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TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 4 CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL

8.326.4.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.326.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.326.4.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.326.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.4.3 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; 8.326.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.326.4.4 DURATION: Permanent
[2/1/95; 8.326.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.4.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.326.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.4.6 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; 8.326.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.4.7 DEFINITIONS: [RESERVED]

8.326.4.8 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; 8.326.4.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.4.9 CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients for case management services furnished to recipients who are chronically mentally ill [42 U.S.C. Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service restrictions and general reimbursement methodology.
[2/1/95; 8.326.4.9 NMAC - Rn, 8 NMAC 4.MAD.773, 3/1/12]

8.326.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are reimbursed for furnishing case management services to recipients who are chronically mentally ill:

(1) community mental health centers funded by the mental health division of the department of health;

(2) Indian tribal governments; and

(3) other community-based agencies which have demonstrated direct experience in case management services and success in serving the target population, as certified by the department of health.

B. **Agency qualifications:** Agencies must be certified by the mental health division of the department of health. Agencies must meet the following criteria.

(1) agencies must have demonstrated direct experience in successfully serving the target population; and

(2) agencies must demonstrate knowledge of available community services and methods for accessing them.

C. **Case manager qualification:** Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services for recipients who are chronically mentally ill. Case managers must meet at least one of the following requirements:

(1) bachelor's degree in social work, counseling, psychology or a related field, from an accredited institution and one year of experience in the mental health field; or

(2) licensed as a registered nurse with one year of experience in the mental health field;

(3) in the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three (3) years of experience working with individuals with chronic mental illness;

(b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with chronic mental illness.

D. 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; 8.326.4.10 NMAC - Rn, 8 NMAC 4.MAD.773.1, 3/1/12]

8.326.4.11 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*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result, and relationship of the service furnished to goals identified in the plan of care.

[2/1/95; 8.326.4.11 NMAC - Rn, 8 NMAC 4.MAD.773.2, 3/1/12]

8.326.4.12 ELIGIBLE RECIPIENTS: Medicaid covers case management services furnished to medicaid recipients who are chronically mentally ill and who are not residents of an institution for mental disease. Chronic mental illness is defined by diagnosis, disability and duration. The major diagnoses include schizophrenia, affective disorders, bipolar disorders, and serious personality disorders, such as borderline personality. The illness must be of a duration of more than one year and cause serious impairment of functions relative to daily living.

[2/1/95; 8.326.4.12 NMAC - Rn, 8 NMAC 4.MAD.773.3, 3/1/12]

8.326.4.13 COVERED SERVICES: Medicaid covers the following case management service activities for recipients who are chronically mentally ill:

A. assessment of the recipient's medical and social needs and functional limitations using standardized needs assessment instruments;

B. development and implementation of individualized plan of care;

C. mobilizing the use of "natural helping" networks, such as family members, church members and friends;

D. development of increased opportunities for community access and involvement including assistance in the location of housing, community living skills, teaching, vocational, civil and recreational service programs;

E. coordination and monitoring of the delivery of services; and

F. evaluation of the effectiveness of services furnished under the plan of care and revision of the plan as conditions warrant.

[2/1/95; 8.326.4.13 NMAC - Rn, 8 NMAC 4.MAD.773.4, 3/1/12]

8.326.4.14 NONCOVERED SERVICES: Case management 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 specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not eligible for these services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

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

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished under other categories, such as therapies, transportation or counseling; or

H. services considered by MAD or its designee to be excessive based on the needs of recipient and documentation in the case management file.

[2/1/95; 8.326.4.14 NMAC - Rn, 8 NMAC 4.MAD.773.5, 3/1/12]

8.326.4.15 PLAN OF CARE:

A. Case managers develop and implement plans of care in conjunction with the recipients, families or legal guardian(s), therapists, physicians, or others who assist with the recipient's care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care 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 an assessment and evaluation of 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) description of the intermediate and long-range goals with the projected timetable for their attainment, including information about the duration and scope of services;

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

(5) the plan of care must be retained by agency providers and available for utilization review purposes; plans of care must be updated and revised, as indicated, at least every six (6) months or more often, as indicated by the recipient's condition.

[2/1/95; 8.326.4.15 NMAC - Rn, 8 NMAC 4.MAD.773.6, 3/1/12]

8.326.4.16 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. **Prior approval:** Certain procedures or services which are part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** 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. **Reconsideration:** 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; 8.326.4.16 NMAC - Rn, 8 NMAC 4.MAD.773.7, 3/1/12]

8.326.4.17 REIMBURSEMENT:

CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services 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 their 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 procedure or service.

D. For case management services rendered by an institution, the costs associated with case management services must be removed from their cost reports prior to cost settlement or rebasing.

[2/1/95; 8.326.4.17 NMAC - Rn, 8 NMAC 4.MAD.773.8, 3/1/12]

HISTORY OF 8.326.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 310.28, Case Management Services for the Chronically Mentally Ill, filed 7/13/90.

History of Repealed Material:

MAD Rule 310.28, Case Management Services for the Chronically Mentally Ill, filed 7/13/90 - Repealed effective 2/1/95.