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8.321.2 SPECIALIZED BEHAVIORAL HEALTH SERVICES

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

8.321.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.321.2.1 NMAC - N, 1-1-14]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC - N, 1-1-14]

8.321.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.321.2.3 NMAC - N, 1-1-14]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC - N, 1-1-14]

8.321.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - N, 1-1-14]

8.321.2.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.321.2.6 NMAC - N, 1-1-14]

8.321.2.7 DEFINITIONS: [RESERVED]

8.321.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.321.2.8 NMAC - N, 1-1-14]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

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

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency, and for an individual provider. Services must be in compliance with the statutes, rules and regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.2 NMAC and 8.310.3 NMAC.

C. Each specialized behavioral health service may have specific non-covered services. The following are the non-covered services for all specialized behavioral health services:

(1) hypnotherapy;

(2) biofeedback;

(3) conditions that do not meet the standard of medical necessity as defined in MAD rules;

(4) treatment for personality disorders for adults 21 years and older without a diagnosis indicating medical necessity for treatment;

(5) treatment provided for adults 21 years and older in alcohol or drug residential centers;

(6) educational or vocational services related to traditional academic subjects or vocational training;

(7) experimental or investigational procedures, technologies or non-drug therapies and related services;

(8) activity therapy, group activities and other services which are primarily recreational or divisional in nature;

(9) electroconvulsive therapy;

(10) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside his or her scope of practice;

(11) treatment of intellectual disabilities alone;

(12) services not considered medically necessary for the condition of the MAP eligible recipient;

(13) services for which prior authorization is required but was not obtained; and

(14) milieu therapy.

D. All behavioral health services must meet with the current MAD definition of medical necessity found in the NMAC rules.

E. Performance of a behavior health service cannot be delegated to a provider or practitioner not licensed for independent practice except as furnished within the limits of MAD benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local statutes, laws and rules. A behavioral health professional service must be provided directly to the MAP eligible recipient by the licensed behavioral health professional listed in Subsection B, H, I and J of Section 9 of this rule or where specifically allowed in a MAD rule. When a service is performed by supervised master's level provider, nurse, bachelor's level and another health professional not listed in Subsections H-J of Section 9 of this rule, that service cannot be billed by the licensed supervisor even though the services may have been furnished under his or her direction. All specialized behavioral health services are reimbursed as follows, except when instructed within a particular specialized service's reimbursement section.

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

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure.

(2) Reimbursement to a provider for covered services is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) The provider's billed charge must be its usual and customary charge for services.

(ii) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(3) Reimbursement is made for an Indian health services (IHS) agency or a federal qualified health center (FQHC) by following its federal guidelines and special provisions and as detailed in 8.310.12 NMAC.

F. All specialized behavioral health services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made, see 8.302.5 NMAC. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions

for authorization of services. A specialized behavioral health service may have additional prior authorization requirements listed in the service's prior authorization section.

G. General MAD treatment plan requirements for specialized behavioral health services: A MAD treatment plan and all supporting documentation must be available for review by HSD or its authorized agency in the MAP eligible recipient's file. Specific treatment plan elements may be required for a specialized behavioral health service listed in that service section's the treatment plan subsection. MAD makes available on its website comprehensive treatment plan requirements and requires a provider to use the applicable treatment plan requirements for services he or she renders. At a minimum, following must be contained in the treatment plan and documents used in the development of the treatment plan:

(1) statement of the nature of the specific problem and specific needs of the MAP eligible recipient;

(2) description of the functional level and symptom status of the MAP eligible recipient, including the following:

(a) mental status assessment;
(b) intellectual function assessment;
(c) psychological assessment;
(d) social assessment which includes community support, housing and legal status;
(e) medical assessment;
(f) physical assessment;
(g) substance abuse assessment;
(h) activities of daily living assessment; and
(i) a DSM IV- TR (or its successor) diagnosis;

(3) description of the MAP eligible recipient's intermediate and long-range goals and approaches for the least restrictive conditions necessary to achieve the purposes of treatment with a projected timetable for each goal attainment;

(4) statement of the duration, frequency, and rationale for services included in the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(5) specific staff responsibilities, proposed staff involvement and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient;

(6) criteria for discharge from services and the projected date for discharge;

(7) identification of services to be provided upon discharge and appointments for these services;

(8) regular, periodic review of the plan to determine effectiveness of treatment and modification as indicated.

H. The following independent providers are eligible to be reimbursed for providing behavioral health professional services:

(1) a physician licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry, to include the groups they form;

(2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as clinical psychologist by the New Mexico regulations and licensing department's (RLD) board of psychologist examiners, to include the groups they form;

(3) an independent social worker (LISW) licensed by RLD's board of social work examiners, to include the groups they form;

(4) a professional clinical mental health counselor (LPCC) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(5) a marriage and family therapist (LMFT) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(6) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by RLD's board of nursing and is certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as his or her certification permits.

I. The following agencies are eligible to be reimbursed for providing behavioral health professional services:

(1) a community mental health center (CMHC)

(2) a federally qualified health clinic (FQHC);
(3) an Indian health services (IHS) hospital and clinic;
(4) a PL 93-638 tribally operated hospitals and clinics;
(5) children, youth and families department (CYFD);
(6) a hospital and its outpatient facility; and
(7) a core service agency (CSA).

J. When providing services supervised and billed by an agency listed above in Subsection I of Section 9, the following practitioner's outpatient services may be reimbursed when the services are within his or her legal scope of practice (see Subsection B of Section 9 of this rule):

(1) a masters level social worker (LMSW) licensed by RLD's board of social work examiners;
(2) a professional mental health counselors (LPC) licensed by RLD's counseling and therapy practice board;
(3) a mental health counselor (LMHC) licensed by RLD's counseling and therapy practice board;
(4) a psychologist associates licensed by the RLD's psychologist examiners board;
(5) a professional art therapists (LPAT) licensed by RLD's counseling and therapy practice board;
(6) an alcohol and drug abuse counselor (LADAC) licensed by RLD's counseling and therapy practice board; and
(7) a MAP eligible recipient under 21 years of age may be identified through a tot to teen healthcheck, self referral, referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns; if the MAP eligible recipient requires extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment:

(a) the receiving provider of the MAP eligible recipient must develop an individualized treatment plan;
(b) the plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

[8.321.2.9 NMAC - N, 1-1-14]

8.321.2.10 APPLIED BEHAVIOR ANALYSIS: MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) services for eligible recipients 12 months up to 21 years of age who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients 12 months up to three years of age who have well-documented risk for the development of ASD. ABA services are provided to an eligible recipient as part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment which stipulates that ABA services be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, etc.). Following a referral to an approved autism evaluation provider (AEP) to confirm the presence of, or risk for ASD, utilizing a comprehensive diagnostic evaluation, and the production of an integrated service plan (ISP) (stage 1), a behavior analytic assessment is conducted and a behavior analytic treatment plan is developed as appropriate for the selected service model (stage 2). ABA services are then rendered by an approved ABA provider (AP) in accordance with the treatment plan (stage 3). A HSD MCO must provide intensive care coordination of services for members authorized for ABA services. See the ABA billing instructions for detailed information for eligible providers and practitioners, service requirements, prior authorizations, and reimbursement for ABA stages 1 through 3. In this section of this rule, members of a MCO are included in the term eligible recipients.

A. Eligible providers: ABA services are rendered by a number of providers and practitioners: an AEP; a behavior analyst (BA), a behavior technician (BT) through an AP; and an ABA specialty care provider. Each ABA provider and practitioner has corresponding enrollment requirements and renders unique services according to his or her provider type and specialty. As an example, a practitioner may be eligible to render services as an AEP, BA or an ABA specialty care provider when the specific ABA billing requirements are met. A BT may only render BT services. A BA may render BT services or possibly ABA specialty care services.

(1) Stage 1 AEP: Completes the comprehensive diagnostic evaluation and develops the ISP for an eligible recipient who has been referred through the MAD approved screening process and the AEP has professional reason to believe the eligible recipient may be diagnosed with ASD. An AEP must:

(a) be a licensed, doctoral-level clinical psychologist or a physician who is board-certified or board-eligible in developmental behavioral pediatrics, pediatric neurology, or child psychiatry;

(b) have experience in or knowledge of the medically necessary use of ABA and other empirically supported intervention techniques;

(c) be qualified to conduct and document both a comprehensive diagnostic evaluation and a targeted evaluation for the purposes of developing an ISP;

(d) have advanced training and clinical experience in the diagnosis and treatment of ASD and related neurodevelopment disorders, including knowledge about typical and atypical child development and experience with variability within the ASD population;

(e) have advanced training in differential diagnosis of ASD from other developmental, psychiatric, and medical disorders;

(f) sign an attestation form affirming that all provider criteria, as outlined above have been and will continue to be met.

(2) Stage 2 BA practitioner: May render ABA stage 2-behavior analytic assessment, service model determination and treatment plan development and stage 3 services-implementation of ABA treatment plan. There are three possible avenues through which a stage 2 practitioner may qualify for BA provider enrollment:

(a) Certified BA, BA without certification, and interim ABA provider/supervisor-time limited.

(b) Documented certification in behavior analysis by the behavior analyst certification board BACB® holds a professional credential issued by a licensing or certification board whose rules, regulations, and standards explicitly stipulate that the provision of ABA services is within the scope of the profession's practice (e.g., BACB®, board of psychologist examiners of the New Mexico regulation and licensing department (RLD);

(c) provide evidence that the provision of ABA services is within the scope of the practitioner's competence by providing documentation of certification as by the BACB®.

