

**EARLY, PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)  
EPSDT SERVICES  
10.8.2013 VERSION**

**TITLE 8 SOCIAL SERVICES  
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT  
(EPSDT) SERVICES  
PART 2 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT  
(EPSDT) SERVICES**

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

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

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

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

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

**8.320.2.6 OBJECTIVE:** The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).  
[8.320.2.6 NMAC - N, 1-1-14]

**8.320.2.7 DEFINITIONS:** [RESERVED]

**8.320.2.8 MISSION STATEMENT:** To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.  
[8.320.2.8 NMAC - N, 1-1-14]

**8.320.2.9 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES:** The medical assistance division (MAD) pays for medically necessary health services including preventive, treatment and ameliorative services for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnostic and treatment (EPSDT) services program. See 42 CFR 441.50 Subpart B.

**A. EPSDT Description:**

- (1) early: assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;
- (2) periodic: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development;
- (3) screening: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;
- (4) diagnostic: the determination of the nature or cause of conditions identified by the screening; and
- (5) treatment: the provision of services needed to control, correct or lessen health problems.

**B. Services provided under EPSDT are accessed following an initial health screening service called the tot to teen healthcheck or health check referral or through other diagnostic evaluations or assessments.**

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

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**8.320.2.10 GENERAL EPSDT SCREENINGS AND REFERRALS:** EPSDT includes a screening component called the “tot to teen healthcheck”. EPSDT also includes diagnostic, treatment, and other necessary health care measures needed to correct or ameliorate physical and behavioral health disorders or conditions discovered during the tot to teen healthcheck or through other diagnostic evaluations or assessments.  
[8.320.2.10 NMAC - N, 1-1-14]

**8.320.2.11 INFORMATION GIVEN TO MAP ELIGIBLE RECIPIENTS:**

A. A MAD MAP eligible recipient under 21 years of age, or his or her family, is provided with the following information:

- (1) benefits of preventive health care;
- (2) services available under EPSDT and where and how to access those services;
- (3) services provided under EPSDT are furnished at no cost to a MAP eligible recipient;
- (4) transportation and scheduling assistance is available upon request; and
- (5) the right to request a HSD administrative hearing.

B. Within 30 calendar days of the initial medical assistance application, and annually at each eligibility redetermination period thereafter, a MAP eligible recipient is furnished with information about the tot to teen healthcheck screen and EPSDT services.

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

**8.320.2.12 EPSDT ELIGIBLE PROVIDERS:** Upon MAD’s approval of a PPA, a licensed practitioner, agency or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HSD/MAD websites, on other program-specific or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD NMAC rules, billing instructions, UR instructions and other pertinent materials. Once enrolled, a provider receives instructions on how to access these documents. MAD makes available on the MAD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider is bound by the provisions of the MAD PPA.

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

**8.320.2.13 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:**

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in the MAD New Mexico administrative code (NMAC) rules and program policies that include but are not limited to supplements, billing instructions, and utilization review (UR) directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient’s enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. Services furnished to a MAP eligible recipient must be within the scope of practice defined by the provider’s licensing board, scope of practice act, or regulatory authority.

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

**8.320.2.14 GENERAL PROVIDER INSTRUCTION:**

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an

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electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only.

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

C. A specific EPSDT service may have additional service restrictions listed in the service's non-covered section. Generally the following are considered to be noncovered by MAD:

- (a) services furnished to an individual who are not eligible for MAD EPSDT services;
- (b) services furnished without the prior authorization of the MAP eligible recipient's primary care provider (PCP) or HSD or its designee;
- (c) services provided by a practitioner who is not in compliance with the statutes, regulations, rules or who renders services outside of the scope of practice as defined by his or her practice board;
- (d) services that are not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient;
- (e) services that are primarily educational or vocational in nature; and
- (f) services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Certain EPSDT procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specific EPSDT service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

E. All EPSDT services are reimbursed as follows, except when otherwise instructed. MAD does not pay a professional component amount to a physical, occupational or speech and language pathologist (SLP) if the therapy is performed in a hospital setting. MAD reimburses the institutional provider for all components of the service.

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

- (a) the provider's billed charge; or
- (b) the MAD fee schedule for the specific service or procedure for the provider:
  - (i) the provider's billed charge must be its usual and customary charge for services.
  - (ii) "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(3) Reimbursement is made for an Indian health service (IHS) facility, a federally qualified health center (FQHC) or rural health clinic (RHC), or by another provider is paid at encounter rates as described elsewhere in applicable rules following its federal guidelines and special provisions.

