the situation;
e. Provide necessary follow-up to ensure continued stabilization;
f. Maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, CCBHCs, crisis respite centers and managed care organizations (as applicable);
g. Be certified by BHSD.

Children's Mobile Response and Stabilization Services (MRSS)

Children's Mobile Response and Stabilization Services (MRSS) is a child, youth, and family specific behavioral health crisis intervention and prevention service. It provides immediate, in-person response, following mobile crisis above, to de-escalate crises that are defined by the family. MRSS prevents future crises or out of home placement through stabilization services and supports, follow up, navigation and access to community supports across the system of care. MRSS services are conducted through a cultural, linguistic, and developmentally appropriate, trauma-responsive framework. MRSS includes all MCIS service components and requirements described above in addition to the service requirements described in this section.

MRSS includes up to 56 days of stabilization services, a critical component of MRSS. To maintain care continuity, whenever possible, stabilization services are conducted by a member of the MRSS team who initially responded to the family. The stabilization period is meant to identify deeper reasons for safety and stability events, particularly when they are re-occurrent.

The MRSS stabilization process initiates the use of a CYFD approved mobile crisis screening and assessment tool that screens for the need to address a higher level of care during the response and helps to identify needs and strengths across life domains and categorizes them in order of urgency. The MRSS stabilization process addresses the child and family's urgent and emergent needs through intensive care coordination. The MRSS eight-week stabilization process is not meant to be a limitation of the stabilization period but part of a continuum of care for stabilization, and the individual may at any time transfer to other long-term services and supports for continued care.

A range of staffing models that include both licensed and non-licensed staff can be used to develop a MRSS team. When not on the scene, a clinical supervisor must be available remotely to provide consultation to the MRSS team. Services are furnished by a multidisciplinary MRSS team that includes at least two members. MRSS teams include at least one behavioral health care professional able to conduct a mobile crisis screening and assessment within their permitted scope of practice under state law, who may be available via telehealth. Additional team members may include:

a. A licensed Mental Health Therapist;
b. Certified Peer Support Specialist;
c. Certified Family Peer Support Workers;
d. Certified Youth Peer Support Specialists
e. Community Support Worker;
f. Community Health Worker;
g. Community Health Representative;
h. Certified Prevention Specialist;
i. Licensed Alcohol and Drug Abuse Counselor (LADAC) or Certified Alcohol and Drug Addiction Consultant (CADAC);

j. Non- independently licensed behavioral health professionals;
k. Oher certified and/or credentialed individuals.

MRSS teams shall have a clinical director who is an independently licensed behavioral health practitioner with a Master's degree in social work, counseling, marriage and family therapy, or psychology and a minimum of one-year supervisory experience.

The MRSS shall ensure that staff complete required training which includes:
a. 30 hours of required MRSS training
b. Cardiopulmonary Resuscitation (CPR) and Crisis Prevention and Intervention (CPI) de-escalation training provided through the behavioral health agency
c. 40 hours of documented MRSS field training- training objectives form
d. Any Medicaid required provider trainings
e. And other trainings outlined in the MRSS provider manual

Program Implementation

MCTs must be certified by BHSD. MRSS teams must be certified by CYFD. In addition, the agency must be enrolled as one of the following:
a. Federally Qualified Health Center;
b. Community Mental Health Center;
c. Hospital or affiliated clinic;
d. an IHS hospital or clinic;
e. Crisis Triage Center;
f. PL 93-638 tribally operated hospital or clinic;
g. a MAD designated CareLink NM Health Home;
h. Behavioral Health Agency; or a
i. Certified Community Behavioral Health Clinic (CCBHC)

MCTs will be identified with a provider specialty type of 134 and MRSS will be identified with a provider specialty type of 139.

The MCOs will contract for MCT and MRSS services only with those providers who have been approved by BHSD or CYFD. MCOs may request a copy of the BHSD or CYFD approval letter from the provider.

MCO's are directed to configure their systems accordingly to reimburse for MCTs and children's MRSS.

All rates described in this LOD have been calculated and considered as a component of the MCO capitations rates.

