State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
HOSPITAL SERVICES
AND
OUT OF STATE AND BORDER AREA PROVIDERS
AND
INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY
The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing amendments to 8.311.2 NMAC, *Hospital Services;* 8.302.4 NMAC, *Out of State and Border Area Providers;* and 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals,* rules to clarify regulatory language and to assure accuracy of existing rules. Detailed below are substantive changes to the rules.

Each of the proposed rules contains provider reimbursement changes as follows:

- For hospital providers, the proposed reimbursement changes are: (1) the rate a provider agrees to be paid by a managed care organization (MCO) when an agreement cannot otherwise be reached will be reduced from 100% of the fee for service rate to 90% of the fee for service rate; (2) the implementation of an outpatient prospective payment system reimbursement methodology will be implemented on September 1, 2010; (3) pursuant to federal requirements for drug items, hospitals cannot bill nor be paid more than the acquisition of an item purchased at federal 340B prices; (4) the allowed $2.00 maximum payment for oral medications dispensed in an outpatient setting will no longer be allowed as MAD will follow Medicare policy; and (5) payment limitations may apply to emergency room services that are not medically necessary.

- For out of state and border area providers, the proposed reimbursement changes are: (1) the rate a provider agrees to be paid by a managed care organization (MCO) when an agreement cannot otherwise be reached will be 90% of the fee for service rate; and (2) placement in an out of state hospital may be restricted to the closest or otherwise most economically prudent choice of provider capable of rendering the service.

- For inpatient psychiatric care provided by free standing psychiatric hospital providers, the proposed reimbursement changes are: (1) the rate a provider agrees to be paid by a managed care organization (MCO) when an agreement cannot otherwise be reached will be 90% of the fee for service rate; and (2) reimbursement rates for free standing psychiatric hospitals which are not cost settled may be limited to rates established by MAD after considering cost to charge ratios and other reimbursement and cost data.

Changes in all three rules:

- Updating the mission statement to the current language.
- Updating the process for obtaining billing instructions and the provider's responsibility to become informed of rules.
- Adding wording stating that payment is made by electronic funds transfer (EFT).
- Adding clarification to providers on their responsibilities and obligations under federal and state laws, regulations, executive orders as stated in the MAD Provider Participation Agreement and any MAD provider rules, appendices, program directions and billing instructions.
- Adding additional language directing providers to follow a coordinated services contractor's instructions for billing.

8.311.2 NMAC *Hospital Services*

- Subsection C, Paragraph (1) of 8.311.2.11NMAC - A change was made amending the accepted applicable reimbursement rate, the rate a provider agrees to be paid by a managed care organization when an agreement cannot otherwise be reached from 100% to 90%.
- Subsection D, Paragraph (1) of 8.311.2.15 NMAC -Additional language was added directing hospitals that purchase drug items at 340B prices may not bill for more than their 340B cost.
- Subsection D, Paragraphs (2 and (4) of 8.311.2.15 NMAC have been added to support outpatient prospective payment system (OPPS) implementation efforts by the Department, including eliminating the allowed $2.00 maximum payment for oral medications dispensed in an outpatient setting.
- Subsections A, B, D and E of 8.311.2.16 NMAC have been added or changed to provide direction to hospitals on what MAD considers covered emergency services and provides clarity concerning MAD's retrospective review, and clarifying payment limitations that may apply to emergency room services that are not medically necessary.

8.302.4NMAC *Out of State and Border Area Providers*

- Subsection C of 8.302.4.11 NMAC - Additional language was added stating the rate a provider agrees to be paid by a managed care organization (MCO) when an agreement cannot otherwise be reached will be 90% of the fee for service rate.
- Subsections C and F of 8.302.4.12 NMAC-Additional language was added to provide instruction and direction on how out of state adopted children may access MAD benefits and services. Additional language was also added to this section providing clarification that placement in an out of state hospital may be restricted to the closest or otherwise most economically prudent choice of provider capable of rendering the service.

8.321.2 NMAC *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*
The current rule is in the old MAD rule format (MAD 742.1). This rule has been reformatted to follow the current New Mexico Administrative Code requirements. Sections have been moved or combined in order to meet these requirements. Changes in the rule are underlined.