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(4) Reimbursement to the local education agency (LEA), regional educational cooperative (REC), and another state-funded educational agency (SFEA) is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's individual education plan (IEP), and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142. and the services are covered by MAD, then MAD is permitted to pay for such services.

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

**8.320.2.15 TOT TO TEEN HEALTHCHECK:** MAD developed the tot to teen healthcheck, the screening segment of EPSDT services. The tot to teen healthcheck includes periodic screening and regularly scheduled assessments of the MAP eligible recipient's general physical growth and development as well as behavioral health and social emotional development.

A. Primary care providers (PCP), dentists, psychologists, IHS public health clinics, FQHC, RHC, community mental health centers (CMHC), hospitals, school-based clinics, independent certified or licensed nurse practitioners and other health care providers may perform tot to teen healthcheck screens or partial health screenings. A provider must meet the participation requirements specified in applicable sections of the MAD NMAC rules. Tot to teen healthcheck screens must be furnished within the scope of the provider's practice, as defined by law.

B. Screening services are furnished to a MAP eligible recipient under 21 years of age. Referrals or treatment for conditions detected during a complete or a partial screen which require further treatment are then covered as part of MAD's EPSDT services. A tot to teen healthcheck can be performed during an office visit for an acute illness as long as the illness does not affect the results or the screening process.

(1) Screening schedule for medical components:

(a) The MAD tot to teen healthcheck periodicity schedule allows for a total of 25 screens.

Screenings are encouraged at the following intervals:

- (i) under age one: six screenings (birth, one, two, four, six and nine months)
- (ii) ages one-two: four screenings (12, 15, 18 and 24 months)
- (iii) ages three-five: three screenings (three, four and five years)
- (iv) ages six-nine: two screenings (six and eight years)
- (v) ages 10-14: four screenings (10, 12, 13 and 14 years)
- (vi) ages 15-18: four screenings (15, 16, 17 and 18 years)
- (vii) ages 19-20: two screenings (19 and 20 years).

(b) Additional screenings may be performed at an interval other than those listed above if a MAP eligible recipient receives care at a time not listed on the periodicity schedule or if any components of the screen were not completed at the scheduled ages. Additional screenings can help bring the MAP eligible recipient up to date with the periodicity schedule.

(c) The established schedule must be followed unless the MAP eligible recipient's medical condition is such that a brief deviation is warranted.

(2) Complete medical screens include the following components:

- (a) a comprehensive health and developmental history, including an assessment of both physical and behavioral health or social emotional development;
- (b) a comprehensive unclothed physical exam;
- (c) appropriate immunizations, according to age and health history, unless medically contraindicated at the time;
- (d) laboratory tests, including an appropriate blood lead level assessment;
- (e) health education, including the MAD anticipatory guidance; and
- (f) vision and hearing screenings at the ages indicated in the MAD EPSDT preventative health guidelines.

(3) MAD pays for partial medical screens to a MAP eligible recipient. Partial medical screens are defined as screens where all the required components of a complete medical screen are not completed for medical reasons.

(4) MAD covers additional medical screens as listed below.

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(a) Behavioral health screenings are performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of a behavioral health disorders or conditions.

(b) Dental examinations are performed at intervals which meet reasonable dental standards. Usually these examinations are furnished every six months. However, examinations can be furnished at other intervals as medically necessary.

(c) Hearing testing is performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of defects in hearing. A hearing test using an audiogram should be given to a MAP eligible recipient at five years of age or prior him or her to entering school. Annual examinations should be furnished if abnormalities are identified.

(d) Interperiodic screens can be performed at intervals beyond those specified in the periodicity schedule. Reimbursement for the performance of interperiodic screens is made only to a MAD provider. Interperiodic screens are screening encounters with health care, developmental, or educational professionals to determine the existence of suspected physical or behavioral health disorders or conditions.

(e) Vision examinations are performed at intervals which meet reasonable vision standards or at other intervals as medically necessary. A vision examination should be furnished before the MAP eligible recipient reaches three years of age and again prior to five years of age or prior to entering school. If no abnormalities are found, screenings should be furnished every two years with a complete examination furnished if indicated.

(f) Other necessary health care or diagnostic services are performed when medically necessary.

C. MAD covers services considered medically necessary for the treatment or amelioration of conditions identified as a result of a complete tot to teen healthcheck screen, partial medical screen, or interperiodic screen. Diagnostic or evaluation services furnished during the screening cannot be duplicated as part of the follow-up treatment. If appropriate, treatment is furnished by the screening provider at the time of the tot to teen healthcheck.

