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TITLE 8 SOCIAL SERVICES
CHAPTER 321 ENHANCED EPSDT – RESIDENTIAL SERVICES
PART 2 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS

8.321.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.321.2.1 NMAC - Rp, 8 NMAC 4.MAD.000.1, 11-1-10]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC – Rp, 8 NMAC.4.MAD.000.2, 11-1-10]

8.321.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act, as amended and by state human services department pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978.
[8.321.2.3 NMAC - Rp, 8 NMAC 4.MAD.000.3 & A, 11/1/10]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC – Rp, 8 NMAC 4.MAD.000.4, 11-1-10]

8.321.2.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - Rp, 8 NMAC 4.MAD.000.5 & A, 11/1/10]

8.321.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance program.
[8.321.2.6 NMAC - Rp, 8 NMAC 4.MAD.000.6 & A, 11/1/10]

8.321.2.7 DEFINITIONS: [RESERVED]

8.321.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.321.2.8 NMAC - Rp, 8 NMAC 4.MAD.002 & A, 11/1/10; A, 2/1/12]

8.321.2.9 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: MAD pays for medically necessary health services furnished to eligible recipients. To help New Mexico medicaid recipients under 21 years of age receive necessary mental health services, medical assistance division (MAD) pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals, as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57]. If the eligible recipient is receiving services immediately before he or she reaches the age of 21 years services may continue based on the following conditions: (1) up to the date the eligible recipient no longer requires the services or (2) the date the eligible recipient reaches the age of 22 years, whichever comes first. The need for inpatient psychiatric care in freestanding psychiatric hospitals must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.
[8.321.2.9 NMAC - Rp, 8 NMAC 4.MAD.742.1 & A, 11/1/10]

8.321.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico medical assistance division (MAD) provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services 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 claims 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, a provider receives instruction on how to access these documents. It is the provider’s responsibility to access these instructions, to understand the information provided

and to comply with the requirements. The provider must contact HSD or its authorized agents obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

A. An eligible provider must be accredited by at least one of the following:

(1) the joint commission (JO) (formerly known as joint commission on accreditation of healthcare organizations); or

(2) the council on accreditation of services for families and children (COA); or

(3) the commission on accreditation of rehabilitation facilities (CARF); or

(4) other accrediting organizations recognized by HSD as having comparable standards;

B. An eligible provider must be licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH) or the comparable agency in another state.

C. An eligible provider must have a written utilization review (UR) plan in effect which provides for review of an eligible recipient's need for the center's services that meet federal requirements; see 42 CFR Sections 456.201 through 456.245.

D. An eligible provider must be an approved MAD provider before it furnishes services; see 42 CFR Sections 456.201 through 456.245.

[8.321.2.10 NMAC - Rp, 8 NMAC 4.MAD.742.11 & A, 11/1/10]

8.321.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must 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 must 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.

B. A provider must verify that an individual is 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.

C. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed upon between the provider and MCOs when the provider enters into contracts with MCOs contracting with HSD for the provision of managed care services to the MAD population.

(1) If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(2) The "applicable reimbursement rate" is defined as the rate paid by HSD to the provider participating in medicaid or other medical assistance programs administered by HSD and excludes disproportionate share hospital and medical education payments.

D. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD under an administrative services contract, 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.

[8.321.2.11 NMAC - Rp, 8 NMAC 4.MAD.742.12 & A, 11/1/10]

8.321.2.12 COVERED SERVICES: MAD covers those inpatient psychiatric hospital services furnished in freestanding psychiatric hospitals which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the eligible recipient. These services must be furnished by eligible providers within the scope and practice of their profession as defined by state law and in accordance with federal regulations. See 42 CFR Section 441 Subpart D.

A. Services must be furnished under the direction of a physician. In the case of eligible recipients under 21 years of age, these services must be furnished under the direction of a board prepared/board eligible/board certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist.

B. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of eligible recipients under 12 years of age, the psychiatrist must be board prepared/board eligible/board certified in child or adolescent psychiatry.

C. The requirement for the specified psychiatrist for eligible recipients under age 12 and eligible recipients under 21 years of age can be waived when all of the following conditions are met:

(1) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;

(2) at the time of admission, a board prepared/board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located;

(3) another facility which is able to furnish a board prepared/board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(4) the admission is for stabilization only and transfer arrangement to the care of a board prepared/board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible under the understanding that if the eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

D. The following services must be furnished by freestanding hospitals to receive reimbursement from MAD.

(1) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(2) regularly scheduled structured counseling and therapy sessions for eligible recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school, attendance and money management;

(4) assistance to an eligible recipient in self- administration of medication in compliance with state policies and procedures;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize eligible recipient by providing support, make referrals, as necessary, and provide follow-up;

(6) a consultation with other professionals or allied care givers regarding a specific eligible recipient;

(7) non-medical transportation services needed to accomplish treatment objectives; and

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients; and

E. payment for performance of these required services is included in the hospital's reimbursement rate.

[8.321.2.12 NMAC - Rp, 8 NMAC 4.742.13 & A, 11/1/10]

