PRESBYTERIAN

Presbyterian Health Plan
Centennial Care
Behavioral Health
Medical Necessity Criteria
2016

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Presbyterian Health Plan Centennial Care behavioral health medical necessity criteria, are based on sound scientific evidence for recognized settings of behavioral health services and are used to decide the medical necessity and clinical appropriateness of services. The criteria are developed in coordination with the defined and approved criteria developed by the New Mexico Behavioral Health Service Division (BHSD) and collaboration with our partner Magellan. Presbyterian Health plan reviews the criteria used to make decisions regarding medical necessity decisions at least annually..

Medical Necessity Definition:

8.302.1.7 DEFINITIONS: Medically necessary services

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;

(3) are provided within professionally accepted standards of practice and national guidelines; and

(4) are required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

B. Application of the 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, such a determination will be made by MAD or its designee.

(2) The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient shall do so by:

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

(b) considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(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 recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition
(4) Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.
(5) Medically necessary service requirements apply to all medical assistance program rules.

Quality of Service Criteria

The following criteria are common to all levels of care for behavioral health conditions and substance use disorders. These criteria will be used in conjunction with criteria for specific level 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 goals of treatment. 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 age and level of development; the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to treatment; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play in treatment with the member's permission
c) Interventions needed to address co-occurring behavioral health or medical conditions.
d) Interventions that will promote the member's participation in care, promote informed decision making, and support the member's broader recovery goals. Examples of such interventions are psycho-education, motivational interviewing, recovery planning and use of an advance directive, as well as facilitating involvement with natural and cultural supports, and self-help or peer 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 as well as within 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 preferences, strengths, broader recovery goals and readiness for change; risks including barriers

to care; past response to discharge; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play 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 which 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, as well as with the school system, legal system or community agencies with the member's permission.

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

a) Completing and 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 that the member understands and agrees with the discharge plan;

c) Scheduling a first appointment within 7 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 psycho-education 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 in the event that there is a crisis prior to the first post-discharge appointment, or if the member needs to resume services.

13. The availability of resources such 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.

ACUTE INPATIENT HOSPITALIZATION

I. DEFINITION OF SERVICE:

Acute Inpatient Psychiatric Hospitalization is a 24-hour secured and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for stabilization of urgent or emergent behavioral health problems. Acute Inpatient Hospitalization is provided specifically for those 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. It 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 of 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 should 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 (which 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 age children and youth, academic schooling funded through the local school system or by the facility is expected.

II. ADMISSION CRITERIA (MEETS A AND B, AND C OR D OR E OR F OR G):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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. 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 which 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.
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 leading 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.

III. CONTINUED STAY CRITERIA (MEETS ALL):

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 which 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.

IV. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her 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.

V. EXCLUSIONARY CRITERIA (MAY MEET ANY):

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 presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications.

WAITING PLACEMENT DAYS (DAP) RATE

I. Description:

Per NMAC 8.321.2.16 Inpatient Days awaiting Placement (DAP) 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 which 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. **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.**

II. Approval Criteria (must meet all):

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. The MCO has authorized the residential level of care sought as the discharge, and documentation of this authorization has been made available to MCO utilization management personnel.

II. Exclusionary Criteria:

A. The member has met his/her 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 MCO psychiatrist peer reviewer has explicitly stated does not appear to meet admission criteria at this time.

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.

I. DEFINITION OF SERVICE:

A 23 Hour Observation Stay occurs in a secure, medically staffed, 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 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. This level of care is available for all age ranges.

If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

The following are exemptions to the general observation stay definition:

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

If an admission is considered an observation stay, 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 recipient 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.

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

II. ADMISSION CRITERIA (MEETS A AND B, AND C OR D OR E):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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 his/her judgment or behavior that could seriously endanger the member or others if not evaluated and stabilized on an emergency basis.

III. DISCHARGE CRITERIA (MEETS BOTH):

A. The member no longer meets admission criteria.
B. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

IV. EXCLUSIONARY CRITERIA (MAY MEET ANY):

A. The member meets admission criteria for Acute Inpatient Hospitalization.
B. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications.

ACCREDITED RESIDENTIAL TREATMENT

I. DEFINITION OF SERVICE:

Accredited Residential Treatment Center Services (ARTC) is a service provided to members under the age of 21 whom, because of the severity or complexity of their behavioral health needs. These are members who, 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 & Family, 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 Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

ARTC services are provided in a 24-hour a day/ 7 days a week accredited (The Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all diagnostic and therapeutic services provided. ARTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on 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, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

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. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), ARTC also includes facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. ARTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, ARTC shall not implement experimental

or investigational procedures, technologies, or non-drug therapies or related services.

II. **ADMISSION CRITERIA (MEETS ALL):**

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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 wellbeing 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 individual is not treated at this level of care.
C. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria including the need for 24 hour staff supervision
B. The current or revised treatment plan can be reasonable 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 which 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. member
E. The member is actively participating in treatment, and is motivated and engaged in are active that lead to the member's discharge plan.
F. The member's parent(s), guardian or custodian is participating in the treatment and discharge planning, If parent (s), guardian 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.

IV. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her individualized discharge criteria.
B. The member can be safely treated at a less intensive/restrictive level of care.
C. An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA FOR ARTC: (MAY MEET ANY)

A. There is evidence (documented) that the ARTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
B. There is evidence that the ARTC treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued ARTC care.
C. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
D. Quality of Service Criteria # 5 has not been met: 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.
E. Quality of Service Criteria # 8 has not been met: 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.

SUBACUTE RESIDENTIAL TREATMENT

Not a Value Added Service, and is only available to providers contracted specifically to provide this service.

I. DEFINITION OF SERVICE:

SubAcute RTC is provided to members under the age of 21 who, because of the severity or complexity of their behavioral health needs, and who require services beyond the scope of the usual Residential Treatment Center Services (RTC) 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 be in need of inpatient hospitalization. SubAcute RTC facilities must be licensed by the New Mexico Department of Children Youth & Family, 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 Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

SubAcute RTC services are provided in a 24-hour a day/ 7 days a week accredited (The Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all the diagnostic and therapeutic services provided by an RTC, **but with a higher staff to client ratio**. SubAcute RTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on 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, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

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. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), SubAcute RTC also includes facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. SubAcute RTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, SubAcute RTC shall not implement experimental or investigational procedures, technologies, or non-drug therapies or related services.

