State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
VISION CARE SERVICES
and
NONCOVERED SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department, Medical Assistance Division, is proposing amendments to 8.310.6 NMAC, *Vision Care Services*, and 8.301.3 NMAC, *Noncovered Services*, rules to clarify regulatory language, to maintain accuracy with existing rules and to identify which adult benefits have been reduced.

Specifically for both rules -

- Replacing outdated word usage, such as Medicaid with MAD
- Providing information on the eligibility of providers and their responsibilities
- Directing providers to enroll and follow a coordinated care contractor's instructions for billing and authorization of services

Specifically for Vision -

- Approving the combined refractive error of sphere and cylinder to equal 0.75 astigmatism as meeting the criteria for the dispensing of corrective lenses if the provider determines that the visual acuity will be significantly improved;
- Clarifying the conditions of coverage for polycarbonate lenses
- Clarifying the replacement criteria for eyeglasses and contact lenses
- Clarifying the provider types allowed to dispense contact lens
- Adult benefits are reduced to allow only one exam, one pair of lenses or pair contact lenses within a thirty-six (36) month period, unless specific criteria has been met

Specifically for Noncovered Services –

- Clarifying when a provider may or may not bill an eligible recipient when a service is not a covered benefit of MAD
- Update MAD's current instructions concerning durable medical equipment and medical supplies

- Clearer statement that MAD does not cover telephone consultations between an eligible recipient and their provider.
- Clarifying that MAD does not reimburse bariatric surgery services or procedures.

VI. RULES

These proposed rule changes refer to 8.310.6 NMAC and 8.301.3 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/registers. If you do not have Internet access, a copy of the 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 March 15, 2010.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 10:00 a.m., on January 11, 2010, in the ASD conference room of Plaza San Miguel, 729 St. Michael's Drive, Santa Fe, New Mexico.

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:

Kathryn Falls, Secretary-Designee
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 January 11, 2010. 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:

_____

KATHRYN FALLS, SECRETARY-DESIGNEE
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 6 VISION CARE SERVICES

8.310.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.310.6.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 12/1/03; A, 3/15/10]

8.310.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program [~~is~~] and other health care programs are 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~~.] Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.310.6.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 12/1/03; A, 3/15/10]

8.310.6.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.310.6.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 12/1/03; A, 3/15/10]

8.310.6.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide [~~policies~~] instruction for the service portion of the New Mexico [~~medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.~~] medical assistance programs.
[2/1/95; 8.310.6.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 12/1/03; A, 3/15/10]

8.310.6.8 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.~~] The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the lives of their communities.
[2/1/95; 8.310.6.8 NMAC - Rn, 8 NMAC 4.MAD.002, 12/1/03; A, 3/15/10]

8.310.6.9 VISION CARE SERVICES: [~~The New Mexico medicaid program (medicaid)~~] MAD pays for medically necessary health services furnished to eligible recipients. [~~Medicaid~~] To help New Mexico MAD eligible recipients receive medically necessary services, MAD pays for covered vision services. [~~This part describes eligible providers, covered services, service limitations and general reimbursement methodology.~~]
[2/1/95; 8.310.6.9 NMAC - Rn, 8 NMAC 4.MAD.715, 12/1/03; A, 3/15/10]

8.310.6.10 ELIGIBLE PROVIDERS:

A. [~~Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for providing vision services:~~] Health care to New Mexico MAD 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 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 to 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. Providers must supply necessary information in order for payment to be made. Eligible providers include:

(1) individuals licensed to practice medicine in New Mexico, who limit their practice to ophthalmology (ophthalmologists) and the groups, corporations, and professional associations they form;

(2) individuals licensed to practice optometry in New Mexico and the groups, corporations, and professional associations they form;

(3) individuals licensed as opticians; opticians are eligible to participate as providers of eyeglasses, contact lenses, supplies, and other vision-related materials; and

(4) IHS or tribal facilities operating under Public Law 93-638.

