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745.2 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help recipients under twenty-one (21) years of age who are in need of behavior management intervention receive services, the New Mexico Medical Assistance Division (MAD) pays for eligible providers to furnish these services as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program [42 CFR § 441.57]. These services can be accessed only through the Tot to Teen HealthCheck screen or other diagnostic evaluations furnished through a HealthCheck referral.

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

745.21 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Agreements by MAD, agencies that meet the following requirements are eligible to be reimbursed for providing behavior management services:

1. Certification as providers of Behavior Management Skills Development Services by the Children, Youth and Families Department (CYFD); and

2. Employ or contract with behavior management specialists who work under the supervision of a licensed practitioner in the area of behavior management services, as described in the certification criteria.

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

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.

745.22 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.

745.23 Eligible Recipients

Behavior management services can be furnished only to Medicaid recipients under twenty-one (21) years of age who need behavior management intervention to avoid inpatient hospitalization, residential treatment, separation from their families or who require continued intensive treatment following hospitalization or out-of-home placement as a transition to avoid return to a more restrictive environment. To receive services, recipients must meet the level of care for this service established by MAD or its designee.

745.24 Covered Services

Medicaid covers services specified in individualized treatment plans which are designed to improve the recipient's performance in targeted behaviors, reduce emotional and behavioral excess, increase social skills and enhance behavioral skills through a regimen of positive intervention and reinforcement.

(A) The following tasks must be performed by behavior management specialists and included in the payment rate:

1. Implementation of the behavior management plan;

2. Instruction and assistance in achieving and/or maintaining appropriate behavior management skills through skilled intervention;

3. Working with foster, adoptive or natural families to help recipients achieve and/or maintain appropriate behavior

management skills; and

4. Maintaining case notes and documentation of activities as required by the agency and the standards under which it operates.

(B) An agency certified for behavioral management skills development services must perform the following:

1. Assessment of the recipient's progress in behavioral management services; and

2. Twenty-four (24) hour availability of appropriate staff to respond to crisis situations.

745.25 Noncovered Services

Behavior management services 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 services:

1. Formal educational or vocational services related to traditional academic subjects or vocational training; and

2. Activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the behavioral management treatment plan.

745.26 Treatment Plan

The treatment plan must be developed by a team of professionals in consultation with recipients, parents, legal guardians, and physicians, if applicable, prior to service delivery or within fourteen (14) days of initiation of services.

(A) The 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 services;

5. 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;

6. Specification of responsibilities, description of 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.

745.27 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 Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

(A) Before any behavior management skills development services are furnished to Medicaid recipients, prior approval must be obtained from MAD or its designee. Required documentation must be included with requests for approval. Request for services are prior approved for an initial thirty (30) day period. Services continue only after approval of the treatment plan by MAD or its designee. A request for continued stay is approved for up to three (3) months.

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.

745.28 Reimbursement

Behavior management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section MAD-702, 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.

(A) The provider's billed charge must be its usual and customary charge for services.

(B) "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.