(3) Stage 2 psychologist with documented education and experience in behavior analysis without BACB® certification: holds a professional credential issued by RLD whose rules, regulations, and standards explicitly stipulate that the provision of ABA services is within the scope of the profession's practice. Provides documentation of training in behavior analysis comparable to that required to be eligible to take an examination for BCBA® or BCBA-D® certification, to include all of the following education, supervised experiential training, and continuing education requirements:

(a) possession of a minimum of a master's degree from an accredited university that was conferred in behavior analysis, education, or psychology, *or* conferred in a degree program in which the candidate completed a BACB® approved course sequence;

(b) completion of graduate level instruction in the following behavior analytic content areas (b)(i) through (b)(x):

(i) ethical and professional conduct (at least 45 classroom hours);

(ii) concepts and principles of behavior analysis (at least 45 classroom hours);

(iii) measurement (at least 25 classroom hours);

(iv) experimental design (at least 20 classroom hours);

(v) identification of the problem and assessment (at least 30 classroom hours);

(vi) fundamental elements of behavior change and specific behavior change procedures (at least 45 classroom hours);

(vii) intervention and behavior change considerations (at least 10 classroom hours);

(viii) behavior change systems (at least 10 classroom hours);

(ix) implementation, management, and supervision (at least 10 classroom hours);

(x) discretionary coursework (at least 30 classroom hours);

(c) supervised experience in the design and delivery of ABA services through supervised independent field work (non-university based) of at least 1500 hours, practicum experience (university based) of at least 1000 hours, or intensive practicum experience (university based) of at least 750 hours, supervised in accordance with the BACB®'s requirements for supervised experience; a significant portion (at least one third) of

the supervised experience must have been accrued with an ASD or closely related population (e.g., Fragile X, Intellectual Disability);

(d) completion of at least 32 hours of continuing education in behavior analysis per two years.

(4) Stage 2 interim ABA provider/supervisor - (time-limited): Up to and including June 30, 2016, ABA services may be delivered and supervised by a clinician who has the minimum qualifications listed below; however, the provider may not refer to him/herself as a "behavior analyst" as this title is reserved for those meeting the criteria above. Rather, the provider, approved on a temporary basis only, may refer to him/herself as an "interim ABA supervisor" or "interim ABA practitioner." The AP must provide documentation of all of the following:

(a) a master's degree which the BACB® recognizes and would lead to certification as a BCBA;

(b) New Mexico licensure, as appropriate for degree and discipline;

(c) clinical experience and supervised training in the evidence-based treatment of children with ASD, specifically ABA;

(d) experience in supervising direct support personnel in the delivery and evaluation of ABA services.

(5) Stage 3 behavioral technician: A BT, under supervision of a BA, may implement Stage 3 ABA treatment plan interventions/services. MAD recognizes two types of BTs:

(a) Registered behavioral technician® (RBT®) by the BACB® with the following:

(i) be at least 18 years of age;

(ii) possess a minimum of a high school diploma or equivalent;

(iii) successfully complete a criminal background registry check;

(iv) complete a minimum of four hours of training in ASD (prior to the BT billing for ABA services) including, but not limited to, training about prevalence, etiology, core symptoms, characteristics, and learning differences;

(v) complete 40 hours of training in ABA that meets the requirements for Registered Behavioral Technician® (RBT®) by the BACB®;

(vi) at least 20 hours of RBT training (in addition) to the four hours of ASD training) must occur prior to the AP billing for BT services; the other 20 hours of RBT training must be accrued, and RBT® certification from the BABC must be secured, no more than 90 calendar days following the first submission of billing for BT services.

(b) Documented training in behavior analysis, without RBT® credential - (time-limited): the BT may render services for up to six months while working towards his or her certification as a RBT® when the AP provides written attestation that the BT meets the following requirements:

(i) be at least 18 years of age;

(ii) possess a minimum of a high school diploma or equivalent;

(iii) successfully complete a criminal background registry check;

(iv) complete a minimum of four hours of training in ASD including, but not limited to, training about prevalence, etiology, core symptoms, characteristics, and learning differences prior to the AP billing for BT services;

(v) complete 40 hours of training (provided by a BA as defined above) with at least 20 hours of training occurring prior to the AP billing for the BT's services, and the other 20 hours accrued no more than 90 calendar days following first submission of billing for the BT's services.

(6) Stage 3 ABA specialty care provider: Eligibility requirements for ABA specialty care providers are practitioners who are enrolled as BAs and must provide additional documentation that demonstrates the practitioner has the skills, training and clinical experience to oversee and render ABA services to highly complex eligible recipients who require specialized ABA services.

B. Eligible recipients: MAD has established a level of care (LOC) (see ABA billing instructions for details) for an eligible recipient to receive ABA services that must be met in addition one of the two categories of eligibility below:

(1) At-risk for ASD: an eligible recipient may be considered 'at-risk' for ASD and therefore eligible for time-limited ABA services, if he or she does not meet full criteria for ASD per the latest version of the diagnostic and statistical manual of mental disorders (DSM) or international classification of diseases (ICD); ABA

services are time limited; see ABA billing instructions for detailed time limits; the eligible recipient must meet all four criteria to meet the at-risk for ABA eligibility criteria:

(a) is between 12 and 36 months of age;

(b) presents with developmental differences and delays as measured by standardized assessments;

(c) demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior);

(d) presents with at least one genetic risk factor (e.g., genetic risk due to having an older sibling with a well-documented ASD diagnosis; eligible recipient has a diagnosis of Fragile X syndrome).

(2) Diagnosed with ASD: an eligible recipient 12 months up to 21 years of age who has a documented medical diagnosis of ASD according to the latest version of the diagnostic and statistical manual of mental disorders (DSM) or the international classification of diseases (ICD) is eligible for ABA services with no time limits if he or she presents a comprehensive diagnostic evaluation completed by either a MAD enrolled AEP or a practitioner meeting MAD's ABA billing instructions of an AEP when the eligible recipient's ISP states ABA services are medically necessary; prior authorizations are set at periodic intervals.

C. Covered services - stage 1: For an eligible recipient 12 months up to 21 years of age who is suspected of having ASD, stage 1 involves (a) screening, and if the results are positive, (b) referral to an AEP for diagnostic evaluation, ISP development, and the determination of medical necessity for ABA. For an eligible recipient who has an existing ASD diagnosis, as provided in accordance with the ABA billing instructions, stage 1 does not require diagnostic re-evaluation, but does require development of an ISP and the determination of medical necessity for ABA. Stage 1 entails that the AEP:

(1) ensures a screening and the referral is completed prior to the to AEP's services; for a detailed description of the requirements of screening and referral requirements refer to the ABA billing instructions;

(2) completes a comprehensive diagnostic evaluation once prior approval is received; the full requirements of a comprehensive diagnostic evaluation are detailed in the ABA billing instructions;

(3) conducts a targeted evaluation when the AEP determines a full comprehensive diagnostic evaluation is not appropriate, see the ABA billing instructions for details on when a targeted evaluation is appropriate;

(4) develops and issues the eligible recipient's evaluation report and ISP following the ABA billing instructions;

(5) develops and issues the eligible recipient's targeted evaluation report and ISP following the ABA billing instructions;

(6) develops and issues the eligible recipient's updated ISP following the ABA billing instructions.

D. Covered services - stage 2 BA: For all eligible recipients, stage 2 involves the prior authorization process for behavior analytic assessment, ABA service model determination, and treatment plan development. Once the AP has received a prior authorization for the assessment and treatment plan development, as outlined below, the family, eligible recipient (as appropriate for age and developmental level), and the AP's supervising BA works collaboratively to make a final determination regarding the clinically appropriate ABA service model, with consultative input from the AEP as needed. Then a behavior analytic assessment addressing needs associated with both skill acquisition and behavior reduction is conducted, and an individualized ABA treatment plan, as appropriate for the ABA service model, is developed by the supervising BA.

(1) Essential practice elements: The BA is ultimately responsible for ensuring that all essential practice elements are apparent throughout service delivery as required in the ABA billing instructions.

(2) Service model determination: ABA treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number of behavioral targets, specific aspects of those behaviors, and the eligible recipient's response to treatment help determine which model is most appropriate. Although existing on a continuum, these models can be generally categorized as focused ABA or comprehensive ABA, both of which are MAD covered ABA stage 3 services. The ABA billing instructions provide the BA with details on each of these requirements. The BA is responsible for completing all of the following services:

(a) the eligible recipient's assessment;

(b) selection and measurement of goals;

(c) treatment plan formulation and documentation.

(3) C**linical management and case supervision:** In order to achieve the desired, medically necessary outcome, all cases require clinical management, and if a BT is tasked with implementing the treatment plan, the BT requires frequent, ongoing case supervision from the BA. Provision of both clinical management and case supervision allows for the individualization of treatment plans, careful and detailed collection and analysis of data, and timely modifications to treatment protocols, all of which are essential to ensuring treatment effectiveness. As such, MAD not only reimburses for, but requires both clinical management and case supervision. See the ABA billing instructions for detailed description of the requirements for rendering clinical management and case supervision.

E. ABA specialty care services: While it is customary for MAD to limit rendering of a benefit to one provider to the same date of service and same time of service, MAD recognizes that there may be cases where the needs of the eligible recipient exceed the expertise of the AP and the logistical or practical ability of the AP to fully support the eligible recipient. In such cases, MAD allows the BA through his or her AP to refer the eligible recipient to a MAD approved, and as appropriate, a MCO contracted ABA specialty care provider.

F. Prior authorizations - general information:

(1) An eligible recipient's utilization review contractor (UR) must extend authorizations every six months including approving new requests for ABA services if the AEP's ISP or update indicates the medical necessity for the continuation of services and the corresponding treatment plan updates specify how these services will be delivered (e.g., service model, allocation of hours, etc.). During the 36-month service authorization period for focused ABA, services may or may not be continuously rendered depending on medical need, availability of service providers, and other factors. Prior authorization must be secured every six months until the end of the 36-month service authorization period. At each six month authorization point, the eligible recipient's UR will assess, with input from the family and AP, whether or not changes are needed in the eligible recipient's ISP, as developed by the AEP. If so, the UR will facilitate contact with the AEP to modify the plan. Additionally, the family or AP may request ISP modifications prior to the MCO's six-month authorization point if immediate changes are warranted to preserve the health and wellbeing of the eligible recipient. See the ABA billing instructions for detailed description of prior authorization requirements.

(2) To secure prior authorization, the BA through the AP must submit the prior authorization request, specifically noting:

(a) the prior authorization request must be submitted with the comprehensive diagnostic evaluation report and ISP from the AEP (developed in stage 1) along with the ABA treatment plan (developed in stage 2 by the AP);

(b) the requested treatment model (focused or comprehensive), maximum hours of service requested per week;

(c) the number of hours of case supervision requested per week, if more than two hours of supervision per 10 hours of intervention is requested; see the ABA billing instructions for detailed requirements for case supervision;

(d) the number of hours of clinical management requested per week, if more than two hours of clinical management per 10 hours of intervention is requested; see ABA billing instructions for detailed requirements for case supervision;

(e) the need for collaboration with an ABA specialty care provider, if such a need has been identified through initial assessment and treatment planning; after services have begun, the AP may refer the eligible recipient to a ABA specialty care provider who may then request prior authorization to render ABA specialty care stage 2 assessment and stage 3 ABA services; see the ABA billing instructions for detailed requirements to access ABA specialty care services.

