State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT
MEDICAID BENEFIT RULES
8.302.2 NMAC, 8.310.2 NMAC, 8.310.3 NMAC, 8.310.12 NMAC, 8.320.2 NMAC, 8.320.6 NMAC, 8.321.2 NMAC, 8.324.4 NMAC, 8.324.5 NMAC, 8.324.7 NMAC, 8.351.2 NMAC, 8.352.2 NMAC AND 8.352.3 NMAC

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY
The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to repeal a number of Medical Assistance Division (MAD) provider rules in order to reduce the number of specific rules and consolidate those services into broad service rules, such as repealing the 17 unique behavioral health service rules into one broad rule that includes these 18 services. HSD is also proposing amendments to a number of MAD provider rules in preparation for the implementation of Centennial Care.

The following rules are being proposed for implementation on January 1, 2014:

8.302.2	Billing for Medicaid Services
8.310.2	Medicaid General Benefit
8.310.3	Professional Providers and Reimbursements
8.310.12	IHS and Tribal 638 Facilities
8.320.2	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
8.320.6	School Based Services for MAP Eligible Recipients under Twenty-One Years of Age
8.321.2	Specialized Behavioral Health Enrollment and Reimbursement
8.324.4	Pharmacy Services, Prescribing and Practitioner Administered Drug Items

8.324.5	Vision Appliances, Hearing Appliances, Durable Medical Equipment, Oxygen, Medical Supplies, Prosthetics and Orthotics
8.324.7	Transportation and Lodging Services
8.351.2	Sanctions and Remedies
8.352.2	Claimant Hearings
8.352.3	Provider Hearings

The Department will promulgate a separate register for the repeal of the rules being incorporated into these consolidated rules.

VI. RULES

These proposed rules will be contained in 8.310.2 NMAC, 8.310.3 NMAC, 8.310.12 NMAC, 8.320.2 NMAC, 8.320.6 NMAC, 8.321.2 NMAC, 8.324.4 NMAC, 8.324.5 NMAC, and 8.324.7 NMAC. This register and the proposed rules are available on the MAD website at http://www.hsd.state.nm.us/mad/registers/2013. If you do not have internet access, a copy of the proposed rules may be requested by contacting MAD at 505-827-3152.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective January 1, 2014.

VIII. PUBLIC HEARING

Due to the large number of rules, public hearings will take place according to the schedule below. All public hearings will take place in the ***Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM.***

Public Hearing Topic	Date and Time of Public Hearing
8.310.2 NMAC, Medicaid General Benefit 8.310.3 NMAC, Professional Providers and Reimbursements	Monday, December 2, 2013 8:30 am – 10:30 am
8.351.2 NMAC, Sanctions and Remedies 8.352.2 NMAC, Claimant Hearings 8.352.3 NMAC, Provider Hearings	Monday, December 2, 2013 10:30 am – 12:30 pm
8.310.12 NMAC, IHS and Tribal 638 Facilities	Monday, December 2, 2013 12:30 pm – 1:30 pm

Public Hearing Topic	Date and Time of Public Hearing
8.324.4 NMAC, Pharmacy Services, Prescribing and Practitioner Administered Drug Items 8.324.5 NMAC, Vision Appliances, Hearing Appliances, Durable Medical Equipment, Oxygen, Medical Supplies, Prosthetics and Orthotics	Monday, December 2, 2013 1:30 pm – 2:30 pm
8.324.7 NMAC, Transportation and Lodging Services	Monday, December 2, 2013 2:30 pm – 3:30 pm
8.320.2 NMAC, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services 8.320.6 NMAC, School Based Services for MAP Eligible Recipients under Twenty-One Years of Age	Tuesday, December 3, 2013 8:30 am – 9:30 am
8.321.2 NMAC, Specialized Behavioral Health Enrollment and Reimbursement	Tuesday, December 3, 2013 1:30 pm – 3:30 pm
8.302.2 NMAC, Billing for Medicaid Services	Tuesday, December 10, 2013 9:30 am – 10:30 am

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 MAD toll free at 1-888-997-2583 and ask for extension 7-3152. In Santa Fe, call 827-3152. 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 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available on December 23, 2013 by MAD 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 p.m. on Tuesday, December 10, 2013. Written and recorded comments will be given the same consideration as testimony made at the public hearing. Interested persons may address comments via telephone to 505-827-3152 or via electronic mail to: Emily.Floyd@state.nm.us.

X. PUBLICATION

Publication of these rules approved by:

Sidonie Squier

SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

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

8.302.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.302.1 NMAC - Rp, 8.302.1 NMAC, 1-1-14]

8.302.2.2 SCOPE: The rule applies to the general public.
[8.302.2 NMAC - Rp, 8.302.2 NMAC, 1-1-14]

8.302.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.302.3 NMAC - Rp, 8.302.3 NMAC, 1-1-14]

8.302.2.4 DURATION: Permanent.
[8.302.4 NMAC - Rp, 8.302.4 NMAC, 1-1-14]

8.302.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.302.5 NMAC - Rp, 8.302.5 NMAC, 1-1-14]

8.302.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.302.6 NMAC - Rp, 8.302.6 NMAC, 1-1-14]

8.302.2.7 DEFINITIONS: [RESERVED]

8.302.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.302.8 NMAC - Rp, 8.302.8 NMAC, 1-1-14]

8.302.2.9 BILLING FOR MEDICAID SERVICES: Health care for New Mexico medical assistance division (MAD) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) 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 instruction, utilization review (UR) instructions, and other pertinent material. 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. MAD makes available on the 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, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, billing instructions 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.
[8.302.9 NMAC - Rp, 8.302.9 NMAC, 1-1-14]

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 authorized representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider. Ordering, referring, prescribing, rendering and attending providers must participate in a medicaid managed care plan or the medicaid fee for service program, or otherwise be identifiable as a participating, out-of-network, or in-network provider for services, as determined by MAD.

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 (ER) physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, their authorized 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 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 MAD. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, UR, 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 one 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.

(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.

G. **Applying co-payments:** MAD has established co-payments for specified groups of eligible recipients for specific services. Exemptions and limits apply to the collection of co-payments.

(1) **Provider responsibilities for collection of co-payments:**

(a) The professional provider is responsible for collecting any applicable co-payments due for any outpatient visit or service provided, including a physician, other practitioner, clinic, urgent care, dental, outpatient therapy, or behavioral health session or visit.

(b) The hospital provider is responsible for collecting any applicable co-payments due for any emergency department (ED) or inpatient services provided.

(i) In the situation where there has been a non-emergent use of the ED by an eligible recipient, the hospital is responsible for determining if there is a co-payment due and, if so, collecting the co-payment. Before assessing a co-payment for non-emergent use of the ED, a hospital must consider the medical needs of the eligible recipient to judge whether care is needed immediately or if a short delay in treatment would be medically acceptable and any particular challenges the eligible recipient may face in accessing follow-up care, such as leave from employment, child care, ability to receive language assistance services, or accessible care for people with disabilities.

(ii) Before assessing a co-payment for non-emergent use of the ED, hospitals must first provide the eligible recipient with the name and location of an available and accessible provider that can provide the service at lesser or no cost sharing and provide a referral to coordinate scheduling for treatment by an alternative provider. If geographical or other circumstances prevent the hospital from meeting this requirement, the co-payment may not be imposed. If the eligible recipient chooses to receive services from the alternative provider, the co-payment may not be assessed. If, after being advised of the available alternative provider and of the amount of the co-payment due, the eligible recipient chooses to continue to receive treatment for a non-emergent condition at the hospital's ED, the hospital shall then assess and collect the co-payment.

(c) The pharmacy is responsible for collecting any co-payments due for drug items dispensed.

(i) When a brand name drug is prescribed, the co-payment for unnecessary use of a brand name drug does not apply when the brand name drug is medically necessary because the available therapeutically equivalent generic alternative would be less effective for treating the eligible recipient's condition, would have more side effects, or a higher potential for adverse reactions exists. If there is no medical justification for the use of the brand name drug, the co-payment for unnecessary use of a brand name drug applies and is collected by the pharmacy.

(ii) If the prescriber has stated that the brand name drug is medically necessary on the prescription and the claim is billed with a dispense as written indicator, the co-payment cannot be applied unless the pharmacy ascertains that the reason for the brand name drug is something other than the medical necessity. This co-payment does not apply to psychotropic drugs. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(d) The provider may not deny covered care or services to an eligible recipient because of the eligible recipient's inability to pay the co-payment amount at the time of service. The eligible recipient remains liable for the co-payment. The provider may attempt to collect the co-payment amount at a later appointment or by billing the recipient.

(e) After an eligible recipient's assistance unit has reached the maximum out-of-pocket cost sharing limit (five percent of the eligible recipient's family's income, calculated on a quarterly basis), a provider shall reimburse any co-payments that it has collected from the recipient in excess of the maximum out-of-pocket cost sharing limit. This includes anytime a provider receives a remittance advice indicating that the co-payment was not deducted from the reimbursement.

(f) A provider is required to report the co-payment amount charged on the CMS-1500, UB, or pharmacy claim form or their corresponding electronic billing transactions.

(g) A provider shall accept the amounts paid by MAD or the MAD contracted managed care organization (MCO) plus any applicable co-payment as payment in full.

(h) A provider may not impose more than one type of cost sharing for any service.

(2) **Provider to understand the application of co-payments:** The provider is responsible for understanding and applying the rules for co-payment including when to contact the payer to determine if a co-payment is applicable for the service for the specific recipient.

(a) Co-payments are not applied when one or more of the following conditions are met:

(i) the service is a medicare claim or medicare advantage claim, or follows other insurer payment, so the payment is therefore toward a deductible, co-insurance, or co-payment determined by the primary payer;

(ii) the recipient is a native American;

(iii) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the eligible recipient;

(iv) the service is a provider preventable condition or is solely to treat a provider preventable condition;

(v) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;

(vi) the maximum family out-of-pocket cost sharing limit has been reached;

(vii) the service was rendered prior to any eligibility being established including when eligibility is retroactively established to the time period of the service; or

(viii) the recipient or service is exempt from co-payment as otherwise described in these rules.

(b) Other than a co-payment for non-emergent use of the ED or for unnecessary use of a brand name drug, co-payments are not applied when the services are one of the following:

(i) family planning services, procedures drugs, supplies, or devices;

(ii) preventive services (well child checks, vaccines, preventive dental cleanings/exams, periodic health exams) unless treatment is rendered; or

(iii) prenatal and postpartum care and deliveries, and prenatal drug items.

(c) A hospital provider must determine the recipient is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED if necessary

(3) **Payment of claims with applicable co-payment:**

(a) Payment to the provider will be reduced by the amount of an eligible recipient's applicable cost sharing obligation, regardless of whether the provider has collected the payment, unless the uncollected co-payment is for non-emergent use of the ED.

(b) A provider may not adopt a policy of waiving all MAP co-payments or use such a policy to promote his or her practice.

(4) **Children's health insurance program (CHIP) co-payment requirement:** Eligible recipients whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients:

(a) $2 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $5 per dental visit, unless all the services are preventive services;

(d) $15 per ED visit, unless a copayment for non-emergent use of the ED is assessed or if the eligible recipient is admitted as an inpatient in which case the inpatient hospital co-payment applies;

(e) $25 per inpatient hospital admission unless the hospital is receiving the recipient as a transfer from another hospital;

(f) $5 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(g) $50 for non-emergent use of the ED.

(5) **Working disabled individual's copayment requirements (WDI):** Eligible recipients whose benefits are determined using criteria for WDI are identified by their category of eligibility. The following co-payments apply to WDI eligible recipients:

(a) $5 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $7 per dental visit, unless all the services are preventive services;

(d) $20 per ED visit, unless a co-payment for non-emergent use of the ED is assessed or if the eligible recipient is admitted as an inpatient in which case the inpatient hospital co-payment applies;

(e) $30 per inpatient hospital admission unless the hospital is receiving the recipient as a transfer from another hospital;

(f) $8 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(g) $28 for non-emergent use of the ED.

(6) **Alternative benefit plan (ABP) co-payment requirements for federal poverty level (FPL) less than or equal to 100 percent:** When an eligible recipient's benefits are determined using criteria for ABP are identified by their category of eligibility and are at an FPL less than or equal to 100 percent, no co-payments apply except for unnecessary services. The following co-payments apply to these ABP eligible recipients:

(a) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(b) $8 for non-emergent use of the ED.

(7) **Alternative benefit plan co-payment requirements for FPL between 101 and 138 percent:** When eligible recipient's benefits are determined using criteria for ABP are those identified by their category of eligibility and at an FPL between 101 and 138 percent co-payments do apply. The following co-payments apply to these ABP eligible recipients:

(a) $3per prescription, applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $8 per outpatient physician or other practitioner, dental visit, rehabilitative or habilitative therapy session (does not apply to ER facility or ER professional charges; does apply to outpatient hospital clinic visits and urgent care visits, but is applied to the professional service, not the facility charge);

(c) $8 per dental visit, unless all the services are preventive services;

(d) $25 per inpatient hospital admission unless the hospital is receiving the recipient as a transfer from another hospital;

(e) $8 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply;

(f) $8 for non-emergent use of the ED; and

(g) a co-payment does not apply to exempt services meeting the definition at section 1932(b)(2) of the social security act and 42 CFR section 438.114 [a]), unless the co-payment is for non-emergent use of the ED or for unnecessary use of a brand name drug, including:

(i) conditions described in Paragraph 2, Subsection G of this section;

(ii) services for eligible recipients enrolled in hospice;

(iii) behavioral health and substance abuse services;

(iv) psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision);

(v) recipients who have a disability type code of MH or PH on his or her eligibility file; and

(vi) emergency services.

(8) **All other MAD eligible recipients:** Providers shall charge the following co-payment amounts on other MAP eligible recipients only in the event of a non-emergent use of the ED or unnecessary uses of a brand name drug. No other co-payments apply.

(a) $3 for unnecessary use of a brand name drug;

(b) $8 for non-emergent use of the ED if the eligible recipient has an income of less than or equal to 150 percent of FPL;

(c) $50 for non-emergent use of the ED if the eligible recipient has an income over 150 percent of FPL;

(d) no co-payment is applied when the claim is for a co-insurance, deductable or co-payment following payment from a primary payer, including medicare; and

(e) No co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility.

(f) The provider shall not charge these co-payments when:

(i) the eligible recipient is native American;

(ii) the eligible recipient is in foster care or has an adoption category of eligibility;

(iii) the eligible recipient does not have a MAP category of eligibility such as being eligible only for the department of health children's medical services program; or

(iv) the eligible recipient resides in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has an institutional care category of eligibility.

(H) For purposes of this section, FPL meant the poverty guidelines updated periodically in the federal register by the U.S. department of health and human services under the authority of 42 U.S.C. 9902(2).

(I) **Billing state gross receipts tax:** For providers subject to, and registered to pay, gross receipts tax and registered to pay gross receipts tax, the provider may include gross receipt tax in the billed amount when the tax applies to the item or service. The provider may only bill tax to the extent the tax is also charged to the general public. A provider may not include gross receipts tax in the billed amount when the provider is not obligated to pay gross receipts tax to the state.

[8.302.10 NMAC - Rp, 8.302.10 NMAC, 1-1-14]

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 also must 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 PPA, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit a PPA 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 MCO from which the capitation payment is recouped resulting in recoupment of a provider's claim by the MCO, 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 hard copy 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 90 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 90 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 90 calendar day allowed grace period.

C. The eligible recipient or their authorized 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 MCO provider, and an out-of-network provider is informed of a recipient's MAD eligibility, the circumstances under which an eligible recipient or their authorized 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 MCO eligible recipient, the provider must provide the eligible recipient or their authorized representative written notification that they have the right to seek treatment with another provider that does accept MAD FFS or MCO eligible recipients. It is the provider's responsibility to have the eligible recipient or their authorized representative receive and sign a statement that they are aware the proposed service may be covered by MAD if rendered by an approved MAD or MAD MCO provider and that by authorizing a non-approved provider to render the service, 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 authorized representative if all the following requirements are satisfied:

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

(b) The eligible recipient or their authorized 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 authorized 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 authorized 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 authorized representative the service is not covered by the MAD program and obtain a signed statement from the eligible recipient or their authorized 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 authorized representative when the service is not a benefit of the program and to inform the eligible recipient or their authorized representative.

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

(5) If the provider claim is denied, the provider cannot use a statement signed by the eligible recipient or their authorized representative to accept responsibility for payment 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 authorized 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 authorized 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) 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 authorized 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 any insurance plan, or other 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. For more details see 8.351.2 NMAC. 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 eligible recipient for whom 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 IHS 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 authorized 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 authorized 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 authorized 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 authorized representative that the specific service is not covered by the MAD program and obtained a signed statement from the eligible recipient or their authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient or their authorized 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 authorized 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.

(4) The provider cannot bill the eligible recipient for office tasks such as billing claims, checking eligibility, making referrals calls, in the form of either routine charges or as penalties including missed appointments, failure to cancel an appointment, failure to show eligibility card or similar charges unless specifically allowed by MAD rules.

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 transaction 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.

[8.302.11 NMAC - Rp, 8.302.11 NMAC, 1-1-14]

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 authorized representative. For behavioral health professional services for which medicare part B applies to a "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 authorized representative that the provider is not a medicare provider or will not accept assignment; and because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the MAD eligible recipient or their authorized representative of the estimated amount for which the eligible recipient will be responsible, that 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 authorized 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 authorized representative. For behavioral health services for which medicare part B applies to a "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.

[8.302.12 NMAC - Rp, 8.302.12 NMAC, 1-1-14]

8.302.2.13 BILLING FOR CONTRACTED SERVICES: MAD only makes payment to a provider who actually rendered the services. However, in the following instances a MAD provider can bill and be paid for covered contracted services.

A. A provider is reimbursed at encounter rates or other all-inclusive rates that may have some contracted services built into those rates. These providers include NF, intermediate care facilities (ICF)-IID, residential treatment centers, a group home, a hospice agency, a federally qualified health center, a rural health clinic, and an IHS or tribal 638 facility.

B. A practitioner group, a clinic, an institutional professional component, and providers of professional services may bill for services furnished by practitioners under contract when the provider applications are approved by MAD, and the following apply:

(1) the MAD provider participation applications are completed by the billing entity and the practitioner rendering the service or in their employ; and

(2) the practitioner is listed as the rendering provider on the claim form.

C. Transportation providers may bill for contracted personnel, equipment or vehicles.

D. A provider may bill MAD directly for contracted services for the construction or assembly of equipment or prosthetic devices, construction of dental devices and prosthetics, hearing and vision prosthesis, orthotics, and repairs, when:

(1) the provider customarily uses the dental laboratory, optical supplier, hearing aid supplier, prosthetic or orthotic supplier equipment dealer, or manufacturer to do work; and

(2) the contractor doing the work does not qualify as an eligible provider in his or her own right.

E. For all other contracted services not specified above, written prior approval must be obtained from MAD or its designee before the provision of services.

F. **Billing rates for contracted services:** All services provided by a contractor and billed through a participating MAD provider must be billed at a rate based on direct and indirect costs, plus a reasonable administrative charge. The billing provider must ensure all MAD requirements are met by the contractor furnishing the service, including prior approval requirements, if applicable. Reimbursement for contracted services is included in the fee paid to the provider. For example, the amount paid to a dentist for a crown includes the dentist's work fitting the crown and the dental lab fees for making the crown.

G. **Recipient freedom of choice:** A provider cannot enter into contracts that are used to restrict an eligible recipient's freedom of choice. Some restrictions to this freedom of choice may apply to the purchases of medical devices and laboratory and radiology tests, and transportation [42 CFR Section 431.54(e)].

[8.302.13 NMAC - Rp, 8.302.13 NMAC, 1-1-14]

8.302.2.14 BILLING AND PAYMENT LIMITATIONS:

A. **Payment not allowed:** MAD does not pay factors either directly or by power of attorney (42 CFR Section 447.10(h)). A factor is an individual or an organization, such as a collection agency or service bureau.

B. **No reimbursement for the discharge day:** An institutional or other residential provider, such as a NF, a hospital, an ICF-IID, and a provider of treatment foster care services are reimbursed for services furnished to an eligible recipient on the day of admission but are not reimbursed for services furnished on day of discharge.

C. **No payment made for wrong services:** A provider shall not bill MAD for:

(1) services provided to the wrong patient;

(2) a service performed on the wrong body part of an eligible recipient; and

(3) an incorrect procedure performed on an eligible recipient.

D. **Payments for acquired conditions:** MAD may deny or limit payment on claims for services to treat a MAD eligible recipient for a condition acquired during the course of a facility stay or in the rendering of other services.

[8.302.14 NMAC - Rp, 8.302.14 NMAC, 1-1-14]

8.302.2.15 INTEREST RATES ON COST SETTLEMENTS: MAD charges interest on overpayments and pays interest on underpayments as a result of year-end cost settlements, unless waived.

A. **Interest periods:** Interest accrues from the date of the final determination of costs or from a date required by a subsequent administrative reversal. Interest is charged on the overpayment balance or paid on the underpayment balance for each 30 calendar day period that payment is delayed.

(1) For purposes of this provision, a final determination is considered to occur when:

(a) MAD, the MAD selected claims processing contractor, or the MAD audit contractor makes a written demand for payment or a written determination of underpayment; or

(b) a cost report which was filed in a timely manner indicates that an amount is due MAD and the amount due is not included with the report.

