State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
MENTAL HEALTH PROFESSIONAL SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY
The Human Services Department, Medical Assistance Division, is proposing changes to 8.310.8 Mental Health Professional Services rules that include *(a)* revisions to clarify regulatory language, accuracy, and provider participation; *(b)* changing the phrase "mental health" to "behavioral health" to match state language usage for mental and substance abuse services; *(c)* expanding adult substance abuse services to eligible MAD recipients; and *(d)* adding Licensed Alcohol and Drug Abuse Counselors (LADACs) to providers who can bill through various agencies for providing services to adult eligible MAD recipients.

More specifically, changes for 8.310.8 include:

- Replacing the phrase "*mental health*" with "*behavioral health*" which is defined to include both mental health and substance abuse treatment
- Extending coverage of Licensed Alcohol and Drug Abuse Counselors when working within an agency to eligible recipients 21-years of age and older
- Including Core Service Agencies as allowable agencies to bill MAD directly
- Updating provider responsibilities and enrollment information
- Making numerous grammatical and format changes
- Removing the 12-session limit on substance abuse coverage to adult MAD eligible recipients
- Removing "*supervised*" from 8.310.8.10C and deferring to the State's various licensing boards to define what type of supervision, if any, is needed for each license
- Removing Registered Independent Mental Health Counselors as eligible providers because there is no longer this type of registration provided by the licensing boards
- Removing schools from this rule because schools have their own specific rules with regard to services and providers.

VI. RULES
These proposed rule changes refer to 8.310.8 NMAC of the Medical Assistance Program Rules Manual. This register and the proposed changes are available on the Medical Assistance Division web site at

www.hsd.state.nm.us/mad . If you do not have Internet access, a copy of these rules may be requested by contacting the Medical Assistance Division at 505-827-3156.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective June 1, 2008.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 9:00 a.m., on April 14, 2008, at the Toney Anaya Building, in Hearing Room 1, 2550 Cerrillos Road., Santa Fe, New Mexico. Parking accessible to persons with physical impairments will be available.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on April 14, 2008. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these rules approved by:

PAMELA S. HYDE, J.D., SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 8 [~~MENTAL~~] BEHAVIORAL HEALTH PROFESSIONAL SERVICES

8.310.8.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) of HSD is to maximize the health status of [~~medicaid eligible individuals~~] eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.310.8.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11/1/04; A, 6-1-08]

8.310.8.9 [~~MENTAL~~] BEHAVIORAL HEALTH PROFESSIONAL SERVICES: [~~The New Mexico medicaid program (medicaid)~~] MAD pays for medically necessary behavioral health (mental health and substance abuse) services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, [~~the New Mexico medical assistance division (MAD)~~] MAD pays for covered professional [~~mental~~] behavioral health services [42 CRF Sections 440.40, 440.60(a) and 441.57]. [~~This part describes eligible providers, covered services, service limitations and general reimbursement methodology.~~]
[2/1/95; 3/1/99; 8.310.8.9 NMAC - Rn, 8 NMAC 4.MAD.717, 11/1/04; A, 6-1-08]

8.310.8.10 ELIGIBLE PROVIDERS:

[~~A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following independent providers are eligible to be reimbursed for providing mental health professional services:~~]A. Upon approval of a New Mexico medical assistance division provider participation agreement by MAD or its designee, licensed practitioners or facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, providers receive instruction on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent material and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement and all applicable statutes, regulations and executive orders. [~~The following independent providers are eligible to be reimbursed for providing behavioral health professional services:~~]

B. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

C. The following independent providers are eligible to be reimbursed for providing behavioral health professional services:

(1) individuals licensed as physicians by the board of medical examiners or board of osteopathy and who are board-eligible or board-certified in psychiatry, or the groups they form;

(2) psychologists (Ph.D., Psy.D. or Ed.D.) licensed as clinical psychologists by the New Mexico board of psychologist examiners, or the groups they form;

(3) licensed independent social workers (LISW) licensed by the New Mexico board of social work examiners, or the groups they form;

(4) licensed professional clinical mental health counselors (LPCC) licensed by the New Mexico counseling and therapy practice board, or the groups they form;

(5) licensed marriage and family therapists (LMFT) who are licensed by the New Mexico counseling and therapy practice board, or the groups they form; [~~and~~]