(3) The request must document hours allocated to other services (e.g., early intervention through FIT) that are in the eligible recipient's ISP in order for the eligible recipient's UR to determine if the requested intensity (i.e., hours per week) is feasible and appropriate.

(4) When an eligible recipient's behavior exceeds the expertise of the AP and logistical or practical ability of the AP to fully support him or her, MAD allows the AP to refer the eligible recipient to his or her UR for prior authorization to allow an ABA specialty care provider to intervene. The UR will approve a prior authorization to the ABA specialty care provider to complete a targeted assessment and provide the primary AP with, or to implement itself, individualized interventions to address the behavioral concerns for which the referral is based on medical documentation.

(5) Services may continue until the eligible recipient ages out of eligibility for comprehensive ABA services as described in the ABA billing instructions.

G. Noncovered services:

(1) The eligible recipient's comprehensive or targeted diagnostic evaluation or the ISP and treatment plan updates recommend placement in a higher, more intensive, or more restrictive level of care and no longer recommends ABA services.

(2) The eligible recipient is in a residential facility that either specializes in or has as part of its treatment modalities MAD ABA services. The facility should render ABA services as detailed in the ABA billing instructions, such as they would general outpatient services of individual, family and group therapy.

(a) The eligible recipient's UR may authorize time limited ABA services while he or she remains in the facility for transition when ABA services are approved to be rendered upon his or her discharge from the facility to a community ABA provider.

(b) Specifically for an eligible recipient who meets admission criteria for ABA services and who is in a treatment foster care placement, he or she is not considered to be in a residential facility and may receive full ABA services.

(3) The referral for the comprehensive diagnostic evaluation did not utilize a MAD ABA specific screening tool as the basis of the referral. The eligible recipient's family or the referring agency must provide a MAD recognized positive screening result to an AEP. At that time, the AEP may request a prior authorization to complete a MAD ABA comprehensive diagnostic evaluation.

(4) The eligible recipient has reached the maximum age range for ABA services.

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

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

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

(8) Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the provider has expertise in the provision of ABA.

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

H. Reimbursement stage 1 - AEP comprehensive diagnostic evaluation and ISP: MAD supports reimbursement for a comprehensive diagnostic evaluation and development of an ISP from an AEP through three situations listed in Subsection C of 8.321.2.10 NMAC. See the ABA billing instructions for a detailed description of specific requirements in order to be reimbursed for AEP services.

I. Reimbursement stage 2 and 3 ABA prior authorization: If the AEP prescribes ABA services as part of the eligible recipient's ISP, and the AP received prior approval from the eligible recipient's UR, the AP may bill from stage 2 and 3 services following the ABA billing instructions.

[8.321.2.10 NMAC - N, 1-1-14; A, 5-1-15; A/E, 5-15-15]

8.321.2.11 ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) SERVICES: To help a MAP eligible recipient under 21 years of age who has been diagnosed as having SED or a chemical dependency, and for whom a less restrictive setting is not appropriate, MAD pays for services furnished to him or her by a ARTC accredited by joint commission (JC) as part of EPSDT program. The need for ARTC must be identified in the MAP eligible recipient's tot to teen healthcheck screen or other diagnostic evaluation.

A. Eligible facilities:

(1) In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing ARTC services to a MAP eligible recipient, an ARTC facility:

(a) must provide a copy of its JC or CARF accreditation as a children's residential treatment facility;

(b) must provide a copy of its CYFD ARTC facility license and certification; and

(c) must have written utilization review (UR) plans in effect which provide for review of the MAP eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245;

(2) If the ARTC is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD ARTC licensing requirements, but is not required to be licensed by CYFD. In lieu of receiving a license, CYFD will provide MAD copies of its facility reviews and recommendations. MAD will work with the facility to address recommendations; and

(3) In lieu of New Mexico CYFD licensure, an out-of-state or MAD border ARTC facility must have JC accreditation and be licensed in its own state as an ARTC residential treatment facility.

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

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

(2) Treatment must be based on the MAP eligible recipient's individualized treatment plan rendered by the ARTC facility's practitioners, within the scope and practice of their professions as defined by state law. See Subsection B of Section 9 of this rule for general behavioral health professional requirements.

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

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

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

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

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

(d) assistance to the MAP eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient, make referrals, as necessary, and provide follow-up to the MAP eligible recipient;

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

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

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

C. Noncovered services: ARTC services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with ARTC services to a MAP eligible recipient:

(1) CCSS, except when provided by a CCSS agency in discharge planning for the MAP eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals; RTC and group services are covered only for MAP eligible recipients under 21 years of age;

(4) formal educational and services which relate to traditional academic subjects or vocational training; and

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

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a ARTC facility. The interdisciplinary team must review the treatment plan at least every 14 calendar days. In addition to the requirements of Subsection G of Section 9 of this rule, all supporting documentation must be available for review in the MAP eligible recipient's file. The treatment plan must also include a statement of the MAP eligible recipient's cultural needs and provision for access to cultural practices.

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

F. Reimbursement: An ARTC agency must submit claims for reimbursement on the UB 04 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

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

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

(b) Services which are not covered in routine services include other MAD services that a MAP eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

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

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

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

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

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

(4) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the New Mexico border (Mexico excluded) are 70 percent of billed charges or a negotiated rate.
[8.321.2.11 NMAC - Rp, 8.321.3 NMAC, 1-1-14]

8.321.2.12 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help a MAP eligible recipient 18 years and older receive medically necessary services, MAD pays for covered assertive community treatment services (ACT) [42 CFR SS 440.40, 440.60(a) and 441.57]. ACT services are therapeutic interventions that address the functional problems associated with the most complex and pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increasing the MAP eligible recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

A. Eligible providers:

(1) An ACT agency must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. See Subsections A and B of Section 9 for MAD general provider requirements.

(2) ACT services must be provided by an agency designating a team of 10 to 12 members; see this Paragraph (5) of this subsection for the required composition. Each team must have a designated team leader. Practitioners on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance abuse treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that a MAP eligible recipient obtains the basic necessities of daily life; and education, support and consultation to the MAP eligible recipient's family and other major supports. The agency must coordinate its ACT services with local hospitals, local crisis units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.

(3) Each ACT team staff member must be successfully and currently certified or trained according to ACT standards developed by HSD or its authorized agents. The approved training will focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices. Each ACT team shall have sufficient numbers of qualified staff to provide treatment, rehabilitation, crisis and support services 24-hours a day, seven days per week.

(4) Each ACT team shall have a staff-to-MAP eligible recipient ratio in keeping with ACT evidence-based practice standards and approved by MAD or its designee.

(5) Each ACT team shall include:

(a) at least one board-certified or board-eligible psychiatrist (full-time position is not required);

(b) two licensed nurses, one of whom shall be a RN;

(c) at least one other MAD recognized independently licensed behavioral health professional, see Subsection H of Section 9 of this rule;

(d) at least one MAD recognized licensed substance abuse professional; see Subsection J of Section 9 of this rule;

(e) at least one employment specialist;

(f) at least one New Mexico certified peer specialist (CPS) through the approved state of New Mexico certification program;

(g) one administrative staff person; and

(h) the MAP eligible recipient shall be considered a part of the team for decisions impacting his or her ACT services.

(6) The agency must have a MAD ACT approval letter to render ACT services to a MAP eligible recipient.

B. Coverage criteria:

(1) MAD covers medically necessary ACT services required by the condition of the MAP eligible recipient.

(2) The interventions are strength-based and focused on promoting symptom stability; increasing the MAP eligible recipient's ability to cope and relate to others; and enhancing the highest level of functioning in the community, including learning, working and recreation and making informed choices.

(3) Interventions may address adaptive skill areas such as: housing; school, work and training opportunities; daily activities; health and safety; medication support; harm reduction; money management and entitlements; promotion of the MAP eligible recipient’s recovery processes; relapse prevention; and service planning and coordination.

(4) The ACT therapy model shall be based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan of the MAP eligible recipient. Specialized therapeutic and rehabilitative interventions falling within the fidelity of the ACT model are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services.

C. MAP eligible recipients:

(1) ACT services are provided to a MAP eligible recipient aged 18 and older who has a diagnosis of SMI, including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression for individuals who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services and who have experienced repeated hospitalizations or incarcerations due to mental illness.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from ACT services.

D. Covered services:

(1) ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

(a) the service is available 24-hours a day, seven days a week;

(b) the service is provided by an interdisciplinary ACT team that includes trained personnel as defined in of Subsection A of Section 6 of this rule;

(c) an individualized treatment plan and supports are developed;

(d) at least 90 percent of services are delivered as community-based, non-office-based outreach services (in vivo);

(e) an array of services are provided based on the MAP eligible recipient's medical need;

(f) the service is MAP eligible recipient-directed;

(g) the service is recovery-oriented;

(h) following the ACT evidence-based model guidelines, the ACT team maintains a low staff-to-patient ratio;

(i) mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations; and

(j) the team is not just a consortium of mental health specialists, but includes collaborative assessment and treatment planning for each MAP eligible recipient; cross-training of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each MAP eligible recipient's care and services; and the team will assist the MAP eligible recipient to access other appropriate services in the community that are not funded by MAD.

(2) Quality measurement: An ACT program's success is evaluated based on outcomes which may include but are not limited to: improved engagement by the MAP eligible recipient in medical and social services; decreased rates of incarceration; decreased rates of hospitalization; decreased use of alcohol or illegal drugs; increased housing stability; increased relationships of the MAP eligible recipient with his or her family (as appropriate); increased employment; and increased attainment of goals self-identified by the service MAP eligible recipient for his own life. Fidelity to the specific evidence-based ACT service model will also be measured to assure that ACT, rather than some other form of intensive case management, is being provided.

(3) ACT services must be provided to the MAP eligible recipient by the treatment team members.