(1) A MAP eligible recipient can be referred for treatment as a result of a tot to teen healthcheck, regardless of whether the provider making the referral is a participating MAD provider. If it is inappropriate for a screening provider to furnish treatment needed by the MAP eligible recipient, referrals must be made only to a qualified MAD provider.

(2) A MAP eligible recipient may be identified through a tot to teen healthcheck, self referral, referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns. For a MAP eligible recipient requires extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of a MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

(c) The plan must be developed in cooperation with the MAP eligible recipient, his or her parents, or guardians, and other health care professionals, as appropriate. In the case of a MAP eligible recipient under 21 years of age who is placed in the custody of the children, youth and families department (CYFD), its assigned social worker, and those appropriate from CYFD's juvenile justice system (JJS) are to be included in the development of the plan.

(d) See to 8.321.2 NMAC for additional information regarding specialized behavioral health services for an ESPDT MAP eligible recipient.

(3) A MAP eligible recipient, when allowed under state law, has the right to refuse proposed medical and behavioral health treatment. He or she has the freedom to select among enrolled MAD providers. Information in this section does not restrict or limit a MAP eligible recipient's rights or choice.

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

**8.320.2.16 EPSDT SPECIAL REHABILITATION (FAMILY INFANT TODDLER EARLY INTERVENTION) SERVICES:** MAD special rehabilitation services are furnished through the New Mexico department of health (DOH) family infant toddler (FIT) program. FIT provides early intervention services for a MAP eligible recipient birth up to his or her third birth year that has or is at risk of a having a developmental delay.

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Developmental delay or at risk of is defined by DOH. A MAP eligible recipient with a developmental delay or is at risk of having a developmental delay is not considered to have a diagnosis of an intellectual or developmental disability. FIT services include evaluation, diagnostics and treatment necessary to correct or treat any defects or conditions or to teach compensatory skills for deficits that directly result from a medical or behavioral health condition. The appropriate information from evaluation and diagnostics is interpreted and integrated in the individual family service plan (IFSP). If the need for special rehabilitation is identified outside of the tot to teen healthcheck process, the MAP eligible recipient's PCP must be notified of the results and be included in the treatment plan development, if the PCP so elects.

A. MAD EPSDT special rehabilitation eligible providers: An enrolled MAD agency certified by DOH as a special rehabilitation services provider is eligible to be reimbursed for furnishing special rehabilitation services to a MAP eligible recipient. Individual providers rendering special rehabilitation services that are employed by or contracted by a MAD special rehabilitation provider agency must meet applicable DOH standards. A provider shall:

- (a) render special rehabilitation services under the direction of a professional acting within his or her scope of practice as defined by state law;
- (b) render special rehabilitation services in the most appropriate least restrictive environment;
- (c) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services or services funded under the state general fund DOH contract.

B. EPSDT special rehabilitation MAP eligible recipients: An individual who has been determined through a multidisciplinary developmental evaluation to have, or be at risk for, a developmental delay and to be in need of special rehabilitative services as defined by DOH is eligible to receive special rehabilitation services. Any individual that has been diagnosed with an intellectual or developmental disability is not eligible for FIT services.

C. EPSDT special rehabilitation treatment plan for a MAP eligible recipient: The need for special rehabilitation services must be documented in the MAP eligible recipient's treatment plan or in his or her IFSP. The treatment plan must be developed in accordance with applicable DOH policies and procedures and federal regulations governing Part C of the Individuals with Disabilities Education Act. The treatment plan or IFSP must be developed within 45 calendar days of the initiation of services and reviewed every six months or more often as indicated. The following must be contained in the treatment plan or IFSP documents and must be available for review in the MAP eligible recipient's agency file:

- (1) a statement of the MAP eligible recipient's present levels of physical development including vision, hearing, and health status;
- (2) an assessment of his or her communications development;
- (3) an assessment of his or her behavioral health status, to include his or her social or emotional development;
- (4) an assessment of his or her cognitive development;
- (5) an assessment of his or her adaptive development;
- (6) his or her family history and other relevant family information;
- (7) a description of his or her intermediate and long-range goals, with a projected timetable for their attainment and dates, and the duration and scope of services;
- (8) the procedures and time lines to determine the progress made toward achieving the outcomes and whether modifications to or revision of the outcomes or services are needed; and
- (9) statement of the specific special rehabilitation services needed to meet the MAP eligible recipient's unique needs and also achieve the outcomes specified, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

D. EPSDT special rehabilitation covered services:

- (1) MAD only covers special rehabilitation services necessary to enhance development in one or more of the following developmental domains:
  - (a) physical and motor;
  - (b) communication;
  - (c) adaptive;
  - (d) cognitive;
  - (e) behavioral health to include social or emotional; or
  - (f) sensory.