(2) The date of final determination for an additional overpayment or underpayment, as determined by the MAD audit contractor, is considered to occur if any of the previously mentioned events occur.

(3) The date of final determination for an unfiled cost report occurs the day after the date the cost report was due. A single extension of time not to exceed 30 calendar days is granted for good cause. A written request for the time extension must be received and approved by MAD before the cost report due date. When the cost report is filed, a second final determination date is calculated based on the occurrence of either of the aforementioned events.

B. **Interest rates:** The interest rate on overpayments and underpayments is based on the prevailing rate specified in bulletins issued under article 8020.20 of the treasury fiscal requirement manual. When a provider signs a repayment agreement with MAD for an overpayment, the following provisions apply:

(1) the rate of interest specified in the agreement is binding unless a default in the agreement occurs; or

(2) the rate of interest on the balance may change to the prevailing rate if the provider or supplier defaults on an installment and the prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

C. **Accrual of interest:** Even though a filed cost report does not show an overpayment, interest begins to accrue on the date of final determination, if MAD, the MAD audit contractor, or the MAD selected claims processing contractor determines that providers have been overpaid.

(1) Interest continues to accrue during administrative or judicial appeals and until final disposition of claims.

(2) If a cost report is filed which indicates that an amount is due MAD, interest on the amount due accrues from the date the cost report is filed unless:

(a) the full payment on the amount due accompanies the cost report; or

(b) the provider and the MAD audit contractor agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30 calendar day period.

(3) If the MAD audit contractor determines that a further overpayment exists, interest accrues from the date of final determination.

(4) If the cost report is not filed, interest accrues from the day following the date the report was due, plus a single extension of time not to exceed 30 calendar days if granted for good cause, until the time the cost report is filed. Written requests for time extensions must be received for approval by MAD before cost reports due dates.

(5) Interest accrues on an underpayment owed by MAD to a provider beginning 30 calendar days from the date of MAD's notification of the underpayment by the MAD audit contractor.

D. **Interest charge waivers:** MAD may waive the interest charges when:

(1) the overpayment is liquidated within 30 calendar days from the date of the final determination; or

(2) MAD determines that the administrative cost of collection exceeds the interest charges; interest is not waived for the period of time during which cost reports are due but remain unfiled for more than 30 calendar days.

E. **Interest charges with installment or partial payments:** If an overpayment is repaid in installments or recouped by withholding from several payments due to a billing provider, the amounts are applied in the following manner:

(1) each payment or recoupment is applied first to accrued interest and then to the principle; and

(2) after each payment or recoupment, interest accrues on the remaining unpaid balance; if an overpayment or an underpayment determination is reversed following an administrative hearing, appropriate adjustments are made on the overpayment or underpayment and the amount of interest charged.

F. **Allowable interest cost:** Allowable interest cost is the necessary and proper interest on both current and capital indebtedness. An interest cost is not allowable if it is one of the following:

(1) an interest assessment on a determined overpayment; or

(2) interest on funds borrowed to repay an overpayment; following an administrative review and favorable provider decision, interest paid on funds borrowed to repay an overpayment or the interest assessed on an overpayment becomes an allowable cost.

[8.302.15 NMAC - Rp, 8.302.15 NMAC, 1-1-14]

HISTORY OF 8.302.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

SP-004.1902, Methods and Standards of Establishing Payment Rates - Other Types of Care, filed 3-5-81.
SP-004.2000, Section 4, General Program Administration Direct Payments to Certain Recipients for Physician's or Dentist's Services, filed 3-5-81.
SP-004.2100, Section 4, General Program Administration Prohibition Against Reassignment of Provider Claims, filed 3-5-81.
SP-006.0100, Section 6, Financial Administration Fiscal Policies and Accountability, filed 3-5-81.
SP-006.0200, Section 6, Financial Administration Cost Allocation, filed 3-5-81.
SP-006.0300, Section 6, Financial Administration State Financial Participation, filed 3-5-81.
SP-004.1905, Definition of Timely Payment Requirement for the State of New Mexico, filed 6-10-81.
ISD 304.1000, Provider Reimbursement Responsibility, filed 1-7-80.
ISD 304.1000, Provider Reimbursement Responsibility, filed 9-9-81.
ISD 304.2000, Recipient Reimbursement Responsibility, filed 1-9-80.
ISD 304.3000, Reimbursement Limitations, filed 1-7-80.
ISD 304.3000, Reimbursement Limitations, filed 9-9-81.
ISD 304.3000, Reimbursement Limitations, filed 12-17-85.
ISD 304.4000, Billing Limitations, filed 1-7-80.
ISD 304.4000, Billing Limitations, filed 9-9-81.
ISD 304.7000, Reimbursement To Out-of-State Providers, filed 1-7-80.
ISD 304.7000, Reimbursement To Out-of-State Providers, filed 9-9-81.
ISD 304.8000, Third Party Liability, filed 1-7-80.
ISD 304.8000, Third Party Liability, filed 9-9-81.
ISD 304.9000, Usual and Customary, filed 1-7-80.
ISD 304.9000, Reasonable Charge Pricing, filed 9-9-81.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 2-17-84.
ISD Rule 304.9000, Reasonable Charge Price, filed 3-30-84.
MAD Rule 304.9, Reimbursement, filed 12-15-87.
MAD Rule 304.9, Reimbursement, filed 8-11-88.
MAD Rule 304, Billing and Reimbursement, filed 11-8-89.
MAD Rule 304, Billing and Reimbursement, filed 4-21-92.

History of Repealed Material:

MAD Rule 304, Billing And Reimbursement, filed 4-21-92 - Repealed effective 2-1-95.
8.302.2 NMAC, Billing for Medicaid Services, filed xx-xx-xx - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONALS
PART 2 MEDICAID GENERAL BENEFIT DESCRIPTION

8.310.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.2.1 NMAC - Rp, 8.310.2.1 NMAC, 1-1-14]

8.310.2.2 SCOPE: The rule applies to the general public.
[8.310.2.2 NMAC - Rp, 8.310.2.2 NMAC, 1-1-14]

8.310.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.310.2.3 NMAC - Rp, 8.310.2.3 NMAC, 1-1-14]

8.310.2.4 DURATION: Permanent.
[8.310.2.4 NMAC - Rp, 8.310.2.4 NMAC, 1-1-14]

8.310.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.2.5 NMAC - Rp, 8.310.2.5 NMAC, 1-1-14]

8.310.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.2.6 NMAC - Rp, 8.310.2.6 NMAC, 1-1-14]

8.310.2.7 DEFINITIONS: [RESERVED]

8.310.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.310.2.8 NMAC - Rp, 8.310.2.8 NMAC, 1-1-14]

8.310.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico medical assistance division (MAD) pays for medically necessary health care services furnished by a MAD enrolled medical provider. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991).

B. MAD pays for medically necessary behavioral health professional services including assessments, evaluations, and therapy required by the condition of the MAP eligible recipient [42 CFR Sections 440.40, 440.60(a) and 441.571].

C. MAD covers services which are medically necessary for the diagnosis or treatment of illnesses, injuries or conditions of a MAP eligible recipient, as determined by MAD or its designee. All services must be furnished within the limits of the MAD New Mexico administrative code (NMAC) rules policies and instructions within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. Any claim submitted for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service. All claims are subject to pre-payment or post-payment review and recoupment.

D. HSD, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to MAP eligible recipients.

E. A provider must be eligible for participation as a MAD approved provider at the time services are furnished. MAD does not cover services performed during a time period when the provider or facility did not meet required licensing or certification requirement.

F. If a MAP eligible recipient is enrolled with a MAD managed care organization (MCO), the provider must contact that member's MCO for specific reimbursement information. A MCO contracted with the state of New Mexico is not required to follow the MAD fee-for-service (FFS) fee schedules or reimbursement methodologies unless otherwise instructed by MAD. Reimbursement arrangements are determined contractually between the MCO and the provider.

[8.310.2.9 NMAC - Rp, 8.310.2.9 NMAC, 1-1-14]

8.310.2.10 RELATIONSHIP TO MEDICARE: MAD covers medically necessary health services furnished to a MAP eligible recipient who meets specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to MAP eligible recipient 65 years of age and older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other MAP eligible recipients as specified by other provisions of the Social Security Act.

A. New Mexico has entered into an agreement with the social security administration to pay a medicaid MAP eligible recipient's premium for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, MAD pays for the medicare co-insurance, deductible and copayment amounts for a MAP eligible recipient subject to the following reimbursement limitations.

(1) Medicaid payment for the co-insurance, deductible, copayment or other patient responsibility is limited such that the payment from medicare, plus the amount allowed by MAD for the co-insurance, copayment and deductible, shall not exceed the MAD allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance, copayment, deductible or other patient responsibility. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance, copayment or deductible from the MAP eligible recipient or his or her authorized representative. For services for which medicare part B applies a 50 percent co-insurance rate, medicare co-insurance, copayment and deductible amounts are paid at an amount that allows the provider to receive more than MAD allowed amount, not to exceed a percentage determined by HSD.

(2) MAD will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance, deductible and copayment together do not exceed the MAD allowable amount. MAD will pay the full medicare co-insurance and deductible when MAD does not have a specific amount allowed for the service. When MAD does not use an equivalent payment methodology for a service, the full coinsurance, deductible and copayment amounts will be paid. This occurs when providers are paid at encounter rates, percent of billed charges followed by cost settlements, or when providers are entitled to a full reimbursement rate such as for federally qualified health centers and hospital outpatient prospective payment system reimbursement.

[8.310.2.10 NMAC - Rp, 8.310.2.10 NMAC, 1-1-14]

8.310.2.11 SERVICE LIMITATIONS AND RESTRICTIONS: MAD covers the following services with the frequency limits indicated. For purpose of this rule, a provider is considered part of the same provider group if he or she practices in the same office or clinic or has direct access to the MAP eligible recipient's medical or behavioral health records. Exceeding these limits requires prior authorization.

A. **Office visits in a practitioner's office:** Visits are limited to one-per-day from the same provider or provider group, unless the claim documents a change in the MAP eligible recipient's condition that could not have been anticipated at the first visit.

B. **Physical medicine modalities in a professional practitioner's office:** These modalities are limited to three-per-month. The limit is met when the same modality is performed three times during a calendar month, when three different modalities are performed during a month, or when three different modalities are performed during one visit.

C. **Physical medicine procedures and kinetic activities in a professional practitioner's office:** These services are limited to three-per-month from the same provider or provider group. The limit is met when the same procedure is performed three times during a calendar month, when three different procedures are performed during a month, or when three procedures are performed during one visit.

D. **Manipulation, osteo-manipulative therapy, or myofacial release in a professional practitioner's office:** These services are limited to three manipulations per calendar month, regardless of the area or areas manipulated. The limit is met when a manipulation of three different areas or of the same area at three different visits is performed during a month.

E. **Medically necessary services:** All services are limited to those that are medically necessary, including the length of time and the frequency of service.

[8.310.2.11 NMAC - Rp, 8.310.2.11 NMAC, 1-1-14]

8.310.2.12 SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope of their practice board and licensure.

A. **Medical practitioner services:**

(1) Second surgical opinions: MAD covers second opinions when surgery is considered.

(2) Services performed in an outpatient setting: MAD covers procedures performed in the office, clinic or as outpatient institutional services as alternatives to hospitalization. These procedures are those for which an overnight stay in a hospital is seldom necessary.

(a) A MAP eligible recipient may be hospitalized if he or she has existing medical conditions that predispose him or her to complications even with minor procedures.

(b) Claims may be subject to pre-payment or post-payment review.

(c) Medical justification for performance of these procedures in a hospital must be documented in the MAP eligible recipient's medical record.

(3) Noncovered therapeutic radiology and diagnostic imaging services: MAD does not pay for kits, films or supplies as separate charges. All necessary materials and minor services are included in the service or procedure charge. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay an additional amount for contrast media except in the following instances:

(a) radioactive isotopes;

(b) non-ionic radiographic contrast material; or

(c) gadolinium salts used in magnetic resonance imaging.

(4) Midwives services: MAD covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and rules and within the scope of their practice board and licensure. Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postnatal care.

(a) Separate trimesters completed and routine vaginal delivery can be covered if a MAP eligible recipient is not under the care of one provider for the entire prenatal, delivery and postnatal periods.

(b) MAD covers laboratory and diagnostic imaging services related to essentially normal pregnancy. These services can be billed separately.

(c) Non-covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(i) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the MAP eligible recipient;

(ii) services furnished by an apprentice; unless billed by the supervising midwife;

(iii) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

B. **Pharmaceutical, vaccines and other items obtained from a pharmacy:** MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to a pharmacy is not a MAD allowed benefit.

C. **Laboratory and diagnostic imaging services:** MAD covers medically necessary laboratory and diagnostic imaging services ordered by primary care provider (PCP), certified nurse practitioner (CNP), or clinical nurse specialists (CNS) and performed in the office by a provider or under his or her supervision by a clinical laboratory or a radiology laboratory, or by a hospital-based clinical laboratory or radiology laboratory that are a enrolled MAD provider. See 42 CFR Section 440.30.

(1) MAD covers interpretation of diagnostic imaging with payment as follows: when diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, payment is made only for the professional component of the service. This limitation does not apply if the hospital does not bill for any component of the radiology procedures and does not include the cost associated with furnishing these services in its cost reports.

(2) A provider may bill for the professional components of imaging services performed at a hospital or independent radiology laboratory if the provider does not request an interpretation by the hospital radiologist.

(3) Only one professional component is paid per radiological procedure.

(4) Radiology professional components are not paid when the same provider or provider group bills for professional components or interpretations and for the performance of the complete procedure.

(5) Professional components associated with clinical laboratory services are payable only when the work is actually performed by a pathologist who is not billing for global procedures and the service is for anatomic and surgical pathology only, including cytopathology, histopathology, and bone marrow biopsies, or as otherwise allowed by the Medicare program.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless a MAP eligible recipient is an inpatient of nursing facilities or hospitals.

(7) **Noncovered laboratory services:** MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from a MAP eligible recipient who is not a resident of a NF or hospital. MAD does not cover the following specific laboratory services:

(a) clinical laboratory professional components, except as specifically described under covered services above;

(b) specimens, including pap smears, collected in a provider's office or a similar facility and conveyed to a second provider's office, office laboratory, or non-certified laboratory;

(c) laboratory specimen handling or mailing charges;

(d) specimen collection fees other than those specifically indicated in covered services; and

(e) laboratory specimen collection fees for a MAP eligible recipient in NF or inpatient hospital setting.

D. **Reproductive health services:** MAD pays for family planning and other related health services [42 CFR Section 440.40(c)] and supplies furnished by or under the supervision of a MAD enrolled provider acting within the scope of his or her practice board or licensure.

(1) Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "*consent to sterilization*" or a "*hysterectomy acknowledgement*" form. MAD covers a medically necessary sterilization under the following conditions [42 CFR Section 441.251 et seq]:

(a) a MAP eligible recipient 21 years and older at the time consent is obtained;

(b) a MAP eligible recipient is not mentally incompetent. Mentally incompetent is a declaration of incompetency as made by a federal, state, or local court. A MAP eligible recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;

(c) a MAP eligible recipient is not institutionalized. For this section, institutionalized is defined as:

(i) an individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or an intermediate care facility for the care and treatment of mental illness;

(ii) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness;

(d) a MAP eligible recipient seeking sterilization must be given information regarding the procedure and the results before signing a consent form. This explanation must include the fact that sterilization is a final, irreversible procedure. A MAP eligible recipient must be informed of the risks and benefits associated with the procedure;

(e) a MAP eligible recipient seeking sterilization must also be instructed that his or her consent can be withdrawn at any time prior to the performance of the procedure and that he or she does not lose any other MAD benefits as a result of the decision to have or not have the procedure; and

(f) a MAP eligible recipient voluntarily gives informed consent to the sterilization procedure [42 CFR Section 441.257(a)].

(2) Hysterectomies: MAD covers only a medically necessary hysterectomy. MAD does not cover a hysterectomy performed for the sole purpose of sterilization [42 CFR Section 441.253].

(a) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by the MAP eligible recipient prior to the operation.

(b) Acknowledgement of the sterilizing results of the hysterectomy is not required from a MAP eligible recipient who has been previously sterilized or who is past child-bearing age as defined by the medical community. In this instance, the PCP signs the bottom portion of the hysterectomy form which states the MAP eligible recipient has been formerly sterilized, and attaches it to the claim.

(c) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

(3) **Other covered services:** MAD covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy or contraception.

(4) Noncovered reproductive health care: MAD does not cover the following specific services:

(a) sterilization reversal services;

(b) fertility drugs;

(c) in vitro fertilization;

(d) artificial insemination;

(e) hysterectomies performed for the sole purpose of family planning;

(f) induced vaginal deliveries prior to 39 weeks unless medically indicated;

(g) caesarean sections unless medically indicated; and

(h) elective procedures to terminate a pregnancy.

E. **Nutritional services:** MAD covers medically necessary nutritional services which are based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the MAP eligible recipient. MAD covers only those services furnished by PCP, licensed nutritionists or licensed dieticians. MAD covers the following services:

(1) nutritional assessments for a pregnant MAP eligible recipient and for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnosis and treatment (EPSDT) program. Nutritional assessment is defined as an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake;

(2) nutrition counseling to or on behalf of a MAP eligible recipient under 21 years of age who has been referred for a nutritional need. Nutrition counseling is defined as advising and helping a MAP eligible recipient obtain appropriate nutritional intake by integrating information from the nutrition assessment with information on food, other sources of nutrients and meal preparation, consistent with cultural background and socioeconomic status.

(3) Noncovered nutritional services: MAD covers only those services furnished by a PCP, licensed nutritionist or licensed dietician. MAD does not cover the following specific services:

(a) services not considered medically necessary for the condition of the MAP eligiblerecipient as determined by MAD or its designee;

(b) dietary counseling for the sole purpose of weight loss;

(c) weight control and weight management programs; and

(d) commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management. See 8.324.5 NMAC.

F. **Transplant services:** Non-experimental transplant services are covered. MAD does not cover any transplant procedures, treatments, use of a drug, a biological product, a product or a device which are considered unproven, experimental, investigational or not effective for the condition for which they are intended or used. See 8.325.6 NMAC.

G. **Dental services:** Dental services are covered as an optional medical service for a MAP eligible recipient. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the MAP eligible recipient [42 CFR Section 440.100(a)]. MAD also covers dental services, dentures and special services for a MAP eligible recipient who qualifies for services under the EPSDT program [42 CFR Section 441.55].

(1) Emergency dental care: MAD covers emergency care for all MAP eligible recipients. Emergency care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For a MAP eligible recipient under 21 years of age, care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) Prior authorization requirements are waived for emergency care, but the claim can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

(2) Diagnostic services: MAD coverage for diagnostic services is limited to the following:

(a) for a MAP eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(b) one clinical oral examination every 12 months for a MAP eligible recipient 21 years and older; and

(c) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

(3) Radiology services: MAD coverage of radiology services is limited to the following:

(a) one intraoral complete series every 60 months per MAP eligible recipient. This series includes bitewing x-rays;

(b) additional bitewing x-rays once every 12 months per MAP eligible recipient; and

(c) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per MAP eligible recipient.

(4) Preventive services: MAD coverage of preventive services is subject to certain limitations.

(a) Prophylaxis: MAD covers for a MAP eligible recipient under 21 years of age one prophylaxis service every six months. MAD covers for a MAP eligible recipient 21 years of age and older who has a developmental disability, as defined in 8.314.12 NMAC, one prophylaxis service every six months. For a MAP eligible recipient 21 years of age and older without a developmental disability, as defined in 8.314.12 NMAC, MAD covers one prophylaxis service once in a 12 month-period.

(b) Fluoride treatment: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride treatment every six months. For a MAP eligible recipient 21 years of age and older MAD, covers one fluoride treatment once in a 12-month period.

(c) Molar sealants: MAD only covers for a MAP eligible recipient under 21 years of age, sealants for permanent molars. Each MAP eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For a MAP eligible recipient 21 years of age and older, MAD does not cover sealant services.

(d) Space maintenance: MAD covers for a MAP eligible recipient under 21 years of age fixed unilateral and fixed bilateral space maintainers (passive appliances). For a MAP eligible recipient 21 years of age and older, MAD does not cover space maintenance services.

(5) Restorative services: MAD covers the following restorative services:

(a) amalgam restorations (including polishing) on permanent and deciduous teeth;

(b) resin restorations for anterior and posterior teeth;

(c) one prefabricated stainless steel crown per permanent or deciduous tooth;

(d) one prefabricated resin crown per permanent or deciduous tooth; and

(e) one recementation of a crown or inlay.

(6) Endodontic services: MAD covers therapeutic pulpotomy for a MAP eligible recipient under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

(7) Periodontic services: MAD covers for a MAP eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(a) a collaborative practice dental hygienist may provide periodontal scaling and root planning, per quadrant after diagnosis by a MAD enrolled dentist; and

(b) a collaborative practice dental hygienist may provide periodontal maintenance procedures with prior authorization.

(8) Removable prosthodontic services: MAD covers two denture adjustments per every 12 months per MAP eligible recipient. MAD also covers repairs to complete and partial dentures.

(9) Fixed prosthodontics services: MAD covers one recementation of a fixed bridge.

