HUMAN SERVICES DEPARTMENT

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Letter of Direction #62

Date: **May 21, 2021**

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

From: **Nicole Comeaux, Director, Medical Assistance Division**
Neal Bowen, Director, Behavioral Health Services Division

Subject: **Crisis Triage Centers**

Title: **Implementation of Crisis Triage Center Services**

The purpose of this Letter of Direction (LOD) is to provide guidance and directives to the Centennial Care 2.0 Managed Care Organizations (MCOs) for implementation of the Crisis Triage Center (CTC) services.

Crisis Triage Center Services

Crisis Triage Center (CTC) services are covered for all Medicaid members who are 14 years of age and older. This includes recipients who are covered by the Alternative Benefit Plan (ABP). CTCs must be licensed by the New Mexico Department of Health. CTCs may serve youth 14 years through 17 years only, adults 18 years and older only, or both populations, depending on the scope of the DOH license. CTCs may follow one of two service models: clients are present for 23 hours or less, generally referred to as the non-residential model, or a mix of clients who are present for 23 hours or less, as well as those who are present for more than 24 hours, generally referred to as the residential/non-residential model. In this model the average length of stay is five to seven days, but individual length of stay is based on daily readiness for discharge evaluations conducted by the CTC.

MCOs are directed to pay for services rendered by any Medicaid-enrolled CTC within their network of providers. CTCs are reimbursed through an agency specific cost based bundled rate; the agency is responsible for providing its rate information to each MCO. Medical assessments (90792) and mental health intake assessments (90791) are part of determining eligibility for CTC services, and as such are not included in the CTC's bundled rate and will be billed separately on a professional claim form (e.g. CMS-1500 or 837P). A CTC may also bill separately for comprehensive community support services (CCSS) (H2015) for discharge planning and transition purposes, which will also be billed on a professional claim form.

CTC proxy rates
CTCs are reimbursed through an agency specific cost based bundled rate developed by the agency and HSD. Because the rate setting process can take several months, some providers will receive a proxy rate they can use to bill while their final rate is being developed. HSD will provide a letter with approved rates established to each provider, both for the proxy rate and the final rate. The providers will then present the letter to the MCOs to establish the individual provider rates.

When the CTC is prepared to switch from the proxy rate to their actual rate, MCOs are directed to make that transition in a timely matter. Whether the final rate is higher or lower than the proxy rate, there will be no retroactive adjustment for the difference.

Expedited Credentialing, Contracting and Configuration
MCOs are directed to expedite credentialing and contracting with Medicaid-enrolled CTCs. MCOs are also directed to expedite any systems configurations necessary to recognize the CTC as a network provider with sufficient accuracy to pay claims using the billing codes included in this LOD.

Retroactive payment
MCOs are directed to pay CTC claims retroactive to the date the provider enrolled with Conduent as a MAD provider type 342, with specialty type 246 if the provider offers services using the mixed residential/non-residential model, or specialty 247 if the provider uses the non-residential, 23 hours or less model.

Prior Authorization
Crisis triage services do not require prior authorization (PA) but are provided as approved by the crisis triage center provider agency. To facilitate discharge planning and transitions of care, CTCs using the residential model are instructed to inform the client's MCO on admission and prior to discharge so that care coordination can be engaged as needed.

However, CTCs may offer other procedures or services that may require prior authorization from MAD or its designee when such services require prior authorization for other MAD eligible recipients. MCOs are directed to waive any PA requirements for 30 days from the date of this LOD, or until MCOs have fully configured their system with the changes in this LOD, whichever is greater.

CTC Billing Codes
All fees will be based on established individual provider rates. HSD has provided a letter with approved rates established to each provider. The providers will then present the letter to the MCOs to establish the individual provider rates.

The following billing codes are to be used when billing Medicaid MCOs for CTC services on the UB claim form:

1. For residential/non-residential CTC, bill one or the other revenue code depending on length of stay:
    a. Bill rev code 0169, room and board if staying more than 24 hours
    b. Bill rev code 0513, psychiatric admission staying less than 24 hours
    c. Type of bill is 089X

No other revenue codes can be billed on the claim submitted with this combination of revenue code and type of bill 089x. And no procedure code should be billed in conjunction with either revenue code 0169 or 0513.

2. For a non-residential only (outpatient) CTC, bill the following revenue code and do not include any procedure code associated with this bundled revenue code:

a. Bill rev code 0513, psychiatric clinic
b. Type of bill is 0131

3. For services rendered in the non-residential only CTC, billed with type of bill 0131, in addition to the bundled revenue code 0513, the following revenue codes should be included as additional informational lines to be paid at zero dollars ($0.00), if that specific service was rendered. The CTC may include whatever applicable procedure code that further defines any revenue code used; however, a procedure code is not necessarily required:

a. 0914 – individual therapy
b. 0915 – group therapy
c. 0916 – family therapy
d. 0944 – drug rehab
e. 0945 – alcohol rehab
f. 0961 – psychiatric
g. 0984 – medical social services

Informational Only: BHSD (State General Fund) will pay an additional $50 per client per day of CTC services for room and board, billed through the BHSD Star system. This funding is only available for CTCs who are billing Medicaid for CTC services as specified above. If this code should get billed on the CTC claim received by the MCO, it should be denied by the MCO.

- Room and board per diem ($50 per client per day) = HCPCS H0047

Sunset

This LOD will sunset upon inclusion in the Behavioral Health Policy and Billing Manual.

Any questions regarding this LOD should be directed to Tiffany Wynn, Deputy Director for Treatment and Programs, tiffany.wynn@state.nm.us