II. ADMISSION CRITERIA (MEETS ALL):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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 individual is not treated at this level of care.
C. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions

III. CONTINUED STAY CRITERIA (MEETS ALL):

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, 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 reasonable 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 which includes specific 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.
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. 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.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.
B. The member has not benefited from SubAcute Residential Treatment Center 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 linkage to appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA FOR SUB-ACUTE RTC: (MAY MEET ANY)

1. There is evidence (documented) that the Sub Acute RTC placement is intended as
2. an alternative to incarceration or community corrections involvement, and medical necessity have 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 of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Sub Acute RTC care.
3. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
4. 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.

5. 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.

RESIDENTIAL TREATMENT CENTER SERVICES

I. DEFINITION OF SERVICE:

Residential Treatment Center Services (RTC), as governed by NMAC 8.321.2.20 (non-accredited RTC) are provided to members under the age of 21 years who require 24-hour treatment and supervision in a safe therapeutic environment.

NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES:

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot to Teen Healthcheck screen or other diagnostic evaluation furnished through a Healthcheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of nay financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

1. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
2. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
3. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management;
4. Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
5. Appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up;
6. Consultation with other professionals or allied care givers regarding a specific recipient;
7. Non-medical transportation services needed to accomplish the treatment objective; and
8. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Noncovered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

1. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
2. Room and board;
3. Services for which prior approval was not obtained;

4. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
5. Formal educational or vocational services related to traditional academic subjects or vocational training;
6. Experimental or investigations procedures, technologies, or non-drug therapies and related services;
7. Drugs classified as "ineffective" by FDA Drug Evaluations; and
8. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, legal guardians or others in whose care recipients will be released after discharge.

The plan must be developed within fourteen (14) days of the recipient's admission.

(A) The interdisciplinary team must review the treatment plan at least every thirty (30) days.

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

1. Statement of the nature of the specific problem and the specific needs of the recipient;
2. Description of the functional level of the recipient, including the following:
    - A. Mental status assessment;
    - B. Intellectual function assessment;
    - C. Psychological assessment;
    - D. Educational assessment;
    - E. Vocational assessment;
    - F. Social assessment;
    - G. Medication assessment; and
    - 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 therapy services;
5. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;
6. Specification of staff responsibilities, description of proposed staff involvement, and 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 recipient; and
7. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

II. ADMISSION CRITERIA (MEETS ALL):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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 his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.
D. Less restrictive or intensive levels of treatment have been tried and shown to be iinadequate to meet the member's needs. Documentation exists to support these contentions.

III. CONTINUED STAY CRITERIA (MEETS ALL):

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 reasonable 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 which 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, or other barriers to discharge exist which 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/or custodian is participating in treatment and discharge planning.. If parent(s), guardian or custodian care are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning. Criteria for this is 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.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.
B. The member has not realized substantial benefit from Residential Treatment 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 linkage to appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA FOR RTC: (MAY MEET ANY)

A. There is evidence that the RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have 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 individual 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.
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.

TREATMENT FOSTER CARE I and II

I. DEFINITION OF SERVICE:

Treatment Foster Care (TFC), as governed by NMAC 8.321.2.25 and NMAC 8.321.2.26 is a behavioral health service provided to members under the age of 21 years who are placed in a 24-hour community-based supervised, trained, surrogate family through a TFC placement agency licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority.

NMAC citation 8.322.2/ MAD citation 745.1 TREATMENT FOSTER CARE Level I and Level II: The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for treatment foster care services must be identified in the Tot to Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities Providers who furnish services to Medicaid recipients 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 recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those services included in individualized treatment plans which are designed to help recipients develop skills necessary for successful reintegration into the natural family or transition into the community.

(A) The family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:

1. Participation in the development of treatment plans for recipients by providing input based on their observations;
2. Assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan;
3. Recording information and documentation of activities, as required by the foster care agency and the standards under which it operates;
4. Helping recipients maintain contact with their families and enhancement of those relationships;
5. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
6. Assisting recipients obtain medical, educational, vocational, and other services to reach goals identified in treatment plans.

(B) The following services must be furnished by the agency certified for treatment foster care to receive reimbursement from Medicaid. Payment for performance of these services is included in the provider's reimbursement rate:

1. Assessment of the recipient's progress in TFC and assessment of family interactions and stress;
2. Regularly scheduled counseling and therapy sessions for recipients in individual, family, or group sessions;
3. Facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques, and self-care techniques;
4. Crisis intervention, including twenty-four (24) hour availability of appropriate staff to respond to crisis situations; and
5. When a return to the natural family is planned, assessment of family strengths and needs and development of a family service plan.

Noncovered Service

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following services:

1. Room and Board;
2. Formal educational or vocational services related to traditional academic subjects or vocational training; and
3. Respite care.

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with recipients, families or legal guardians, physicians, if applicable, and others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC program.

(A) The treatment team must review the treatment plan every thirty (30) days.
(B) The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:

1. Statement of the nature of the specific problem and the specific needs of the recipient;

2. Description of the functional level of the recipient, including the following:

A. Mental status assessment;
B. Intellectual function assessment;
C. Psychological assessment;
D. Educational assessment;
E. Vocational assessment;
F. Social assessment;
G. Medication assessment; and
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 therapy services;
5. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
6. Specification of staff and TFC parent responsibilities, description of proposed 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 recipient; and

7. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

NMAC citation 322.5/ MAD citation 745.5 TREATMENT FOSTER CARE (LEVEL II): The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for treatment foster care services must be identified in the Tot to Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology. [11-1-99]

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by the provider on behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds. [11-1-99]

Covered Services

Treatment Foster Care II is a mental and behavioral health treatment modality provided by a specially trained treatment foster care parent or family in his or her or their home. Treatment parents are employed by or contracted for and trained by a TFC agency certified by The New Mexico Children, Youth and Families Department (CYFD). TFC II combines the normalizing influence of family-based care with individualized treatment interventions and social supports, thereby creating a therapeutic environment in the family context or maintaining and extending an existing therapeutic context established in TFC. Through the provision of TFC II services, the child's symptoms are expected to decrease and functional level to improve or maintain so that he or she may be discharged successfully to a less restrictive setting, that best meets the child's needs. Medicaid covers those services included in the individualized treatment plan which are designed to help recipients develop skills necessary for successful reintegration into the biological, foster or adoptive family or transition to the community. TFC II will allow for a step-down from TFC when the child improves and no longer meets those utilization review criteria. TFC II will also allow entry into the program at a lower level of care for those children who would benefit optimally from the treatment foster care model.