Billing and Reimbursement

Mobile crisis and stabilization will use the following procedure codes and modifiers:

SERVICE	PROCEDURE CODE	MODIFIER(S)	MRSS Modifier	Unit	FFS RATE
HUB					
MOBILE CRISIS – HUB	S9485	HO	HA	Per diem	$1,541.34

– LICENSED RESPONSE					
MOBILE CRISIS – HUB – NON-LICENSED RESPONSE	S9485		HA	Per diem	$1,355.29
MOBILE CRISIS – HUB-LICENSED RESPONSE WITH PEER	S9485	HT	HA	Per diem	$1,549.47
TEAM RESPONSE WITH TELEHEALTH IN HUB	S9485	GT	HA	Per diem	$926.68
Dandelion					
LICENSED RESPONSE – CRISIS LICENSED & CRISIS LEVEL 1 NON-LICENSED	H2011	HO	HA	15 minutes	$74.10
NON-LICENSED RESPONSE – CRISIS LEVEL 2 NON-LICENSED & CRISIS PEER/YOUTH & FAMILY SUPPORT	H2011		HA	15 minutes	$65.82
LICENSED RESPONSE – CRISIS LICENSED & CRISIS PEER/YOUTH & FAMILY SUPPORT	H2011	HT	HA	15 minutes	$74.10
TEAM RESPONSE WITH TELEHEALTH	H2011	GT	HA	15 minutes	$46.72
TELEPHONIC					
MOBILE CRISIS FOLLOW-UP - TELEPHONE	H0030	HA		15 minutes	$23.70
STABILIZATION SERVICES – for individuals age 21 and under					
STABILIZATION SERVICES – LICENSED & PEER	S9482	HA, HT		15 minutes	$77.49
STABILIZATION SERVICES – LICENSED & NON-LICENSED	S9482	HA, HT		15 minutes	$77.49
STABILIZATION SERVICES – NON-LICENSED ONLY	S9482	HA		15 minutes	$41.45
STABILIZATION SERVICES – LICENSED ONLY	S9482	HA, HO		15 minutes	$51.98

Billing Guidance

- Crisis providers cannot bill a Dandelion (H2011), Hub (S9485) and/or MRSS stabilization (S9482) rate on the same day. Crisis providers cannot bill a Hub (S9485) and a Telephonic follow-up call (H0030) in the same day.
- MCIS and MRSS by their nature are crisis services and are not subject to prior approval. MCIS is authorized for no more than 72 hours per episode. Activities beyond the 72-hour period for MCIS must have prior authorization by the State or its designee. If the beneficiary of MCIS and MRSS has another crisis within 72 hours of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed. If a crisis episode occurs outside of the 72-hour response period, is it considered a new crisis episode. The stabilization component of MRSS is authorized for no more than 8 weeks and prior authorization is not required. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode.
- For children/youth in need of regular care beyond 72 hours who have been seen by an MRSS team, use of MRSS stabilization services will be determined in conjunction with the caregiver and are based on risk factors identified in the MRSS screen including but not limited to housing and economic stability, potential for harm to self or others, substance use and/or behavioral health challenges, school behavioral and attendance challenges. The goal of stabilization should be to stabilize the youth in school, to address immediate de-stabilizing economic factors and address immediate family needs and/or transition the child/youth to a longer-term community behavioral health service or support.
- In the event the child/youth has an existing provider and treatment plan, and the MRSS provider is comfortable working with the existing provider, an individual in ongoing treatment may continue to see that provider while receiving stabilization services. The existing provider would be working with the youth to provide continuity and support to get them back into their community setting as soon as possible. The existing provider could advise the MRSS team to provide input, etc. However, the MRSS provider should ensure that the existing treatment plan is sufficient and does not need to be modified as a result of the crisis being experienced by the child/youth. The existing provider cannot bill for crisis services/stabilization, and the crisis stabilization provider cannot bill for other behavioral health services, as noted on the chart below.
- MCT and MRSS are organized outpatient services.
  - Because Hubs operate 24/7 and are location-based outpatient services the service may not exceed 23 hours.
  - If an individual is seen by a Hub mobile team and then transferred to a CTC program, then the program should bill the S9485 per diem. A subsequent 24-hour period would be billed to the CTC program. The MCT or MRSS provider should not bill multiple per diems for the first 24 hours of care. If a provider has both a mobile crisis team and a CTC, the provider may not bill using the mobile crisis codes within 24 hours of admission to a CTC.
  - Agencies who operate MCTs, and have an outpatient behavioral health program should be supporting their caseloads during outpatient crisis situations and not billing for outpatient therapy and crisis intervention on the same day (i.e., MCT and MRSS are not after-hours support for large agencies with established caseloads). However, there may be circumstances in which an individual is referred from an independent provider to the crisis services following one of these services provided by an independent practitioner earlier in the day, where it may be clinically appropriate

for the independent licensed practitioner to submit a claim for their services prior to the individual receiving mobile crisis or MRSS.

