PART 426 COMMUNITY MENTAL HEALTH SERVICES

REVISION NOTE:

Document #5433, effective 7-2-92, readopted with amendments Part He-M 426. Document #5433 superseded all prior filings for the section in this Part. The prior filings for former Part He-M 426 included the following documents:

#4313, eff 9-25-87
#4798, eff 4-24-90 Interim
#4921, eff 8-22-90
#5178, eff 7-19-91

Document #5589, effective 2-25-93, and Document #5703, effective 9-17-93, superseded or amended different sections in He-M 426 after Document #5433 as noted in the source notes.

Document #5971, effective 2-1-95, superseded or amended several sections in He-M 426. Document #5971 also adopted a new section He-M 426.13 entitled "Case Management Services" and renumbered existing sections He-M 426.13 through He-M 426.20 as He-M 426.14 through He-M 426.21. The source notes for He-M 426.14 through He-M 426.21 therefore now contain the filing history of rules which had been numbered He-M 426.13 through He-M 426.20 prior to Document #5971.

He-M 426.01 Purpose. The purpose of these rules is to describe the services provided by CMHPs and community mental health providers that are offered to persons eligible for services pursuant to He-M 401 and are reimbursable under the medicaid program.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92, EXPIRED: 7-2-98

New. #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.02 Definitions. The words and phrases in this rule shall mean the following:

(a) "Assertive Community Treatment (ACT)" means the evidence-based practice of delivering comprehensive and effective services to individuals by a multidisciplinary team primarily in their homes, communities, and other natural environments.

(b) "Acute episode" means a sudden, generally unexpected, debilitating, and precipitous event in a psychiatric disorder.

(c) "Advanced practice registered nurse (APRN)" means a registered nurse who is licensed as having specialized clinical qualifications as provided in RSA 326-B:18 and is certified in psychiatric mental health.

(d) "Affiliated agency" means an agency that provides mental health or related services to individuals served by a community mental health program and that coordinates services and service planning with the community mental health program.

(e) "Commissioner" means the commissioner of the department of health and human services.

(f) "Community mental health program (CMHP)" means a program operated by the state, city, town, or county, or a community based New Hampshire nonprofit corporation for the purpose of

planning, establishing, and administering an array of community-based, mental health services pursuant to He-M 403 and as defined in RSA 135-C:2, IV.

(g) "Community mental health provider" means a medicaid provider of community mental health services that has been previously approved by the commissioner to provide specific mental health services pursuant to He-M 426.

(h) "Competitive employment" means community-based employment at prevailing wage jobs, which reflect consumer preferences, strengths, and goals. The term includes positions in mainstream settings that are part or full time for any number of hours and result in payment of the Federal Insurance Contributions ACT (FICA) tax. The term refers to employment in which an individual earns the same pay and benefits as everyone else who holds the same position. The term includes self-employment that results in, or has the potential to result in, payment of the Self-Employment Contributions Act Tax (SECA). The term does not include employment that is set aside for mental health consumers or work that is controlled by a service agency.

(i) "Continuous treatment team" means a team of licensed practitioners of the healing arts and other mental health clinicians whose caseload is 12 or fewer individuals per direct service staff and who provide intensive treatment through an array of services to individuals who have mental illness and may have a history of substance abuse.

(j) "Covered services" means rehabilitative, treatment, and other community mental health services that are funded by the department and are available through CMHPs, community mental health providers, or agencies affiliated with such programs or providers.

(k) "Current Procedural Terminology" means a listing of descriptive terms and identifying codes for reporting and billing medical services and procedures, developed by the American Medical Association (AMA) in 2007 CPT available as listed in Appendix A.

(l) "Department" means the New Hampshire Department of Health and Human Services.

(m) "Evidence-based practices" means mental health practices that have consistently demonstrated their ability to help consumers achieve desired outcomes in mental health service research trials, where such trials have been conducted by multiple researchers with similar outcomes.

(n) "Evidence-based supported employment (EBSE)" means the provision of vocational supports to individuals following the Supported Employment Evidence Based Practice Kit (2010), available as listed in Appendix A, to ensure successful competitive employment in the community.

(o) "Facility" means New Hampshire hospital or a receiving facility designated pursuant to RSA 135-C:26 and He-M 405, Glencliff Home, or an acute psychiatric residential treatment program.

(p) "Functional support services" means medically necessary individual and group interventions that support optimal functioning and enhance resiliency, recovery, and integration in the community.

(q) "Family member" means the parent, foster parent, legal guardian, child, stepchild, brother, sister, spouse, significant other, grandparent, grandchild, stepparent, aunt, uncle, or first cousin of the individual.

(r) "Illness management and recovery (IMR)" means a specific set of services aimed at promoting recovery that are based on the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A.

(s) "Individual" means any person receiving or applying for services from a program or community residence. The term includes client.

(t) "Individual service plan (ISP)" means a written proposal that:

(1) Is developed annually as the result of a service planning process pursuant to He-M 401; and

(2) Includes the identification of an individual's:

a. Goals and objectives;

b. Treatments and services;

c. Timelines for achieving the stated goals; and

d. Referrals to other specialized health services when appropriate.

(u) "Individualized resiliency and recovery oriented services (IROS)" means the following set of services:

(1) Illness management and recovery (IMR);

(2) Supported employment (SE);

(3) Crisis intervention;

(4) Therapeutic behavioral services;

(5) Family support; and

(6) Medication support.

(v) "Institution for mental diseases (IMD)" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Further, an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

(w) "Intensive partial hospitalization services" means clinically oriented programs designed to promote stabilization and rapid amelioration of the symptoms of any combination of acute or severe psychiatric disturbances.

(x) "Licensed practitioner of the healing arts" means a person who provides psychotherapy or other services identified pursuant to He-M 426 and meets the qualifications of He-M 426.08(h).

(y) "Long-term care" means services covered by Medicaid for Medicaid recipients who have been determined eligible pursuant to the criteria outlined in He-M 401.

(z) "Mental illness" means a condition of a person who is determined severely mentally disabled in accordance with He-M 401.05 through He-M 401.07 and who has at least one of the following psychiatric disorders classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as listed in Appendix A:

(1) Schizophrenia spectrum and other psychotic disorders except for the following:

a. Schizotypal personality disorder;

b. Substance or medication induced psychotic disorder; and

c. Psychotic disorder due to another medical condition;

(2) Bipolar and related disorders except for the following:

a. Substance or medication induced bipolar and related disorder; and

b. Bipolar disorder and related disorder due to another medical condition;

(3) Depressive disorders except for the following:

a. Disruptive mood dysregulation disorder;

b. Premenstrual dysphoric disorder;

c. Substance or medication induced depressive disorder; and

d. Depressive disorder due to another medical condition;

(4) Borderline personality disorder;

(5) Panic disorder;

(6) Obsessive compulsive disorder;

(7) Post traumatic stress disorder;

(8) Bulimia nervosa;

(9) Anorexia nervosa;

(10) Other specific feeding or eating disorders;

(11) Unspecified feeding or eating disorders; and

(12) Major neurocognitive disorders where psychiatric symptom clusters cause significant functional impairment and one or more of the following symptom categories are the focus of psychiatric treatment:

a. Anxiety;

b. Depression;

c. Delusions;

d. Hallucinations; and

e. Paranoia.

(aa) "Natural support" means a reference to people in a variety of roles who are engaged in supportive relationships with people in recovery outside of behavioral health settings. Examples of natural supports include family, friends, and other loved ones, landlords, employers, neighbors, or any other person who plays a positive, but non-professional, role in someone's recovery.

(ab) "Not otherwise classified" means a category of covered CMHP services consisting of treatment or services rendered which do not meet the requirements of the procedures identified in He-M 426.07 - He-M 426.14 but meet the requirements identified pursuant to He-M 426.14(b).

(ac) "Nursing facility" means an institution as defined pursuant to He-E 802.01(s).

(ad) "Pre-admission screening and resident review (PASRR)" means procedures by which the department, in conformance with section 1919(b)(3)(F)(i) and (ii) of the Social Security Act, determines whether persons with mental illness who are applying for placement or currently residing in nursing facilities are in need of nursing facility level of service and, if so, whether they are in need of specialized services pursuant to He-M 1302.07.

(ae) "Peer support specialist" means CMHP staff who self-identify as having experience with a mental health or substance use condition and who chooses to become a service practitioner in the health care system.

(af) "Psychotherapy" means face to face clinical intervention or assessment and monitoring necessary to determine the course and progress of therapy that:

(1) Is based on psychological treatment principles;

(2) Has as its purpose the improvement of interpersonal and self-care skills, psychological understanding, or a change in behavior(s), or any combination of these;

(3) Is provided by a professional qualified pursuant to He-M 426.08(h)-(l);

(4) Is monitored through the clinical record; and

(5) Is based on an ISP.

(ag) "Recipient" means an individual who is eligible for reimbursement of CMHP and community mental health provider services under the state medicaid program.

(ah) "Restorative partial hospitalization services" means evidenced informed services that address integrated health care goals and objectives and are intended to impact the person's whole health status, improve physical and overall health status indicators, as these factors have an important impact the individual's mental health, maximize a recipient's strengths, increase his or her ability to function in his or her living environments, and lead to integration of the recipient into the community.

