INDEX

722 OUTPATIENT PSYCHIATRIC SERVICES AND PARTIAL HOSPITALIZATION

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The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive a range of mental health services, the New Mexico Medical Assistance Division (MAD) pays for outpatient psychiatric services and partial hospitalization services for recipients of any age in specialty units of general hospitals.

This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

722.1 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by MAD, general acute care hospitals are eligible to be reimbursed for providing outpatient psychiatric services and partial hospitalization services if they are licensed and certified by the Licensing and Certification Bureau of the New Mexico Department of Health (DOH) to participate in the Title XVIII (Medicare) program.

722.2 Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, 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 Section MAD-701, GENERAL PROVIDER POLICIES. Documentation must be sufficient to demonstrate that coverage criteria is met, including:

1. A treatment plan in which the services are prescribed by a psychiatrist or certified Ph.D. psychologist;

2. Supervision and periodic evaluation of the recipient, either individually or in

a group, by the psychiatrist or certified Ph.D. psychologist to assess the course of treatment. At a minimum, this periodic evaluation of services at intervals indicated by the condition of the recipient, must be documented in the recipient's record. Medicaid does not cover outpatient hospital psychiatric services without periodic psychiatrist or certified Ph.D. psychologist evaluation; and

3. Medical justification of any activity therapies, recipient education programs and psychosocial programs.

722.3 Coverage Criteria

Medicaid covers only services which comply with current state mental health codes and standards developed by the Mental Health Division of the DOH.

722.31 Treatment Plan Services must be prescribed by a psychiatrist or certified Ph.D. psychologist and furnished under an individualized written treatment plan established by the psychiatrist or certified 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 specify the diagnoses and anticipated goals.

722.32 Supervision and Evaluation Services must be supervised and evaluated periodically as indicated by the recipient's condition, by a psychiatrist or certified Ph.D. psychologist. The evaluation is necessary to determine the extent to which treatment goals are being met and whether changes in direction or emphasis of the treatment are needed.

(A) The evaluation must be based on periodic consultations and conferences with therapists and staff, review of medical records and recipient interviews.

(B) Psychiatrist or certified Ph.D. psychologist entries in medical records must support this involvement. The psychiatrist or certified Ph.D. psychologist must provide treatment to the recipient periodically, as indicated by the recipient's condition, to determine the extent to which treatment goals are being meet and whether changes in direction or

emphasis are needed.

722.33 Reasonable Expectation of Improvement Services must be for the purpose of diagnostic study or be reasonably expected to improve the recipient's condition. At a minimum, the treatment must be designed to reduce or control the recipient's psychiatric symptoms to prevent relapse or hospitalization and improve the recipient's level of functioning. Medicaid covers services to control symptoms and maintain the recipient's functional level to avoid further deterioration or hospitalization.

722.4 Covered Services

Medicaid covers outpatient psychiatric hospital services which are medically necessary for the diagnosis and/or treatment of a mental illness, as indicated by the condition of the recipient. Services and stabilization must be for the purpose of diagnostic study or be expected to improve the recipient's condition.

(A) Services must be furnished by Medicaid participating providers within the scope and practice of their profession as defined by state laws or regulations.

(B) At a minimum, hospitals must provide the following services which are included in the outpatient reimbursement rate:

1. Necessary evaluations and psychological testing for 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 multi-family groups based on individualized needs, as specified in the treatment plan;

3. Age-appropriate skills development in 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 twenty-four (24) hours to respond to crisis situations, evaluate 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 a treatment objective; and

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

722.5 Noncovered Services

Outpatient psychiatric services and partial hospitalization are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific outpatient psychiatric services:

1. Meals and transportation;

2. Activity therapies, group activities, or other services and programs primarily recreational or diversional in nature;

3. Geriatric or other day care programs providing social and recreational activities to recipients who need some supervision during the day;

4. Psychosocial programs, which are usually community support groups for the purpose of social interaction in non-medical settings. Hospital programs may include psychosocial components which are not primarily for social or recreational purposes; however, if a recipient's outpatient hospital program consists entirely of psychosocial activities, the services are not covered.

5. Formal educational or vocational services related to traditional academic subjects or job training;

6. Hypnotherapy or biofeedback;

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

8. Services not covered under Medicare outpatient hospital psychiatric services regulations.

722.6 Treatment Plan

An individualized treatment plan must be developed by a team of professionals in consultation with recipients, parents, legal guardian(s) and/or others who participate in a recipient's care within fourteen (14) days of the initiation of service.

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

(B) The following information must be contained in the treatment plan or documents supporting the treatment plan:

1. Statement of the nature of the specific problem and 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 a projected timetable for their attainment;

5. Statement, duration, frequency, and rationale of services included in the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

6. Specific staff responsibilities, 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 discharge or discontinuation of services and the projected date of discharge or discontinuation of service.

722.7 Prior Approval and Utilization Review

All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

722.71 Prior Approval Certain procedures performed by outpatient psychiatric service providers 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.

722.72 Eligibility Determination Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

722.73 Reconsideration Providers who disagree with prior approval request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

722.8 Reimbursement

Hospital outpatient psychiatric service providers must submit claims for reimbursement on the UB-92 claim form or its successors. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

722.81 Methodology for Determination of Payment and Settlements For outpatient hospital services furnished by approved Title XIX (Medicaid) hospitals for Medicaid reimbursement purposes, the amount paid by Medicaid through its claims processing contractor for services furnished to recipients and covered under Medicaid, the manner of payment and the manner of settlement of overpayments and underpayment is determined under methods and procedures furnished for determining allowable payment for outpatient hospital services under Title XVIII (Medicare) of the Social Security Act.

722.82 Payments Using Medicare Allowable Cost Method For those services reimbursed under the Medicare allowable cost method, Medicaid reduces the Medicare allowable costs by three (3%) percent. The interim rate of payment is seventy-seven (77%) percent of billed charges. These provisions are applicable to all hospitals approved for participation as Title XIX hospitals in the Medicaid program.

In no case may reimbursement for outpatient hospital services exceed reasonable costs as defined by Medicare, either for hospital or physician claims. Laboratory services may not exceed the maximum levels established by Medicare.

722.83 Professional Components Psychiatry and Ph.D. psychology services are not reimbursed to hospitals but may be paid as professional components. See

Section MAD-717, PSYCHIATRY AND PSYCHOLOGY SERVICES.

722.84 Clinic Facility Fees Hospitals may not bill a clinic facility fee when services are furnished by psychiatrists or Ph.D. psychologists, unless written notification is given to MAD and the professional component reimbursement is reduced in accordance with the provisions for hospital based physician services. See Section MAD-711, MEDICAL SERVICE PROVIDERS.

Hospitals may not bill a clinic facility fee for services furnished by master's level counselors, master's level psychology associates, master's level independent social workers or case managers when services furnished by these practitioners are billed as professional services under separate provider numbers.

Costs associated with these services must be isolated in the hospital's cost report before cost settlement.