(A) The therapeutic family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:

1. Participation in the development of treatment plans for recipients by providing input based on their observations;
2. Assumption of primary responsibility for implementing the in-home treatment strategies as specified in an individualized treatment plan;
3. Recording of information and documentation of all activities required by the foster care agency and the standards under which it operates;
4. Helping recipients maintain contact with their families and fostering enhancement of those relationships as appropriate;
5. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
6. Through coordinating, linking and monitoring services, assist recipients to obtain medical, educational, vocational, and other necessary services to reach goals identified in the treatment plan.

(B) The following services must be performed by the agency or be contracted for and overseen by the agency certified for treatment foster care to receive reimbursement from Medicaid.

1. Assessment of the recipient and his biological, foster or adoptive family's strengths and needs;
2. Development of a discharge plan that includes a strengths and needs assessment of the recipient's family when a return to that family is planned, including a family service plan;
3. Development and monitoring of the treatment plan;
4. Assessment of the recipient's progress in TFC II;
5. Assessment of the TFC II family's interaction with the recipient, his or her biological, foster or adoptive family, and any stressors identified;
6. Facilitation of age-appropriate skills development in the areas of household management, nutrition, physical, behavioral and emotional health, basic life skills, social skills, time management, school and/or work attendance, money management, independent living skills, relaxation techniques, and self-care techniques;
7. Ensuring the occurrence of counseling or therapy sessions for recipients in individual, family and/or group sessions as specified in the treatment plan; and

8. Ensuring the availability of crisis intervention, including twenty-four (24) hour a day, seven (7) days a week) availability of appropriately licensed parties to respond to crisis situations. [11-1-99]

Noncovered Service

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following services:

1. Room and Board;
2. Formal educational or vocational services related to traditional academic subjects or vocational training; and
3. Respite care. [11-1-99]

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with the recipient, his or her biological, foster or adoptive family or legal guardian, physician(s), when applicable, and others in whose care the recipient is involved and/or in whose care to whom the recipient will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC II program.

(A) The treatment coordinator must review the treatment plan every thirty (30) days.

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

1. Statement of the nature of the specific problem and the specific needs and strengths of the recipient;
2. Description of the functional level of the recipient, including the following:
    A. Mental status assessment;
    B. Intellectual function assessment;
    C. Psychological assessment;
    D. Educational assessment;
    E. Vocational assessment;
    F. Social assessment;
    G. Medication assessment; and
    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;

5. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
6. Specification of staff and TFC II parent responsibilities and the description and frequency of the following components: proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, special diet, and special procedures recommended for the health and safety of the recipient; and
7. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge. [11-1-99]

II. ADMISSION CRITERIA (Meets A, B, E, and C or D):

**These admission criteria are for both TFC I and II, with some caveats, as noted below.*

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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 his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.
E. Less restrictive or intensive levels of treatment have been tried and shown to be iinadequate to meet the member's needs. Documentation exists to support these contentions.
F.

FOR <u>TFC I</u> THE FOLLOWING ADDITIONAL ADMISSION CRITERIA MUST BE MET:

F. The member is unable to participate independently (without 24-hour adult supervision) in age appropriate activities.

FOR <u>TFC II</u> THE FOLLOWING ADDITIONAL ADMISSION CRITERIA 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 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. Members in TFC II can generally participate independently in age appropriate activities (e.g. dressing self at age 7, working at age 16, 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; 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.

III. CONTINUED STAY CRITERIA (MEETS ALL):

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 reasonable 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) which includes specific 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.
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.

IV. CRITERIA FOR TRANSITION FROM TFC I TO TFC II (MEETS ALL):

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 treatment foster care 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 is able to participate independently in age appropriate activities without continuous adult supervision.

V. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.
B. The member has not benefited from Treatment Foster Care 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.

VI. EXCLUSIONARY CRITERIA FOR TFC I AND TFC II (MAY MEET ANY)

A. There is evidence that the TFC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have 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 individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
D. Quality of Service Criteria: 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.
E. Quality of Service CriteriaTreatment 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.

GROUP HOME

I. DEFINITION OF SERVICE:

Group Home is a lower level of care than Residential Treatment Center 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 Treatment Foster Care in that they are residentially and group based, rather than family and community based.

NMAC citation 321.4 /MAD citation 742.3 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES:

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot to Teen HealthCheck screen or other diagnostic evaluation furnished through a

HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients 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 recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of nay financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

1. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
2. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
3. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management;
4. Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
5. Appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up;
6. Consultation with other professionals or allied care givers regarding a specific recipient;
7. Non-medical transportation services needed to accomplish the treatment objective; and

8. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Noncovered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

1. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
2. Room and board;
3. Services for which prior approval was not obtained;
4. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
5. Formal educational or vocational services related to traditional academic subjects or vocational training;
6. Experimental or investigations procedures, technologies, or non-drug therapies and related services;
7. Drugs classified as "ineffective" by FDA Drug Evaluations; and
8. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, legal guardians or others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of the recipient's admission.

(A) The interdisciplinary team must review the treatment plan at least every thirty (30) days.

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

1. Statement of the nature of the specific problem and the specific needs of the recipient;
2. Description of the functional level of the recipient, including the following:
    A. Mental status assessment;
    B. Intellectual function assessment;
    C. Psychological assessment;
    D. Educational assessment;
    E. Vocational assessment;

F. Social assessment;
G. Medication assessment; and
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 therapy services;
5. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;
6. Specification of staff responsibilities, description of proposed staff involvement, and 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 recipient; and
7. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

II. ADMISSION CRITERIA (MEETS A, B AND C, AND EITHER D OR E):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 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 have been tried and shown to 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 is in need of 24-hour therapeutic milieu, but does not require the intensive staff assistance that is provided in Residential Treatment Center Services.

