State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
HOSPITAL SERVICES;
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT INPATIENT HOSPITALS;
INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS;
AND
OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULE CHANGES

V. BACKGROUND SUMMARY

The Human Services Department, Medical Assistance Division, is proposing changes to 8.311.2 NMAC *Hospital Services*, 8.311.3 NMAC *Methods and Standards for Establishing Payment Inpatient Hospitals*, 8.321.2 NMAC *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*, and 8.321.5 NMAC *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals* by adding language that affects reimbursement rates. Specifically these proposed changes are:

- Interim reimbursement rates for inpatient specialty hospitals payment are established by MAD to equal or closely approximate the final payment rates that apply under cost settlement TEFRA principles. If they are not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.Otherwise, 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.
- Reimbursement rates for specialty hospitals not subject to cost settlement. If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.
- Establish reimbursement for critical access hospitals under the Outpatient Prospective Payment System (OPPS) will be reimbursed at the rates determined by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If a provider is not cost settled, the reimbursement rate will be a the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.

The changes in the hospitals, methods and standards, inpatient psychiatric hospitals, and outpatient/partial psychiatric hospitals rule are being proposed at this time to assure payments and interim payments to providers are reasonable.

An increase or reduction in overall provider payments is not anticipated.

VI. RULES

This proposed rule changes refer to 8.311.2 NMAC, *Hospital Services;* 8.311.3 NMAC, *Methods and Standards for Establishing Payment Inpatient Hospitals;* 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals;* 8.321.5 NMAC, *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals,* of the Medical Assistance Program Policy Manual. These proposed rule changes are attached to this register and have 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 505-827-3157.

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 1:30 pm on October 17, 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 7-3157. In Santa Fe call 827-3157. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

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 17, 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

TITLE 8 SOCIAL SERVICES
CHAPTER 321 ENHANCED EPSDT - RESIDENTIAL SERVICES
PART 5 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS

8.321.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.321.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 12/1/11]

8.321.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.321.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 12/1/11]

8.321.5.3 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 Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[2/1/95; 8.321.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3; A, 12/1/11]

8.321.5.4 DURATION: Permanent
[2/1/95; 8.321.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 12/1/11]

8.321.5.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.321.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5; A, 12/1/11]

8.321.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.321.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 12/1/11]

8.321.5.7 DEFINITIONS: [RESERVED]

8.321.5.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2/1/95; 8.321.5 NMAC - Rn, 8 NMAC 4.MAD.002; A, 12/1/11]

8.321.5.9 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS: The New Mexico [~~medicaid program (medicaid)~~] medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under [~~twenty-one (21)~~] 21 years of age receive the level of services needed, [~~the New Mexico medical assistance division (MAD)~~] MAD pays for partial hospitalization services furnished in freestanding psychiatric hospitals as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57]. The need for outpatient or partial hospitalization services 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.~~]
[2/1/95; 8.321.5.9 NMAC - Rn, 8 NMAC 4.MAD.742.4; A, 12/1/11]

8.321.5.10 ELIGIBLE PROVIDERS:

~~**[A.** Upon approval of New Mexico medical assistance program provider participation agreements by MAD, freestanding psychiatric hospitals are eligible to be reimbursed for providing partial hospitalization to medicaid recipients under [twenty-one (21)] 21 years of age under the early and periodic screening, diagnosis and treatment (EPSDT) program if they meet the following criteria:~~

~~(1) accredited by the joint commission on accreditation of healthcare organizations (JCAHO); 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.~~

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

A. Health care to New Mexico 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 facilities:

(1) accredited by the joint commission of healthcare organizations (JCAHO); 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.

B. When services are billed to and paid by a MAD fee-for-service coordinated services contractor, 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.

[8.321.5.10 NMAC - Rp, 8 NMAC 4.MAD.742.41; A, 12/1/11]

8.321.5.11 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 furnished to recipients. See 8.302.1 NMAC, General Provider Policies. Providers must maintain records documenting the source and amount of any financial resource collected or receive by provider by 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 programs 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.

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 MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, 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. See 8.302.1 NMAC, *General Provider Policies*.

[8.321.5.8 NMAC - Rp, 8 NMAC 4.MAD.742.42; A, 12/1/11]

8.321.5.12 COVERAGE CRITERIA: [~~Medicaid~~] MAD covers only those services which meet the following criteria:

A. Services are prescribed by a psychiatrist or licensed Ph.D. psychologist and furnished under an individualized written treatment plan established by the psychiatrist or licensed Ph.D. psychologist after any necessary consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals.