(ai) "Serious emotional disturbance (SED)" means severe mental disability in persons under the age of 18, and includes all psychiatric disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 with the exception of developmental disabilities, intellectual disabilities, neurocognitive disorders, anti-social personality disorders, and and conditions "due to another medical condition."

(aj) "State fiscal year" means the period of time extending from July 1 of one year through June 30 of the following year.

(ak) "Subcontractor" means an person or organization that enters into an agreement with a CMHP to receive payments from the CMHP for the delivery of medicaid funded mental health services described in an ISP.

(al) "Transitional employment" means time-limited employment for the purpose of vocational assessment or training.

(am) "Unit" means a period of time during which services are rendered. Where units refer to a specific length of time, units are reimbursed in whole units and time of service is rounded to the nearest whole unit.

(an) "Visit" means all services provided to a recipient per appointment or encounter with a provider.

(ao) "Work preparation" means interventions that assist in obtaining or maintaining competitive employment, and may include cues for social norms and activities of daily living (ADL).

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5971, eff 2-1-95; amd by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss by #8867, eff
4-13-07; ss by #9285, eff 9-30-08; ss by #9581, eff 10-24-09; amd by #12079, eff 12-29-16; ss by #12154, eff 3-28-17

He-M 426.03 Recipient Eligibility. All medicaid recipients who are not residents of an IMD shall be eligible to receive the services of CMHPs and community mental health providers when services are delivered in accordance with an ISP.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; ss by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.04 Community Mental Health Providers.

(a) Community mental health providers approved prior to August 22, 1997 shall be authorized to continue to provide medicaid funded mental health services until the date of expiration of provider status as long as the provider:

(1) Is in compliance with applicable rules;

(2) The provider shall have a plan which describes:

a. Methods for collaborative service planning and service delivery with the regional CMHP, including joint development and approval of an ISP for each individual;

b. Service planning which includes the individual's family members and other persons significant to the individual, to the extent that the individual wishes such persons to be involved;

c. Service linkages so there is continuity of care between the community mental health provider and CMHP with minimal resource duplication; and

d. Provision of 24 hour emergency services, which:

1. Are contracted or provided directly by the community mental health provider or CMHP; and

2. Include contingency plans for each individual; and

(3) Maintains a quality assurance plan which shall:

a. Include quality assurance indicators to identify problems that impact directly or indirectly on individuals or on areas which influence individual care;

b. Provide for the development and monitoring of corrective action plans to correct identified problems or deficiencies, where such plans specify time frames and persons responsible for corrective action;

c. Specify how quality assurance findings are utilized in staff development and annual staff evaluations; and

d. Allow the department to conduct announced or unannounced quality assurance reviews of the community mental health providers to assure that such services and programs are operated in accordance with the department's rules, contract provisions, and the federally approved state plan mandated by Public Law 106-310.

(b) Only CMHPs or their subcontractors shall be authorized to provide the medicaid funded community mental health services described in these rules.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5971, eff 2-1-95; ss by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.05 Provider Participation.

(a) Providers of services shall provide sufficient privacy to maintain confidentiality of communication between recipient and staff members.

(b) CMHPs shall be staffed by a multidisciplinary team consisting of licensed practitioners of the healing arts in:

(1) Psychiatry;

(2) Psychology;

(3) Psychiatric social work;

(4) Psychiatric nursing; and

(5) Mental health counseling.

(c) CMHPs shall have as a medical director a psychiatrist who is either board certified or eligible for application for certification according to the most recent regulations of the American Board of Psychiatry and Neurology, Inc., or its successor organization, to assume medical responsibility for all clinical diagnoses and treatment programs. The medical director shall be at the CMHP a minimum of 20 hours per week.

(d) Services offered by CMHPs shall be overseen by a psychiatrist responsible for the individual's care as documented in the ISP.

(e) An M.D. or APRN enrolled in a residency training program in psychiatry from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education shall deliver services in accordance with his or her specific board of licensure.

(f) Providers of community mental health services shall have multidisciplinary staff conferences pursuant to He-M 401.12 to review the progress of current cases. Each CMHP shall have a quality assurance program including utilization and peer review to evaluate the effectiveness of covered services as contained in He-M 426.04.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; ss by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.06 Provider Limitations.

(a) The services listed in He-M 426.07 - He-M 426.17 shall be covered services, available under the medicaid program to all eligible medicaid recipients when provided by, or recommended by, a licensed practitioner of the healing arts pursuant to these rules. Services identified in He-M 426.07 - He-M 426.17 may be provided by CMHPs. Community mental health providers shall only provide those services identified in He-M 426.07 - He-M 426.17 for which they have received approval pursuant to He-M 426.04.

(b) Services provided in an inpatient hospital setting shall only be reimbursable through medicaid if provided by a legally qualified psychiatrist. Services provided in an IMD shall not be reimbursable.

(c) Services recommended by a licensed practitioner of the healing arts shall be provided in accordance with department rules and state law.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92, EXPIRED: 7-2-98

New. #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.07 Medication-Related Services.

(a) Administration of medication by injection shall:

(1) Be a covered CMHP service;

(2) Be performed by a physician, physician assistant, registered nurse, or licensed practical nurse licensed to practice in New Hampshire; and

(3) Include administering intramuscular medication required for the treatment of a recipient's mental illness.

(b) The service outlined in (a) above shall not include administration of oral medication, or medical analysis and review performed pursuant to a medication check. Administration of medication by injection and medication check may be billed, using the respective billing codes, as part of the same visit.

(c) Nursing assessment and evaluation for the purpose of reviewing medication compliance, education and symptomatology shall be a covered service when provided by a registered nurse or licensed practical nurse. There shall be no more than one procedure billed per recipient per day.

(d) Brief office visit shall be a covered service when conducted for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic or personality disorders by physicians, physician assistants or APRNs within the purview of their respective professions. This service shall be billed in accordance with current procedural terminology.

(e) Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy conducted by physicians, physician assistants, or APRNs within the purview of their respective professions shall be a covered service.

(f) Brief office visits, nursing assessment and evaluation, or pharmacologic management shall not be billed for recipients on days during which the recipient is in attendance at a partial hospitalization program. A nurse assessment and evaluation shall not be billable on the same day as a medication check.

(g) Comprehensive medication service for clozapine or clozaril management shall be a covered service provided by a physician, physician assistant, APRN, registered nurse, or licensed practical nurse within the purview of their respective profession to prescribe, monitor the effects of, review, or adjust prescribed clozapine or clozaril. Treatment may be provided up to a maximum of once per day, when a documented drop in the individual's white blood cell count (WBC) occurs.

(h) Comprehensive medication service for clozapine or clozaril management shall include the following:

(1) Ensuring that the required blood sample is drawn;

(2) Ensuring that the WBC is within established limits;

(3) Recording the WBC;

(4) Sending the results of the WBC to the prescribed clozapine or clozaril monitoring system;

(5) Writing the prescription for clozapine or clozaril as appropriate;

(6) Ensuring that the individual is provided with a supply of clozapine or clozaril as appropriate; and

(7) Signature by a physician, physician assistant, or APRN.

(i) Medication services described in (c) through (f) above shall be limited to one service per day and shall not be billed on the same day as any other service described in (c) through (f) above.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5971, eff 2-1-95; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.08 Psychotherapeutic Services.

(a) Individual psychotherapy shall:

(1) Be a covered CMHP service;

(2) Include therapy, crisis intervention, or assessment and monitoring necessary to determine the course and progress of therapy or to stabilize an individual experiencing an acute psychiatric episode; and

(3) Be verbal, with the therapist in direct, personal, involvement with the recipient to the exclusion of other recipients, individuals, and duties.

(b) Individual psychotherapy shall be billed in accordance with current procedural terminology. Individual therapy with medication management shall be billed as one procedure when delivered during the same visit.

(c) Group psychotherapy per person shall:

(1) Be a covered CMHP service; and

(2) Be therapy, or assessment and monitoring necessary to determine the course and progress of therapy, that is performed in a direct, personal, involvement with the recipient in a setting with other recipients or individuals.

(d) Group psychotherapy shall be billed in accordance with current procedural terminology.

(e) Group psychotherapy shall meet the following criteria:

(1) A minimum of 2 unrelated recipients and a maximum of 10 recipients shall be in attendance to constitute a group;

(2) Sessions shall be scheduled often enough to provide effective treatment consistent with the ISP;

(3) The group focus shall be face-to-face dialogue of a verbal rather than performance nature; and

(4) Individual progress notes for each session shall be recorded in each recipient's record with specific attention directed toward goal achievement as stated in the recipient's ISP.

(f) Family therapy shall be:

(1) A covered service; and

(2) Psychotherapy with:

a. The primary identified recipient and that recipient's natural or surrogate family member(s); or

b. The natural or surrogate family member(s) without the recipient present.