III. CONTINUED STAY CRITERIA (MEETS ALL):

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.
A. 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, 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 reasonable 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 which includes specific 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.
E. 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.
F. 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.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her 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.

V. EXCLUSIONARY CRITERIA (MAY MEET ANY):

A. There is evidence that the Group Home placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have 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 of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Group Home care.
C. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
D. MCO Quality of Service Criteria # 5 has not been met: 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.
E. MCO Quality of Service Criteria # 8 has not been met: 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.

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

ABA services are provided to a Medical Assistance Programs (MAP) eligible member 12 months up to 21 years of age. A member's eligibility for ABA service falls into one of two categories: "At Risk for ASD" or "Diagnosed with ASD." An eligible member must meet the level of care (LOC) Criteria detailed below, which includes medically necessary criteria, and the requirements which have been detailed in 8.321.2 NMAC and the Medical Assistance Program Manual Supplement 16-08.

I) ADMISSION CRITERIA for Diagnosed with ASD and At-Risk for ASD
(Must meet A-G for admission)

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; and/or
C. The eligible member presents a safety risk to self or others. (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, maladaptive behavior.
E. The eligible member's caregivers are able to 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 A member may be considered At-Risk for ASD, and therefore eligible for time-limited, Focused ABA Services if he or she does not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when he or she meets all of the following criteria:
        a) Is between 12 and 36 months of age;
        b) Presents with developmental differences and/or delays as measured by standardized assessment;
        c) Demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior);
        d) Presents with at least one genetic risk factor (e.g., the eligible member has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD; the eligible member has a diagnosis of Fragile X syndrome).
    2. *Diagnosed with ASD:* An eligible member 12 months up to 21 years of age 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.

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.

II) CONTINUED ELIGIBILITY CRITERIA

(Must meet A THROUGH C, OR BOTH A AND D for continuation)

- **A.** The eligible member continues to meet the 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 ABA Provider (AP) when requesting prior authorization for continuation of ABA services, the treatment plan and the treatment plan report (i.e., graphs, peer review) must be updated to reflect what interventions will be changed to produce measurable gains

III) DISCHARGE CRITERIA

(Must meet one of A-D for discharge)

Individualized discharge criteria are developed with appropriate, realistic, and timely follow-up care and these criteria are included in the initial or most current ABA Treatment Plan. An eligible member may be discharged from ABA services when any of the following are present:

- **A.** The eligible member has met his or her 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.

IV) EXCLUSIONARY CRITERIA

(Must meet one of A-F for exclusion)

An eligible member may be excluded from ABA services when any of the following are present:

- **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 LOC (Not to include treatment foster care: See note in Section III.).

B. The eligible member's provider, such as psychiatrist, recommends higher LOC.
C. The eligible member is in an out-of-home placement (Not to include treatment foster care: See note in Section III).
    a. 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 his or her discharge from the facility to a community ABA provider.

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.

PARTIAL HOSPITALIZATION, PSYCHIATRIC, ADULT

I. DEFINITION OF SERVICE:

Centennial Care pays for partial hospitalization services furnished in freestanding psychiatric hospitals. The need for outpatient or partial hospitalization services must be identified in a diagnostic evaluation furnished through a referral.

Partial Hospitalization is an intensive, structured and medically staffed, psychiatrically supervised treatment program intended for stabilization of acute psychiatric symptoms. The services are essentially of the same nature and intensity (including medical and nursing services) as would be provided in an inpatient setting, except that the consumer is in the program less than 24 hours a day. Partial Hospitalization is designed for consumers with serious behavioral disorders or disturbances of community functioning that require an intensive, ambulatory and active treatment program. The consumer can be maintained safely in the community but requires close monitoring. Support systems should be available and willing to assist the consumer with participation in treatment whenever possible. Partial Hospitalization offers intensive, multi-modal structured clinical services within a stable therapeutic milieu setting. An individualized treatment plan is developed, reviewed and updated on a regular basis. Partial Hospitalization programs may vary considerably depending upon the age and severity of illness of the consumers for whom the program is designed.

This level of care is available for all age ranges, but admission should be to a program that is age appropriate. For school age consumers, elementary and secondary schooling funded through the local school system or by the facility is expected.

II. ADMISSION - SEVERITY OF NEED

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-5 diagnosis.

B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, 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 stay.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
2) as a result of the patient'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:

1) the patient 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, *or*
2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

III. ADMISSION - INTENSITY AND QUALITY OF SERVICE

Criteria A, B, C, D, and E must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should include caretakers‘/guardians‘/family members‘ involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants‘ work schedules or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

D. A Urine Drug Screen (UDS) is 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 is considered.

E. For patients over 60 years of age, assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment.

IV. CONTINUED STAY

Criteria A, B, C, D, and E must be met to satisfy the criteria for continued stay.

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 (both severity of need and intensity of service needs), *or*
2. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
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 necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet 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 criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, 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 patient‘s post-partial hospitalization needs.

C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, 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-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

PARTIAL HOSPITALIZATION, PSYCHIATRIC, CHILD AND ADOLESCENT

I. DEFINITION OF SERVICE:

Centennial Care pays for medically necessary health services furnished to eligible recipients. To help Centennial Care recipients under 21 years of age receive the level of services needed, Centennial Care pays for partial hospitalization services furnished in freestanding psychiatric hospitals as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR Section 441.57]. The need for outpatient or partial hospitalization services must be identified in the Tot to Teen Healthcheck screen or other diagnostic evaluation furnished through a Healthcheck referral.

