2024-2025 Presbyterian Turquoise Care Behavioral Health Medical Necessity Criteria

PPC112209

Table of Contents

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I. Introduction

Presbyterian Health Plan, Inc. (Presbyterian), in collaboration with Magellan Healthcare (Magellan), developed the following Turquoise Care behavioral health medical necessity criteria. Based on the defined and approved criteria developed by the New Mexico Behavioral Health Service Division (BHSD) and scientific evidence for recognized settings of behavioral health services, the following criteria are used to decide the medical necessity and clinical appropriateness of services. Presbyterian reviews the following criteria annually to ensure it remains current.

II. Medical Necessity Definition

A. According to 8.302.1.7 NMAC, medically necessary services are defined as clinical and rehabilitative physical or behavioral health services that are:

1. Essential to prevent, diagnose or treat medical conditions, or they are essential to enable an eligible member to attain, maintain or regain functional capacity.
2. Delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral healthcare needs of the eligible member.
3. Provided within professionally accepted standards of practice and national guidelines.
4. Required to meet the physical and behavioral health needs of the eligible member and are not primarily for the convenience of the eligible member, the provider or the payer.

B. Application of Definition

1. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit. When appropriate, these determinations are made by the Medical Assistance Division (MAD) or its designee.

2. The MAD, or its authorized designee, determines the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible member by considering and evaluating the following:

    a. The eligible member's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible member within their scope of practice, taken into consideration the eligible member's clinical history, including the impact of previous treatment and service interventions, and consulted with other qualified healthcare professionals with applicable specialty training, as appropriate.

    b. The views and choices of the eligible member or their personal representative regarding the proposed covered service as provided by the provider or through independent verification of those views.

    c. Considering the services being provided concurrently by other service delivery systems.

3. Physical and behavioral health services shall not be denied solely because the eligible member has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of the diagnosis, type of illness or condition.

C. Decisions regarding MAD benefit coverage for eligible members under 21 years of age shall be governed by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program coverage rules.

D. Medically necessary service requirements apply to all medical assistance program rules.

III. Quality of Service Criteria

The following criteria are common to all levels of care for behavioral health conditions and substance use disorders, and they will be used along with criteria for specific levels of care.

1. The member is eligible for benefits.

2. The provider completes a thorough initial evaluation, including current assessment information.

3. The member's condition and proposed services are covered under the terms of the benefit plan.

4. The member's current condition can be most efficiently and effectively treated in the proposed level of care.

5. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
6. There must be a reasonable expectation that essential and appropriate services will improve the member's presenting problems within a reasonable period of time. "Improvement" in this context is measured by weighing the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the current level of care. Improvement must also be understood within the framework of the member's broader recovery goals.
7. The goal of treatment is to improve the member's presenting symptoms to the point that treatment in the current level of care is no longer required.
8. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.
9. The member has provided informed consent to treatment. Informed consent includes the following:
    a. The member has been informed of safe and effective alternatives.
    b. The member understands the potential risks and benefits of treatment.
    c. The member is willing and able to follow the treatment plan including the safety precautions for treatment.
10. The treatment/service plan stems from the member's presenting condition and clearly documents realistic and measurable treatment goals as well as the treatments that will be used to achieve the treatment goals. The treatment/service plan also considers the following:
    a. Use of treatments that are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
    b. Significant variables, such as the member's:
        i. Age and level of development
        ii. Preferences, strengths, broader recovery goals and readiness for change
        iii. Risks, including barriers to care

iv. Past response to treatment

v. Understanding of their condition, its treatment and self-care

vi. Family/social support in treatment with the member's permission

c. Interventions needed to address co-occurring behavioral health or medical conditions.

d. Interventions that promote the member's participation in care, promote informed decision making, and support the member's broader recovery goals.

i. Examples of such interventions are psycho-education, motivational interviewing, recovery planning, use of an advance directive, and the involvement of natural and cultural supports, such as self-help and/or peer support programs.

e. Involvement of the member's family/social supports in treatment and discharge planning, with the member's permission, when such involvement is clinically indicated.

f. How treatment will be coordinated with other behavioral health and medical providers, the school system, legal system and community agencies with the member's permission.

g. How the treatment plan will be altered as the member's condition changes, or when the response to treatment isn't as anticipated.

11. The discharge plan stems from the member's response to treatment and considers the following:

a. Significant variables, including the member's:

i. Preferences, strengths, broader recovery goals and readiness for change

ii. Risks, including barriers to care

iii. Past response to discharge

iv. Understanding of their condition, its treatment and self-care

v. Family/social support in treatment with the member's permission

b. The availability of a lower level of care which can effectively and safely treat the member's current clinical condition.

c. The availability of treatments that are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.

d. Involvement of the member's family/social supports in discharge planning, with the member's permission, when such involvement is clinically indicated.

e. How discharge will be coordinated with the provider of post-discharge behavioral health care, medical providers, the school system, legal system and community agencies with the member's permission.

12. How the risk of relapse will be mitigated, including:

a. Completing an accurate assessment of the member's current level of function and ability to follow through on the agreed upon discharge plan.

b. Confirming that the member has engaged in shared decision-making about the discharge plan and understands and agrees with the discharge plan.

c. Scheduling a first appointment within seven days of discharge when care at a lower level is planned.

d. Assisting the member with overcoming barriers to care (e.g., a lack of transportation or child care challenges).

e. Ensuring that the member has an adequate supply of medication to bridge the time between discharge and the first scheduled follow-up psychiatric assessment.

f. Providing psychoeducation and motivational interviewing, assisting with recovery planning and use of an advance directive, and facilitating involvement with self-help and peer programs.

g. Confirming that the member understands what to do if there is a crisis prior to the first post-discharge appointment, or if the member needs to resume services.

13. The availability of resources, natural and cultural supports, such as self-help and peer support programs, and peer-run services, which may augment treatment, facilitate the member's transition from the current level of care and support the member's broader recovery goals.

IV. Services Requiring Prior Authorization

A. Acute Inpatient Psychiatric Hospitalization

Definition of Service:

Acute inpatient psychiatric hospitalization is a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for stabilization of urgent or emergent behavioral health problems.

Acute inpatient psychiatric hospitalization is provided specifically for members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services and is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital. The care must be provided under the direction of an attending physician who performs a face-to-face interview with the member within 24 hours of admission. The care involves an individualized treatment plan that is reviewed and revised frequently based on the member's clinical status.

This level of care will not be authorized solely as a substitute for management within the adult corrections, juvenile justice or protective services systems, as an alternative to specialized schooling that should be provided by the local school system, or simply to serve as respite or housing.

This level of care is available for all age ranges, but admission should be to a unit that is age appropriate. For school-aged children and youth, it is expected that academic schooling is funded through the local school system or by the facility.

For more detailed information, please reference NMAC 8.321.2.16.

Acute Inpatient Psychiatric Hospitalization	
Admission Criteria	Must meet A and B plus C or D, E, F, or G: A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the member has been diagnosed with a condition identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that requires, and is likely to benefit from, the proposed therapeutic intervention. B. Treatment cannot safely be administered in a less restrictive level of care. C. There is an indication of actual or potential imminent danger to self that cannot be controlled outside of a 24-hour treatment setting. Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.

Acute Inpatient Psychiatric Hospitalization	
	D. There is an indication of actual or potential imminent danger to others and the impulses to harm others cannot be controlled outside of a 24-hour treatment setting. An example of an indication includes a current threat and means to kill or injure someone. E. There is an indication of actual or potential grave passive neglect that cannot be treated outside of an acute 24-hour treatment setting. F. There is disordered or bizarre thinking, psychomotor agitation or retardation and/or a loss of impulse control or impairment in judgment that leads to behaviors that place the member or others in imminent danger. These behaviors cannot be controlled outside of a 24-hour treatment setting. G. There is a co-existing medical illness that complicates the psychiatric illness or treatment. Together, the illnesses or treatment pose a high risk of harm for the member and cannot be managed outside of a 24-hour treatment setting.
Continued Stay Criteria	Must meet all the following: A. The member continues to meet admission criteria, including the need for 24- hour medical supervision. B. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required inpatient treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities. C. The member is making meaningful and measurable progress at the current level of care and/or the current or revised treatment plan can be reasonably expected to bring about significant improvements in the behaviors and/or symptoms leading to admission. Progress is documented toward treatment goals. D. An individualized discharge plan has been developed and includes specific time-limited, realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
Discharge Criteria	Must meet all the following: A. The member has met their individualized discharge criteria. B. The member can be safely treated at a less intensive level of care. C. An individualized discharge plan has been developed. The first after-care appointment has been scheduled by the facility within a time frame commensurate with the member's needs, but no later than seven days from discharge.
Exclusionary Criteria	Must meet one of the following: A. The condition of primary clinical concern is one of a medical nature (not behavioral health) and, as outlined in the current Mixed Services Protocol, should be covered by another managed care entity. B. The member appears to have been presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or inappropriate seeking of medications.