- 8.321.2.9 NMAC -Additional language was added to clarify the circumstances when a youth may continue inpatient services after his 21st birthday.
- Subsection C of 8.321.2.11NMAC - Additional language was added stating the rate a provider agrees to be paid by a managed care organization (MCO) when an agreement cannot otherwise be reached will be 90% of the fee for service rate.
- 8.321.2.12 NMAC - New language was added informing hospitals that their reimbursement includes payment for a number of itemized services.
- 8.321.2.14 NMAC and 8.321.16 NMAC -A number of changes were added to meet the Code of Federal Register (CFR) requirements that became effective after the current rule was adopted. Language was also updated to meet current behavioral health terminology and support the direction of the State Behavioral Health Purchasing Collaborative's efforts to assist children in receiving the most appropriate level of care in their home and community before moving to a higher level of care and to ensure that the care provided at this level supports a child's re-entry back to his home and community.
- 8.321.2.17 NMAC -New language was added specifically addressing issues of percent of billed charges at a fee schedule rate, payment levels made by other payers, and negotiated rate allowed when a hospital provides unique services to a MAD recipient.
- Subsections A and F of 8.302.4.12 NMAC - Additional language was added to align current federal regulations that allow an expansion of how MAD determines when a provider is either out-of-state or in a border area. Additional language was also added detailing the conditions when a recipient may utilize an out-of-state provider as a border area provider for routine or emergency care.

VI. RULE

These proposed rule changes refer to 8.311.2 NMAC *Hospital Services*, 8.302.4 NMAC, *Out of State and Border Area Providers*, and 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals* of the Medical Assistance Program Policy Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010 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 September 15, 2010.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 1:00 p.m. on Thursday, July 29, 2010, in the ASD Conference Room, Plaza San Miguel, 729 St. Michael's Drive, Santa Fe.

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.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, 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 July 29, 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 regulations approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 4 OUT-OF-STATE AND BORDER AREA PROVIDERS

8.302.4.3 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[~~, or other state statute.~~] or by state statute. See NMSA 1978, Sections 27-2-12 et seq. (2006).
[2/1/95; 8.302.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3 & A, 8/14/08; A, 9/15/10]

8.302.4.6 OBJECTIVE: The objective of [~~these rules~~] this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.302.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6 & A, 8/14/08; A, 9/15/10]

8.302.4.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.~~] 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 life of their communities.
[2/1/95; 8.302.4.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 8/14/08; A, 9/15/10]

8.302.4.9 OUT-OF-STATE AND BORDER AREA PROVIDERS: Border area services are those that are rendered within 100 miles of the New Mexico state border (Mexico excluded). Out-of-state services are those that are rendered in an area more than 100 miles from the New Mexico border (Mexico excluded). To help New Mexico eligible recipients receive medically necessary services, [~~MAD~~] the medical assistance division (MAD) pays for border area services to the same extent and subject to the same rules and requirements that such services are covered when provided within the state. MAD pays for out-of-state services as described under 8.302.4.12 NMAC, *covered out-of-state services.*
[2/1/95; 8.302.4.9 NMAC - Rn, 8 NMAC 4.MAD.704 & A, 8/14/08; A, 9/15/10]

8.302.4.10 ELIGIBLE PROVIDERS: [~~Out-of-state providers and border providers must be licensed or certified by their respective states to be considered eligible to provide services to New Mexico recipients, or if providing a New Mexico home and community-based services waiver service to a New Mexico medicaid waiver recipient, a provider that meets the New Mexico home and community-based services waiver standards and requirements in all respects. To be reimbursed for furnishing services to New Mexico medicaid recipients, out-of-state or border providers must complete the New Mexico medical assistance program provider participation application and have the application approved by the New Mexico medical assistance division (MAD).~~

~~A. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. 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 instruction, utilization review instructions, and other pertinent materials. The following providers are eligible to apply for a provider participation agreement, bill and receive reimbursement for furnishing medical services:~~

~~(1) border area and out-of-state providers licensed by or certified by their respective states to practice medicine or osteopathy [42 CFR Section 440.50 (a)(1)(2)]; and other providers licensed or certified by their state to perform services equivalent to those covered by the medical assistance programs in New Mexico; practices or groups formed by these individuals may also receive reimbursement for services;~~

~~(2) border providers within 100 miles of the New Mexico state border (Mexico excluded), are subject to the rules governing the provision of services for an in-state provider; and~~

~~(3) out-of-state providers more than 100 miles from the New Mexico state border (Mexico excluded).~~

~~B. Once enrolled, a provider receives 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~~

~~materials 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.~~]

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 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. 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. The following providers are eligible to apply for a provider participation agreement, bill and receive reimbursement for furnishing medical services:

(1) border area and out-of-state providers licensed by or certified by their respective states to practice medicine or osteopathy [42 CFR Section 440.50 (a)(1)(2)]; and other providers licensed or certified by their state to perform services equivalent to those covered by the medical assistance programs in New Mexico; practices or groups formed by these individuals may also receive reimbursement for services;

(2) border area providers within 100 miles of the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider; and

(3) out-of-state providers more than 100 miles from the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider and any additional rules that may be specified for the specific services and providers within this manual.

