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8.315.3 PSYCHOSOCIAL REHABILITATION SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 3 PSYCHOSOCIAL REHABILITATION SERVICES

8.315.3.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.315.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.315.3.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.315.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.315.3.3 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).
[2/1/95; 8.315.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.315.3.4 DURATION: Permanent
[2/1/95; 8.315.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.315.3.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.315.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.315.3.6 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, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.315.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.315.3.7 DEFINITIONS: [RESERVED]

8.315.3.8 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.
[2/1/95; 8.315.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.315.3.9 PSYCHOSOCIAL REHABILITATION SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico adult recipients receive a range of psychosocial services, the New Mexico medical assistance division (MAD) pays for psychosocial rehabilitation services. This part describes eligible providers, eligible recipients, covered services, service limitations, and general reimbursement methodology.
[1/15/97; 8.315.3.9 NMAC - Rn, 8 NMAC 4.MAD.737, 3/1/12]

8.315.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following agencies which are certified by the department of health (DOH) as a psychosocial rehabilitation agency are eligible to be reimbursed for furnishing psychosocial rehabilitation services:

- (1) community psychosocial centers designated by the New Mexico department of health;
- (2) Indian health service agencies;
- (3) federally qualified health centers; and
- (4) other agencies which meet department of health certification criteria.

B. **Agency requirements:** Agencies which furnish psychosocial rehabilitation services must have direct experience in successfully serving individuals with severe and/or persistent functional impairment as a result of a mental disorder.

C. **Agency staff requirements:** Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of psychosocial rehabilitation services.
[1/15/97; 8.315.3.10 NMAC - Rn, 8 NMAC 4.MAD.737.1, 3/1/12]

8.315.3.11 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 provided to recipients. See 8.302.1 NMAC, *General Provider Policies*. [1/15/97; 8.315.3.11 NMAC - Rn, 8 NMAC 4.MAD.737.2, 3/1/12]

8.315.3.12 ELIGIBLE RECIPIENTS: Eligible recipients are those who are receiving medicaid and for whom medical necessity for the services has been determined according to the guidelines for evidencing medical necessity established by the department of health. The recipients receiving these services cannot be residents of an institution for mental illness. [1/15/97; 8.315.3.12 NMAC - Rn, 8 NMAC 4.MAD.737.3, 3/1/12]

8.315.3.13 COVERAGE CRITERIA: Medicaid covers only those psychosocial rehabilitation services which comply with DOH mental health standards as detailed in the psychiatric rehabilitation user's manual and are medically necessary to meet the individual needs of the recipient, as delineated in the treatment plan. Medical necessity is based upon the recipient's level of functioning as affected by the mental disability. The services are limited to goal oriented psychosocial rehabilitative services which are individually designed to accommodate the level of the recipient's functioning and which reduce the disability and restore the recipient to his/her best possible level of functioning. [1/15/97; 8.315.3.13 NMAC - Rn, 8 NMAC 4.MAD.737.4, 3/1/12]

8.315.3.14 COVERED SERVICES: Medicaid covers psychosocial rehabilitation services which are medically necessary in the assessment and planning of care, and those specific services which reduce symptomatology and restore basic skills necessary to function independently in the community. Medicaid covers the following psychosocial rehabilitation services as defined and described in the department of health's psychiatric rehabilitation user's manual:

- A. psychosocial interventions designed to address the functional limitations, deficits, and behavioral excesses, through capitalizing on personal strengths and developing coping strategies and supportive environments;
- B. community based crisis care which must include the availability of appropriate staff to respond to a crisis situation on a twenty-four (24) hour a day basis, respond to crisis situations; determine the severity of the crisis situation, stabilize the recipient, make referrals to appropriate agency(ies), and provider follow-up;
- C. psychosocial clinical consultations by psychosocial professionals to assess the individual's status and develop plans of care;
- D. therapeutic interventions designed to meet clinically determined needs through scheduled, structured sessions; and
- E. medication services that are goal-directed interventions such as the evaluation of the need for psychotropic medications and subsequent assessment and management of pharmacologic treatment.

[1/15/97; 8.315.3.14 NMAC - Rn, 8 NMAC 4.MAD.737.5, 3/1/12]

8.315.3.15 NONCOVERED SERVICES: Psychosocial rehabilitation services are subject to the limitations and coverage restrictions which exist for other medicaid services. An overview of non-covered services is contained in 8.301.3 NMAC, *General Noncovered Services*.

[1/15/97; 8.315.3.15 NMAC - Rn, 8 NMAC 4.MAD.737.6, 3/1/12]

8.315.3.16 TREATMENT PLAN: 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 by HSD, DOH or their agents in the recipient's file:

- A. statement of the nature of the specific problem and specific needs of the recipient;
- B. description of the functional level and symptom status of the recipient, including the following:
 - (1) mental status assessment;
 - (2) intellectual function assessment;
 - (3) psychological assessment;
 - (4) social assessment which includes community support, housing and legal status;
 - (5) medical assessment;

- (6) physical assessment;
- (7) substance abuse assessment; and
- (8) activities of daily living assessment;
- C. description of intermediate and long-range goals and approaches for the least restrictive conditions necessary to achieve the purposes of treatment with a projected timetable for their attainment;
- D. statement of the duration, frequency, and rationale for services included in the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
- E. 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
- F. criteria for discontinuation of services and the projected date for discontinuation of services; and
- G. plan is regularly and periodically reviewed to determine effectiveness of treatment and is modified as indicated.

[1/15/97; 8.315.3.16 NMAC - Rn, 8 NMAC 4.MAD.737.7, 3/1/12]

8.315.3.17 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 8.302.5 NMAC, *Prior Authorization and Utilization Review*. For psychosocial rehabilitation services, reviews are retrospective.

A. **Retrospective review:** Psychosocial rehabilitation services are furnished pursuant to an assessment, diagnostic summary formulation and a treatment plan. Providers determine medical necessity of services based upon the service guidelines included in the DOH manual for evidencing medical necessity. All plans are subject to retrospective review to determine whether services provided met the service guidelines.

B. **Reviews for crisis intervention:** When crisis intervention services are required, the claim is subject to retrospective review by DOH in accordance with criteria listed in the users manual billing guidelines. Reviews must be submitted to the DOH.

C. **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.

D. **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*.

[1/15/97; 8.315.3.17 NMAC - Rn, 8 NMAC 4.MAD.737.8, 3/1/12]

8.315.3.18 REIMBURSEMENT: Psychosocial rehabilitation providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. **General reimbursement:** Reimbursement for 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:
 - (a) the provider's billed charge must be their usual and customary charge for services;
 - (b) "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.

B. **Reimbursement for specific entities:** Reimbursement for Indian health service agencies and federally qualified health centers follow the guidelines and special provisions for those entities. See respective sections.

[1/15/97; 8.315.3.18 NMAC - Rn, 8 NMAC 4.MAD.737.9, 3/1/12]

HISTORY OF 8.315.3 NMAC: [RESERVED]