(4) ACT program provides three levels of interaction with a MAP eligible recipient:

(a) face-to-face encounters are at least 60 percent of all ACT team activities with approximately 90 percent of ACT encounters occurring outside of the IOP agency's office (in vivo);

(b) a collateral encounter where the collaterals are members of the MAP eligible recipient's family or household or significant others (e.g. landlord, criminal justice staff, and employer) who regularly interact with him or her and are directly affected by or have the capability of affecting the MAP eligible recipient's condition, and are identified in the service plan as having a role in treatment; a collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff that is assisting an ACT MAP eligible recipient in locating housing);

(c) assertive outreach consists of the ACT team being 'assertive' about knowing what is going on with a MAP eligible recipient and acting quickly and decisively when action is called for, while increasing the MAP eligible recipient's independence; the team must closely monitor the relationships that the MAP eligible recipient has within the community and intervene early if a difficulty arises;

(d) collateral encounters and assertive outreach combined must not exceed 40 percent of the total ACT team activities for each MAP eligible recipient; and

(e) all of the above activities must be indicated in the MAP eligible recipient's service plan.

E. Non-covered services: ACT services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for MAD general noncovered behavioral health services. MAD does not cover other psychiatric, mental health nursing, therapeutic, substance abuse or crisis services when billed in conjunction with ACT services to a MAP eligible recipient, except for medically necessary medications and hospitalizations.

F. Reimbursement: ACT agencies must submit claims for reimbursement on the CMS 1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements. [8.321.2.12 NMAC - N, 1-1-14]

8.321.2.13 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: To help a MAP eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD furnishes these services as part of the EPSDT program and when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation [42 CFR Section 441.57]. MAD pays for medically necessary

behavior management skills development services (BMS) which are services designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the MAP eligible recipient in his or her home or community. BMS services assist in preventing inpatient hospitalizations or out-of-home residential placement of the MAP eligible recipient through use of teaching, training and coaching activities designed to assist him or her in acquiring, enhancing and maintaining the life, social and behavioral skills needed to function successfully within his or her home and community settings. BMS is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the MAP eligible recipient's treatment or service plan.

A. Eligible providers:

(1) an agency must be certified by CYFD to provide BMS services; and

(2) see Subsections A and B of Section 9 of this rule for MAD general provider requirements.

B. Covered services: MAD reimburses for services specified in the MAP eligible recipient's individualized treatment plan which are designed to improve his or her performance in targeted behaviors, reduces emotional and behavioral episodic events, increases social skills and enhances behavioral skills through a regimen of positive intervention and reinforcement.

(1) Implementation of a MAD eligible recipient's BMS treatment plan must be based on a relevant clinical assessment covering an integrated program of therapeutic services, as applicable. The following tasks must be identified in the MAP eligible recipient's BMS treatment plan:

(a) the treatment plan must identify all targeted behaviors that are to be addressed by the behavior management specialist;

(b) the treatment plan should include, when appropriate, a goal of working with the MAP eligible recipient's foster, adoptive, or natural family in order to assist with the achievement and maintenance of behavior management skills; and

(c) the treatment plan must identify the behavior management specialist who is responsible for implement of the plan, including but not limited to:

(i) assistance in achieving and maintaining appropriate behavior management skills through teaching, training and coaching activities; and

(ii) maintaining case notes and documentation of tasks as required by the agency and pursuant to the standards under which it operates in accordance with NMAC rules, including licensed professional standards.

(2) Supervision of behavioral management staff by an independent level practitioner is required for this service. See Section 9 of this rule. The supervisor must ensure that:

(a) an assessment (within the past 12 months) of the MAP eligible recipient is completed which identifies the need for BMS;

(b) the assessment is signed by the recipient, his parent or legal guardian; and

(c) the BMS specialist receives supervision on a regular basis.

(3) An agency certified for BMS services must:

(a) develop a BMS treatment plan based on a relevant and recent clinical assessment (within the last 12 months), as part of a comprehensive treatment plan covering an integrated program of therapeutic services, as applicable;

(b) identify all targeted behaviors that are to be addressed by the behavioral management specialist;

(c) ongoing assessment of the MAP eligible recipient's progress in behavioral management skills by the BMS supervisor; and

(d) offer 24-hour availability or appropriate staff to respond to the MAP eligible recipient's crisis situations.

(4) A MAP eligible recipient's treatment plan must be reviewed at least every 30 calendar days and notation of this review must be maintained in the recipient's file

C. MAP eligible recipients: In order to receive BMS services, a MAP eligible recipient must be under the age of 21 years, be diagnosed with a behavioral health condition and:

(1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;

(2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) require behavior management support following an institutional or other out-of-home placement as a transition to maintain the MAP eligible recipient in his or her home and community.

D. Non-covered services: BMS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

(1) activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the BMS treatment plan;

(2) services provided in a residential treatment facilities; and

(3) as services provided in lieu of services that should be provided as part of the MAP eligible recipient's individual educational plan (IEP).

E. Reimbursement: A BMS agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and 8.302.2 NMAC.

[8.321.2.13 NMAC - Rp, 8.322.3 NMAC, 1-1-14]

8.321.2.14 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): To help a New Mexico MAP eligible recipient receive medically necessary services, MAD pays for covered CCSS. This culturally sensitive service coordinates and provides services and resources to a MAP eligible recipient and his or her family necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the MAP eligible recipient's community, as well as strengths that may aid the MAP eligible recipient and family in the recovery or resiliency process.

A. Eligible providers: In addition to the requirements of Subsections A and B of Section 9, of this rule, in order to be eligible to be reimbursed for providing CCSS services, an agency must be: a FQHC; an IHS hospital or clinic; a PL 93-638 tribally operated hospital or clinic; or be a MAD enrolled CSA. CCSS services are certified by CYFD for MAP eligible recipients under 21 years of age and department of health (DOH) for those recipients over 21 years of age. For MAP eligible recipient ages 18 through 20, the CCSS certification or a license may be from either CYFD or DOH, as appropriate.

(1) Community support workers (CSW) (not a peer or family specialist), must possess the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the CSW must have:

(a) the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS;

(b) a bachelor's degree in a human service field from an accredited university and one year of relevant experience with the target population;

(c) an associate's degree and a minimum of two years of experience working with the target population;

(d) a high school graduation or general educational development (GED) test and a minimum of three years of experience working with the target population; or

(e) a New Mexico peer or family specialist certification and have completed 20 hours of documented training or continuing education, as identified in the CCSS service definition.

(2) CCSS agency supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the supervisory staff must hold:

(a) a bachelor's degree in a human services field from an accredited university or college;

(b) have four years of relevant experience in the delivery of case management or community support services with the target population;

(c) have at least one year of demonstrated supervisory experience; and

(d) completed 20 hours of documented training or continuing education, as identified in the New Mexico behavioral health collaborative CCSS service definition.

(3) CSA clinical supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the clinical supervisory staff must:

(a) be a licensed independent practitioner as detailed in Subsections B and H of Section 9 of this rule; and

(b) have one year of documented supervisory training.

(4) Certified peer worker (CPW) must:

(a) be 18 years of age or older;
(b) have a high school diploma or GED;
(c) be self-identified as a current or former consumer of mental health or substance abuse services;
(d) have at least two years of mental health or substance abuse recovery; and
(e) be a currently certified New Mexico CPW.

(5) Certified family specialist (CFS) must:
(a) be 18 years of age or older;
(b) have a high school diploma or GED;
(c) have personal experience navigating any of the child and family-serving systems, advocating for family members who are involved with the child and family behavioral health systems; and must also have an understanding of how these systems operate in New Mexico;
(d) be a currently certified New Mexico CFS; and
(e) must be well-grounded in his or her symptom self-management if the family specialist is a current or former consumer of behavioral health services.

B. Covered services: The purpose of CCSS is to surround a MAP eligible recipient and his or her family with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, with at a minimum 60 percent face-to-face and in vivo (where the MAP eligible recipient is located). that address barriers that impede the development of skills necessary for independent functioning in the community.

(1) CCSS activities include:
(a) assistance to the MAP eligible recipient in the development and coordination of his or her treatment plan including a recovery or resiliency management plan, a crisis management plan, and, when requested, his or her advanced directives related to the MAP eligible recipient's behavioral health care; and
(b) assessment support and intervention in crisis situations, including the development and use of crisis plans that recognize the early signs of crisis or relapse, use of natural supports, alternatives to the utilization of emergency departments and inpatient services.

(2) Individualized interventions, with the following objectives:
(a) services and resources coordination to assist the MAP eligible recipient in gaining access to necessary rehabilitative, medical and other services;
(b) assistance in the development of interpersonal and community coping and functional skills (e.g., adaptation to home, school and work environments), including:
(i) socialization skills;
(ii) developmental issues;
(iii) daily living skills;
(iv) school and work readiness activities; and
(v) education on co-occurring illness;
(c) encouraging the development of natural supports in workplace and school environments;
(d) assisting in learning symptom monitoring and illness self-management skills (e.g. symptom management), relapse prevention skills, knowledge of medication and side effects, and motivational and skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms that interfere with the MAP eligible recipient's daily living and to support him or her in maintaining employment and school tenure;
(e) assisting the MAP eligible recipient in obtaining and maintaining stable housing; and
(f) any necessary follow-up to determine if the services accessed have adequately met the MAP eligible recipient's needs.

(3) At least 60 percent of non-facility-based CCSS provided must be face-to-face and in vivo (where the MAP eligible recipient is located). The CSW must monitor and follow-up to determine if the services accessed have adequately met the MAP eligible recipient's specific treatment needs.

(4) The CSW will make every effort to engage the MAP eligible recipient and his or her family in achieving the member's treatment or recovery goals.

(5) When the service is provided by a CPS or CFS, the above functions and interventions should be performed with a special emphasis on recovery values and process, such as:

(a) empowering the MAP eligible recipient to have hope for, and participate in, his or her own recovery;

(b) helping the MAP eligible recipient to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;

(c) helping the MAP eligible recipient to identify and achieve his or her personalized recovery goals; and

(d) promoting the MAP eligible recipient's responsibility related to illness self-management.

(6) Limited CCSS services may be provided by a CSA during discharge planning while a MAP eligible recipient is receiving the following services:

(a) accredited residential treatment (ARTC);

(b) residential treatment (RTC);

(c) group home service;

(d) impatient hospitalization; or

(e) treatment foster care (TFC I and II).

