State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
ANESTHESIA SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department, Medical Assistance Division (MAD), is proposing a change to the Medicaid anesthesia provider reimbursement. Along with these proposed changes in benefits, the entire rule, 8.310.5 NMAC, *Anesthesia Services*, was reviewed for clarity resulting in additional changes in the wording but not otherwise affecting the benefits of the program.

If implemented as proposed, Medicaid anesthesia services rules will closely parallel the Medicare methodology for payment. MAD will then implement the anesthesia schedule to be 105% of the Medicare 2007 schedule. To implement the Medicaid fee schedule, MAD will use: (1) the Current Procedural Terminology (CPT) anesthesia procedure codes rather than the surgical procedure codes currently used; (2) Medicare base units; and (3) 105% of the Medicare 2007 fee schedule conversion factor for pricing base and time units. The conversion factor used will be $16.55.

The anticipated over all financial impact will be an increase in payment for base units due to using Medicare base units, and a decrease in payment for time units due to the lower conversion rate based on Medicare resulting in an estimated reduction in fee-for-service program payments of approximately $60,000 annually. The proposed payment schedule may be seen on the MAD website at http://www.hsd.state.nm.us/mad/PFeeSchedules.html.

Other changes in the rule being proposed at this time include the following:

- Replacing outdated word usage, such as Medicaid with MAD, the Medical Assistance Division;
- Providing more instruction on the eligibility of providers and their responsibilities;
- Directing providers to enroll and follow a managed care or coordinated care contractor's instructions for billing and authorization of services;
- Requiring documentation of complications and emergency conditions for payment based on additional units and reimbursement;

- Adding language to align MAD rules with Medicare reimbursement practices including eliminating separate payment for qualifying circumstances and physical status modifier.

VI. RULES

These proposed rule changes refer to 8.310.5 NMAC of the Medical Assistance Program Policy Manual. This register is available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010 . The proposed rule changes are attached to the register. 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 10:00 a.m. on Thursday, July 29, 2010, in the South Park conference room, 2055 S. Pacheco, Ste. 500-590, Santa Fe, NM.

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 rules approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 5 ANESTHESIA SERVICES

8.310.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.310.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 6/1/03; A, 9/15/10]

8.310.5.3 STATUTORY AUTHORITY: [~~The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA, 1978 (Repl. Pamp. 1991.~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[2/1/95; 8.310.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 6/1/03; A, 9/15/10]

8.310.5.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.310.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 6/1/03; A, 9/15/10]

8.310.5.6 OBJECTIVE: [~~The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review and provider reimbursement.~~] The objective of these rules is to provide instruction for the service portion of the New Mexico medicaid program.
[2/1/95; 8.310.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 6/1/03; A, 9/15/10]

8.310.5.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid eligible individuals to 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.
[2/1/95; 8.310.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 6/1/03; A, 9/15/10]

8.310.5.9 ANESTHESIA SERVICES: [~~The New Mexico medicaid program (medicaid)~~] The medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico [~~medicaid~~] eligible recipients receive medically necessary services, [~~the New Mexico medical assistance division (MAD)~~] MAD pays for covered anesthesia services. [~~This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.~~]
[2/1/95; 8.310.5.9 NMAC - Rn, 8 NMAC 4.MAD.714 & A, 6/1/03; A, 9/15/10]

8.310.5.10 ELIGIBLE PROVIDERS: [~~Upon approval of medical assistance division program provider participation agreements by MAD, the following providers are eligible to be reimbursed for providing anesthesia services:~~]

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 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:

[~~A.~~] (1) Individuals licensed to practice medicine or osteopathy who are certified or eligible to be certified by the American board of anesthesiology. Payments are made to an individual [~~providers~~] provider or the group practices to which they belong; for physicians not certified or eligible to be certified by the American board of anesthesiology, anesthesia services are limited to their scope of practice as determined by the medical board.

[~~B.~~] (2) Nurse anesthetists certified by the American association of nurse anesthetists council of certification and licensed as registered nurses[~~,~~] within the scope of their practice and specialty as defined by state law.

[~~C.~~] (3.) [~~Anesthesiologist~~] Anesthesiology assistants certified by the national commission on the certification of [~~anesthesiologists~~] anesthesiology assistants (NCCAA) and licensed as [~~anesthesiologist~~] anesthesiology assistants within the scope of their practice and specialty as defined by state law.

