

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 7 ADULT PROTECTIVE SERVICES CASE MANAGEMENT

8.326.7.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.7.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.7.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.7.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.7.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.7.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.7.4 DURATION: Permanent
[2/1/1995; 8.326.7.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.7.5 EFFECTIVE DATE: January 31, 1996
[2/1/1995; 8.326.7.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.7.6 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.
[2/1/1995; 8.326.7.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.7.7 DEFINITIONS: [RESERVED]

8.326.7.8 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.
[2/1/1995; 8.326.7.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.326.7.9 ADULT PROTECTIVE SERVICES CASE MANAGEMENT: 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 adults, individuals who are 18 years or older, who have been neglected, abused, or exploited [42 U.S.C. Section 136n(g)(1)(2)]. This part describes eligible providers, eligible population, covered services, service limitations, and general reimbursement information.
[1/31/1996; 8.326.7.9 NMAC - Rn, 8 NMAC 4.MAD.776, 3/1/2012]

8.326.7.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for furnishing case management services to an eligible recipient.

(1) Government agencies or their delegates which by law receive reports or allegations of abuse, exploitation or neglect and who by New Mexico state law are required to provide adult protective services for the target population.

(2) 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.

B. Agency qualifications: Agencies must demonstrate direct experience in successfully serving the target population; and past performance of such agencies must demonstrate knowledge of available community services and methods for gaining access to those services.

C. Case manager qualifications: Case managers employed by an agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have the necessary skills to meet the needs of specified recipients. In some instances, it is important that individuals have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. Case managers must also at a minimum, have a current license at the baccalaureate level issued by the New Mexico board of social work. These individuals must work under the direct supervision of an experienced case manager within the agency who meets the educational requirements specified above.

[1/31/1996; 8.326.7.10 NMAC - Rn, 8 NMAC 4.MAD.776.1, 3/1/2012]

8.326.7.11 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 services, type of contact, category of case management services 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 the goals identified in the individual service plan.

[1/31/1996; 8.326.7.11 NMAC - Rn, 8 NMAC 4.MAD.776.2, 3/1/2012]

8.326.7.12 ELIGIBLE RECIPIENTS: Case management services are available for eligible medicaid recipients who meet all of the following criteria:

- A.** individuals who are eighteen (18) years of age or older;
- B.** individuals who are residents of the state of New Mexico;
- C.** individuals who are not residents of an institution; and
- D.** individuals who through investigation are found to be abused, neglected or exploited; abuse is defined as knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish, or the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of an adult; neglect is defined as failure of the caretaker of an adult to provide basic needs such as clothing, food, shelter, supervision and care for the physical and mental health for that adult or failure by an adult to provide such basic needs for him/herself; exploitation is defined as an unjust or improper use of an adult's resources for another's profit or advantage, pecuniary or otherwise.

[1/31/1996; 8.326.7.12 NMAC - Rn, 8 NMAC 4.MAD.776.3, 3/1/2012]

8.326.7.13 COVERED SERVICES: Medicaid covers the following case management services for adults who have been abused, neglected or exploited:

- A.** services which help recipients gain access to medical, social, educational or other needed services.
- B.** assessment of a recipient's medical and social needs and functional limitations using standardized needs assessment instruments;
- C.** development and implementation of an individualized plan of care designed to help recipients retain or achieve the maximum degree of independence;
- D.** mobilization of the use of "natural helping" networks such as family members, church members, community organizations, support groups and friends; and
- E.** coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the plan of care, if necessary.

[1/31/1996; 8.326.7.13 NMAC - Rn, 8 NMAC 4.MAD.776.4, 3/1/2012]

8.326.7.14 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 services as adult protective services case management:

- A.** services furnished to individuals who are not medicaid eligible or who do not meet the definition of an adult who is abused, neglected or exploited;
- B.** services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

- C. formal educational or vocation services related to traditional academic subjects or vocational training;
- D. client outreach activities in which a provider attempts to contact potential recipients;
- E. administrative activities, such as medicaid eligibility determinations and intake processing;
- F. case management for a recipient who is institutionalized, except for the last thirty (30) days of the institutionalization to ensure follow-up services;
- G. institutional discharge planning which is a required condition for payment of hospital, nursing home or residential treatment center services;
- H. services which are furnished under other categories, such as therapies, transportation or counseling; or
- I. services considered by MAD or its designee to be excessive based on the needs of the recipient and documentation in the case management file.

[1/31/1996; 8.326.7.14 NMAC - Rn, 8 NMAC 4.MAD.776.5, 3/1/2012]

8.326.7.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation and cooperation with recipients, families or legal guardian(s), primary physicians, as appropriate and others involved with the recipient's care.

B. 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 in the recipient's file:

- (1) statement of the nature of the specific problem and the specific needs of the recipient;
- (2) description of the functional level of the recipient, including the following:
 - (a) mental status assessment;
 - (b) intellectual function assessment;
 - (c) psychological assessment;
 - (d) educational assessment;
 - (e) vocational assessment;
 - (f) social assessment;
 - (g) medical assessment; and
 - (h) physical assessment.
- (3) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and
- (4) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued.

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.

[1/31/1996; 8.326.7.15 NMAC - Rn, 8 NMAC 4.MAD.776.6, 3/1/2012]

8.326.7.16 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 specified in the treatment plan 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.

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*.

[1/31/1996; 8.326.7.16 NMAC - Rn, 8 NMAC 4.MAD.776.7, 3/1/2012]

8.326.7.17 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*. Once enrolled, instructions on documentation, billing and claims processing are sent to the medicaid providers. Reimbursement for case management providers is made at the lesser of the following:

- (1) the provider's billed charge; or
- (2) the MAD fee schedule for the specific service.

B. The provider's billed charge must be its usual and customary charge for the services.

C. "Usual and customary charge" refers to the amount which an 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 any cost settlement or rebasing.

[1/31/1996; 8.326.7.17 NMAC - Rn, 8 NMAC 4.MAD.776.8, 3/1/2012]

HISTORY OF 8.326.7 NMAC: [RESERVED]