(7) CCSS services may not be provided in conjunction with the following services:

(a) multi-systemic therapy (MST); or

(b) assertive community treatment (ACT).

C. MAP eligible recipients:

(1) CCSS is provided to a MAP eligible recipient 21 years and under who meets the criteria for or is diagnosed as either or both: (a) at risk of or experiencing serious emotional disturbances (SED); (b) has a chronic substance abuse disorder.

(2) MAD covers CCSS for a MAP eligible recipient 21 years and older diagnosed with a severe mental illness (SMI). A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from CCSS.

D. Non-covered services: CCSS are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.310.2 NMAC for a detailed description of MAD general non-covered services and Subsection C of Section 9 of this rule for all non-covered MAD behavioral health services or activities. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST) or ACT services.

E. Reimbursement: CCSS agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives direction on how to access NMAC rules, instructions for documentation, billing, and claims processing. General reimbursement instructions are found in this rule under Subsection D of Section 9.

[8.321.2.14 NMAC - N, 1-1-14]

8.321.2.15 DAY TREATMENT: MAD pays for services furnished by a day treatment provider as part of the EPSDT program for eligible MAP recipients under 21 years of age [42 CFR section 441.57]. The need for day treatment services must be identified through an EPSDT tot-to-teen health check or other diagnostic evaluation. Day treatment services include MAP eligible recipient and parent education, skill and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented utilizing a clinical model for service delivery and support.

A. Eligible providers: An agency must be certified by CYFD to provide day treatment services in addition to the meeting the general provider enrollment requirements in Subsections A and B of Section 9.

B. MAP eligible recipients: MAD covers day treatment services for a MAP eligible recipient under age 21 who:

(1) is diagnosed with an emotional, behavioral, and neurobiological or substance abuse problems;

(2) may be at high risk of out-of-home placement;

(3) requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school;

(4) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services; or

(5) is able to benefit from this LOC.

C. Covered services:

(1) Behavioral health day treatment services are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include parent and MAP eligible recipient education, skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. Counseling services may be provided in addition to the BMS services. The goals of the service must be clearly documented, utilizing a clinical model for service delivery and support.

(2) The goal of day treatment is to maintain the MAP eligible recipient in his or her home or community environment.

(3) Day treatment services must be provided in a school setting or other community setting. However, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered. Programming is designed to complement and coordinate with the MAP eligible recipient's educational system.

(4) Services must be based upon the MAP eligible recipient's individualized BMS treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the MAP eligible recipient's adaptive functioning.

(5) The following services must be furnished by a day treatment service agency to receive reimbursement from MAD:

(a) the assessment and diagnosis of the social, emotional, physical and psychological needs of the MAP eligible recipient and his or her family for treatment planning ensuring that evaluations already performed are not unnecessarily repeated;

(b) development of individualized treatment and discharge plans and ongoing reevaluation of these plans;

(c) regularly scheduled individual, family, multi-family, group or specialized group sessions focusing on the attainment of skills, such as managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention, if applicable;

(d) family education and family outreach to assist the eligible recipient in gaining functional and behavioral skills;

(e) supervision of self-administered medication, as clinically indicated;

(f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each MAP eligible recipient's individualized treatment plan;

(g) availability of appropriate staff to provide crisis intervention during program hours;

(h) day treatment services are provided at a minimum of four hours of structured programming per day, two to five days per week based on acuity and clinical needs of the MAP eligible recipient and his or her family as identified in the treatment plan; and

(i) payment for performance of these services is included in the day treatment reimbursement rate.

(6) Only those activities of daily living and basic life skills that are assessed as being a clinical problem should be addressed in the treatment plan and deemed appropriate to be included in the MAP eligible recipient's individualized program.

(7) A family who is unable to attend the regularly scheduled sessions at the day treatment facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the day treatment agency.

D. Noncovered services: Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

(1) educational programs, other than those indicated above;

(2) pre-vocational training;

(3) vocational training which is related to specific employment opportunities, work skills or work settings;

(4) any service not identified in the treatment plan;

(5) recreation activities not related to the treatment issues;

(6) leisure time activities such as watching television, movies or playing computer or video games;

(7) transportation reimbursement for the therapist who delivers services in the family's home; or

(8) a partial hospitalization program and all residential programs cannot be offered at the same time as day treatment services.

E. Prior authorization: See Subsection F of Section 9 of this rule for the general behavioral health services prior authorization requirements.

F. Treatment plan: In addition to the General Treatment Plan requirements in Subsection G of Section 9 of this rule, the treatment plan must be reviewed at least every 30 calendar days or more often when indicated based on the changing clinical needs.

G. Reimbursement: Day treatment providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how access documentation, billing and claims processing information.

[8.321.2.15 NMAC - Rp, 8.322.4 NMAC, 1-1-14]

8.321.2.16 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: To assist the MAP eligible recipient receive necessary mental health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program. If the MAP eligible recipient is receiving services immediately before he or she reaches the age of 21 years, services may continue based on the following conditions, whichever comes first: (1) up to the date the MAP eligible recipient no longer requires the services, or (2) the date the MAP eligible recipient reaches the age of 22 years. The need for inpatient psychiatric care in freestanding psychiatric hospital must be identified in the MAP eligible recipient's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

A. Eligible providers: An MAD eligible provider must be accredited by at least one of the following:

(1) the joint commission (JC);

(2) the council on accreditation of services for families and children (COA);

(3) the commission on accreditation of rehabilitation facilities (CARF);

(4) another accrediting organization recognized by MAD as having comparable standards;

(5) be licensed and certified by the New Mexico DOH or the comparable agency if in another state;

(6) have a written utilization review (UR) plan in effect which provides for the review of a MAP eligible recipient's need for the facility's services that meet federal requirements; see 42 CFR Sections 456.201 through 456.245; or

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

B. Covered services: MAD covers those inpatient psychiatric hospital services furnished in freestanding psychiatric hospitals which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the MAP eligible recipient. These services must be furnished by eligible providers within the scope and practice of his or her profession (see Section 9 of this rule) and in accordance with federal regulations; see 42 CFR Section 441 Subpart D. Services must be furnished under the direction of a physician.

(1) In the case of a MAP eligible recipient under 21 years of age these services:

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

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

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

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

(b) at the time of admission, a board prepared, board eligible, or board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located;

(c) another facility which is able to furnish a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(d) the admission is for stabilization only and transfer arrangement to the care of a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible under the understanding that if the MAP eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the MAP eligible recipient is stable for transfer in accordance with professional standards.

(3) The following services must be furnished by a freestanding hospital to receive reimbursement from MAD:

(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) regularly scheduled structured counseling and therapy sessions for MAP eligible recipient, group, family, or a multifamily group based on individualized needs, as specified in the MAP eligible recipient's treatment plan;

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

(d) assistance to a MAP eligible recipient in his or her self administration of medication in compliance with state policies and procedures;

(e) appropriate staff available on a 24-hour basis to respond to crisis situations; determine the severity of the situation; stabilize MAP eligible recipient by providing support; make referrals, as necessary; and provide follow-up;

(f) a consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(g) non-medical transportation services needed to accomplish treatment objectives; and

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

C. Non-covered services: Services furnished in a freestanding psychiatric hospital are subject to the limitations and coverage restrictions which exist for other MAD services; see Subsection C of Section 9 of this rule for MAD general non-covered services. MAD does not cover the following specific services for a MAP eligible recipient in a freestanding psychiatric hospital in the following situations:

(1) conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM);

(2) services in freestanding psychiatric hospital for MAP eligible recipient 21 years of age or older;

(3) services furnished after the determination by MAD or its designee has been made that the MAP eligible recipient no longer needs hospital care;

(4) formal educational or vocational services, other those indicated above, related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active treatment plan for a MAP eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b); or

(5) drugs classified as "ineffective" by the FDA drug evaluation.

D. MAD covers "awaiting placement days" in a freestanding psychiatric hospital when the MAD utilization review (UR) contractor determines that a MAP eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the MAP eligible recipient requires a residential LOC which cannot be immediately located. Those days during which the MAP eligible recipient is awaiting placement to the lower LOC are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the weighted

average rate paid by MAD for ARTC services to a MAP eligible recipient classified as level III, IV, or IV+, plus five percent. A separate claim form must be submitted for awaiting placement days.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with a MAP eligible recipient, his or her parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days.

(1) The treatment team must consist of at a minimum (see CFR 42 441.156(c-d):

(a) either a:

(i) board eligible or board certified psychiatrist;

(ii) a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy;

(iii) a physician licensed to practice medicine;

(iv) osteopathic physician with specialized training and experience in the diagnosis and treatment of mental illness, or

(v) a psychologist who has a master's degree in clinical psychology or who has been certified by the state and his or her RLD practice board;

(b) the team must also include one of the following:

(i) a psychiatric social worker;

(ii) an occupational therapist who is licensed by the state and who has specialized training in treating a MAP eligible recipient under the age of 21 years of age with SED:

(iii) a RN with specialized training or one year's experience in treating a recipient under the age of 21 years; or

(iv) a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by his or her RLD practice board.

(2) The treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file. The following must be contained in the treatment plan or documents used in the development of the treatment plan:

(a) shall be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the MAP eligible recipient's situation and reflects the need for inpatient psychiatric care;

(b) shall be developed by a team of professionals as defined in Paragraph (1) of Subsection E above in consultation with the MAP eligible recipient and, his or her parent, legal guardian, or others in whose care he or she will be released after discharge;

(c) shall have stated treatment objectives;

(d) shall be prescribed in an integrated program of therapies, activities, and experiences designed to meet the objectives;

(e) include, at the appropriate time, a post-discharge plan and coordination of inpatient services with partial a discharge plan, and related community services to ensure continuity of care with the MAP eligible recipient's family, school, and community upon discharge;

(f) shall have a statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(g) shall have a description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

(h) shall have a statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including the provision for review and modification of the plan;

(i) shall have specification of staff responsibilities, description of proposed staff involvement, and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the MAP eligible recipient; and

(j) shall have the criteria for release to less restrictive settings for treatment and discharge plans, the criteria for discharge, and the projected date of discharge.