B. Once enrolled, [~~providers receive~~] a provider receives a packet of information, including [~~medicaid~~] MAD-program policies, billing instructions, utilization review instructions, and other pertinent materials from MAD. ~~Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.~~] A provider is responsible for ensuring that he has received and understands these materials and for updating his knowledge as new materials are provided by MAD.

C. 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.

[2/1/95; 8.310.6.10 NMAC - Rn, 8 NMAC 4.MAD.715.1 & A, 12/1/03; A, 3/15/10]

8.310.6.11 PROVIDER RESPONSIBILITIES:

[~~A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*.~~

~~B. 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. Providers must maintain records that are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*.~~]

A. A provider who furnishes services to medicaid or other health care program eligible recipients 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. 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.*

[D.] C. [~~Providers~~] A provider must ensure that prescriptions for eyeglasses or contact lenses are accurate to the extent that the prescription corrects the eligible recipient's vision to the degree of acuity indicated on the [~~report of~~] vision examination form.

[~~E.~~] D. [~~Eyeglass~~] An eyeglass and contact lens [~~suppliers are~~] supplier is responsible for verifying that the correct prescription is provided.

(1) If [~~prescriptions are inaccurate and recipients are~~] a prescription is inaccurate and an eligible recipient is unable to use their eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

(2) If the eyeglasses or contact lenses are not ground to the correct prescription, payment for the eyeglasses or contact lenses is subject to recoupment.

[2/1/95; 8.310.6.11 NMAC - Rn, 8 NMAC 4.MAD.715.2 & A, 12/1/03; A, 3/15/10]

8.310.6.12 COVERED SERVICES: [~~Medicaid~~] MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases [~~and~~]. MAD pays for the correction of refractive errors, as required by the condition of the eligible recipient. All services must be furnished within the limits of [~~medicaid~~] MAD benefits, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and regulations.

A. **Exam:** [~~Medicaid~~] MAD covers routine eye exams. Coverage for [~~adults~~] an eligible adult recipient over 21 years of age is limited to one routine eye exam in a [~~twenty-four-month~~] three-year period. [~~Exams~~] An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the visual

examination form and indicated by diagnosis on the claim. Exam coverage for an eligible recipient under 21 years of age is limited to one routine eye exam in a 12 month period.

B. **Corrective lenses:** [~~Medicaid covers~~] MAD does cover one set of corrective lenses for adult recipients 21 years of age or older once in a 36 month period. Coverage for [~~adults~~] an eligible recipient under 21 years of age is limited to one set of corrective lenses in a [~~twenty-four-month~~] 12 month period, unless an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the visual examination form and indicated by diagnosis on the claim.

(1) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

(a) -1.00 myopia (nearsightedness);

(b) + 1.00 for hyperopia (farsightedness);

(c) +0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal .75 will be accepted if the visual acuity is improved significantly;

(d) + 1.00 for presbyopia (farsightedness of aging); or

(e) +2.00 for diplopia (double vision) - prism lenses.

(2) If an existing prescription is updated, there must be a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal .75 will be accepted if the visual acuity is improved significantly. [~~Exceptions are~~] An exception is considered for the following:

(a) [~~recipients~~] an eligible recipient over 21 years of age with cataracts;

(b) an ophthalmologist or optometrist recommends a change due to a medical condition; or

[~~(b)~~] (c) [~~recipients~~] an eligible recipient under [~~twenty-one (21)~~] 21 years of age.

C. **Bifocal lenses: [**~~Medicaid~~] MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

D. **Tinted lenses:** [~~Medicaid~~] MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the "comments" section of the visual examination form, and the prescription meets the dioptic correction purchase criteria:

(1) aniridia;

(2) albinism, ocular;

(3) traumatic defect in iris;

(4) iris coloboma, congenital;

(5) chronic keratitis;

(6) sjogren's syndrome;

(7) aphakia, U.V. filter only if intraocular lens is not U.V. filtered; [~~and~~]

(8) rod monochromaly;

(9) pseudoaphakia; and

(10) other diagnosis confirmed by ophthalmologist or optometrist that is documented on visual examination form.