B. Days Awaiting Placement (DAP) Rate

Definition of Service:

Days Awaiting Placement (DAP) for an inpatient setting is a negotiated rate used when a Medicaid-eligible member no longer meets acute care criteria and it is verified that the eligible member requires a residential level of care that may not be immediately located. Those days during which the eligible member is awaiting placement to the lower level of care are termed “awaiting placement days.” These circumstances must be beyond the control of the inpatient provider.

Important: DAP is intended to be brief and to support transition to the lower level of care. DAP may not be used solely because the inpatient provider did not pursue or implement a discharge plan in a timely manner.

For more detailed information, please reference NMAC 8.321.2.16.

Waiting Placement Days (DAP)	
Approval Criteria	Must meet all the following: A. The member is covered by Medicaid as administered by the Medical Assistance Division definition and the member has a DSM-diagnosed condition that has required an acute inpatient psychiatric level of care currently. B. The member no longer meets continued stay criteria for inpatient acute psychiatric care and/or does meet discharge criteria, and there is a specific discharge plan in place to a residential level of care but documented barriers to implementation of that plan exist that are beyond the control of the provider or facility. C. The provider has made reasonable efforts to identify and obtain the services needed to implement the discharge plan and continues to actively work to identify resources to implement that plan. D. Presbyterian has authorized the residential level of care sought as the discharge and documentation of this authorization has been made available to Presbyterian’s Utilization Management team.
Exclusionary Criteria	Must meet one of the following: A. The member has met their individualized discharge criteria and substantial barriers to discharge no longer exist. B. The inpatient facility cannot demonstrate that it continues to actively work to eliminate barriers to the planned discharge. C. The inpatient facility is pursuing a discharge to a level of care or service that a Presbyterian network psychiatrist peer reviewer has explicitly stated does not appear to meet admission criteria at this time.

C. 23-Hour Observation Stay

This is not a level of care that requires prior authorization but is a level of care that is separate and distinct from psychiatric inpatient level of care.

Definition of Service:

A 23-hour observation stay occurs in a secure, medically staffed and psychiatrically supervised facility. This level of care, like acute inpatient hospitalization, involves the highest level of skilled psychiatric services. This service can be rendered in a psychiatric unit of a general hospital or in the emergency department of a licensed hospital. The care must be provided under the direction of an attending physician who has performed a face-to-face evaluation of the member. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services.

A 23-Hour Observation Stay provides an opportunity to evaluate members whose needed level of care is not readily apparent. In addition, it may be used to stabilize a member in crisis when it is anticipated that the member's symptoms will resolve in less than 24 hours. This level of care is available for all ages ranges and may be considered when support systems and/or a previously developed crisis plan have not sufficiently succeeded in stabilizing the member and the likelihood for further deterioration is high.

If a provider orders an eligible member to remain in the hospital for less than 24 hours, then the stay is not covered as inpatient admission and is classified as an observation stay, which is considered an outpatient service.

The following are exemptions to the general observation stay definition:

- The eligible member dies
- Documentation in medical records indicates that the eligible member left against medical advice or was removed from the facility by his legal guardian against medical advice
- An eligible member is transferred to another facility to obtain necessary medical care unavailable at the transferring facility
- An inpatient admission results in delivery of a child

Please also note that if an admission is considered an observation stay, then the admitting hospital is notified that the services are not covered as an inpatient admission. A hospital must bill these services as outpatient observation services.

Outpatient observation services must be medically necessary and must not involve premature discharge of an eligible member in an unstable medical condition. The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. The observation stay review does not replace the review of one- and two-day stays for medical necessity.

Important: Medically unnecessary admissions, regardless of length-of-stay, are not covered benefits.

23-Hour Observation Stay	
Admission Criteria	Must meet and B plus C, D or E: A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the member has a DSM- diagnosed condition that requires, and is likely to benefit from, therapeutic intervention in less than 24 hours in a secure setting. B. The member cannot be evaluated in a less restrictive level of care. C. The member is expressing suicidal ideation or is expressing threats of harm to others that must be evaluated on a continuous basis for severity and lethality. D. The member has acted in disruptive, dangerous or bizarre ways that require further immediate observation and assessment. An evaluation of the etiology of such behaviors is needed, especially if suspected to be chemically or organically induced. E. The member presents with significant disturbances of emotions or thought processes that interfere with their judgment or behavior and could seriously endanger the member or others if not evaluated and stabilized on an emergency basis.
Discharge Criteria	Must meet both the following: A. The member no longer meets admission criteria. B. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.
Exclusionary Criteria	Must meet one of the following: A. The member meets admission criteria for acute inpatient hospitalization. B. The member appears to have been presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or inappropriate seeking of medications.

D. Accredited Residential Treatment

Definition of Service:

Accredited residential treatment center services (ARTC) is a service provided to members under the age of 21 who, because of the severity or complexity of their behavioral health needs as a result of a recognized psychiatric disorder(s), are a significant danger to themselves or others. ARTC facilities must be licensed by the New Mexico Department of Children Youth & Families Licensing and Credentialing Authority (or similar body when located in other states). The need for ARTC services must be identified in the Tot-to-Teen Health Check or other

diagnostic evaluation furnished through a health check referral, and the member must meet medical necessity criteria as part of EPSDT program services (42 CFR Section 441.57).

ARTC services are provided in a 24/7 facility that is accredited by the Joint Commission (www.jointcommission.org/). Facilities provide all diagnostic and therapeutic services. ARTC units are always medically staffed with direct psychiatric services provided several days a week and with psychiatric consultation available within 24 hours. Services are provided under the direction of an attending psychiatrist, and the treatment plan is reviewed frequently and updated based on a member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated.

Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, then alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

Important: This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems as an alternative to specialized schooling, which should be provided by the local school system, or simply to serve as respite or housing. It is expected that the local school system or facility will fund the academic schooling.

For more detailed information, please reference NMAC 8.321.2.11.

Accredited Residential Treatment	
Admission Criteria	Must meet all the following: A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention. B. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the member or others is substantially at risk. These problems require a supervised, structured and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the member is not treated at this level of care. C. Less restrictive or intensive levels of treatment would be inadequate to meet the member's needs. Documentation exists to support these contentions.
Continued Stay Criteria	Must meet all the following: A. The member continues to meet admission criteria including the need for 24-hour staff supervision.

Accredited Residential Treatment	
	B. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals. C. The treatment and therapeutic goals are objective, measurable and time-limited to address the alleviation of psychiatric symptoms and precipitating psychosocial stressors. D. An individualized discharge plan has been developed/updated and includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met. E. The member is actively participating in treatment and is motivated and engaged. F. The member's parent(s), guardian or custodian is participating in the treatment and discharge planning. If parent(s), guardian(s) or custodian are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning. G. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited and achievable.
Discharge Criteria	Must meet all the following: A. The member has met their individualized discharge criteria. B. The member can be safely treated at a less intensive/restrictive level of care. C. An individualized discharge plan with referral to appropriate, realistic and timely follow-up care is in place.
Exclusionary Criteria	Must meet one of the following: A. There is documented evidence that the ARTC placement is intended as an alternative to incarceration or community corrections involvement and medical necessity has not been met. B. There is evidence that the ARTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued ARTC care. C. The member demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin. D. Quality of Service criterion No. 5 and/or No. 8 are not met.

E. Sub-Acute Residential Treatment Center Services

Sub-acute residential treatment center services are not considered value-added services and are only available to providers contracted specifically to provide these services.

Definition of Service:

Sub-acute residential treatment is provided to members under the age of 21 who, because of the severity or complexity of their behavioral health needs, require services beyond the scope of the usual residential treatment center (RTC) services milieu or other out-of-home or community-based treatment services. These are members who, as a result of a recognized psychiatric disorder(s), are a significant danger to themselves or others, but not so acute as to need inpatient hospitalization. Sub-acute RTC facilities must be licensed by the New Mexico Department of Children Youth & Families Licensing and Credentialing Authority (or similar body when located in other states). The need for RTC services must be identified in the Tot-to-Teen Health Check or other diagnostic evaluation furnished through a health check referral and the member must meet medical necessity criteria as part of EPSDT program services (42 CFR Section 441.57).