(10) Oral surgery services:

(a) simple and surgical extractions: MAD coverage includes local anesthesia and routine post-operative care. Erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(b) autogenous tooth reimplantation of a permanent tooth: MAD covers for a MAP eligible recipient under 21 years of age; and

(c) the incision and the drainage of an abscess for a MAP eligible recipient.

(11) Adjunctive general services: MAD covers emergency palliative treatment of dental pain for a MAP eligible recipient. MAD also covers general anesthesia and intravenous sedation for a MAP eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. For a MAP eligible recipient under 21 years of age, MAD covers the use of nitrous oxide analgesia. For a MAP eligible recipient 21 years of age and older, MAD does not cover the use of nitrous oxide analgesia.

(12) Hospital care: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with a prior authorization, unless one of the following conditions exist:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified; or

(c) any service which requires a prior authorization in an outpatient setting must have a prior authorization if performed in an inpatient hospital.

(12) Behavioral management: Dental behavior management as a means to assure comprehensive oral health care for persons with developmental disabilities is covered. This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment of a special needs MAP eligible recipient. Dentists who have completed the training and received their certification from DOH are eligible for reimbursement.

(13) Noncovered dental services: MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. MAD covers orthodontic services only for a MAP eligible recipient under 21 years of age and only when specific criteria are met to assure medical necessary. MAD does not cover the following specific services:

(a) surgical tray is considered part of the surgical procedure and is not reimburse separately for tray;

(b) sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

(c) oral preparations, including topical fluorides dispensed to a MAP eligible recipient for home use;

(d) permanent fixed bridges;

(e) procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

(f) procedures for desensitization, re-mineralization or tooth bleaching;

(g) occlusal adjustments, disking, overhang removal or equilibration;

(h) mastique or veneer procedures;

(i) treatment of TMJ disorders, bite openers and orthotic appliances;

(j) services furnished by non-certified dental assistants, such as radiographs;

(k) implants and implant-related services; or

(l) removable unilateral cast metal partial dentures.

H. **Podiatry and procedures on the foot:** MAD covers only medically necessary podiatric services furnished by a provider, as required by the condition of the MAP eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and rules. MAD covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, post a hazard to a MAP eligible recipient with a medical condition. MAD covers the treatment of warts on the soles of the feet (plantar warts). Medical justification for the performance of routine care must be documented in the MAP eligible recipient's medical record. MAD covers the following specific podiatry services.

(1) Routine foot care: Routine foot care services that do not meet the coverage criteria of medicare part B are not covered by MAD. MAD covers services only when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination. A MAP eligible recipient with diagnoses marked by an asterisk(*) in the list below must be under the active care of a physician. to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60-calendar days after the routine foot care service. A CNP, physician assistant (P.A.) and a CNS do not satisfy the coverage condition of "active care by a PCP".

(2) Common billed diagnoses: The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;

(b) arteriosclerosis obliterans;

(c) buerger's disease;

(d) chronic thrombophlebitis*;

(e) neuropathies involving the feet associated with:

(i) malnutrition and vitamin deficiency*;

(ii) malnutrition (general, pellagra);

(iii) alcoholism;
(iv) malabsorption (celiac disease, tropical sprue);
(v) pernicious anemia;
(vi) carcinoma*;
(vii) diabetes mellitus*;
(viii) drugs or toxins*;
(ix) multiple sclerosis*;
(x) uremia (chronic renal disease)*;
(xi) traumatic injury;
(xii) leprosy or neurosyphilis;
(xiii) hereditary disorders;
(xiv) hereditary sensory radicular neuropathy;
(xv) fabry's disease; and
(xvi) amyloid neuropathy.

(3) Routine foot care services: MAD covers routine foot care services for a MAP eligible recipient who has a systemic condition and meets the severity in the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) class A findings: non-traumatic amputation of foot or integral skeletal portion thereof;
(b) class B findings:
(i) absent posterior tibial pulse;
(ii) absent dorsalis pedis pulse; and
(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness);
(c) class C findings:
(i) claudication;
(ii) temperature changes (e.g., cold feet);
(iii) edema;
(iv) paresthesias (abnormal spontaneous sensations in the feet); or
(v) burning.

(4) Subluxated foot structure: Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

(5) Foot warts: MAD covers the treatment of warts on the feet.

(6) Asymptomatic mycotic nails: MAD covers the treatment of asymptomatic mycotic nails in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care.

(7) Mycotic nails: MAD covers the treatment of mycotic nails in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(a) marked, significant limitation;
(b) pain; or
(c) secondary infection.

(8) Orthopedic shoes and other supportive devices: MAD only covers these items when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics who is a MAP eligible recipient.

(9) Hospitalization: If the MAP eligible recipient has existing medical condition that would predispose him or her to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered.

(10) Noncovered podiatric services: A provider is subject to the limitations and coverage restrictions that exist for other medical services.

MAD does not cover the following specific services or procedures.

(a) Routine foot care is not covered except as indicated under "covered services" for a MAP eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(i) trimming, cutting, clipping and debriding toenails;

(ii) cutting or removal of corns, calluses, or hyperkeratosis;

(iii) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast MAP eligible recipient; and

(iv) any other service performed in the absence of localized illness, injury or symptoms involving the foot.

(b) Services directed toward the care or the correction of a flat foot condition are not covered. Flat foot is defined as a condition in which one or more arches of the foot have flattened out.

(c) Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to a diabetic MAP eligible recipient.

(d) Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

(e) MAD will not reimburse for services that have been denied by medicare for coverage limitations.

I. **Anesthesia:** MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the MAP eligible recipient. All services must be provided within the limits of MAD benefit package, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and rules.

(1) 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.

(2) An anesthesia service is not covered if the medical or surgical procedure is not a MAD covered service.

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

(4) Separate payment is not allowed for the anesthesia complicated by the physical status of the MAP eligible recipient.

J. **Vision:** MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a MAP eligible recipient. MAD pays for the correction of refractive errors required by the condition of the MAP eligible recipient. All services must be furnished within the limits of the MAD benefits package, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules.

(1) Vision exam: MAD covers routine eye exams. Coverage for an eligible adult recipient 21 years of age and older of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the MAP eligible recipient's visual examination record and indicated by diagnosis on the claim. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

(2) Noncovered vision services: MAD does not cover vision services that are performed for aesthetic or cosmetic purposes. MAD covers orthoptic assessments and treatments only when specific criteria are met to assure medical necessity.

K. **Hearing:** All audiology screening, diagnostic, preventive or corrective services require medical clearance. Audiologic and vestibular function studies are rendered by an audiologist or a PCP. Hearing aid dealers and dispensers are not reimbursed for audiological, audiometric or other hearing tests. Only licensed audiologists and PCPs are reimbursed for providing these testing services.

L. **Client medical transportation:** MAD covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MAP eligible recipient in or out of his or her home community [42 CFR 440.170]. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment. MAD reimburses a MAP eligible recipient or the transportation provider for medically necessary transportation subject to the following:

(1) free alternatives: Alternative transportation services which may be provided free of charge include volunteers, relatives or transportation services provided by a nursing facility (NF) or another residential center. A MAP eligible recipient must certify in writing that he or she does not have access to free alternatives;

(2) least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before the MAP eligible recipient can use more expensive transportation alternatives;

(3) non-emergency transportation service: MAD covers non-emergency transportation services for a MAP eligible recipient who does not have primary transportation to a MAD covered service and who is unable to access a less costly form of public transportation;

(4) long distance common carriers: MAD covers long distance services furnished by a common carrier if the MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the MAP eligible recipient's local county income support division (ISD) office;

(5) ground ambulance services: MAD covers services for a MAP eligible recipient provided by ground ambulances when:

(a) an emergency which requires ambulance service is certified by the attending provider or is documented in the provider's records as meeting emergency medical necessity as defined as:

(i) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(ii) medical necessity for ambulance services is established if the MAP eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health;

(b) scheduled, non-emergency ambulance services: these services are covered when ordered by the MAP eligible recipient's attending provider who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's medical or behavioral condition; and

(c) Reusable items and oxygen: MAD covers non-reusable items and oxygen required during transportation. Coverage for these items is included in the base rate reimbursement for a ground ambulance;

(6) air ambulance services: MAD covers services for a MAP eligible recipient provided by an air ambulance, including a private airplane, if an emergency exists and the medical necessity for the service is certified by his or her attending provider.

(a) an emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(b) MAD covers the following services for air ambulances:

(i) non-reusable items and oxygen required during transportation;

(ii) professional attendants required during transportation; and

(iii) detention time or standby time up to one hour without provider documentation; if the detention or standby time is more than one hour, a statement from the attending provider or flight nurse justifying the additional time is required;

(7) lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical or behavioral health services and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, in-state lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15-calendar days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the attending provider's statement of need. Authorization forms for direct payment to a MAD approved lodging provider by MAD are available through local county ISD offices. In addition, overnight lodging could include the following situations:

(a) a MAP eligible recipient who is required to travel more than four hours each way to receive medical or behavioral health services; or

(b) a MAP eligible recipient who is required to travel less than four hours each way and is receiving daily medical or behavioral health services and is not sufficiently stable to travel or must be near a facility because of the potential need for emergency or critical care.

(8) meal services: MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to a meal provider by MAD are available through local county ISD offices.

(9) coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for a MAP eligible recipient for one attendant if the medical necessity for the attendant is certified in writing by the MAP eligible recipient's attending provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. MAD only covers transportation services or related expenses for a MAP eligible recipient and as certified, his or her attendant. Transportation services and related expenses will not be reimbursed by MAD for any other individual accompanying the MAP eligible recipient to a MAD covered medical or behavioral health service.

(10) coverage for a MAP eligible waiver recipient: Transportation of a MAP eligible waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy or an outpatient behavioral health therapy.

(11) out-of-state transportation and related expenses: All out-of-state transportation, meals and lodging must be prior approved by MAD or its designee. Out-of-state transportation is approved only if the out-of-state medical or behavioral health service is approved by MAD or its designee. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

(a) Requests for out-of-state transportation must be coordinated through MAD or its designee;

(b) Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30-calendar days by MAD or its designee. Re-evaluation authorizations are completed prior to expiration and every 30-calendar days, thereafter;

(c) Border cities: A border city is a city within 100 miles of a New Mexico border (Mexico excluded). Transportation to a border city is treated as in-state provider service. A MAP eligible recipient who receives a MAD reimbursable service from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, to determine when a provider is considered an out-of-state provider or a border area provider.

(12) client medical transportation fund: In a non-emergency situation, a MAP eligible recipient can request reimbursement from the client medical transportation (CMT) fund through his or her local county ISD office for money spent on transportation, meals and lodging by the MAP eligible recipient. For reimbursement from the CMT fund, a MAP eligible recipient must apply for reimbursement within 30-calendar days from the date of appointment or the date he or she is discharged from the hospital.

(a) Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the MAD approved provider visit to receive reimbursement:

(i) submit a letter on the provider's stationary which indicates that the MAP eligible recipient kept the appointment for which the CMT fund reimbursement is requested. For medical or behavioral health services, written receipts confirming the date of service must be given to the MAP eligible recipient for submission to the local county ISD office;

(ii) proper referral with original signatures and documentation stating that the MAD services are not available within the community from the MAD requesting provider, when a referral is necessary;

(iii) verification of current eligibility of the recipient for a MAD service for the month the appointment and travel is made;

(iv) certification that free alternative transportation services are not available and that the MAP eligible recipient is not enrolled in a HSD contracted managed care organization (MCO);

(v) verification of mileage; and

(vi) documentation justifying a medical attendant.

(b) Preparation of referrals for travel outside the home community: If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical care, the transportation provider must obtain a written verification from the referring provider or from the service provider containing the following information for the provider to retain with his or her billing records:

(i) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(ii) the name of the out of community medical or behavioral health provider; and

(iii) justification that the medical or behavioral health care is not available in the home community.

(c) Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. An emergency is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical or behavioral health appointment.

(i) The ISD CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate utilization review (UR) contractor verifies that the recipient is eligible for a MAD service and has a medical or behavioral health appointment prior to advancing money from the CMT fund and that the MAP eligible recipient is not enrolled in a HSD contracted MCO;

(ii) written referral for out of community service must be received by the CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate UR contractor no later than 30-calendar days from the date of the medical or behavioral health appointment for which the advance funds were requested. If a MAP eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated; see Section OIG-900, Restitutions.

(d) MAP Eligible recipients enrolled in a HSD contracted MCO: A member enrolled in HSD contracted MCO on the date of service is not eligible to use the client medical transportation fund for services that are the responsibility of the MAP eligible recipient's MCO.

(13) Noncovered transportation services: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a non-covered MAD service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

(a) an attendant where there is not the required certification from the MAP eligible recipient's medical or behavioral health provider;

(b) minor aged children of the MAP eligible recipient that are simply accompanying him or her to medical or behavioral health service;

(c) transportation to a non-covered MAD service;

(d) transportation to a pharmacy provider; see 8.324.7 NMAC.

M. **Telemedicine services:**

(1) The telemedicine originating-site is the location of a MAP eligible recipient at the time the service is being furnished via an interactive telemedicine communications system. The origination-site can be any medically warranted site. An interactive telemedicine communication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant-sites. Coverage for services rendered through telemedicine provided at the originating-site are covered to the same extent the service and the provider are covered when not provided through telemedicine. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities.

(2) The distant-site is the location where the PCP or practitioner is physically located at time of the telemedicine service. All services are covered to the same extent the service and the provider are covered when not provided through telemedicine. For these services, use of the telemedicine communications system fulfills the requirement for a face-to-face encounter.

(3) Store and forward technology for images is covered when the image was captured and transferred using a telemedicine system during a telemedicine event.

(4) Telemedicine providers: Reimbursement for services at the originating-site and the distant-site are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

(5) A telemedicine originating-site communication system fee is covered if the MAP eligible recipient was present at and participated in the telemedicine visit at the originating-site and the system in use meets the definition of a telemedicine system.

(6) Noncovered telemedicine services: A service provided through telemedicine is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine.

N. **Transplantation services:** MAD covered transplantation services include hospital, a PCP, laboratory, outpatient surgical, and other MAD covered services necessary to perform the selected transplantation.

Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement.

O. **Pregnancy termination services:** MAD does not cover the performance of 'elective' pregnancy termination procedures. MAD will only pay for services to terminate a pregnancy when certain conditions are met.

(1) A provider of pregnancy termination services must submit with his or her billing, the written certification of a provider that the procedure meets one of the following conditions:

(a) the procedure is necessary to save the life of the MAP eligible recipient as certified in writing by a provider;

(b) the pregnancy is a result of rape or incest, as certified by the treating provider, the appropriate reporting agency, or if not reported, the MAP eligible recipient is not physically or emotionally able to report the incident; or

(c) the procedure is necessary to terminate an ectopic pregnancy; or

(d) the procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient.

(2) Psychological services: MAD covers behavioral health services for a pregnant MAP eligible recipient.

(3) Oral medications: MAD covers oral medications approved by the FDA have been determined a benefit by MAD for pregnancy termination. MAD will cover oral medications when administered by a provider acting within the scope of his or her practice board and licensure.

(4) Informed consent: Under New Mexico law, the provider may not require any MAP eligible recipient to accept any medical service, diagnosis, or treatment or to undergo any other health service provided under the plan if the MAP eligible recipient objects on religious grounds or in the case of a non-emancipated MAP eligible recipient, the legal parent or guardian of the non-emancipated MAP eligible recipient objects.

(a) Consent: Voluntary, informed consent by a MAP eligible recipient 18 years of age and older, or an emancipated minor MAP eligible recipient must be given to the provider prior to the procedure to terminate pregnancy, except in the following circumstances:

(i) in instances where a medical emergency exists; a medical emergency exists in situations where the attending PCP certifies that, based on the facts of the case presented, in his or her best clinical judgment, the life or the health of the MAP eligible recipient is endangered by the pregnancy so as to require an immediate pregnancy termination procedure;

(ii) in instances where the MAP eligible recipient is unconscious, incapacitated, or otherwise incapable of giving consent. In such circumstances, the consent shall be obtained as prescribed by New Mexico law;

(iii) in instances where pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the MAP eligible recipient;

(iv) consent is valid for 30-calendar days from the date of signature, unless withdrawn by the MAP eligible recipient prior to the procedure.

(b) Required acknowledgements: In signing the consent, the MAP eligible recipient must acknowledge that she has received, at least, the following information:

(i) alternatives to pregnancy termination;

(ii) medical procedure(s) to be used;

(iii) possibility of the physical, mental, or both, side effects from the performance of the procedure;

(iv) right to receive pregnancy termination behavioral health services from an independent MAD provider; and

(v) right to withdraw consent up until the time the procedure is going to be performed.

(c) Record retention: A dated and signed copy of the consent, with counseling referral information, if requested, must be given to the MAP eligible recipient. The provider must keep the original signed consent with the MAP eligible recipient's medical records.

(d) Consent for a MAP eligible recipient under 18 years of age who is not an emancipated minor, in instances not involving life endangerment, rape or incest: Informed written consent for an non-emancipated minor to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or another adult acting 'in loco parentis' to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating PCP shall note the minor's objections or the unavailability of the parent or guardian in the minor's chart, and:

(i) certify in his or her best clinical judgment, the minor is mature enough and well enough informed to make the decision about the procedure. In the circumstance where sufficient maturity and information is not present or apparent, certify that the procedure is in the minor's best interests based on the information provided to the treating PCP by the minor; or,

(ii) refer the minor to an independent MAD behavioral health provider in circumstances where the treating PCP believes behavioral health services are necessary before a clinical judgment can be rendered on the criteria established in paragraph (1) above. The referral shall be made on the same day of the visit between the minor and the treating PCP where consent is discussed. The independent MAD behavioral health provider shall meet with the minor and confirm in writing to the treating PCP whether or not the minor is mature enough and sufficiently informed to make the decision about the procedure. In the circumstance where sufficient maturity and information is not present or apparent, that the procedure is in the minor's best interests based on the information provided to the independent MAD behavioral health provider by the minor; this provider's written report is due to the treating PCP within 72 hours of initial referral;

(iii) a minor shall not be required to obtain behavioral health services referenced in paragraph (2) above; however, if the treating PCP is unable or unwilling to independently certify the requirements established in paragraph (1) above, the minor must be informed by the treating PCP that written consent must be obtained by the parent, legal guardian or parent 'in loco parentis' prior to performing the procedure; or, that the minor must obtain a court order allowing the procedure without parental consent.

P. **Behavioral health professional services:** Behavioral health services are addressed specifically in 8.321.2 NMAC.

Q. **Experimental or investigational services:** MAD covers medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD; see 8.325.6 NMAC. Covered transplantation services include a hospital, a PCP, a laboratory, an outpatient surgical and other MAD-covered services necessary to perform the selected transplantation. Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement. MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices, except the following:

(1) phase I, II, III or IV: MAD may approve coverage for routine patient care costs incurred as a result of the MAP eligible recipient's participation in a phase I, II, III, or IV cancer trial that meets the following criteria. The cancer clinical trial is being conducted with the approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the FDA in the form of an investigational new drug application;

(e) the federal department of veteran affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

(2) Review and approval: The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research risks of the federal national institutes of health.

(3) Experimental or investigational interventions: Any medical, surgical, or other healthcare procedure or treatment, including the use of a drug, a biological product, another product or device, is considered experimental or investigational if it meets any of the following conditions:

(a) current, authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of a drug, a biological product, another product or device for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting;

(b) the drug, biological product, other product, device, procedure or treatment (the "technology") lacks final approval from the FDA or any other governmental body having authority to regulate the technology;

(c) the medical, surgical, other health care procedure or treatment, including the use of a drug, a biological product, another product or device is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting.

(4) Review of conditions: On request of MAD or its designee, a provider of a particular service can be required to present current, authortative medical and scientific evidence that the proposed technology is not considered experimental or investigational.

(5) Reimbursement: MAD does not reimburse for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products or devices that are considered experimental or investigational, except as specified as follows. MAD will reimburse a provider for routine patient care services, which are those medically necessary services that would be covered if the MAP eligible recipient were receiving standard cancer treatment, rendered during the MAP eligible recipient's participation in phase I, II, III, or IV cancer clinical trials.

(6) Experimental or investigational services: MAD does not cover procedures, technologies or therapies that are considered experimental or investigational; see 8.325.6 NMAC.

R. **Smoking cessation:** MAD covers tobacco cessation services for a pregnant MAP eligible recipient and for a MAP eligible recipient under the age of 21 years of age.

(1) Eligible medical, dental, and behavioral health practitioner: Cessation counseling services may be provided by one of the following:

(a) by or under the supervision of a physician; or

(b) by any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law.

(c) Generally, eligible practitioners would be medical practitioners, including independently enrolled CNPs, behavioral health and dental practitioners. Physician assistants and CNPs not enrolled as independent MAD providers, and registered nurses and dental hygienists may bill for counseling services through the enrolled entity under which their other services are billed, when under the supervision of a dentist or physician.

(d) Counseling service must be prescribed by a MAD enrolled licensed practitioner.

(2) Eligible pharmacy providers: For rendering tobacco cessation services, eligible pharmacists are those who have attended at least one continuing education course on tobacco cessation in accordance with the federal public health guidelines found in the United States department of health and human services; public health services' *Quick Reference Guide for Clinicians*, and *Treating Tobacco Use and Dependence.*

(3) Tobacco cessation drug items: MAD covers all prescribed tobacco cessation drug items for a MAP eligible recipient as listed in this section when ordered by a MAD enrolled prescriber and dispensed by a MAD enrolled pharmacy. MAD does not require prior authorization for reimbursement for tobacco cessation products, but the items must be prescribed by a MAD enrolled practitioner. Tobacco cessation products include, but are not limited to the following:

(a) sustained release buproprion products;

(b) varenicline tartrate tablets; and

(c) prescription and over-the-counter (OTC) nicotine replacement drug products, such as a patch, gum, or inhaler.