(g) Billing for family therapy shall be as follows:

(1) Only one family member's medicaid identification number shall be billed regardless of the eligibility of other members or their inclusion in the problem;

(2) If a child who has been determined eligible for services pursuant to He-M 401 is the primary reason for the family to be receiving therapy, then that child's medicaid identification number shall be used when billing for services;

(3) If the primary recipient is not present but continues to be the focus of the therapy, that recipient's medicaid identification number shall be used when billing for services and the reason why the recipient was not present shall be documented; and

(4) This procedure shall be billed in accordance with current procedural terminology.

(h) For the purpose of providing psychotherapy without supervision, clinical staff of CMHPs or providers shall meet the applicable following minimum qualifications:

(1) Psychiatrists shall meet the requirements of RSA 135-C:2, XIII;

(2) Psychologists shall be licensed in accordance with RSA 329-B;

(3) Pastoral psychotherapists shall be licensed in accordance with RSA 330-A:17;

(4) Marriage and family therapists shall be licensed in accordance with RSA 330-A:21;

(5) Clinical mental health counselors shall be licensed in accordance with RSA 330-A:19;

(6) Clinical social workers shall be licensed in accordance with RSA 330-A:18; and

(7) Nurses shall be registered as required by RSA 326-B:6 and have a master's degree in psychiatric nursing or be licensed as an advanced registered nurse practitioner (APRN) with a psychiatric mental health specialty in accordance with RSA 326-B:11.

(i) Except as provided pursuant to (k) and (m) below, anyone providing psychotherapy services who does not meet the established standards as indicated in (h) above shall:

(1) Have completed at least one year of work in the field of psychiatric or mental health services under the supervision of a psychiatrist, doctoral level psychologist or a licensed mental health professional or person authorized pursuant to RSA 329-B:28, I(e); and

(2) Have at least a master's degree in marriage and family therapy, psychology, social work, rehabilitation counseling, or education/counseling from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education; or

(3) Be a registered nurse with a certificate in mental health nursing from the American Nurses's Association.

(j) Persons who qualify to provide psychotherapy pursuant to (i) above shall have ongoing supervision of at least 2 hours per month. There shall be direct individual or group supervision of at least one hour per month by a licensed practitioner of the healing arts. The second hour may be peer review or case review, such as client centered conferences. Direct supervision shall occur when the supervisor meets with the clinician to review his or her clinical practice in order to evaluate his or her performance.

(k) Persons who are enrolled in formal internships in a professional field of study of mental health services and provide psychotherapy services shall:

(1) Be enrolled in at least a master's degree program in psychology, social work, rehabilitation counseling, education/counseling, or nursing at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education; or

(2) Be enrolled in a doctoral or post-doctoral program at a college or university accredited in psychology by an accrediting agency recognized by the U.S. Department of Education.

(l) Persons providing psychotherapy pursuant to (k) above shall receive direct supervision of at least one hour per week from a licensed practitioner of the healing arts, appropriate to the intern's field of study. The medicaid program shall reimburse CMHPs and community mental health providers only when supervision occurs and is documented. Direct supervision shall occur when the supervisor meets with the intern to review his or her clinical practice in order to evaluate his or her performance. The supervisor shall write and sign a weekly note in the intern's supervisory record stating his or her observations and recommendations relative to the intern's performance, and a monthly note summarizing his or her evaluation.

(m) Pursuant to RSA 135-C:3, persons providing medicaid reimbursed psychotherapy services in approved CMHPs prior to July 1, 1987, the initial effective date of He-M 426, shall be considered to have met the standards for other providers of psychotherapy set forth in (i) above and shall be supervised in accordance with the applicable requirements in (j) above.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5971, eff 2-1-95; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.09 Emergency Services.

(a) Emergency services shall be:

(1) Covered CMHP services;

(2) Face to face interventions for the purposes of:

a. Reducing a recipient's acute psychiatric symptoms;

b. Reducing the likelihood of the recipient harming self or others; or

c. Assisting the recipient to return to his or her pre-crisis level of functioning; and

(3) Conducted with the therapist in direct, personal, involvement with the recipient and at the recipient's request, natural and surrogate family members.

(b) Emergency services shall be available 24 hours a day, 7 days per week and be accessible to individuals anywhere in the region served by the CMHP.

(c) As follow-up to the initial emergency response, an individual shall be eligible to receive a maximum of 5 emergency service sessions, consisting of not more than 6 15-minute units per session, for the purpose of stabilization of the emergency situation prior to intake or referral to another service or agency.

(d) Emergency services shall be billed in 15-minute units, and shall be limited to 6 units per recipient per day to a maximum of 6 sessions per period of acute psychiatric crisis.

(e) Emergency services shall be provided by staff of discrete emergency services programs or other staff serving as part of a formalized emergency services rotation.

(f) Emergency assessment shall be provided for the purpose of emergency evaluation for hospital placement, crisis respite care, revocation of conditional discharge, or other out-of-home placement.

(g) The providers of emergency assessment shall meet the qualifications established in He-M 426.08(h)-(m).

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92, EXPIRED: 7-2-98

New. #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08 (from He-M 426.08); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.10 Evaluations and Testing.

(a) Psychiatric diagnostic interview exam shall include:

(1) History of present illness;

(2) Mental status examination; and

(3) Disposition.

(b) Psychiatric diagnostic interview exam shall:

(1) Be a covered CMHP service when conducted by staff meeting qualifications as outlined in He-M 426.08(h)-(k);

(2) Be billed for the initial intake service;

(3) Be billed as one event;

(4) Be billed in accordance with current procedural terminology; and

(5) Be co-signed by a licensed supervisor when completed by CMHC staff qualified pursuant to He-M 426.08 (i)-(l).

(c) Evaluation and management shall include:

(1) History of present illness;

(2) Examination; and

(3) Medical decision-making.

(d) Evaluation and management shall:

(1) Be a covered CMHP service;

(2) Be billed as one event; and

(3) Be billed in accordance with current procedural terminology.

(e) Psychological testing shall be a covered CMHP service and consist of psychometric or projective tests, or both, with a written report. This procedure shall be billed per hour and be limited to 6 hours per recipient per 6 month period.

(f) Neuropsychological tests shall be evaluations that are:

(1) Designed to determine the functional consequences of known or suspected brain injury through testing of the neurocognitive domains responsible for language, including:

a. Perception;

b. Memory;

c. Language;

d. Problem solving;

e. Adaptation; and

f. Constructional praxis; and

(2) Carried out on persons who have suffered neurocognitive effects of medical disorders that impinge directly or indirectly on the brain.

(g) Neuropsychological tests shall be billed per hour and be limited to 6 hours per recipient per 6 month period. Persons licensed by state statute to provide psychological services shall provide this service.

(h) Neuropsychological testing may be performed by persons enrolled in formal internship in a professional field of study of psychology or neuropsychological testing if they are enrolled in a doctoral or postdoctoral program at a college or university accredited in psychology by an accrediting agency recognized by the U.S. Department of Education.

(i) Persons providing neuropsychological testing pursuant to (h) above shall receive direct supervision of at least one hour per week from a person licensed by state statute to provide psychological services:

(1) Direct supervision shall occur when the supervisor meets with the intern to review his or her neurological testing practice in order to evaluate his or her performance;

(2) The supervisor shall write and sign a weekly note in the intern's supervisory record stating his or her observations and recommendations relative to the intern's performance;

(3) The supervisor shall write and sign a monthly note summarizing his or her evaluation; and

(4) The person shall meet the supervision requirements relative to meeting his or her internship requirements, if applicable.

(j) The medicaid program shall reimburse CMHPs and community mental health providers only when supervision occurs and is documented.

(k) PASRR evaluations shall be covered CMHP services and include psychiatric evaluations and related services to determine appropriateness for nursing home placement.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5971, eff 2-1-95; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08 (from He-M 426.09);ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.11 Partial Hospitalization Services.

(a) Partial hospitalization shall be a covered service and shall consist of intensive partial hospitalization services and restorative partial hospitalization services as described in (e) and (f) below.

(b) Only individuals certified to receive long-term care services pursuant to He-M 426.19 shall be eligible for partial hospitalization services.

(c) Programs shall operate a minimum of 6 hours per day on weekdays and 4 hours per day on holidays and weekends for each day for which services are billed.

(d) Billing for partial hospitalization services shall be in half day or full day units, as follows:

(1) One half day of partial hospitalization shall be attendance at staff directed programs for at least 2 and less than 3 hours; and

(2) A full day of partial hospitalization shall be attendance at staff directed programs for 3 or more hours.

(e) Intensive partial hospitalization services shall be provided as follows:

(1) Placement into intensive partial hospitalization shall be made only with a written order from a psychiatrist, and be based on symptoms affecting the recipient's ability to function adequately in a community setting;

(2) Intensive partial hospitalization shall be offered no fewer than 5 days per week and be designed to provide short-term, structured, and active treatments which are problem-solving in nature and which are directed toward full or partial recovery from the prevailing crisis and the return of the recipient to a pre-crisis level of functioning;

(3) The provision of intensive partial hospitalization services shall be based on identified recipient needs as documented in the recipient's ISP;

(4) Intensive partial hospitalization services shall include:

a. Individual or group psychotherapy;

b. Psychological evaluations and testing;

c. Medication monitoring, evaluation, administration, and education;

d. Clinical assessments to assist in individual service planning;

e. Family or significant other psychotherapy; and

f. Psychologically supportive individual or group activities.

