State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
BILLING FOR MEDICAID SERVICES

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 8.302.2 NMAC, *Billing for Medicaid Services,* to provide information to providers on how to correctly report service units. It is the Department's intention to follow the Centers for Medicare and Medicaid Services (CMS) guidelines for reporting service units for reimbursement. Also in this rule, the Department is proposing if an eligible recipient's provider has inappropriately turned that eligible recipient's account over to a collection entity, the provider must now notify the eligible recipient they have directed the collection entity to stop further actions or demands against the eligible recipient. The eligible recipient will now have the information which allows the eligible recipient to verify that his/her credit report has been corrected by the collection entity.

VI. RULES
These proposed rule changes refer to 8.302.2 NMAC *Billing for Medicaid Services* of the Medical Assistance Program Policy Manual. The proposed changes are attached to this register which has been posted to our website at www.hsd.state.nm.us/mad/registers/2011. 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 December 1, 2011.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed rules will be held at 10:30 am on October, 19, 2011 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:

Sidonie Squier, 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 October 19, 2011. 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: Barbara.watkins@state.nm.us.

X. PUBLICATIONS

Publication of these rules approved by:

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SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

ITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 2 BILLING FOR MEDICAID SERVICES

8.302.2.10 BILLING INFORMATION:

A. **Billing for services:** MAD only makes payment to a provider or to the following individuals or organizations for services:

(1) a government agency or third party with a court order, based on a valid provider payment assignment. See 42 CFR Section 447.10(d)(e); or

(2) a business agent, such as billing service or accounting firm that provides statements and receives payment in the name of the provider. The agent's compensation must be related to the cost of processing the claims and not based on a percentage of the amount that is billed or collected or dependent upon collection of the payment.

B. **Billing for services from group practitioners or employers of practitioners:** MAD may make payments to a group practice and to an employer of an individual practitioner if the practitioner is required to turn over his fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2)(3). MAD may make payments to a facility where the services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system if the facility, foundation, plan, or organization is required by contract to submit claims for an individual practitioner.

C. **Billing for referral services:** A referring provider must submit to the provider receiving the referral, specimen, image, or other record, all information necessary for the provider rendering the service to bill MAD within specified time limits. An eligible recipient or their personal representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider.

D. **Hospital-based services:** For services that are hospital based, the hospital must provide MAD recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, their personal representative, or MAD is not responsible for payment if the hospital-based provider does not obtain this information from the hospital as necessary to bill MAD within the specified time limits.

E. **Coordinated service contractors:** Some MAD services are managed by a coordinated service contractor. Contracted services may include behavioral health services, dental services, physical health services, transportation, pharmacy or other benefits as designated by the medical assistance division. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.

F. Reporting of service units: A provider must correctly report service units.

(1) For current procedural terminology (CPT) codes or healthcare common procedural coding system (HCPCS) codes that describe how units associated with time should be billed, providers are to follow those instructions.

(2) For CPT or HCPCS for services for which the provider is to bill 1 unit per 15 minute or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or 1 hour.

time spent	**number of 15-minute units that may be billed**	**number of 1-hour units that may be billed**
Less than 8 minutes	0 *services that are in their entirety less than 8 minutes cannot be billed.*	0 *services that are in their entirety less than 8 minutes cannot be billed.*
8 minutes through 22 minutes	1	.25
23 minutes through 37 minutes	2	.5
38 minutes through 52 minutes	3	.75
53 minutes through 67 minutes	4	1
68 minutes through 82 minutes	5	1.25
83 minutes through 97 minutes	6	1.5

(3) Only time spent directly working with an eligible recipient to deliver treatment services is counted toward the time codes.

(4) Total time spent delivering each service using a timed code must be recorded in the medical record of each eligible recipient. If services provided are appropriately described by using more than one CPT or HCPCS code within a single calendar day, then the total number of units that can be billed is limited to the total treatment time. Providers must assign the most units to the treatment that took the most time.

(5) The units for codes do not take precedence over CMS's national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to 8.310.5 NMAC, *Anesthesia Services.*

(7) Units billed by a home and community-based services waiver provider, a behavioral health provider, an early intervention provider, and all rehabilitation services providers must also follow the requirements of this section unless exceptions are specifically stated in published MAD program rules or provider billing instructions.

[2/1/95; 8.302.2.10 NMAC - Rn, 8 NMAC 4.MAD.702.1, 5/1/04; A, 7/1/05; A, 5/1/10; A, 12/1/11]

8.302.2.11 BILLING AND CLAIMS FILING LIMITATIONS:

A. Claims must be received within the MAD filing limits as determined by the date of receipt by MAD or its selected claims processing contractor.

(1) Claims for services must be received within 90 calendar days of the date of service unless an alternative filing limit is stated within this section.