(6) individuals licensed as clinical nurse specialists or certified nurse practitioners by the board of nursing who are certified in psychiatric nursing by a national nursing organization, or the groups they form, who can furnish services to adults or children as their certification permits; and

[~~B.~~] D. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following agencies are eligible to be reimbursed for providing [~~mental~~] behavioral health professional services:

(1) community mental health centers and core service agencies licensed by the [~~department of health and/or the children, youth and families department~~] appropriate state or federal agency/department;

(2) federally qualified health centers (FQHCs);

(3) Indian health service (IHS) hospitals and clinics;

(4) PL 93-638 tribally operated hospitals and clinics;

(5) children, youth and families department; and

[~~(6) schools providing services identified in individualized education plans or individualized family services plans.~~]

(6) outpatient hospital facilities

[~~C.~~] E. Upon approval of New Mexico medical assistance program provider participation agreement by MAD or its designee, agencies listed above in Subsection B of 8.310.8.10 NMAC may be reimbursed for [~~supervised~~] outpatient [~~therapy~~] services only to eligible recipients under twenty-one (21) years of age, [~~as defined below in Subsection B of 8.310.8.10 NMAC may be reimbursed for supervised outpatient therapy services,~~] as defined below in Subsection B of 8.310.8.13 NMAC, provided by:

(1) licensed masters level social workers (LMSW);

(2) licensed professional mental health counselors (LPC);

(3) licensed mental health counselors (LMHC);

(4) licensed psychologist associates;

(5) licensed professional art therapists (LPAT); and

(6) registered mental health counselors [~~(RMHC; and;~~] (RMHC).

[~~(7) registered independent mental health counselors (RIMHC)~~] licensed alcohol and drug abuse counselors (LADAC).

[~~D.~~] F. Services must be provided within the scope of the practice and licensure for each provider and must be in compliance with the statutes, rules and regulations of the applicable Practice Act.

[~~E. 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; 3/1/99; 8.310.8.10 NMAC - Rn, 8 NMAC 4.MAD.717.1 & A, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.11 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. See 8.302.1 NMAC for recipients whose medicaid coverage is restricted and 8.302.12 NMAC for dual eligible medicaid recipients. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients.~~]

A. A provider who furnishes services to medicaid or other health care program eligible recipients agrees to comply with all federal and state laws, regulations. and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also agrees to conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that individuals are eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 3/1/99; 8.310.8.11 NMAC - Rn, 8 NMAC 4.MAD.717.2, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.12 COVERAGE CRITERIA:

A. [~~Medicaid~~] MAD covers medically necessary [~~mental~~] behavioral health professional services including evaluations, therapy, tests and reports required by the condition of the recipient. All services must be furnished within the limits of [~~medicaid~~] MAD benefits, within the scope and practice of the eligible provider's respective profession as defined by state law, and in accordance with applicable federal, state, and local laws and regulations.

B. **Medical necessity:** All services must be provided in compliance with the current [~~medicaid~~] MAD definition of medical necessity.

[2/1/95; 3/1/99; 8.310.8.12 NMAC - Rn, 8 NMAC 4.MAD.717.3, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.13 COVERED SERVICES:

A. **Inpatient treatment and evaluations:** Except as noted below in 8.310.8.14 NMAC, [~~medicaid~~] MAD covers [~~mental~~] behavioral health professional services during an inpatient psychiatric admission including admission evaluations, testing, therapy and treatment for the acute phase of an illness when these services are furnished by licensed board-eligible or board-certified psychiatrists, licensed clinical psychologists (Ph.D., Psy.D., or Ed.D.), or individuals licensed as clinical nurse specialists or certified nurse practitioners by the board of nursing who are certified in psychiatric mental health nursing by a national nursing organization; and are consistent with the comprehensive [~~treatment~~] service plan in effect at the inpatient facility. Acute care psychiatric hospitals and specialty units of general acute care hospitals are considered inpatient facilities for purposes of [~~medicaid~~] MAD coverage.