(5) The daily services and activities of an intensive partial hospitalization program shall consist of:

a. A minimum of 2 hours per day of any combination of activities contained in (e)(4)a. - e. above; and

b. The remainder of the day may consist of activities contained in (e)(4)f. above;

(6) Participation in this program shall not exceed 20 treatment days per acute episode without a written order from a psychiatrist and a documented service plan review; and

(7) There shall be no reimbursement from medicaid for any treatment exceeding 30 days per episode, or 90 days per state fiscal year.

(f) Restorative partial hospitalization shall be provided as follows:

(1) Services shall encourage the development of those skills necessary for transfer to a variety of community living environments, including employment settings, and, as much as possible, reduce a recipient's dependency on state or federally funded programs while enabling the recipient to become a productive member of society, earn a wage, and live as independently as possible;

(2) Placement and participation in restorative partial hospitalization services shall be based on the needs of the recipient as documented in the ISP and functional deficits identified in the eligibility determination process pursuant to He-M 401;

(3) Restorative treatment shall:

a. Promote emotional, behavioral, physical health, and psychological change;

b. Minimize the effects of mental disorders;

c. Promote health maintenance through clinical activities which foster the reduction of psychological stress;

d. Promote independent living;

e. Help maintain the individual in a community setting;

f. Teach skills necessary for an individual to function in the environments in which he or she lives and works; and

g. Utilize accepted principles of psychosocial rehabilitation;

(4) Restorative partial hospitalization services shall consist of the following components:

a. A comprehensive identification of the recipient's skills, strengths, and deficits in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function, as such environment is consistent with the goals listed in the individual's ISP;

b. Active recipient involvement which requires that assessment and intervention procedures be explained to and understood by the recipient;

c. Teaching of skills necessary for the recipient to succeed in his or her chosen environments;

d. A crisis management plan which shall serve to avert crises or mobilize resources rapidly to respond to crises and be implemented by intensive partial hospitalization services staff, emergency services staff, or other appropriate staff within the CMHP; and

e. Case management to assure linkage with all necessary services and people involved in the recipients' care, coordinated service planning, and monitoring of progress toward goals;

(5) Restorative partial hospitalization services shall include the following services:

a. Individual or group counseling and psychotherapy;

b. Medication monitoring, evaluation, administration, and education;

c. Family or significant other services, counseling, and psychotherapy;

d. Teaching daily living skills, community living skills, and self-care skills;

e. Nutritional services;

f. Basic education;

g. Recreational services;

h. Psychological evaluations and testing; and

i. Psychologically supportive individual or group activities;

(6) Recreational activities such as bowling, swimming, and field trips shall be billable only when they are adjunct to, but not the only component of, the restorative partial hospitalization service; and

(7) Medicaid reimbursement for restorative partial hospitalization services shall not be made for a recipient for any day in which the recipient receives fewer than 2 hours of service, exclusive of recreational activities, unless in a given week the average per day participation in non-recreational activities exceeds 2 hours per day of service to the recipient.

(g) In addition to requirements listed in (e) and (f) above, reimbursement criteria for intensive and restorative partial hospitalization services shall include the following:

(1) Out-of-facility activities shall be covered under the following circumstances:

a. The activities shall be directed by the partial hospitalization staff as part of a program based in the CMHP; and

b. Stipends shall not be paid to recipients of partial hospitalization services in connection with the activities;

(2) The medicaid rate for partial hospitalization shall be all inclusive;

(3) On a day that a recipient receives partial hospitalization services, no reimbursement for other covered services shall be made except as allowed in (4) below;

(4) The following services shall be reimbursable on any day that a recipient receives partial hospitalization services:

a. Case management services when provided under an approved case management option of the medicaid program;

b. Emergency visits if they occur outside of the normal operating hours of the partial hospitalization program;

c. Services provided by an assertive community treatment team;

d. Individualized resiliency and recovery oriented services;

e. Medication checks for clozaril and clozapine management;

f. Psychiatric evaluation for medicaid eligibility; and

g. Services provided by a mobile crisis team, which is a multidisciplinary team that provides crisis stabilization and case management services as an alternative to hospitalization.

(5) Services provided on a day the recipient did not attend partial hospitalization shall be billed in the normal manner for the service; and

(6) Reimbursement for partial hospitalization services shall be limited to services for outpatients.

(h) Staff who provide partial hospitalization services shall meet the following criteria:

(1) A partial hospitalization program shall employ a partial hospitalization supervisor who performs the following duties:

a. Supervises all staff of the partial hospitalization program;

b. Provides program administration; and

c. Ensures partial hospitalization services are coordinated with other services to assure continuity of recipient service; and

(2) The supervisor of partial hospitalization services shall minimally have:

a. Full time employment equaling 3 years' experience in programs for persons with long term mental illness;

b. One year of supervisory, management, or administrative experience; and

c. A baccalaureate degree in social work, rehabilitation, psychology, education, or a related human services field.

(i) Each staff person providing partial hospitalization services shall at a minimum have:

(1) Either:

a. A baccalaureate degree in social work, rehabilitation, psychology, education, or a related human services field; or

b. An associate's degree in social work, rehabilitation, psychology, education, or a related human services field and the following experience:

1. Two years of experience working with persons who have severe mental disability; or

2. Two years of experience that provides an person with an understanding of mental illness and that was acquired as an adult in the provision of significant supports to persons with mental illness, including the experience acquired by family members of persons with mental illness or by other persons who have personal knowledge of mental illness; and

(2) Completed the training curriculum based on the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A, if the staff will be providing IMR services.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5971, eff 2-1-95; ss by #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08 (from He-M 426.10); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.12 Individualized Resiliency and Recovery Oriented Services (IROS).

(a) IROS shall be a covered service and consist of:

(1) Evidence-based practices delivered in accordance with the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A, which describes the following services:

a. Illness management and recovery (IMR), group;

b. Illness management and recovery, individual; and

c. Evidence-based supported employment (EBSE); and

(2) Functional support services including the following:

a. Crisis intervention;

b. Group therapeutic behavioral services;

c. Individual therapeutic behavioral services;

d. Family support; and

e. Medication support.

(b) IROS shall be provided in the individual's current living, employment or educational situation. or other community setting taking into account the individual's preferences.

(c) IROS provided in any office setting shall not exceed 1 hour per month, or 12 hours per state fiscal year with the exception of computer-based EBSE, IMR, crisis intervention, and medication support.

(d) IROS shall not be eligible for reimbursement if provided in an office setting with the exception of (c) above, with the exception of computer-based EBSE, IMR, crisis intervention and medication support.

(e) Only individuals eligible to receive long-term services pursuant to He-M 426.19 shall be eligible to receive IROS.

(f) Quality assurance reviews shall be as follows:

(1) A sample of clinical records for recipients of IROS services shall be reviewed as part of a quality assurance review;

(2) The purpose of this review shall be to determine whether documentation in the clinical record conforms with all requirements outlined in He-M 408 and He-M 426.12; and

(3) Fidelity review process utilizing the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A.

(g) IROS shall be face-to-face individual and group interventions that include the elements and objectives in (h)-(j) below. IROS shall be billed as a group intervention when 2 or more unrelated recipients are in attendance, not to exceed 10 participants.

(h) Illness management and recovery (IMR), delivered on an individual and group basis, shall:

(1) Be based on the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A, and ensure fidelity to that model;

(2) Have as its objective teaching individuals with a mental illness, strategies for:

a. Collaborating actively in their treatment with professionals;

b. Reducing their risk of relapses and rehospitalizations;

c. Reducing the severity and distress related to symptoms; and

d. Improving their social support;

(3) Include the following specific components, at a minimum:

a. Psychoeducation about the nature of mental illness and its treatment;

b. Behavioral tailoring to help individuals incorporate the taking of medications into their daily routines;

c. Relapse prevention planning;

d. Teaching coping strategies to manage distressing, persistent symptoms;

e. Cognitive behavior therapy strategies for psychosis, depression, and bipolar disorder; and

f. Social skills training;

(4) Incorporate the following:

a. An assessment, identification, and documentation of the target symptom(s) or problem(s);

b. The specification of the goals or desired outcomes; and

c. The specific interventions that will be used to achieve the desired outcomes;

(5) Be of a duration that allows the time necessary to complete the IMR curriculum; and

(6) Be individual or group interventions that support recipients' optimal functioning and enhance resiliency, recovery, and integration in the community.

