TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 3 CASE MANAGEMENT SERVICES FOR PREGNANT WOMEN AND THEIR INFANTS

8.326.3.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/1995; 8.326.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012]

8.326.3.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.3.3 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).
[2/1/1995; 8.326.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012]

8.326.3.4 DURATION: Permanent.
[2/1/1995; 8.326.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.3.5 EFFECTIVE DATE: February 1, 1995.
[2/1/1995; 8.326.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.3.6 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, non-covered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.3.7 DEFINITIONS: [**RESERVED**]

8.326.3.8 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.]~~ To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[2/1/1995; 8.326.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012; A, xx/xx/xxxx]

8.326.3.9 CASE MANAGEMENT SERVICES FOR PREGNANT WOMEN AND THEIR INFANTS: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible pregnant women ~~[up to sixty (60) days following the end of the month of the delivery [42 U.S.C. Section 1396n(g)(1)(2)]~~ on the day the pregnancy ends through the last day in which the 12-month postpartum period ends. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[2/1/1995; 5/15/1996; 8.326.3.9 NMAC - Rn, 8 NMAC 4.MAD.772, 3/1/2012]

8.326.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following certified agencies are eligible to be reimbursed for furnishing case management services to eligible pregnant women and their infants:

(1) public health offices of the New Mexico department of health;

(2) Indian tribal governments or Indian health services;

(3) federally qualified health centers (FQHC); and

(4) other community-based agencies which meet the requirements for participation.

B. Agency qualifications: Community-based agencies must be certified by the department of health and meet the following criteria:

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

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

C. Case manager qualifications: Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services. It can be important that case managers have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area. At a minimum, case managers must have one of the following qualifications:

(1) case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker; the nurse or social worker must have two [~~(2)~~] years of experience in community health and at least one [~~(1)~~] year of experience in maternal health or child health;

(2) or be a licensed registered nurse or have a bachelors degree in social work with a minimum of two [~~(2)~~] years of experience in community health and at least two [~~(2)~~] years experience in maternal health or child health nursing;

(3) in the event that there are no candidates with the above qualifications, an individual with an associates degree and four [~~(4)~~] years of experience in social, community health [~~and/or~~] or maternal health and child health may be employed as a case manager;

(4) if no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five years of experience in social services, community health or maternal health and child health may be considered; agencies that are considering hiring individuals [~~in option 3 or 4~~] listed in Paragraph (3) and (4) of 8.326.3.10 NMAC must complete a waiver process.

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.

[2/1/1995; 5/15/1996; 8.326.3.10 NMAC - Rn, 8 NMAC 4.MAD.772.1, 3/1/2012]

8.326.3.11 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 individual service plan.

[2/1/1995; 5/15/1996; 8.326.3.11 NMAC - Rn, 8 NMAC 4.MAD.772.2, 3/1/2012]

8.326.3.12 ELIGIBLE RECIPIENTS: Case management services are available to medicaid eligible pregnant women and their infants [~~up to sixty (60) days following the end of the month of the delivery~~] up to 12-months following the delivery in accordance with 8.291.400.14 NMAC.

[2/1/1995; 5/15/1996; 8.326.3.12 NMAC - Rn, 8 NMAC 4.MAD.772.3, 3/1/2012]

8.326.3.13 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers case management services for pregnant women and their infants which help recipients gain access to medical, social, educational or other needed services. Case management services provide necessary coordination with providers of non-medical services, such as nutrition or education programs, when these services are necessary to enable recipients to benefit from the health services paid for by medicaid.

A. Medicaid covers the following case management service activities furnished to pregnant women [~~up to sixty (60) days following the end of the month of the delivery~~]:

(1) identification of programs appropriate for the recipient's needs, including those which teach basic maternal and child health skills;

(2) help in accessing the identified programs;

(3) assessment of the service needs of recipients to coordinate the delivery of services when multiple providers or programs are involved in the provision of care;

(4) reassessment to ensure that the services which were obtained are necessary and appropriate in meeting the recipient's needs; and

(5) determination of whether any additional services are warranted.

B. Medicaid covers five [~~(5)~~] hours of case management services per client per pregnancy. The five [~~(5)~~] hours include services to both the pregnant recipient and the infant. Additional units of service require prior approval by MAD or its designee.
[2/1/1995; 5/15/1996; 8.326.3.13 NMAC - Rn, 8 NMAC 4.MAD.772.4, 3/1/2012]

8.326.3.14 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, who are not pregnant, or who are not residents of New Mexico;

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

C. formal educational or vocational services which are 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 by other practitioners, such as therapies, transportation and homemaker or personal care services; and

H. services considered by MAD or its designee to be excessive based on the needs of the recipient and on the documentation by the case manager.
[2/1/1995; 5/15/1996; 8.326.3.14 NMAC - Rn, 8 NMAC 4.MAD.772.5, 3/1/2012]

8.326.3.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation with the recipients, families or legal guardian(s), physicians and others involved with 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 needs of the woman or infant;

(2) description of the intermediate and long-range goals with the projected timetable for their attainment, including specific information on the duration and scope of services; and

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

C. The plan of care must be retained by agency providers and be 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.
[2/1/1995; 5/15/1996; 8.326.3.15 NMAC - Rn, 8 NMAC 4.MAD.772.6, 3/1/2012]

8.326.3.16 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 treatment plan can require prior approval from MAD or its designee. See utilization instruction for those services. 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*.
[2/1/1995; 5/15/1996; 8.326.3.16 NMAC - Rn, 8 NMAC 4.MAD.772.7, 3/1/2012]

8.326.3.17 REIMBURSEMENT:

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 furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing

[2/1/1995; 5/15/1996; 8.326.3.17 NMAC - Rn, 8 NMAC 4.MAD.772.8, 3/1/2012]

HISTORY OF 8.326.3 NMAC: [**RESERVED**]