Sub-acute RTC services are provided in a 24/7 facility that is accredited by the Joint Commission (www.jointcommission.org/). Facilities provide all the diagnostic and therapeutic services provided by an RTC, but with a higher staff-to-client ratio. Sub-acute RTC units are always medically staffed with direct psychiatric services provided several days a week and with psychiatric consultations available within 24 hours. Services are provided under the direction of an attending psychiatrist, and the treatment plan is reviewed frequently and updated based on the member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated.

Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, then alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

Important: This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems as an alternative to specialized schooling, which should be provided by the local school system, or simply to serve as respite or housing. It is expected that the local school system or facility will fund the academic schooling.

For more detailed information, please reference NMAC 8.321.2.11.

Sub-Acute Residential Treatment Center Services	
Admission Criteria	Must meet all the following: A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention. B. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the member or others is substantially at risk. These problems require a supervised, structured and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to

Sub-Acute Residential Treatment Center Services	
	experience a deterioration of their condition to the point that inpatient hospitalization may be required if the member is not treated at this level of care. C. Less restrictive or intensive levels of treatment would be inadequate to meet the member's needs. Documentation exists to support these contentions.
Continued Stay Criteria	Must meet all the following: A. The member continues to meet admission criteria, including 24-hour staff supervision. B. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required sub-acute RTC treatment has been developed, implemented and updated, with the member's or guardian's participation whenever possible. The treatment plan includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited. C. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals. D. An individualized discharge plan has been developed/updated and includes specific realistic, objective and measurable discharge criteria with plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met. E. The member is participating in treatment or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment. F. The member's parent(s), guardian or custodian is participating in the treatment and discharge planning, or persistent efforts are being made and documented to involve them unless it is clinically contraindicated.
Discharge Criteria	Must meet A or B plus C and D: A. The member has met their individualized discharge criteria. B. The member has not benefited from sub-acute RTC services despite documented persistent efforts to engage the member. C. The member can be safely treated at a less intensive/restrictive level of care. D. An individualized discharge plan with referral to appropriate, realistic and timely follow-up care is in place.
Exclusionary Criteria	Must meet one of the following: A. There is documented evidence that the sub-acute RTC placement is intended as an alternative to incarceration or community corrections involvement and medical necessity has not been met. There is evidence that the sub-acute RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued sub-acute RTC care. B. The member demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

Sub-Acute Residential Treatment Center Services	
	C. Quality of Service criterion No. 5: The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made. D. Quality of Service criterion No. 8: Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

F. Non-Accredited Residential Treatment Centers

Definition of Service:

Non-accredited RTC services are provided to members under the age of 21 years who require 24-hour treatment and supervision in a safe therapeutic environment.

For more detailed information, please refer to NMAC 8.321.2.20.

Non-Accredited Residential Treatment Centers	
Admission Criteria	Must meet all the following: A. Medical necessity has been demonstrated according to NMAC 8.305.1 and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention. B. The member is experiencing emotional or behavioral problems in the home, community and/or treatment setting to such an extent that the safety or well-being of the member or others is at risk. These problems require a supervised, structured and 24-hour continuous therapeutic milieu in a residential setting. C. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of their condition to the point that a more restrictive treatment setting may be required if the member is not treated at this level of care at this time. D. Less restrictive or intensive levels of treatment would be inadequate to meet the member's needs. Documentation exists to support these contentions.
Continued Stay Criteria	Must meet all the following:

Non-Accredited Residential Treatment Centers	
	A. The member continues to meet admission criteria including the need for 24-hour staff supervision. B. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required residential treatment has been developed, implemented and updated, with the member's or guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited. C. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals. D. An individualized discharge plan has been developed and includes specific, realistic, objective and measurable discharge criteria with plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met or other barriers to discharge exist that the provider has made reasonable efforts to mitigate. E. The member is actively participating in treatment and is motivated and engaged in active efforts to lead to the member's discharge plan. F. The member's parent(s), guardian or custodian is participating in treatment and discharge planning. If parent(s), guardian or custodian care are not involved, then alternative natural supports need to be identified to engage in treatment and discharge planning. Criteria for this includes weekly involvement in family therapy, treatment planning and discharge planning. G. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited and achievable.
Discharge Criteria	Must meet A or B plus C and D: A. The member has met their individualized discharge criteria. B. The member has not realized substantial benefit from RTC services despite documented persistent efforts to engage the member. C. The member can be safely treated at a less intensive/restrictive level of care. D. An individualized discharge plan with referral to appropriate, realistic and timely follow-up care is in place.
Exclusionary Criteria	Must meet one of the following: A. There is evidence that the RTC placement is intended as an alternative to incarceration or community corrections involvement and medical necessity has not been met. B. There is evidence that the RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued RTC care. C. The member demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin. D. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.

Non-Accredited Residential Treatment Centers	
	E. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

G. Treatment Foster Care I and II

Definition of Service:

Treatment Foster Care (TFC) is a behavioral health service provided to members under 21 years of age who are placed in a 24-hour community-based, supervised and trained surrogate family through a TFC placement agency licensed by the New Mexico Department of Children Youth & Families Licensing and Credentialing Authority.

For more details, please refer to NMAC 8.321.2.25 and NMAC 8.321.2.26.

Treatment Foster Care I and II	
Admission Criteria for TFC I and II (caveats are noted)	Must meet A, B and E plus C or D for TFC I and II: A. Medical necessity has been demonstrated according to NMAC 8.305.1, and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic interventions implemented in a TFC/family living experience treatment setting. B. The member's current (within 30 days of proposed admission) medical and psychiatric symptoms require and can be managed safely in a 24-hour supervised community/home-based setting. C. The member is immediately at risk for needing a higher level of services and/or being excluded from community, home or school activities due to clinically significant disruptive symptoms or behaviors. These symptoms or behaviors are not amenable to treatment in the member's own home or a standard foster care environment. D. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of their condition to the point that a more restrictive treatment setting may be required if the member is not treated at this level of care at this time. E. Less restrictive or intensive levels of treatment would be inadequate to meet the member's needs. Documentation exists to support these contentions. **For TFC I only**, below is an additional admission criterion that must be met: F. The member is unable to participate independently (without 24-hour adult supervision) in age-appropriate activities. **For TFC II Only**, below is an additional admission criterion that must be met: G. The member has met the treatment goals of TFC I or is able to participate independently in age-appropriate activities without 24-hour adult supervision. Additionally, to be appropriate for TFC II, the member's treatment needs or social, behavioral, emotional or

Treatment Foster Care I and II	
	functional impairments are not as serious or severe as those exhibited by members who meet criteria for TFC I; therefore, services are less clinically intensive than those provided in TFC I. **Note**: Members in TFC II can generally participate independently in age-appropriate activities (e.g. dressing themselves at age 7, working at age 16 and attending school without parental classroom supervision), while members in TFC I could require supervision for those activities. TFC II is often, but not always, used as a transition from TFC I. Some members may be admitted directly to TFC II. Conversely, not all members in TFC I need to go to TFC II before discharge from TFC.
Continued Stay Criteria	Must meet all the following: A. The member continues to meet all relevant admission criteria. B. The member continues to need 24-hour adult supervision and/or assistance to develop, restore or maintain skills and behaviors that are necessary to live safely in their own home and community. C. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required TFC treatment has been developed, implemented and updated according to licensing rules, with the member's and/or legal guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited. D. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals. E. An individualized discharge plan has been developed (and updated since the last clinical review/approval) and includes specific realistic, objective and measurable discharge criteria with plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met. F. The member is participating in treatment or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment. G. The parent, legal guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.
Criteria for Transition from TFC I to TFC II	Must meet all the following: A. A review of the individualized treatment and permanency plan shows that the member has met a significant portion of all TFC I treatment goals. B. Continued stay in a TFC setting is necessary to maintain the gains made in TFC I, but member does not require the intensity of supervision associated with TFC I. C. The member can participate independently in age-appropriate activities without continuous adult supervision.
Discharge Criteria	Must meet A or B plus C and D: A. The member has met their individualized discharge criteria. B. The member has not benefited from TFC despite documented persistent efforts to engage the member. C. The member can be safely treated at a less intensive level of care.