(i) Evidence-based supported employment (EBSE) shall:

(1) Be based on the Supported Employment Evidence Based Practice Kit (2010) as, available as listed in Appendix A, and fidelity to that model;

(2) Have as its objective the participation in competitive employment for individuals eligible under He-M 401;

(3) Utilize a team approach inclusive of an employment specialist for treatment;

(4) Include medicaid and non-medicaid funded services, funded in part by New Hampshire Vocational Rehabilitation;

(5) Include the following specific components and criteria:

a. Support of an individual's entry into or return to competitive employment on a permanent status, where potential applicants include persons in the general population;

b. Full integration of SE staff with other CMHP staff;

c. Eligibility based primarily on consumer choice, where eligibility criteria such as the following shall be irrelevant:

1. Job readiness;

2. Lack of substance abuse;

3. No history of violent behavior;

4. Minimal intellectual functioning; and

5. Mild symptoms;

d. Supports for individuals that are:

1. Provided on an ongoing basis;

2. Not time limited; and

3. Based on the individual's continued need for services, as documented in the ISP;

e. Vocational assessment which shall gather information about psychiatric history, symptoms, functional limitations, coping skills and strengths and how these affect the consumer's employment history and daily functioning as it is relates to employment, and excludes competency testing, screening for exclusionary criterion, work readiness evaluations, vocational testing, interest inventories, situational assessments, and transitional employment;

f. Job search support which shall assist an individual in managing symptoms so that they may develop a plan for approaching employers, identify personal preferences, identify and develop supports around work preparation, have individual outreach to employers, obtain support related to interviews, and include other interventions around meeting with other providers regarding benefits, work incentives, and other vocational supports; and

g. Follow-along supports which shall include interventions, strategies, and prompts to assist individuals in managing their psychiatric symptoms as they affect employment and address the following:

1. Managing social conflicts or challenges in the workplace;

2. Managing symptoms that impact getting to and from employment;

3. Managing work related income;

4. Coordinating benefits and entitlement as impacted by work; and

5. Improving ability to communicate on and off the job;

(6) Be direct, active, face-to-face clinical interventions necessary for the individual to achieve the goals and objectives identified on the ISP;

(7) Be individual interventions; and

(8) Be delivered as a clinical service if they are directly related to an individual's symptoms due to a mental illness which inhibits the individual from participating in or obtaining competitive employment.

(j) The individual's treatment planning team shall include an EBSE specialist to assure services effectively address symptoms and challenges that prevent the individual from successfully achieving their employment goals.

(k) The EBSE components in(j)(5)e.-g. above shall not be a medicaid billable service when they, either:

(1) Do not include the individual; or

(2) Do not address symptoms related to an individual's mental illness.

(l) Documentation of interventions for EBSE shall comply with He-M 408.09.

(m) Functional support services (FSS) shall be medically necessary individual or group interventions that shall:

(1) Be direct, active, face-to-face clinical interventions necessary for the individual to achieve the goals and objectives identified on the ISP;

(2) Actively engage the individual in planned and unplanned, therapeutic activities;

(3) Be billed as an individual service when provided on a one-to-one basis;

(4) Be billed as a group service when provided with 2 or more recipients present;

(5) Exclude activities that are social and recreational in nature without active clinical intervention;

(6) Enhance resiliency, recovery, and integration in the community;

(7) Support the restoration of an individual to the best possible functional level; and

(8) Include interventions consisting of:

a. Crisis intervention services, delivered on an individual basis, that:

1. Are designed for individuals who are experiencing acute exacerbation of symptoms that increase the likelihood that the individual will harm himself, herself

or others, or that imminently jeopardize the individual's ability to remain in the community;

2. Include continuous assessment and monitoring of safety and symptoms;

3. Include family, friends, or significant others when appropriate; and

4. Are delivered based on a direct benefit to the service recipient with each crisis intervention service specifically documented in the clinical record;

b. Therapeutic behavioral services, delivered on an individual and group basis, that are specific and individualized interventions whose primary objective is to develop, reinforce and apply skills and strategies to ameliorate or reduce symptoms and behaviors that impede an individual's ability to function in an age and developmentally appropriate manner and return the individual to an optimal level of functioning;

c. Family support, delivered on an individual basis, that:

1. Consists of face-to-face, specific interventions provided to family members, caregivers, or significant others;

2. Supports and maintains the management of the eligible recipient's mental illness or serious emotional disturbance, and maintains the individual's tenure in the community;

3. Has as its primary objective the enhancement and promotion of the recipient's resiliency and recovery;

4. Includes assistance to the family member or caregiver, in delivering specific interventions to the individual to promote the goals and objectives identified in the individual service plan as required by He-M 401; and

5. Is provided in accordance with the following:

(i) The ISP shall specify who shall be present during the delivery of this service; and

(ii) Family support services shall be delivered based on a direct benefit to the service recipient, and documented as such; and

d. Medication support, delivered on an individual basis, that:

1. Is a specific and individualized intervention that is designed to support the individual in maintaining his or her medication regimen, as prescribed in the clinical record, as a strategy to promote effective management of his or her mental illness;

2. Is modeled on the concept of "behavioral tailoring" which includes developing strategies for incorporating medication into the individual's daily routine, as outlined in the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A;;

3. Is not billed when these interventions are delivered during the course of a routine or comprehensive medication check as outlined in He-M 426.07; and

4. Includes the following as described in the Illness Management and Recovery Evidence Based Practice Kit (2010):

(i) Providing accurate information about medications for mental illness, including both their advantages and disadvantages;

(ii) Providing an opportunity for recipients to talk openly about their beliefs about medication and their experience with taking various medications;

(iii) Helping recipients weigh the advantages and disadvantages of taking medications; and

(iv) Helping recipients who have decided to take medications to develop strategies for taking medication regularly, including behavioral tailoring and simplifying the medication regimen.

(n) The following IROS services shall be billed separately from one another, with one claim submitted per day for each category below:

(1) Illness management and recovery, group;

(2) Illness management and recovery, individual;

(3) Evidence-based supported employment;

(4) Crisis intervention;

(5) Group therapeutic behavioral services; and

(6) Individual therapeutic behavioral services, family support services, and medication support services.

(o) The CMHP shall separately aggregate the minutes for each category listed in (n) above that are provided in a single day into a single claim before determining the number of billable 15 minute units for each category.

(p) Billing for functional support services provided to each individual, except for crisis intervention services, those who are served on an ACT team, and all functional support services provided to individuals eligible to receive children's program services under He-M 401, shall be limited as follows:

(1) Individual therapeutic behavioral services, family support services, and medication support services shall be limited to a combined total of 10 units per day; and

(2) Group therapeutic behavioral services shall be limited to 10 units per day.

(q) A CMHP or community mental health provider may request a waiver of the 10 unit daily limit by submitting the request in writing to the department in accordance with He-M426.24.

(r) In addition to the requirements in He-M 426.24, the waiver request shall include the following:

(1) Supporting documentation that the provision of functional support services beyond the 2.5 hours per day is necessary to allow the individual to achieve the desired outcome;

(2) A statement by the clinician most familiar with the needs of the individual that there are no other treatment modalities available, such as peer support, community support, or other natural supports, that will enable the individual to achieve the desired outcome;

(3) A copy of the current and previous ISP, signed by the psychiatrist, which specifies the frequency, duration and purpose of the requested functional support services in excess of 10 units per day;

(4) A copy of the current eligibility determination form; and

(5) The date range for the waiver, which shall not exceed the date range specified on the ISP.

(s) A waiver request shall be granted by the commissioner, or designee, in accordance with He-M 426.24 and the following:

(1) The commissioner, or designee, determines that there are extenuating circumstances unique to the individual that would make a denial of the waiver request clinically contraindicated; or

(2) The commissioner, or designee, determines that approval of the waiver can reasonably be expected to prevent the need for more costly services within the following 12 months, including prevention of hospitalization or institutionalization.

(t) A recipient whose waiver request to exceed 10 units per day is not granted by the commissioner or his or her designee may appeal pursuant to He-C 200.

(u) IROS shall be reimbursed at a per diem rate if services are provided in:

(1) A non-hospital receiving facility designated pursuant to He-M 405 or He-M 1005; or

(2) A facility licensed by the department or certified as a community residence by the department, if such facilities meet the following criteria:

a. A psychiatrist shall be available 24 hours per day for consultation or treatment, as appropriate, to address medical, medication, and other issues under the domain of a psychiatrist;

b. Supervision shall be provided by program staff who meet the criteria of (a) above;

c. Supervision shall be sufficient to ensure the individual's safety and implementation of ISPs;

d. Supervision of individuals shall be provided whenever individuals are present in the facility unless an individual's ISP requires that that individual be left alone;

e. All service components shall be available within the program and may be provided on site or off; and

f. There shall be regular communication between residential staff and each resident's case manager to ensure that services are provided in accordance with an ISP and that there is no duplication of service.

(v) Reimbursement for IROS pursuant to (u) above shall preclude the possibility of billing for IROS in 15-minute units within the community residence with the exception of IMR provided by non-residential staff. For any day on which an individual receives per diem services, residential staff of the same program shall not also bill for IROS in 15-minute units for that individual.

(w) Reimbursement for services provided on a per diem basis in an acute psychiatric residential treatment program designated pursuant to He-M 1005.04 shall preclude the possibility of billing for any

other service described in He-M 426.07 through He-M 426.12 except case management services, emergency services, psychological testing, and intake psychiatric diagnostic interview.

(x) Documentation for IROS services shall include:

(1) The start and duration of each event; or

(2) The start and stop time for each event.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92, EXPIRED: 7-2-98

New. #7088, eff 8-31-99; ss by #8867, eff 4-13-07; ss by #9285, eff 9-30-08; ss by #9581, eff 10-24-09; ss by #12154, eff 3-28-17

He-M 426.13 IROS Staff Qualifications.