B. **Outpatient therapy services:** [~~Medicaid~~] MAD covers outpatient assessments, evaluations, testing and therapy. Services may require prior authorization from MAD or its designee and will be reviewed based on criteria approved by HSD. Any currently allowable treatment modality (individual, group, [~~family~~] family, multi-family) in any combination is covered. Frequency of services is to be determined by medical necessity. Services furnished by eligible providers must be specified in the [~~client's~~] eligible recipient's [~~treatment~~] service plan. [~~The plan must be completed by the third (3rd) therapy session.~~] In the treatment of [~~minor age clients~~] under-aged eligible recipients , the [~~treatment~~] service plan must document involvement of [~~clients family~~] eligible recipient's family, and if applicable, others involved in the [~~child's~~] eligible child recipient's care. Adult [~~clients~~] eligible recipients, or [~~guardians~~] their personal representatives, whenever appropriate, should participate in the development of their [~~treatment~~] service plans. The service plan and all supporting documentation must be available for review in the [~~client~~] eligible recipient's record. Services must be consistent with the [~~treatment~~] service plan in effect at the time the services are provided.

C. **Therapy in partial hospital settings, [~~JCAHO- or COA-accredited RTCs~~] Joint Council on Accreditation of Healthcare Organizations (JCAHO), or Council on Accreditation (COA)-accredited residential treatment and group home services (RTC), non-accredited residential treatment and group home services and treatment foster care:** Routine [~~mental~~] behavioral health care is covered for eligible recipients under the age of twenty-one (21) in partial hospitalization programs, JCAHO- or COA-accredited RTCs, non-accredited residential treatment and group home services, and treatment foster care. Additional services not covered by the fixed rates may be provided only after obtaining prior authorization from the utilization review agent. The additional services must be consistent with the [~~treatment~~] service plan. Services not covered by fixed rates that would be eligible for prior authorization may include:

(1) Medication management of psychotropic medications for eligible recipients in accredited residential treatment services and treatment foster care placement.

(2) Psychological testing; which is not duplicative and is clinically necessary to meet the "extraordinary and specific," complex diagnostic needs of the [~~client~~] eligible recipient, (see Paragraph (3) of Subsection C of 8.310.8.13 NMAC below). Such psychological testing will not replace the routine psychological testing provided within the scope of the program.

(3) Individual, group and family therapy; which is additional to the core program therapies and is performed by clinicians whose specialized training is necessary to treat documented "extraordinary and specific" [~~client~~] eligible recipient needs. Additional group therapy will be reimbursed only for eligible recipients placed in treatment foster care. Conditions and circumstances which meet the definition of "extraordinary and specific need":

(a) complex diagnoses or symptom presentations such as, but not limited to, continuing psychotic features, persistent aggression which does not remit with standard behavioral interventions, or secondary encopresis.

(b) diagnostic questions which are persistent, recurring, or complicated.

(c) clinical situations or conditions which threaten further decompensation without intensive treatment.

D. **Injections:** [~~Medicaid~~] MAD covers injections subject to the injection and pharmacy [~~policies~~] rules, See 8.310.2 NMAC, *Medical Service Providers* and 8.324.4 NMAC, *Pharmacy Services*.

E. **Medication review visits:** [~~Medicaid~~] MAD covers brief office visits performed by an M.D., D.O, qualified psychologist, qualified nurse as defined above in Paragraph (7) of Subsection A of 8.310.8.10 NMAC for the sole purpose of monitoring or changing prescriptions in the treatment of covered disorders.

F. **Treatment for substance abuse:** [~~Medicaid covers up to twelve (12) hours of psychiatric therapy services for the treatment of alcohol abuse for recipients over twenty (20) years of age.~~] MAD covers medically necessary outpatient services for the treatment of alcohol and substance abuse for eligible recipients.

G. **Services provided to recipients under twenty-one (21) years of age:** Additional services are covered for eligible recipients under twenty-one (21) years of age. See 8.320.2 NMAC, *EPSDT Services* [MAD-740].

H. **Disorders covered for eligible recipients under twenty-one (21) years of age:** [~~Medicaid~~] MAD covers services for [~~the following disorders~~] personality disorders for eligible recipients under twenty-one (21) years of age only [~~:~~].

[~~(1) personality disorders;~~]

[~~(2) substance abuse or dependence~~].