Partial Hospitalization is an intensive, structured and medically staffed, psychiatrically supervised treatment program intended for stabilization of acute psychiatric symptoms. The services are essentially of the same nature and intensity (including medical and nursing services) as would be provided in an inpatient setting, except that the consumer is in the program less than 24 hours a day. Partial Hospitalization is designed for consumers with serious behavioral disorders or disturbances of community functioning that require an intensive, ambulatory and active treatment program. The consumer can be maintained safely in the community but requires close monitoring. Support systems should be available and willing to assist the consumer with participation in treatment whenever possible. Partial Hospitalization offers intensive, multi-modal structured clinical services within a stable therapeutic milieu setting. An individualized treatment plan is developed, reviewed and updated on a regular basis. Partial Hospitalization programs may vary considerably depending upon the age and severity of illness of the consumers for whom the program is designed.

This level of care is available for all age ranges, but admission should be to a program that is age appropriate. For school age consumers, elementary and secondary schooling funded through the local school system or by the facility is expected.

II. ADMISSION - SEVERITY OF NEED

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-5 diagnosis.

B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, 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 stay.

C. Either:

1. there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
2. as a result of the patient'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:

1. the patient 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, or
2. the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

III. ADMISSION - INTENSITY AND QUALITY OF SERVICE

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for at least
weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

D. A Urine Drug Screen (UDS) is 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 is considered.

IV. CONTINUED STAY

Criteria A, B, C, D, and E must be met to satisfy the criteria for continued stay.

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 (both severity of need and intensity of service needs), *or*
2. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
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 necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of ned 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 criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, 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 patient‘s post-partial hospitalization needs.

C. The individual plan of active treatment includes at least weekly family therapy and/or support system involvement, unless there is an identified, 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-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

PARTIAL HOSPITALIZATION, SUBSTANCE USE DISORDERS

I.DEFINITION OF SERVICE : The need for outpatient or partial hospitalization services must be identified in a diagnostic evaluation furnished through a referral.

Partial Hospitalization is an intensive, structured and medically staffed, psychiatrically supervised treatment program intended for stabilization of a substance use disorder. The services are essentially of the same nature and intensity (including medical and nursing services) as would be provided in an inpatient setting, except that the consumer is in the program less than 24 hours a day. Partial Hospitalization is designed for consumers with serious substance use disorders that require an intensive, ambulatory and active treatment program. The consumer can be maintained safely in the community but requires close monitoring. Support systems should be available and willing to assist the consumer with participation in treatment whenever possible. Partial Hospitalization offers intensive, multi-modal structured clinical services within a stable therapeutic milieu setting. An individualized treatment plan is developed, reviewed and updated on a regular basis. Partial Hospitalization programs may vary considerably depending upon the age and severity of illness of the consumers for whom the program is designed.

This level of care is available for all age ranges, but admission should be to a program that is age appropriate.

II. ADMISSION CRITERIA – SEVERITY OF NEED

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-5 criteria and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

B. The patient’s condition requires a structured program of substance use rehabilitation services with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, rehabilitation treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.

C. The patient’s detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. The patient demonstrates motivation to manage symptoms or make behavioral change.

F. The patient is capable of developing skills to manage symptoms or make behavioral change.

III. ADMISSION CRITERIA – INTENSITY AND QUALITY OF SERVICE
Criteria A, B, C, D, E, and F must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. There is a structured program with evaluation by a psychiatrist or a licensed Ph.D. psychologist within 48 hours, frequent nursing and/or medical supervision, active substance use rehabilitation treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, there is sufficient availability of medical and/or nursing services to manage this patient's ancillary detoxification needs.

C. The individualized plan of substance use rehabilitation treatment for partial hospitalization requires treatment by a multidisciplinary team. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants work schedule or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.

F. For patients over 60 years of age, assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment.

IV. CONTINUED STAY CRITERIA

Criteria A .B, C, D, E, and F must be met to satisfy the criteria for continued stay.

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 (both severity of need and intensity of service needs), or

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet 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 criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, 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 patient's post-partial hospitalization needs.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

E. 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.

F. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

ELECTROCONVULSIVE THERAPY (ECT)

ECT is a benefit for the Alternative Benefit Plan (Medicaid Expansion Population) and is a Value Added (non-entitlement) Service for standard Medicaid recipients.

I. DEFINITION OF SERVICE:

Electroconvulsive therapy (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 leading 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 along with alternative treatments considered, 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 or for anesthesia services.

References:
The Practice of Electroconvulsive Therapy: Recommendations for Training, Treatment, and Privileging (2nd edition) American Psychiatric Publishing, Inc. www.appi.org
Coverage Determination Guideline (2013) OPTUM by United Behavioral Health.

II. CRITERIA FOR APPROVAL (MEETS ALL):

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. 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 treatment resistant depression or psychotic disorder, is experiencing a severe or prolonged manic episode unresponsive to usual

treatments, cannot tolerate usual psychotropic medications, exhibits food refusal leading to nutritional compromise or is experiencing such intense suicidal ideation that there is an urgent need for response, or it is the member's choice for treatment.

II. CRITERIA FOR MAINTENANCE ELECTROCONVULSIVE THERAPY (MEETS ALL):

A. The member meets the criteria for approval for ECT as outlined above, received ECT, and had a positive response.
B. Other treatment options are not viable for the member.
C. A second opinion from another (other than the current treating psychiatrist) is obtained every 6 months documenting the need for maintenance ECT.

VII. EXCLUSIONARY CRITERIA (MAY MEET ANY):

The member is under age 18 as electroconvulsive therapy is considered aversive treatment and thereby is prohibited in the treatment of minors. Reference: According to 32A-6A-8 special rules applicable to aversive intervention; A. An intervention expressly listed in the "aversive intervention" definition in Section 4 [32A-6A-4 NMSA 1978] of the Children's Mental Health and Developmental Disabilities Act is prohibited.

HOSPITALIZATION (PSYCHIATRIC OR DETOXIFICATION UNIT), SUBSTANCE USE DISORDERS, DETOXIFICATION (ABP ONLY)

Criteria for Admission
The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, and C must be met to satisfy the criteria for severity of need.
A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.

B. Detoxification cannot be safely or effectively managed at a less-intensive level of care and/or by an organized support system.