(a) All staff providing IROS shall be supervised by a supervisor who:

(1) Provides program administration and coordinates such services with other service providers to assure continuity of recipient service;

(2) Has at least 3 years of full-time employment experience in programs for persons with long term mental illness or SED;

(3) Has at least one year of supervisory, management, or administrative experience;

(4) Has a baccalaureate degree or higher in social work, rehabilitation, psychology, education, or a related human services field; and

(5) Has received training in the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A, if the staff will be providing IMR.

(b) Each staff person providing IROS shall at a minimum have:

(1) Either:

a. A baccalaureate degree in social work, rehabilitation, psychology, education, or a related human services field; or

b. An associate's degree in social work, rehabilitation, psychology, education, or a related human services field and the following experience:

1. Two years of experience working with persons who have severe mental disability or SED; or

2. Two years of experience that provides a person with an understanding of mental illness and that was acquired as an adult in the provision of significant supports to persons with mental illness, including the experience acquired by family members of persons with mental illness or by other persons who have personal knowledge of mental illness; and

(2) Received training in the evidence-based practice in Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A, developed by Dartmouth, if those staff will be providing those services.

(c) CMHPs and providers shall document completion of training pursuant to (a)(5) and (b)(2) above in personnel files.

(d) Any staff person who does not meet the criteria of (b) above shall be eligible to provide IROS services if:

(1) Such staff person was providing mental illness management services under former He-M 426.11 for at least 2 years prior to the 4/13/2007 effective date of former He-M 426.11; and

(2) The following criteria are met:

a. The staff person shall receive individual or group supervision of at least one hour per week provided by a supervisor meeting the qualifications of (a) above;

b. A supervisor meeting the criteria of (a) above shall be available at all times to provide back-up support or consultation; and

c. A record of the following shall be maintained in the staff person's personnel file:

1. The staff person's educational background; and

2. Supervision provided, including:

(i) The professional title and level of education of the supervisor;

(ii) The supervisory schedule; and

(iii) The staff development and training needs and how they have been addressed; and

(3) In instances when the staff will provide IMR services, the staff person has received training in the Illness Management and Recovery Evidence Based Practice Kit (2010), available as listed in Appendix A.

(4) Such person is a peer support specialist;

a. Peer support specialists shall:

1. Enter into a mutually supportive, non-authoritative relationship that support wellness and recovery as defined by the individual being serviced;

2. Participate in trainings as required by the employer and the department;

3. Function as a member of the individual's treatment team;

4. Function as an advocate for the individuals served;

5. Provide services pursuant to the individual service plan;

6. Participate in and attend treatment team meetings;

7. Be supervised by a supervisor as defined in He-M 426.13(a);

8. Meet quarterly with a peer trained in intentional peer support (IPS) for a peer review to evaluate effectiveness of IPS and to review the principles of IPS;

9. Be certified in wellness action recovery plans, intentional peer support, whole health action management or equivalents authorized by the department within 12 months of employment at the CMHC; and

10. Receive annually:

(i) One evidence based practice training;

(ii) Client rights training; and

(iii) One suicide prevention training.

Source. (See Revision Note at part heading for He-M 426) #5971, eff 2-1-95; ss by #7088, eff 8-31-99; amd by #8282, eff 2-8-05; ss and moved by #8867, eff 4-13-07 (from He-M 426.12); ss by #9285, eff 9-30-08; ss by #9581, eff 10-24-09; ss by #12154, eff 3-28-17

He-M 426.14 Services to Determine Medicaid Eligibility.

(a) Copying a portion of a recipient's record to be used for medicaid eligibility determination shall:

(1) Be a covered CMHP service; and

(2) Be limited to one unit per 6 month period.

(b) Psychiatric evaluation for medicaid eligibility shall:

(1) Be a covered CMHP service;

(2) Refer to one evaluation session of any duration; and

(3) Be limited to one session per recipient per 6-month period.

(c) Psychiatric evaluation for medicaid eligibility shall include the following:

(1) History of present illness;

(2) Family and social history;

(3) Current mental status examination;

(4) Psychiatric diagnosis;

(5) Associated medical problems; and

(6) An assessment of disability including a suggested individual treatment plan and further diagnostic evaluation studies, with a written report to the office of family services.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; ss by #5589, eff 2-25-93; ss by #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07 (from He-M 426.13); ss by #9118, EMERGENCY RULE, eff 4-1-08, EXPIRES: 9-28-08; ss by #9285, eff 9-30-08 (from He-M 426.13); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.15 Targeted Case Management Services.

(a) Case management shall:

(1) Assist individuals eligible under the state plan in gaining access to needed medical, social, educational, and other services, on a one to one basis only;

(2) Be a covered CMHP service;

(3) Consist of at least one direct contact, either face-to-face or by telephone, with the individual or guardian within every 90 days;

(4) Be documented in the clinical record, including:

a. Whether the goals specified in the care plan have been achieved;

b. Whether the individual has declined services in the care plan;

c. Timelines for providing services and reassessment; and

d. The need for, and occurrences of, coordination with case managers of other programs.

(5) For each event, the documentation shall include:

a. The name of the individual;

b. The dates of case management service;

c. The name of the provider agency;

d. The nature, content, and units of case management service received, including, for units:

1. The start time and duration of each event; or

2. The start and stop time for each event; and

e. The signature of the person who provided the service.

(6) Be billed only by the agency that is the primary service provider for individuals who receive services from both the behavioral health and developmental services systems.

(b) The primary service provider shall be:

(1) The agency that provides the greater dollar value of services to the individual; or

(2) The agency chosen by the consumer to provide case management subject to the following:

a. Persons who are conditionally discharged from a designated receiving facility in accordance with He-M 609 shall be considered eligible for a case manager from the behavioral health system in addition to a case manager from the developmental services system in cases where the developmental services system is the primary service provider;

b. Pursuant to He-M 426.24, providers may, with the consent of the consumer, request a waiver from He-M 426.16(a)(6) to enable consumers to receive case management by both systems; and

c. The commissioner shall grant a waiver if a review of the person's clinical condition establishes that the person has symptoms that are acute or severe and that require multiple services from the secondary service provider.

(c) Case management services shall be limited to the following:

(1) Assessment and periodic reassessment of an eligible individual to determine service needs, including the following activities:

a. Taking the individual's history;

b. Gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual;

c. Assessing the individual's strengths; and

d. Determining the individual's preferences;

(2) The assessment shall determine the need for the following services:

a. Medical services including, but not limited to, primary care, dental care, home health care, and assistance with activities of daily living (ADL);

b. Educational services including, but not limited to, obtaining high school or advanced degrees, skill-building classes, parenting education, and other support groups;

c. Social services including, but not limited to, employment, housing, and transportation; and

d. Other services, including but not limited to, opportunities for personal development, maintenance and support of social and familial relationships and the pursuit of hobbies and interests such as spiritual development;

(3) Development and periodic revision of a specific and comprehensive care plan based on the information collected through an assessment or reassessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. An individual may decline to receive services in the care plan;

(4) Referral and related activities to help an individual obtain needed services, such as scheduling appointments, but not including transportation, escort, and childcare services; and

(5) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring shall occur no less frequently than annually.

(d) An individual shall be eligible to receive case management services when:

(1) Services are delivered in accordance with an ISP; and

(2) The individual is:

a. A severely mentally disabled person who is eligible to receive department-funded services pursuant to He-M 401; or

b. A family member of a person who is eligible for long-term care as defined in He-M 401 and is under age 21.

(e) Case management services for an individual who has been admitted to a hospital or nursing facility shall include:

(1) Providing ongoing case management services on behalf of the individual in order to ensure that services and supports are established and maintained within the community and within the community mental health system;

(2) Establishing and maintaining contact with community agencies and individuals to develop community resources, to foster access to services other than those offered through the state mental health system, and to encourage community support to the individual when he or she returns to the community;

(3) Arranging, in collaboration with the hospital or nursing facility, community supports appropriate to the individual's need;

(4) Participating in the service planning process, from initial treatment planning through discharge planning, and supporting the participation of the individual, the family, and the guardian in the treatment planning process and, with the individual's or guardian's consent, involving significant others;

(5) Providing information necessary for individual service planning, with the consent of the individual, pursuant to He-M 408;

(6) Participating in making discharge plans and in securing access to available community resources of choice in order to foster a smooth transition to the community; and

(7) After an individual involuntary commitment and conditional discharge pursuant to He-M 609, advising the administrators of the CMHP or provider and the hospital concerning the individual's progress with, and suggesting revisions in, the discharge conditions.

(f) Transitional case management shall:

(1) Be provided to individuals, under the age of 22 and over the age of 64, who are transitioning from a hospital or nursing facility to the community;

(2) Be a covered service during the last 180 consecutive days of a medicaid eligible person's institutional stay if provided for the purpose of community transition; and

(3) Be billed if the following conditions are met:

a. The individual has been discharged from the hospital or nursing facility;

b. The individual is enrolled with the community case management provider; and

c. The individual is receiving medically necessary services in a community setting.