[2/1/95; 8.302.4.10 NMAC - Rn, 8 NMAC 4.MAD.704.1 & A, 8/14/08; A, 9/15/10]

8.302.4.11 PROVIDER RESPONSIBILITIES: [~~A provider who furnishes services to medicaid and other health care program eligible recipients must comply with all federal and state laws and regulations relevant to the provision of services as specified in the MAD provider participation agreement. A provider must also conform to MAD program rules and instruction, as updated. A provider is also responsible for following coding manual guidelines and MS correct coding initiatives, including not improperly unbundling or upcoding services. 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.~~]

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 centers for medicaid and medicare (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 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. 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; 8.302.4.11 NMAC - Rn, 8 NMAC 4.MAD.704.2 & A, 8/14/08; 9/15/10]

8.302.4.12 COVERED OUT-OF-STATE SERVICES: MAD covers services and procedures furnished by [~~out-of-state providers when medically necessary for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition only~~] a provider located within 100 geographical miles of the New Mexico border, even though the road miles may be greater than 100 miles, to the same extent and using the same coverage rules as for an in-state provider. See 8.302.4.9 NMAC, *Out of State and Border Area Providers*. When it is the general practice for an eligible recipient in a New Mexico locality to access medical services in a location more than 100 geographical miles from the New Mexico border, MAD will treat that out-of-state location as a border area. MAD covers services and procedures furnished by a provider more than 100 geographical miles from the New Mexico border, excluding Mexico, to the extent and using the same coverage rules as for in-state provider when one or more of the following conditions are met.

A. An eligible recipient is out-of-state at the time the services are needed and the delivery of services is of an emergent or urgent nature or if the eligible recipient's health would be endangered by traveling back to New Mexico. Services must be medically necessary to stabilize the eligible recipient's health and prevent significant adverse health effects, including preventable hospitalization. Claims for such services are subject to pre-payment or post-payment reviews to assure the emergent or urgent need [~~for~~] or medical necessity of the services.

B. On-going-services provided by a medical assistance program within the state continue to be necessary when the eligible recipient is visiting another state.

C. [~~Care is medically necessary for eligible recipient foster children placed by the state of New Mexico in out-of-state homes or institutions.~~] Care is medically necessary for an eligible recipient that is placed by the state of New Mexico in foster care in an out-of-home placement or in an institution. Care is medically necessary for an eligible recipient that was adopted from New Mexico and resides out-of-state. If the agreement with the other state requires that state's medicaid program pay for covered services, MAD will only consider payment when a service is not covered by the other state and the eligible recipient would be eligible for that service if living in New Mexico.

D. Durable medical equipment, medical supplies, prosthetics or orthotics are purchased from out-of-state vendors.

E. Clinical laboratory tests, radiological interpretations, professional consultations or other services are performed by out-of-state laboratories but do not require the eligible recipient to leave the state.

F. Medical services or procedures considered medically necessary are not available in the state of New Mexico. All services that are not available in New Mexico require prior authorization when provided by an out-of-state provider. An out-of-state service may be limited to the closest provider or an otherwise economically prudent choice of provider capable of rendering the service.

G. Services, such as personal assistance, are needed by an eligible recipient out-of-state if that recipient is eligible to receive services through a medicaid home and community-based services waiver program and is traveling to another state.

[2/1/95; 8.302.4.12 NMAC - Rn, 8 NMAC 4.MAD.704.3 & A, 8/14/08; A, 9/15/10]

8.302.4.17 REIMBURSEMENT: Reimbursement to an out-of-state or border area provider is made at the same rate as for an in-state provider except as otherwise stated in the relevant specific providers and services sections of the MAD program rules manual.

[~~A. The billed charge must be provider's usual and customary charge for the service or procedure.~~]

[~~B. "Usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.~~]

A. Upon enrollment, 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 billed change which must be the provider's usual and customary charge for service; "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; or

(2) the MAD fee schedule for the specific service or procedure.