(4) Covered services: MAD makes reimbursement for assessing a pregnant or postpartum MAP eligible recipient's tobacco dependence including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, and may bill using the E&M codes. MAD covers face-to-face counseling when rendered by an appropriate provider. The effectiveness of counseling is comparable to pharmacotherapy alone. Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session refers face-to-face MAP eligible recipient contact of either

(a) intermediate session (greater than three minutes up to 10 minutes); or

(b) intensive session (greater than 10 minutes).

(5) Documentation for counseling services: Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered, which may consist of documentation of tobacco use. The rendering practitioner must maintain documentation that face-to-face counseling was prescribed by a practitioner, even if the case is a referral to self, consistent with other MAD NMAC rules and other materials.

(6) Limitations on counseling sessions: A cessation counseling attempt includes up to four cessation counseling sessions (one attempt plus up to four sessions). Two cessation counseling attempts (or up to eight cessation counseling sessions) are allowed in any 12-month period. During the 12-month period, the practitioner and the MAP eligible recipient have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

S. **Other services:** Other covered and noncovered services including hospitalization and other residential facilities, devices for hearing and vision correction, behavioral health services, home and community based services, EPSDT services, case management and other adjunct and specialty services are described in other NMAC rules.
[8.310.2.12 NMAC - Rp, 8.310.2.12 NMAC, 1-1-14]

8.310.2.13 GENERAL NONCOVERED SERVICES

A. **General noncovered services:** MAD does not cover certain procedures, services, or miscellaneous items. See specific provider or service rules or sections of this rule for additional information on service coverage and limitations. A provider cannot turn an account over to collections or to any other factor intending to collect from the MAP eligible recipient or his or her authorized representative.; see 8.302.2.NMAC. A provider cannot bill a MAP eligible recipient or his or her authorized representative for the copying of the MAP eligible recipient's records, and must provide copies of the MAP eligible recipient's records to other providers upon request of the MAP eligible recipient.

B. **Appointment, interest and carrying charges:** MAD does not cover penalties on payments for broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts. A provider may not bill a MAP eligible recipient or his or her authorized representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of CHIP or WDI who may be charged up to $5 for a missed appointment.

C. **Contract services:** Services furnished by a contractor, an organization, or an individual who is not the billing provider must meet specific criteria for coverage as stated in MAD or its designee's MAD NMAC rules, billing instructions, policy manuals; see 8.302.2 NMAC.

D. **Cosmetic services and surgeries:** MAD does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, for hair loss, and personal care items such as non-prescription lotions, shampoos, soaps or sunscreens. MAD does not cover cosmetic surgeries performed for aesthetic purposes. "*Cosmetic surgery*" is defined as a procedure performed to improve the appearance of physical features that may or may not improve the functional ability of the area of concern. MAD covers only a surgery that meets specific criteria and is approved as medically necessary reconstructive surgery.

E. **Postmortem examinations:** MAD does not cover postmortem examinations.

F. **Education or vocational services:** MAD does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for a MAP eligible recipient under 21 years of age, as part of the EPSDT program and for a pregnant MAP eligible recipient. MAD does not cover formal educational or vocational training services, unless those services are included as active treatment services for a MAP eligible recipient in intermediate care facility for individuals with intellectual disabilities (ICF-IID)or for a MAP eligible recipient under 21 years of age receiving inpatient psychiatric services [42 CFR 441.13(b)]. "*Formal educational services*" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of a MAP eligible recipient for paid or unpaid employment.

G. **Hair or nail analysis:** MAD does not cover hair or nail analysis.

H. **Preparations dispensed for home use:** MAD does not cover oral, topical, otic, or ophthalmic preparations dispensed to a MAP eligible recipient by a PCP, a CNP, a P.A., or an optometrist for home use or self administration unless authorized by MAD to assure the availability of medications.

I. **Telephone services:** MAD does not cover any telephone consultations between the MAP eligible recipient and his or her provider.

J. **Routine physical examinations:** MAD only covers a routine physical examination for a MAP eligible recipient residing in a NF or an ICF-IID facility. Physical examinations, screenings, and treatment are available to a MAP eligible recipient under 21 years of age through the tot to teen healthcheck screen, New Mexico's EPSDT screening program.

K. **Screening services:** MAD does not cover screening services that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. MAD covers screening services for a MAP eligible recipient under 21 years of age through the tot to teen healthcheck program. MAD covers screening services ordered by a provider for cancer detection such as pap smears and mammograms for a MAP eligible recipient when medically appropriate.

L. **Services not covered by medicare:** MAD does not cover services, procedures, or devices that are not covered by medicare due to their determination that the service is not medically necessary or that the service is experimental or not effective.

M. **Bariatric surgery services:** Bariatric surgery services are covered only when medically indicated and alternatives are not available.

N. **Services and tests which are not routinely warranted due to the MAP eligible recipient's age:** MAD does not reimburse for routine screening, tests, or services which are not medically necessary due to the age of the MAP eligible recipient:

(1) Papanicolaou test (pap smear) for women under 21 years of age unless prior history or risk factors make the test medically warranted; and

(2) prostate specific antigen (PSA) test for men under age 40 unless prior history or risk factors make the test medically warranted.

O. **Services for surrogate mothers:** MAD does not pay for services for pregnancy, complications encountered during pregnancy related conditions, prenatal care and post partum care, or delivery for services to a surrogate mother for which an agreement or contract between the surrogate mother and another party exists. [8.310.2.13 NMAC - Rp, 8.310.2.13 NMAC, 1-1-14]

8.310.2.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to UR 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. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for hard 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:** Procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization was obtained remain subject to UR at any point in the payment process, including after payment has been made. It is the provider's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary, see 8.311.2.16 NMAC.

(1) Dental services: MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when a prior authorization is received from MAD or its designee. MAD covers medically necessary orthodontic services to treat handicapping malocclusions for a MAP eligible recipient under 21 years of age by prior authorization.

(2) Transplantation services: A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

(3) Pregnancy termination services: Services to terminate a pregnancy do not require a prior authorization from MAD or its designee.

(4) Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for MAD 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 a MAP eligible recipient has other health insurance.

(5) Reconsideration: A provider who disagrees with a prior authorization -request denial and another review decision can request reconsideration; see 8.350.2 NMAC.

B. **Prior authorization and UR:** MAD has developed an UR process to regulate provider compliance with MAD quality control and cost containment objectives [42 CFR Section 456, *Utilization Control*]. Specific details pertinent to a service or a provider are contained in MAD NMAC rules or UR instructions for that specific service or provider type. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, UR 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 his or her MAD provider participation agreement (PPA) and all applicable statutes, regulations, rules, and executive orders.

MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made.

C. **Medical necessity requirements:** MAD reimburses a provider for furnishing MAD covered service to a MAP eligible recipient only when the service is medically necessary. Medical necessity is required for the specific service, level of care (LOC), and service setting, if relevant to the service. A provider must verify that MAD covers a specific service and that the service is medically necessary prior to furnishing the service. Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service that are reviewed and approved by MAD. MAD denies payment for services that are not medically necessary and for services that are not covered by MAD. The process for determining medical necessity is called UR. The UR of a MAD service may be performed directly by MAD or its designee, or another state agency designated by MAD.

D. **Timing of UR:**

(1) A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements. The following are examples of the reviews that may be performed:

(a) prior authorization review (review occurs before the service is furnished);

(b) concurrent review (review occurs while service is being furnished);

(c) pre-payment review (claims review occurring after service is furnished but before payment);

(d) retrospective review (review occurs after payment is made); and

(e) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

(2) Prior authorization reviews: A claim for a service that requires a prior authorization are paid only if the prior authorization was obtained and approved by MAD or MAD's UR contractor, prior to services being furnished. A prior authorization specifies the approved number of service units that a provider is authorized to furnish to a MAP eligible recipient and the date the service must be provided.

(a) A prior authorization does not guarantee that an individual is eligible for a specific MAD service. A provider must verify that individuals are eligible for a specific MAD service at the time the service is furnished.

(b) Information on the specific service or procedure that requires a prior authorization for a specific provider type are contained in the applicable MAD rules and the UR instructions for that provider type or service.

(c) A service that has been approved by MAD or its designee does not prevent a later denial of payment if the service has been determined to be not medically necessary or if the individual was not eligible for the service.

(d) A prior authorization review is used to authorize service for a MAP eligible recipient before a service is furnished. A request for a retroactive prior authorization may be approved only under the following circumstances:

(i) approval is made as part of the process of determining MAD eligibility for certain categories, such as a MAD institutional care or home and community-based services waiver (HCBSW) programs. In these situations, the determination of medical necessity for an institutional LOC of the service is a factor in establishing MAD eligibility and may be made after the MAP eligible recipient receives NF or HCBSW services;

(ii) the service is furnished before the determination of the effective date of the recipient's MAP eligibility for a MAD service or the servicing provider's MAD PPA; a retrospective request for a prior authorization is based on retrospective recipient or provider eligibility must be received in writing by MAD or its designee within 30 calendar days of the date of the eligibility determination;

(iii) in cases of medical emergency. A medical emergency is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in one of the following:

(a) an individual's death;

(b) placement of an individual's health in serious jeopardy;

(c) serious impairment of bodily functions; or

(d) serious dysfunction of any bodily organ or part.

(iv) a service that is furnished to a medicare recipient who is also eligible for a MAD service and medicare has denied payment for a reason that is not based on medical necessity. Requests for a retroactive prior authorization must be accompanied by a copy of the document from medicare that denied payment

and states the reason for denial. A service denied payment by medicare because of lack of medical necessity is not covered by MAD.

(3) Concurrent review: A concurrent review is conducted while the service is being furnished. A continued stay or continued service review is concurrent review for medical necessity.

(4) Prepayment review: A prepayment review is conducted after a service has been furnished and a claim for payment has been filed by the provider. If a service is not a covered MAD benefit or not medically necessary, payment for that service will be denied.

(5) Retrospective review: A retrospective review is conducted after the claim has been processed and payment is made. Information from the paid claim is compared with the provider records detailing the service and medical necessity.

(a) If MAD determines the service specified on the claim was not performed or, was not a covered benefit or was not medically necessary, the MAD payment is recouped.

(b) Retrospective review involves the review of a specific portion or the entire record of service. Depending on the service, validation of either or both the diagnosis or procedure, validation of diagnostic related groups (DRGs), and quality of care are examples of indicators or issues which may be reviewed.

(c) A retrospective review may be conducted by MAD or its designee on a random or selective basis. In addition to reviews performed by a MAD staff or its designee, MAD analyzes statistical data to determine utilization patterns. Specific areas of overutilization may be identified that result in recoupment or repayment from either or both a provider or the assignment of a MAP eligible recipient to a MAD medical management designated provider.

(d) A selective or scheduled review is conducted to focus on the overutilization and underutilization of a specific service or provider. The service or procedure selected for this focused retrospective review is identified by MAD as potential or actual problems.

E. **Denial of payment:** If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

F. **Review of decisions:** A provider who disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision; see 8.350.2 NMAC. A provider who is not satisfied with the reconsideration determination may request a HSD provider administrative hearing; see 8.352.3 NMAC.

[8.310.2.14 NMAC - Rp, 8.310.2.14 NMAC, 1-1-14]

HISTORY OF 8.310.2 NMAC:

History of Repealed Material:

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 3 PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT

8.310.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.3.1 NMAC - Rp, 8.310.3.1 NMAC, 1-1-4]

8.310.3.2 SCOPE: The rule applies to the general public.
[8.310.3.2 NMAC - Rp, 8.310.3.2 NMAC, 1-1-4]

8.310.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1-1-4]

8.310.3.4 DURATION: Permanent.
[8.310.3.4 NMAC - Rp, 8.310.3.4 NMAC, 1-1-4]

8.310.3.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.3.5 NMAC - Rp, 8.310.3.5 NMAC, 1-1-4]

8.310.3.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.3.6 NMAC - Rp, 8.310.3.6 NMAC, 1-1-4]

8.310.3.7 DEFINITIONS: [RESERVED]

8.310.3.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.310.3.8 NMAC - Rp, 8.310.3.8 NMAC, 1-1-4]

8.310.3.9 ELIGIBLE PROVIDERS:

A. Health care to eligible medical assistance program (MAP) recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by the HSD medical assistance division (MAD). Upon approval of a New Mexico MAD provider participation agreement (PPA) 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 a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD New Mexico administrative code (NMAC) 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. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD PPA 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. Upon approval of the New Mexico medical assistance PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) medical practitioners:

(a) a physician licensed to practice medicine or osteopathy;

(b) a licensed certified nurse practitioner under the supervision or in collaboration with a physician or as an independent practitioner;

(c) a licensed physician assistant certified by the national commission on certification of physician assistants under the supervision of a physician;

(d) a licensed pharmacist clinician under the supervision of a physician;

(e) a licensed clinical nurse specialist under the supervision or in collaboration with a physician or as an independent practitioner;

(f) a licensed nurse anesthetist certified by the American association of nurse anesthetists council on certification of nurse anesthetists;

(g) a licensed anesthesiologist assistant certified by the national commission for certification of anesthesiologist assistants (NCCAA);

(h) a licensed podiatrist;

(i) a licensed and certified nurse midwife;

(j) a licensed midwife;

(k) a licensed dietician or a licensed nutritionist under the direction of a licensed physician;

(l) a licensed optometrist; or

(m) a licensed audiologist certified by the American speech and hearing association;

(2) dental practitioners:

(a) a licensed dentist; or

(b) a licensed dental hygienist certified for collaborative practice;

(3) therapists:

(a) a physical therapist licensed by the physical therapy board under the state of New Mexico regulations and licensing division (RLD);

(b) an occupational therapist licensed by the board of occupational therapy under RLD; or

(c) a speech pathologist licensed by the board of speech, language, hearing under RLD;

(4) clinical laboratory, radiology, and diagnostic facilities:

(a) an independent clinical laboratory having a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory;

(b) a licensed radiological facility; or

(c) a licensed diagnostic laboratory;

(5) transplant centers: practitioners and facilities licensed or certified to furnish specialized transplant medical or surgical services;

(6) other providers described in other rules found in the MAD NMAC rules eligible to provide services or receive reimbursement, such as behavioral health services, early and periodic screening, diagnostic and treatment (EPDST) services, institutional services, and other specialized services.

B. Upon approval of the New Mexico MAD PPA agreement by MAD or its designee, the clinic, professional association, or other legal entity may be enrolled as a MAD provider in order that payment may be made to the clinic, professional association, or other legal entity formed by one or more individual practitioners. The individual practitioners that are employed by or contracted by the clinic, professional practice or other legal entity must also be enrolled as individual providers. All requirements under state law and regulations or rules regarding supervision, direction, and approved supervisory practitioners must be met. Such entities include:

(1) professional components for inpatient and outpatient institutions;

(2) professional corporations and other legal entities;

(3) licensed diagnostic and treatment centers, including a birthing center licensed as a diagnostic and treatment center;

(4) licensed family planning clinics;

(5) public health clinics or agencies;

(6) Indian health services (IHS) facilities; and

(7) PL.93-638 tribal 638 facilities.

C. All services rendered must be within the legal scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD including meeting requirements for medical necessity.

D. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers outside of New Mexico, a provider's out of state license may be accepted in lieu of licensure in New Mexico if the out of state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

E. Additional licensure or certification requirements may be required for specialized services such as services provided to MAP special needs recipients. Transplantation providers are eligible for enrollment if licensed as state transplantation centers by the licensing and certification bureau of the New Mexico department of health (DOH); or if certified as transplantation centers by the centers for medicare and medicaid services (CMS).

F. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and MAD NMAC rules or meet federal requirements for providing services to IHS facilities or tribal contract facilities.
[8.310.3.9 NMAC - Rp, 8.310.3.9 NMAC, 1-1-4]

8.310.3.10 COVERED SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of MAD NMAC rules and benefits and within the scope and practice of the provider's professional standards.
[8.310.3.10 NMAC - Rp, 8.310.3.10 NMAC, 1-1-4]

8.310.3.11 REIMBURSEMENT: Providers must submit claims for reimbursement on the CMS-1500, American dental association (ADA), or universal billing (UB) claim form or their successor or their electronic equivalents, as appropriate to the provider type and service.

A. A provider is responsible for following coding manual guidelines and CMS national correct coding initiatives, including not improperly unbundling or upcoding services, not reporting services together inappropriately, and not reporting an inappropriate number or quantity of the same service on a single day. Bilateral procedures and incidental procedure are also subject to special billing payment policies. The payment for some services includes payment for other services. For example, payment for a surgical procedure may include hospital visits and follow up care or supplies which are not paid separately.

B. General reimbursement:

(1) reimbursement to professional service providers is made at the lesser of the following:

(a) the provider's billed charge; or

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

(2) the billed charge must be the provider's usual and customary charge for the service or procedure.

(3) "usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.

C. Reimbursement limitations:

(1) nurses: reimbursement to a CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

(2) midwife services: reimbursement for midwife maternity services is based on one global fee, which includes prenatal care, delivery and postnatal care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at 77 percent of the rate paid to physicians for furnishing the global services and at 100 percent of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule;

(3) surgery: surgical assistants are reimbursed at 20 percent of the allowed primary surgeon amount. Surgical assistants are paid only when the surgical code allows for assistants as determined by medicare, CMS, or MAD. Physician assistants and pharmacist clinicians are not eligible to receive reimbursement for assisting during surgery. CNP's, midwives, and CNS's can only be paid as surgical assistants when it is within the scope of their practice as determined by state statute and their licensing boards.

(4) physician extenders: physician assistants, pharmacist clinicians and other providers not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works.

(5) hospital settings: reimbursement for services provided in hospital settings that are ordinarily furnished in a provider's office is made at 60 percent of the fee schedule allowed amount. MAD follows medicare principles in determining which procedures and places of service are subject to this payment reduction. For services not covered by medicare, the determination is made by MAD. For facility-based providers, costs billed separately as a professional component must be identified for exclusion from the facility cost report prior to cost settlement or rebasing.

(6) dietician and nutrition services: for nutritional counseling services, physicians and clinics must include the charges for nutritional services in the office visit code when services are furnished by physicians. The level of the office visit reflects the length and complexity of the visit. For services furnished as part of prenatal or postpartum care, nutritional counseling services are included in the reimbursement fees for prenatal and postpartum care and are not reimbursed separately. Nutritional assessment and counseling services can be billed as a separate

charge only when services are furnished to a MAP eligible recipient under age 21 by licensed nutritionists or licensed dieticians who are employed by eligible providers. Reimbursement is made to eligible providers and not directly to the nutritionists or dieticians.

(7) laboratory and diagnostic imaging reimbursement limitations:

(a) use of medicare maximums: the MAD payment does not exceed the amount allowed by medicare for any laboratory service. Medicare notifies MAD on an annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums for reimbursement upon implementation by MAD.

(b) referrals from providers: physicians and other private practitioners cannot bill for laboratory tests which are sent to an outside laboratory or other facility. Payment for laboratory services cannot be made directly to a practitioner unless the tests were performed in his or her own office. Laboratories can bill for tests sent to other laboratories only if the CLIA number of the other laboratory is identified on the claim form. State facilities which contract for services with other state-operated laboratories, such as the state health laboratory, can bill for those services providing the amount billed for the service does not exceed the amount paid by the state facility to the contractor.

(c) reimbursement for collection costs: MAD does not reimburse an independent clinical laboratory separately for associated collection costs such as office visits, home visits or nursing home visits.

(d) services performed as profile or panel: individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel. MAD cannot be billed for individual lab procedures that are considered included in a profile or panel.

(8) radiology:

(a) non-profit licensed diagnostic and treatment centers and state facilities: non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center.

(b) reimbursement for additional charges: reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

(c) reimbursement for inclusive procedures: reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

(d) reimbursement for the professional component of a radiology service does not exceed 40 percent of the amount allowed for the complete procedure.

(i) a professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(ii) a claim for "supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

(9) telemedicine providers: reimbursement for services at the originating-site (where the MAP eligible recipient is located) and the distant-site (where the provider is located) are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

D. Reimbursement for services furnished by medical interns or residents: 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 only made through an institutional reimbursement process. Medical or surgical services performed by an intern or a resident that are unrelated to educational services, internship, or residency, are reimbursed according to the MAD fee schedule for physician services when all of the following provisions are met:

(1) services are identifiable physician services that are performed by the physician in person;

(2) services must contribute to the diagnosis or treatment of the MAP eligible recipient's medical condition;

(3) an intern or resident is fully licensed as a physician;

(4) 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

(5) services are excluded from outpatient hospital costs; when these criteria are met the services are considered to have been furnished by the practitioner in his or her capacity as a physician and not as an intern or resident.

E. Services of an assistant surgeon in an approved teaching program:

(1) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since the resident is available to perform services unless the following exceptional medical circumstances exist:

(a) an assistant surgeon is needed due to unusual medical circumstances;

(b) the surgery is performed by a team of physicians during a complex procedure; or

(c) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the MAP eligible recipient's medical condition;

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

F. Reimbursement for dental residents: Reimbursement can be made for dental residents in an approved teaching program when all the following conditions are met:

(1) the resident is fully licensed as a dentist for independent practice;

(2) the costs of the dental residency program is not included in the direct or graduate medical education payments to a provider operating the teaching program; and

(3) only one dental claim is submitted for the service; the supervising dentist and the rendering dentist will not be both paid for the service or procedure.