(g) Case managers shall not exercise the state agency's authority to authorize or deny the provision of other services under the state plan.

(h) All staff providing case management services shall be supervised in accordance with the requirements contained in He-M 426.13(a) relative to supervision of staff providing functional support services.

(i) Each staff person providing case management services shall meet the requirements contained in He-M 426.13(b) and (d) relative to requirements for staff providing functional support services.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5703, eff 9-17-93; ss by #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07; ss by #9285, eff 9-30-08 (from He-M 426.14); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; ss by #12154, eff 3-28-17

He-M 426.16 Assertive Community Treatment (ACT).

(a) Assertive community treatment (ACT) services shall be:

(1) Based on "The Assertive Community Treatment Implementation Resource Kit" (Evaluation Edition 2003) available as noted in Appendix A;

(2) Provided with fidelity to the Dartmouth Assertive Community Treatment Scale (DACTS) found in "The Assertive Community Treatment Implementation Resource Kit" (Evaluation Edition 2003);

(3) Customized to the individual's needs, and shall vary over time as the individual's needs change; and

(4) Provided to allow the individual a reasonable opportunity to live independently in the community.

(b) ACT teams shall be available:

(1) To the individual 24 hours per day, 7 days per week.

(2) From midnight to 8:00 a.m. services shall be provided on an on-call basis;

(3) In the event of a crisis and consistent with safety concerns, to conduct a face to face meeting within 3 hours, to de-escalate the crisis.

(c) Every individual eligible for services under He-M 401 shall be assessed for ACT services at the time of intake, at quarterly service reviews, upon request, and in the event of discharge from a facility, the Glencliff Home, or from emergency department admission.

(d) The decision to provide ACT services shall be made on an individualized basis with careful consideration for the individual's clinical needs and shall utilize the following criteria:

(1) The individual shall have a severe mental illness or a severe and persistent mental illness;

(2) The individual shall have a primary diagnosis of psychotic or major mood disorder, with or without a co-occurring substance use disorder;

(3) An individual diagnosed with a personality disorder shall not be excluded from ACT services solely due to diagnosis;

(4) The individual shall be 18 years or older; and

(5) The individual shall meet at least one of the following criteria:

a. Has had lengthy or multiple uses of acute psychiatric hospitalization in past 12 months;

b. Has used multiple emergency services or crisis services within the past 12 months due to symptoms of a mental illness;

c. Has consistently demonstrated the inability to engage in and benefit from other community based mental health services as a result of symptoms of mental illness for the past 12 months;

d. Had involvement with the legal system as a result of symptoms of mental illness that have resulted in arrest, incarceration, probation, or parole within the past 12 months;

e. Is currently in-patient at a facility and could move to a less restrictive environment if the individual were to receive ACT services; or

f. Is currently residing in a community residence as identified in He-M 1002 and could move to a less restrictive environment if the individual were to receive ACT services.

(e) The decision to transfer individuals to a less intensive level of care shall be made on an individualized basis with careful consideration of the individual's clinical needs and shall utilize the following criteria:

(1) The individual has maintained stable housing in the community for more than 12 months;

(2) The individual has utilized an emergency room due to psychiatric symptoms no more than twice in the past 12 months;

(3) The individual has consistently demonstrated the ability to engage in and benefit from community based mental health services;

(4) The individual has not been arrested or incarcerated during the past 12 months due to psychiatric symptoms;

(5) The individual has mutually agreed with ACT team members that he or she is ready to transition to a less intensive level of care; and

(6) The individual has required no more than 2 ACT team contacts for the month in a 6 month period.

(f) Once the individual has satisfied criteria in He-M 426.16(e), the ACT team shall take steps below to commence transition planning. Once these steps have been accomplished, the individual shall be transitioned from ACT to lower intensity services:

(1) The ACT team meets with the individual to identify and discuss individual transition planning goals and objectives;

(2) The ACT team and the individual have identified and met with appropriate non-ACT service providers in order to coordinate continuity of care;

(3) The individualized service plan is updated to reflect transition planning goals and identified service needs; and

(4) The crisis plan has been updated and developed with the assistance of identified non-ACT service providers.

(g) No ACT team shall terminate services provided to an individual because that individual has withdrawn consent or cannot be located unless the ACT team can document at least 3 months of persistent, caring attempts to engage that individual.

(h) The requirement in (g) above shall not limit the individual's right to decline ACT services in accordance with RSA 135-C:16 and RSA 135-C:57, III.

(i) The community mental health program (CMHP) providing ACT services shall make available written information provided by the department to individuals that describes ACT services, the right to file a complaint, and contact information for legal assistance.

(j) The written information in (i) shall be given directly to any individual who has specifically requested ACT service but for whom the treatment team has determined that ACT services are not clinically appropriate.

(k) Commencing in 2017, the department shall conduct an ACT fidelity assessment of each CMHP every other year. The CMHP shall conduct a self-assessment fidelity review in the year(s) the department does not conduct the review.

Source. #12079, eff 12-29-16

He-M 426.17 Services Not Otherwise Classified.

(a) The invoice for services not otherwise classified in this rule shall be accompanied by a statement describing the service including the following:

(1) The name of the recipient receiving the service(s);

(2) The type, frequency, and duration of the service(s);

(3) The name, title, and professional qualifications of the person(s) providing the service(s); and

(4) The reason(s) why the service(s) was provided, which shall include reference to the recipient's ISP.

(b) Services not otherwise classified shall be:

(1) Designed to meet a specific need identified in a recipient's ISP; and

(2) Allowed by federal requirements.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #5589, eff 2-25-93; ss by #5703, eff 9-17-93; amd by #5971, eff 2-1-95; amd by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss by #8282, eff 2-8-05; ss and moved by #8867, eff 4-13-07 (from He-M 426.15); ss by #9285, eff 9-30-08 (from He-M 426.15); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; renumbered by #12079 (from He-M 426.16); ss by #12154, eff 3-28-17

He-M 426.18 Documentation. Clinical information and documentation of services as required by He-M 408 shall be maintained by the CMHP or community mental health provider.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; ss by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07 (from He-M 426.16); ss by #9285, eff 9-30-08 (from He-M 426.16); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; renumbered by #12079 (from He-M 426.17); ss by #12154, eff 3-28-17

He-M 426.19 Medicaid Payment for Long-Term Care Certification.

(a) Except for those medicaid recipients eligible to receive early and periodic screening, diagnosis and treatment (EPSDT) pursuant to He-W 546 or eligible to receive long-term care services in accordance with (b) below, the medicaid payment limit per fiscal year for all community mental health services shall be the limit established by the commissioner with approval of the US Department of Health and Human Services Centers for Medicare and Medicaid Services as an amendment to the Title XIX State Plan in accordance with He-W 520.02 and Section 1902(a) of the Social Security Act. The fiscal year runs from July 1 to June 30. Individual service limits shall still apply.

(b) An individual shall qualify for services in excess of the annual medicaid payment limit if that individual has been certified for long-term care services by:

(1) Determination by the CMHP that the individual is eligible to receive department funded services pursuant to He-M 401; or

(2) Determination by a CMHP that a child through age 17 is eligible for services pursuant to He-M 401 unless the psychiatrist has approved the child to remain until age 21in a children's program pursuant to He-M 401.

(c) The department shall recover any medicaid payments in excess of the medicaid payment limit per state fiscal year for a recipient under each of the following circumstances:

(1) The recipient's record lacks a properly completed eligibility statement which covers long-term care services billed for the period under review;

(2) The eligibility period has expired and the redetermination of eligibility has not been completed;

(3) Documentation in the clinical record fails to substantiate that the recipient meets the criteria for certification for long-term care; and

(4) The recipient's diagnosis does not meet the criteria in He-M 401.

(d) Certifications made pursuant to (b)(1) above and dated later than the service period being billed for shall be invalid.

(e) For individuals eligible as adults with severe or severe and persistent mental illness with low service utilization pursuant to He-M 401.07, the commissioner shall establish a limit on the payment for services per state fiscal year. The limit shall be subject to approval by the US Department of Health and Human Services Centers for Medicare and Medicaid Services as an amendment to the Title XIX State Plan in accordance with He-W 520.02 and Section 1902(a) of the Social Security Act. The annual limit shall be waived if the standards established by He-M 426.24 are met.

(f) Mental health assessment by a non-physician for the purpose of determining long-term care eligibility shall be a covered service when performed by individuals meeting the qualifications in He-M 401.04(b).

(g) Comprehensive geriatric assessment and treatment planning performed by assessment team for the purpose of determining long-term care eligibility shall be a covered service when performed by individuals meeting the qualifications in He-M 401.04(b).

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; amd by #6568, eff 8-22-97; ss by #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07 (from He-M 426.17); ss by #9285, eff 9-30-08 (from He-M 426.17); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-18); renumbered by #12079 (from He-M 426.18); ss by #12154, eff 3-28-17

He-M 426.20 Fair Hearings. Any medicaid recipient who has been found ineligible for long-term care services by the CMHP or community mental health provider may appeal the adverse decision by requesting a fair hearing in accordance with He-C 200. Complaints regarding provision of services may be filed in accordance with He-M 309, and He-M 204

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; ss and moved by #6568, eff 8-22-97 (from He-M 426.20); ss by #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07 (from He-M 426.18); ss by #9285, eff 9-30-08 (from He-M 426.18); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17l; renumbered by #12079 (from He-M 426.19); ss by #12154, eff 3-28-17

He-M 426.21 Revocation of Approval as a Community Mental Health Provider.