E. **Polycarbonate lenses**: MAD covers polycarbonate lenses for:

(1) an eligible recipient under 21years of age for medical conditions which require prescriptions for high power lenses;

(2) an eligible recipient under 21 years of age with monocular vision;

(3) an eligible recipient under 21years of age who works in a high-activity physical job.

[~~E.~~] F. **Balance lenses:** [~~Medicaid~~] MAD covers balance lenses for an eligible recipient under 21 years of age without a prior authorization in the following situations:

(1) lenses used to balance an aphakic eyeglass lens; or

(2) [~~recipient~~] an eligible recipient under 21years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

[~~F.~~] G. **Frames:** [~~Medicaid~~] MAD covers frames for corrective lenses. Coverage for an eligible recipient 21 years of age or older is limited to one frame in a 36 month period. Coverage for [~~adults~~] an eligible recipient under 21 years of age is limited to one frame in a [~~twenty-four-month~~] 12-month period.

(1) an ophthalmologist or optometrist has documented a medical condition that requires replacement; and

(2) other situations will be reviewed on a case-by-case basis.

[~~G.~~] H. **Contact lenses:** [~~Medicaid~~] MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient over 21 years of age is limited to one pair of contact lenses in a [~~twenty-four-month period~~] three-year period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. [~~Requests~~] A request for prior authorization will be evaluated on dioptic criteria [~~and/or~~] or visual acuity, the eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(1) the eligible recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian, at least 3.00 diopters of anisometropia.

(2) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

[~~H.~~] I. **Replacement:** Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the eligible recipient, may be replaced for the following:

(1) [~~recipients~~] the eligible recipient is under [~~twenty-one (21)~~] 21 years of age; or

(2) [~~recipients~~] the eligible recipient is [~~twenty-one (21)~~] 21 years of age or older [~~and who have developmental disabilities.~~] and has a developmental disability.

(3) Documentation for replacement:

(a) the eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion and must be recorded on the [~~report of~~] visual examination form; and

(b) the loss, deterioration or breakage must be documented [~~in the appropriate section of~~] on the visual examination form.

[~~I.~~] J. **Prisms:** All prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the visual examination form.

[~~J.~~] K. **Lens tempering:** [~~Medicaid~~] MAD covers lens tempering on new glass lenses only.

[~~K~~] L. **Lens edging:** [~~Medicaid~~] MAD covers lens edging and lens insertion.

[~~L.~~] M. **Minor repairs:** [~~Medicaid~~] MAD covers minor repairs to eyeglasses.

[~~M.~~] N. **Dispensing fee:** [~~Medicaid~~] MAD pays a dispensing fee to [~~ophthalmologists, optometrists, or opticians~~] an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not covered by MAD to prescribe and fit contact lenses.

[~~N.~~] O. **Eye prosthesis:** [~~Medicaid~~] MAD covers eye prostheses (artificial eyes). Refer to 8.324.8 NMAC, *Prosthetics and Orthotics*.

[2/1/95; 8.310.6.12 NMAC - Rn, 8 NMAC 4.MAD.715.3 & A, 12/1/03; A, 7/1/04; A, 3/15/10]

8.310.6.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All [~~medicaid~~] MAD 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 Approval and Utilization Review*. [~~Once enrolled, providers receive instructions and documentation forms necessary for prior approval 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 [~~can~~] may require prior authorization from MAD or its designee. Contact lenses, either the original prescription or replacement, require prior authorization. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** [~~Prior authorization 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.~~] The prior authorization of a service does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time the service is furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** [~~Providers who disagree with prior authorization denials or other review decisions~~] A provider who disagrees with a prior authorization denial or another review decision may request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953]. decisions can request a re-review and a reconsideration.
[2/1/95; 8.310.6.13 NMAC - Rn, 8 NMAC 4.MAD.715.4 & A, 12/1/03; A, 3/15/10]

8.310.6.14 NONCOVERED SERVICES: Vision services are subject to the limitations and coverage restrictions that exist for other [~~medicaid~~] MAD services. [~~Providers must notify recipients of medicaid-covered and non-covered services by medicaid prior to providing services. If recipients choose to obtain non-covered services, they will be responsible for payment.~~] See 8.301.3 NMAC, *General Noncovered Services* and 8.302.1 NMAC, *General Provider Policies*. [~~Medicaid~~] MAD does not cover the following specific vision services:

A. orthoptic assessment and treatment;
B. photographic procedures, such as fundus or retinal photography and external ocular photography;
C. polycarbonate lenses other than for prescriptions for high-power lenses or monocular vision
D. ultraviolet (UV) lenses;
E. trifocals;
F. progressive lenses;
G. tinted or photochromic lenses, except in cases of documented medical necessity. See Subsection D of 8.310.6.12 NMAC above;
H. oversize frames and oversize lenses;
I. low vision aids;
J. eyeglass cases;
K. eyeglass or contact lens insurance; and
L. anti-scratch, anti-reflective, or mirror coating.

[2/1/95; 8.310.6.14 NMAC - Rn, 8 NMAC 4.MAD.715.5 & A, 12/1/03; A, 7/1/04; A, 3/15/10]

8.310.6.15 REIMBURSEMENT:

A. [~~Vision service providers,~~] A vision service provider, except an IHS and 638 [~~facilities,~~] facility, must submit claims for reimbursement on the [~~HCFA-1500~~] CMS 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. [~~Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD.~~

~~B. Reimbursement to vision providers for covered services, procedures and other vision service appliances 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 charges must be the usual and customary charge for such services.~~

~~(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.~~] Once enrolled, a provider receives instructions on documentation, billing, and claims processing. Reimbursement to a provider 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 his 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.

[2/1/95; 8.310.6.15 NMAC - Rn, 8 NMAC 4.MAD.715.6 & A, 12/1/03; A, 3/15/10]

TITLE 8 SOCIAL SERVICES
CHAPTER 301 MEDICAID GENERAL BENEFIT DESCRIPTION
PART 2 GENERAL BENEFIT DESCRIPTION

8.301.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[1-1-95; 8.301.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3-1-06; A, 3-15-10]

8.301.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program [~~is~~] and other health care programs are 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.~~] Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[1-1-95; 8.301.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3-1-06; A, 3-15-10]

8.301.3.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide [~~policies~~] instruction for the service portion of the New Mexico [~~Medicaid program.~~] medical assistance program.
[1-1-95, 2-1-95; 8.301.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3-1-06; A, 3-15-10]

8.301.3.8 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.~~] The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the lives of their communities.
[2-1-95; 8.301.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3-1-06; A, 3-15-10]

8.301.3.9 GENERAL NONCOVERED SERVICES: MAD does not cover certain procedures, services, or miscellaneous items. [~~This section contains a general description of the types of services that Medicaid does not cover. Also~~] See specific provider or service sections for additional information on service coverage and limitations. A provider cannot turn an account over to collections or to any other factor intending to collect from the eligible recipient or their personal representative. See 8.302.2.11 NMAC, *billing for medicaid services.* A provider cannot bill an eligible recipient or their personal representative for the copying of the eligible recipient's records, but must provide copies of the records to other providers upon request.
[2-1-95; 8.301.3.9 NMAC - Rn, 8 NMAC 4.MAD.602 & A, 3-1-06; A, 3-15-10]

8.301.3.10 APPOINTMENT, INTEREST AND CARRYING CHARGES: [~~Medicaid~~] MAD does not cover penalties on payments for broken or missed appointments, costs of waiting time, [~~and~~] or interest or carrying charges on accounts. [~~Providers may not bill Medicaid or Medicaid recipients~~] A provider may not bill an eligible recipient or their personal representative for the penalties associated with missed or broken appointments, with the exception of recipient eligibility categories of [~~SCHIP~~] CHIP or WDI who may be charged up to $5 for a missed appointment.
[2-1-95; 8.301.3.10 NMAC - Rn, 8 NMAC 4.MAD.602.1 & A, 3-1-06; A, 3-15-10]