(2) Inpatient hospital and other inpatient facility claims must be received within 90 calendar days of the date of the eligible recipient's discharge, transfer, or otherwise leaving the facility.

(3) When the provider can document that a claim was filed with another primary payer including medicare, medicaid managed care organizations, medicare replacement plans, or another insurer, the claim must be received within 90 calendar days of the date the other payer paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payer, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit the claim to another primary payer within a sufficient timeframe to reasonably allow the primary payer to complete the processing of the claim and also meet the MAD timely filing limit. Denials by the primary payer due to the provider not meeting administrative requirements in filing the claim must be appealed by the provider to the primary payer. The MAD program only considers payment for a claim denied by the other primary payer when under the primary payer's plan the MAD recipient is not eligible, the diagnosis, service or item is not within the scope of the benefits, benefits are exhausted, pre-existing conditions are not covered, or out-of-pocket expenses or the deductibles have not been met. MAD will evaluate a claim for further payment including payment toward a deductible, co-insurance, co-payment or other patient responsibility. Claims for payment towards a deductible, co-insurance, co-payment or other patient responsibility must also be received within 90 calendar days of the date of the other payer's payment, not to exceed 210 calendar days from the date of service.

(4) For an eligible recipient for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within 120 calendar days of the date the eligibility was added to the eligibility record of MAD or its selected claims processing contractor.

(5) For a provider of services not enrolled as a MAD provider at the time the services were rendered, including a provider that is in the process of purchasing an enrolled MAD provider entity such as a practice or facility, claims must be received within 90 calendar days of the date the provider is notified of the MAD approval of the provider participation agreement, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit a provider participation agreement within a sufficient timeframe to allow completion of the provider enrollment process and submission of the claim within the MAD timely filing limit.

(6) For claims that were originally paid by a medicaid managed care organization from which the capitation payment is recouped resulting in recoupment of a provider's claim by the managed care organization, the claim must be received within 90 calendar days of the recoupment from the provider.

(7) For claims that were originally paid by MAD or its selected claims processing contractor and subsequently recouped by MAD or its selected claims processing contractor due to certain claims conflicts such as overlapping duplicate claims, a corrected claim subsequently submitted by the provider must be received within 90 calendar days of the recoupment.

B. The provider is responsible for submitting the claim timely, for tracking the status of the claim and determining the need to resubmit the claim.

(1) Filing limits are not waived by MAD due to the providers inadequate understanding of the filing limit requirements or insufficient staff to file the claim timely or failure to track pending claims, returns, denials, and payments in order to resubmit the claim or request an adjustment within the specified timely filing limitation.

(2) A provider must follow up on claims that have been transmitted electronically or on paper in sufficient time to resubmit a claim within the filing limit in the event that a claim is not received by MAD or its

selected claims processing contractor. It is the provider's responsibility to re-file an apparently missing claim within the applicable filing limit.

(3) In the event the provider's claim or part of the claim is returned, denied, or paid at an incorrect amount the provider must resubmit the claim or an adjustment request within 90 calendar days of the date of the return, denial or payment of an incorrect amount, that was submitted in the initial timely filing period. This additional 60 calendar day period is a one-time grace period following the return, denial or mis-payment for a claim that was filed in the initial timely filing period and is based on the remittance advice date or return notice. Additional 60 calendar day grace periods are not allowed. However, within the 90 calendar day grace period the provider may continue to resubmit the claim or adjustment requests until the 90 calendar day grace period has expired.

(4) Adjustments to claims for which the provider feels additional payment is due, or for which the provider desires to change information previously submitted on the claim, the claim or adjustment request with any necessary explanations must be received by MAD or its selected claims processing contractor with the provider using a MAD-approved adjustment format and supplying all necessary information to process the claim within the one-time 60 calendar day allowed grace period.

C. The eligible recipient or their personal representative is responsible for notifying the provider of MAD eligibility or pending eligibility and when retroactive MAD eligibility is received. When any provider including an enrolled provider, a non-enrolled provider, a managed care organization provider, and an out-of-network provider is informed of a recipient's MAD eligibility, the circumstances under which an eligible recipient or their personal representative can be billed by the provider are limited.

(1) When the provider is unwilling to accept the eligible recipient as a MAD fee-for-service (FFS) or managed care recipient, the provider must provide the eligible recipient or their personal representative written notification that they have the right to seek treatment with another provider that does accept a MAD fee-for-service or managed care eligible recipient. It is the provider's responsibility to have the eligible recipient or their personal representative receive and sign a statement that they are aware that the proposed service may be covered by MAD if rendered by an approved MAD or MAD managed care organization provider and that by authorizing a non-approved provider to render the service, that they agree to be held financially responsible for any payment to that provider. A provider may only bill or accept payment for services from an eligible recipient or their personal representative if all the following requirements are satisfied:

(a) The eligible recipient or their personal representative is advised by the provider before services are furnished that the particular provider does not accept patients whose medical services are paid for by MAD.