Treatment Foster Care I and II	
	D. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.
Exclusionary Criteria for TFC I and II	Must meet one of the following: A. There is evidence that the TFC placement is intended as an alternative to incarceration or community corrections involvement and medical necessity has not been met. B. There is evidence that the TFC treatment episode is intended to defer or prolong a permanency plan determination or is substituting for permanent housing. C. The member demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

H. Group Home

Definition of Service:

Group home is a lower level of care than RTC services and is indicated when a structured home-based living situation is unavailable or not clinically appropriate for the member's behavioral health needs and the member needs services focused on psychosocial skills development. Group home services also differ from TFC services in that they are residential and group-based, rather than family and community-based.

Group Home	
Admission Criteria	Must meet A, B and C plus D or E: A. Medical necessity has been demonstrated according to NMAC 8.305.1 and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention. B. The member may manifest significant psychological or behavioral disturbances but can participate in age-appropriate community-based activities (including school) with assistance from group home staff or with other support. C. Less restrictive or intensive levels of treatment would be inadequate to meet the member's needs. Documentation exists to support these contentions. D. A structured home-based living situation is unavailable or is not appropriate for the member's needs. E. The member needs 24-hour therapeutic milieu but does not require the intensive staff assistance
Continued Stay Criteria	Must meet all the following: A. The member continues to meet admission criteria. B. The member continues to need 24-hour supervision and assistance to develop or restore skills and behaviors that are necessary to live safely in the home and community. C. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required group home treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible,

Group Home	
	and includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited. D. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals. E. An individualized discharge plan has been developed and includes specific realistic, objective and measurable discharge criteria with plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met. F. The member is participating in treatment or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment. G. The parent, guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.
Discharge Criteria	Must meet A or B plus C and D: A. The member has met their individualized discharge criteria. B. The member has not benefited from group home services despite documented persistent efforts to engage the member. C. The member can be safely treated at a less intensive level of care D. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.
Exclusionary Criteria	Must meet one of the following: A. There is evidence that the group home placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity has not been met. B. There is evidence that the group home treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued group home care. C. The member demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

I. Applied Behavioral Analysis (ABA) – Stage 3 and Specialty Care Providers

Definition of Service:

ABA services are provided to members ages12 months to 21 years old who are eligible for Medical Assistance Programs (MAP). A member's eligibility for ABA service falls into one of two categories: "At Risk for Autism Spectrum Disorder (ASD)" or "Diagnosed with ASD." An eligible member must meet the level of care criteria detailed below, which includes medically necessary criteria and the requirements that have been detailed in the Medical Assistance Program Manual Supplement 16-08.

For more detailed information, please reference NMAC 8.321.2.

Applied Behavioral Analysis (ABA) – Stage 3 and Specialty Care Providers	
Admission Criteria	Must meet A-G: A. Services are determined to be medically necessary per NMAC 8.302.1.7. and the Medical Assistance Program Manual Supplement 16-08. B. The eligible member cannot adequately participate in home, school or community activities because the presence of behavioral excesses (i.e., socially significant behaviors) and/or the absence of functional skills interfere with meaningful participation in these activities. C. The eligible member presents a safety risk to self or others **Note**: The presence of safety risk to self or others does not need to meet the threshold criteria for out-of-home placement. D. There is a reasonable expectation that ABA services will result in measurable improvement in the acquisition of functional, adaptive skills, and/or the reduction of non-functional and maladaptive behavior. E. The eligible member's caregivers can participate and commit meaningfully to ABA interventions and activities to be conducted outside the formal treatment environment. F. The eligible member follows the prescribed three-stage comprehensive approach to evaluation, assessment and treatment as outlined in the MAD ABA Billing Instructions and the Medical Assistance Program Manual Supplement 16-08. G. The eligible member meets one of the following two categories: 1. **At-Risk for ASD**: Eligible members may be considered at-risk for ASD and eligible for time-limited, focused ABA services if they do not meet full criteria for ASD per the latest version of the DSM or the International Classification of Diseases (ICD), and when they meet all of the following criteria: a. Are between 12 and 36 months of age. b. Present with developmental differences and/or delays as measured by standardized assessment. c. Demonstrate some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior). d. Present with at least one genetic risk factor (e.g., the eligible member has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD, or the eligible member has a diagnosis of Fragile X syndrome, etc.). 2. **Diagnosed with ASD**: An eligible member age 12 months to 21 years old, who has a medical diagnosis of ASD according to the latest DSM or ICD criteria, is eligible for ABA services if the evaluation leading up to a diagnosis of ASD meets service requirements as stated in NMAC 8.321.2 (10.C) Covered services - stage 1 and the Medical Assistance Program Manual Supplement 16-08.

Applied Behavioral Analysis (ABA) – Stage 3 and Specialty Care Providers	
	a. When a member has been diagnosed with ASD within the last 12 months by an in-state or out-of-state provider who meets Stage 1 provider requirements, an ICD may be developed.
Continued Eligibility Criteria	Must meet A-C or Both A and D: A. The eligible member continues to meet ABA admission criteria. B. There is evidence the child, family and social supports can continue to participate effectively in this service. C. The eligible member responds positively to ABA services, as evidenced by quantitative data submitted by the ABA provider (AP) when requesting prior authorization for continuation of ABA services. D. When the eligible member does not respond positively to ABA services, as evidenced by quantitative data and clinical information submitted by the AP when requesting prior authorization for continuation of ABA services, then the treatment plan and the treatment plan report (i.e., graphs, peer review, etc.) must be updated to reflect what interventions will be changed to produce measurable gains.
Discharge Criteria	Must meet one of the following: A. The eligible member has met their individualized discharge criteria. B. The eligible member has reached the defining age limit as specified for At-Risk for ASD eligibility, which is up to 3 years of age, or for Diagnosed with ASD eligibility, which is under 21 years of age. C. The eligible member can be appropriately treated at a less intensive level of care. D. The eligible member requires a higher level of care, which includes out-of-home placement. **Note**: Out-of-home placement would not include treatment foster care because ABA services could continue at that level of care.
Exclusionary Criteria	Must meet one of the following: A. The eligible member's Comprehensive or Targeted Diagnostic Evaluation or the ISP and/or Treatment Plan Updates recommend placement in a higher, more intensive or more restrictive level of care. **Note**: This does not include treatment foster care; see the previous note above in the discharge criteria listed for ABA – Stage 3 and Specialty Care Providers table. B. The eligible member's provider, such as a psychiatrist, recommends a higher level of care. The eligible member is in an out-of-home placement **Note**: This does not include treatment foster care: See the previous note above in the discharge criteria listed for ABA – Stage 3 and Specialty Care Providers table. C. An exception is that time-limited ABA services may be authorized while the member remains in the out-of-home facility for transition when ABA services are approved to be rendered upon the member's discharge from the facility to a community ABA provider.

Applied Behavioral Analysis (ABA) – Stage 3 and Specialty Care Providers	
	D. The referral for the Comprehensive Diagnostic Evaluation did not follow the Eligibility requirements defined in 8.321.2 Section 10(B). E. The member has reached the maximum age for ABA services. F. Family/caregiver is unable to participate in the treatment plan.

J. Partial Hospitalization (Adult, Child and Adolescent Psychiatric)

Definition of Service:

The Partial Hospitalization Program (PHP) is structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinical services. PHP can be provided in acute care or freestanding psychiatric hospitals. The need for outpatient or partial hospitalization services must be identified in a diagnostic evaluation. To help Turquoise Care members under 21 years of age receive the level of services needed, Turquoise Care pays for partial hospitalization services furnished in acute care or freestanding psychiatric hospitals as part of EPSDT program services (42 CFR Section 441.57). The need for outpatient or partial hospitalization services must be identified in the Tot-to-Teen Health Check screening or other diagnostic evaluation furnished through a health check referral.

Partial hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services are like those that would be provided in an inpatient setting, except that the member is in the program less than 24 hours a day and it is a time-limited program. Partial hospitalization is designed for members with serious behavioral disorders or disturbances of community functioning that require an intensive, ambulatory and active treatment program. The member can be maintained safely in the community but requires close monitoring. Support systems should be available and willing to assist the member with participation in treatment whenever possible.

Partial hospitalization offers intensive and multi-modal structured clinical services within a stable therapeutic milieu setting. Appropriate staff is available on a 24-hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the member, make referrals as necessary and provide follow-up. An individualized treatment plan is developed, reviewed and updated on a regular basis. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should involve caretakers, guardians and family members unless a valid reason has been identified to explain why such a plan is not clinically appropriate or feasible.