G. Non-independent practitioners: Reimbursement for services furnished by a physician assistant, a pharmacist clinician, or another practitioner whose license is not for independent practice, is made only to the billing supervising practitioner or entity rather than directly to the supervised practitioner.

H. Surgical procedures: Reimbursement for surgical procedures is subject to certain restrictions and limitations.

(1) When multiple procedures that add significant time or complexity to care are furnished during the same operative session, the major procedure is reimbursed at 100 percent of the allowable amount, the secondary procedure is reimbursed at 50 percent of the allowable amount and any remaining procedures are reimbursed at 25 percent of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly. "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same MAP eligible recipient on the same date of service.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier. Reimbursement for bilateral procedures is 150 percent of the amount allowed for a unilateral procedure.

(3) Surgeons are not reimbursed for the performance of incidental procedures, such as incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias, or tubal ligations done in conjunction with cesarean sections.

(4) Providers are not reimbursed for performing complete physical examinations or histories during follow-up treatment after a surgical procedure.

(5) Other health care related to a surgery is considered to be reimbursed in the payment for the surgery and is not paid as a separate cost. Surgical trays and local anesthesia are included in the reimbursement for the surgical procedure.

(6) Under certain circumstances, the skills of two surgeons, usually with different surgical specialties may be required in the management of a specific surgical problem. The total allowed value of the procedure is increased by 25 percent and each surgeon is paid 50 percent of that amount.

I. Maternity services: Reimbursement for maternity care is based on one global fee. Routine prenatal, delivery and post-natal care are included in the global fee. Services related to false labor and induced labor are also included in the global fee.

(1) If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code.

(2) MAD pays based on a modifier for high-risk pregnancies or for complicated pregnancies. The determination of high risk is based on a claims review.

(3) Based on the eligibility category, MAD may pay only for pregnancy-related services. The determination of whether services are related or non-related to pregnancy is based on the diagnosis. Pregnancy-related includes anything which may affect the health of the MAP eligible recipient mother or her fetus, or outcome of her fetus, including pre-existing and chronic conditions.

(4) If partial services are furnished by a midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code.

(5) If the services furnished include a combination of services performed by a midwife and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.

(6) MAD pays supply fees only when a MAP eligible recipient is accommodated for two hours or more in the home or a birthing center prior to delivery. Payment for use of a licensed birthing center includes supplies.

(7) MAD covers postnatal care by a midwife as a separate service only when the midwife does not perform the delivery.

(8) Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.

(9) Reimbursement for cesarean sections and inductions is made only when the service is medically necessary. These services are not covered as elective procedures.

J. Services limited by frequency:

(1) services furnished by another provider: where coverage of services provided to MAP eligible recipient is restricted or limited by frequency of services, procedures or materials, it is a provider's responsibility to determine if a proposed service has already been furnished by another provider, such that the MAP eligible recipient has exhausted the benefit. Examples include but are not limited to dental services, vision exams and eyeglasses.

(2) direct MAP eligible recipient payment for services: a provider can make arrangements for direct payment from a MAP eligible recipient or his or her authorized representative for noncovered services. A MAP eligible recipient or his or her authorized representative can only be billed for noncovered services if:

(a) a MAP eligible recipient or his or her authorized representative is advised by a provider of the necessity of the service and the reasons for the non-covered status;

(b) a MAP eligible recipient or his or her authorized representative is given options to seek treatment at a later date or from a different provider;

(c) a MAP eligible recipient or his or her auhtorized representative agrees in writing to be responsible for payment; and

(d) the provider fully complies with the MAD NMAC rules relating to billing and claims filing limitations.

(3) services considered part of the total treatment: a provider cannot bill separately for the services considered included in the payment for the examination, another service, or for routine post-operative or follow-up care.

K. Anesthesia services:

(1) Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time.

(a) Each 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 conversion factor allowed for each unit.

(b) The reimbursement per anesthesia unit may vary depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) and a non-directed CRNA.

(c) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiologist assistant, one time unit is allowed for each 15-minute period a MAP eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15-minute period.

(2) Medical direction: Reimbursement is made at 50 percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA). Reimbursement is made at 50 percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. 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 a MAP eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-MAP eligible recipients and the remaining is a MAP eligible recipient, this represents three concurrent cases.

(a) Time units for medical direction are allowed at one time unit for each 15-minute interval.

(b) Anesthesia claims are not payable if the surgery is not a MAD benefit or if any required documentation was not obtained.

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

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

(ii) prescribes the anesthesia plan; and

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

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

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

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

(vii) provides indicated post-anesthesia care.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(3) Monitored anesthesia care: Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

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

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

(ii) prescription of the anesthesia care required;

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

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

(v) provision of indicated postoperative anesthesia care.

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

(c) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

(4) Medical supervision: If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than 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.

(5) 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).

(6) 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 MAP eligible recipient's record.

(7) Pre-anesthetic exams and cancelled surgery: A pre-anesthetic examination and evaluation of a MAP eligible recipient 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.

(8) 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.

(9) 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.

(10) Anesthesia services furnished by the same physician providing the medical and surgical service:

(a) A physician who both performs and provides moderate sedation for medical or 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:

(i) local or topical anesthesia; to
(ii) moderate (conscious) sedation; to
(iii) regional anesthesia; to
(iv) general anesthesia.

(b) Moderate sedation is a drug-induced depression of consciousness during which a MAP eligible recipient 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.
[8.310.3.11 NMAC - Rp, 8.310.3.11 NMAC, 1-1-4]

HISTORY OF 8.310.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0100, Physician Services, filed 1-9-80.
ISD 310.0100, Physician Services, filed 6-16-80.
ISD 310.0100, Physician Services, filed 4-2-82.
ISD-Rule-310.0100, Physician Services, filed 9-2-83.
ISD-Rule-310.0100, Physician Services, filed 3-30-84.
ISD Rule-310.0100, Physician Services, filed 4-26-84.
ISD Rule-310.0100, Physician Services, filed 2-25-86.
MAD Rule 310.01, Physician Services, filed 12-15-87.
MAD Rule 310.01, Physician Services, filed 4-27-88.
MAD Rule 310.01, Physician Services, filed 4-20-92.
MAD Rule 310.01, Physician Services, filed 3-10-94.
MAD Rule 310.27, Anesthesia Services, filed 7-2-90.

History of Repealed Material:
MAD Rule 310.01, Physician Services, filed 3-10-94 - Repealed effective 2-1-95.
8.310.2 NMAC, Medical Services Providers, filed 2-16-04 - Repealed effective 1-1-14.
MAD Rule 310.27, Anesthesia Services, filed 7-2-90 - Repealed effective 2-1-95.

8.310.5 NMAC, Anesthesia Services, filed 5-12-03 - Repealed effective 1-1-14.
8.310.13 NMAC, Telehealth Services, filed 7-17-07 - Repealed 1-1-14.
8.324.2 NMAC, Laboratory Services, filed 2-17-12 - Repealed 1-1-14.
8.324.3 NMAC, Diagnostic Imaging and Therapeutic Radiology Services, filed 2-17-12 - Repealed 1-1-14.
8.324.9 NMAC, Nutrition Services, filed 2-17-12 - Repealed 1-1-14.
8.325.3 NMAC, Reproductive Services, filed 1-18-95 - Repealed 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICE
PART 12 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES

8.310.12.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.12.1 NMAC - N, 1-1-14]

8.310.12.2 SCOPE: This rule applies to the general public.
[8.310.12.2 NMAC - N, 1-1-14]

8.310.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.310.12.3 NMAC - N, 1-1-14]

8.310.12.4 DURATION: Permanent.
[8.310.12.4 NMAC - N, 1-1-14]

8.310.12.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.12.5 NMAC - N, 1-1-14]

8.310.12.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.310.12.6 NMAC - N, 1-1-14]

8.310.12.7 DEFINITIONS: [RESERVED]
[8.310.12.7 NMAC - N, 1-1-14]

8.310.12.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.310.12.8 NMAC - N, 1-1-14]

8.310.12.9 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES: HSD, through the medical assistance division (MAD), pays for medically necessary health services furnished to an eligible recipient, including American indian and Alaska native (AI/AN) eligible recipients. The Indian health service (IHS) is a federal agency within the United States department of health and human services (DHHS) that is responsible for providing health services to AI/ANs based on the unique government-to-government relationship between federally recognized tribes and nations and the federal government. The IHS health care delivery system consists of health facilities owned and operated by IHS, facilities owned by IHS and operated by tribes or tribal organizations under Title I or Title III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) agreements, and facilities owned and operated by tribes or tribal organizations under such agreements, hereafter referred to as "IHS and tribal 638 facilities". Pursuant to Section 1911 of the Social Security Act [42 U.S.C. 1369j] and the 1996 memorandum of agreement between the IHS and the centers for medicare and medicaid services (CMS), IHS and tribal 638 facilities are eligible to be reimbursed by MAD for furnishing covered healthcare services to a medical assistance programs (MAP) eligible AI/AN recipient.
[8.310.12.9 NMAC - N, 1-1-14]

8.310.12.10 ELIGIBLE PROVIDERS:

A. Health care to a medical assistance program (MAP) eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico provider participation agreement (PPA) 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 an eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing contractor. MAD makes available on the 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 material. 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 therein and comply with the requirements. Providers must contact HSD or its authorized agents for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to provisions of the MAD PPA and applicable statutes, regulations, rules and executive orders. MAD, or its selected claims processing contractor, issues payment to a provider using electronic funds transfer (EFT) only. Upon approval of the provider's PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) IHS facilities;
(2) Public Law 93-638 tribal facilities;
(3) urban indian facilities (follows the rules for a federally qualified health center);
(4) IHS or tribal 638 facility pharmacies which follow 8.324.4 NMAC; and
(5) off site locations on federal land and facilities approved by MAD.

B. Practitioners contracted or employed by the above facilities are enrolled as individual providers for rendering services when appropriate.

C. Services rendered must be medically necessary and within the scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD.

D For services provided under the federal public health service, including IHS, rendering providers must meet the requirements of the public health service corp.

[8.310.12.10 NMAC - N, 1-1-14]

8.310.12.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all applicable laws, regulations, rules, standards, and the provisions of the MAD PPA. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include, but are not limited to, supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require a prior authorization. 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. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority.

[8.310.12.11 NMAC - N, 1-1-14]

8.310.12.12 COVERED SERVICES: MAD covers medically necessary services and procedures for diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition. Services must be furnished within the limits of MAD rules and within the scope of practice of the provider's professional standards.

A. **Outpatient encounters and visits:** An outpatient encounter or visit is face-to-face contact between a practitioner and an eligible recipient as documented in the eligible recipient's medical or behavioral health record. An encounter or visit can occur at an IHS facility, a tribal 638 facility, or a MAD recognized offsite location. To be billable as an encounter, the eligible recipient must be seen by a level of practitioner who would be eligible to be enrolled as a MAD provider or a practitioner comparable to that required by other service and provider rules. Examples include the following: audiologist, behavioral health professional, certified nurse midwife, certified nurse practitioner, clinical nurse specialist, dentist, dental hygienist, licensed dietician, occupational therapist, optometrist, pharmacist clinician, physician assistant, physician, physical therapist, podiatrist, speech therapist and other provider types within their scope of practice as designated by MAD. See 8.310.2 NMAC, 8.310.3 NMAC and 8.321.2 NMAC.

(1) Encounters and visits at the same facility, on the same day, for the same or related diagnosis constitutes a single visit.

(2) Multiple encounters can occur on the same date of service. The following are examples of types of separate encounters:

(a) an eligible recipient receives a service that is not associated with the initial encounter and the service provided is for a different principal diagnosis; or

(b) an eligible recipient has the same diagnosis and is seen at two different facilities (different

provider numbers) and one of the facilities is unable to provide the necessary services for the diagnosis or treatment of the eligible recipient's condition.

B. **Inpatient hospital stays:** An inpatient hospital stay occurs when an eligible recipient is admitted and stays over night.

C. **Services not subject to OMB codes or rates:** Some services are covered by MAD when occurring within an IHS or a tribal facility but are not included or billed as the OMB rate. These services are covered to the extent described under applicable rules for the service, and include:

(1) anesthesia (professional charges);
(2) ambulatory surgical center facility services;
(3) targeted case management;
(4) durable medical equipment;
(5) hearing appliances (hearing testing is reimbursed at the OMB rate);
(6) lab charges;
(7) radiology imaging services;
(8) physician inpatient hospital visits and surgeries;
(9) smoking cessation;
(10) telemedicine's originating site facility fee; and
(11) vision appliances, including frames, lenses, dispensing, and contacts (vision exams are at the OMB rate).

D. **Behavioral health services:**

(1) outpatient behavioral health services billed using the outpatient OMB codes include assessments and evaluations, outpatient therapies, comprehensive community support services (CCSS), and other services as approved by MAD.

(2) other specialized behavior health services may be reimbursed at the MAD fee for service rate or at an OMB rate, as agreed between the facility and MAD.

(3) prior to billing specialized behavioral health services including CCSS, the IHS or tribal 638 facility must submit documentation to MAD demonstrating the ability to adhere to the service definitions and standards for the specific service. See 8.321.2 NMAC.

E. **Pharmacy Services:** See 8.324.4 NMAC for an IHS and a tribal 638 facility enrolled as a pharmacy. Pharmacy services are not part of the OMB rate.

(1) Pharmacy claims may exceed some days supply limitations if the eligible recipient lives far from an IHS or tribal 638 facility.

(2) IHS and tribal 638 facility pharmacy claims are not subject to formularies or preferred drug lists.

F. **Transportation Services:** For a detailed description of transportation services, see 8.324.7 NMAC.

[8.310.12.12 NMAC - N, 1-1-14]

8.310.12.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: IHS and tribal 638 facilities need not obtain prior authorization for services, but must continue to follow standards of care within its scope of practice and retain documentation in the eligible recipient's medical and behavioral health record. MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before or after services are furnished.

[8.310.12.13 NMAC - N, 1-1-14]

8.310.12.14 NON-COVERED SERVICES: For a detailed description of non-covered MAD service, see 8.310.2 NMAC.

[8.310.12.14 NMAC - N, 1-1-14]

8.310.12.15 REIMBURSEMENT: OMB rates are published annually in the federal register and are applicable to an IHS and a tribal 638 facility. These rates are applied retroactively to their effective date.

A. IHS OMB outpatient and inpatient reimbursement rates include facility fees and professional fees except as described in this rule.

(1) Outpatient encounters and visits: MAD reimburses outpatient encounters and visits at the OMB outpatient encounter rate.

(2) Inpatient hospital service: MAD reimburses covered inpatient hospital admissions at the medicaid OMB hospital inpatient per diem rate.

B. Services not subject to the OMB rates are reimbursed according to MAD rules for the specific service.

C. **Electronic billing requirements:** Electronic billing of claims is required unless an exemption has been allowed by MAD. Exemptions will be given on a case by case basis with consideration given to barriers faced by the provider in electronic billing, such as small volume for which developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply when paper attachments must accompany the claim form.

D. **Responsibility for claims:** A provider is responsible for all claims submitted under his national provider identifier (NPI) or another provider number, including responsibility for accurate coding representing the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, CMS correct coding initiatives, and MAD NMAC rules.
[8.310.12.15 NMAC - N, 1-1-14]

HISTORY OF 8.310.12 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES
PART 2 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

8.320.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.320.2.1 NMAC - Rp, 8.320.2.1 NMAC, 1-1-14]

8.320.2.2 SCOPE: The rule applies to the general public.
[8.320.2.2 NMAC - Rp, 8.320.2.2 NMAC, 1-1-14]

8.320.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.320.2.3 NMAC - Rp, 8.320.2.3 NMAC, 1-1-14]

8.320.2.4 DURATION: Permanent.
[8.320.2.4 NMAC - Rp, 8.320.2.4 NMAC, 1-1-14]

8.320.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.320.2.5 NMAC - Rp, 8.320.2.5 NMAC, 1-1-14]

8.320.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.320.2.6 NMAC - Rp, 8.320.2.6 NMAC, 1-1-14]

8.320.2.7 DEFINITIONS: [RESERVED]

8.320.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.320.2.8 NMAC - Rp, 8.320.2.8 NMAC, 1-1-14]

8.320.2.9 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES: The medical assistance division (MAD) pays for medically necessary health services including preventive, treatment and ameliorative services for a medical assistance program (MAP) eligible recipient under 21 years of age through the early and periodic screening, diagnostic and treatment (ESPDT) services program. See 42 CFR 441.50 Subpart B.

A. EPSDT Description:

(1) early: assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;

(2) periodic: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development;

(3) screening: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;

(4) diagnostic: the determination of the nature or cause of conditions identified by the screening; and

(5) treatment: the provision of services needed to control, correct or lessen health problems.

B. Services provided under EPSDT are accessed following an initial health screening service called the tot to teen healthcheck or health check referral or through other diagnostic evaluations or assessments.
[8.320.2.9 NMAC - Rp, 8.320.2.9 NMAC, 1-1-14]

8.320.2.10 GENERAL EPSDT SCREENINGS AND REFERRALS: EPSDT includes a screening component called the "tot to teen healthcheck". EPSDT also includes diagnostic, treatment, and other necessary health care measures needed to correct or ameliorate physical and behavioral health disorders or conditions discovered during the tot to teen healthcheck or through other diagnostic evaluations or assessments.

[8.320.2.10 NMAC - Rp, 8.320.2.10 NMAC, 1-1-14]

8.320.2.11 INFORMATION GIVEN TO MAP ELIGIBLE RECIPIENTS:

A. A MAP eligible recipient under 21 years of age, or his or her family, is provided with the following information:

(1) benefits of preventive health care;
(2) services available under EPSDT and where and how to access those services;
(3) services provided under EPSDT are furnished at no cost to a MAP eligible recipient;
(4) transportation and scheduling assistance is available upon request; and
(5) the right to request a HSD administrative hearing.

B. Within 30 calendar days of the initial medical assistance application, and annually at each eligibility redetermination period thereafter, a MAP eligible recipient is furnished with information about the tot to teen healthcheck screen and EPSDT services.

[8.320.2.11 NMAC - Rp, 8.320.2.11 NMAC, 1-1-14]

8.320.2.12 EPSDT ELIGIBLE PROVIDERS: Upon MAD's approval of a PPA, a licensed practitioner, agency or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HSD/MAD websites, on other program-specific or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD New Mexico administrative code (NMAC) rules, billing instructions, utilization review (UR) instructions and other pertinent materials. Once enrolled, a provider receives instructions on how to access these documents. MAD makes available on the 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, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider is bound by the provisions of the MAD PPA.

[8.320.2.12 NMAC - Rp, 8.320.2.12 NMAC, 1-1-14]

8.320.2.13 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in the MAD NMAC rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determine if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP 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 a MAP eligible recipient.

C. Services furnished to a MAP eligible recipient must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority.

[8.320.2.13 NMAC - Rp, 8.320.2.13 NMAC, 1-1-14]

8.320.2.14 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an electronic health record (EHR) incentive payment 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 MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. When approved, 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 PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using

the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency or each individual provider. Services must be in compliance with the statutes, rules and regulations of his or her practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.

C. A specific EPSDT service may have additional service restrictions listed in the service's non-covered section. Generally the following are considered to be noncovered by MAD:

(1) services furnished to an individual who is not eligible for MAD EPSDT services;

(2) services furnished without the prior authorization of the MAP eligible recipient's primary care provider (PCP) or HSD or its designee;

(3) services provided by a practitioner who is not in compliance with the statutes, regulations, rules or who renders services outside of the scope of practice as defined by his or her practice board;

(4) services that are not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient;

(5) services that are primarily educational or vocational in nature; and

(6) services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Certain EPSDT procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All EPSDT services are subject to UR 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. 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 specific EPSDT service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

E. All EPSDT services are reimbursed as follows, except when otherwise instructed. MAD does not pay a professional component amount to a physical, occupational or speech and language pathologist (SLP) if the therapy is performed in a hospital setting. MAD reimburses the institutional provider for all components of the service.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a provider for covered services at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) the provider's billed charge must be its usual and customary charge for services;

(ii) "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(2) Services not paid according to a fee schedule are reimbursed using the methodology and rate in effect at the time of service.

(3) Reimbursement to the local education agency (LEA), regional educational cooperative (REC), and another state-funded educational agency (SFEA) is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's individual education plan (IEP), and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142. and the services are covered by MAD, then MAD is permitted to pay for such services.

[8.320.2.14 NMAC - Rp, 8.320.2.14 NMAC, 1-1-14]

8.320.2.15 TOT TO TEEN HEALTHCHECK: MAD developed the tot to teen healthcheck, the screening segment of EPSDT services. The tot to teen healthcheck includes periodic screening and regularly scheduled assessments of the MAP eligible recipient's general physical growth and development as well as behavioral health and social emotional development.

A. Primary care providers (PCP), dentists, psychologists, IHS public health clinics, federally qualified health center (FQHC), rural health clinic (RHC), community mental health centers (CMHC), hospitals, school-based clinics, independent certified or licensed nurse practitioners and other health care providers may perform tot to teen healthcheck screens or partial health screenings. A provider must meet the participation requirements specified in applicable sections of the MAD NMAC rules. Tot to teen healthcheck screens must be furnished within the scope of the provider's practice, as defined by law.