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(2) Special rehabilitation services generally involve the MAP eligible recipient's family and are designed to support and enhance the MAP eligible recipient's developmental services and are provided through FIT. The following are a list of covered services.

(a) Developmental evaluation and rehabilitation services are the assessments performed to determine if motor, speech, language and psychological problems exist with the MAP eligible recipient or to detect the presence of his or her developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating a MAP eligible recipient's medical or other health-related condition. Services also include consultation with the family and other professional staff. These services are provided as a result of a referral from the MAP eligible recipient's PCP.

(b) Nursing services are performed by a MAD enrolled certified nurse practitioner (CNP), registered nurse (RN) or licensed practical nurse (LPN) within the scope of his or her practice relevant to the medical and rehabilitative needs of the MAP eligible recipient. These services are provided as the result of a referral from the MAP eligible recipient's PCP. Services include the administration and monitoring of medication, catheterization, tube feeding, suctioning, and the screening and referral for other health needs. Nursing services also include explanations to the MAP eligible recipient's family or other professional staff concerning the treatments, therapies, and physical or social emotional health conditions.

(c) Physical therapy services are provided by or under the direction of a qualified MAD enrolled physical therapist (PT) as a result of a referral from the MAP eligible recipient's PCP. Physical therapy services are the evaluations required to determine the MAP eligible recipient's need for physical therapy and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the family and other professional staff.

(d) Occupational therapy services are provided by or under the direction of a qualified MAD enrolled occupational therapist (OT) as the result of a referral from the MAP eligible recipient's PCP. Occupational therapy services include the evaluation of the MAP eligible recipient to determine if he or she is experiencing problems that interfere with his or her functional performance and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the MAP eligible recipient's family and other professional staff.

(e) Behavioral health services are diagnostic or active treatments with the intent to reasonably improve the MAP eligible recipient's condition; see 8.321.2 NMAC for a detailed description of behavioral health services.

(f) Speech, language and hearing services provided by or under the direction of a MAD enrolled SLP or audiologist, as the result of a referral by the MAP eligible recipient's PCP. Speech, language and hearing services are the evaluations required to determine the MAP eligible recipient's need for these services and recommendations for a course of treatment. Treatment is provided to a MAP eligible recipient with a diagnosed speech, language or hearing disorder which adversely affects his or her functioning. Services also include consultations with the MAP eligible recipient's family and other professional staff.

E. EPSDT special rehabilitation noncovered services: Special rehabilitation services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

F. EPSDT special rehabilitation prior approval and utilization: All MAD EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. Specifically for special rehabilitation services, a maximum of 14 hours per month of services to a MAP eligible recipient can be furnished by a provider before prior approval is required from DOH.

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

**8.320.2.17 EPSDT CASE MANAGEMENT SERVICES:** MAD pays for case management services furnished to a medically at risk MAP eligible recipient under 21 years of age as an EPSDT service. The need for case management services must be identified in the tot to teen healthcheck screen or through other diagnostic evaluations or assessments.

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A. EPSDT case management eligible providers: A qualified MAD enrolled case management agency is eligible to be reimbursed for furnishing services to a MAP eligible recipient. An agency must demonstrate direct experience in successfully serving medically at risk individuals under the age of 21 years and demonstrate knowledge of available community services and methods for gaining access to those services.

(1) The following agencies can furnish case management services:

- (a) a governmental agency;
- (b) a native Indian tribal government;
- (c) the IHS;
- (d) a federally qualified health center; and
- (e) a community case management agency.

(2) Case manager qualifications: A case manager employed by a MAD enrolled case management agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have at least one year of experience serving medically at risk individuals under the age of 21 years. Case managers must have the necessary skills to meet the needs of a particular MAP eligible recipient. In some instances, it is important that the case manager have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. In addition, a case manager must meet one of the following requirements:

(a) hold a bachelor's degree in social work, counseling, psychology, sociology, education, special education, cultural anthropology or a related health or social service field from an accredited institution; a case manager with a bachelor's degree in another field can substitute two years of direct experience in serving the medically at risk population for the required field of study; or

(b) be licensed as a RN or LPN;

(c) case management services for medically fragile MAP eligible recipients must be provided by a licensed RN; and