F. Prior authorization and utilization review: All MAD services are subject to UR for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.302.5 NMAC. Once

enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

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

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

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

G. Discharge planning: Plans for discharge must begin upon admittance to the facility and be included in the MAP eligible recipient's treatment plan. If the MAP eligible recipient will receive services in the community or in the custody of CYFD, the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the MAP eligible recipient, his or her family, and school and community.

H. Reimbursement: A freestanding psychiatric hospital service providers must submit claims for reimbursement on the UB04 claim form or its successor; see 8.302.2 NMAC. Once enrolled, providers receive instructions on how to access information on documentation, billing, and claims processing.

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

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

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

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

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

(a) If the provider and the HSD contracted MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

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

[8.321.2.16 NMAC - Rp, 8.321.2 NMAC, 1-1-14]

8.321.2.17 INTENSIVE OUTPATIENT PROGRAM SERVICES: To help a MAP eligible recipient receive medically necessary services, MAD pays for intensive outpatient program (IOP) services. IOP services provide a time-limited, multi-faceted approach to treatment service for a MAP eligible recipient who requires structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be delivered through a MAD approved agency, as specified in this section.

A. Eligible providers: See Subsection A of Section 9 of this rule for MAD general provider requirements.

(1) Specific to IOP, the following types of agencies are eligible to be reimbursed for providing IOP services when they have a research-based model meeting the requirements of this Section Subsection C of this rule:

(a) a CMHC
(b) a FQHC;
(c) an IHS facility;
(d) a PL.93-638 tribal 638 facility;
(e) a MAD CSA; or
(f) an agency approved by MAD after demonstrating that the agency meets all the requirements of IOP program services and supervision requirements; such a MAD approved IOP agency is allowed to have services rendered by non-independent practitioners as listed in Subsection J of Section 9 of this rule.

(2) Each IOP program must have a clinical supervisor. The clinical supervisor may also serve as the IOP program supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) be licensed as a MAD approved independent practitioner; see Subsection H of Section 9 of this rule;
(b) two years relevant experience with an IOP program;
(c) one year demonstrated supervisory experience; and
(d) expertise in both mental health and substance abuse treatment.

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

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

(5) The agency must hold a MAD IOP approval letter and be enrolled by MAD to render IOP services to a MAP eligible recipient. A MAD IOP agency will be provisionally approved for a specified timeframe to render IOP services to a MAP eligible recipient. During this provisional approved time, MAD or its designee will determine if the IOP agency meets MAD IOP requirements and if so, the agency will receive an approval letter for IOP full enrollment.

B. Coverage criteria: The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. Treatment services should address co-occurring mental health disorders, as well as substance use disorders, when indicated. The IOP services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MAD enrolled behavioral health providers, with the intent that the IOP service shall not exclude a MAP eligible recipient with co-occurring disorder.

C. Covered services:

(1) MAD covers services and procedures that are medically necessary for the evaluation, assessment, diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. See Subsection C of Section 9 of this rule for general behavioral health provider requirements. Also see 8.310.2 NMAC.

(2) IOP core services include:

(a) individual therapy;
(b) group therapy (group membership may not exceed 15 in number); and
(c) psycho-education for the MAP eligible recipient and his or her family.

(3) A MAP eligible recipient youth or transition-age young adult is defined for this service as 17 years of age and under. This population should engage in IOP treatment in an environment separate from recipients 18 years of age and older who are receiving IOP services.

(4) Co-occurring mental health and substance use disorders: IOP must accommodate the needs of the MAP eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated multi-disciplinary approach or coordinated, concurrent services with MAD behavioral health providers. Medication management services are available to oversee the use of psychotropic medications.

(5) The duration of a MAP eligible recipient's IOP intervention is typically three to six months. The amount of weekly services per MAP eligible recipient is directly related to the goals and objectives specified in his or her treatment or service plan.

(6) IOP services must be rendered through one of the following research-based models:

(a) matrix model adult treatment model;

(b) matrix model adolescent treatment model;

(c) Minnesota treatment model;

(d) integrated dual disorder treatment; or

(e) other researched-based models than those identified in (a)-(d) above must be approved by MAD or its designee.

(7) IOP services not provided in accordance with the conditions for coverage as specified in this rule are not a MAD covered service and are subject to recoupment.

D. IOP MAP Eligible recipients:

(1) IOP services are provided to a MAP eligible recipient, 13 through 17 years of age diagnosed with substance abuse disorder or with co-occurring disorder (SED and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

(2) IOP services are provided to a MAP eligible recipient 18 years of age and over diagnosed with substance abuse disorder or with a co-occurring disorder (SMI and substance abuse) or that meets the ASAM patient placement criteria for level two (II) - intensive outpatient treatment.

(3) Before engaging in an IOP program, the MAP eligible recipient must have a treatment file containing:

(a) one diagnostic evaluation; and

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

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD services see Subsection C of Section 9 of this rule for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

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

(3) ACT;

(4) partial hospitalization;

(5) outpatient therapies (individual, family and group therapy may be billed only if there are clinical issues beyond the scope of IOP services);

(6) multi-systemic therapy (MST);

(7) activity therapy; or

(8) psychosocial rehabilitation (PSR) group services.

F. Reimbursement: See Subsection E of Section 9 of this rule for MAD behavioral health general reimbursement requirements and Subsection F for general prior authorization requirements; specifically for IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

[8.321.2.17 NMAC - N, 1-1-14]

8.321.2.18 MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION: MAD provides coverage for medication assisted treatment for opioid addiction (MAT) to a MAP eligible recipient through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment Programs.

A. Eligible providers: An opioid treatment center agency is a public or private facility operating a federally certified program to dispense methadone, other narcotic replacement, or narcotic agonist drug items, as part of a detoxification treatment or maintenance treatment as defined in 42 CFR Part 8 Certification of Opioid Treatment Programs. In addition to the requirements found in Subsections A and B of Section 9 of this rule, the following are requirements of an opioid treatment facility:

(1) The agency must maintain documentation supporting the medical necessity of MAT services in the MAP eligible recipient's medical record per the requirements in 42 CFR Part 8, Certification of Opioid Treatment Programs; and

(2) A MAT agency must provide the following:

(a) its DEA certification to operate an opioid treatment program (OTP);

(b) a copy of substance abuse and mental health services administration (SAMHSA), center for substance abuse treatment (CSAT) approval to operate an OTP;

(c) a copy of accreditation by the joint committee (JC) or a copy of the commission on accreditation of rehabilitation facilities (CARF) accreditation; and

(d) its HSD behavioral health services division (BHSD) approval letter as a methadone provider.

B. Covered services: MAT services use a drug or biological that is recognized in the treatment of substance use disorder and provided as a component of a comprehensive treatment program. MAT is also a benefit as a conjunctive treatment regimen for a MAP eligible recipient who is addicted to a substance that can be abused and who meets the DSM-IV-TR and subsequent editions' criteria for a substance use disorder diagnosis.

C. MAT MAP eligible recipients:

(1) The agency must ensure through its internal policies and procedures that a MAP eligible recipient is treated for opioid dependency only after the agency's physician determines and documents that:

(a) the MAP eligible recipient meets the definition of opioid dependence using generally accepted medical criteria, such as those contained in DSM-IV-TR and subsequent editions;

(b) the MAP eligible recipient has received an initial medical examination as required by 7.32.8.19 NMAC, *opioid treatment program admissions*;

(c) if the MAP eligible recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting MAT services unless the MAP eligible recipient receives a waiver of this requirement from the agency's physician because the MAP eligible 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 dependence within the last 24 months; or

(iv) meets any other requirements specified in 7.32.8 NMAC, *opioid treatment program* regarding waivers, consent, and waiting periods.

(2) The agency must ensure that a MAP eligible recipient requesting long-term or short-term opioid withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period be assessed by the agency's medical director or physician to determine if other forms of treatment may be more appropriate.

D. Noncovered services: MAT services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services.

E. Reimbursement: See Subsection E of Section 9 of this rule for MAD general reimbursement requirements. Specifically:

(1) the MAT agency, except an IHS or a 638 tribal facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor; see 8.302.2 NMAC and 8.310.12 NMAC for IHS reimbursement details;

(2) the coverage of services provided to a MAP eligible recipient can be greater than the services required under 42 CFR Part 8 or its successor, *certification of opioid treatment programs;* MAD recognizes it is beneficial to the MAP eligible recipient to receive necessary comprehensive medical and behavioral health services when they can be rendered by the MAT agency at the same time as MAT services.

(a) The reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, other narcotic replacement or agonist drug items, and substance abuse and HIV counseling as well as other services performed by the agency, unless otherwise described as separately reimbursed are required by 42 CFR Part 8.12 (f), or its successor.

(b) The following additional MAD reimbursements will be made for the specific drug item if separately reimbursed service payable to the MAT agency:

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

(ii) 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 Section 9 of this rule requirements;

(iii) a MAP 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;

(iv) laboratory services provided by a certified laboratory facility when billed by the offsite laboratory, see 8.310.2 and 8.310.3 NMAC;

(v) full medical examination, prenatal care and gender specific services for a pregnant MAP eligible recipient; if she is referred to a provider outside the agency, payment is made to the provider of the service; or

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

(c) the quantity of service billed for administering or dispensing for each day cannot exceed the combined total of the drug items administered that day plus the number of drug items dispensed on that day; and

(d) for an IHS and a tribal 638 facility, MAD does not consider MAT services to be outside the IHS all inclusive rate and CCSS is therefore reimbursed at the MAT fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC.

(3) Claims billed for MAT services must include the MAP eligible recipient's substance use disorder diagnosis.

[8.321.2.18 NMAC - Rp, 8.325.11 NMAC, 1-1-14]

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

A. Eligible providers: In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST licensure by MST Inc, of Mt. Pleasant, South Carolina, or any of its approved subsidiaries. MST Inc is a national organization located in Mt. Pleasant, South Carolina, deemed by MAD to be the primary authority on licensure of New Mexico MST programs.

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

(a) a master's level independently licensed behavioral health professional clinical supervision; see Subsection H of Section 9 of this rule);

(b) a licensed master's and bachelor's level behavioral health staff able to provide 24 hour coverage, seven days per week; see Subsection J of Section 9 of this rule);

(c) a licensed master's level behavioral health practitioner that is required to perform all therapeutic interventions; aA bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of his or her RLD practice board licensure or practice (see Subsection B of Section 9 of this rule);

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

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

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection H of Section 9) who is MST trained; this supervision, following the MST supervisory protocol, is provided to team members on topics directly related to the needs of the MAP eligible recipient and his or her family on an ongoing basis; and

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

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

B. MAP eligible recipients:

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

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

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

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

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

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

(c) case management; and

(d) crisis stabilization.