(a) Approval as a community mental health provider shall be revoked, following written notice pursuant to (b)(2) below and opportunity for a hearing pursuant to He-C 200, due to:

(1) Failure of the provider to comply with this rule or any other applicable rule promulgated by the department;

(2) The provider failing to provide information requested by the department and required pursuant to chapter He-M 400 or knowingly giving false or misleading information to the department;

(3) Refusal by the provider to admit any employee of the department authorized to monitor or inspect the provider's services and programs;

(4) Any reported abuse, neglect, or exploitation of individuals by a provider's staff if:

a. Such personnel have not been prevented from having contact with individuals as of the reporting date of the alleged violation; and

b. Such abuse, neglect, or exploitation is founded based on a protective investigation performed by the department in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested;

(5) Revocation of licensure or denial of application for licensure pursuant to RSA 151; or

(6) Revocation of certification pursuant to He-M 1002.

(b) Revocation of approval shall be in accordance with the following:

(1) Upon determination that a provider meets any of the criteria for revocation listed in (a) above, the commissioner shall revoke the approval of the provider;

(2) Revocation shall only occur following:

a. The provision of 30 days' written notice by the commissioner to the provider stating the reason(s) for the revocation and, if applicable, the specific rule(s) with which the provider is alleged to not comply; and

b. Opportunity for a hearing on the decision pursuant to He-C 200, if requested by the provider;

(3) The commissioner shall withdraw a notice of revocation if, within the notice period, the provider takes corrective action resulting in the elimination of the reason(s) for revocation; and

(4) Pending corrective action by the provider eliminating the reason(s) for revocation, a provider shall not accept additional individuals if a notice of revocation has been issued concerning a violation which presents potential danger to the health or safety of the individuals being served.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92; ss and moved by #6568, eff 8-22-97 (from He-M 426.21); ss by #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07 (from He-M 426.19); ss by #9285, eff 9-30-08 (from He-M 426.19); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; renumbered by #12079 (from He-M 426.20); ss by #12154, eff 3-28-17

He-M 426.22 Suspension of Approval.

(a) In the event that a violation poses an immediate and serious threat to the health or safety of the individuals, the commissioner shall suspend a provider's approval immediately upon issuance of written notice specifying the reasons for the action.

(b) In the event that the commissioner suspends the approval of a provider, the suspension shall be effective from the date that the violation occurred until such time as the commissioner determines that the provider is in compliance with all applicable rules adopted by the commissioner and no longer poses an immediate and serious threat to the health or safety of the individuals served by the provider.

(c) At the time that the commissioner suspends the approval of a provider, the commissioner or his or her designee shall schedule a hearing to be held within 10 working days, in accordance with He-C 204.

(d) A hearing held pursuant to (c) above shall:

(1) Have as its purpose determination of whether the provider in fact posed an immediate and serious threat to the health and safety of its individuals at the time its approval was suspended; and

(2) Afford the provider an opportunity to show that:

a. Since the time that its approval was suspended it has come into compliance with all applicable rules promulgated by the department and no longer poses an immediate and serious threat to the health or safety of its individuals; or

b. It had never been out of compliance or had never posed an immediate and serious threat to the health or safety of its individuals.

Source. (See Revision Note at part heading for He-M 426) #5433, eff 7-2-92, EXPIRED: 7-2-98

New. #7088, eff 8-31-99; ss and moved by #8867, eff 4-13-07 (from He-M 426.20); ss by #9285, eff 9-30-08 (from He-M 426.20); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; renumbered by #12079 (from He-M 426.21); ss by #12154, eff 3-28-17

He-M 426.23 Payment.

(a) Medicaid payments shall be made for CMHP services rendered to recipients with both psychiatric and intellectual disability diagnoses for services related to the psychiatric diagnosis. Medical and billing records shall support this classification. The claim shall indicate the primary diagnosis related to the service rendered.

(b) Community mental health services shall be paid at rates set by the department based on the audited costs of covered services as determined by units of services provided by all community mental health providers divided by the sum of costs for the individual's transportation, staff and staff related costs to provide such services incurred by all community mental health providers.

(c) Claims for medicare-eligible medicaid recipients shall be submitted to medicare for all medicare covered services prior to submitting claims to medicaid.

(d) Except for claims for people not eligible for medicaid, claims for service shall be submitted to the fiscal agent designated by the department.

(e) Claims for services necessary to determine the appropriateness of nursing home referral, PASRR, for people who are not eligible for medicaid shall be submitted to:

NH Department of Health and Human Services
Behavioral Health
PASRR Office
105 Pleasant Street
Concord, NH 03301

Source. #8867, eff 4-13-07 (from He-M 426.21); ss by #9285, eff 9-30-08 (from He-M 426.21); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; renumbered by #12079 (from He-M 426.22); ss by #12154, eff 3-28-17

He-M 426.24 Waivers.

(a) A CMHP or community mental health provider may request a waiver of specific procedures outlined in this part, in writing, from the department.

(b) A request for a waiver shall include:

(1) A specific reference to the section of the rule for which a waiver is being sought;

(2) A full description of why a waiver is necessary; and

(3) A full explanation of alternative provisions or procedures proposed by the CMHP or community mental health provider.

(c) No provision or procedure prescribed by statute shall be waived.

(d) A request for a waiver shall be granted after the commissioner or his or her designee determines that the alternative proposed by the CMHP or community mental health provider meets the objective or intent of the rule and:

(1) Does not negatively impact the health or safety of recipients; and

(2) Does not affect the quality of CMHP or community mental health provider services.

(e) Upon receipt of approval of a waiver request, the CMHP's or community mental health provider's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which the waiver was sought.

(f) Waivers shall be granted in writing for a specific duration not to exceed 5 years except as in (g) below.

(g) Those waivers which relate to the following shall be effective for the CMHP's or community mental health provider's current certification period only:

(1) Fire safety; or

(2) Other issues relative to consumer health, safety or welfare that require periodic reassessment.

(h) A CMHP or community mental health provider may request a renewal of a waiver from the department. Such request shall be made at least 30 days prior to the expiration of a current waiver.

Source. #9285, eff 9-30-08 (from He-M 426.22); ss by #11182, INTERIM, eff 9-29-16, EXPIRES: 3-28-17; renumbered by #12079 (from He-M 426.23); ss by #12154, eff 3-28-17

APPENDIX A: INCORPORATION BY REFERENCE INFORMATION

Rule	Title	Publisher; How to Obtain; and Cost
He-M 401.02(s)	Diagnostic and Statistical Manual of Mental Disorders, (Fourth Edition, Text Revision) (DSM-IV-TR, 2000)	Available from the publisher, American Psychiatric Publishing (http://www.appi.org/Home), a division of the American Psychiatric Association (APA) (www.psychiatry.org). Cost is $121.00.
He-M 426.02(k)	American Medical Association 2017 CPT	https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2730008&navAction=push; or for a full text at a Cost: $89.95, published by the American Medical Association, PO Box 930876 Atlanta GA 31193-0876.
He-M 426.02(n), and He-M 426.12(i)	Supported Employment Evidence Based Practice Kit (2010)	Available on line free of charge at: http://store.samhsa.gov/product/Supported-Employment-Evidence -Based-Practices-EBP-KIT/SMA08-4365.
He-M 426.02(r), He-M 426.11(i)(2), He-M 426.12(a)(i), (f)(3), (h)(1), (m)(8)d.2., (m)(8)d.4, He-M 426.13(a)(5), (b)(2) and (d)(3)	Illness Management and Recovery Evidence Based Practice Kit (2010)	Available on line free of charge at: http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT /SMA09-4463.
He-M 426.02(z), and (ai),	Diagnostic and Statistical Manual of Mental Disorders, (Fifth Edition, Text Revision) (DSM-5)	Available from the publisher, American Psychiatric Publishing (http://www.appi.org/Home), a division of the American Psychiatric Association (APA) (www.psychiatry.org). Cost is $155.00.
He-M 426.16 (a)(1)	"The Assertive Community Treatment Implementation Resource Kit" (Evaluation Edition 2003)	Available free of charge as pdf at http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

APPENDIX B: – STATUTES IMPLEMENTED

RULE	STATE OR FEDERAL STATUES THE RULE IMPLEMENTS
He-M 426.01, He-M 426.02 intro., (a)-(c), (e)-(s), (u)-(ap), 426.03–426.15 and 426.17-426.24	RSA 135-C:1; 57
He-M 426.01, 426.03-426.11, 426.14-23	RSA 135-C:1; RSA 135-C:57
He-M 426.02 – 426.12 -426.13	RSA 135-C:1; 57
He-M 426.02(d) and (t)	RSA 135-C:1; RSA 135-C:57
He-M 426.16	RSA 135-C:5