TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 5 CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS

8.326.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.326.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.326.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.326.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.5.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.326.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.326.5.4 DURATION: Permanent
[2/1/95; 8.326.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.5.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.326.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.5.6 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; 8.326.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.5.7 DEFINITIONS: [RESERVED]

8.326.5.8 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; 8.326.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.5.9 CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who are traumatically brain injured [42 U.S.C. Section 1396n (g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[2/1/95; 10/15/96; 8.326.5.9 NMAC - Rn, 8 NMAC 4.MAD.774, 3/1/12]

8.326.5.10 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 for certification as case management agencies:

(1) government or community agencies which meet certification standards developed by MAD or its designee;

(2) Indian tribal governments;

(3) Indian health services; and

(4) federally qualified health centers (FQHC).

B. 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.

C. **Qualification of case management agencies:** Case management agencies must have direct experience in serving traumatically brain-injured adults and must demonstrate knowledge of available community services and methods for gaining access to those services.

D. **Qualifications of case managers:** Case managers employed by case management agencies must have the education, skills, abilities and experience to perform case management services for adults with traumatic brain injuries. Case managers may also need language skills, cultural sensitivity and acquired knowledge and expertise unique to a geographic area. Case managers must have at least one of the following qualification:

(1) bachelor's degree from an accredited institution in social work, counseling, psychology or a related field and one year of experience working with traumatically brain injured adults;

(2) licensed as a registered nurse with one year of experience working with traumatically brain injured adults; or

(3) if 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 experience in the mental health or traumatic brain injury field; or

(b) high school graduation or general educational development (GED) test and a minimum of five (5) years experience in the mental health or traumatic brain injury field.

(4) This individual must work under the direct supervision of an experienced case manager within the agency who meets the educational and experience requirements, described above.

[2/1/95; 10/15/96; 8.326.5.10 NMAC - Rn, 8 NMAC 4.MAD.774.1, 3/1/12]

8.326.5.11 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*.

A. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

B. 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*.

C. 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 of intended result and relationship of the service furnished to goals identified in the individual plan of care.

[2/1/95; 10/15/96; 8.326.5.11 NMAC - Rn, 8 NMAC 4.MAD.774.2, 3/1/12]

8.326.5.12 ELIGIBLE INDIVIDUALS:

A. Case management services are available for eligible medicaid recipients who meet all of the following criteria:

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

(2) resident of the state of New Mexico;

(3) resident of Santa Fe, Chavez, Dona Ana, San Juan, McKinley or San Miguel counties;

(4) suffer from traumatic brain injury; and

(5) reside outside an institution.

B. **Definition of traumatic brain injury:** "Traumatic brain injury" is defined as an insult to the brain which is not caused by a degenerative or congenital process, but by an external physical force. The physical force produces a diminished or altered state of consciousness resulting in impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments can be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

C. **Recipient freedom of choice:** Adults with traumatic brain injuries are not required to receive case management services even if they are eligible for the service. Case management services can only be furnished at the request of recipients. Recipients have the freedom to choose among medicaid-eligible case management agencies and specific case managers within an agency.

[2/1/95; 10/15/96; 8.326.5.12 NMAC - Rn, 8 NMAC 4.MAD.774.3, 3/1/12]

8.326.5.13 COVERED SERVICES: Medicaid covers those case management services for traumatic brain-injured adults which are medically necessary to help these recipients gain access to needed medical, social, educational and other services. Medicaid covers the following specific case management services:

A. identification of programs which are appropriate for a recipient's needs and provision of assistance to the recipient in accessing those programs;

B. assessment of the service needs of recipients to coordinate the delivery of services if multiple providers or programs are involved in the provision of care; and

C. reassessment to ensure that the services obtained are medical necessary and appropriate to meet the recipient's needs.

[2/1/95; 10/15/96; 8.326.5.13 NMAC - Rn, 8 NMAC 4.MAD.774.4, 3/1/12]

8.326.5.14 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 activities:

A. services furnished to individuals who are not medicaid-eligible, who do not meet the definition of traumatically brain injured, or who are not residents of Santa Fe county or the state of New Mexico;

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

C. daily independent living skills training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning: if recipients are in medical institutions, medicaid covers case management only for the thirty (30) days prior to discharge; this service cannot duplicate required discharge planning activities conducted by medical institutions;

G. actual provision of services or treatment identified in the case management assessment; or

H. services furnished by other practitioners, such as therapies, transportation, homemaker or personal care services or psycho-social rehabilitation services.

[2/1/95; 10/15/96; 8.326.5.14 NMAC - Rn, 8 NMAC 4.MAD.774.5, 3/1/12]

8.326.5.15 PLAN OF CARE:

A. Case managers develop and implement individualized plans of care in consultation with recipients, families or legal guardians, physicians and others involved in the care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the recipients;

(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, 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 care for achieving these intermediate and long-range goals, including review and modification of the plan;

(5) the plan of care must be retained by agency providers and available for utilization review purposes; plans of care must be updated and revised, at least every six (6) months or more often, as indicated by the recipient's condition.

[2/1/95; 10/15/96; 8.326.5.15 NMAC - Rn, 8 NMAC 4.MAD.774.6, 3/1/12]

8.326.5.16 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 a part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. 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.*

[2/1/95; 10/15/96; 8.326.5.16 NMAC - Rn, 8 NMAC 4.MAD.774.7, 3/1/12]

8.326.5.17 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*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for 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.

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 case management services furnished by an institution or clinic, the costs associated with case management services must be removed from cost reports prior to cost settlement or rebasing.

[2/1/95; 10/15/96; 8.326.5.17 NMAC - Rn, 8 NMAC 4.MAD.774.8, 3/1/12]

HISTORY OF 8.326.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 310.36, Case Management Services for the Traumatically Brain Injured, filed 7/19/94.

History of Repealed Material:

MAD Rule 310.36, Case Management Services for the Traumatically Brain Injured, filed 7/19/94 - Repealed effective 2/1/95.