[~~D. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.~~]

B. 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; 8.310.5.10 NMAC - Rn, 8 NMAC 4.MAD.714.1 & A, 6/1/03; A, 9/15/10]

8.310.5.11 PROVIDER RESPONSIBILITIES: [~~Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, General Provider Policies. 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 provided to recipients. See 8.302.1 NMAC, General Provider Policies.~~]

A. A provider who furnishes services to medicaid and other health care programs eligible recipients must comply with all federal and state laws, regulations, and executive orders relevant to the provision of medical services as specified in the MAD provider participation agreement. A provider must adhere to the MAD program rules and instruction as specified in this manual and its appendices, and program directions and billing instruction as specified in this 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 up-coding services. See 8.302.1 NMAC, *General Provider Policies*.

B. A provider must verify that individuals are eligible for a specific health care program administered by 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.*

[2/1/95; 8.310.5.11 NMAC - Rn, 8 NMAC 4.MAD.714.2, 6/1/03; A, 915/10]

8.310.5.12 COVERED SERVICES: [~~Medicaid~~] MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the eligible recipient. All services must be provided within the limits of [~~medicaid~~] MAD benefits, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and regulations.

[2/1/95; 8.310.5.12 NMAC - Rn, 8 NMAC 4.MAD.714.3, 6/1/03; A, 9/15/10]

8.310.5.13 PRIOR APPROVAL 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 Section [~~MAD-705 [8.302.5 NMAC~~] 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 instruction. 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 approval:** Certain procedures or services can require prior approval 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.~~] process, including after payment has been made. See Subsection A of 8.311.2.16 NMAC, *Emergency Room Services.*

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

C. **Reconsideration**: [~~Providers~~] A provider who [~~disagree~~] disagrees with prior [~~approval~~] authorization request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953 [8.350.2 NMAC], Reconsideration of Utilization Review Decisions.

[2/1/95; 8.310.5.13 NMAC - Rn, 8 NMAC 4.MAD.714.4, 6/1/03; A, 9/15/10]

8.310.14 NONCOVERED SERVICES: Anesthesia services are subject to the limitations and coverage restrictions which exist for other [~~medicaid~~] MAD services. See [~~Section MAD-602 [8.301.3 NMAC]~~] 8.301.3 NMAC, General Noncovered Services.

(A) When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

(B) An anesthesia service is not payable if the medical or surgical procedure is not a medicaid or other health care benefit.

(C) Separate payment is not allowed for qualifying circumstances; payment is considered bundled into the anesthesia allowance.

(D) Separate payment is not allowed for modifiers (modifiers that begin with the letter "P") that are used to indicate that the anesthesia was complicated by the physical status of the patient.

[2/1/95; 8.310.5.14 NMAC - Rn, 8 NMAC 4.MAD.714.5, 6/1/03; A, 9/15/10]

8.310.5.15 REIMBURSEMENT:

A. [~~Anesthesia providers~~] An anesthesia provider must submit claims for reimbursement on the [~~HCFA-1500~~] CMS 1500 claim form or its successor. [~~See Section MAD-702 [8.302.2 NMAC]~~] See 8.302.2 NMAC, *Billing forMedicaid Services.* [~~Once enrolled, providers receive instructions on documentation, billing and claims processing.~~] Reimbursement for anesthesia services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the maximum allowed by MAD for the specific service or procedure.

[~~(a) The provider's billed charge must be their usual and customary charge for services.~~

~~(b) "Usual and customary charge" refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.~~]

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

C. "Usual and customary charge" refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.

[~~B.~~] D. **Reimbursement units:** Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia [~~"base units",~~] "base units" plus units for time.

(1) Each [~~surgical~~] anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the [~~dollar amount~~] conversion factor allowed for each unit.

(2) The [~~dollar amounts allowed~~] reimbursement per anesthesia unit [~~vary~~] varies depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse [~~anesthesiologist~~] anesthetist (CRNA), [~~anesthesiologist~~] anesthesiology assistant (AA) and a non-directed CRNA.

(3) Time units vary, depending on the service. For anesthesia provided directly by a physician anesthesiologist, CRNA, or an [~~anesthesiologist~~] anesthesiology assistant, one [~~(1)~~] time unit is allowed for each [~~fifteen (15)~~] 15 minute period [~~a~~] an eligible recipient is under anesthesia. For medical direction, one [~~(1)~~] time unit is allowed for each [~~thirty (30)~~] 15 minute period.

[~~C.~~] E. **Medical direction:** Medical direction by a physician anesthesiologist, not the surgeon or assistant surgeon, to a certified registered nurse anesthetist (CRNA) or an [~~anesthesiologist~~] anesthesiology assistant (AA) is [~~payable using the following methodologies:~~] paid on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving an eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-eligible recipients and the remaining a MAD eligible recipient, this represents three concurrent cases.

