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8.321.3 ACCREDITED RESIDENTIAL TREATMENT CENTER SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 321 ENHANCED EPSDT - RESIDENTIAL SERVICES
PART 3 ACCREDITED RESIDENTIAL TREATMENT CENTER SERVICES

8.321.3.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.321.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.321.3.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.321.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.321.3.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.321.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.321.3.4 DURATION: Permanent
[2/1/95; 8.321.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.321.3.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.321.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.321.3.6 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; 8.321.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.321.3.7 DEFINITIONS: [RESERVED]

8.321.3.8 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; 8.321.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.321.3.9 ACCREDITED RESIDENTIAL TREATMENT CENTER SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary services furnished to eligible recipients. To help recipients under twenty-one (21) years of age who have been diagnosed as having a severe emotional disturbance, a mental disorder or a chemical dependency, and for whom less restrictive settings are not appropriate, the New Mexico medical assistance (MAD) pays for mental health services furnished to this group of recipients by residential treatment centers accredited by the joint commission on accreditation of healthcare organizations (JCAHO) as part of early and periodic screening, diagnosis and treatment (EPSDT) services. The need for accredited residential treatment center 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, covered services, service limitations, and general reimbursement methodology.
[2/1/95; 8.321.3.9 NMAC - Rn, 8 NMAC 4.MAD.742.2, 3/1/12]

8.321.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, residential treatment centers are eligible to be reimbursed for services to recipients if:

(1) centers are accredited as children's residential treatment centers by the JCAHO;

(2) centers are licensed as residential treatment centers by the New Mexico children, youth and families department (CYFD); and

(3) centers have written utilization review (UR) plans in effect which provide for review of recipients' need for the centers' services that meet federal requirements; see 42 CFR Section 456.201 through 456.245.

B. For out-of-state centers, accreditation by JCAHO and licensing in their own state are accepted in lieu of New Mexico licensure.

C. 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.

[2/1/95; 8.321.3.10 NMAC - Rn, 8 NMAC 4.MAD.742.21, 3/1/12]

8.321.3.11 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*. Providers must maintain records documenting the source and amount of any financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

[2/1/95; 8.321.3.11 NMAC - Rn, 8 NMAC 4.MAD.742.22, 3/1/12]

8.321.3.12 COVERED SERVICES: Medicaid covers accommodation and residential treatment services which are medically necessary for the diagnosis and/or treatment of a recipient's condition. Residential treatment centers must provide an interdisciplinary psychotherapeutic treatment program on a twenty-four (24) hour basis to eligible recipients.

A. Treatment must be furnished under the direction of a physician.

B. Treatment must be furnished based on an individualized treatment plan by providers, within the scope and practice of their profession as defined by state law.

C. Treatment must be reasonably expected to improve the recipient's condition. The treatment must be designed to reduce or control symptoms or maintain levels of functioning. Control of symptoms and maintenance of a functional level to avoid hospitalization or further deterioration are acceptable expectations of improvement.

D. The following services must be furnished by centers to receive reimbursement from medicaid. Payment for performance of these services is included in the center's reimbursement rate:

(1) performance of necessary evaluations and psychological testing and development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(2) regularly scheduled structured counseling and therapy sessions for recipients, groups, families or multifamily groups based on individualized needs, as specified in the treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management;

(4) assistance to recipients in self-administration of medication in compliance with state policies and procedures;

(5) appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients, make referrals, as necessary, and provide follow-up;

(6) consultation with other professionals or allied care givers regarding a specific recipient;

(7) non-medical transportation services needed to accomplish the treatment objective; and

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients.