NOTE: In the event the recipient has an existing provider and treatment plan, and the crisis provider is comfortable working with the existing provider, an individual in ongoing treatment may continue to see that provider while receiving crisis services. The existing provider would be working with the individual to provide continuity and support to get them back into their community setting as soon as possible. The existing provider could advise the crisis team to provide input, etc. However, the crisis provider should ensure that the existing treatment plan is sufficient and does not need to be modified as a result of the crisis being experienced by the individual. The existing provider cannot bill for crisis services/stabilization, and the crisis stabilization provider cannot bill for other behavioral health services as noted on the chart below. Evidence-based practice teams such as ACT, DBT, MST, New Mexico High Fidelity Wraparound and FFT should provide crisis services for their caseload and those individuals should not be served by MCT or MRSS. However, if the MCT/MRSS team is dispatched to an ACT, DBT, MST, New Mexico High Fidelity Wraparound or FFT recipient, then the MCT/MRSS team can bill for the initial contact until the EBP team relieves them. MRSS ongoing stabilization services should not be billed when a child/youth is under the care of an ACT, DBT, MST, New Mexico High Fidelity Wraparound or FFT team.

Billable Services

Face-to-face contacts with youth and adults and relevant family and kinship network members and collateral contacts are billable. The rates set include costs for the following:

- Direct contacts with individuals and relevant family, caregivers and kinship network members.
- Direct contacts with clinically relevant collateral contacts such as teachers, school administrators, social workers, probation officers and some social network contracts when clinically indicated.
- Indirect contact, such as phones calls, with both individuals, caregivers, and relevant family and kinship network members, and collateral contacts.
- Costs of certification, training, and data documentation as well as the time spent performing these tasks.
- Face-to-face contacts with individuals, caregivers, and relevant family and kinship network members and collateral contacts are billable.

The following activities may not be billed:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Client Transportation: Rates include staff travel to and from the site of the crisis. If the staff is traveling back to the office, the individual may ride with the staff member(s). However, there is no adaptive or secure transportation costs included in the mobile crisis rate. If adaptive or secure

transportation for the individual or family is needed, then those additional medical transportation costs for service needs are not considered part of Crisis Services may be covered by the transportation service through the State Plan. Services provided in the car are considered transportation and time may not be billed.

- Covered services that have not been rendered.
- Services not in compliance with the crisis service definition within the Behavioral Health Policy and Billing Manual or licensure standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's crisis participant-directed care coordination plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved crisis service description.
- Services that do not follow the requirements outlined in the provider contract, service manual, or licensure standards.
- Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, service manual, or licensure standards will not be reimbursed.

The following billing guidance outlines which codes providers should not be billed concurrently if the individual is currently receiving MCT or MRSS services. This is also guidance for agencies who operate a MCT and have an outpatient behavioral health program. In those instances, the agencies should support their caseloads during outpatient crisis situations and not bill for outpatient therapy and crisis intervention on the same day. However, there may be circumstances in which an individual is referred from an independent provider to crisis services following one of these services provided by an independent practitioner earlier in the day, where it may be clinically appropriate for the independent licensed practitioner to submit a claim for their services prior to the individual receiving mobile crisis or MRSS.

Billing Guidance Overlap

Code	Description	Billable on same DOS as MCT or MRSS	Comments
36415	Blood draw routine venipuncture	Yes	
90785	Interactive complexity	No	
90791	Diagnostic evaluation without med	No	
90792	Diagnostic evaluation with med	No	

Code	Description	Billable on same DOS as MCT or MRSS	Comments
90832–90834, 90836–90838	Individual counseling/ psychotherapy	No	
90839, 90840	Crisis psychotherapy	No	
90846, 90847, 90849	Family counseling/psychotherapy	No	
90853	Group counseling/psychotherapy	No	
90863	Pharmacologic management add-on	No	
90885	Psy evaluation of records	No	
90889	Preparation of report	No	
96110	Developmental testing; limited	No	
96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146,	Psychosocial testing	Yes	
96150–96155	Behavior intervention	No	
96160	Administration and Interpretation of Patient-Focused Health Risk Assessment	No	
99201–99205, 99211–99215, 99217–99223, 99231–99236, 99238–99239 99241-99245 99251-99255 99304-99310 99354-99357 99406-99407	E&M	No	

Code	Description	Billable on same DOS as MCT or MRSS	Comments
99281–99285	Emergency department (ED) visits	Yes	The HUB goal is diversion from ED and continuity between ED discharge and community service referral. Multiple ED visits and HUB billings would indicate that a crisis plan was not developed and that HUB was not being utilized appropriately – necessitating additional oversight.
G0175	Scheduled interdisciplinary team	No	
G0176 (individual or group)	Activity Therapy such as music, dance, art or play (not for recreation)	Yes	
G0406, G0407, G0407	Inpatient Consultation Telehealth	No	Can be billed on the same day if individual needs to be transferred, but same provider may not bill for both MCT/MRSS and inpatient
G0443	Other Brief Intervention	No	
G0444	Other Behavioral Health Screening	No	
G0493	Skilled services of an RN for the Observation and Assessment of the Patients condition	No	
G0515	Cognitive Enhancement Therapy	No	
H0001	Opioid Treatment Exam – initial medical exam Alcohol and/or drug assessment	No	
H0010 or Rev code 0229	Sub-acute detox (ASAM 3.2-WM)	No	Can be billed on the same day if individual needs to be transferred, but same provider may not bill for both MCT/MRSS and residential detox
H0011, H008, H009, or Rev code 0229	Residential acute detox (ASAM 3.7-WM)	No	Can be billed on the same day if individual needs to be transferred, but same provider may not bill for both MCT/MRSS and residential detox
H0014 or Rev code 0229	Ambulatory detox (H0014)	Yes	
H0015	IOP (ASAM 2.1)	Yes	