A specific treatment goal of a multidisciplinary team is to improve symptoms and level of functioning enough to return the member to a lesser level of care. PHPs may vary considerably depending upon the age and severity of illness of the members for whom the program is

designed. PHPs shall offer at least 20 hours per week of skilled treatment services. This level of care is available for all age ranges, but admission should be to a program that is age appropriate. For school-age members, it is expected that the local school system or facility will provide elementary and secondary schooling.

A. **Partial Hospitalization for Adults with Substance Use Disorders**

1. Please refer to the 2013 third edition of The ASAM Criteria, level 2.5: Partial Hospitalization Services Adults.

B. **Partial Hospitalization for Adolescents with Substance Use Disorders**

1. Please refer to the 2013 third edition of The ASAM Criteria, level 2.5: Partial Hospitalization Services Adolescent.

C. **Adult Accredited Residential Treatment Center for Adults with Substance Use Disorders**

1. Please refer to the 2013 third edition of The ASAM Criteria, level 3: Residential/Inpatient Services.

Partial Hospitalization (Adult, Child and Adolescent Psychiatric)	
Admission Criteria	Must meet all the following: A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, the proposed therapeutic intervention. Presence of the illness(es) must be documented through the assignment of an appropriate DSM diagnosis. B. There is clinical evidence that the member's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and psychiatric nursing or medical assessment no less than three times per week, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital visit. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours. C. Either: 1. There is clinical evidence that the member would be at risk to self or others if they were not in a PHP. 2. As a result of the member's mental disorder, there is an inability to adequately care for one's physical needs and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self. D. Additionally, either the member: 1. Can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time. 2. Is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

Partial Hospitalization (Adult, Child and Adolescent Psychiatric)	
	E. The member is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care. F. For members over 60 years of age, assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment.
Continued Stay Criteria	Must meet all the following: A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following: 1. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria. 2. The emergence of additional problems that meet the admission criteria. 3. That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in or would result in exacerbation of the psychiatric illness to the degree that would require continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet the severity of need based on justifying the expectation that there would be a decompensation. B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting the above criterion A of the Continued Stay Criteria and this is documented by progress notes for each day of partial hospitalization that are written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the member's post-partial hospitalization needs. A urine drug screen (UDS) should be considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider should be considered. C. There is evidence of at least weekly family and/or support system therapeutic involvement, unless there is an identified and valid reason why such a plan is not clinically appropriate or feasible. D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-partial hospitalization treatment resources. E. All applicable elements in admission are applied as related to assessment and treatment, if clinically relevant and appropriate.

V. Alternative Benefit Plan (ABP) Service

A. Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) is a benefit for the Alternative Benefit Plan (i.e., Medicaid expansion population) and is a value-added (non-entitlement) service for standard Medicaid members.

Definition of Service:

ECT is a beneficial treatment for certain disorders and is usually administered in an inpatient or outpatient facility that provides both psychiatric and anesthesiology services. ECT should be considered when a member has severe or treatment resistant depression, psychotic disorders, or prolonged or severe mania. In addition, ECT may be indicated when there is a history of a positive response to ECT, a contraindication to standard psychotropic medication treatments, or when there is an urgent need for response, such as severe suicidality or food refusal that leads to nutritional compromise.

A valid consent must be obtained for ECT. If the member is not competent to refuse or consent to the procedure, then a treatment guardian should be obtained. The person giving consent should be informed of the risks and benefits of ECT and the alternative treatments to ECT, and the record should document that the member or guardian clearly understands these elements of the consent. These criteria will be used to authorize the procedure of ECT. Authorization for this procedure does not imply authorization for a particular level of care.

Electroconvulsive Therapy	
Approval Criteria	Must meet all the following: A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the member has a DSM-diagnosed condition that requires, and is likely to benefit from, the proposed therapeutic intervention. B. A second opinion from a psychiatrist confirms that ECT is an appropriate treatment for the member. C. A medical evaluation indicates no contraindication for ECT. D. Informed consent for ECT has been obtained and documented in the treatment record. E. The member has been diagnosed with major depression, mania, catatonia, and certain acute schizophrenic exacerbations. F. One of the following describes the member: 1. Is unresponsive to effective medications (i.e., adequate dose and duration) that are indicated for the their condition. 2. Is unable to tolerate effective medications. 3. Has a medical condition for which medication is contraindicated. 4. Had favorable response to ECT in the past. 5. Is unable to safely wait until medication is effective due to inanition (i.e., a condition characterized by marked weakness, extreme weight loss, and a decrease in metabolism resulting from prolonged and severe insufficiency of food), stupor, extreme agitation, high suicide or homicide risk, etc.
Maintenance Criteria	Must meet all the following: A. The member meets the approval criteria for ECT, received ECT and had a documented positive response. B. Other treatment options are not viable for the member.

Electroconvulsive Therapy	
	C. A second opinion from another provider (other than the current treating psychiatrist) is obtained every nine months to document the need for maintenance ECT.
Exclusionary Criteria	Must meet one of the following: A. ECT shall not be performed on a child except by order of a court upon a finding that the treatment is necessary to prevent serious harm to the child (NM Statute 32A-6-14). The clinical criteria noted above must also be met. B. ECT is considered experimental, investigational and/or unproven for all other indications not noted above. C. Multiple monitored electroconvulsive therapy (MMECT) is considered experimental, investigational and/or unproven.

VI. Services That Do Not Require Prior Authorization

A. Assertive Community Treatment

Definition of Services:

Assertive community treatment (ACT) encompasses comprehensive and intensive outpatient services delivered in the community, such as the client's home or residence and/or other community settings. These services are directed toward the rehabilitation of behavioral, social and emotional deficits and/or amelioration of symptoms of mental disorder. Such services are directed primarily to individuals with severe and persistent mental disorders and/or complex symptoms that require multiple mental health and support services to maintain the member in the community. ACT services are active and rehabilitative in focus and are initiated when there is a reasonable likelihood that such services will lead to specific and observable improvements in the individuals functioning and community tenure.

Medical necessity for ACT services is established by satisfying the admission and continued care criteria outlined in the following table. Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

Assertive Community Treatment	
Admission Criteria	Must meet all the following: A. Risk to self, others or property is considered to be low although, without treatment or support, the individual's potential risk in these areas may be increased. B. The member is medically stable and does not require a level of care that includes more intensive medical monitoring.

Assertive Community Treatment	
	C. The member lives independently in the community or demonstrates a capacity to live independently and transform from a dependent residential setting to independent living. D. Degree of impairment (must meet the following 1 or 2 and potentially may need to meet 3): 1. The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home environment without assistance or support and exhibits impairments arising from a psychiatric disorder, which compromises their judgment, impulse control and/or cognitive perceptual abilities. 2. The member exhibits significant impairment in social, interpersonal or familial functioning arising from a psychiatric disorder, which indicates a need for assertive treatment to stabilize or reverse the condition. 3. The member exhibits impairment in occupational or educational functioning arising from a psychiatric disorder, which indicates a need for counseling, training or rehabilitation services or supports to stabilize or reverse the condition.
Continued Stay Criteria	Must meet all the following: A. Clinical evidence indicates a persistence of the problems that necessitated the provision of treatment services and there is a broad and persistent effect on the individual's ability to effectively manage day-to-day activities of living and self-support on an independent basis. B. There is a reasonable expectation that the member will benefit from the ACT program. This is observable as a positive and beneficial response to treatment and follow-through with treatment recommendations including, but not limited to, medication adherence, homework assignments and collaboration with the ACT team in treatment. C. The member is making attempts/progress toward goals and is benefiting from the plan of care, as evidenced by attainment of therapeutic rapport, lessening of symptoms over time and stabilization of psychosocial functioning through service planning, homework and team involvement. D. Treatment promotes the member's self-efficiency and maximizes independent functioning. Treatment techniques are employed to encourage use of natural support systems to promote the member's mastery of their environment. Active assessment of ongoing need for ACT team support is completed every six months.

B. Behavioral Health Day Treatment (Child and Adolescent)

Definition of Services:

Behavioral health day treatment is a non-residential treatment program designed for children and adolescents under the age of 21 who have emotional, behavioral, neurobiological or substance abuse problems and may be at high risk of out-of-home placement. Behavioral health day treatment services are specialized services/training provided after school, on weekends or when school is not in session. Services include counseling (individual, group and family), parent consumer education, and skill and socialization training that focus on the

amelioration of functional and behavioral deficits. Intensive coordination/linkage with schools and or other child-serving agencies are included. The goals of the service are clearly documented and utilize a clinical model for service delivery and support.