8.321.2.13 NONCOVERED SERVICES: Services furnished in freestanding psychiatric hospitals are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.301.3 NMAC, *Medicaid General Noncovered Services*. MAD does not cover the following specific services for an eligible recipient in freestanding psychiatric hospitals:

A. services not considered medically necessary for the condition of the eligible recipient, as determined by MAD or its designee;

B. conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM);

C. services for which prior authorization was not obtained;

D. services in freestanding psychiatric hospital for eligible recipient 21 years of age or older;

E. services furnished after the determination by MAD or its designee has been made that the eligible recipient no longer needs hospital care;

F. formal educational or vocational services related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active treatment plan for an eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b);

G. experimental or investigational procedures, technologies, or non-drug therapies and related

services or treatment;

H. drugs classified as "ineffective" by the FDA drug evaluation;

I. activity therapy, group activities, and other services primarily recreational or diversional in nature;

J. MAD covers “awaiting placement days” in freestanding psychiatric hospitals when the MAD utilization review (UR) contractor determines that an eligible recipient under 21 years of age no longer meets acute care criteria and the children’s mental health services review panel determines that the eligible recipient requires a psychosocial residential level of care which cannot be immediately located.

K. those days during which the eligible recipient is awaiting placement to the lower level of care are termed awaiting placement days; and

L. payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for psychosocial accredited residential services for eligible recipients classified as level III, IV, or IV+ plus five percent; a separate claim form must be submitted for awaiting placement days.

[8.321.2.13 NMAC - Rp, 8 NMAC 4.MAD.742.14 & A, 11/1/10]

8.321.2.14 TREATMENT PLAN: The treatment plan must be developed by a team of professionals in consultation with an eligible recipient, parent(s), legal guardian(s) or others in whose care the eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals.

A. The interdisciplinary team must review the treatment plan at least every five calendar days.

B. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment team must consist of at a minimum (see CFR 42 441.156(c-d):

(1) either a:

(a) board eligible or board certified psychiatrist; or

(b) clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(c) a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master’s degree in clinical psychology or who has been certified by the state or its licensing board; and

(2) the team must also include one of the following:

(a) a psychiatric social worker; or

(b) an occupational therapist who is licensed by the state and who has specialized training in treating an eligible recipient under the age of 21 years of age with a severe emotional disturbance (SED); or

(c) a registered nurse with specialized training or one year’s experience in treating eligible recipients under the age of 21 years; or

(d) a psychologist who has a master’s degree in clinical psychology or who has been certified by the state or by the state’s licensing board.

C. The treatment plan and all supporting documentation must be available for review in the eligible recipient's file. The treatment plan of care must at a minimum:

(1) be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the eligible recipient’s situation and reflects the need for inpatient psychiatric care; and

(2) be developed by a team of professionals specified in Subsection A of 8.321.2.14 NMAC in consultation with the eligible recipient and, his or her parents, legal guardians, or others in whose care he or she will be released after discharge; and

(3) state treatment objectives; and

(4) prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

(5) include, at the appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the eligible recipient’s family, school, and community upon discharge;

(6) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(7) description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

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

(9) specification of staff responsibilities, description of 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 eligible recipient; and

(10) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

[8.321.2.14 NMAC - Rp, 8 NMAC 4.MAD.742.15 & A, 11/1/10]

8.321.2.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity, inspection of care, 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, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. All inpatient services for an eligible recipient under 21 years of age in a freestanding psychiatric hospital, require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the eligible recipient has other health insurance.

C. A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decision.*

[8.321.2.15 NMAC - Rp, 8 NMAC 4.MAD.742.16 & A, 11/1/10]

8.321.2.16 DISCHARGE PLANNING: Plans for discharge must be included in the eligible recipient's treatment plan. Discharge must not be delayed because post-hospital planning is neglected. If the eligible recipient will receive services in the community or in the custody of the children, youth, and families department (CYFD), the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the eligible recipient's family, school and community.

[8.321.16 NMAC – Rp, 8 NMAC 4 MAD 742.17 & A, 11/1/10]

8.321.2.17 REIMBURSEMENT: Freestanding psychiatric hospital service providers must submit claims for reimbursement on the UB04 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. Reimbursement rates for New Mexico freestanding psychiatric hospitals are based on TEFRA provisions and principles of reimbursement. See 8.311.3.11 NMAC, *payment methodology for PPS-exempt hospitals and exempt units within hospitals*, and 8.311.3.14 NMAC, *determination of actual, allowable and reasonable costs,* contained in 8.311.3 NMAC, *Methods and Standards for Establishing Payment – Inpatient Hospital Services*. Covered inpatient services provided in freestanding psychiatric hospitals will be reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals.

B. If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

C. Reimbursement rates for services furnished by psychiatrists and licensed Ph.D. psychologists in freestanding psychiatric hospitals are contained in that provider section. See 8.310.8, *Behavioral Health Professional Services*. Services furnished by psychiatrists and psychologists in freestanding psychiatric hospitals cannot be included as inpatient psychiatric hospital charges.

[8.321.2.17 NMAC - Rp, 8 NMAC 4.MAD.742.18 & A, 11/1/10; A, 2/1/12]

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