B. A provider agrees to be paid by a MAD managed care organization (MCOs) at an amount mutually-agreed between the provider and the MCO when the provider enters into a contract with an MCO contracted with HSD for the provision of managed care services to the MAD population. If the provider and the MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay the provider 90 percent of the "applicable reimbursement rate" based on the type of the provider. The "applicable

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

[2/1/95; 8.302.4.17 NMAC - Rn, 8 NMAC 4.MAD.704.6 & A, 8/14/08; A, 9/15/10]

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 2 HOSPITAL SERVICES

8.311.2.3 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 [~~Title XIX of~~] the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.311.2.3 NMAC - Rp/E, 8 NMAC 4.MAD.000.3, 1/1/09; A, 9/15/10]

8.311.2.6 OBJECTIVE: The objective of [~~these rules~~] this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.311.2.6 NMAC - Rp/E, 8 NMAC 4.MAD 000.6, 1/1/09; A, 9/15/10]

8.311.2.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.~~] 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 life of their communities.
[8.311.2.8 NMAC - Rp/E, 8 NMAC 4.MAD 000.8, 1/1/09; A, 9/15/10]

8.311.2.9 HOSPITAL SERVICES: [~~MAD~~] The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico [~~MAD~~] eligible recipients receive necessary services, MAD pays for inpatient, outpatient, and emergency services furnished in general hospital settings.
[8.311.2.9 NMAC – Rp/E, 8 NMAC 4.MAD 721, A, 9/15/10]

8.311.2.10 ELIGIBLE PROVIDERS [~~Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners of 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 contractor. 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 instruction, 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 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 found in 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.~~] 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 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. 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. Eligible providers include:

A. a general acute care hospital, rehabilitation, extended care or other specialty hospital

(1) licensed by the New Mexico department of health (DOH), and

(2) participating in the Title XVIII (medicare) program or accredited by the joint commission (previously known as JCAHO accreditation);

B. a rehabilitation inpatient unit or a psychiatric unit in an inpatient hospital (referred to as a prospective payment system exempt unit (PPS-exempt));

C. a free-standing psychiatric hospital may be reimbursed for providing inpatient and outpatient services to an eligible recipient under 21 years of age; see [~~*MAD-742.1]*~~ 8.321.2 NMAC, *Inpatient Psychiatric Services in Free-Standing Hospital;*.

D. a border area and out-of-state hospital is eligible to be reimbursed by MAD if its licensure and certification to participate in its state medicaid or medicare program is accepted in lieu of licensing and certification by MAD; and.

E. a hospital certified only for emergency services is reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.

[8.311.2.10 NMAC - Rp/E, 8 NMAC 4.MAD 721.1, 1/1/09; A, 9/15/10]

8.311.2.11 **PROVIDER RESPONSIBILITIES:**

A. A provider who furnishes services to [~~a MAD~~] an 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, as well as current 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 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. See 8.302.1 NMAC, *General Provider Policies*.

C. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed 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 [~~one hundred percent (100%)~~] shall accept, 90 percent of the "applicable reimbursement rate" based on the provider type.

(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 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.

[8.311.2.11 NMAC - Rp/E, 8 NMAC 4.MAD.721.2, 1/1/09; A, 9/15/10]

8.311.2.12 **COVERED SERVICES** MAD covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis, the treatment of an illness or injury or as required by the condition of the eligible recipient. MAD covers items or services ordinarily furnished by a hospital for the care and treatment of an eligible recipient. These items or services must be furnished under the direction of [~~a~~] an enrolled MAD physician, podiatrist, or dentist with staff privileges in a hospital which is an enrolled MAD provider. Services must be furnished within the scope and practice of the profession as defined by state laws and in accordance with applicable federal and state and local laws and regulations.

[8.311.2.12 NMAC - Rp/E, 8 NMAC 4.MAD 721.3, 1/1/09; A, 9/15/10]

8.311.2.14 **INPATIENT SERVICES:** MAD coverage of some inpatient services may be conditional or limited.

A. **Medically warranted days** A general hospital is not reimbursed for days of acute level inpatient services furnished to an eligible recipient as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

B. **Awaiting placement days:**

(1) When the MAD utilization review (UR) contractor determines that an eligible recipient no longer meets the care criteria in a rehabilitation, extended care or other specialty hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement in a lower level of care facility are termed "awaiting placement days". Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for the level of nursing facility services required by the eligible recipient (high NF or low NF).

(2) When the MAD UR contractor determines that a recipient under 21 years of age no longer meets acute care criteria and it is verified that an appropriate reviewing authority has made a determination that the eligible recipient requires a residential level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement to the lower level of care are termed "awaiting placement days". MAD does not cover residential care for individuals over 21 years of age.

(3) Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for residential services that may have different levels of classification based on the medical necessity for the placement of the eligible recipient. See 8.302.5 NMAC, [~~*MAD Billing Instructions*~~] *Prior Authorization and Utilization Review*. A separate claim form must be submitted for awaiting placement days.

(4) MAD does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits~~,~~ or**,** in the case of the eligible recipient under twenty-one (21) years of age requiring residential services, licensed Ph.D. psychologist visits, are not included in this limitations.

C. **Private rooms:** A hospital is not reimbursed for the additional cost of a private room unless the private room is medically necessary to protect the health of the eligible recipient or others.

