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8.320.5 EPSDT CASE MANAGEMENT

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TITLE 8 SOCIAL SERVICES
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES
PART 5 EPSDT CASE MANAGEMENT

8.320.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.320.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.320.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.320.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.320.5.3 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 and by the state human services department pursuant to state statute. See NMSA 1978 Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.320.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.320.5.4 DURATION: Permanent
[2/1/95; 8.320.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.320.5.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.320.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.320.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.320.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.320.5.7 DEFINITIONS: [RESERVED]

8.320.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.320.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.320.5.9 EPSDT CASE MANAGEMENT: The New Mexico Medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico medical assistance division (MAD) pays for medicaid case management services furnished to those recipients under twenty-one (21) years of age who are medically at risk, as a early and periodic screening, diagnosis and treatment (EPSDT) service. The need for case management services must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral. This part describes eligible providers, eligible population, covered services, service limitations, and general reimbursement information.
[2/1/95; 8.320.5.9 NMAC - Rn, 8 NMAC 4.MAD.744, 3/1/12]

8.320.5.10 ELIGIBLE PROVIDERS: Upon approval of New Mexico medical assistance program provider participation agreements by MAD, a qualified case management agency provider is eligible to be reimbursed for furnishing services to an eligible recipient.

A. The following agencies can furnish case management services:
   (1) government or community agencies;
   (2) Indian tribal governments;
   (3) Indian health services; and
   (4) federally qualified health centers.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are

responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. **Agency qualifications:** Agencies must demonstrate direct experience in successfully serving medically at risk recipients and demonstrate knowledge of available community services and methods for gaining access to those services.

D. **Case manager qualifications:** Case managers employed by an 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 recipients. Case managers must have the necessary skills to meet the needs of specified recipients. In some instances, it is important that individuals have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. Case managers must also meet one of the following requirements:

(1) 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; individuals with a bachelor's degree in another field can substitute two (2) years of direct experience in serving the medically at risk population for the required field of study;

(2) licensed as registered or licensed practical nurses; or

(3) if there are no suitable candidates with the previously described qualifications, individuals with the following education and experience can be employed as case managers:

(a) associate's degree and a minimum of three (3) years of experience in community health or social services; or

(b) high school education or graduate equivalence diploma (GED) and a minimum of four (4) years of experience in community health or social services;

(c) these individuals must work under the direct supervision of an experienced case manager within the agency who meets the educational requirements specified above.

E. **Agency restrictions:** For recipients with developmental disabilities or severe emotional disturbances, MAD restricts the type of agencies that can provide case management services to these recipients. See 42 U.S.C. Section 1396n(g)(1)(2). Case management providers for recipients with developmental disabilities or severe emotional disturbances must be certified by the New Mexico department of health (DOH) and/or children, youth and families department (CYFD).

[2/1/95; 8.320.5.10 NMAC - Rn, 8 NMAC 4.MAD.744.1, 3/1/12]

8.320.5.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of services, type of contact, category of case management services furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result, and relationship of the service furnished to the goals identified in the plan of care.

[2/1/95; 8.320.5.11 NMAC - Rn, 8 NMAC 4.MAD.744.2, 3/1/12]

8.320.5.12 ELIGIBLE RECIPIENTS: Recipients who are eligible for EPSDT case management must be considered medically at risk. "Medically at risk" is defined as those individuals who have a diagnosed physical or mental condition which has a high probability of impairing their cognitive, emotional, neurological, social or physical development.

[2/1/95; 8.320.5.12 NMAC - Rn, 8 NMAC 4.MAD.744.3, 3/1/12]

8.320.5.13 COVERED SERVICES:

A. Medicaid covers the following case management services:

(1) assessment of a recipient's medical and social needs and functional limitations; recipients must be reassessed every six (6) months, unless more frequent reassessment is indicated by a recipient's condition;

(2) development and implementation of plans of care designed to help recipients retain or achieve the maximum degree of independence; certain EPSDT enhanced services can be furnished only if included in the plan of care including private duty nursing, therapeutic group home, treatment foster care, psycho-social rehabilitation, residential treatment, behavior management skills development, and day treatment;

(3) mobilization of the use of "natural helping" networks such as family members, church members, community organizations, support groups and friends; and

(4) coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the plan of care, if necessary.

B. Medicaid covers case management services furnished to recipients in institutions only for the last thirty (30) days of institutionalization to ensure follow-up services; case management services do not replace the discharge planning functions required of the institution.

[2/1/95; 8.320.5.13 NMAC - Rn, 8 NMAC 4.MAD.744.4, 3/1/12]

8.320.5.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific services as ESPDT case management:

A. services to individuals who are not eligible or who do not meet the definition of medically at risk;

B. services which are furnished by other practitioners, such as therapists, transportation, homemakers or personal care service providers;

C. formal educational or vocation services related to traditional academic subjects or vocational training;

D. client outreach activities in which a provider attempts to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning which is a required condition for payment of hospital, nursing home or residential treatment center services; discharge planning must not be billed separately as targeted case management services;

G. services which are not documented by the case manager in a recipient's file;

H. case management for a recipient who is institutionalized, except for the last thirty (30) days of the institutionalization to ensure follow-up services; and

I. services to recipients who receive case management services through home and community-based services waiver programs.

[2/1/95; 8.320.5.14 NMAC - Rn, 8 NMAC 4.MAD.744.5, 3/1/12]

8.320.5.15 TREATMENT PLAN: The treatment plan is developed by the case manager in cooperation with recipients, families or legal guardian(s), primary physicians, as appropriate and others involved with the recipient's care within thirty (30) days of the initiation of services. The plan must be reviewed every six (6) months or more often as indicated. Social workers may be involved in the development of the treatment plan in the case of recipients who are in the custody of CYFD or other state agencies. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:

A. statement of the nature of the specific problem and the specific needs of the recipient;

B. description of the functional level of the recipient, including the following:

(1) mental status assessment;

(2) intellectual function assessment;

(3) psychological assessment;

(4) educational assessment;

(5) vocational assessment;

(6) social assessment;

(7) medical assessment; and

(8) 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 rational of the treatment plan 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.

[2/1/95; 8.320.5.15 NMAC - Rn, 8 NMAC 4.MAD.744.6, 3/1/12]

8.320.5.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review 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. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are specified in the treatment plan can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.320.5.16 NMAC - Rn, 8 NMAC 4.MAD.744.7, 3/1/12]

8.320.5.17 REIMBURSEMENT: Case management 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.

A. Reimbursement for case management providers is made at the lesser of the following:

(1) the provider's billed charge; or

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

B. The provider's billed charge must be its usual and customary charge for the services.

C. "Usual and customary charge" refers to the amount which an individual provider charges the general public in the majority of cases for specific services.

D. Reimbursement rates are based on the diagnosis and severity of illness.

E. For case management services furnished by an institution, costs associated with case management must be removed from the cost reports prior to any cost settlement or rebasing.

[2/1/95; 8.320.5.17 NMAC - Rn, 8 NMAC 4.MAD.744.8, 3/1/12]

HISTORY OF 8.320.5 NMAC:

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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.
MAD Rule 310.17, EPSDT Services, filed 7/14/93.
MAD Rule 310.17, EPSDT Services, filed 11/12/93.
MAD Rule 310.17, EPSDT Services, filed 12/17/93.
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History of Repealed Material:
MAD Rule 310.17, EPSDT Services, filed 11/30/94 - Repealed effective 2/1/95.