The goal of day treatment is to increase adaptive functioning and to develop skills for both the member and their family unit to maintain the member in their home or community environment. Day treatment services are also designed to transition individuals who are discharged from residential services that require intensive therapeutic interventions to facilitate family reunification and/or emancipation in the least restrictive environment.

Provision of day treatment services must be preceded by documentation of the individual member's needs as determined through initial assessment and ongoing reassessment. Day treatment components include the following:

A. Assessment and diagnosis of the social, emotional, physical and psychological needs of the child/adolescent and family for treatment planning while ensuring that evaluations already performed are not unnecessarily repeated.

B. Development of a treatment plan and discharge plan and regular reevaluation of these plans is required. Services are based upon the child's/adolescent's individualized treatment plan goals and should include interventions with significant members of the family. Services are designed to enhance adaptive functioning.

C. Regularly scheduled individual, family, multi-family, group and/or specialized group sessions focusing on the attainment of skills, such as anger management, communication and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention, if applicable, are required.

D. Family sessions are an important component of the program and family outreach is encouraged.

E. Supervision of self-administered medication as clinically indicated.

F. Therapeutic recreational activities that are supportive of the clinical objectives and identified in the individualized treatment plan.

G. Availability of appropriate staff to provide crisis intervention is also required.

H. A minimum of four hours of structured programming per day, two to five days per week, based on acuity and clinical needs of the child/adolescent.

Day treatment services are provided in a school setting or other community setting that is distinct from other behavioral health services in staffing, program description and physical space. The services are delivered by licensed behavioral health providers employed by a mental health/substance abuse organization.

Behavioral Health Day Treatment (Child and Adolescent)	
Admission Criteria	Must meet all the following: A. The member has a DSM-5 or the current edition of the ICD diagnosed psychiatric condition that requires, and is likely to benefit from, structured therapeutic intervention. B. The member is under 21 years of age. C. The member's functioning level is impaired due to a serious emotional disturbance or serious mental illness despite continued outpatient interventions. Mental health symptoms interfere with day-to-day social functioning at home, work and/or school. D. The supports and services of less intensive intervention have been unsuccessful or are inappropriate for the member's need, and the member is at risk for out-of-home placements or the member is transitioning from a higher level of service back into the community. E. Family members demonstrate a willingness to assist the member in achieving their recovery and resiliency goals.
Continued Stay Criteria	Must meet all the following: A. The member continues to meet admission criteria for this service. B. An individualized treatment plan with measurable goals and objectives that addresses the member's specific needs has been developed with participation from the member and their family whenever possible, which includes consideration of all applicable and appropriate treatment modalities. C. The treatment plan is reviewed and modified as needed and at least every 30 days. D. There is reasonable expectation that the member will benefit from this service. E. The member and family express a desire to continue with the recommended interventions. F. An individualized discharge plan with specific, realistic, objective and measurable discharge criteria, including plans for appropriate follow-up care, has been developed. A timeline for expected implementation and completion is in place but discharge criteria has not been met. G. Progress toward discharge goals is being made as evidenced by adherence with treatment or measurable reduction in symptoms.
Discharge Criteria	Must meet A or B plus C and D: A. The member has met their individualized discharge criteria. B. The member has not benefited from Family Support Services, despite documented efforts to engage the member and the family. C. The member can be safely treated at a less intensive level of care. D. A discharge plan with appropriate, realistic and timely follow-up care is in place.

C. Behavior Management Services

Definition of Services:

Turquoise Care pays for medically necessary health services furnished to eligible members. To help members under 21 years of age who need behavior management intervention receive services, Turquoise Care pays for eligible providers to furnish these services as part of the EPSDT program (42 CFR § 441.57). These services can be accessed only through the Tot-to-Teen Health Check screening or other diagnostic evaluations furnished through a health check referral.

In addition to admission criteria, continued stay criteria and discharge criteria, this section describes eligible providers, provider responsibilities, eligible members, covered services, services not covered under Turquoise Care and the treatment plan.

Behavior Management Services	
Eligible Providers	Upon approval of New Mexico Medical Assistance Program (MAP) provider agreements by MAD, agencies that meet the following requirements are eligible to be reimbursed for providing behavior management services: A. Certification as providers of Behavior Management Skills Development Services by the Children, Youth and Families Department (CYFD). B. Employ or contract with behavior management specialists who work under the supervision of a licensed practitioner in the area of behavior management services as described in the certification criteria. Members have the right to receive services from the eligible provider of their choice. Once enrolled, providers receive a packet of information that includes Medicaid program policies, billing instructions, utilization review instructions, certification standards and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
Provider Responsibilities	Providers who furnish services to Medicaid members must comply with all specified Medicaid participation requirements. See Section MAD-701, General Provider Policies. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid members have other health insurance. Providers must maintain records that are sufficient to fully disclose the extent and nature of the services furnished to members.
Eligible Members	Behavior management services can be furnished only to Medicaid members under 21 years of age who are diagnosed with a behavioral health condition and who need behavior management intervention to avoid inpatient hospitalization or residential treatment, or who require continued intensive treatment following hospitalization or out-of-home placement as a transition to avoid return to a more restrictive environment. To receive services, members must meet the level of care for this service established by MAD or its designee.

Behavior Management Services	
Covered Services	Medicaid covers services specified in individualized treatment plans that are designed to improve the member's performance in targeted behaviors, reduce emotional and behavioral excess, increase social skills and enhance behavioral skills through a regimen of positive intervention and reinforcement. A. The following tasks must be performed by behavior management specialists and included in the payment rate: 1. Implementation of the behavior management plan. 2. Instruction and assistance in achieving and/or maintaining appropriate behavior management skills through skilled intervention. 3. Working with foster, adoptive or biological families to help members achieve and/or maintain appropriate behavior management skills. 4. Maintaining case notes and documentation of activities as required by the agency and the standards under which it operates. B. An agency certified for behavioral management skills development services must: 1. Perform an assessment of the member's progress in behavioral management services. 2. Ensure 24-hour availability of appropriate staff to respond to crisis situations.
Services Not Covered Under Turquoise Care	Behavior management services are subject to the limitations and coverage restrictions that exist for other Medicaid services. See Section MAD-602, General Noncovered Services. Medicaid does not cover the following specific services: A. Formal educational or vocational services related to traditional academic subjects or vocational training. B. Activities that are not designed to accomplish the objectives delineated in covered services and which are not included in the behavioral management treatment plan. C. Services provided in lieu of services that should be provided as part of the MAP-eligible member's individual educational plan (IEP).
The Treatment Plan	The treatment plan must be developed by a team of professionals in consultation with members, parents, legal guardians, and physicians, if applicable, prior to service delivery or within 14 days of initiation of services. A. The team must review the treatment plan at least every 30 days. B. The treatment plan and all supporting documentation must be available for review in the member's file, and the following must be contained in the treatment plan or documents used in the development of the treatment plan: 1. Statement of the nature of the specific problem and the specific needs of the member. 2. Description of the functional level of the member, including the following: a. Mental status assessment b. Intellectual function assessment c. Psychological assessment

Behavior Management Services	
	d. Educational assessment e. Vocational assessment f. Social assessment g. Medication assessment h. Physical assessment 3. Statement of the least restrictive conditions necessary to achieve the purposes of treatment. 4. Description of intermediate and long-range goals with the projected timetable for their attainment and the duration and scope of services. 5. Statement and rationale of the treatment plan for achieving intermediate and long-range goals, including provisions for review and modification of the plan. 6. Specification of responsibilities, description of staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the member. 7. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge and projected date of discharge.
Admission Criteria	All the following specified requirements for Severity of Need and Intensity and Quality of Service must be met to satisfy the criteria for admission. **Severity of Need**: A. There is clinical evidence that the patient has a DSM-5 or a diagnosis in the current edition of the ICD for a disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to out-of-home placement in an acute psychiatric hospital or residential treatment facility in the absence of behavioral management services (NMAC 8.321.2). B. The member demonstrates significant psychological or behavioral disturbances but can participate in age-appropriate community-based activities, including school, with assistance from behavioral management services or with other available support. C. The patient is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital or residential treatment level of care. **Intensity and Quality of Service**: A. The evaluation and assignment of a DSM-5 diagnosis or diagnosis in the current edition of the ICD that is a result from a face-to-face behavioral health evaluation by a licensed provider. B. There is ongoing assessment of the member's progress in behavioral management services. C. There is 24-hour availability of appropriate staff to respond to crisis situations.