D. **Services performed in an outpatient setting:** MAD covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.

(1) An eligible recipient may be hospitalized if there is an existing medical condition which predisposes the eligible recipient to complications even with minor procedures.

(2) All claims for one- or two-day stays for hospitalization are subject to pre-payment or post-payment review.

E. **Observation stay:** If a physician orders an eligible recipient to remain in the hospital for less than twenty-four (24) hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

(1) The following are exemptions to the general observation stay definition:

(a) the eligible recipient dies;

(b) documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by his legal guardian against medical advice;

(c) an eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or

(d) an inpatient admission results in delivery of a child.

(2) MAD or its designee determines whether an eligible recipient's admission falls into one of the exempt categories or considers it to be a one-or two- day stay.

(a) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

(b) A hospital must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

(3) The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. See MAD 953, *Reconsideration of Utilization Review Decisions.*

(4) The observation stay review does not replace the review of one- and two-day stays for medical necessity.

(5) MAD does not cover medically unnecessary admissions, regardless of length of stay.

F. **Review of hospital admissions:** All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different

hospital, and readmission are reviewed by MAD or its designee. MAD or its designee performs a medical review to verify the following:

(1) admission to acute care hospital is medically necessary;

(2) all hospital services and surgical procedures furnished are appropriate to the eligible recipient's condition and are reasonable and necessary to the care of the eligible recipient;

(3) patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected; hospitals are not reimbursed for inappropriate admissions or transfers; and

(4) the method of payment and its application by a hospital does not jeopardize the quality of medical care.

G. **Non-covered services:** MAD does not cover the following specific inpatient benefits:

(1) a hospital service which is not considered medically necessary by MAD or its designee for the condition of the eligible recipient;

(2) a hospital service that requires prior authorization for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) a hospital service which is furnished to an individual who was not eligible for MAD services on the date of service;

(4) an experimental or investigational procedure, technology or therapy and the service related to it, including hospitalization, anesthesiology, laboratory tests, and imaging services; see MAD-765, *Experimental or Investigational Procedures or Therapies*;

(5) a drug classified as "ineffective" by the federal food and drug administration;

(6) private duty or incremental nursing services;

(7) laboratory specimen handling or mailing charges; and

(8) formal educational or vocational training services which relate to traditional academic subjects or training for employment.

H. **Covered services in hospitals certified for emergency services-only:** Certain inpatient and outpatient services may be furnished by a hospital certified to participate in the Title XVIII (medicare) program as an emergency hospital. MAD reimburses a provider only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the eligible recipient which necessitates the use of the most accessible hospital equipped to furnish emergency services.

(1) MAD covers the full range of inpatient and outpatient services furnished to an eligible recipient in an emergency situation in a hospital which is certified for emergency services-only.

(2) MAD reimbursement for emergency services furnished in a hospital certified for an emergency services-only is made for the period during which the emergency exists.

(a) Documentation of the eligible recipient's condition, the physician's statement that emergency services were necessary, and the date when, in the physician's judgment, the emergency ceased, must be attached to the claim form.

(b) An emergency no longer exists when it becomes safe from a medical standpoint to move the eligible recipient to a certified inpatient hospital or to discharge the eligible recipient.

(c) Reimbursement for services in an emergency hospital is made at a percentage of reasonable charges as determined by HSD. No retroactive adjustments are made.

I. **Patient self determination act:** An adult eligible recipient must be informed of his right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies*.

J. **Psychiatric services furnished to an eligible recipient under 21 years of age in PPS-exempt units of acute care hospitals:** Services furnished to [~~a MAD~~] an eligible recipient must be under the direction of a physician. In the case of psychiatric services furnished to an eligible recipient under 21 years of age, these services must be furnished under the direction of board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of an eligible recipient under 12 years of age, the psychiatrist must be board eligible/board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and under 21 years of age may 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; and

(2) at the time of admission, a 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; and

(3) another facility which is able to furnish a 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 arrangements to the care of a 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 with the understanding that if the eligible recipient needs to transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

K. **Reimbursement for inpatient services**: MAD reimburses for inpatient hospital services using different methodologies. See 8.311.3 NMAC, *Methods and Standards for Establishing Payment Rates – Inpatient Hospital Services.*

(1) all services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider may bill for services or supplies; an exception to this general rule applies to durable medical equipment delivered for discharge and ambulance transportation.

(2) A physician's services are not reimbursed to a hospital under Hospital Services regulations, but may be payable as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*, for information on the professional component of services.

(3) Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.

(a) Transportation is included in a DRG payment when an eligible recipient is transported to a different facility for procedure(s) not available at the hospital where the eligible recipient is a patient.

