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TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 15 INTENSIVE OUTPATIENT PROGRAM (IOP) SERVICES

8.310.15.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.15.1 NMAC - N, 11-13-09]

8.310.15.2 SCOPE: The rule applies to the general public.
[8.310.15.2 NMAC - N, 11-13-09]

8.310.15.3 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 27-2-12 et seq. (Repl. Pamp. 1991).
[8.310.15.3 NMAC - N, 11-13-09]

8.310.15.4 DURATION: Permanent
[8.310.15.4 NMAC - N, 11-13-09]

8.310.15.5 EFFECTIVE DATE: November 13, 2009, unless a later date is cited at the end of a section.
[8.310.15.5 NMAC - N, 11-13-09]

8.310.15.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.310.15.6 NMAC - N, 11-13-09]

8.310.15.7 DEFINITIONS: [RESERVED]

8.310.15.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.310.15.8 NMAC - N, 11-13-09]

8.310.15.9 INTENSIVE OUTPATIENT PROGRAM SERVICES: MAD pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive medically necessary services, MAD pays for covered intensive outpatient program (IOP) services. IOP services provide a time-limited, multi-faceted approach to treatment service for eligible recipients who require structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be delivered through a MAD approved agency, as specified in 8.310.15.10 NMAC, *eligible providers*.
[8.310.15.9 NMAC - N, 11-13-09]

8.310.15.10 ELIGIBLE PROVIDERS:

A. Healthcare to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of New Mexico MAD provider participation 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 covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/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 instruction, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instructions 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 provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or

its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

C. The following six types of agencies are eligible to be reimbursed for providing IOP services when they have a researched-based model meeting the requirements of Subsection F of 8.310.15.14 NMAC, *covered services*:

(1) a community mental health center (CMHC);
(2) a rural health clinic (RHC);
(3) a federally qualified health center (FQHC);
(4) an Indian health services (IHS) facility;
(5) a PL.93-638 tribal 638 facility; and
(6) an agency approved by MAD after demonstrating that the agency meets all the requirements of an IOP program services and supervision requirements.

D. Services must be provided within the scope of the practice and licensure for each provider and must be in compliance with the statutes, rules and regulations of the applicable practice act and must be eligible for reimbursement as described in 8.310.8 NMAC *Behavioral Health Professional Services*.

E. Each IOP program must have a clinical supervisor. The clinical supervisor may also serve as the IOP program supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(1) licensed as an independent practitioner, see Subsection C above;
(2) two years relevant experience with IOP eligible recipients;
(3) one year demonstrated supervisory experience; and
(4) expertise in both mental health and substance abuse treatment.

F. IOP providers are required to develop and implement a program evaluation system.

G. Provider agencies must maintain the appropriate state facility licensure if offering medication treatment or medication replacement services.

H. The agency must provide MAD with a letter of readiness review approval from the appropriate state agency.

[8.310.15.10 NMAC - N, 11-13-09]

8.310.15.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an 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 an eligible recipient.

C. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

See 8.302.1 NMAC, *General Provider Policies*.

[8.310.15.11 NMAC - N, 11-13-09]

8.310.15.12 ELIGIBLE RECIPIENTS:

A. IOP services are provided to youth, aged 13-17 years, diagnosed with substance abuse disorders or with co-occurring disorders (serious emotional disturbance and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

B. IOP services are provided to adults aged 18 years and over diagnosed with substance abuse disorders or with co-occurring disorders (serious mental illness and substance abuse) or that meet the ASAM patient placement criteria for level two (II) - intensive outpatient treatment.

C. Before engaging in an IOP program, the eligible recipient must have a treatment file from an appropriate practitioner or agency that contains at least the following items:

(1) one diagnostic evaluation; and

(2) one individualized service plan that includes IOP as an intervention.

[8.310.15.12 NMAC - N, 11-13-09]

8.310.15.13 COVERAGE CRITERIA: IOP services provide a time-limited, multi-faceted approach to treatment service for eligible recipients who require structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be culturally-sensitive and incorporate recovery and resiliency values into all service interventions. Treatment services should address co-occurring mental health disorders, as well as substance use disorders, when indicated. The IOP services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with behavioral health providers, with the intent that the IOP service shall not exclude consumers with co-occurring disorders.

[8.310.15.13 NMAC - N, 11-13-09]

8.310.15.14 COVERED SERVICES:

A. MAD covers services and procedures that are medically necessary for the evaluation, assessment, diagnosis and treatment of, an illness or injury as indicated by the eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope and practice of the provider's professional standards. See 8.310.8 NMAC, *Behavioral Health Professional Services,* for those providers that are approved to provide behavioral health services reimbursable by MAD.

B. IOP core services include:

(1) individual therapy;

(2) group therapy (group membership may not exceed 15 in number; and

(3) psycho education for the eligible recipient and their family.

C. Eligible recipient youth or transition-age young adult is defined as "seventeen (17) years and under." This population should engage in IOP treatment in an environment separate from the adult eligible recipient.

D. Co-occurring mental health and substance use disorders: IOP must accommodate the needs of the eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated multi-disciplinary approach or coordinated, concurrent services with behavioral health providers. Medication management services are available to oversee use of psychotropic medications.

E. Duration: the duration of IOP intervention is typically three to six months; the amount of weekly services per eligible recipient is directly related to the goals and objectives specified in the eligible recipient's treatment or service plan.

F. IOP services must be rendered through one of the following research-based models:

(1) any models other than those identified below must be approved by HSD or its authorized agents;

(2) matrix model adult treatment model;

(3) matrix model adolescent treatment model;

(4) Minnesota treatment model; or

(5) integrated dual disorder treatment.

G. Services not provided in accordance with the conditions for coverage as specified in 8.310.15.10 NMAC, *eligible providers,* and 8.310.15.14 NMAC, *covered services,* are not covered services and are subject to recoupment.

[8.310.15.14 NMAC - N, 11-13-09]

8.310.15.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity, inspection of care, 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.

See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. 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. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. See Subsection A of 8.311.2.16 NMAC, *emergency room services*.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with prior authorization denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.310.15.15 NMAC - N, 11-13-09]

8.310.15.16 NONCOVERED SERVICES: The following services may not be billed in conjunction with IOP services:

A. acute inpatient;

B. residential treatment services (i.e., accredited residential treatment centers, residential treatment centers, group home, and transitional living services;

C. assertive community treatment;

D. partial hospitalization;

E. outpatient therapies (family and group therapy may be billed only if there are clinical issues beyond the scope of the IOP services);

F. multi-systemic therapy;

G. activity therapy;

H psychosocial rehabilitation (PSR) services group; and

I. services provided by a practitioner that is not an eligible provider as listed in 8.310.8 NMAC, *Behavioral Health Professional Services.*

[8.310.15.16 NMAC - N, 11-13-09]

8.310.15.17 REIMBURSEMENT:

A. An IOP service provider must submit claims for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be their usual and customary charge for services. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

C. IOP services furnished by IOP licensed providers are billed by the eligible agencies identified in Subsection C of 8.310.15.14 NMAC, *covered services*, whether they are employed or whether they furnish services under contract.

E. IOP services must be provided directly to the eligible recipient by the licensed IOP professional allowed to provide the services as listed in Subsection A - D of 8.310.15.10 NMAC, *eligible providers*.

[8.310.15.17 NMAC - N, 11-13-09]

HISTORY OF 8.310.15 NMAC: [RESERVED]