B. Treatment is supervised and periodically evaluated by a psychiatrist or licensed Ph.D. psychologist to determine the extent to which treatment goals are being [~~realized; and~~] realized. The psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any therapist involved in the eligible recipient's treatment. The psychiatrist or licensed Ph.D. psychologist must see the eligible recipient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

[~~(1) the evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records and recipient interviews; for purposes of the evaluation, periodic is defined as once every twelve (12) sessions with therapists and staff; psychiatrist or licensed Ph.D. psychologist entries in medical records must support this involvement.~~

~~(2) the psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any therapist involved in the recipient's treatment; the psychiatrist or licensed Ph.D. psychologist must see the recipient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.~~]

C. Treatment must be reasonably expected to improve the eligible recipient's condition or designed to reduce or control the eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the eligible recipient's level of functioning. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.
[2/1/95; 8.321.5.12 NMAC - Rn, 8 NMAC 4.MAD.742.43; A, 12/1/11]

8.321.5.13 COVERED SERVICES AND SERVICE LIMITATIONS: The following services must be furnished by a partial hospitalization [~~providers~~] provider to receive reimbursement from medicaid. Payment for performance of these services is included in the facility's reimbursement rate:

A. performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

B. regularly scheduled structured counseling and therapy sessions for recipients, groups, families or multifamily groups based on individualized needs furnished by social workers, trained psychiatric nurses, other [~~mental~~] behavioral health professionals who are employed by the hospital, as specified in the treatment plan;

C. 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;

D. assistance to [~~recipients~~] the eligible recipient in self-administration of medication in compliance with state policies and procedures;

E. appropriate staff available on a [~~twenty-four (24)~~] 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize [~~recipients~~] the eligible recipient by providing support, make referrals as necessary and provide follow-up;

F. consultation with other professionals or allied care givers regarding a specific recipient;

G. non-medical transportation services needed to accomplish the treatment objective; and

H. therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of [~~recipients~~] the eligible recipient.
[2/1/95; 8.321.5.13 NMAC - Rn, 8 NMAC 4.MAD.742.44; A, 12/1/11]

8.321.5.14 NONCOVERED SERVICES: Partial hospitalization services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services.* [~~Medicaid~~] MAD does not cover the following specific services under partial hospitalization:

A. meals and transportation;

B. activity therapies, group activities or other services which are primarily recreational or diversional in nature;

C. [~~day care~~] programs which provide social and recreational activities to recipients who need some supervision during the day;

D. programs which are generally community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction. Medicaid does not cover the service if [~~a~~] an eligible recipient's outpatient hospital program consists entirely of social activities.

E. formal educational and vocational services related to traditional academic subjects or vocational training. Non-formal education services can be covered if they are part of an active treatment plan for [~~recipients~~] the eligible recipient under the age of [~~twenty-one (21)~~] 21 receiving inpatient psychiatric services. See 42 CFR Section 441.13(b).

F. hypnotherapy or biofeedback;

G. services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction; and

H. services not considered medically necessary for the condition of the eligible recipient.

[2/1/95; 8.321.5.14 NMAC - Rn, 8 NMAC 4.MAD.742.45; A, 12/1/11]

8.321.5.15 TREATMENT PLAN: An individualized treatment plan must be developed by a team of professionals in consultation with [~~recipients~~] the eligible recipient, parents legal guardians or others in whose care [~~recipients~~] the eligible recipient will be released after discharge within [~~fourteen (14)~~] 14 days of the eligible recipient's admission [~~or the initiation of services~~].

A. the interdisciplinary team must [~~review~~] participate in the treatment [~~plan~~] planning at least every [~~thirty (30)~~] 30 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 eligible recipient's file:

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

(2) description of the functional level of the eligible recipient, including the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

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

D. description of intermediate and long-range goals, with the 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 provisions for the 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 eligible recipient; and

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

[2/1/95; 8.321.5.15 NMAC - Rn, 8 NMAC 4.MAD.742.46; A, 12/1/11]

8.321.5.16 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: [~~All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Authorization and Utilization Review. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.~~

~~**A.** All outpatient and partial hospitalization services furnished in freestanding psychiatric hospitals for recipients under twenty-one (21) years of age require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.~~

~~**B.** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.~~

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

All 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 8.302.5 NMAC, *Prior Authorization and Utilization Review.* The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** All outpatient and partial hospitalization services furnished in freestanding psychiatric hospitals for recipients under 21 years of age require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. See Subsection A of 8.311.2.16 NMAC, *emergency room services.*

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

C. **Reconsideration:** A provider who disagrees with prior authorization denials or other review decisions can request a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.*

[2/1/95; 8.321.5.16 NMAC - Rn, 8 NMAC 4.MAD.742.47; A, 12/1/11]

8.321.5.17 REIMBURSEMENT: Providers of partial hospitalization services must submit claims for reimbursement on the [~~UB-92~~] UB claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. [~~Outpatient partial hospitalization services are reimbursed using the Title XVIII (medicare) principles. For those services reimbursed using the medicare allowable cost methodology, medicaid reduces the medicare allowable costs by three percent (3%). The interim rate of payment is seventy-seven percent (77%) of billed charges. If any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.~~]

A. Outpatient and partial hospitalization services are reimbursed at an interim rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles. For those services reimbursed using the medicare allowable cost methodology, medicaid reduces the medicare allowable costs by three percent. Outpatient and partial hospitalization services that are not cost settled, will be reimbursed at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011. Otherwise, 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.