(b) Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See 8.324.7 NMAC, *Transportation Services.*

L. **Reimbursement limitations for capital costs** Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

(1) The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a MAD provider.

(2) The cost of construction is expected to include only the cost of buildings and fixed equipment.

(3) A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

[8.311.2.14 NMAC – Rp/E, 8 NMAC 4.MAD 721.5, 1/1/09; A, 9/15/10]

8.311.2.15 **OUTPATIENT SERVICES:** MAD covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of an eligible recipient. Services must be furnished within the scope and practice of a professional provider as defined by state laws and regulations.

A. **Outpatient covered services:** Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. A partial hospitalization program in a general hospital psychiatric unit is considered under outpatient services. See 8.321.5 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization.*

B. **Outpatient noncovered services** MAD does not cover the following specific outpatient benefits:

(1) outpatient hospital services not considered medically necessary for the condition of the eligible recipient;

(2) outpatient hospital services that require prior approval for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) outpatient hospital services furnished to an individual who was not eligible for MAD services on the date of service;

(4) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(5) drugs classified as "ineffective" by the federal food and drug administration;

(6) laboratory specimen handling or mailing charges; and

(7) formal educational or vocational services which relate to traditional academic subjects or training for employment;

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, 90 percent of the "applicable reimbursement rate" based on the provider type; and

(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.

C. **Prior authorization:** Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, and speech therapies services require prior authorization. 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, 90 percent of the "applicable reimbursement rate" based on the provider type; and

(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 , medical education payments, and final cost settlement adjustments to interim rates.

D. **Reimbursement for outpatient services** [~~Effective January 1, 2009,~~] Effective September 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates.

(1) Reimbursement for laboratory services, [~~and~~] radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals which purchase drugs items at 340-B prices may not bill for more than their 340-B cost.

[~~(2) Reimbursement for oral medications dispensed in a hospital outpatient setting is limited to usual charges up to a maximum of two dollars per visit per eligible recipient.~~

~~(3)~~] (2) Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on approved methods. See 8.302.2 NMAC, *Billing For Medicaid Services.*

[~~(4)~~] (3) [~~For MAD fee-for-service (FFS) contracted providers only, when applicable due to federal requirements, the OPPS rates will be implemented following approval of the New Mexico state plan by the centers for medicare and medicaid services (CMS). Until implemented, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent (3%). The interim rate of payment is established by MAD.~~] For services not reimbursed using the outpatient prospective payment system (OPPS) methodology or fee schedule, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent. An interim rate of payment is established by MAD. A rate of payment for providers not subject to the cost settle process is also established by MAD. Both 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.

[8.311.2.15 NMAC - Rp/E, 8 NMAC 4.MAD 721.6, 1/1/09; A, 9/15/10]

8.311.2.16 **EMERGENCY ROOM SERVICES:** MAD covers emergency room services which are medically necessary for the diagnosis and treatment of medical or surgical emergencies to an eligible recipient and which are within the scope of the MAD program.

A. **Covered emergency services:** [~~A medical or surgical emergency is defined as a condition which develops unexpectedly and requires immediate medical attention to prevent death or serious impairment to the health of an eligible recipient.~~] An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

B. **Retrospective review:** An emergency room service may be subject to prepayment or post-payment review. [~~verifying whether or not the circumstances warranted emergency room service. If it is determined that an emergency service was furnished in a non-emergency situation, the emergency room charge may be denied.~~

~~(1) The eligible recipient or their personal representative is responsible for payment of a denied emergency room charge and may be billed directly by the provider.~~]

~~(2) The use of an ancillary service is reviewed and paid if medically appropriate for the condition treated, even though the condition was not an emergency. An ancillary service which is denied as not medically appropriate may not be billed to the eligible recipient or their personal representative.~~] A provider, including an enrolled provider, a non-enrolled provider, a managed care organization provider, or an out of network provider cannot bill an eligible recipient for emergency room services including diagnostic and ancillary services which have been denied due to lack of medical necessity or lack of being an emergency except as specifically allowed by 8.302.2 NMAC, *Billing for Medicaid Services*. When an eligible recipient has identified himself or herself to a provider as a Medicaid eligible recipient and is enrolled in a managed care organization, the provider of services must accept and adhere to the provisions of 42 CRF 438 Subpart C Enrollee Rights and Protections which state the administrative and payment responsibilities of a managed care organization and limit the financial responsibilities that can be passed on to an eligible recipient. Payment may be limited to medically necessary diagnostic and treatment services to sufficiently assess the recipient's condition and need for emergency services, the duration of a condition, and available alternatives to emergency room services.

C. **Prior authorization:** Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non-emergency settings also require prior approval in emergency settings.

