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8.310.8 BEHAVIORAL HEALTH PROFESSIONAL SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 8 BEHAVIORAL HEALTH PROFESSIONAL SERVICES

8.310.8.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.310.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11/1/04; A, 7/16/08]

8.310.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.310.8.2 NMAC – Rn, 8 NMAC 4.MAD.000.3, 11/1/04]

8.310.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is 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).
[2/1/95; 8.310.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11/1/04; A, 7/16/08]

8.310.8.4 DURATION: Permanent.
[2/1/95; 8.310.8.4 NMAC – Rn, 8 NMAC 4.MAD.000.3, 11/1/04]

8.310.8.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.310.8.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11/1/04; A, 11/1/05]

8.310.8.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.310.8.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11/1/04; A, 7/16/08]

8.310.8.7 DEFINITIONS: [RESERVED]
[2/1/95; 8.310.8.7 NMAC – Rn, 8 NMAC 4.MAD.000.3, 11/1/04]

8.310.8.8 MISSION STATEMENT: 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.
[2/1/95; 8.310.8.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11/1/04; A, 7/16/08; A/E, 1/1/10]

8.310.8.9 BEHAVIORAL HEALTH PROFESSIONAL SERVICES: MAD pays for medically necessary behavioral health (mental health and substance abuse) services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for covered professional behavioral health services] [42 CRF Sections 440.40, 440.60(a) and 441.57].
[2/1/95; 3/1/99; 8.310.8.9 NMAC - Rn, 8 NMAC 4.MAD.717, 11/1/04; A, 7/16/08]

8.310.8.10 ELIGIBLE PROVIDERS:

A. Health care 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 a 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 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 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 independent providers are eligible to be reimbursed for providing behavioral health professional services:

(1) individuals licensed as physicians by the board of medical examiners or board of osteopathy and who are board-eligible or board-certified in psychiatry, or the groups they form;

(2) psychologists (Ph.D., Psy.D. or Ed.D.) licensed as clinical psychologists by the New Mexico board of psychologist examiners, or the groups they form;

(3) licensed independent social workers (LISW) licensed by the New Mexico board of social work examiners, or the groups they form;

(4) licensed professional clinical mental health counselors (LPCC) licensed by the New Mexico counseling and therapy practice board, or the groups they form;

(5) licensed marriage and family therapists (LMFT) who are licensed by the New Mexico counseling and therapy practice board, or the groups they form;

(6) individuals licensed as clinical nurse specialists or certified nurse practitioners by the board of nursing who are certified in psychiatric nursing by a national nursing organization, or the groups they form, who can furnish services to adults or children as their certification permits.

D. The following agencies are eligible to be reimbursed for providing behavioral health professional services:

(1) community mental health centers (CMHC);
(2) federally qualified health centers (FQHCs);
(3) Indian health service (IHS) hospitals and clinics;
(4) PL 93-638 tribally operated hospitals and clinics;
(5) children, youth and families department (CYFD);
(6) hospitals and their outpatient facilities; and
(7) core service agencies (CSA).

E. When providing services supervised and billed by agencies listed above in Subsection D of 8.310.8 NMAC, the following practitioners' outpatient services may be reimbursed when the services are within their legal scope of practice and meet the definitions of covered services in 8.310.8.13 NMAC:

(1) licensed masters level social workers (LMSW);
(2) licensed professional mental health counselors (LPC);
(3) licensed mental health counselors (LMHC);
(4) licensed psychologist associates;
(5) licensed professional art therapists (LPAT);
(6) registered mental health counselors RMHC; and
(7) licensed alcohol and drug abuse counselors (LADAC).

F. 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 and with the MAD program policy manual.

[2/1/95; 3/1/99; 8.310.8.10 NMAC - Rn, 8 NMAC 4.MAD.717.1 & A, 11/1/04; A, 11/1/05; A, 7/16/08; A/E, 1/1/10]

8.310.8.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to medicaid or other health care program eligible recipients 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 must also 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 individuals are 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. See 8.302.1 NMAC, *General Provider Policies.*

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.
[2/1/95; 3/1/99; 8.310.8.11 NMAC - Rn, 8 NMAC 4.MAD.717.2, 11/1/04; A, 11/1/05; A, 7/16/08; A/E, 1/1/10]

8.310.8.12 COVERAGE CRITERIA:

A. MAD covers medically necessary behavioral health professional services including evaluations, therapy, and tests required by the condition of the eligible recipient. All services must be furnished within the limits of MAD benefits, within the scope and practice of the eligible provider's respective profession as defined by state law, and in accordance with applicable federal, state, and local laws and regulations.