8.301.3.11 CONTRACT SERVICES: Services furnished by contractors, organizations, or individuals who are not the billing provider must meet specific criteria for coverage [~~by Medicaid.~~] as stated in MAD or its designee's rules. See 8.302.2 NMAC, *billing for medicaid services.*
[2-1-95; 8.301.3.11 NMAC - Rn, 8 NMAC 4.MAD.602.2 & A, 3-1-06; A, 3-15-10]

8.301.3.12 COSMETIC SERVICES AND SURGERIES: [~~Medicaid~~] MAD does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, for hair loss, and personal care items such as non-prescription lotions, shampoos, soaps or sunscreens. [~~Medcaid~~] MAD does not cover cosmetic surgeries performed for aesthetic purposes. "Cosmetic surgery" is defined as procedures performed to improve the appearance of physical features[~~. The procedures~~] that may or may not improve the functional ability of the area of concern. [~~Medicaid~~] MAD covers only surgeries that meet specific criteria and are approved as medically necessary reconstructive surgeries.
[2-1-95; 8.301.3.12 NMAC - Rn, 8 NMAC 4.MAD.602.3 & A, 3-1-06; A, 3-15-10]

8.301.3.13 DENTAL SERVICES: [~~Medicaid~~] MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. [~~Medicaid~~] MAD covers orthodontic services only for [~~recipients~~] an eligible recipient less than [~~twenty-one (21)~~] 21 years of age and only when specific criteria are met. See 8.310.7 NMAC, *Dental Services*.
[2-1-95; 8.301.3.13 NMAC - Rn, 8 NMAC 4.MAD.602.4 & A, 3-1-06; A, 3-15-10]

8.301.3.14 DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES: [~~Medicaid~~] MAD does not cover separate charges for kits, films, or supplies[~~, or other material used in the performance of diagnostic imaging or therapeutic radiology services~~]. All necessary materials and minor services are included in the service or procedure charge. See Section [~~MAD-752~~] 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services.*
[2-1-95; 8.301.3.14 NMAC - Rn, 8 NMAC 4.MAD.602.5, 3-1-06; A, 3-15-10]

8.301.3.15 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES: [~~Medicaid~~] MAD does not cover durable medical equipment or medical supplies that do not meet [~~any of the following criteria~~] the definition of durable medical equipment as described in 8.324.5.12 NMAC, *covered durable medical equipment and medical supplies*. The following criteria are applied to each request as part of the determination of non-coverage:

A. items that do not primarily serve a therapeutic purpose [~~and/or~~] or are generally used for comfort or convenience purposes;

B. environment-control equipment that is not primarily medical in nature[~~, such as air cleaners~~];

C. institutional equipment that is not appropriate for home use[~~, such as air fluidized bead beds~~];

D. items that are not generally accepted by the medical profession as being therapeutically effective or are determined by medicare regulations to be ineffective or unnecessary;

E. items that are hygienic in nature[~~, such as home type bed baths~~];

F. hospital or physician diagnostic items[~~, such as cardiovert~~];

G. instruments or devices manufactured for use by physicians[~~, such as esophageal dilator~~];

[~~H. items not essential to the administration of moist heat therapy, such as hydrocollator heating units;~~

[~~I.~~] H. exercise equipment not primarily medical in nature or for the sole purpose of muscle strengthening or muscle stimulation without a medically necessary purpose;

[~~J. items that produce no demonstrable therapeutic effect, such as myoflex muscle stimulators;~~]

[~~K.~~] I. support exercise equipment primarily for institutional use[~~, such as parallel bars~~];

[~~L.~~] J. items that are not reasonable or necessary for monitoring the pulse of homebound eligible recipients with or without cardiac pacemakers[~~, such as pulse tachometers~~];

[~~M.~~] K. items that are used to improve appearance or for comfort purposes[~~, such as sauna baths or wigs; and~~

~~N.~~] L. items that are precautionary in nature[~~, such as spare tanks of oxygen in addition to portable backup systems~~] except those needed to prevent urgent or emergent events; and

[~~O.~~] M. a provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have an excess of a 15 calendar day supply of the item before releasing the next supply to the eligible recipient; see 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies.*
[2-1-95; 8.301.3.15 NMAC - Rn, 8 NMAC 4.MAD.602.6 & A, 3-1-06; A, 3-15-10]

