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TITLE 8 SOCIAL SERVICES
CHAPTER 321 ENHANCED EPSDT - RESIDENTIAL SERVICES
PART 5 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS

8.321.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.321.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1 & A, 2/1/12]

8.321.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.321.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 2/1/12]

8.321.5.3 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 27-1-12 et seq.
[2/1/95; 8.321.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3 & A, 2/1/12]

8.321.5.4 DURATION: Permanent
[2/1/95; 8.321.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 2/1/12]

8.321.5.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.321.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 2/1/12]

8.321.5.6 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; 8.321.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 2/1/12]

8.321.5.7 DEFINITIONS: [RESERVED]

8.321.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[2/1/95; 8.321.5.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 2/1/12]

8.321.5.9 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under 21 years of age receive the level of services needed, MAD pays for partial hospitalization services furnished in freestanding psychiatric hospitals as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57]. The need for outpatient or partial hospitalization services must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.
[2/1/95; 8.321.5.9 NMAC - Rn, 8 NMAC 4.MAD.742.4 & A, 2/1/12]

8.321.5.10 ELIGIBLE PROVIDERS:
A. Health care to New Mexico 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 instructions, 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 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. Eligible providers include facilities:

(1) accredited by the joint commission of healthcare organizations (JCAHO); and

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH) or the comparable agency in another state.

B. When services are billed to and paid by a MAD fee-for-service coordinated services contractor, 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.

[8.321.5.10 NMAC - Rp, 8 NMAC 4.MAD.742.41 & A, 2/1/12]

8.321.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care programs 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.

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 MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, 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*.

[8.321.5.8 NMAC - Rp, 8 NMAC 4.MAD.742.42 & A, 2/1/12]

8.321.5.12 COVERAGE CRITERIA: MAD covers only those services which meet the following criteria:

A. Services are prescribed by a psychiatrist or licensed Ph.D. psychologist and furnished under an individualized written treatment plan established by the psychiatrist or licensed Ph.D. psychologist after any necessary consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals.

B. Treatment is supervised and periodically evaluated by a psychiatrist or licensed Ph.D. psychologist to determine the extent to which treatment goals are being realized. The psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any therapist involved in the eligible recipient's treatment. The psychiatrist or licensed Ph.D. psychologist must see the eligible recipient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

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

[2/1/95; 8.321.5.12 NMAC - Rn, 8 NMAC 4.MAD.742.43 & A, 2/1/12]

8.321.5.13 COVERED SERVICES AND SERVICE LIMITATIONS: The following services must be furnished by a partial hospitalization provider to receive reimbursement from medicaid. Payment for performance of these services is included in the facility's reimbursement rate:

A. performance of necessary evaluations and psychological testing for the 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 furnished by social workers, trained psychiatric nurses, other behavioral health professionals who are employed by the hospital, 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 the eligible recipient in self-administration of medication in compliance with state policies and procedures;

E. appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient 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 the eligible recipient.

[2/1/95; 8.321.5.13 NMAC - Rn, 8 NMAC 4.MAD.742.44 & A, 2/1/12]

8.321.5.14 NONCOVERED SERVICES: Partial hospitalization services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. MAD does not cover the following specific services under partial hospitalization:

A. meals and transportation;

B. activity therapies, group activities or other services which are primarily recreational or diversional in nature;

C. programs which provide social and recreational activities to recipients who need some supervision during the day;

D. programs which are generally community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction; medicaid does not cover the service if an eligible recipient's outpatient hospital program consists entirely of social activities.

E. formal educational and vocational services related to traditional academic subjects or vocational training; non-formal education services can be covered if they are part of an active treatment plan for the eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b).

F. hypnotherapy or biofeedback;

G. services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction; and

H. services not considered medically necessary for the condition of the eligible recipient.

[2/1/95; 8.321.5.14 NMAC - Rn, 8 NMAC 4.MAD.742.45 & A, 2/1/12]

8.321.5.15 TREATMENT PLAN: An individualized treatment plan must be developed by a team of professionals in consultation with the eligible recipient, parents legal guardians or others in whose care the eligible recipient will be released after discharge within 14 days of the eligible recipient's admission.

A. the interdisciplinary team must participate in the treatment planning at least every 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 eligible recipient's file:

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

(2) description of the functional level of the eligible 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 treatment plan for achieving these intermediate and long-range goals, including provisions for the 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 eligible 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; 8.321.5.15 NMAC - Rn, 8 NMAC 4.MAD.742.46 & A, 2/1/12]

8.321.5.16 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:** All outpatient and partial hospitalization services furnished in freestanding psychiatric hospitals for recipients under 21 years of age 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. 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 reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.*

[2/1/95; 8.321.5.16 NMAC - Rn, 8 NMAC 4.MAD.742.47 & A, 2/1/12]

8.321.5.17 REIMBURSEMENT: Providers of partial hospitalization services must submit claims for reimbursement on the UB 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. Outpatient and partial hospitalization services are reimbursed at an interim rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles. For those services reimbursed using the medicare allowable cost methodology, medicaid reduces the medicare allowable costs by three percent. Outpatient and partial hospitalization services that are not cost settled, will be reimbursed at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

B. If any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

[2/1/95; 8.321.5.17 NMAC - Rn, 8 NMAC 4.MAD.742.48 & A, 2/1/12]

HISTORY OF 8.321.5 NMAC:

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