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

(a) promote the family's capacity to monitor and manage the MAP eligible recipient's behavior;

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

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

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

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

D. Non-covered services: MST services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general non-covered specialized behavioral health services.

E. Reimbursement: MST agencies must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the provider agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.19 NMAC - Rp, 8.322.6 NMAC, 1-1-14]

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

A. Eligible providers: In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing RTC or group home services to a MAP eligible recipient, an agency must meet the following requirements:

(1) a RTC and group home must be certified by CYFD. If the provider is certified by CYFD as a RTC, that certification will suffice if all other CYFD group home certification requirements are met; or

(2) if the RTC or group home is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD certifying requirements but is not required to be certified by CYFD; in lieu of receiving a certificate, CYFD will provide MAD copies of the facility review and recommendations; MAD will work with the provider to address the recommendations.

B. Covered services: MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient. The following are covered services:

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

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

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

(4) assistance to the MAP eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, making referrals, as necessary, and provide follow-up;

(6) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective; and

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

C. Non-covered services: RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to a MAP eligible recipient:

(1) CCSS except by a CCSS agency when discharge planning with the MAP eligible recipient from the RTC or group home facility;

(2) services not considered medically necessary for the condition of the MAP eligible recipient, as determined by MAD or its designee;

(3) room and board;

(4) services for which prior approval was not obtained; or

(5) services furnished after the a MAD or its designee determination that the recipient no longer meets the LOC for RTC or group home care.

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a RTC or group home. In addition to the requirements of Subsection G of Section 9 of this rule, the interdisciplinary team must review the treatment plan at least every 14 days. The MAP eligible recipient's file must contain the treatment plan and the documents used in the development of the treatment plan and all other supporting documentation.

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

F. Reimbursement: A RTC or group home agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility, MAD considers RTC

services to be outside the IHS all inclusive rate and RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

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

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

(b) Services which are not covered in routine services include:

(i) direct services furnished by a psychiatrist or licensed Ph.D. psychologist; these services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) other MAD services that a MAP eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

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

(i) room and board; and

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

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home agency cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

[8.321.2.20 NMAC - Rp, 8.321.4 NMAC, 1-1-14]

8.321.2.21 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN A FREESTANDING PSYCHIATRIC HOSPITAL: To help a MAP eligible recipient under 21 years of age receive the level of services needed, MAD pays for outpatient hospital and partial hospitalization services furnished in a freestanding psychiatric hospital as part the EPSDT program. These services are provided upon release of an inpatient stay to address follow-up care. The need for outpatient or partial hospitalization services must be identified in the tot to teen health check screen or other diagnostic evaluation furnished through a health check referral.

A. Eligible providers: In addition to the requirements found in Subsections A and B of Section 9 of this rule, an eligible provider includes a facility JO accredited, and licensed and certified by DOH or the comparable agency in another state.

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

(1) Services that are prescribed by a psychiatrist or licensed Ph.D. psychologist and furnished under an individualized written treatment plan established by the MAD enrolled psychiatrist or licensed Ph.D. psychologist after any necessary consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished, indicate the diagnoses, anticipated goals and must be developed with the MAP eligible recipient and his or her parent or guardian. The treatment plan must be developed within 14 calendar days of admission to the partial hospitalization or outpatient program.

(2) Treatment is supervised and periodically evaluated by a MAD enrolled psychiatrist or licensed Ph.D. psychologist to determine the extent to which treatment goals are being realized. The psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any behavioral health practitioner involved in the MAP eligible recipient's treatment. The psychiatrist or licensed Ph.D. psychologist must see the MAP eligible recipient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

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

C. Covered services and service limitations: The following services must be furnished by a MAD enrolled provider delivering outpatient hospital or a partial hospitalization as part of the freestanding psychiatric hospital services to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

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

(2) regularly scheduled structured counseling and therapy sessions for a MAP eligible recipient, his or her family, group or multifamily group based on individualized needs furnished by social workers, trained psychiatric nurses, other behavioral health professionals who are employed by the hospital, as specified in the treatment plan;

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

(4) assistance to the MAP eligible recipient in his or her self-administration of medication in a manner that complies with state policies and procedures;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, provide follow-up for crisis situation and schedule follow-up appointments;

(6) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective;

(8) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(9) non-medical transportation services needed to accomplish the treatment objective;

(10) discharge planning and referrals as necessary to community programs as part of the planning.

D. Non-covered services: Outpatient and partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for all general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services with outpatient and partial hospitalization:

(1) meals;

(2) transportation by the partial hospitalization provider;

(3) activity therapies, group activities or other services which are primarily recreational or divisional in nature;

(4) programs which provide social and recreational activities to recipients who need some supervision during the day

(5) programs which are generally community support groups in non-medical settings for a SED individual for the purpose of social interaction;

(6) outpatient hospital program consisting entirely of social activities;

(7) 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 MAP eligible recipient; see 42 CFR Section 441.13(b);

(8) hypnotherapy or biofeedback; or

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

E. Treatment plan: An individualized treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge within 14 calendar days of the MAP eligible recipient's admission. The interdisciplinary team must participate in the treatment planning at least every 30 calendar days. See Subsection G of Section 9 of this rule for MAD general treatment plan requirements.

F. Prior authorization: All outpatient and partial hospitalization services furnished in a freestanding psychiatric hospital must be prior authorization (PA) from MAD or its UR contractor; see Subsection F of Section 9 this rule for MAD general prior authorization requirements.

G. Reimbursement: A provider of outpatient and partial hospitalization services must submit claims for reimbursement on the UB 04 claim form or its successor. See 8.302.2 NMAC and Subsection E of Section 9 of this rule for MAD general reimbursement requirements. Specific to outpatient and partial hospitalization services:

(1) are reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles; for those services reimbursed using the medicare allowable cost methodology, MAD reduces the medicare allowable costs by three percent; outpatient and partial hospitalization services that are not cost settled, will be reimbursed at the provider's cost-to-charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012; otherwise, rates are established after considering available cost-to-charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration; and

(2) 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.

[8.321.2.21 NMAC - Rp, 8.321.5 NMAC, 1-1-14]

8.321.2.22 OUTPATIENT BEHAVIORAL HEALTH PROFESSIONAL SERVICES:

A. Psychological, counseling and social work: These services mean diagnostic or active treatments with the intent to reasonably improve a MAP eligible recipient's physical, social, emotional and behavioral health or substance abuse condition. Services are provided to a MAP eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling and social work services are performed by licensed psychological, counseling and social work staff acting within their scope of practice (see Subsections B, H-J of Section 9 of this rule). These services include, but are not limited, to testing and evaluation that appraise cognitive, emotional and social functioning and self-concept. Therapy and treatment includes the planning, managing and providing a program of psychological services to the MAP eligible recipient with diagnosed behavioral health condition and may include consultation with his or her family and other professional staff.

B. An assessment or evaluation must be conducted at least annually or more frequently if indicated by the MAP eligible recipient's condition or applicable federal or state statute, regulation, rule or law. The assessment must be signed by the practitioner operating within his or her scope of licensure (see Subsection B of Section 9 of this rule). Based on the MAP eligible recipient's annual assessment, the MAP eligible recipient's treatment file must document the extent to which his or her treatment goals are being met and whether changes in direction or emphasis of the treatment are needed.

[8.321.2.22 NMAC - N, 1-1-14]

8.321.2.23 PSYCHOSOCIAL REHABILITATION SERVICES: To help adult MAP eligible recipient with SMI receive a range of psychosocial services, MAD pays for psychosocial rehabilitation services (PSR). The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore his or her best possible level of functioning.

A. Eligible providers:

(1) The following psychosocial rehabilitation agencies are eligible to be reimbursed for furnishing PSR to a MAP eligible recipient:

(a) an IHS facility;

(b) a CMHC licensed by DOH; or

(c) a CSA with CMHC licensure;

(2) An agency which furnishes PSR services must have direct experience in successfully serving individuals with SMI.

(3) 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 Section 9 of this rule for MAD general provider requirements. A PSR agency must have the following:

(a) its copy of DOH licenses as a CMHC if so enrolled; and

(b) a copy of its New Mexico behavioral health collaborative letter of approval as a CSA if so enrolled;

B. Coverage criteria: MAD covers only those PSR services which comply with DOH mental health standards and are medically necessary to meet the individual needs of the MAP eligible recipient, as delineated in his or her treatment plan. Medical necessity is based upon the MAP eligible recipient's level of functioning as

affected by his or her SMI. The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore the recipient to his or her best possible level of functioning.

C. Covered services: MAD covers PSR services which include a cadre of services designed to reduce symptomatology and restore basic skills necessary to function independently in the MAP eligible recipient's community. MAD covers the following PSR services detailed below for a MAP eligible recipient. These services are further defined by current procedure terminology (CPT) and healthcare common procedure coding system (HCPCS) identified for PSR.

(1) Psychosocial therapy interventions designed to address the functional limitations, deficits, and behavioral excesses through capitalizing on personal strengths and developing coping strategies and supportive environments.

(2) Community-based crisis intervention which must include:

(a) the availability of appropriate staff to respond to a crisis situation on a 24-hour a day basis;

(b) determining the severity of the crisis situation;

(c) stabilizing the MAP eligible recipient; and

(d) making referrals to appropriate agency(ies) and provider follow-up.

(3) Psychosocial clinical consultations by professionals to assess the MAP eligible recipient's status, if applicable.

(4) Therapeutic interventions designed to meet the MAP eligible recipient's clinically determined needs through scheduled structured sessions.

(5) Medication services that are goal-directed interventions such as the evaluation of the need for psychotropic medication and subsequent assessment and management of the MAP eligible recipient's pharmacologic treatment.

(6) Services must be individualized for each MAP eligible recipient and identified in his or her treatment plan.

D. MAP eligible recipients: A MAP eligible recipient is 21 years or older diagnosed with SMI and for whom the medical necessity for PSR services was determined. A resident in an institution for mental illness is not eligible for this service.