8.301.3.16 EDUCATIONAL OR VOCATIONAL SERVICES: [~~Medicaid~~] MAD does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for [~~recipients~~] an eligible recipient less than [~~twenty-one (21)~~] 21 years of age, as part of the early and periodic screening, diagnosis and treatment (EPSDT) program and for pregnant women. [~~Medicaid~~] MAD does not cover formal educational or vocational training services, unless those services are included as active treatment services for [~~recipients~~] an eligible recipient in intermediate care facilities for the mentally retarded or for [~~recipients~~] an eligible recipient less than [~~twenty-one (21)~~] 21 years of age receiving inpatient psychiatric services. See 42 CFR 441.13(b). "Formal educational services" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of eligible recipients for paid or unpaid employment.
[2-1-95; 8.301.3.16 NMAC - Rn, 8 NMAC 4.MAD.602.7 & A, 3-1-06; A, 3-15-10]

8.301.3.17 EXPERIMENTAL OR INVESTIGATIONAL SERVICES: [~~Medicaid~~] MAD does not cover procedures, technologies or therapies that are considered experimental or investigational. See Section [~~MAD-765,~~] 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Therapies.*
[2-1-95; 8.301.3.17 NMAC - Rn, 8 NMAC 4.MAD.602.8, 3-1-06; A, 3-15-10]

8.301.3.18 FOOT CARE: [~~Medicaid~~] MAD does not cover certain routine foot care services. For detailed description of covered and non-covered services, see 8.310.11 NMAC, *Podiatry Services.*
[2-1-95; 8.301.3.18 NMAC - Rn, 8 NMAC 4.MAD.602.9 & A, 3-1-06; A, 3-15-10]

8.301.3.19 HAIR OR NAIL ANALYSIS: [~~Medicaid~~] MAD does not cover hair or nail analysis.
[2-1-95; 8.301.3.19 NMAC - Rn, 8 NMAC 4.MAD.602.10, 3-1-06; A, 3-15-10]

8.301.3.20 LABORATORY SERVICES: [~~Medicaid~~] MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from [~~recipients who are not residents of nursing facilities or hospital inpatient~~] an eligible recipient who is not a resident of a nursing facility or hospital. See Section [~~MAD-751~~] 8.324.2 NMAC, *Laboratory Services*.
[2-1-95; 8.301.3.20 NMAC - Rn, 8 NMAC 4.MAD.602.11, 3-1-06; A, 3-15-10]

8.301.3.21 PHARMACY SERVICES: [~~Medicaid~~] MAD does not cover methadone used in drug treatment programs. [~~Medicaid~~] MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, [~~Medicaid~~] MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to pharmacies is not a benefit of the program when other options are available. See also 8.324.4 NMAC, *Pharmacy Services*[~~.~~].
[2-1-95; 8.301.3.21 NMAC - Rn, 8 NMAC 4.MAD.602.12 & A, 3-1-06; A, 3-15-10]

8.301.3.22 POSTMORTEM EXAMINATIONS: [~~Medicaid~~] MAD does not cover postmortem examinations.
[2-1-95; 8.301.3.22 NMAC - Rn, 8 NMAC 4.MAD.602.13, 3-1-06; A, 3-15-10]

8.301.3.23 PREGNANCY TERMINATION PROCEDURES: [~~Medicaid~~] MAD does not cover elective pregnancy termination procedures. For detailed description of covered and non-covered services[~~.~~], see 8.325.7 NMAC, *Pregnancy Termination Procedures.*
[2-1-95; 8.301.3.23 NMAC - Rn, 8 NMAC 4.MAD.602.14 & A, 3-1-06; A, 3-15-10]

8.301.3.24 PREPARATIONS DISPENSED FOR HOME USE: [~~Medicaid~~] MAD does not cover oral, topical, otic, or ophthalmic preparations dispensed to [~~recipients~~] an eligible recipient by physicians, clinics, nurse practitioners, physician assistants, or optometrists for home use or self administration unless authorized by MAD to assure the availability of medications.
[2-1-95; 8.301.3.24 NMAC - Rn, 8 NMAC 4.MAD.602.15 & A, 3-1-06; A, 3-15-10]