(c) if there are no suitable case managers with the previously described qualifications, an agency can employ a case manager with the following education and experience rendering services under the direct supervision of an experienced case manager who meets the qualifications specified in section 28, subsection B of this rule:

(i) hold an associate's degree and have a minimum of three years of experience in community health or social services; or

(ii) hold a high school diploma or a graduate equivalence diploma (GED) and a minimum of four years of experience in community health or social services;

(3) Agency restrictions: MAD restricts the type of agency that can provide case management services to a MAP eligible recipient with developmental disabilities. See [42 U.S.C. Section 1396n(g)(1)(2)]. A case management provider for a MAP eligible recipient with developmental disability or severe emotional disturbance must be certified by DOH or CYFD.

(4) MAP eligible recipients: When a MAD enrolled recipient is determined to be medically at risk, he or she is eligible for case management services. "Medically at risk" is defined as an individual who has a diagnosed physical or social emotional condition which has a high probability of impairing his or her cognitive, emotional, neurological, social or physical development.

B. EPSDT case management treatment plan (CMTP) or the individualized service plan (ISP): The CMPT or if for a medically fragile MAP eligible recipient, an ISP, is developed by the case manager in cooperation with MAP eligible recipient, his or her family or legal guardian, his or her PCP, as appropriate, and others involved with the MAP eligible recipient's care. The CMTP is developed within 30 calendar days of the initiation of services. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated. For a MAP eligible recipient who is medically fragile, the ISP is written and approved within 60 calendar days of the initiation of services which are to start immediately. The ISP is reviewed regularly during the monthly visits however; the MAP eligible recipient is reassessed annually with a new ISP developed with the MAP eligible recipient, his or her family and the interdisciplinary team. A social worker may be involved in the development of the treatment plan in the case of a MAP eligible recipient who is in the custody of CYFD or another state agency.

(1) The following, as appropriate, must be contained in the CMTP and ISP or documents used in the development of each. The CMTC, the ISP, and all supporting documentation must be available for review in the MAP eligible recipient's file:



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- recipient;
- (a) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;
  - (b) description of the functional level of the MAP eligible recipient, including the following:
    - (i) social emotional or behavioral health status assessment;
    - (ii) intellectual function assessment;
    - (iii) psychological assessment;
    - (iv) educational assessment;
    - (v) vocational assessment;
    - (vi) social assessment;
    - (vii) medical assessment; and
    - (viii) physical assessment.
  - (c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;
  - (d) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and
  - (e) statement and rationale of the CMTP or ISP for achieving these intermediate and long-range goals, including provisions of review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued for the MAP eligible recipient.
- (2) Assessments must be performed face-to-face with the MAP eligible recipient, his or her family or legal guardian.
- (3) The agency must have a statement of the specific case management services needed to meet the MAP eligible recipient's unique needs and to achieve the outcomes specified in the CMTP or ISP, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

**C. EPSDT case management covered services:**

- (1) MAD covers the following case management services:
- (a) face-to-face assessment of the MAP eligible recipient's medical, behavioral health, social needs and functional limitations. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated.
  - (b) the development and implementation of plans of care designed to help the MAP eligible recipient retain or achieve the maximum degree of independence; certain EPSDT enhanced services can be furnished only if included in the CMTP or ISP, including private duty nursing;
  - (c) the mobilization of the use of natural helping networks such as family members, church members, community organizations, support groups and friends; and
  - (d) the coordination and monitoring of the delivery of services, the evaluation of the effectiveness and quality of the services, and the revision of the MAP eligible recipient's CMTP or ISP, when appropriate.

(2) When a MAP eligible recipient is in an out-of-home placement, MAD covers comprehensive coordinated support services (CCSS) detailed in 8.321.2 NMAC during the last 30 calendar days of his or her placement.

**D. EPSDT case management noncovered services:** Case management services are subject to the limitations and coverage restrictions which exist for other MAD services., case management services may not be billed in conjunction:

- (1) services to an individual who is not eligible or who does not meet the MAD definition of medically at risk;
- (2) services furnished by other practitioners such as: therapists, transportation providers, homemakers or personal care service providers;
- (3) formal educational or vocation services related to traditional academic subjects or vocational training;
- (4) client outreach activities in which a provider attempts to contact potential recipients;
- (5) administrative activities, such as MAD eligibility determinations and agency intake processing;
- (6) institutional discharge planning which is a required condition for payment of hospital, nursing home, treatment foster care or other residential treatment center services. Discharge planning must not be billed separately as a targeted case management service;

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(7) services which are not documented by the case manager in the MAP eligible recipient's agency file;

(8) services to a recipient who receives case management services through a home and community-based services waiver program.