C. Detoxification at an acute (medical) inpatient level of care is not required because the patient does not present with:
1) co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered, or

2) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm or

3) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances

II. Admission - Intensity and Quality of Service
Criteria A, B, C, D, E, F, and G must be met to satisfy the criteria for intensity and quality of service.
A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and licensed registered nurse staffing. This staffing must provide 24-hour on-site services, including skilled observation and medication administration.

C. Treatment must include at least once-a-week psychiatric reassessments, and

D. Documentation of blood and/or urine drug screen is ordered upon admission.

E. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

F. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

G. Treatment interventions provided once daily are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

Criteria A, B, C, D, and E must be met to satisfy the criteria for continued stay.
A. Admission criteria continue to be met.
B. There are physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.
C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-residential treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

ASSERTIVE COMMUNITY TREATMENT

I. DESCRIPTION OF SERVICES

The purpose of these criteria is to define and clarify when assertive community treatment mental health services meet the definition of medical necessity.

PRINCIPLES FOR CERTIFICATION

Assertive Community Treatment 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/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 which require multiple mental health and support services to maintain the individual in the community. Such services are active and rehabilitative in focus, and are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individuals functioning and community tenure.

Medical necessity for assertive community treatment services is established by satisfying the admission and continued care criteria outlined in the following sections. 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.

II. CRITERIA FOR ADMISSION

1. 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; **and**

2. The individual is medically stable and does not require a level of care that includes more intensive medical monitoring; **and**

3. The individual lives independently in the community or demonstrates a capacity to live independently and transform from a dependent residential setting to independent living.

4. Degree of impairment-(must meet A or B; may meet C)

A. Individual 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 his/her judgment, impulse control and/or cognitive perceptual abilities.
B. Individual 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.
C. Individual 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.

III. CRTIERIA FOR CONTINUED STAY

Continuation of assertive community treatment services is appropriate for individuals who meet each of the criteria A-D outlined below.

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 individual 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. Individual 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 individual self-efficiency and maximizes independent functioning. Treatment techniques are employed to encourage use of natural support systems to promote an individual mastery of his/her environment. Active assessment of ongoing need for ACT team support completed every six months.

BEHAVIORAL HEALTH DAY TREATMENT-CHILDREN & ADOLESCENTS

VI. DEFINITION OF SERVICE:

http://www.bhc.state.nm.us/BHServices/ServiceDefinition.html

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, weekends, or when school is not in session. Services include counseling (individual, group, family), parent consumer education, 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, utilizing a clinical model for service delivery and support.

The goal of day treatment is to increase adaptive functioning and developing 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 those individuals being discharged from residential services that require intensive therapeutic interventions to facilitate family reunification and/or emancipation in a least restrictive environment.

Provision of Day treatment services must be preceded by documentation of individual member needs as determined through initial assessment and on-going reassessment. Day treatment components include:

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/adolescent's individualized treatment plan goals and should include interventions with significant member of the family, which 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 managing anger, communicating 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. The program includes 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 are also included in the program
g. Availability of appropriate staff to provide crisis intervention is also required
h. Day treatment services provide 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 practitioners employed by a mental health// substance abuse organization.
Day treatment provides services a minimum of four hours of structured programming per day, two to five days per week based on acuity.

II. ADMISSION CRITERIA (MEETS ALL):

A. The member has a DSMor the current edition of the ICD diagnosed psychiatric condition that requires, and is likely to benefit from structure 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 members 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 the member's recovery and resiliency goals.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria for this service.
B. An individualized treatment plan with measureable goals and objectives that addresses the member's specific needs has been developed, with the member's and family's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
C. The treatment plan is reviewed and modified as needed 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 have not been met.
G. Progress towards discharge goals is being made as evidenced by adherence with treatment or measurable reduction in symptoms.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her 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.

BEHAVIOR MANAGEMENT SERVICES

I. DEFINITION OF SERVICE:

Centennial Care pays for medically necessary health services furnished to eligible recipients. To help recipients under twenty-one (21) years of age who are in need of behavior management intervention receive services, Centennial Care pays for eligible providers to furnish these services as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program [42 CFR § 441.57]. These services can be accessed only through the Tot to Teen HealthCheck screen or other diagnostic evaluations furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Agreements by MAD, agencies that meet the following requirements are eligible to be reimbursed for providing behavior management services:

1. Certification as providers of Behavior Management Skills Development Services by the Children, Youth and Families Department (CYFD); and
2. 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. Recipients have the right to receive services from the eligible provider of their choice. Once enrolled, providers receive a packet of information; including 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 recipients 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 recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients.

Eligible Recipients

Behavior management services can be furnished only to Medicaid recipients less than twenty one (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, recipients must meet the level of care for this service established by MAD or its designee.

Covered Services

Medicaid covers services specified in individualized treatment plans which are designed to improve the recipient'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 natural families to help recipients achieve and/or maintain appropriate behavior management skills; and
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 perform the following:

1. Assessment of the recipient's progress in behavioral management services; and
2. Twenty-four (24) hour availability of appropriate staff to respond to crisis situations.

II. SERVICES NOT COVERED UNDER CENTENNIAL CARE

Behavior management services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific services:

1. Formal educational or vocational services related to traditional academic subjects or vocational training; and
2. Activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the behavioral management treatment plan.
3. Services provided in lieu of services that should be provided as part of the MAP eligible recipient’s individual educational plan (IEP).

III. THE TREATMENT PLAN

The treatment plan must be developed by a team of professionals in consultation with recipients, parents, legal guardians, and physicians, if applicable, prior to service delivery or within fourteen (14) days of initiation of services.

(A) The team must review the treatment plan at least every thirty (30) days.

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

1. Statement of the nature of the specific problem and the specific needs of the recipient;

2. Description of the functional level of the recipient, including the following;

A. Mental status assessment;
B. Intellectual function assessment;
C. Psychological assessment;
D. Educational assessment;
E. Vocational assessment;
F. Social assessment;
G. Medication assessment; and
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 these intermediate and long-range goals, including provisions for the 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 recipient; and

7. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

IV. ADMISSION CRITERIA

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the
criteria for admission.