B. If any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

[2/1/95; 8.321.5.17 NMAC - Rn, 8 NMAC 4.MAD.742.48; A, 12/1/11]

HISTORY OF 8.321.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.1700, EPSDT Services, filed 2/13/80.
ISD 310.1700, EPSDT Services, filed 6/25/80.
ISD Rule 310.1700, EPSDT Services, filed 10/22/84.
MAD Rule 310.17, EPSDT Services, filed 5/1/92.
MAD Rule 310.17, EPSDT Services, filed 7/14/93.
MAD Rule 310.17, EPSDT Services, filed 11/12/93.

MAD Rule 310.17, EPSDT Services, filed 12/17/93.
MAD Rule 310.17, EPSDT Services, filed 3/14/94.
MAD Rule 310.17, EPSDT Services, filed 6/15/94.
MAD Rule 310.17, EPSDT Services, filed 11/30/94.

History of Repealed Material:
MAD Rule 310.17, EPSDT Services, filed 11/30/94 - Repealed effective 2/1/95.

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

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. **MCO payment rates:** If a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obliged to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. 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. **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.

E. **Reimbursement for outpatient services:** Effective November 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates. The OPPS rules for payment for packaged services, separately reimbursed services are based on the medicare ambulatory payment classification (APC) methodology.

(1) Reimbursement for laboratory services, radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals must identify drugs items purchased at 340B prices.

(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.*

(3) For critical access hospital providers, the MAD outpatient prospective payment system (OPPS) fee-for-service rate will be set based on the provider's reported cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.

(4) 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 settlement process is also established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If the provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011. Otherwise, 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, 10/15/10; A, 12-1-11]

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 3 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT-INPATIENT HOSPITAL SERVICES

8.311.3.10 GENERAL REIMBURSEMENT POLICY: The state of New Mexico human services department (hereinafter called the department) will reimburse inpatient hospital services rendered on or after October 1, 1989 in the following manner:

A. Covered inpatient services provided to eligible recipients admitted to in-state acute care hospitals and acute care units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in 8.311.3.12 NMAC, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through D below.

B. Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care units within hospitals located out-of-state or in border areas (Mexico excluded) will be reimbursed at a prospectively set rate as described in Paragraph (16) of Subsection C of 8.311.12 NMAC, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsections C through D below or at a negotiated rate not to exceed the rate paid by federal programs such as medicare. Negotiation of rates will only be allowed when the department determines that the hospital provides a unique service required by an eligible recipient.

C. Inpatient services provided in rehabilitation and specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principles of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Finance Reduction Act) and is described in 8.311.3.11 NMAC of this section.

D. Indian health services hospitals will be reimbursed using a per diem rate established by the federal government.

E. New Mexico providers entering the MAD program will be reimbursed at the peer group median rate for the applicable peer group, until such time as a distinct rate can be established, unless the hospital meets the criteria for prospective payment exemption as described in Subsections C through D above.

F. All hospitals which meet the criteria in Subsection A of 8.311.3.13 NMAC will be eligible for a disproportionate share adjustment.

G. Effective for discharges on or after April 1, 1992, and in accordance with Section 4604 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the department provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs or long lengths of stay for children who have not attained the age of six years in disproportionate share hospitals and for infants under one year of age in all hospitals. The outlier adjustment for these cases is described in Subsection F of 8.311.3.12 NMAC.

H. MAD covered inpatient services provided in specialty hospitals will be reimbursed at an interim rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011. Otherwise, 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.

[2-1-95; 8.311.3.10 NMAC - Rn, 8 NMAC 4.MAD.721.D.I, 1-1-01; A, 4-1-11; A, 12-1-11]

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

8.321.2.17 REIMBURSEMENT: Freestanding psychiatric hospital service providers must submit claims for reimbursement on the UB04 claim form or its successor. See 8.302.2 NMAC, *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 8.311.3.11 NMAC, *payment methodology for PPS-exempt hospitals and exempt units within hospitals*, and 8.311.3.14 NMAC, *determination of actual, allowable and reasonable costs,* contained in 8.311.3 NMAC, *Methods and Standards for Establishing Payment – Inpatient Hospital Services.* Covered inpatient services provided in freestanding psychiatric hospitals will be reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals.

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.~~] If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011. Otherwise, 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.

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, *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, 11/1/10; A, 12/1/11]