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

**8.320.2.18 EPSDT PERSONAL CARE SERVICES:** MAD pays for medically necessary personal care services (PCS) furnished to a MAP eligible recipient under 21 years of age as part of the EPSDT program when the services are part of his or her IEP or IFSP for the treatment of correction, amelioration, or prevention of deterioration of a MAD identified medical or behavioral health condition, see [42 CFR Section 440.167]. PCS provides a range of services to a MAP eligible recipient who is unable to perform some or all activities of daily living (ADLs) or instrumental activities of daily living (IADLs) because of a disability or a functional limitation. A prescribed course of regular PCS services and daily living assistance supports the MAP eligible recipient to live in his or her home rather than an institution and allows him or her to achieve the highest possible level of independence. These services include, but are not limited to, such activities as bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance, and communicating. A MAP eligible recipient may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCS services may be required because a cognitive impairment prevents a MAP eligible recipient from knowing when or how to carry out the task. In such cases, PCS services may include cuing along with supervision to ensure that the MAP eligible recipient performs the task properly.

A. EPSDT PCS eligible providers:

(1) agencies that meet the following conditions are eligible to enroll as providers and be reimbursed for providing EPSDT PCS services:

(a) a licensed nursing or home health agency that is a public agency, a private for-profit agency, or private non-profit agency; and

(b) the PCS attendant to the MAP eligible recipient must be supervised by a MAD enrolled RN.

(2) certification for participation as a medicare home health agency is not required. A MAP eligible recipient's family member may not furnish PCS services to him or her. In this instance, a family member is defined as a legally responsible relative, such as parents of minor child and stepparent who is legally responsible for minor child. For a MAP eligible recipient 18 to 21 years of age, parents or other relatives may provide PCS services if they are not legally responsible for the MAP eligible recipient. The parent or another relative must be employed by a MAD approved PCS agency eligible to bill for PCS services and must meet all MAD required training and supervision standards.

B. EPSDT PCS ATTENDANT TRAINING:

(1) The PCS agency is responsible for ensuring that the PCS attendant has completed a training program and is competent to provide assigned tasks as a PCS attendant specific to the MAP eligible recipient's needs.

(2) The PCS attendant training program must consist of no less than 40 hours of training to be completed by the PCS attendant in the first year of employment. Ten hours of training must be completed prior to placing the employee in a MAP eligible recipient's home. Two of the 10 hours may include agency orientation. Eight of the 10 hours of training must be specific to the MAP eligible recipient.

(3) The training curriculum must include, at a minimum, the following areas:

(a) communication;

(b) MAP eligible recipient's rights;

(c) recording of information in MAP eligible recipient's records;

(d) nutrition and meal preparation;

(e) care of ill and disabled children and adolescents;

(f) emergency response (first aid, CPR, 911, etc.);

(g) basic infection control;

(h) housekeeping skills; and

(i) home safety and fire protection.

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C. EPSDT PCO criteria: PCS services are defined as medically necessary tasks pertaining to a MAP eligible recipient's physical or cognitive functional ability. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's functional level. Services are covered under specific criteria.

(1) The MAP eligible recipient must have a need for assistance with at least two or more ADL's or IADL's or both such as eating, bathing, dressing and toileting activities, appropriate to his or her age.

(2) PCS services must be medically necessary, prescribed by the MAP eligible recipient's PCP and included in the MAP eligible recipient's ITP.

(3) The need for PCS services is evaluated based on the availability of the MAP eligible recipient's family members, natural supports, such as other community resources or friends that can aid in providing such care.

(4) PCS services must be provided with the consent of the MAP eligible recipient's parent or guardian if the MAP eligible recipient is under the age of 18 years. If a MAP eligible recipient over the age of 18 years, and he or she is able to provide consent, his or her consent is required.

(5) PCS services are furnished in the MAP eligible recipient's place of residence and outside his or her home when medically necessary and when not available through other existing benefits and programs such as home health, early intervention or school programs. PCS services are services furnished to a MAP eligible recipient who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or an institution for mental illness.

(6) Medically necessary PCS services to support a MAP eligible recipient attend school are furnished in partnership with the MAP eligible recipient's school as an alternative to his or her participation in a homebound program. PCS services should foster the MAP eligible recipient's independence. PCS services are furnished only to a MAP eligible recipient based on MAD or its designee's UR contractor's approval. PCS services may not be furnished to a non-MAP eligible recipient in the school setting.