I. Admission - Severity of Need

Criteria A, B, and C, must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSMor a diagnosis in the current edition of the ICD - a disorder that is amenable to active

psychiatric treatment and has a high degree of potential for leading to out of home placement (NMAC 8.321.2),in an acute psychiatric
hospital or residential treatment facility in the absence of behavioral management services

B The recipient 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 the 24 hour medical/nursing monitoring or
procedures provided in a hospital or residential treatment level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSMdiagnosis, or diagnosis in the current edition of the ICD which must result from a face-to-face behavioral health evaluation by a licensed practitioner.
B. There is ongoing Assessment of the recipient's progress in behavioral management services
C. There is Twenty-four (24) hour availability of appropriate staff to respond to crisis situations.
D. A discharge plan is initially formulated that is directly linked to 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 consumer’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 fourteen (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.

V. CONTINUED STAY CRITERIA (MUST MEET ALL)

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 problems meeting criterion IVA, and this is documented in progress
notes, 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.

VI. DISCHARGE CRITERIA (MUST MEET EITHER A OR B, AND C AND D)

A. The recipient has met the goals outlined in the comprehensive treatment plan.
B. The recipient has not participated in the behavioral management services despite reasonable efforts to engage the recipient and modify the treatment plan as appropriate.
C. The recipient can be safely and effectively treated at a less intensive level of care.
D. An appropriate, realistic discharge plan with timely follow-up is in place.

COMPREHENSIVE COMMUNITY SUPPORT SERVICES

http://www.bhc.state.nm.us/BHServices/ServiceDefinition.html

I. DEFINITION OF SERVICE:

The purpose of Comprehensive Community Support Services (CCSS) is to surround individuals/families with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services consist of a variety of interventions, primarily face-to-face and in community locations that address barriers that impede the development of skills necessary for independent functioning in the community.

Community Support Services also include assistance with identifying and coordinating services and supports identified in an individual's service plan; supporting an individual 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 mental 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 NM 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 be certified to provide CCSS services by CYFD/LCA or DOH/DHI.

Other providers eligible to provide CCSS include:

- FQHCs
- IHS or 638 Tribal Facilities

CCSS staff must meet the state minimum requirements.

II. EXCLUSIONS

This service may not be billed in conjunction with:

- Multi-systemic Therapy
- Assertive Community Treatment
- Accredited Residential Treatment
- Residential Treatment Services
- Group Home services
- Inpatient Hospitalization
- Partial Hospitalization
- Treatment Foster Care
- Recreational outings

• Transitional Living Services
• Resource Development (NMCD)

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.

III. THE TREATMENT PLAN

1. Assistance to the individual 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.

2. 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.

3. Individualized interventions, with the following objectives:

• Services and resources coordination to assist the individual in gaining access to necessary rehabilitative, medical and other services;

• Assistance 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;

• Assistance 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 individual to obtain and maintain stable housing;

• Any necessary follow-up to determine if the services accessed have adequately met the individual's needs;

4. 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.

5. For individuals and/or their families: The community support worker will make every effort to engage the client in achieving treatment/recovery goals.
6. 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.
7. Behavior management interventions are not considered to be Comprehensive Community Support Services and should be billed under Behavior Management Services

IV. GUIDELINES FOR ADMISSION

Comprehensive community support services are appropriate for adults, adolescents and children who have a serious mental disorder, who meet each of the guidelines outlined below in A and B.

A. Severity of Need

1. A clinical evaluation indicates that the individual has a primary DSM-IV-TR or 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:
    a. Inability to care for personal needs and carry out independent living skills,
    b. Limited school or employment performance,
    c. Interpersonal relationship problems, and
    d. Limited ability to manage psychiatric symptoms.
2. Without adequate comprehensive community support services, impairment described in number 1 above puts the individual at risk for:
    a. A higher level of care, or
    b. Loss of a basic support, such as housing or employment.
3. 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; and
4. Expectation that the individual's condition can improve through provision of medically necessary and appropriate rehabilitation intervention.

B. Intensity of Service

1. The individual requires a program of rehabilitation supports to remain in the community; and
2. The individual treatment plan documents active rehabilitation services geared toward improving the individual's symptoms, behavior, or level of functioning.

V. GUIDELINES FOR CONTINUED CARE

Continuation of comprehensive community support services is appropriate for individuals who meet all of the guidelines below (A-C).

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 - occupational, residential, scholastic, social - in any or all of the following:
   1. Ability to care for personal needs and carry out independent living skills;
   2. School or employment performance;
   3. Interpersonal relationships, and
   4. Ability to manage psychiatric symptoms.

B. The individual's continuing need for the services provided by Comprehensive Community Support Services privileged staff in order for the individual to:
   1. Live as independently as possible in the community, and
   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 mental disorder, and
   2. The individual's condition can be expected to improve or be maintained through medically necessary and appropriate comprehensive community support intervention.

MULTI-SYSTEMIC THERAPY (MST)

I. 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. 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 individual 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).

SEVERITY OF NEED

Criteria A, or B, or C (at least one) *and* D, E, F and G must be met:

A. The youth's treatment planning team or child and family team (CFT) recommends that he or she participate in MST *or*

B. Youth diagnosed with depression or other DSMor 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) *or*

C. Youth with substance abuse issues if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment *and*

D. Externalizing behaviors symptomatology such as chronic or violent juvenile offenses, resulting in a DSMor 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. Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting
F. Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems
G. Less intensive treatment has been ineffective or is inappropriate.

II. INTENSITY AND QUALITY OF SERVICE

Criteria A, B, C, D and E all must be met: Multi-Systemic Therapy (MST) 57

A. Provide practical and goal-oriented treatment that specifically targets the factors in a youth's social network that are contributing to the problem behaviors.
B. Provide at least weekly encounters with the youth or family for an expected duration of service of three to six months.
C. MST treatment directly provides the following support and services within the family's home or community:
    1. Availability of services 24 hours a day, seven days a week
    2. Assessment and ongoing treatment planning based the specific behavior
    3. Family therapy
    4. Individual therapy (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.
E. 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.