Code	Description	Billable on same DOS as MCT or MRSS	Comments
H0017	Psychosocial rehabilitation	No	
H0020	Methadone Clinic Services	Yes	
H0020	Opioid Treatment	Yes	
H0025	Opioid Treatment Program (Individual)	No	
H0025	Opioid Treatment Program (group)	No	
H0030	Crisis intervention call	No	Cannot bill a Hub (S9485) and crisis call/telephonic follow-up rate (H0030) on the same day
H0031	Comprehensive MH Health assessment and development of treatment plan for recipient who is not SMI or SED	No	
H0033	Oral Medication administration and direct observation for Suboxone	No	
H0038	Individual Peer Support (individual and group)	No	
H0039	Assertive Community Treatment per diem (with or without modifier)	No	ACT teams should be providing Crisis Intervention for their caseload
H0048	Urine drug screen	Yes	
H0049	Alcohol and/or drug screening	No	
H0050	Alcohol and/or drug services, brief	No	
H2000	Comprehensive Multidisciplinary team evaluation	No	
H2010	Comprehensive Medication Services	No	
H2011	Crisis intervention per 15 minutes	No	Cannot bill a Dandelion (H2011), Hub (S9485) and/or MRSS stabilization (S9482) rate on the same day
H2012, S0220, S0221	Day Treatment	No	Day Treatment should be providing crisis intervention for their caseload
H2014	Behavior Management Skills	No	

Code	Description	Billable on same DOS as MCT or MRSS	Comments
H2015 (with or without modifier 16)	Comprehensive Community Support Services	No	
H2017	Psychosocial rehabilitation (with or without any modifier)	No	
H2033 (with or without modifier 32)	Multi-systemic therapy (with or without any modifier)	No	MST team should be providing crisis care
H2034	Alcohol and/or drug treatment program – halfway house (ASAM 3.1)	No	Individual may not be in residential SUD and MCT/MRSS/CTC at same time
H2036	SUD drug treatment program (ASAM 3.5 and 3.7) (with and without modifiers)	No	Individual may not be in residential SUD and MCT/MRSS/CTC at same time
J-Codes	Medications	Yes	
Q3014	Telehealth Facility fee Unit	No	Telehealth included in MCT and MRSS
Rev code 0169 and 0513	Crisis Triage Center (CTC) Residential/Non-residential	No	May report the following for tracking purposes only on the same date as CTC billing: Revenue Codes 0905, 0906, 0914, 0915, 0916, 0944, 0945, 0961, 0984
Rev codes 0190, 1001, 1002, 1005, 1003, H0017, H0018, H0019	Residential Treatment Centers for Youth and Adults	No	Child/Adult may not be in residential services at same time as receiving MCT/MRSS/CTC
Rev. codes 0116, 0126, 0114, 0124	Inpatient Stays	No	Can be billed on the same day if individual needs to be transferred, but same provider may not bill for both MCT/MRSS and inpatient
S0201 or Rev. code 0912	Partial Hospitalization	No	PH should be providing crisis care
S5145 and S5145	Treatment Foster Care Level 1-2	No	Child may not be in residential services at same time as receiving MCT/MRSS/CTC
S9485	Crisis intervention per diem	No	Cannot bill a Dandelion (H2011), Hub (S9485) and/or MRSS stabilization (S9482) rate on the same day
T1001	Nursing assessment evaluation	No	

Code	Description	Billable on same DOS as MCT or MRSS	Comments
T1007	Treatment or service plan update	No	

Implementation

MCOs are directed to implement changes associated with these instructions, including system changes and provider contract negotiations as needed no later than 60 days from the date of issuance of this directive. HSD directs the MCOs to provide biweekly updates to HSD on the status of implementation every other Friday beginning March 15, 2024, until otherwise directed by HSD.

For any claims submitted after July 1, 2023 but not paid based on these new parameters, the MCOs are directed to adjust payments retroactive to July 1, 2023. The deadline to reprocess claims is June 30, 2024.

MCOs should also continue to engage in BHSD facilitated billing and credentialing meetings and find ways to reduce or remove provider administrative barriers for accessing behavioral health services.

This LOD will sunset upon completion of the Centennial Care Program on June 30, 2024.