Behavior Management Services	
	D. A discharge plan is initially formulated based on the behaviors and/or symptoms that resulted in admission to services and begins to identify appropriate post-service resources. E. A behavior management plan that addresses the patient's specific psychological and behavioral disturbances has been developed by a team of professionals in consultation with the patient, the patient's parents, legal guardians and physicians, if applicable, prior to service delivery or within 14 days of initiation of services and includes all elements listed above. F. Both the patient and the patient's authorized representative, guardian, parent or foster parent are actively involved in development of both the treatment plan and the behavior management plan.
Continued Stay Criteria	A. There is evidence of objective, measurable, intermediate and long-ranged therapeutic clinical goals that must be met before the patient can return to a lower level of care. B. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less intensive level of care and that this plan is reviewed at least every 30 days. C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the challenges meeting Severity of Need Admission Criteria listed above and the reasonable expectations of the treatment plan are documented in progress notes that are written and signed by the provider. D. There is evidence of active member and family involvement in the treatment. E. There is evidence of progress being made toward the identified clinical goals.
Discharge Criteria	A. The member has met the goals outlined in the comprehensive treatment plan. B. The member has not participated in the behavioral management services, despite reasonable efforts to engage the member and modify the treatment plan as appropriate. C. The member can be safely and effectively treated at a less intensive level of care. D. An appropriate and realistic discharge plan with timely follow-up is in place.

D. Comprehensive Community Support Services (CCSS)

Definition of Services:

The purpose of Comprehensive Community Support Services (CCSS) is to provide individuals/families with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in regards to independent living, learning, working, socializing and recreation. CCSS consist of a variety of interventions that primarily occur in face-to-

face settings and in community locations that address barriers that impede the development of skills necessary for independent functioning in the community.

CCSS also include assistance with identifying and coordinating services and supports identified in an individual's service plan, supporting the member and family in crisis situations, and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

Eligible Providers

Services must be delivered by a behavioral health provider organization. The organization must be a legally recognized entity in the United States, qualified to do business in New Mexico and must meet standards established by the State of New Mexico or its designee and requirements of the funding source.

The agency must be a licensed community mental health center or core service agency and must receive CCSS training through the State of New Mexico or the University of New Mexico (UNM) and attest that they have received this training. Other providers eligible to provide CCSS include federally qualified health centers (FQHC) and Indian Health Services (IHS) or 638 Tribal facilities. CCSS staff must meet the state's minimum requirements.

Comprehensive Community Support Services	
Exclusions	This service may not be billed in conjunction with any of the following: • Multi-systemic therapy • Assertive community treatment • Accredited residential treatment • Residential treatment services • Group home services • Inpatient hospitalization • Partial hospitalization • Treatment foster care • Transitional living services • Resource development (New Mexico Corrections Department) Under limited circumstances, CCSS can be billed by the primary community support worker to assist individuals with their transition from higher levels of care. CCSS will be limited to a maximum of 16 units per each discharge from a higher level of care.

Comprehensive Community Support Services	
Treatment Plan	The treatment plan must include the following: A. Assistance to the member in the development and coordination of the individual's service plan including a recovery/resiliency management plan, crisis management plan and, when requested, advanced directives related to his/her behavioral healthcare. B. Assessment, support and intervention in crisis situations including the development and use of crisis plans which recognize the early signs of crisis/relapse, use of natural supports, use of alternatives to emergency departments and inpatient services. C. Individualized interventions, with the following objectives: • Coordinating services and resources to assist the member in gaining access to necessary rehabilitative, medical and other services. • Assisting in the development of interpersonal, community-coping and functional skills (including adaptation to home, school and work environments) including: 1. Socialization skills 2. Developmental issues 3. Daily living skills 4. School and work readiness activities 5. Education in co-occurring illness • Encouraging the development and eventual succession of natural supports in workplace and school environments. • 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/skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living and supports consumers to maintain employment and school tenure. • Assisting the member to obtain and maintain stable housing. • Providing any necessary follow-up to determine if the services accessed have adequately met the individual's needs. D. The majority (60% or more) of CCSS provided must be face-to-face and in vivo (where the client is). The community support worker must provide follow-up to determine if the services accessed have adequately met the individual's treatment needs. E. For individuals and/or their families, the community support worker will make every effort to engage the client in achieving treatment/recovery goals. **Note:** • Individuals participating in medication management as the primary focus of service are not subject to the off-site (in vivo) service requirement or the consumer-staff ratio.

Comprehensive Community Support Services	
	• Behavior management interventions are not considered to be CCSS and should be billed under Behavior Management Services.
Admission Criteria	CCSS are appropriate for adults, adolescents and children who have a serious mental disorder and meet all the following criteria for Severity of Need and Intensity and Service: **Severity of Need:** A. A clinical evaluation indicates that the member has a primary DSM-5 or the current edition of the ICD-diagnosed condition that is the cause of significant psychological, personal care, vocational, education or social impairment, such as: 1. Inability to care for personal needs and perform independent living skills. 2. Limited school or employment performance. 3. Interpersonal relationship problems. 4. Limited ability to manage psychiatric symptoms. B. Without adequate comprehensive community support services, impairment described in No. 1 above puts the member at risk for one of the following: 1. A higher level of care. 2. Loss of a basic support, such as housing or employment. A. Based on the individual's history or current condition, less frequent intervention is not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need for a more intensive level of care. B. Expectation that the individual's condition can improve through provision of medically necessary and appropriate rehabilitation intervention. **Intensity of Service:** A. The member requires a program of rehabilitation supports to remain in the community. B. The individual treatment plan documents active rehabilitation services geared toward improving the individual's symptoms, behavior or level of functioning.
Continued Care Criteria	Must meet all the following: A. The expectation that continuation of services will promote, maintain or improve the individual's level of functioning in at least one of the four environments (i.e., occupational, residential, scholastic and/or social) in any or all the following: 1. Ability to care for personal needs and perform independent living skills. 2. School or employment performance. 3. Interpersonal relationships. 4. Ability to manage psychiatric symptoms.

Comprehensive Community Support Services	
	B. The individual's continuing need for the services provided by CCSS privileged staff for the member to achieve both the following: 1. Live as independently as possible in the community. 2. Avoid inpatient care. C. Clinical evidence indicating that: 1. Termination or reduction of comprehensive community support services would result in an exacerbation of the behavioral health disorder. 2. The individual's condition can be expected to improve or be maintained through medically necessary and appropriate comprehensive community support intervention.

E. Multi-Systemic Therapy

Definition of Services:

The specific requirements for Severity of Need and Intensity and Quality of Service must be met to satisfy the criteria for admission of youth defined as between 10 to 18 years of age. Multi-Systemic Therapy (MST) provides an intensive home/family and community-based treatment for individuals who are at risk of out-of-home placement or are returning home from placement and their families. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services include an initial assessment to identify the focus of the MST interventions to be used with the member and family. Specialized therapeutic and rehabilitative interventions are available to address specific areas of need such as substance abuse, delinquency, violent behavior, etc. Services are primarily provided in the home, but workers also intervene at school and other community settings.

MST services may not be clinically appropriate for individuals who meet criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior; youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers; the referral problem is limited to serious sexual misbehavior; youth has a primary diagnosis of autism spectrum disorder or mental retardation; low-level need cases; or youth who have previously received MST services or other intensive family- and community-based treatment (except when specific conditions have been identified that have changed in the youth's ecology compared to the first course of treatment).

Multi-Systemic Therapy	
Admission Criteria	**Severity of Need:**

Multi-Systemic Therapy	
	Must meet either criterion A, B, or C plus D, E, F and G: A. The youth member's treatment planning team or child and family team (CFT) recommends that they participate in MST. B. The youth member is diagnosed with depression, DSM-5 or the current edition of the ICD disorders when the existing mental and behavioral health issues manifest in outward behaviors that impact multiple systems (e.g., family, school, community, etc.). C. The youth member with substance abuse issues, if they meet the criteria below and MST, is deemed clinically more appropriate than focused drug and alcohol treatment. D. The you member is externalizing behaviors symptomatology such as chronic or violent juvenile offenses resulting in a DSM-5, the current edition of the ICD-diagnosis of conduct disorder, or other diagnoses consistent with such symptomatology (e.g., behavioral disorder not otherwise specified, etc.). E. The youth member is at risk for out-of-home placement or is transitioning back from an out-of-home setting. F. There is ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings as a result of behavioral problems. G. Less intensive treatment has been ineffective or is inappropriate. **Intensity and Quality of Service** Must meet all the following: A. Provide practical and goal-oriented treatment that specifically targets the factors in a youth member's social network that are contributing to the problem behaviors. B. Provide at least weekly encounters with the youth member or their family for an expected duration of service of three to six months. C. MST treatment directly provides the following support and services within the youth member's home or community: 1. Availability of services 24/7. 2. Assessment and ongoing treatment planning based the specific behavior. 3. Family therapy. 4. Individual therapy, which is not the primary mode of treatment and is not provided to caregivers or family members. 5. Parent counseling related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals. 6. Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors. 7. Referral for psychological assessment, psychiatric evaluation and medication management if needed. D. MST treatment is attuned to the importance of ethnicity and culture for all clients referred for services. By maintaining the youth within the community in the least restrictive environment, MST treatment interventions strengthen the family and youth's relationship with community resources and the people managing them.