(7) Only a trained PCS attendant who has successfully demonstrated service competency such as bathing, dressing, eating and toileting may provide PCS services to a MAP eligible recipient. The PCS attendant must be employed by a MAD approved PCS agency and works under the direct supervision of a MAD approved RN.

(8) The supervisory RN must be employed or contracted by the PCS agency and have one year direct patient care experience. The supervisory RN is responsible for conducting and documenting visits at the MAP eligible recipient's residence for the purpose of assessing his or her progress and the PCS attendant's performance. The ITP should be updated as indicated and in cooperation with the MAP eligible recipient's case manager. These visits will be conducted and documented every 62 calendar days or more often if the MAP eligible recipient's condition warrants it.

D. EPSDT PCS covered services: MAD covers the following personal care services:

(1) basic personal care services consist of bathing, care of the teeth, hair and nails, assistance with dressing, and assistance with toileting activities;

(2) assistance with eating and other nutritional activities, when medically necessary, i.e., due to documented weight loss or another physical effect; and

(3) cognitive assistance such as prompting or cuing.

E. EPSDT PCS noncovered services: PCS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for general non-covered MAD EPSDT services or activities. Specifically, PCS services may not be billed in conjunction with the following services:

(1) any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings, and administration of medications;

(2) services that are not in the MAP eligible recipient's approved ITP and for which prior approval has not been received;

(3) services not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient.

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F. EPSDT PCS treatment plan: The MAP eligible recipient's ITP is approved by MAD or its designated UR contractor prior to the initiation of PCS services. The PCS ITP is developed as a result of a face-to-face assessment of the MAP eligible recipient and must include the following:

- (1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient for PCS services;
- (2) description of the physical or cognitive functional level of the recipient as evidenced by the PCP's clinical evaluation, including social emotional or behavioral health status, intellectual functioning and the documented medical necessity for PCS services;
- (3) description of intermediate and long-range service goals that includes the scope and duration of service, how goals will be attained and the projected timetable for their attainment;
- (4) specification of the PCS attendant's responsibilities, including tasks to be performed by the attendant and any special instructions for the health and safety of the MAP eligible recipient;
- (5) a statement of the least restrictive conditions necessary to achieve the goals identified in the plan; and
- (6) the ITP must be reviewed and revised in cooperation with the MAP eligible recipient's case manager according to his or her clinical needs at least every six months.

[8.320.2.18 NMAC – N, 1-1-14]

**8.320.2.19 EPSDT PRIVATE DUTY NURSING SERVICES:** MAD pays for private duty nursing (PDN) services as part of the EPSDT program [42 CFR Section 441.57]. Services must be accessed through the tot to teen healthcheck screen. A MAP eligible recipient is under 21 years, who has been referred for PDN services shift care (not intermittent care), must meet the established medically fragile criteria and parameters that have been approved by MAD.

A. EPSDT PDN eligible providers: A nurse working for a MAD approved PDN agency must have a RN or LPN on staff that meets MAD requirements. Services must be furnished under the direction of the MAP eligible recipient's PCP. Certification for participation as a medicare home health agency is not required. The following agencies are eligible to be reimbursed for providing EPSDT PDN services:

- (1) a licensed nursing agency; or
- (2) a FQHC.

B. EPSDT PDN coverage criteria: PDN services must be furnished by a RN or a LPN in the MAP eligible recipient's home or in his or her school setting if it is medically necessary for school attendance. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's function level in a home setting.

- (1) EPSDT PDN services are for a MAP eligible recipient under 21 years of age who requires more individual and continuous care than can be received through the MAD home health program.
- (2) EPSDT PDN services must be ordered by the MAP eligible recipient's PCP and must be included in his or her approved treatment plan. Services furnished must be medically necessary and be within the scope of the nursing profession. A MAP eligible recipient must have an approved ISP before nursing services can begin. Prior authorization for these services is required.

