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TITLE 8 SOCIAL SERVICES
CHAPTER 321 ENHANCED EPSDT - RESIDENTIAL SERVICES
PART 4 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES

8.321.4.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.321.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.321.4.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.321.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.321.4.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.321.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.321.4.4 DURATION: Permanent
[2/1/95; 8.321.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.321.4.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.321.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.321.4.6 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; 8.321.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.321.4.7 DEFINITIONS: [RESERVED]

8.321.4.8 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; 8.321.4.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.321.4.9 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico medical assistance division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57]. The need for non-accredited residential treatment center and group home 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; 8.321.4.9 NMAC - Rn, 8 NMAC 4.MAD.742.3, 3/1/12]

8.321.4.10 ELIGIBLE PROVIDERS: Upon approval of New Mexico medical assistance program provider participation agreements by MAD, residential treatment centers which are not accredited by the joint commission on accreditation of healthcare organizations (JCAHO) or group homes that meet the certification standards established by MAD or its designee and are licensed and certified as residential services providers by the New Mexico children, youth and families department (CYFD) are eligible for medicaid reimbursement. 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; 8.321.4.10 NMAC - Rn, 8 NMAC 4.MAD.742.31, 3/1/12]

8.321.4.11 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; 8.321.4.11 NMAC - Rn, 8 NMAC 4.MAD.742.32, 3/1/12]

8.321.4.12 COVERED SERVICES: Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. 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:

A. performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;

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

C. 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;

D. assistance to recipients in self-administration of medication in compliance with state policies and procedures;

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

F. consultation with other professionals or allied care givers regarding a specific recipient;

G. non-medical transportation services needed to accomplish the treatment objective; and

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

[2/1/95; 8.321.4.12 NMAC - Rn, 8 NMAC 4.MAD.742.33, 3/1/12]

8.321.4.13 NONCOVERED SERVICES: Services furnished by non-accredited treatment centers or group homes 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 activities furnished in non-accredited residential treatment centers or group homes:

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

B. room and board;

C. services for which prior approval was not obtained;

D. services furnished after the determination is made by MAD or its designee that the recipient no longer needs care;

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

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

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

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

[2/1/95; 8.321.4.13 NMAC - Rn, 8 NMAC 4.MAD.742.34, 3/1/12]

8.321.4.14 TREATMENT PLAN: An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients,

parents, legal guardians or others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of the recipient's admission.

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;

(3) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

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

(5) 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;

(6) 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

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

[2/1/95; 8.321.4.14 NMAC - Rn, 8 NMAC 4.MAD.742.35, 3/1/12]

8.321.4.15 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. All inpatient services for recipients under twenty-one (21) years of age furnished in non-accredited residential centers or group homes 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; 8.321.4.15 NMAC - Rn, 8 NMAC 4.MAD.742.36, 3/1/12]

8.321.4.16 REIMBURSEMENT:

A. Non-JCAHO residential treatment or group home providers must submit claims for reimbursement on the long term care turn around document (TAD) 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 for the specific service or procedure.

B. The provider's billed charge must be its 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 and level of intensity of services required by the individual served.

D. MAD fee schedule is based on the actual cost data submitted by the provider. The cost data is grouped into the 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, consultation, nursing and room and board. The fee schedule reimbursement covers those services considered routine in the residential setting. See Section MAD-742.23, *covered services*.

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

(a) direct services furnished by psychiatrist or licensed Ph.D psychologists; these services can be billed directly by those providers; see 8.310.8 NMAC, *Behavioral Health Professional Services*; and

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

(2) A vacancy factor of twenty-four (24) days annually for each recipient is built into the rate to allow for therapeutic leave and trail 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.

E. 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.

F. Providers must submit annual cost reports in a form prescribe 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 his 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 payments until such time as the cost report is received.

G. Services furnished by psychiatrists, psychologists or master's level independent social workers to any recipient of a group home or residential treatment center can be billed separately only when furnished by a provider who is not an employee or contractor of the facility where the recipient resides. These services are only furnished upon prior approval by MAD or its designee. Services furnished by psychiatrists, psychologists and licensed master's level independent social workers cannot be billed as psychosocial rehabilitation services.
[2/1/95; 8.321.4.16 NMAC - Rn, 8 NMAC 4.MAD.742.37, 3/1/12]

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