[~~(1) For medical direction of two (2) nurse anesthetists or AA's performing two (2) concurrent procedures, the base units are reduced by ten percent (10%);~~

~~(2) For medical direction of three (3) nurse anesthetists performing three (3) concurrent procedures, the base units are reduced by twenty-five percent (25%); and~~

~~(3) For medical direction of four (4) nurse anesthetists performing four (4) concurrent procedures, the base units are reduced by forty percent (40%).~~]

[~~(a)~~] (1) Time units for medical direction are allowed at one [~~(1)~~] time unit for each [~~thirty (30)~~] 15 minute interval.

[~~(b) All the following requirements must be met before anesthesiologists are reimbursed for medical direction:~~

~~(a) the anesthesiologist does not perform any other service during the same period of time;~~

~~(b) the anesthesiologist cannot furnish anesthesia and provide medical direction concurrently;~~

~~(c) the anesthesiologist provides pre-anesthesia examinations or evaluations;~~

~~(d) the anesthesiologist participates in the anesthesia plan, including induction and emergence;~~

~~(e) the anesthesiologist monitors the course of anesthesia administration at frequent intervals;~~

~~(f) the anesthesiologist remains physically present and available in the operating suite for immediate diagnosis and treatment of emergencies; and~~

~~(g) the anesthesiologist provides any indicated post-anesthesia care.~~]

(2) Medical direction is a covered service only if the physician:

(a) performs a pre-anesthesia examination and evaluation; and

(b) prescribes the anesthesia plan; and

(c) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(d) ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified anesthetist; and

(e) monitors the course of anesthesia administration at frequent intervals; and

(f) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) provides indicated post-anesthesia care.

(3) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(4) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(5) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(6) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

[~~D.~~] F. **Monitored anesthesia care:** Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(1) "Monitored anesthesia care" [~~as defined by the American society of anesthesiologists~~] is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological eligible recipient reaction to the surgical procedure and includes:

(a) performance of a pre-anesthetic examination and evaluation;

(b) prescription of the [~~anesthetic~~] anesthesia care required;

(c) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the eligible recipient's physiological signs;

(d) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(e) provision of indicated postoperative anesthesia care.

(2) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

[~~(2)~~] (3) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

G. **Medical supervision:** If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised as opposed to medically directed anesthesia services. The MAD payment to the CRNA will be 50 percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.

[~~E. Epidural rates:~~ ~~Reimbursement for an initial epidural is paid using the base units for the procedure plus time units required to perform the initial procedure. No additional units for risk factors or time can be billed for epidural anesthesia. All subsequent epidural injections are paid at one (1) unit per injection.~~]

H. **Obstetric anesthesia:** Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

I. **Unusual circumstances:** When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the patient's record.

J. **Pre-anesthetic exams/cancelled surgery:** A pre-anesthetic examination and evaluation of a patient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

[~~E~~] K. **Performance of standard procedures:** If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units or units for time.

L. **Add-on codes for anesthesia:** Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

M. **Anesthesia services furnished by the same physician providing the medical and surgical service:**

(1) A physician who both performs and provides moderate sedation for medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who performs and provides local or minimal sedation for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

(a) local or topical anesthesia; to
(b) moderate (conscious) sedation; to
(c) regional anesthesia; to
(d) general anesthesia.

(2) moderate sedation is a drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

N. **Reimbursement for services furnished by interns or residents:**

(1) Reimbursement in an approved teaching program: reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in another hospital that participates in a teaching program is made through an institutional reimbursement; MAD cannot be billed directly by an intern or a resident for these services.

(2) Services performed in an outpatient and an emergency room setting: medical or surgical services performed by an intern or a resident in a hospital outpatient department or emergency room, that are unrelated to educational services, are reimbursed according to the fee schedule for physician services when all of the following provisions are met:

(a) services are identifiable physician services that are performed by the physician in person; and
(b) services must contribute to the diagnosis or treatment of the eligible recipient's medical condition; and
(c) an intern or resident is fully licensed as a physician; and
(d) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and
(e) services are excluded from outpatient hospital costs; when these criteria are met, the services are considered to have been furnished by the practitioner in their capacity as a physician and not as an intern or resident.

(3) Services of an assistant surgeon in an approved teaching program:

(a) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since a resident is available to perform services, unless the following exceptional medical circumstances exist:
(i) an assistant surgeon is needed due to unusual medical circumstances;
(ii) the surgery is performed by a team of physicians during a complex procedure; or
(iii) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the eligible recipient's medical condition.

(b) this reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

[2/1/95; 8.310.5.15 NMAC - Rn, 8 NMAC 4.MAD.714.6 & A, 6/1/03; A, 9/15/10]