B. **Medical necessity:** All services must be provided in compliance with the current MAD definition of medical necessity.
[2/1/95; 3/1/99; 8.310.8.12 NMAC - Rn, 8 NMAC 4.MAD.717.3, 11/1/04; A, 11/1/05; A, 7/16/08; A/E, 1/1/10]

8.310.8.13 COVERED SERVICES:

A. **Inpatient treatment and evaluations:** Except as noted below in 8.310.8.14 NMAC, MAD covers behavioral health professional services during an inpatient psychiatric admission including admission evaluations, testing, therapy and treatment for the acute phase of an illness when these services are furnished by licensed board-eligible or board-certified psychiatrists, licensed clinical psychologists (Ph.D., Psy.D., or Ed.D.), or individuals licensed as clinical nurse specialists or certified nurse practitioners by the board of nursing who are certified in psychiatric mental health nursing by a national nursing organization; and are consistent with the comprehensive service plan in effect at the inpatient facility. Acute care psychiatric hospitals and specialty units of general acute care hospitals are considered inpatient facilities for purposes of MAD coverage.

B. **Outpatient therapy services:** MAD covers outpatient assessments, evaluations, testing and therapy. Services may require prior authorization from MAD or its designee and will be reviewed based on criteria approved by HSD. Any currently allowable treatment modality (individual, group, family, multi-family) in any combination is covered. Frequency of services is to be determined by medical necessity. Services furnished by eligible providers must be specified in the eligible recipient's treatment or service plan. In the treatment of under-age eligible recipients, the treatment or service plan must document involvement of eligible recipient's family, and if applicable, others involved in the eligible child recipient's care. Adult eligible recipients, or their personal representatives, whenever appropriate, should participate in the development of their plans. The treatment or service plan and all supporting documentation must be available for review in the eligible recipient's record. Services must be consistent with the treatment plan in effect at the time the services are provided.

C. **Therapy in partial hospital settings, joint council on accreditation of healthcare organizations (JCAHO), or council on accreditation (COA)-accredited residential treatment and group home services (RTC), non-accredited residential treatment and group home services and treatment foster care:** Routine behavioral health care is covered for eligible recipients under the age of 21 in partial hospitalization programs, JCAHO- or COA-accredited RTCs, non-accredited residential treatment and group home services, and treatment foster care. Additional services not covered by the fixed rates may be provided only after obtaining prior authorization from the utilization review agent. The additional services must be consistent with the service plan. Services not covered by fixed rates that would be eligible for prior authorization may include:

(1) medication management of psychotropic medications for eligible recipients in accredited residential treatment services and treatment foster care placement;

(2) psychological testing; which is not duplicative and is clinically necessary to meet the "extraordinary and specific," complex diagnostic needs of the eligible recipient, (see Paragraph (3) of Subsection C of 8.310.8.13 NMAC below); such psychological testing will not replace the routine psychological testing provided within the scope of the program;

(3) individual, group and family therapy; which is additional to the core program therapies and is performed by clinicians whose specialized training is necessary to treat documented "extraordinary and specific" eligible recipient needs; additional group therapy will be reimbursed only for eligible recipients placed in treatment foster care; conditions and circumstances which meet the definition of "extraordinary and specific need":

(a) complex diagnoses or symptom presentations such as, but not limited to, continuing psychotic features, persistent aggression which does not remit with standard behavioral interventions, or secondary encopresis;

(b) diagnostic questions which are persistent, recurring, or complicated.

(c) clinical situations or conditions which threaten further decompensation without intensive treatment.

D. **Injections:** MAD covers injections subject to the injection and pharmacy rules, See 8.310.2 NMAC, *Medical Service Providers* and 8.324.4 NMAC, *Pharmacy Services*.

E. **Medication review visits:** MAD covers brief office visits performed by an M.D., D.O, qualified psychologist, qualified nurse as defined above in Subsection A of 8.310.8.10 NMAC for the sole purpose of monitoring or changing prescriptions in the treatment of covered disorders.

F. **Treatment for substance abuse:** MAD covers medically necessary outpatient services for the treatment of alcohol and substance abuse for eligible recipients.

G. **Services provided to recipients under 21 years of age:** Additional services are covered for eligible recipients under 21 years of age. See 8.320.2 NMAC, *EPSDT Services* [MAD-740].

H. **Disorders covered for eligible recipients under 21 years of age:** MAD covers services for personality disorders for eligible recipients under 21 years of age only.