B. Screening services are furnished to a MAP eligible recipient under 21 years of age. Referrals or treatment for conditions detected during a complete or a partial screen which require further treatment are then covered as part of MAD's EPSDT services. A tot to teen healthcheck can be performed during an office visit for an acute illness as long as the illness does not affect the results or the screening process.

(1) Screening schedule for medical components:

(a) The MAD tot to teen healthcheck periodicity schedule allows for a total of 25 screens. Screenings are encouraged at the following intervals:

(i) under age one: six screenings (birth, one, two, four, six and nine months)
(ii) ages one-two: four screenings (12, 15, 18 and 24 months)
(iii) ages three-five: three screenings (three, four and five years)
(iv) ages six-nine: two screenings (six and eight years)
(v) ages 10-14: four screenings (10, 12, 13 and 14 years)
(vi) ages 15-18: four screenings (15, 16, 17 and 18 years)
(vii) ages 19-20: two screenings (19 and 20 years).

(b) Screenings may be performed at intervals other than as described on the periodicity schedule or in addition to those on the periodicity schedule if a MAP eligible recipient receives care at a time not listed on the periodicity schedule or if any components of the screen were not completed at the scheduled ages. Additional screenings can help bring the MAP eligible recipient up to date with the periodicity schedule.

(c) The established schedule must be followed unless the MAP eligible recipient's medical condition is such that a brief deviation is warranted.

(2) Complete medical screens include the following components:

(a) a comprehensive health and developmental history, including an assessment of both physical and behavioral health or social emotional development;

(b) a comprehensive unclothed physical exam;

(c) appropriate immunizations, according to age and health history, unless medically contraindicated at the time;

(d) laboratory tests, including an appropriate blood lead level assessment;

(e) health education, including the MAD anticipatory guidance; and

(f) vision and hearing screenings at the ages indicated in the MAD EPSDT preventative health guidelines.

(3) MAD pays for partial medical screens to a MAP eligible recipient. Partial medical screens are defined as screens where all the required components of a complete medical screen are not completed for medical reasons.

(4) MAD covers additional medical screens as listed below.

(a) Behavioral health screenings are performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of a behavioral health disorders or conditions.

(b) Dental examinations are performed at intervals which meet reasonable dental standards. Usually these examinations are furnished every six months. However, examinations can be furnished at other intervals as medically necessary.

(c) Hearing testing is performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of defects in hearing. A hearing test using an audiogram should be given to a MAP eligible recipient at five years of age or prior to him or her to entering school. Annual examinations should be furnished if abnormalities are identified.

(d) Interperiodic screens can be performed at intervals beyond those specified in the periodicity schedule. Reimbursement for the performance of interperiodic screens is made only to a MAD provider. Interperiodic screens are screening encounters with health care, developmental, or educational professionals to determine the existence of suspected physical or behavioral health disorders or conditions.

(e) Vision examinations are performed at intervals which meet reasonable vision standards or at other intervals as medically necessary. A vision examination should be furnished before the MAP eligible recipient reaches three years of age and again prior to five years of age or prior to entering school. If no

abnormalities are found, screenings should be furnished every two years with a complete examination furnished if indicated.

(f) Other necessary health care or diagnostic services are performed when medically necessary.

C. MAD covers services considered medically necessary for the treatment or amelioration of conditions identified as a result of a complete tot to teen healthcheck screen, partial medical screen, or interperiodic screen. Diagnostic or evaluation services furnished during the screening cannot be duplicated as part of the follow-up treatment. If appropriate, treatment is furnished by the screening provider at the time of the tot to teen healthcheck.

(1) A MAP eligible recipient can be referred for treatment as a result of a tot to teen healthcheck, regardless of whether the provider making the referral is a participating MAD provider. If it is inappropriate for a screening provider to furnish treatment needed by the MAP eligible recipient, referrals must be made only to a qualified MAD provider.

(2) A MAP eligible recipient may be identified through a tot to teen healthcheck, self referral, or referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns. For a MAP eligible recipient requiring extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of a MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

(c) The plan must be developed in cooperation with the MAP eligible recipient, his or her parents, or guardians, and other health care professionals, as appropriate. In the case of a MAP eligible recipient under 21 years of age who is placed in the custody of the children, youth and families department (CYFD), its assigned social worker, and those appropriate from CYFD's juvenile justice system (JJS) are to be included in the development of the plan.

(d) See to 8.321.2 NMAC for additional information regarding specialized behavioral health services for an ESPDT MAP eligible recipient.

(3) A MAP eligible recipient, when allowed under state law, has the right to refuse proposed medical and behavioral health treatment. He or she has the freedom to select among enrolled MAD providers. Information in this section does not restrict or limit a MAP eligible recipient's rights or choice.

[8.320.2.15 NMAC - Rp, 8.320.2.15 NMAC, 1-1-14]

8.320.2.16 EPSDT SPECIAL REHABILITATION (FAMILY INFANT TODDLER EARLY INTERVENTION) SERVICES: MAD special rehabilitation services are furnished through the New Mexico department of health (DOH) family infant toddler (FIT) program. FIT provides early intervention services for a MAP eligible that has or is at risk of having a developmental delay from birth to his or her third birth year. Developmental delay or at risk of is defined by DOH. A MAP eligible recipient with a developmental delay or who is at risk of having a developmental delay is not considered to have a diagnosis of an intellectual or developmental disability. FIT services include evaluation, diagnostics and treatment necessary to correct or treat any defects or conditions or to teach compensatory skills for deficits that directly result from a medical or behavioral health condition. The appropriate information from evaluation and diagnostics is interpreted and integrated in the individual family service plan (IFSP). If the need for special rehabilitation is identified outside of the tot to teen healthcheck process, the MAP eligible recipient's PCP must be notified of the results and be included in the treatment plan development, if the PCP so elects.

A. MAD EPSDT special rehabilitation eligible providers: An enrolled MAD agency certified by DOH as a special rehabilitation services provider is eligible to be reimbursed for furnishing special rehabilitation services to a MAP eligible recipient. Individual providers rendering special rehabilitation services that are employed by or contracted by a MAD special rehabilitation provider agency must meet applicable DOH standards. A provider shall:

(1) render special rehabilitation services under the direction of a professional acting within his or her scope of practice as defined by state law;

(2) render special rehabilitation services in the most appropriate least restrictive environment;

(3) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services or services funded under the state general fund DOH contract.

B. EPSDT special rehabilitation MAP eligible recipients: An individual who has been determined through a multidisciplinary developmental evaluation to have, or be at risk for, a developmental delay and to be in need of special rehabilitative services as defined by DOH is eligible to receive special rehabilitation services. Any individual that has been diagnosed with an intellectual or developmental disability is not eligible for FIT services.

C. EPSDT special rehabilitation treatment plan for a MAP eligible recipient: The need for special rehabilitation services must be documented in the MAP eligible recipient's treatment plan or in his or her IFSP. The treatment plan must be developed in accordance with applicable DOH policies and procedures and federal regulations governing Part C of the Individuals with Disabilities Education Act. The treatment plan or IFSP must be developed within 45 calendar days of the initiation of services and reviewed every six months or more often as indicated. The following must be contained in the treatment plan or IFSP documents and must be available for review in the MAP eligible recipient's agency file:

(1) a statement of the MAP eligible recipient's present levels of physical development including vision, hearing, and health status;

(2) an assessment of his or her communications development;

(3) an assessment of his or her behavioral health status, to include his or her social or emotional development;

(4) an assessment of his or her cognitive development;

(5) an assessment of his or her adaptive development;

(6) his or her family history and other relevant family information;

(7) a description of his or her intermediate and long-range goals, with a projected timetable for their attainment and dates, and the duration and scope of services;

(8) the procedures and time lines to determine the progress made toward achieving the outcomes and whether modifications to or revisions of the outcomes or services are needed; and

(9) statement of the specific special rehabilitation services needed to meet the MAP eligible recipient's unique needs and also achieve the outcomes specified, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

D. EPSDT special rehabilitation covered services:

(1) MAD only covers special rehabilitation services necessary to enhance development in one or more of the following developmental domains:

(a) physical and motor;

(b) communication;

(c) adaptive;

(d) cognitive;

(e) behavioral health to include social or emotional; or

(f) sensory.

(2) Special rehabilitation services generally involve the MAP eligible recipient's family and are designed to support and enhance the MAP eligible recipient's developmental services and are provided through FIT. The following are a list of covered services:

(a) Developmental evaluation and rehabilitation services are the assessments performed to determine if motor, speech, language and psychological problems exist with the MAP eligible recipient or to detect the presence of his or her developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating a MAP eligible recipient's medical or other health-related condition. Services also include consultation with the family and other professional staff. These services are provided as a result of a referral from the MAP eligible recipient's PCP.

(b) Nursing services are performed by a MAD enrolled certified nurse practitioner (CNP), registered nurse (RN) or licensed practical nurse (LPN) within the scope of his or her practice relevant to the medical and rehabilitative needs of the MAP eligible recipient. These services are provided as the result of a referral from the MAP eligible recipient's PCP. Services include the administration and monitoring of medication, catheterization, tube feeding, suctioning, and the screening and referral for other health needs. Nursing services also include explanations to the MAP eligible recipient's family or other professional staff concerning the treatments, therapies, and physical or social emotional health conditions.

(c) Physical therapy services are provided by or under the direction of a qualified MAD enrolled physical therapist (PT) as a result of a referral from the MAP eligible recipient's PCP. Physical therapy services are the evaluations required to determine the MAP eligible recipient's need for physical therapy and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a

medical problem interfering with age appropriate functional performance. Services also include consultation with the family and other professional staff.

(d) Occupational therapy services are provided by or under the direction of a qualified MAD enrolled occupational therapist (OT) as the result of a referral from the MAP eligible recipient's PCP. Occupational therapy services include the evaluation of the MAP eligible recipient to determine if he or she is experiencing problems that interfere with his or her functional performance and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the MAP eligible recipient's family and other professional staff.

(e) Behavioral health services are diagnostic or active treatments with the intent to reasonably improve the MAP eligible recipient's condition; see 8.321.2 NMAC for a detailed description of behavioral health services.

(f) Speech, language and hearing services provided by or under the direction of a MAD enrolled SLP or audiologist, as the result of a referral by the MAP eligible recipient's PCP. Speech, language and hearing services are the evaluations required to determine the MAP eligible recipient's need for these services and recommendations for a course of treatment. Treatment is provided to a MAP eligible recipient with a diagnosed speech, language or hearing disorder which adversely affects his or her functioning. Services also include consultations with the MAP eligible recipient's family and other professional staff.

E. EPSDT special rehabilitation noncovered services: Special rehabilitation services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

F. EPSDT special rehabilitation prior approval and utilization: All MAD EPSDT services are subject to UR 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. Specifically for special rehabilitation services, a maximum of 14 hours per month of services to a MAP eligible recipient can be furnished by a provider before prior approval is required from DOH.

[8.320.2.16 NMAC - Rp, 8.320.2.16 NMAC, 1-1-14]

8.320.2.17 EPSDT CASE MANAGEMENT SERVICES: MAD pays for case management services furnished to a medically at risk MAP eligible recipient under 21 years of age as an EPSDT service. The need for case management services must be identified in the tot to teen healthcheck screen or through other diagnostic evaluations or assessments.

A. EPSDT case management eligible providers: A qualified MAD enrolled case management agency is eligible to be reimbursed for furnishing services to a MAP eligible recipient. An agency must demonstrate direct experience in successfully serving medically at risk individuals under the age of 21 years and demonstrate knowledge of available community services and methods for gaining access to those services.

(1) The following agencies can furnish case management services:

(a) a governmental agency;

(b) a native Indian tribal government;

(c) the IHS;

(d) a FQHC; and

(e) a community case management agency.

(2) Case manager qualifications: A case manager employed by a MAD enrolled case management agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have at least one year of experience serving medically at risk individuals under the age of 21 years. Case managers must have the necessary skills to meet the needs of a particular MAP eligible recipient. In some instances, it is important that the case manager have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. In addition, a case manager must meet at least one of the following requirements:

(a) hold a bachelor's degree in social work, counseling, psychology, sociology, education, special education, cultural anthropology or a related health or social service field from an accredited institution; a case manager with a bachelor's degree in another field can substitute two years of direct experience in serving the medically at risk population for the required field of study; or

(b) be licensed as a RN or LPN;

(c) case management services for medically fragile MAP eligible recipients must be provided by a licensed RN; and

(d) if there are no suitable case managers with the previously described qualifications, an agency can employ a case manager with the following education and experience rendering services under the direct supervision of an experienced case manager who meets the qualifications specified in section 28, subsection B of this rule:

(i) hold an associate's degree and has a minimum of three years of experience in community health or social services; or

(ii) hold a high school diploma or a graduate equivalence diploma (GED) and has a minimum of four years of experience in community health or social services.

(3) Agency restrictions: MAD restricts the type of agency that can provide case management services to a MAP eligible recipient with developmental disabilities. See 42 U.S.C. Section 1396n(g)(1)(2). A case management provider for a MAP eligible recipient with developmental disability or severe emotional disturbance must be certified by DOH or CYFD.

(4) MAP eligible recipients: When a MAD enrolled recipient is determined to be medically at risk, he or she is eligible for case management services. "Medically at risk" is defined as an individual who has a diagnosed physical or social emotional condition which has a high probability of impairing his or her cognitive, emotional, neurological, social or physical development.

B. EPSDT case management treatment plan (CMTP) or individualized service plan (ISP): The CMTP or ISP is developed by the case manager in cooperation with the MAP eligible recipient, his or her family or legal guardian, his or her PCP, as appropriate, and others involved with the MAP eligible recipient's care. The CMTP is developed within 30 calendar days of the initiation of services. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated. For a MAP eligible recipient who is medically fragile, the ISP is written and approved within 60 calendar days of the initiation of services which are to start immediately. The ISP is reviewed regularly during the monthly visits; however, the MAP eligible recipient is reassessed annually with a new ISP developed with the MAP eligible recipient, his or her family and the interdisciplinary team. A social worker may be involved in the development of the treatment plan in the case of a MAP eligible recipient who is in the custody of CYFD or another state agency.

(1) The following, as appropriate, must be contained in the CMTP and ISP or documents used in the development of each. The CMTP, the ISP, and all supporting documentation must be available for review in the MAP eligible recipient's file:

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

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

(i) social emotional or behavioral health status assessment;

(ii) intellectual function assessment;

(iii) psychological assessment;

(iv) educational assessment;

(v) vocational assessment;

(vi) social assessment;

(vii) medical assessment; and

(viii) physical assessment.

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and

(e) statement and rationale of the CMTP or ISP for achieving these intermediate and long-range goals, including provisions of review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued for the MAP eligible recipient.

(2) Assessments must be performed face-to-face with the MAP eligible recipient, his or her family or legal guardian.

(3) The agency must have a statement of the specific case management services needed to meet the MAP eligible recipient's unique needs and to achieve the outcomes specified in the CMTP or ISP, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

C. EPSDT case management covered services:

(1) MAD covers the following case management services:

(a) face-to-face assessment of the MAP eligible recipient's medical, behavioral health, social needs and functional limitations. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated;

(b) the development and implementation of plans of care designed to help the MAP eligible recipient retain or achieve the maximum degree of independence; certain EPSDT enhanced services can be furnished only if included in the CMTP or ISP, including private duty nursing;

(c) the mobilization of the use of natural helping networks such as family members, church members, community organizations, support groups and friends; and

(d) the coordination and monitoring of the delivery of services, the evaluation of the effectiveness and quality of the services, and the revision of the MAP eligible recipient's CMTP or ISP, when appropriate.

(2) When a MAP eligible recipient is in an out-of-home placement, MAD covers comprehensive coordinated support services (CCSS) detailed in 8.321.2 NMAC during the last 30 calendar days of his or her placement.

D. EPSDT case management noncovered services: Case management services are subject to the limitations and coverage restrictions which exist for other MAD services. Case management services may not be billed in conjunction with:

(1) services to an individual who is not eligible or who does not meet the MAD definition of medically at risk;

(2) services furnished by other practitioners such as: therapists, transportation providers, homemakers or personal care service providers;

(3) formal educational or vocation services related to traditional academic subjects or vocational training;

(4) client outreach activities in which a provider attempts to contact potential recipients;

(5) administrative activities, such as MAD eligibility determinations and agency intake processing;

(6) institutional discharge planning which is a required condition for payment of hospital, nursing home, treatment foster care or other residential treatment center services. Discharge planning must not be billed separately as a targeted case management service;

(7) services which are not documented by the case manager in the MAP eligible recipient's agency file; or

(8) services to a recipient who receives case management services through a home and community-based services waiver program.

[8.320.2.17 NMAC - Rp, 8.320.2.17 NMAC, 1-1-14]

8.320.2.18 EPSDT PERSONAL CARE SERVICES: MAD pays for medically necessary personal care services (PCS) furnished to a MAP eligible recipient under 21 years of age as part of the EPSDT program when the services are part of his or her IEP or ISP for the treatment of correction, amelioration, or prevention of deterioration of a MAD identified medical or behavioral health condition, see 42 CFR Section 440.167. PCS provides a range of services to a MAP eligible recipient who is unable to perform some or all activities of daily living (ADLs) or instrumental activities of daily living (IADLs) because of a disability or a functional limitation. A prescribed course of regular PCS services and daily living assistance supports the MAP eligible recipient to live in his or her home rather than an institution and allows him or her to achieve the highest possible level of independence. These services include, but are not limited to, activities such as bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance, and communicating. A MAP eligible recipient may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCS services may be required because a cognitive impairment prevents a MAP eligible recipient from knowing when or how to carry out the task. In such cases, PCS services may include cuing along with supervision to ensure that the MAP eligible recipient performs the task properly.

A. EPSDT PCS eligible providers:

(1) agencies that meet the following conditions are eligible to enroll as providers and be reimbursed for providing EPSDT PCS services:

(a) a licensed nursing or home health agency that is a public agency, a private for-profit agency, or private non-profit agency; and

(b) the PCS attendant to the MAP eligible recipient must be supervised by a MAD enrolled RN.

(2) certification for participation as a medicare home health agency is not required. A MAP eligible recipient's family member may not furnish PCS services to him or her. In this instance, a family member is defined as a legally responsible relative, such as parents of minor child or stepparent who is legally responsible for minor child. For a MAP eligible recipient 18 to 21 years of age, parents or other relatives may provide PCS services if they are not legally responsible for the MAP eligible recipient. The parent or another relative must be employed by a MAD approved PCS agency eligible to bill for PCS services and must meet all MAD required training and supervision standards.

B. **EPSDT PCS ATTENDANT TRAINING:**

(1) The PCS agency is responsible for ensuring that the PCS attendant has completed a training program and is competent to provide assigned tasks as a PCS attendant specific to the MAP eligible recipient's needs.

(2) The PCS attendant training program must consist of no less than 40 hours of training to be completed by the PCS attendant in the first year of employment. Ten hours of training must be completed prior to placing the employee in a MAP eligible recipient's home. Two of the 10 hours may include agency orientation. Eight of the 10 hours of training must be specific to the MAP eligible recipient.

(3) The training curriculum must include, at a minimum, the following areas:

(a) communication;
(b) MAP eligible recipient's rights;
(c) recording of information in MAP eligible recipient's records;
(d) nutrition and meal preparation;
(e) care of ill and disabled children and adolescents;
(f) emergency response (first aid, CPR, 911, etc.);
(g) basic infection control;
(h) housekeeping skills; and
(i) home safety and fire protection.

C. EPSDT PCO criteria: PCS services are defined as medically necessary tasks pertaining to a MAP eligible recipient's physical or cognitive functional ability. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's functional level. Services are covered under specific criteria.

(1) The MAP eligible recipient must have a need for assistance with at least two or more ADL's or IADL's or both such as eating, bathing, dressing and toileting activities, appropriate to his or her age.

(2) PCS services must be medically necessary, prescribed by the MAP eligible recipient's PCP and included in the MAP eligible recipient's individual treatment plan (ITP).

(3) The need for PCS services is evaluated based on the availability of the MAP eligible recipient's family members or natural supports, such as other community resources or friends that can aid in providing such care.

(4) PCS services must be provided with the consent of the MAP eligible recipient's parent or guardian if the MAP eligible recipient is under the age of 18 years. If a MAP eligible recipient is emancipated or is at least 18 years old and is able to provide consent, his or her consent is required.

(5) PCS services are furnished in the MAP eligible recipient's place of residence and outside his or her home when medically necessary and when not available through other existing benefits and programs such as home health, early intervention or school programs. PCS services are services furnished to a MAP eligible recipient who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or an institution for mental illness.

(6) Medically necessary PCS services to support a MAP eligible recipient attend school are furnished in partnership with the MAP eligible recipient's school as an alternative to his or her participation in a homebound program. PCS services should foster the MAP eligible recipient's independence. PCS services are furnished only to a MAP eligible recipient based on MAD or its designee's UR contractor's approval. PCS services may not be furnished to a non-MAP eligible recipient in the school setting.

(7) Only a trained PCS attendant who has successfully demonstrated service competency such as bathing, dressing, eating and toileting may provide PCS services to a MAP eligible recipient. The PCS attendant must be employed by a MAD approved PCS agency and work under the direct supervision of a MAD approved RN.