D. **Noncovered emergency services:** MAD does not cover the following specific emergency services:

(1) [~~emergency~~] diagnostic and ancillary services which are not considered medically necessary as emergency services;

(2) emergency services furnished to individuals who were not eligible for MAD services on the date of service;

(3) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(4) drugs classified as "ineffective" by the federal food and drug administration; and

(5) laboratory specimen handling or mailing charges.

E. **Reimbursement for emergency room service:** An emergency service furnished by an eligible provider is reimbursed [~~at the outpatient rate~~] as outpatient hospital services. See Section D of 8.311.2 NMAC, *Reimbursement for Outpatient Services.*

(1) An emergency room service furnished in a DRG- reimbursed hospital in conjunction with an inpatient admission is included with the charges for inpatient care. In this case, a payment for an emergency room service is included in the DRG rate.

(2) A physician's service furnished in an emergency room is not reimbursed to a hospital but may be paid as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*.

(3) A service furnished in an urgent care center of a hospital which does not meet the definition of an emergency, may not be submitted as an emergency room service.

[8.311.2.16 NMAC – Rp/E, 8 NMAC 4.MAD 721.7, 1/1/09; A, 9/15/10]

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

8.321.2.3 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[~~, or other state statute.~~] or by state statute. See NMSA 1978, Sections 27-2-12 et seq. [~~(Repl. Pamp. 1991)~~] (2006).
[8.321.2.3 NMAC - Rp, 8 NMAC 4.MAD.000.3, A, 9-15-10]

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, 9-15-10]

8.321.2.6 OBJECTIVE: The objective of [~~these rules~~] this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.321.2.6 NMAC - Rp, 8 NMAC 4.MAD.000.6; A, 9-15-10]

8.321.2.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) of HSD is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.~~] 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.
[8.321.2.8 NMAC - Rp, 8 NMAC 4.MAD.002; A, 9-15-10]

8.321.2.9 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: [~~The New Mexico medicaid program (medicaid)~~] MAD pays for medically necessary health services furnished to eligible recipients. To help recipients under [~~twenty-one (21)~~] 21 years of age receive necessary mental health services, [~~the New Mexico~~] 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 then 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. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[8.321.2.9 NMAC - Rp, 8 NMAC 4.MAD.742.1; A, 9-15-10]

8.321.2.10 ELIGIBLE PROVIDERS: [~~Upon approval of New Mexico medical assistance program provider participation agreements by MAD, freestanding psychiatric hospitals are eligible to be reimbursed for services to recipients under 21 years of age through EPSDT. The hospital must be accredited by the joint commission on accreditation of healthcare organizations (JCAHO) and licensed by the licensing and certification bureau of the New Mexico department of health (DOH); and the hospital must have a written utilization review (UR) plan in effect which provides for the review of the recipient's need for the furnished services that meet federal requirements. See 42 CFR Sections 456.201-456.245. Out-of-state hospitals, JCAHO accredited and licensed in their own state, are accepted in lieu of New Mexico licensure. MAD must approve the out-of-state hospital's New Mexico medical assistance program provider participation application before it furnishes services. 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.~~]

A. 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. Eligible providers include:

(1) accredited by at least one of the following:

(a) the Joint Commission (JO) (formerly known as Joint Commission on Accreditation of Healthcare Organizations); or

(b) the Council on Accreditation of Services for Families and Children (COA); of

(c) the Commission on Accreditation of Rehabilitation Facilities (CARF); or

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

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH) or the comparable agency in another state; and

(3) has 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; and

(4) must be an approved MAD provider before it furnishes services. See 42 CFR Sections 456.201 through 456.245.

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.

[8.321.2.10 NMAC - Rp, 8 NMAC 4.MAD.742.11; A, 9-15-10]

8.321.2.11 PROVIDER RESPONSIBILITIES: [~~Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, 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 Section MAD-701, GENERAL PROVIDER POLICES. Providers must maintain records documenting the source and amount of any financial resources collected or received by providers on behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.~~]

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. 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 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, 90 percent of the "applicable reimbursement rate" based on the provider type; and

(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.

