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771 CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

The New Mexico Medical Assistance Program (Medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who have developmental disabilities [42 U.S.C. § 1396n(g)(1)(2)].

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

771.1 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by the New Mexico Medical Assistance Division (MAD), the following agencies are eligible to be reimbursed for providing case management services:

1. State agencies in New Mexico providing case management services to individuals with developmental disabilities;

2. Indian tribal governments and Indian health service clinics; and

3. Community-based agencies in New Mexico that do not furnish adult day habilitation, work related services, and/or adult residential services to individuals with developmental disabilities.

771.11 Agency Qualification Agencies must be certified by the Developmental Disabilities Division of the New Mexico Department of Health and meet the MAD approved standards for agencies providing case management for adults who are developmentally disabled.

(A) Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

(B) Agencies must demonstrate direct experience in case management services and success in serving the target population.

(C) Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct, and other general rules.

771.12 Case Manager Qualifications Case managers employed by case management agencies must possess the education, skills, abilities, and experience to perform case management service for adults with developmental disabilities.

At a minimum, case managers must meet one of the following qualifications:

1. Bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services related field and one (1) year of experience working with individuals with developmental disabilities;

2. Licensed as a registered or licensed practical nurse with one year of experience working with individuals with developmental disabilities; or

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 developmental disabilities; or

    B. High school graduation or General Educational Development (GED) test and a minimum of four (4) years of experience working with individuals with developmental disabilities.

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.

771.2 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 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.

771.3 Eligible Recipients

Case management services are available for eligible Medicaid recipients that meet all of the following criteria:

1. Twenty-one (21) years of age or older;

2. Resident of the state of New Mexico;

3. Meet the state definition of an individual with a developmental disability;

4. Placement on the list for developmental disability services by the Community Services Team (CST) of the Developmental Disabilities Division of the Department of Health;

5. Resides outside a Medicaid certified Intermediate Care Facility for the Mentally Retarded (ICF-MR); and

6. Not a participant in a Home and Community- Based Services Waiver program.

Information on the individual is gathered by the CST and used to complete an assessment and assign an "Urgency of Need" priority. Recipients assigned a Priority One are individuals who are in danger of becoming homeless or victims of abuse, if suitable placement services are not received. Recipients assigned a Priority Two are individuals whose condition will deteriorate without placement. Recipients assigned a Priority Three are individuals who could benefit from case management but whose present condition is acceptable.

771.4 Covered Services

Medicaid coverage for case management services varies by the Priority assigned recipients by the CST.

771.41 Case Management Services for Recipients Assigned a Priority Three Case management services for recipients assigned a Priority Three are limited. Medicaid covers assessments of recipients' needs and the coordination and performance of evaluations and assessments. A follow-up is performed during the third month with appropriate recommendations.

Medicaid covers case management services for recipients classified as Priority Three only for an initial ninety (90) day period, unless the recipient's Urgency of Need priority changes to Priority One or Priority Two.

771.42 Case Management Services for Recipients Assigned Priority One or Priority Two Medicaid covers case management services for those recipients assigned a Priority One or Priority Two for up to sixty (60) days after suitable placement or services are received. Medicaid covers the following case management service activities for these recipients:

1. Assessment of the recipient's medical and social needs and functional limitations;

2. Coordination and monitoring of evaluations and services;

3. Help in identifying available service providers and programs to enhance the recipient's community access and involvement, including:

   A. Arrangement of transportation;

   B. Location of housing;

   C. Location of providers to teach living skills;

   D. Location of vocational or educational services; and

   E. Location of civic or recreational services, as needed.

4. Facilitation and participation in the development, review, and evaluation of a plan of care and revision of that plan when warranted; and

5. Assessment of the recipient's progress and continued need for services.

771.43 Administrative Activities Medicaid eligibility determinations or intake processing are covered services for individuals with developmentally disabilities who have not applied for Medicaid but who have been referred to the CST for evaluation. These administrative services are billed as administrative activities, not as case management services.

771.5 Noncovered Services

Case 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 activities:

1. Services furnished to individuals who are not Medicaid eligible or do not meet the definition of an eligible recipient for these case management services;

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

3. Formal educational or vocational services which relate to traditional academic subjects or job training;

4. Outreach activities to contact potential recipients, except as described under covered services;

5. All administrative activities conducted after the initial ninety (90) day referral by the CST;

6. Institutional discharge planning which must be furnished by the institution prior to discharge;

7. Services which are furnished under other categories, such as therapies, transportation, or counseling;

8. Services which are considered by MAD or its designee to be excessive based on the condition of the recipient;

9. Monitoring the quality of service provider agencies;

10. Resource development; and

11. Testifying before governmental bodies, such as city council meetings or legislative committees, even if on behalf of the recipient.

771.6 Plan of Care

Case managers develop and implement plans of care (POC) based on standards developed by the Developmental Disabilities Division of the Department of Health. For purposes of compliance with Medicaid regulations, the following must be contained in the plan of care or documents used to develop the plan of care. The plan of care and supporting documents must be available for review in the recipient's file:

1. Statement of the nature of the specific problem and 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 and placement options with the projected timetable for their attainment, including information on the duration and scope of services; and

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

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.

771.7 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.

771.71 Prior Approval Certain procedures or services which are part of the recipients' plan of care 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.

771.72 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.

771.73 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.

771.8 Reimbursement

Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Instructions on documentation, billing, and claims processing are sent to approved Medicaid providers.

Reimbursement for covered 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.

(A) The provider's billed charge must be their usual and customary charge for an average month of services to individuals who are part of the target population. Monthly charges are based on a cost analysis conducted periodically by the New Mexico Department of Health.

(B) "Usual and customary charge refers to the amount which the individual providers charge the general public in the majority of cases for a specific procedure or service.

(C) 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.