(b) The eligible recipient or their personal representative is advised by the provider regarding the necessity, options, and the estimated charges for the service, and of the option of going to a provider who accepts MAD payment,

(2) The eligible recipient is financially responsible for payment if a provider's claims are denied because of the eligible recipient's or their personal representative's failure to notify the provider of established eligibility or retroactive eligibility in a timely manner sufficient to allow the provider to meet the filing limit for the claim.

(3) When a provider is informed of MAD eligibility or pending MAD eligibility prior to rendering a service, the provider cannot bill the eligible recipient or their personal representative for the service even if the claim is denied by MAD or its selected claims processing contractor unless the denial is due to the recipient not being eligible for the MAD program or the service or item is not a benefit of the MAD program. In order to bill the eligible recipient for an item or service that is not a benefit of the program, prior to rendering the service or providing the item the provider must inform the eligible recipient or their personal representative that the service is not covered by the MAD program and obtain a signed statement from the eligible recipient or their personal representative acknowledging such notice. It is the provider's responsibility to understand or confirm the benefits of the MAD program and to inform the eligible recipient or their personal representative when the service is not a benefit of the program and to inform the eligible recipient or their personal representative.

(4) The provider must accept medicaid payment as payment in full and cannot bill a remaining balance to the eligible recipient or their personal representative other than a MAD allowed copayment, coinsurance or deductible.

(5) The provider cannot use a statement signed by the eligible recipient or their personal representative to accept responsibility for payment if the claim is denied as the basis to bill an eligible recipient or their personal representative unless such billing is allowed by MAD rules. It is the responsibility of the provider to meet the MAD program requirements for timely filing and other administrative requirements, to provide information

to MAD or its selected claims processing contractor regarding payment issues on a claim, and to accept the decision of MAD or its selected claims processing contractor for a claim. The eligible recipient or their personal representative does not become financially responsible when the provider has failed to met the timely filing and other administrative requirements in filing a claim. The eligible recipient or their personal representative does not become financially responsible for payment for services or items solely because MAD or its selected claims processing contractor denies payment for a claim.

(6) The provider cannot bill the eligible recipient or their personal representative for charges that are denied for lack of medical necessity or not being an emergency unless the provider determined prior to rendering the service that medical necessity requirements or emergency requirements were not met and informed the eligible recipient that MAD will not pay for the services and the eligible recipient or their personal representative has signed a statement of the choice to proceed with the service or item.

(7) When a provider has been informed of MAD eligibility or pending MAD eligibility of a recipient, the provider cannot turn an account over to collections or to any other entity intending to collect from the eligible recipient or their personal representative. If a provider has turned an account over for collection, it is the provider's responsibility to retrieve that account from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor and to notify the eligible recipient.

D. The filing limit does not apply to overpayments or money being returned to MAD or its selected claims processing contractor.

(1) If a provider receives payment from another source, such as an indemnity insurance plan, HMO, or responsible third party, after receiving payment from MAD, an amount equal to the lower of either the insurance payment or the amount paid through the medicaid program must be remitted to MAD or its selected claims processing contractor third party liability unit, properly identifying the claim to which the refund applies.

(2) For claims for which an over-payment was made to the provider, the provider must return the overpayment to MAD or its selected claims processing contractor. The timely filing provisions for payments and adjustments to claims do not apply when the provider is attempting to return an overpayment.

E. MAD or its selected claims processing contractor may waive the filing limit requirement in the following situations:

(1) An error or delay on the part of MAD or its selected claims processing contractor prevented the claim from being filed correctly within the filing limit period. In considering waiver of a filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim in a timely manner and the follow up efforts made to secure payment in a timely manner from the other payer.

(2) The claim was filed within the filing limit period but the claim is being reprocessed or adjusted for issues not related to the filing limit.

(3) The claim could not be filed timely by the provider because another payer or responsible party could not or did not process the claim timely or provide other information necessary to file the claim timely. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim and to follow up on the payment from another payer or responsible party in order to attempt to meet the MAD filing limit.

(4) A recipient for which MAD or medicare eligibility was established by hearing, appeal, or court order. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the hearing or court decision.

(5) The claim is being reprocessed by MAD or its selected claims processing contractor for issues not related to the provider's submission of the claim. These circumstances may include when MAD is implementing retroactive price changes, or reprocessing the claim for accounting purposes.

(6) The claim was originally paid but recouped by another primary payer. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the recoupment.

(7) The claim is from a federal Indian health services facility operating within the federal department of health and human services which is responsible for Native American health care or is a PL 93-638 tribally operated hospital and clinic which must be finalized within two years of the date of service.

(8) The claim is from a medicaid school-based service program when providing services to a MAD eligible recipient through an individualized education plan or an individualized family service plan to which an initial filing limit of 120 calendar days is applied.