(8) The supervisory RN must be employed or contracted by the PCS agency and have one year direct patient care experience. The supervisory RN is responsible for conducting and documenting visits at the MAP eligible recipient's residence for the purpose of assessing his or her progress and the PCS attendant's performance. The ITP should be updated as indicated and in cooperation with the MAP eligible recipient's case manager. These

visits will be conducted and documented every 62 calendar days or more often if the MAP eligible recipient's condition warrants it.

D. EPSDT PCS covered services: MAD covers the following personal care services:

(1) basic personal care services consist of bathing, care of the teeth, hair and nails, assistance with dressing, and assistance with toileting activities;

(2) assistance with eating and other nutritional activities, when medically necessary, i.e., due to documented weight loss or another physical effect; and

(3) cognitive assistance such as prompting or cuing.

E. EPSDT PCS noncovered services: PCS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities. Specifically, PCS services may not be billed in conjunction with the following services:

(1) any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings, and administration of medications;

(2) services that are not in the MAP eligible recipient's approved ITP and for which prior approval has not been received;

(3) services not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient.

F. EPSDT PCS treatment plan: The MAP eligible recipient's ITP is approved by MAD or its designated UR contractor prior to the initiation of PCS services. The PCS ITP is developed as a result of a face-to-face assessment of the MAP eligible recipient and must include the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient for PCS services;

(2) description of the physical or cognitive functional level of the recipient as evidenced by the PCP's clinical evaluation, including social emotional or behavioral health status, intellectual functioning and the documented medical necessity for PCS services;

(3) description of intermediate and long-range service goals that includes the scope and duration of service, how goals will be attained and the projected timetable for their attainment;

(4) specification of the PCS attendant's responsibilities, including tasks to be performed by the attendant and any special instructions for the health and safety of the MAP eligible recipient;

(5) a statement of the least restrictive conditions necessary to achieve the goals identified in the plan; and

(6) the ITP must be reviewed and revised in cooperation with the MAP eligible recipient's case manager according to his or her clinical needs at least every six months.

[8.320.2.18 NMAC - Rp, 8.320.2.18 NMAC, 1-1-14]

8.320.2.19 EPSDT PRIVATE DUTY NURSING SERVICES: MAD pays for private duty nursing (PDN) services as part of the EPSDT program, see 42 CFR Section 441.57. Services must be accessed through the tot to teen healthcheck screen. A MAP eligible recipient is under 21 years, who has been referred for PDN services shift care (not intermittent care), must meet the established medically fragile criteria and parameters that have been approved by MAD.

A. EPSDT PDN eligible providers: A nurse working for a MAD approved PDN agency must have a RN or LPN on staff that meets MAD requirements. Services must be furnished under the direction of the MAP eligible recipient's PCP. Certification for participation as a medicare home health agency is not required. The following agencies are eligible to be reimbursed for providing EPSDT PDN services:

(1) a licensed nursing agency; or

(2) a FQHC.

B. EPSDT PDN coverage criteria: PDN services must be furnished by a RN or a LPN in the MAP eligible recipient's home or in his or her school setting if it is medically necessary for school attendance. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's function level in a home setting.

(1) EPSDT PDN services are for a MAP eligible recipient under 21 years of age who requires more individual and continuous care than can be received through the MAD home health program.

(2) EPSDT PDN services must be ordered by the MAP eligible recipient's PCP and must be included in his or her approved treatment plan. Services furnished must be medically necessary and be within the scope of

the nursing profession. A MAP eligible recipient must have an approved ISP before nursing services can begin. Prior authorization for these services is required.

C. EPSDT PDN treatment plan: The need for skilled nursing services must be included in the MAP eligible recipient's ITP or ISP. The ISP meeting must have been held and the ISP written by the RN or case manager must be approved before nursing services can start. The plan must contain the following:

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

(2) description of the functional level of the MAP eligible recipient as documented by the PCP's clinical evaluation, including social, emotional or behavioral health status, intellectual functioning and medical necessity which identify and document the need for a PDN;

(3) specific clinical problems relating to:

(a) physical assessment needs including the identification of durable medical equipment or medical supplies needed by the MAP eligible recipient;

(b) psychosocial evaluation including level of support from family in reaching projected clinical goals; and

(c) medication history including status of compliance of the MAP eligible recipient;

(4) applicable clinical interventions related to the identified clinical problem including measurable goals;

(5) statement of the least restrictive conditions necessary to achieve the goals identified in the plan;

(6) description of intermediate and long-range goals with the projected timetable for their attainment and duration and scope of services, and strengths and priorities of the family and MAP eligible recipient;

(7) statement and rationale of the nursing care plan for achieving these intermediate and long-range goals including provisions for the review and modification of the plan;

(8) specification of nursing responsibilities, description of the proposed nursing care, orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient; and

(9) a transition plan that identifies what the plan will be after discharge from PDN services.

C. EPSDT PDN covered services: MAD covers the following PDN services:

(1) skilled nursing services furnished to the MAP eligible recipient's at his or her home; and

(2) skilled nursing services which are medically necessary for attending school and furnished to the MAP eligible recipient in the school setting. These services are an alternative to his or her participation in a homebound program. Nursing services are furnished only to a MAP eligible recipient and not to others in the school setting.

D. EPSDT PDN noncovered services: PDN services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

[8.320.2.19 NMAC - Rp, 8.320.2.19 NMAC, 1-1-14]

8.320.2.20 EPSDT REHABILITATION SERVICES: MAD pays for medically necessary services, including outpatient services furnished to a MAP eligible recipient under 21 years of age by or under the supervision of licensed PT; OT; and master's level SLP. A MAP eligible recipient under 21 years of age who is eligible for a home and community based waiver program receives medically necessary rehabilitation services through the EPSDT rehabilitation services, the home and community based waiver program provides rehabilitation services only for the purpose of community integration.

A. EPSDT rehabilitation eligible providers: A PT, OT and master's level SLP is eligible to be reimbursed for furnishing services to a MAP eligible recipient under 21 years of age in need of EPSDT rehabilitation services.

(1) The following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to a MAP eligible recipient:

(a) a master's level SLP licensed by the regulation and licensing department (RLD) board of speech-language pathology and audiology;

(b) a PT licensed as physical therapists by the RLD physical therapy board;

(c) an OT licensed as occupational therapists by the RLD board of examiners for occupational therapy;

(d) certified outpatient rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy, licensed by DOH;

(e) home health agencies licensed and certified by DOH; and

(f) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the DOH;

(g) a PT assistant licensed by the RLD physical therapy board and working under the supervision of a licensed PT;

(h) an OT assistant licensed by the RLD occupational therapy board and working under the supervision of a licensed OT;

(i) a SLP licensed by the RLD board of speech-language pathology and audiology; and

(j) SLP apprentices and clinical fellows licensed by the RLD board of speech-language pathology and working under the supervision of a licensed SLP.

B. EPSDT rehabilitation covered services: MAD covers speech therapy, physical therapy and occupational therapy services provided to a MAP eligible recipient under 21 years of age. MAD covers evaluations, individual therapy and group therapy in an outpatient setting. Services must be medically necessary and provided for the purpose of diagnostic study or treatment. Even though a MAP eligible recipient is receiving therapy services or can access therapy services at his or her school, he or she may require additional medically necessary services in addition to those provided at a school. Services must be designed to improve, restore or maintain the MAP eligible recipient's condition including controlling symptoms and maintaining the functional level to avoid further deterioration as indicated his or her ITP. The provider, following the MAP eligible recipient's PCP orders, will develop the treatment plan.

(1) Physical, occupational, and speech therapy services must be specifically related to the active written treatment plan developed by qualified a PT, OT, SLP therapist with authorization from the MAP eligible recipient's PCP.

(2) Services must be performed within the scope and practice of the RLD practice board and as defined by state statute and rule.

(3) All services provided by or under the supervision of a SLP, OT, PT must be prescribed or ordered by the MAP eligible recipient's PCP. The PCP must be a physician or doctor of osteopathy, certified nurse practitioner, or physician assistant licensed to practice in New Mexico.

C. EPSDT rehabilitation noncovered services:

(1) Services furnished by or under the supervision of a SLP, OT, PT are subject to the limitations and coverage restrictions that exist for other MAD services.

(2) MAD does not cover these specific services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Prior Authorization: All therapy services with the exception of the initial evaluation require prior authorization from MAD or its designee.

[8.320.2.20 NMAC - Rp, 8.320.2.20 NMAC, 1-1-14]

HISTORY OF 8.320.2 NMAC:

History of Repealed Material:

8.320.2 NMAC, Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services, filed xx-xx-xx - Repealed effective, 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES:
PART 6 SCHOOL-BASED SERVICES FOR MAP ELIGIBLE RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE

8.320.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.320.6.1 NMAC - N, 1-1-14]

8.320.6.2 SCOPE: The rule applies to the general public.
[8.320.6.2 NMAC - N, 1-1-14]

8.320.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.320.6.3 NMAC - N, 1-1-14]

8.320.6.4 DURATION: Permanent.
[8.320.6.4 NMAC - N, 1-1-14]

8.320.6.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.320.6.5 NMAC - N, 1-1-14]

8.320.6.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance division's (MAD) medical assistance programs (MAP).
[8.320.6.6 NMAC - N, 1-1-14]

8.320.6.7 DEFINITIONS: [RESERVED]

8.320.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.320.6.8 NMAC - N, 1-1-14]

8.320.6.9 SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE: MAD pays for medically necessary services for a MAP eligible recipient under twenty-one years of age when the services are part of the MAP eligible recipient's individualized education program (IEP) or an individualized family service plan (IFSP) for treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.
[8.320.6.9 NMAC - N, 1-1-14]

8.320.6.10 GENERAL PROVIDER INSTRUCTIONS: Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an electronic health record (EHR) incentive payment 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 MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD/MAD or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When approved, 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 PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply

necessary information in order for payment to be made. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency or each individual provider. Services must be in compliance with the statutes, rules and regulations of his or her practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.
[8.320.6.10 NMAC - N, 1-1-14]

8.320.6.11 ELIGIBLE PROVIDERS:

A. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, local education agencies (LEAs), regional educational cooperatives (RECs), and other state-funded educational agencies (SFEAs) that meet specified requirements are eligible to be reimbursed for furnishing services to an MAP eligible recipient. The LEA, REC, or other SFEA must enter into a governmental services agreement (GSA) with HSD and abide by the terms and conditions of it.

B. The following individual service providers must be employed by, or under contract to, the LEA, REC, or other SFEA when furnishing treatment and meet other specified qualification criteria:

(1) physical therapists (PT);

(2) physical therapy assistants working under the supervision of a MAD enrolled PT;

(3) occupational therapists (OT);

(4) occupational therapy assistants working under the supervision of a MAD enrolled licensed occupational therapist;

(5) speech and language pathologists (SLP) and clinical fellows;

(6) apprentices in speech-language (ASL) working under the supervision of a MAD enrolled licensed speech therapist;

(7) audiologists;

(8) licensed nutritionists or registered dieticians;

(9) case managers meeting one of the following requirements:

(a) bachelor's degree in social work, counseling, psychology, nursing or a related health or social services field from an accredited institution;

(b) one year experience serving medically-at-risk children or adolescents; or

(c) a licensed registered (RN);

(10) For a LEA, REC, or other SFEA that employs a RN or a licensed practical nurse (LPN) not as a case worker, each is under the oversight of the department of health's (DOH) district health officer, as provided by state statue (NMSA 1978, Section 24-1-4). A LPN must work under the supervision of a RN who is a PED licensed school nurse.

C. As applicable, each provider must be licensed by the public education department (PED) when such licensure exists.

D. As applicable, each provider must be licensed by its specific regulation and licensing division (RLD)'s board of practice or by PED.
[8.320.6.11 NMAC - N, 1-1-14]

8.320.6.12 PROVIDER RESPONSIBILITIES:

A. **General responsibilities:**

(1) A provider who furnishes services to a MAP eligible recipient must comply with all terms and conditions of his or her MAD PPA and the MAD New Mexico administrative code (NMAC) rules.

(2) A provider must verify that an individual is a MAP eligible recipient at the time services are billed.

(3) A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HSD regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

B. **Documentation requirements:**

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to a MAP eligible recipient who is currently receiving MAD services or has received MAD services in the past. Payment for services billed to MAD that are not substantiated in the MAP eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of creation or until ongoing audit issues are resolved, whichever is longer; see 8.302.2 NMAC.

(2) For services covered under this rule, complete copies of the MAP eligible recipient's IEP or IFSP with the individualized treatment plan (ITP) portions of the IEP or IFSP signed by the primary care provider (PCP) must be maintained as part of the required records.

(3) Documents in the MAP eligible recipient's file must include:

(a) the IEP with the ITP or the IFSP with the ITP; and

(b) evaluation performed by the provider or the annual and current present level of performance;

(c) annual PCP authorization;

(d) treatment notes that relate directly to the IEP or IFSP goals and objectives specific to each MAP eligible recipient; and

(e) billing information recorded in units of time; see 8.302.2 NMAC.

C. **Record availability:** The provider must upon request promptly furnish to HSD, the secretary of the federal department of health and human services, or the state medicaid fraud control unit any information required in this rule, including the MAP eligible recipient and employee records, and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims.

[8.320.6.12 NMAC - N, 1-1-14]

8.320.6.13 COVERED SERVICES: MAD covers the following services when medically necessary and billed by specified providers in school settings.

A. For services in Subsections A-E of this rule, a provider must first develop and then update the MAP eligible recipient's present level of performance for each of his or her IEP or IFSP cycles. MAD requires the following elements be included in the provider's treatment notes:

(1) the specific activity provided to the MAP eligible recipient for each date of service billed;

(2) a description of the level of engagement and the ability of the MAP eligible recipient for each date of service billed; and

(3) the outcomes of session on the impact on the MAP eligible recipient's exceptionality for each date of service billed.

B. To be reimbursed for a MAD service, all of the requirements in this subsection must be met.

(1) Services must be medically necessary, must be ordered or authorized by the MAP eligible recipient's PCP, and must meet the needs specified in his or her IEP or IFSP. The services must be necessary for the treatment of the MAP eligible recipient's specific identified condition.

(2) The ITP portion of the IEP or IFSP must be signed by the MAP eligible recipient's PCP and be developed in conjunction with the appropriate qualified PT, OT, SLP, audiologist, or a RN.

(3) Services require prior authorization by the PCP. The requirement for prior authorization is met when the PCP signs the ITP portion of the IEP or IFSP and services are performed in accordance with the IEP or IFSP that has been signed by the PCP. If the PCP signature cannot be obtained to meet the prior authorization requirement, the service will require prior authorization by MAD or its designee.

(4) Frequency and duration of services billed may not exceed those specified in the MAP eligible recipient's IEP or IFSP.

(5) Reimbursement is made directly to the LEA, REC, or other SFEA when therapy, licensed nutritionists or registered dieticians, transportation, case manager, or nurse providers furnish services under contract to the LEA, REC, or other SFEA.

C. **Therapy services:** MAD covers physical, occupational, audiological and speech evaluations, and therapy required for treatment of an identified medical condition.

D. **Nutritional assessment and counseling:** MAD covers nutritional assessment and counseling when billed by a licensed nutritionist or dietician for a MAP eligible recipient who has been referred for a nutritional need when part of his or her ITP. A nutritional assessment consists of an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical, and dietary data, including a recommendation for appropriate nutritional intake.

E. **Transportation services:** MAD covers transportation services for a MAP eligible recipient who must travel from his or her school to receive a covered service from a MAD provider when the service is unavailable in the school setting and when the service is medically necessary and is identified in the MAP eligible recipient's IEP or IFSP; see 8.324.7 NMAC. MAD covers transportation to and from the school on the date a medically necessary service is billed in the school setting for a MAP eligible recipient who has a disability.

(1) Medical services are billed on the specific day on which transportation is billed and are specified in the ITP portion of his or her IEP or IFSP.

(2) The MAP eligible recipient requires transportation in a vehicle adapted to serve his or her needs.

(3) Transportation occurs in a modified school bus for disabled students.

F. **Case management:** MAD covers case management services billed in school settings to a MAP eligible recipient who is medically at risk. MAD pays for services billed by a single case management service provider during a given time period. Medically at risk refers to MAP eligible recipient who has a diagnosed physical condition which has high probability of impairing cognitive, emotional, neurological, social, or physical development.

(1) The service is developed in conjunction with a qualified case manager.

(2) MAD covers the following case management services.

(a) The assessment of the MAP eligible recipient's medical, social and functional abilities at least every six months, unless more frequent reassessment is indicated by the MAP eligible recipient's condition.

(b) The development and implementation of a comprehensive case management plan of care that helps the MAP eligible recipient retain or achieve the maximum degree of independence.

(c) The mobilization of the use of natural helping networks, such as family members, church members, community organizations, support groups, friends, and the school, if the MAP eligible recipient is able to attend.

(d) Coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the case management plan of care as necessary.

(e) All services must be delivered to be eligible for MAD reimbursement.

(3) A MAP eligible recipient has the freedom to choose a case management service provider. MAD will pay for only *one* case management provider to furnish services to a MAP eligible recipient at any given time period. If a MAP eligible recipient has a case manager or chooses to use a case manager who is not employed or under contract to the LEA, REC or other SFEA, the LEA, REC or other SFEA must coordinate with the case manager in the development of the MAP eligible recipient's ITP.

G. **Nursing:** MAD covers certain nursing services required for treatment of a diagnosed medical condition that qualifies a MAP eligible recipient for an IEP or IFSP when provided by a licensed RN or LPN. Nursing services require professional nursing expertise and are provided by a licensed RN or a LPN and must be provided in accordance with the New Mexico Nursing Practice Act and must be a covered MAD service.

H. **Administrative activities**: MAD covers the cost of certain administrative activities that directly support efforts to provide health-related services to a MAP eligible recipient with special education and health care needs. These administrative activities include, but are not limited to, providing information about MAD services and how to access them; facilitating the eligibility determination process; assisting in obtaining transportation and translation services when necessary to receive health care services; making referrals for MAD reimbursable services; and coordinating and monitoring MAD covered medical services.

(1) Payment for an allowable administrative activity is contingent upon the following:

(a) the LEA, REC or other SFEA must complete a MAD PPA to become an approved school-based health services provider;

(b) the LEA, REC or other SFEA must enter into a governmental services agreement (GSA) with HSD and agree to abide by the terms and conditions of the GSA;

(c) the LEA, REC or other SFEA must submit claims for allowable administrative activities in accordance with federal and state regulations, rules and guidelines; the centers for medicare and medicaid services (CMS) Medicaid School-Based Administrative Claiming Guide, May 2003, or its successor; and the New Mexico Medicaid Guide for School-Based Services, November 2004, or its successor.

(2) Administrative claiming is subject to compliance reviews and audits conducted by HSD, the state medicaid fraud control unit and CMS. By signing the MAD PPA, the LEA, REC or other SFEA agrees to cooperate fully with HSD, the state medicaid fraud control unit and CMS in the performance of all reviews and audits and further agrees to comply with all review and audit requirements.

[8.320.6.13 NMAC - N, 1-1-14]

8.320.6.14 INDIVIDUALIZED TREATMENT PLAN:

A. The ITP must specify:

(1) the MAP eligible recipient's objectives and goals; and

(2) the duration, the frequency of the service for the MAP eligible recipient.

B. The plan is developed by the LEA, REC or other SFEA in conjunction with the MAP eligible recipient, his or her family, and applicable service providers. The ITP portion of the IEP or IFSP must be reviewed and signed at least annually by the MAP eligible recipient's PCP to meet requirements for prior authorization of services provided to the MAP eligible recipient. If this review and PCP signature are not performed annually or when there is a change to the current IEP or IFSP, the service will require prior authorization by MAD or its designee.

C. The ITP is a plan of care agreed upon by the MAP eligible recipient, his or her parents or legal guardians, the evaluating therapists, the IEP or IFSP committee, and the MAP eligible recipient's teacher, all of whom are included in the IEP or IFSP. The ITP utilizes the MAP eligible recipient's health history, medical and educational evaluations and recommendations by the PCP and other medical providers, as applicable. If medical needs are identified in the IEP or IFSP, the medical portion of the IEP or IFSP is the MAP eligible recipient's ITP. The ITP must be incorporated into the IEP or IFSP. See 8.321.2 NMAC for behavioral health services. [8.320.6.14 NMAC - N, 1-1-14]

8.320.6.15 SCHOOL-BASED SETTING COUNSELING, EVALUTION AND THERAPY: MAD pays for medically necessary services billed to a MAP eligible recipient under 21 years of age when the services are part of his or her individualized education plan (IEP) or individualized family service plan (IFSP) for the treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.

A. Upon approval of the provider's MAD PPA, a local education agencies (LEA), regional educational cooperative (REC), and another state-funded educational agencies (SFEA) that meet specified requirements are eligible to be reimbursed for furnishing services to a MAP eligible recipient. The LEA, REC, or other SFEA must develop a collaborative plan with the community. Requirements for such plans will be described in MAD written guidelines and available on its website. The rendering practitioners listed detailed below must be employed by or under contract with the LEA, REC, or other SFEA when furnishing treatment to a MAP eligible recipient. A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HSD or MAD regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

(1) Social work practitioners who meet one of the following requirements are eligible to receive reimbursement thru the provider for services to a MAP eligible recipient:

(a) is licensed by RLD's as a LISW and a MAD enrolled provider; or

(b) is licensed by RLD as either a LMSW or a licensed bachelor social worker (LBSW), and supervised by a New Mexico licensed Ph.D., Psy.D., Ed.D., or LISW who is a MAD enrolled provider; and

(c) services provided by licensed LBSW or licensed LMSW must be within the scope of his or her practice board respectively, supervised and periodically evaluated in accordance with his or her practice board requirements.