[2/1/95; 8.321.3.12 NMAC - Rn, 8 NMAC 4.MAD.742.23, 3/1/12]

8.321.3.13 NONCOVERED SERVICES: Services furnished in residential treatment centers 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 for recipients in residential treatment centers:

A. services not considered medically necessary for the condition of the recipient, as determined by MAD or its designee;

B. services for which prior approval was not requested;

C. services furnished to ineligible individuals; residential treatment center services are covered only for recipients under twenty-one (21) years of age;

D. services furnished after MAD or its designee determines that the recipient no longer needs JCAHO accredited residential treatment center care;

E. formal educational and services which relate to traditional academic subjects or vocational training;

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

G. drugs classified as "ineffective" by the FDA drug evaluation; and

H. activity therapy, group activities, and other services primarily recreational or diversional in nature.

[2/1/95; 8.321.3.13 NMAC - Rn, 8 NMAC 4.MAD.742.24, 3/1/12]

8.321.3.14 TREATMENT PLAN: The treatment plan must be developed by a team of professionals in consultation with recipients, parents, legal guardians and/or others in whose care the recipient will be released after discharge. The plan must be developed within fourteen (14) days of the recipient's admission to a JCAHO accredited residential treatment center.

A. The interdisciplinary team must review the treatment plan at least every thirty (30) days.

B. 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:

(1) statement of the nature of the specific problem and the specific needs of the recipient;

(2) description of the functional level of the recipient including the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment;

C. statement of the least restrictive conditions necessary to achieve the purposes of treatment;

D. description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;

E. statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;

F. specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the recipient; and

G. criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

[2/1/95; 8.321.3.14 NMAC - Rn, 8 NMAC 4.MAD.742.25, 3/1/12]

8.321.3.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid 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*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. All services for recipients under twenty-one (21) years of age furnished in accredited residential treatment centers 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. 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. 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; 8.321.3.15 NMAC - Rn, 8 NMAC 4.MAD.742.26, 3/1/12]

8.321.3.16 REIMBURSEMENT:

A. JCAHO residential treatment centers must submit claims for reimbursement on the long term care turn around document 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 is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule.

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 service or procedure.

D. The fee schedule is based on actual cost data submitted by providers. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission/discharge planning, clinical support, non-personnel operating, administration and consultation.

(1) The fee schedule reimbursement covers those services considered routine in the residential setting. See 8.321.3.12 NMAC, *covered services*. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(2) Services which are not covered in routine services include:

(a) direct services furnished by psychiatrists or licensed Ph.D. psychologists; these services can be billed directly by the provider. See 8.310.8 NMAC, *Behavioral Health Professional Services*; and

(b) other medicaid services that a recipient might require, such as pharmacy services, physician visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable section of the medical assistance program manual.

(3) Services which are not covered in the routine rate and are not a medicaid-covered services include:

(a) room and board;

(b) education and vocational services; and

(c) services not related to medical necessity, clinical treatment and/or patient care.

E. A vacancy factor of twenty-four (24) days annually for each recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, providers cannot bill nor be reimbursed for days when the recipient is absent from the facility.

F. The fee schedule will be updated annually each July 1st, based on the state salary increase passed by the New Mexico legislature. MAD or its designee will conduct an in depth review of cost report information every three (3) years to see if adjustments, beside the yearly update, are indicated. The next such review and possible adjustment to the fee schedule will take place prior to the determination of the fee schedule for July 1, 1997.

G. Providers must submit annual cost reports in a form prescribed by MAD. Cost reports are due ninety (90) days after the close of the provider's fiscal year end.

(1) If a provider cannot meet this due date, they can request a thirty (30) day extension for submission. This request must be made in writing and received by MAD prior to the original due date.

(2) Failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all medicaid payment until such time as the cost report is received.

H. Reimbursement rates for out-of-state centers located more than one hundred (100) miles from the New Mexico border (Mexico excluded) are seventy percent (70%) of billed charges or a negotiated rate.
[2/1/95; 8.321.3.16 NMAC - Rn, 8 NMAC 4.MAD.742.27, 3/1/12]

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MAD Rule 310.17, EPSDT Services, filed 12/17/93.
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