E. Non-covered services: PSR services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for all general noncovered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. Prior authorization: For PSR, reviews are retrospective.

(1) Retrospective review: An assessment, diagnostic summary formulation and a treatment plan determine the type of PSR services rendered to a MAP eligible recipient. An agency's staff determines medical necessity of services based upon the service guidelines included in the DOH manual for evidencing medical necessity. All plans are subject to retrospective review to determine whether services provided met the service guidelines.

(2) Reviews for crisis intervention: When crisis intervention services are required, the claim is subject to retrospective review in accordance with the definition and requirements of the service criteria. Reviews must be submitted to DOH.

G. Treatment plan: See Subsection G of Section 9 of this rule for MAD general treatment plan requirements. The following must be contained in the treatment plan and documents used in the development of the MAP eligible recipient's treatment plan. The treatment plan and all supporting documentation must be available for review by HSD, DOH or their agents in the MAP eligible recipient's file.

H. Reimbursement: A PSR agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC.

[8.321.2.23 NMAC - N, 1-1-14]

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

[8.321.2.24 NMAC - N, 1-1-14]

8.321.2.25 TREATMENT FOSTER CARE I: MAD pays for medically necessary services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level I (TFC I) and meets this LOC as part of the EPSDT program. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into the community. TFC I agency provides therapeutic services to a MAP eligible recipient who is experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a TFC I setting. The need for TFC I services must be identified in the tot to teen healthcheck or other diagnostic evaluation furnished through the MAP eligible recipient's healthcheck referral.

A. Eligible agencies: In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing TFC I services to a MAP eligible recipient, the agency must be certified as provider of TFC by CYFD. A MAP eligible recipient has the right to receive services from any MAD TFC enrolled agency of his or her choice.

B. Covered services: The family living experience is the core treatment service to which other individualized services can be added, as appropriate to meet the MAP eligible recipient's needs.

(1) A TFC I parent is either employed or contracted by the TFC I agency and receives appropriate training and supervision by the TFC I agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when the MAP eligible recipient is normally at home, and is able to be physically present to meet the MAP eligible recipient's emotional and behavioral needs. The treatment foster parent responsibilities include, but are not limited to:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in the MAP eligible recipient's treatment plan;

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

(d) assisting the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals;

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan; and

(g) work with all appropriate and available community-based resources to secure services for and to advocate for the MAP eligible recipient.

(2) The following services must be furnished by the TFC I agency. Payment for performance of these services is included in the TFC I agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC I foster parents initial and ongoing training;

(b) providing support, assistance and training to the TFC I foster parents;

(c) assessment, pre placement and placement to determine the MAP eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC I and assessment of family interactions and stress;

(e) treatment planning as defined Subsection G of Section 9 of this rule and treatment team meetings;

(f) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group setting for the MAP eligible recipient;

(g) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the MAP eligible recipient;

(h) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations;

(i) when a MAP eligible recipient's return to his or her family is planned, assessment of the family's strengths, needs and the development of a family service plan.

(j) for TFC I, the treatment coordinator must conduct a private face to face visit with the MAP eligible recipient within the first two weeks of placement and at least twice monthly thereafter;

(k) for TFC I, the treatment coordinator has a face to face interview with the MAP eligible recipient's treatment foster parents within the first two weeks of placement and at least twice monthly thereafter;

(l) for TFC I, the treatment coordinator must have a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week as the face to face contact.

C. Non-covered service: TFC I services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for all noncovered MAD behavioral health services or activities. Specific to TFC I services MAD does not cover:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS except when planning a discharge from the MAP eligible recipient's TFC I placement.

D. Prior authorization: Before any TFC I service is furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. Treatment plan: The treatment plan must be developed by MAP eligible recipient's treatment team in consultation with the MAP eligible recipient, family or legal guardian, primary care provider, if applicable, and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC I program.

(1) The treatment team must review the treatment plan every 30 calendar days.

(2) In addition to the requirements of Subsection G of Section 9 of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) substance abuse assessment;

(ii) educational assessment; and

(iii) vocational assessment;

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and TFC I foster parent responsibilities and the description and frequency of the following components: (i) proposed staff involvement, (ii) orders for medication, (iii) treatments, restorative and rehabilitative services, (iv) activities, therapies, social services, (v) special diet, and (vi) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for his or her release to less restrictive settings for treatment, including TFC II.

F. Reimbursement: A TFC I agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.25 NMAC - Rp, 8.322.2 NMAC, 1-1-14]

8.321.2.26 TREATMENT FOSTER CARE II: MAD pays for behavioral health services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level II (TFC II) and meets this LOC as part of the EPSDT. The therapeutic family living experience is the core treatment service to which other individualized services can be added. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into his or her community. The need for TFC II services must be identified in the MAP eligible recipient's tot to teen health check or other diagnostic evaluation furnished through a health check referral.

A. Eligible agencies: In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing TFC II services to a MAP eligible recipient, the agency must be certified as provider of TFC by CYFD. A MAP eligible recipient has the right to receive services from any MAD enrolled TFC agency of his or her choice.

B. Covered services: All services covered in TFC I are required in TFC II. TFC II allows for a step down from TFC I when the MAP eligible recipient's symptoms improve and allow for less intensive supervision by the family, age appropriate activities are allowed with some degree of independence or gains have been met in TFC I; however, continued monitoring is required to maintain these achievements as identified in the treatment plan. TFC II also allows for entry into this LOC for those MAP eligible recipients who would benefit optimally from a treatment foster care placement but who do not have the severity of symptoms and behaviors as required for TFC I.

(1) A TFC II parent is either employed or contracted by the TFC II agency and receives appropriate training and supervision by the TFC II agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when the MAP eligible recipient is normally at home, and is able to be physically present to meet the MAP eligible recipient's emotional and behavioral needs. The treatment foster parent responsibilities include:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in the MAP eligible recipient's treatment plan;

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

(d) assisting the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals;

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan; and

(g) work with all appropriate and available community-based resources to secure services for and to advocate for the MAP eligible recipient.

(2) The following services must be furnished by the TFC II agency. Payment for performance of these services is included in the TFC II agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC II foster parents initial and ongoing training;

(b) providing support, assistance and training to the TFC II foster parents;

(c) assessment, pre placement and placement to determine the MAP eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC II and assessment of family interactions and stress;

(e) treatment planning as defined Subsection G of Section 9 of this rule and treatment team meetings;

(f) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group setting for the MAP eligible recipient;

(g) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the MAP eligible recipient;

(h) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations; and

(i) when a MAP eligible recipient's return to his or her family is planned, assessment of the family's strengths, needs and the development of a family service plan.

(j) for TFC II, the treatment coordinator must conduct a private face to face visit with the MAP eligible recipient within the first two weeks of placement and at least once monthly thereafter;

(k) for TFC I, the treatment coordinator has a face to face interview with the MAP eligible recipient's treatment foster parents within the first two weeks of placement and at least once monthly thereafter;

(l) for TFC II, the treatment coordinator must have a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week as the face to face contact.

C. Non-covered service: TFC II services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with TFC II services to a MAP eligible recipient:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS, except when planning discharge from the TFC II placement.

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

E. Treatment plan: The treatment plan must be developed by treatment team in consultation with the MAP eligible recipient, his or her family or legal guardian, primary care provider, if applicable, and others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC II program. The treatment plan must meet all requirements found in Subsection G of Section 9 of this rule.

(1) The treatment coordinator must review the treatment plan every 30 calendar days;

(2) In addition to the requirements of Subsection G of Section 9 of this rule, the following must be contained in the treatment plan and documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) a statement of the nature of the specific problem and the specific needs and strengths of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

- **(i)** mental status assessment;
- **(ii)** intellectual function assessment;
- **(iii)** psychological assessment;
- **(iv)** educational assessment;
- **(v)** vocational assessment;
- **(vi)** social assessment;
- **(vii)** medication assessment; and
- **(viii)** physical assessment.

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of intermediate and long-range goals with the projected timetable for their attainment;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and TFC II foster parent responsibilities and the description and frequency of the following components: (i) proposed staff involvement, (ii) orders for medication, (iii) treatments, restorative and rehabilitative services, (iv) activities, therapies, social services, (v) special diet, and (vi) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge and projected date of discharge of the MAP eligible recipient.

F. Reimbursement: A TFC II agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.26 NMAC - Rp, 8.322.5 NMAC, 1-1-14]

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ISD 310.1700, EPSDT Services, filed 6-25-80.
ISD Rule 310.1700, EPSDT Services, filed 10-22-84.
MAD Rule 310.17, EPSDT Services, filed 5-1-92.
MAD Rule 310.17, EPSDT Services, filed 7-14-93.
MAD Rule 310.17, EPSDT Services, filed 11-12-93.
MAD Rule 310.17, EPSDT Services, filed 12-17-93.
MAD Rule 310.17, EPSDT Services, filed 3-14-94.
MAD Rule 310.17, EPSDT Services, filed 6-15-94.
MAD Rule 310.17, EPSDT Services, filed 11-30-94.

History of Repealed Material:

MAC Rule 310.17, EPSDT Services, filed 11-30-94 - Repealed effective 2-1-95.
8.321.2 NMAC, Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals, filed 10-8-10 - Repealed effective 1-1-14.
8.321.3 NMAC, Accredited Residential Treatment Center Services, filed 2-17-12 - Repeal effective 1-1-14.
8.321.4 NMAC, Non- Accredited Residential Treatment Center Services, filed 2-17-02 - Repeal effective 1-1-14
8.321.5 NMAC, Outpatients and Partial Hospitalization Services in Freestanding Psychiatric Hospitals, filed 1-5-12 - Repealed effective 1-1-14.
8.322.2 NMAC, Treatment Foster Care, filed 2-17-12 - Repealed effective 1-1-14.
8.322.3 NMAC, Behavioral Management Skills Development Services, filed 10-12-05 - Repealed effective 1-1-14.
8.322.4 NMAC, Day Treatment, filed 10-12-05 - Repealed effective 1-1-14.
8.322.5 NMAC, Treatment Foster Care II, filed 2-17-12 - Repealed effective 1-1-14.
8.322.6 NMAC, Multi-Systemic Therapy, filed 11-16-07 - Repealed effective 1-1-14.