8.301.3.25 PROVIDER INELIGIBILITY: [~~Providers~~] A provider must be eligible for participation [~~in Medicaid~~] as a MAD approved provider at the time services are furnished. [~~Medicaid~~] MAD does not cover services performed during a time period when the [~~providers or facilities~~] provider or facility did not meet required licensing or certification requirement, or when the providers' participation [~~was~~] is not approved by MAD.
[2-1-95; 8.301.3.25 NMAC - Rn, 8 NMAC 4.MAD.602.16 & A, 3-1-06; A, 3-15-10]

8.301.3.26 REPRODUCTIVE HEALTH SERVICES: [~~Medicaid~~] MAD does not cover certain reproductive health services. See Section [~~MAD-762~~] 8.325.3 NMAC, *Reproductive Health Services*
[2-1-95; 8.301.3.26 NMAC - Rn, 8 NMAC 4.MAD.602.17, 3-1-06; A, 3-15-10]

8.301.3.27 [~~**NON-COVERED SERVICES**: Medicaid does not cover broken appointments, or telephone consultations. Transportation to pharmacies is not a benefit of the program when other options are available.~~]
TELEPHONE SERVICES: MAD does not cover any telephone consultations between the eligible recipient and their provider. MAD does pay for telehealth services as described in 8.310.13 NMAC, *Telehealth Services*.

[2-1-95; 3-1-99; 8.301.3.27 NMAC - Rn, 8 NMAC 4.MAD.602.18 & A, 3-1-06; A, 3-15-10]

8.301.3.28 ROUTINE PHYSICAL EXAMINATIONS: [~~Medicaid covers routine physical examinations for non-institutionalized recipients less than twenty-one (21) years of age. Medicaid covers routine examinations for recipients residing in nursing facilities or intermediate care facilities for the mentally retarded~~**]** MAD only covers routine examinations for an eligible recipient residing in a nursing facility or intermediate care facility for the mentally retarded. Physical examinations, screenings, and treatment are available to [~~recipients~~] an eligible recipient less than [~~twenty-one (21)~~] 21 years of age through the tot to teen healthcheck screen, New Mexico's EPSDT screening program.
[2-1-95; 8.301.3.28 NMAC - Rn, 8 NMAC 4.MAD.602.19 & A, 3-1-06; A, 3-15-10]

8.301.3.29 SCREENING SERVICES: [~~Medicaid~~] MAD does not cover screening services that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. [~~Medicaid~~] MAD covers screening services for [~~children~~] an eligible recipient less than [~~twenty-one (21)~~] 21 years of age through the tot to teen healthcheck program. [~~Medicaid~~] MAD covers screening services ordered by [~~providers~~] a provider for cancer detection, such as pap smears and mammograms.
[2-1-95; 8.301.3.29 NMAC - Rn, 8 NMAC 4.MAD.602.20 & A, 3-1-06; A, 3-15-10]

8.301.3.30 SERVICES NOT COVERED BY MEDICARE: MAD does not cover services, procedures, or devices that are not covered by medicare due to their determination that the [~~service, procedure or device is ineffective or of questionable efficacy~~] service is not medically necessary or that the service is experimental or not effective.
[2-1-95; 8.301.3.30 NMAC - Rn, 8 NMAC 4.MAD.602.21 & A, 3-1-06; A, 3-15-10]

8.301.3.31 [~~**SERVICE REQUIREMENTS NOT SATISFIED:** Medicaid does not reimburse for services or procedures for which any required prior authorization, documentation, acknowledgements, or filing limits have not been met by providers. See 8.302.1 NMAC, *General Provider Policies*.~~] **BARIATRIC SURGERY SERVICES:** MAD does not reimburse for bariatric surgery services or procedures.
[2-1-95; 3-1-99; 12-1-99; 8.301.3.31 NMAC - Rn, 8 NMAC 4.MAD.602.22 & A, 3-1-06; A, 3-15-10]