2/1/95; 3/1/99; 8.310.8.13 NMAC - Rn, 8 NMAC 4.MAD.717.4 & A, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.14 NONCOVERED SERVICES: [~~Mental~~] Behavioral health professional services are subject to the limitations and coverage restrictions which exist for other [~~medicaid~~] MAD services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. [~~Medicaid~~] MAD does not cover the following [~~mental~~] behavioral health specific services:

A. hypnotherapy;

B. biofeedback;

C. conditions which do not meet the standard of medical necessity as defined in [~~medicaid~~] MAD [~~regulations~~] rules;

D. [~~conditions defined only by V-codes in the current version of the international classification of diseases that are diagnosed as non-treatable conditions (however diagnoses which arise from conditions defined by V-codes and which meet the [medicaid] MAD definition of medical necessity are covered);~~] conditions defined only by V-codes in the current version of the international classification of diseases that are not treatable conditions and do not meet the MAD definition of medical necessity are not covered.

E. treatment for personality disorders;

F. treatment provided for adults 21 and older in alcohol or drug [~~rehabilitation units~~] residential centers;

G. milieu therapy;

H. educational or vocational services related to traditional academic subjects or vocational training;

I. experimental or investigational procedures, technologies or non-drug therapies and related services;

J. activity therapy, group activities and other services which are primarily recreational or [~~divisional~~] divisional in nature;

K. electroconvulsive therapy;

L. services provided by non-licensed counselors, therapists and/or social workers, except where exempted by law; and

M. treatment of mental retardation alone.

[2/1/95; 3/1/99; 8.310.8.14 NMAC - Rn, 8 NMAC 4.MAD.717.5, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All [~~medicaid~~] MAD services may be 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*. [~~Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.~~] The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. [~~Any service may be reviewed prospectively, concurrently or retrospectively.~~] Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. See Subsection A of 8.311.2.16 NMAC, *Covered Emergency Services* [MAD-721.71].

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid or other health care programs. Providers must verify that individuals are eligible [~~for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance~~] for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[2/1/95; 3/1/99; 8.310.8.15 NMAC - Rn, 8 NMAC 4.MAD.717.6, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.16 REIMBURSEMENT:

A. [~~Mental~~] Behavioral health professional service 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. Reimbursement to providers for covered 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 [~~mental~~] behavioral health professional service providers who are members of a practice plan affiliated with a state operated teaching hospital, reimbursement will equal the lesser of the provider's billed charge or the average rate paid for the service by commercial insurers as established by MAD. Providers eligible to be paid under this part will be paid on an interim claims-specific basis through the MAD claims processing system. The final payment for services provided will be made through a supplemental payment made in a specified time period that reflects any difference between the interim payment amounts and the average rate paid by commercial insurers for the services.

E. [~~Mental~~] Behavioral health providers requiring supervision (see Subsection C of 8.310.8.10 NMAC) cannot bill [~~medicaid~~] MAD directly. Services furnished by these licensed [~~master's level~~] providers are billed by the eligible agencies identified in Subsection B of 8.310.8.10 NMAC, above, whether they are employed or whether they furnish services under contract.

F. [~~Mental~~] Behavioral health professional services must be provided directly to the eligible recipient by the licensed [~~mental~~] behavioral health professionals listed in Subsection A of 8.310.8.10 NMAC, above. Services performed by supervised master's level providers, nurses, bachelor's level and other health professionals cannot be billed by the licensed supervisors even though the services may have been furnished under their direction.

G. Separate professional component billing is allowed for [~~mental~~] behavioral health services performed within a hospital setting by psychiatrists and licensed psychologists (Ph.D., Psy.D., or Ed. D.).

H. For facility-based providers, costs billed separately as a professional component must be excluded from the facility cost report prior to cost settlement or rebasing.

[2/1/95; 3/1/99; 8.310.8.16 NMAC - Rn, 8 NMAC 4.MAD.717.7, 11/1/04; A, 11/1/05; A, 6-1-08]

8.310.8.17 REIMBURSEMENT FOR HOSPITAL-BASED SERVICES: Reimbursement for office visits, diagnostic procedures, or surgical services furnished in hospital settings that are ordinarily furnished in a provider's office is paid at sixty percent (60%) of the fee schedule-allowed amount for each professional service. [~~Medicaid~~] MAD follows medicare principles in determining which procedures are subject to this payment reduction.

[8.310.8.17 NMAC - N, 11/1/05; A, 6-1-08]