Multi-Systemic Therapy	
Continued Stay Criteria	Must meet all the following: A. Treatment does not require more intensive level of care. B. The treatment plan has been developed, implemented and updated based on the youth member's clinical condition and response to treatment, and based on the strengths of the family, with realistic goals and objectives that are clearly stated. C. Progress is clearly evident in objective terms, but the goals of treatment have not yet been achieved or it is evident that there are adjustments in the treatment plan to address the lack of progress. D. The family is actively involved in treatment, or there are active, persistent efforts being made that are expected to lead to engagement

F. Psychological Testing

Definition of Services:

Prior to psychological testing, the member must be assessed by a qualified behavioral health provider. The diagnostic interview determines the need for, and extent of, the psychological testing. Testing may be completed at the onset of treatment to assist with necessary differential diagnosis issues and/or help resolve specific treatment planning questions. It also may occur later in treatment if the member's condition has not progressed since the institution of the initial treatment plan and there is no clear explanation for the lack of improvement.

Psychological Testing	
Admission Criteria	Must meet all the following criteria for Severity of Need and Intensity and Quality of Care: **Severity of Need:** A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual. B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations. C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment. **Intensity and Quality of Care:** A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), medical psychologist (M.P.), or other qualified provider as permitted by applicable state and/or federal law and who is credentialed by and contracted with Presbyterian administers the tests.

Psychological Testing	
	B. Requested tests must be standardized, valid and reliable to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in Standards for Educational and Psychological Testing.
Exclusionary Criteria	Must meet one of the following: A. The testing is primarily for educational or vocational purposes. B. The testing is primarily for the purpose of determining if a member is a candidate for a specific medication or dosage. C. Unless allowed by the member's benefit plan, the testing is primarily for the purpose of determining if the member is a candidate for a medical or surgical procedure. D. The testing results could be invalid due to the influence of a substance, substance abuse, substance withdrawal or any situation that would preclude valid psychological testing results from being obtained (e.g., a member who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered). E. The testing is primarily for diagnosing ADHD, unless the diagnostic interview, clinical observations and results of appropriate behavioral rating scales are inconclusive. F. Two or more tests are requested that measure the same functional domain. G. Testing is primarily for forensic (i.e., legal) purposes, including custody evaluations, parenting assessments or other court or government-ordered/requested testing, or testing that is requested by an administrative body (e.g., a licensing board, worker's compensation, or criminal or civil litigation). H. Requested tests are experimental, antiquated or not validated. I. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider unless pre-approved by Magellan. J. The testing is primarily to determine the extent or type of neurological impairment as potentially related to a remediation or treatment plan unless allowed by the member's benefit plan. K. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s) unless justified by specific testing circumstances. L. Structured interview tools do not have psychometric properties or normative comparisons.

G. Psychosocial Rehabilitation Services (Adult, Adolescent and Child)

Definition of Services:

Psychosocial rehabilitation services (PSR) facilitate the development of a member's independent living and social skills, including the ability to make decisions regarding self-care, management of illness, life, work and community participation. The services promote the use of resources to integrate the member into the community. Services may be provided onsite in a rehabilitation facility or offsite in a setting most conducive to promoting the member's participation in the community. This may include the member's home, rehabilitation residence, job

site, education setting, community setting, etc. Level of intensity may vary depending upon changes in the member's environment or the member's needs.

Medical necessity for PSR is established by satisfying the admission and continued care criteria outlined in the following sections. The criteria contained here apply to programs and services that are less intensive than partial hospitalization. Satisfaction of all admission and continued care criteria must be documented in the member's medical record based upon the condition and factors identified below before rehabilitation services are authorized.

Psychosocial Rehabilitation Services (Adult, Adolescent and Child)	
Admission Criteria	PSR are appropriate for adults, adolescents and children members who have a serious behavioral health disorder and meet all the following criteria for both Severity of Need and Intensity of Services. **Severity of Need:** A. A clinical evaluation indicates that the member has a primary DSM-5 or the current edition of the ICD diagnosis of a behavioral health disorder that is the cause of significant psychological, personal care, vocational, education or social impairment, such as: 1. Inability to care for personal needs and perform independent living skills. 2. Limited school or employment performance. 3. Interpersonal relationship problems. 4. Limited ability to manage psychiatric symptoms. B. Without adequate PSR, impairment described in section A puts the member at risk for a higher level of care or loss of basic support, such as housing or employment. C. Based on the individual's history or current condition, less frequent intervention is not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care. D. Expectation that the member's condition can improve through provision of medically necessary and appropriate rehabilitation intervention. **Intensity of Services:** A. The member requires a program of rehabilitation supports to remain in the community. B. The individual treatment plan documents active rehabilitation services geared to improving the individual's symptoms, behavior or level of functioning.
Continued Stay Criteria	Must meet all the following: A. The expectation that continuation of services will promote, maintain or improve the member's level of functioning in at least one of the four environments (i.e., occupational, residential, scholastic and/or social) in any or all the following: 1. Ability to care for personal needs and perform independent living skills.

Psychosocial Rehabilitation Services (Adult, Adolescent and Child)	
	2. School or employment performance. 3. Interpersonal relationships. 4. Ability to manage psychiatric symptoms. B. The member's continuing need for the services provided by PSR privileged staff for the member to achieve both the following: 1. Live as independently as possible in the community. 2. Avoid inpatient care. C. Clinical evidence indicating both the following: 1. Termination or reduction of PSR would result in an exacerbation of the behavioral health disorder. 2. The member's condition can be expected to improve or be maintained through medically necessary and appropriate psychosocial rehabilitative intervention

H. Behavioral Health Respite

Definition of Services:

As part of Turquoise Care's comprehensive service system, behavioral health respite service is for short-term direct care and supervision of the eligible member to afford the parent(s) or caregiver(s) a respite for their care of the member and takes place in the member's home or another setting. Behavioral health respite services may include a range of activities to meet the social, emotional and physical needs identified through the service or treatment plan and documented in the treatment record. These services may be provided for a few hours during the day or for longer periods of time that may involve overnight stays. While usually planned, behavioral health respite services can also be provided in an emergency or unplanned basis.

Prior Authorization: Behavioral health respite services are covered for 30 days or 720 hours per year without prior authorization, at which time prior authorization must be acquired for additional respite care.

For more detailed information, please reference Supplement 19-04 from the State of New Mexico Medical Assistance Program Manual.

Behavioral Health Respite	
Admission Criteria	Must meet criterion A or B plus C and D: A. Members up to 21 years of age are diagnosed with a severe emotional disturbance (SED), as defined by the state of New Mexico, and reside with the same primary caregivers daily.

Behavioral Health Respite	
	B. Regardless of whether youth members in protective services custody are diagnosed with SED, their placement may be at risk. C. Outpatient services alone will not meet the family's needs for support and education. D. Family and caregivers are unable to participate in the normal activities of daily life in the community as a result of caring for the member, thus putting the member at risk for out-of-home service level beyond the scope of respite care.
Continued Stay Criteria	The member's condition must continue to meet admission criteria.
Discharge Criteria	Must meet all the following: A. The member has met their individualized discharge criteria. B. The member can be safely treated at a less intensive level of care. C. An individualized discharge plan with appropriate, realistic and timely follow-up care has been formulated.
Exclusionary Criteria	Must meet one of the following: A. Member meets the criteria for a more or less intensive and restrictive level of care. B. Member is at risk to harm self, others or property. C. Member has a medical condition(s) that prevents utilization of respite care. D. This service may not be billed in conjunction with TFC, group home residential services or inpatient treatment. E. Respite services are not used as a substitute for permanent housing or child care.