INDEX

8.322.2 TREATMENT FOSTER CARE

This page intentionally left blank

TITLE 8 SOCIAL SERVICES
CHAPTER 322 ENHANCED EPSDT - COMMUNITY MENTAL HEALTH SERVICES
PART 2 TREATMENT FOSTER CARE

8.322.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.322.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.322.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.322.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.322.2.3 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 Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.322.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.322.2.4 DURATION: Permanent
[2/1/95; 8.322.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.322.2.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.322.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.322.2.6 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; 8.322.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.322.2.7 DEFINITIONS: [RESERVED]

8.322.2.8 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; 8.322.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.322.2.9 TREATMENT FOSTER CARE: 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 mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57]. The need for treatment foster care services must be identified in the tot to teen healthcheck 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; 8.322.2.9 NMAC - Rn, 8 NMAC 4.MAD.745.1, 3/1/12]

8.322.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, agencies that meet the following requirements are eligible to be reimbursed for furnishing treatment foster care:

(1) certified as providers of treatment foster care by the children, youth and families department (CYFD);

(2) services are furnished either through agency staff or contracted personnel; and

(3) services are furnished by licensed clinical professionals or under their supervision.

B. Recipients have the right to receive services from the eligible provider of their choice.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, certification standards, 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; 8.322.2.10 NMAC - Rn, 8 NMAC 4.MAD.745.11, 3/1/12]

8.322.2.11 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 provided 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; 8.322.2.11 NMAC - Rn, 8 NMAC 4.MAD.745.12, 3/1/12]

8.322.2.12 COVERED SERVICES: Medicaid covers those services included in individualized treatment plans which are designed to help recipients develop skills necessary for successful reintegration into the natural family or transition into the community.

A. The family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:

(1) participation in the development of treatment plans for recipients by providing input based on their observations;

(2) assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan;

(3) recording information and documentation of activities, as required by the foster care agency and the standards under which it operates;

(4) helping recipients maintain contact with their families and enhancement of those relationships;

(5) supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and

(6) assisting recipients obtain medical, educational, vocational and other services to reach goals identified in treatment plans.

B. The following services must be furnished by the agency certified for treatment foster care to receive reimbursement from medicaid. Payment for performance of these services is included in the provider's reimbursement rate:

(1) assessment of the recipient's progress in TFC and assessment of family interactions and stress;

(2) regularly scheduled counseling and therapy sessions for recipients in individual, family or group sessions;

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

(4) crisis intervention, including twenty-four (24) hour availability of appropriate staff to respond to crisis situations; and

(5) when a return to the natural family is planned, assessment of family strengths and needs and development of a family service plan.
[2/1/95; 8.322.2.12 NMAC - Rn, 8 NMAC 4.MAD.745.13, 3/1/12]

8.322.2.13 NONCOVERED SERVICE: Treatment foster care 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 services:

A. room and board;

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

C. respite care.
[2/1/95; 8.322.2.13 NMAC - Rn, 8 NMAC 4.MAD.745.14, 3/1/12]

8.322.2.14 TREATMENT PLAN: The treatment plan must be developed by treatment team in consultation with recipients, families or legal guardians, physicians, if applicable, and others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC program.

A. The treatment team must review the treatment plan 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 treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(6) specification of staff and TFC parent responsibilities, description of proposed staff involvement, 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; 8.322.2.14 NMAC - Rn, 8 NMAC 4.MAD.745.15, 3/1/12]

8.322.2.15 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 services furnished to recipients under twenty-one (21) years of age by treatment foster care agencies 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; 8.322.2.15 NMAC - Rn, 8 NMAC 4.MAD.745.16, 3/1/12]

8.322.2.16 REIMBURSEMENT: Treatment foster care 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.

A. Reimbursement to providers for covered treatment foster care services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD maximum allowed rate.

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

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

[2/1/95; 8.322.2.16 NMAC - Rn, 8 NMAC 4.MAD.745.17, 3/1/12]

HISTORY OF 8.322.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
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.
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.
MAD Rule 310.17, EPSDT Services, filed 3/14/94.
MAD Rule 310.17, EPSDT Services, filed 6/15/94.
MAD Rule 310.17, EPSDT Services, filed 11/30/94.

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