[~~C.~~] D. 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.
[8.321.2.11 NMAC - Rp, 8 NMAC 4.MAD.742.12; A, 9-15-10]

8.321.2.12 COVERED SERVICES: [~~Medicaid~~] 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 [~~a~~] 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 [~~a~~] 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 eligible recipients under 12 years of age, a child psychiatrist are 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 [~~Medicaid~~] 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 [~~recipients~~] an eligible recipient in self- administration of medication in compliance with state policies and procedures;

(5) appropriate staff available on a [~~twenty-four (24)~~] 24 hour basis to respond to crisis situations, determine the severity of the situation, stabilize [~~recipients~~] 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, 9-15-10]

8.321.2.13 NONCOVERED SERVICES: Services furnished in freestanding psychiatric hospitals are subject to the limitations and coverage restrictions which exist for other [~~Medicaid~~] MAD services. [~~See Section MAD-602, GENERAL NONCOVERED SERVICES.~~] See 8.301.3 NMAC, *Medicaid General Non Covered Services*. [~~Medicaid~~] MAD does not cover the following specific services for [~~recipients~~] 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);

[~~B.~~] C. Services for which prior [~~approval~~] authorization was not obtained;

[~~C.~~] D. Services in freestanding psychiatric hospital for [~~Medicaid recipients 22~~] eligible recipient 21 years of age or older.

[~~D.~~] E. Services furnished after the determination by MAD or its designee has been made that the eligible recipient no longer needs hospital care;

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

[~~F.~~] G. Experimental or investigational procedures, technologies, or non-drug therapies and related services or treatment;

[~~G.~~] H. Drugs classified as "ineffective" by the FDA drug evaluation; and

[~~H.~~] I. Activity therapy, group activities, and other services primarily recreational or diversional in nature.

[~~I.~~] J. [~~Medicaid~~] MAD covers “awaiting placement days” in freestanding psychiatric hospitals when the MAD utilization review (UR) contractor determines that [~~a~~] 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.

[~~J.~~] K. Those days during which the eligible recipient is awaiting placement to the lower level of care are termed awaiting placement days.

[~~K.~~] L. Payment to the hospital for awaiting placement days is made at the weighted average rate paid by [~~Medicaid~~] 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, 9-1510]

8.321.2.14 TREATMENT PLAN: [~~An individualized~~] The treatment plan must be developed by a team of professionals in consultation with an eligible recipient, [~~parents~~] parent(s), legal [~~guardians~~] guardian(s) or others in whose care the eligible recipient will be released after discharge. The plan must be developed within [~~fourteen (14) days~~] 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 [~~30~~] 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 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:~~

~~(i) mental status assessment;~~

~~(ii) intellectual function assessment;~~

~~(iii) psychological assessment;~~

~~(iv) educational assessment;~~

~~(v) vocational assessment;~~

~~(vi) social assessment;~~

~~(vii) medication assessment; and~~

~~(viii) physical assessment.~~

~~C. statement of the least restrictive conditions necessary to achieve the purposes of treatment;~~

~~D. description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;~~

~~E. 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;~~

~~F. 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 recipient; and~~

~~C. criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.~~] 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.

B. 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 8.321.2.14A 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, 9-15-10]

8.321.2.15 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: All [~~Medicaid~~] 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 Section MAD 705, PRIOR APPROVAL AND UTILIZATION REVIEW.~~] See 8.302.5 NMAC, *Prior Authorization and Utilization Review.* Once enrolled, providers receive instructions and documentation forms necessary for prior [~~approval~~] authorization and claims processing.

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

B. Prior [~~approval~~] authorization of services does not guarantee that individuals are eligible for [~~Medicaid~~] MAD services. Providers must verify that [~~individuals are~~] an individual is eligible for [~~Medicaid~~] MAD services at the time services are furnished and determine if [~~medicaid recipients have~~] the eligible recipient

has other health insurance.

C. [~~Providers who disagree~~] A provider who disagrees with prior [~~approval~~] authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decision.*

[8.321.2.15 NMAC - Rp, 8 NMAC 4.MAD.742.16; A, 9-15-10]

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 [~~has a case manager~~] 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, 9-15-10]

8.321.2.17 REIMBURSEMENT: Freestanding psychiatric hospital service providers must submit claims for reimbursement on the [~~UB92~~] UB04 claim form or its successor. [~~See Section MAD-702, BILLING FOR MEDICAID SERVICES.~~] See 8.302.2 MAC, *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 Section II, Payment Methodology for PPS-Exempt Hospitals and Exempt Units Within Hospitals, and Section V, Determination of Actual, Allowable and Reasonable Costs contained in 8.311.3 NMAC, *Methods and Standards for Establishing Payment – Inpatient Hospital Services*.

B. [~~Reimbursement rates for hospitals outside New Mexico are 75 percent of billed charges or a negotiated rate, not to exceed the rate of federal programs such as CHAMPUS or medicare. Negotiation of rates is allowed only when MAD determines that the hospital provides a unique services required by recipients.~~] Reimbursement rates for hospitals not subject to cost settlement are paid at a percent of billed charges on a fee schedule rate established by the department 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. Negotiation of rates is allowed only when MAD determines that the hospital provides a unique service required by an eligible recipient.

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 NMAC, *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, 9-15-10]