C. EPSDT PDN treatment plan: The need for skilled nursing services must be included in the MAP eligible recipient's ITP or ISP. The ISP meeting must have been held and the ISP written by the RN or case manager must be approved before nursing services can start. The plan must contain the following:

- (1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;
- (2) description of the functional level of the MAP eligible recipient as documented by the PCP's clinical evaluation, including social, emotional or behavioral health status, intellectual functioning and medical necessity which identify and document the need for a PDN;
- (3) specific clinical problems relating to:
  - (a) physical assessment needs including the identification of durable medical equipment or medical supplies needed by the MAP eligible recipient;
  - (b) psychosocial evaluation including level of support from family in reaching projected clinical goals;

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- (c) medication history including status of compliance of the MAP eligible recipient; and
  - (4) applicable clinical interventions related to the identified clinical problem including measurable goals;
    - (5) statement of the least restrictive conditions necessary to achieve the goals identified in the plan;
    - (6) description of intermediate and long-range goals with the projected timetable for their attainment and duration and scope of services, and strengths and priorities of the family and MAP eligible recipient;
    - (7) statement and rationale of the nursing care plan for achieving these intermediate and long-range goals including provisions for the review and modification of the plan;
    - (8) specification of nursing responsibilities, description of the proposed nursing care, orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient; and
    - (9) a transition plan that identifies what the plan will be after discharge from PDN services.
  - C. EPSDT PDN covered services: MAD covers the following PDN services:
    - (1) skilled nursing services furnished to the MAP eligible recipient's at his or her home; and
    - (2) skilled nursing services which are medically necessary for attending school and furnished to the MAP eligible recipient in the school setting. These services are an alternative to his or her participation in a homebound program. Nursing services are furnished only to a MAP eligible recipient and not to others in the school setting.
  - D. EPSDT PDN noncovered services: PDN services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9, subsection C of this rule for general non-covered MAD EPSDT services or activities.
- [8.320.2.19 NMAC - N, 1-1-14]

**8.320.2.20 EPSDT REHABILITATION SERVICES:** MAD pays for medically necessary services, including outpatient services furnished to a MAP eligible recipient under 21 years of age by or under the supervision of licensed PT; OT; and master's level SLP. A MAP eligible recipient under 21 years of age who is eligible for a home and community based waiver program receives medically necessary rehabilitation services through the EPSDT rehabilitation services, the home and community based waiver program provides rehabilitation services only for the purpose of community integration.

- A. EPSDT rehabilitation eligible providers: A PT, OT and master's level SLP is eligible to be reimbursed for furnishing services to a MAP eligible recipient under 21 years of age in need of EPSDT rehabilitation services.
  - (1) The following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to a MAP eligible recipient:
    - (a) a master's level SLP licensed by the RLD board of speech-language pathology and audiology;
    - (b) a PT licensed as physical therapists by the RLD physical therapy board;
    - (c) an OT licensed as occupational therapists by the RLD board of examiners for occupational therapy;
    - (d) certified outpatient rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy, licensed by DOH;
    - (e) home health agencies licensed and certified by DOH; and
    - (f) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the DOH.
  - (b) a PT assistant licensed by the RLD physical therapy board and working under the supervision of a licensed PT;
  - (d) an OT assistant licensed by the RLD occupational therapy board and working under the supervision of a licensed OT;
  - (e) a SPL licensed by the RLD board of speech-language pathology and audiology; and
  - (f) SLP apprentices and clinical fellows licensed by the RLD board of speech-language pathology and working under the supervision of a licensed SLP.

B. EPSDT rehabilitation covered services: MAD covers speech therapy, physical therapy and occupational therapy services provided to a MAP eligible recipient under 21 years of age. MAD covers evaluations,

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individual therapy and group therapy in an outpatient setting. Services must be medically necessary and provided for the purpose of diagnostic study or treatment. When a MAP eligible recipient receiving or can access therapy services at his or her school, he or she may require additional medically necessary services. Services must be designed to improve, restore or maintain the MAP eligible recipient's condition including controlling symptoms and maintaining the functional level to avoid further deterioration as indicated his or her ITP. The provider, following the MAP eligible recipient's PCP orders, will develop the treatment plan.

(1) Physical, occupational, and speech therapy services must be specifically related to the active written treatment plan developed by qualified a PT, OT, SLP therapist with authorization from the MAP eligible recipient's PCP.

(2) Services must be performed within the scope and practice of the RLD practice board and as defined by state statute and rule.

(3) All services provided by or under the supervision of a SLP, OT, PT must be prescribed or ordered by the MAP eligible recipient's PCP. The PCP must be a physician or doctor of osteopathy, certified nurse practitioner, or physician assistant licensed to practice in New Mexico.

C. EPSDT rehabilitation noncovered services:

(1) Services furnished by or under the supervision of a SLP, OT, PT are subject to the limitations and coverage restrictions that exist for other MAD services.

(2) MAD does not cover these specific services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Prior Authorization: All therapy services with the exception of the initial evaluation require prior authorization from MAD or its designee.

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

**HISTORY OF 8.320.2 NMAC:**