F. The medicaid program is jointly funded through state and federal sources. Claims will not be processed when the federal standards are not met, thereby precluding federal financial participation in payment of the claim.

G. A provider may not bill an eligible recipient or their personal representative for a service or item when a claim is denied due to provider error in filing the claim or failing to meet the timely filing requirements. It is the provider's responsibility to understand or verify the specific MAD program in which an eligible recipient is enrolled, the covered or non-covered status of a service or item, the need for prior authorization for a service or item, and to bill the claim correctly and supply required documentation. The eligible recipient or their personal representative cannot be billed by the provider when a claim is denied because these administrative requirements have not been met.

(1) The provider cannot bill the eligible recipient or their personal representative for a service or item in the event of a denial of the claim unless the denial is due to the recipient not being eligible for the MAD program; or if the service is not a benefit of the MAD program, prior to rendering the service the provider informed the eligible recipient or their personal representative that the specific service is not covered by the MAD program and obtained a signed statement from the eligible recipient or their personal representative acknowledging such.

(2) The provider cannot bill the eligible recipient or their personal representative for the service in the event that a payment is recouped by another primary payer and MAD or its selected claims processing contractor determines that the claim will not be reimbursed by MAD or its selected claims processing contractor.

(3) The provider cannot turn an account over to collections or to any other factor intending to collect from the eligible recipient or their personal representative. If a provider has turned an account over to a collection agency, it is the provider's responsibility to retrieve that account back from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor.

H. When documentation is required to show the provider met applicable filing limits, the date a claim is received by MAD or its selected claims processing contractor will be documented by the date on the claim control number (TCN) as assigned by MAD or its selected claims processing contractor. Documentation of timely filing when another third party payer, including medicare, is involved will be accepted as documented on explanation of benefits payment dates and reason codes from the third party. Documentation may be required to be submitted with the claim.

[2/1/95; 8.302.2.11 NMAC - Rn, 8 NMAC 4.MAD.702.2 & A, 5/1/04; A, 5/1/10; A, 12/1/11]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS: To receive payment for services furnished to a MAD eligible recipient who is also entitled to medicare, a provider must first bill the appropriate medicare payer. The medicare payer pays the medicare covered portion of the bill. After medicare payment, MAD pays the amount the medicare payer determines is owed for copayments, co insurance and deductibles, subject to medicaid reimbursement limitations. When the medicare payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the coinsurance, deductible, or copayment. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare coinsurance, deductible, or copayment from the eligible recipient or their personal representative. For behavioral health professional services for which medicare part B applies to a [~~50 percent~~] "psych reduction" to the provider payment and increases the eligible recipient coinsurance rate, medicare coinsurance and deductible amounts are paid at an amount that allows the provider to receive 80 percent of the medicare allowed amount even if such amount exceeds the MAD allowed amount for the service. A provider must accept assignment on medicare claims for MAD eligible recipients. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient or their personal representative that the provider is not a medicare provider or will not accept assignment; and that because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the MAD eligible recipient or their personal representative of the estimated amount for which the eligible recipient will be responsible, that the service is available from other providers who will accept assignment on a medicare claim, and identify an alternative provider to whom the eligible recipient may seek services. The provider cannot bill a dually eligible MAD recipient for a service that medicare cannot pay because the provider chooses not to participate in medicare, or which MAD cannot pay because the provider chooses not to accept assignment on a claim, without the expressed consent of the MAD eligible recipient or their personal representative even when the medicare eligibility is established retro-actively and covers the date of service.

A. **Claim crossover:** If there is sufficient information for medicare to identify an individual as a MAD eligible recipient, medicare may send payment information directly to the MAD claims processing contractor in a form known as a "cross-over claim". In all cases where claims fail to crossover automatically to MAD, a

provider must bill the appropriate MAD claims processing contractor directly, supplying the medicare payment and medicare "explanation of benefits" (EOB) information and meet the MAD filing limit.

B. **Medicare replacement plan or other health maintenance organization (HMO) plan:** When a MAD eligible recipient belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for copayments, coinsurance or deductible, subject to medicaid reimbursement limitations. When the payer payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the copayment, coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer copayment, coinsurance or deductible from the eligible recipient or their personal representative. For behavioral health services for which medicare part B applies to a [~~50 percent~~] "psych reduction" to the provider payment and increases the eligible recipient coinsurance rate, medicare coinsurance and deductible amounts are paid at the amount that allows the provider to receive up to 80 percent of the payer amount allowed even if the amount exceeds the MAD allowed amount for the services.

C. All other HMO and medicare replacement plan requirements, including provider network restrictions must be met for medicaid to make payment on a claim.

[2/1/95; 8.302.2.12 NMAC - Rn, 8 NMAC 4.MAD.702.3 & A, 5/1/04; A, 5/1/10]