[2/1/95; 3/1/99; 8.310.8.13 NMAC - Rn, 8 NMAC 4.MAD.717.4 & A, 11/1/04; A, 11/1/05; A, 7/16/08]

8.310.8.14 NONCOVERED SERVICES: Behavioral health professional services are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. MAD does not cover the following behavioral health specific services:

A. hypnotherapy;

B. biofeedback;

C. services which do not meet the standard of medical necessity as defined in MAD rules;

D. conditions defined only by V-codes in the current version of the international classification of diseases that are not treatable conditions and do not meet the MAD definition of medical necessity are not covered;

E. treatment for personality disorders for adults age 21 and older;

F. treatment provided for adults 21 and older in alcohol or drug residential centers;

G. milieu therapy;

H. educational or vocational services related to traditional academic subjects or vocational training;

I. experimental or investigational procedures, technologies or non-drug therapies and related services;

J. activity therapy, group activities and other services which are primarily recreational or diversional in nature;

K. electroconvulsive therapy;

L. services provided by non-licensed counselors, therapists or social workers; and

M. treatment of mental retardation alone.

[2/1/95; 3/1/99; 8.310.8.14 NMAC - Rn, 8 NMAC 4.MAD.717.5, 11/1/04; A, 11/1/05; A, 7/16/08; A/E, 1/1/10]

8.310.8.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services may be subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished, 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, *Covered Emergency Services* [MAD-721.71].

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

C. **Reconsideration:** Providers who disagree with prior authorization request 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].

[2/1/95; 3/1/99; 8.310.8.15 NMAC - Rn, 8 NMAC 4.MAD.717.6, 11/1/04; A, 11/1/05; A, 7/16/08]

8.310.8.16 REIMBURSEMENT:

A. Behavioral health professional service providers must submit claims for reimbursement on the HCFA-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 providers 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.

C. "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.

D. For behavioral health professional service providers who are members of a practice plan affiliated with a state operated teaching hospital, reimbursement will equal the lesser of the provider's billed charge or the average rate paid for the service by commercial insurers as established by MAD. Providers eligible to be paid under this part will be paid on an interim claims-specific basis through the MAD claims processing system. The final payment for services provided will be made through a supplemental payment made in a specified time period that reflects any difference between the interim payment amounts and the average rate paid by commercial insurers for the services.

E. Behavioral health providers listed in Subsection E of 8.310.8.10 NMAC cannot bill MAD directly. Services furnished by these licensed providers are billed by the eligible agencies identified in Subsection D of 8.310.8 NMAC, above, whether they are employed or whether they furnish services under contract.

F. Behavioral health professional services must be provided directly to the eligible recipient by the licensed behavioral health professionals listed in 8.310.8.10 NMAC, above. Services performed by supervised master's level providers, nurses, bachelor's level and other health professionals not listed in Subsection E of 8.310.8.10 NMAC cannot be billed by the licensed supervisors even though the services may have been furnished under their direction.

G. Separate professional component billing is allowed for behavioral health services performed within a hospital setting by psychiatrists and licensed psychologists (Ph.D., Psy.D., or Ed. D.).

H. For facility-based providers, costs billed separately as a professional component must be excluded from the facility cost report prior to cost settlement or rebasing.

[2/1/95; 3/1/99; 8.310.8.16 NMAC - Rn, 8 NMAC 4.MAD.717.7, 11/1/04; A, 11/1/05; A, 7/16/08; A/E, 1/1/10]

8.310.8.17 REIMBURSEMENT FOR HOSPITAL-BASED SERVICES: Reimbursement for office visits, diagnostic procedures, or surgical services furnished in hospital settings that are ordinarily furnished in a provider's office is paid at sixty percent of the fee schedule-allowed amount for each professional service. MAD follows medicare principles in determining which procedures are subject to this payment reduction.

[8.310.8.17 NMAC - N, 11/1/05; A, 7/16/08]

HISTORY OF 8.310.8 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

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ISD Rule 310.1500, Psychiatric and Psychological Services, filed 2/7/86.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12/15/87.
ISD 310.1700, EPSDT Services, filed 2/13/80.
ISD 310.1700, EPSDT Services, filed 6/25/80.
ISD Rule 310.1700, EPSDT Services, filed 10/22/84.
MAD Rule 310.17, EPSDT Services, filed 5/1/92.
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History of Repealed Material:

MAD Rule 310.15 Psychiatric and Psychological Services, filed 12/15/87 - Repealed effective 2/1/95.

MAD Rule 310.17, EPSDT Services, filed 11/30/94 - Repealed effective 2/1/95.