III. CRITERIA FOR CONTINUED STAY

Criteria A, B, C and D must all be met:

A. Treatment does not require more intensive level of care.

B. The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
C. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.
D. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement

PSYCHOLOGICAL TESTING

Prior to psychological testing, the individual must be assessed by a qualified behavioral health care 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 to help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed since the institution of the initial treatment plan and there is no clear explanation for the lack of improvement.

I. Severity of Need

Criteria A, B, and C must be met:

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.

II. Intensity and Quality of Care

Criteria A and B must be met:

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, who is credentialed by and contracted with Presbyterian administers the tests.

B. Requested tests must be standardized, valid and reliable in order 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.

III. Exclusion Criteria

Psychological testing will not be authorized under any of the following conditions:

A. The testing is primarily for educational or vocational purposes.

B. The testing is primarily for the purpose of determining if an individual is a candidate for a specific medication or dosage.

C. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual 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., an individual who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).

E. The testing is primarily for diagnosing attention-deficit hyperactive disorder (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 (legal) purposes, including custody evaluations, parenting assessments, or other court or government ordered or 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 plan of remediation or treatment, unless allowed by the individual'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 particular testing circumstances.

L. Structured interview tools that do not have psychometric properties or normative comparisons.

PSYCHOSOCIAL REHABILITIATION SERVICES: ADULT, ADOLESCENT, CHILD

DESCRIPTION OF SERVICES:

Psychosocial Rehabilitation Services facilitate the development of an individual'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 individual into the community. Services may be provided onsite in a rehabilitation facility or offsite in a setting most conducive to promoting the individual's participation in the community. This may include the individual's home, rehabilitation residence, job site, education setting, community setting, etc. Level of intensity may vary depending upon changes in the individual's environment or the individual's needs.

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

I. GUIDELINES FOR ADMISSION:

Psychosocial Rehabilitation Services are appropriate for adults, adolescents, and children who have a serious mental disorder who meet each of the guidelines outlined below in section A and B.

A. SEVERITY OF NEEDS:

1. A clinical evaluation indicates that the individual has a primary DSM or the current edition of the ICD diagnosis of a mental disorder that is the cause of significant psychological, personal care, vocational, education, or social impairment, such as:

A. Inability to care for personal needs and carry out independent living skills,
B. Limited school or employment performance,
C. Interpersonal relationship problems, and
D. Limited ability to manage psychiatric symptoms;

1. Without adequate Psychosocial Rehabilitation Services, impairment described in section 1 puts the individual at risk:
   For a higher level of care, or Loss of a basic support, such as housing or employment;
2. 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; and
3. Expectation that the individual's condition can improve through provision of medically necessary and appropriate rehabilitation intervention.

B. INTENSITY OF SERVICES:

1. The individual requires a program of rehabilitation supports to remain in the
   community; and
2. The individual treatment plan documents active rehabilitation services geared to improving the individual's symptoms, behavior, or level of functioning.

III. GUIDELINES FOR CONTINUED CARE:

Continuation of Psychosocial Rehabilitation Services is appropriate for individuals who meet all of the guidelines below (A-C).

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 -
occupational, residential, scholastic, social - in any or all of the following:

1. Ability to care for personal needs and carry out independent living skills;
2. School or employment performance;
3. Interpersonal relationships, and
4. Ability to manage psychiatric symptoms.

B. The individual's continuing need for the services provided by Psychosocial Rehabilitation Services privileged staff in order for the individual to:

1. Live as independently as possible in the community, and
2. Avoid inpatient care;

C. Clinical evidence indicating that:

1. Termination or reduction of Psychosocial Rehabilitation Services would result in an exacerbation of the mental disorder, and
2. The individual's condition can be expected to improve or be maintained through medically necessary and appropriate psychosocial rehabilitative intervention

RESPITE

I. DEFINITION OF SERVICE:

Respite, as part of a comprehensive service system, allows the family to strengthen resiliency during the respite while the youth is in a supportive environment. Respite care is provided to youth with a severe emotional disturbance who resides with the family and display challenging behaviors that may periodically overwhelm the family's ability to provide ongoing supportive care.

Services may be provided on a short-term basis (few hours during the day) or for longer periods of time involving overnight stays. Respite may be provided on a planned or unplanned basis. If unplanned respite is needed, the appropriate agency personnel will assess the situation and, with the caregiver, recommend the appropriate setting for respite. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of the caregiver.

In Home Respite Examples:

- Member's Home Environment
- Family/Caregiver/Guardian Home Environment

II. SPECIFICATIONS:

A. A Plan Respite provider is licensed at the 24 hour care level by the State and staff must have access to a New Mexico-licensed independent mental health professional.

B. Staff must have the following:

(a) Basic training in mental health symptomatology.
(b) Emergency response training, (i.e., CPR).
(c) Training in crisis identification and response procedures.

C. Available bed(s) and designated staff assigned for 24 hour supervision.

D. Ability to coordinate with other providers regarding the treatment and discharge planning of members in respite care.
E. A licensed independent mental health practitioner must be on-call 24 hours per day, seven days per week. These individual(s) should be employed or contracted with the in/out-of-home respite provider; and/ or the member's psychiatrist or other licensed mental health professional should be available by phone for consultation 24 hours per day, seven days per week.
F. Continuous documentation of enrollee activities/progress and any Case Management activity while in respite care. All notes co-signed by the appropriate clinical health staff.
G. Immediate access to local hospital/emergency care under the care of a licensed psychiatrist.

III. UTILIZATION MANAGEMENT GUIDELINES:

Admission Criteria
A. Outpatient services will not meet the family's needs for support and education.
B. Family and caregivers are unable to participate in the normal activities of daily life in the community as a result of caring for the enrollee, thus putting the enrollee at risk for out-of-home service level beyond the scope of Respite Care.

Continued Stay Criteria
N/A

Exclusion Criteria (Any one of the following):
A. Member is residing in a licensed therapeutic foster care home or specialized therapeutic foster care home.
B. Member meets the criteria for a more or less intensive and restrictive level of care.
C. Member is at risk to harm self, others or property.
D. Member has medical condition(s) that prevent utilization of Respite care.

Discharge Criteria (Either of the following):
A. Treatment plan goals and objectives have been substantially met.
B. Member meets criteria for a more or less intensive and restrictive level of care.