(i) Supervision must adhere to the requirements of the practitioner's applicable licensing board.

(ii) A MAP eligible recipient receiving services from a LBSW or a LMSW must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) or a LISW who is enrolled as a MAD provider. If the MAP eligible recipient has a current diagnosis from another independently licensed practitioner as detailed in Section 9 of this rule, that diagnosis will be accepted. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and

(d) meets licensure requirements of PED.

(2) Psychologists meeting one of the following requirements are eligible to receive reimbursement thru the provider for services to a MAP eligible recipient:

(a) psychologists (Ph.D., Psy.D., or Ed.D.) licensed by the New Mexico psychologist examiners board and meeting licensure requirements of the public education department; or

(b) master's level practitioners licensed by the New Mexico psychologist examiners board as psychologist associates or licensed by PED as school psychologists and supervised by a psychiatrist or a Ph.D., Psy.D., or Ed.D. who is licensed as a psychologist by the New Mexico psychologist examiners board, enrolled as a MAD provider, and meets licensure requirements of PED.

(3) Physicians and psychiatrists licensed by the board of medical examiners and meet licensure requirements of PED are eligible for reimburse by the provider for services to a MAP eligible recipient.

(4) Case managers who meet one of the following requirements:

(a) bachelor's degree in one of the following: social work, counseling, psychology or a related health or social services field from an accredited institution and having one year experience serving medically-at-risk children or adolescents, and must be a MAD enrolled case manager with the appropriate provider type and specialty; or

(b) a licensed registered (RN) or practical nurse (LPN) or

(c) an individual with a bachelor's degree in another field and two years of direct experience in serving medically-at-risk children or adolescents.

(5) LPC, and LMHC licensed by RLD and meeting licensure requirements of PED. A LMHC and LPC must be supervised by a MAD enrolled licensed LPCC, LMFT, licensed psychologist, or licensed psychiatrist. A LMSW and LBSW must be supervised by a MAD enrolled LPCC, or a Ph.D., Psy.D., or Ed.D. and meet the licensure requirements of PED.

(6) A MAD enrolled LISW, LMFT and LPPC practitioner may render services when licensed by RLD and meet licensure requirements of PED:

(7) The following practitioners may render services when supervision is provided by 8.320.6.10 B (6)(a) or 8.320.6.10.B(10): a licensed LMHC or a licensed LPC. Services provided by licensed LMHC, and a LPC must be within the scope of their practice respectively and supervised and periodically evaluated in accordance with their practice board requirements. Supervision must adhere to the requirements of the practitioner's applicable licensing board.

(a) A MAP eligible recipient receiving services from a LMHC or LPC must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) who is enrolled as a MAD provider. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and is this

(b) A MAP eligible recipient receiving services from an LBSW or an LMSW must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) or a LISW who is enrolled as a MAD provider. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and meets licensure requirements of PED.

(8) A MAD enrolled CNS licensed by RLD and meeting licensure requirements of PED.

B. **MAP eligible recipients:** MAD covers medically necessary treatment to a MAP eligible recipient under 21 years of age who has a MAD-reimbursable service identified in his or her IEP or IFSP.

C. **Documentation requirements:**

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to MAP eligible recipient who is currently receiving MAD services or have received MAD services in the past. Payment for services billed to MAD that are not substantiated in the MAP eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of creation or until ongoing audit issues are resolved, whichever is longer. See Section 8.302.1.

(2) For services covered under this rule, complete copies of the IEPs or IFSPs, with the individualized treatment plan (ITP) portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

(3) Provider written documentation must include:

(a) present level of performance; and

(b) description of actual service delivered or rendered; and

(c) billing information recorded in units of time.

D. **Record availability:** The provider must, on request, promptly furnish to HSD, the secretary of the department of health and human services, or the state medicaid fraud control unit any information under documentation requirements, stated above, including MAP eligible recipient and employee records and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims.

E. **Covered services:** For services in subsections A-F, a provider must first develop and then update the MAP eligible recipient's present level of performance for each IEP cycle. For these services, MAD requires the following elements be included in the provider's notes:

(1) specific activity provided to the MAP eligible recipient for each date of service billed;

(2) description of the level of engagement and ability of the MAP eligible recipient for each date of service billed;

(3) outcomes of session on the impact on the MAP eligible recipient's exceptionality for each date of service billed.

F. MAD covers the following services when medically necessary and billed by specified providers in school settings:

(1) For services covered under this rule, complete copies of the IEPs or IFSPs, with the individualized treatment plan (ITP) portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

(2) Provider written documentation must include:

(a) present level of performance; and

(b) description of actual service delivered or rendered; and

(c) billing information recorded in units of time.

[8.320.6.15 NMAC - N, 1-1-14]

8.320.6.16 NONCOVERED SERVICES: Services billed in school settings are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.301.3 NMAC. MAD does not cover the following services.

A. Services classified as educational.

B. Services to non-MAP eligible individuals.

C. Services billed by a practitioner outside his or her area of expertise.

D. Vocational training that is related solely to specific employment opportunities, work skills or work settings.

E. Services that duplicate services billed outside the school setting unless determined to be medically necessary and MAD or its designee gave prior authorization for the service.

F. Services not identified in the MAP eligible recipient's IEP or IFSP.

G. Services not authorized by the MAP eligible recipient's PCP unless otherwise approved by MAD or its designee.

H. Transportation services listed below:

(1) transportation that a MAP eligible recipient would otherwise receive in the course of attending school;

(2) transportation for a MAP eligible recipient with special education needs under the Individuals with Disabilities Education Act (IDEA) who rides the regular school bus to and from school with non-disabled children; and

(3) transportation of a minor aged child, such as a sibling of the MAP eligible recipient who is simply accompanying the MAP eligible recipient to a MAD service.

[8.320.6.16 NMAC - N, 1-1-14]

8.302.6.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: Certain procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All services are subject to UR 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. 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 specific service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

[8.320.6.17 NMAC - N, 1-1-14]

8.320.6.18 REIMBURSEMENT: Reimbursement to the LEA, REC, or SFEA is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's IEP or IFSP, and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142., and the services are otherwise covered by MAD, then MAD is authorized to pay for such services. The LEA, REC, or other SFEA must submit claims for reimbursement on the 837P electronic format or its successor unless it received written permission from MAD to bill on paper. Reimbursement to the LEA, REC or other SFEA for covered services billed by individual practitioners is made at the MAD fee schedule for the specific service.

[8.320.6.18 NMAC - N, 1-1-14]

HISTORY OF 8.320.6 NMAC:
Pre NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives.
MAD-747 School Based Services For Recipients Under Twenty-one Years of Age, 12-16-94.

History of Repealed Material:
8.320.6 NMAC, School Based Services for Recipients Under Twenty-One Years of Age, xx-xx-xx - Repealed effective, 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 321 BEHAVIORAL HEALTH SERVICES
PART 2 SPECIALIZED BEHAVIORAL HEALTH PROVIDER ENROLLMENT AND REIMBURSEMENT

8.321.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.321.2.1 NMAC - N, 1-1-14]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC - N, 1-1-14]

8.321.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.321.2.3 NMAC - N, 1-1-14]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC - N, 1-1-14]

8.321.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - N, 1-1-14]

8.321.2.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.321.2.6 NMAC - N, 1-1-14]

8.321.2.7 DEFINITIONS: [RESERVED]
[8.321.2.7 NMAC - N, 1-1-14]

8.321.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.321.2.8 NMAC - N, 1-1-14]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by the HSD medical assistance division (MAD). Upon approval of a New Mexico MAD provider participation agreement (PPA) or a MAD electronic health record (EHR) incentive payment 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 MAD covered services to MAP eligible recipients. A provider must be approved 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 MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When approved, 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 his or her MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency, and for an individual provider. Services must be in compliance with the statutes, rules and regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.2 and 8.310.3 NMAC.

C. Each specialized behavioral health service may have specific noncovered services. The following are the noncovered services for all specialized behavioral health services:

(1) hypnotherapy;
(2) biofeedback;
(3) conditions that do not meet the standard of medical necessity as defined in MAD rules;
(4) treatment for personality disorders;
(5) treatment provided for adults 21 years and older in alcohol or drug rehabilitation units;
(6) educational or vocational services related to traditional academic subjects or vocational training;
(7) experimental or investigational procedures, technologies or non-drug therapies and related services;
(8) activity therapy, group activities and other services which are primarily recreational or divisional in nature;
(9) electroconvulsive therapy;
(10) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside his or her scope of practice;
(11) treatment of intellectual disabilities alone;
(12) services not considered medically necessary for the condition of the MAP eligible recipient;
(13) services for which prior authorization is required but was not obtained; and
(14) milieu therapy.

D. All behavioral health services must meet with the current MAD definition of medical necessity found in the MAD New Mexico Administrative Code (NMAC) rules.

E. Performance of a behavior health service cannot be delegated to a provider or practitioner not licensed for independent practice except as furnished within the limits of MAD benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local statutes, laws and rules. A behavioral health professional service must be provided directly to the MAP eligible recipient by the licensed behavioral health professional listed in Section 9, Subsections B, H, I and J of this rule or where specifically allowed in a MAD rule. When a service is performed by supervised master's level provider, nurse, bachelor's level and another health professional not listed in Section 9, Subsections H-J, that service cannot be billed by the licensed supervisor even though the services may have been furnished under his or her direction. All specialized behavioral health services are reimbursed as follows, except when instructed within a particular specialized service's reimbursement section.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a behavioral health provider for covered services at the lesser of the following:

(a) the provider's billed charge; or
(b) the MAD fee schedule for the specific service or procedure.

(2) Reimbursement to a provider for covered services is made at the lesser of the following:

(a) the provider's billed charge; or
(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) The provider's billed charge must be its usual and customary charge for services.
(ii) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(3) Reimbursement is made for an Indian health services (IHS) agency or a federal qualified health center (FQHC) by following its federal guidelines and special provisions and as detailed in 8.310.12 NMAC.

F. All specialized behavioral health 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. 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 specialized behavioral health service may have additional prior authorization requirements listed in the service's prior authorization section.

G. General MAD treatment plan requirements for specialized behavioral health services: A MAD treatment plan and all supporting documentation must be available for review by HSD or its authorized agency in the MAP eligible recipient's file. Specific treatment plan elements may be required for a specialized behavioral

health service listed in that service section's the treatment plan subsection. MAD makes available on its website comprehensive treatment plan requirements and requires a provider to use the applicable treatment plan requirements for services he or she renders. At a minimum, following must be contained in the treatment plan and documents used in the development of the treatment plan:

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

(2) description of the functional level and symptom status of the MAP eligible recipient, including the following:

(a) mental status assessment;
(b) intellectual function assessment;
(c) psychological assessment;
(d) social assessment which includes community support, housing and legal status;
(e) medical assessment;
(f) physical assessment;
(g) substance abuse assessment;
(h) activities of daily living assessment; and
(i) a DSM IV- TR (or its successor) diagnosis.

(3) description of the MAP eligible recipient's intermediate and long-range goals and approaches for the least restrictive conditions necessary to achieve the purposes of treatment with a projected timetable for each goal attainment;

(4) statement of the duration, frequency, and rationale for services included in the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(5) specific staff responsibilities, proposed staff involvement and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient;

(6) criteria for discharge from services and the projected date for discharge;

(7) identification of services to be provided upon discharge and appointments for these services;

(8) regular, periodic review of the plan to determine effectiveness of treatment and modification as indicated.

H. The following independent providers are eligible to be reimbursed for providing behavioral health professional services:

(1) a physician licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry, to include the groups they form;

(2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as clinical psychologist by the New Mexico regulations and licensing department's (RLD) board of psychologist examiners, to include the groups they form;

(3) an independent social worker (LISW) licensed by RLD's board of social work examiners, to include the groups they form;

(4) a professional clinical mental health counselor (LPCC) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(5) a marriage and family therapist (LMFT) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(6) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by RLD's board of nursing and is certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as his or her certification permits.

I. The following agencies are eligible to be reimbursed for providing behavioral health professional services:

(1) a community mental health center (CMHC)
(2) a federally qualified health clinic (FQHC);
(3) an Indian health services (IHS) hospital and clinic;
(4) a PL 93-638 tribally operated hospitals and clinics;
(5) children, youth and families department (CYFD);
(6) a hospital and its outpatient facility; and
(7) a core service agency (CSA).

J. When providing services supervised and billed by an agency listed above in Subsection I of this Section, the following practitioner's outpatient services may be reimbursed when the services are within his or her legal scope of practice (see Section 9, Subsection B of this rule):

(1) a masters level social worker (LMSW) licensed by RLD's board of social work examiners;

(2) a professional mental health counselors (LPC) licensed by RLD's counseling and therapy practice board;

(3) a mental health counselor (LMHC) licensed by RLD's counseling and therapy practice board;

(4) a psychologist associates licensed by the RLD's psychologist examiners board;

(5) a professional art therapists (LPAT) licensed by RLD's counseling and therapy practice board;

(6) an alcohol and drug abuse counselor (LADAC) licensed by RLD's counseling and therapy practice board; and

(7) A MAP eligible recipient under 21 years of age may be identified through a tot to teen healthcheck, self referral, referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns. If the MAP eligible recipient requires extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of the MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

[8.321.2.9 NMAC - N, 1-1-14]

8.321.2.10 APPLIED BEHAVIOR ANALYSIS: MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) for MAP eligible recipients under 21 years of age who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for MAP eligible recipients under 3 years of age who has a well-documented risk for the development of ASD. ABA is provided to a MAP eligible recipient by MAD as part of a three-stage comprehensive approach to assessment and treatment which stipulates that ABA be provided in conjunction with other medically necessary services (e.g., occupational therapy, speech language therapy, medication management, etc.). Following a referral to an approved autism assessment provider (AAP) to confirm the presence of, or risk for, ASD (stage one), a behavior analytic assessment is conducted and a behavior analytic treatment plan is developed, as appropriate for the selected service model (stage two). Then, behavior analytic services are rendered by an approved behavior analytic provider in accordance with the MAP eligible recipient's treatment plan (stage three). See MAD billing instructions for detailed and specific requirements for this service. A MAD provider must completely comply with all MAD NMAC rules and billing instructions to be eligible for reimbursement of this service.

[8.321.2.10 NMAC - N, 1-1-14]

8.321.2.11 ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) SERVICES: To help a MAP eligible recipient under 21 years of age who has been diagnosed as having SED or a chemical dependency, and for whom a less restrictive setting is not appropriate, MAD pays for services furnished to him or her by a ARTC accredited by JC as part of EPSDT program. The need for ARTC must be identified in the MAP eligible recipient's tot to teen healthcheck screen or other diagnostic evaluation.

A. **Eligible facilities:**

(1) In addition to the requirements of Section 9 Subsection A and B of this rule, in order to be eligible to be reimbursed for providing ARTC services to a MAP eligible recipient, an ARTC facility:

(a) must provide a copy of its JC or CARF accreditation as a children's residential treatment facility;

(b) must provide a copy of its CYFD ARTC facility license and certification; and

(c) must have written UR plans in effect which provide for review of the MAP eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245;

(2) If the ARTC is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD ARTC licensing requirements, but is not required to be licensed by CYFD. In lieu of receiving a license, CYFD will provide MAD copies of its facility reviews and recommendations. MAD will work with the facility to address recommendations; and

(3) In lieu of New Mexico CYFD licensure, an out-of-state or MAD border ARTC facility must have JC accreditation and be licensed in its own state as an ARTC residential treatment facility.

B. **Covered services:** MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. An ARTC facility must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient.

(1) Treatment must be furnished under the direction of a MAD board eligible or certified psychiatrist;

(2) Treatment must be based on the MAP eligible recipient's individualized treatment plan rendered by the ARTC facility's practitioners, within the scope and practice of their professions as defined by state law. See Section 9 Subsection B of this rule for general behavioral health professional requirements.

(3) Treatment must be reasonably expected to improve the MAP eligible recipient's condition. The treatment must be designed to reduce or control symptoms or maintain levels of functioning and avoid hospitalization or further deterioration is acceptable expectations of improvement.

(4) The following services must be performed by the ARTC agency to receive MAD reimbursement:

(a) performance of necessary evaluations, psychological testing and development of the MAP eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the MAP eligible recipient's 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 to the MAP eligible recipient;

(d) assistance to the MAP eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient, make referrals, as necessary, and provide follow-up to the MAP eligible recipient;

(f) consultation with other professionals or allied caregivers regarding the needs of the MAP eligible recipient, as applicable;

(g) non-medical transportation services needed to accomplish the MAP eligible recipient's treatment objective; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the MAP eligible recipient.

C. **Noncovered services:** ARTC services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with ARTC services to a MAP eligible recipient:

(1) CCSS, except when provided by a CCSS agency in discharge planning for the MAP eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals. RTC and group services are covered only for MAP eligible recipients under 21 years of age;

(4) formal educational and services which relate to traditional academic subjects or vocational training; and

(5) activity therapy, group activities, and other services primarily recreational or divisional in nature.

D. **Treatment plan:** The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a ARTC facility. The interdisciplinary team must review the treatment plan at least every 14 calendar days. In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file. The treatment plan must also include a statement of the MAP eligible recipient's cultural needs and provision for access to cultural practices.

E. **Prior authorization:** Before any ARTC services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. **Reimbursement:** An ARTC agency must submit claims for reimbursement on the UB 04 form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) The MAD fee schedule is based on actual cost data submitted by the ARTC agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct

service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The MAD fee schedule reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include:

(i) other MAD services that a MAP eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of the MAD NMAC rules; and

(c) Services which are not covered in the routine rate and are not a MAD-covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, an ARTC agency cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

(3) An ARTC agency must submit annual cost reports in a form prescribed by MAD. Cost reports are due 90 calendar days after the close of the agency's fiscal year end.

(a) If an agency cannot meet this due date, it can request a 30 calendar day extension for submission. This request must be made in writing and received by MAD prior to the original due date.

(b) Failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all MAD payments until such time as the cost report is received.

(4) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the New Mexico border (Mexico excluded) are 70 percent of billed charges or a negotiated rate.

[8.321.2.11 NMAC - N, 1-1-14]

8.321.2.12 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help a MAP eligible recipient 18 years and older receive medically necessary services, MAD pays for covered assertive community treatment services (ACT) [42 CFR SS 440.40, 440.60(a) and 441.57]. ACT services are therapeutic interventions that address the functional problems associated with the most complex and pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increasing the MAP eligible recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

A. **Eligible providers:**

(1) An ACT agency must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. See Section 9, Subsection A and B for MAD general provider requirements.

(2) ACT services must be provided by an agency designating a team of 10 to 12 members; see this section paragraph (5) for the required composition. Each team must have a designated team leader. Practitioners on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance abuse treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that a MAP eligible recipient obtains the basic necessities of daily life; and education, support and consultation to the MAP eligible recipient's family and other major supports. The agency must coordinate its ACT services with local hospitals, local crises units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.

(4) Each ACT team staff member must be successfully and currently certified or trained according to ACT standards developed by HSD or its authorized agents. The approved training will focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices. Each ACT team shall have sufficient numbers of qualified staff to provide treatment, rehabilitation, crisis and support services 24-hours a day, seven days per week.

(5) Each ACT team shall have a staff-to-MAP eligible recipient ratio in keeping with ACT evidence-based practice standards and approved by MAD or its designee.

(6) Each ACT team shall include:

(a) at least one board-certified or board-eligible psychiatrist (full-time position is not required);

(b) two licensed nurses, one of whom shall be a RN;

(c) at least one other MAD recognized independently licensed behavioral health professional, see Section 9 Subsection H of this rule;

(d) at least one MAD recognized licensed substance abuse professional; see Section 9 Subsection J of this rule;

(e) at least one employment specialist;

(f) at least one New Mexico certified peer specialist (CPS) through the approved state of New Mexico certification program;

(g) one administrative staff person; and

(h) the MAP eligible recipient shall be considered a part of the team for decisions impacting his or her ACT services.

(7) The agency must have a MAD ACT approval letter to render ACT services to a MAP eligible recipient.

B. **Coverage criteria:**

(1) MAD covers medically necessary ACT services required by the condition of the MAP eligible recipient.

(2) The interventions are strength-based and focused on promoting symptom stability; increasing the MAP eligible recipient's ability to cope and relate to others; and enhancing the highest level of functioning in the community, including learning, working and recreation and making informed choices.

(3) Interventions may address adaptive skill areas such as: housing; school, work and training opportunities; daily activities; health and safety; medication support; harm reduction; money management and entitlements; promotion of the MAP eligible recipient's recovery processes; relapse prevention; and service planning and coordination.

(4) The ACT therapy model shall be based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan of the MAP eligible recipient. Specialized therapeutic and rehabilitative interventions falling within the fidelity model of ACT are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services.

C. **MAP eligible recipients:**

(1) ACT services are provided to a MAP eligible recipient aged 18 and older who has a diagnosis of SMI, including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression for individuals who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services and who have experienced repeated hospitalizations or incarcerations due to mental illness.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from ACT services.

D. **Covered services:**

(1) ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

(a) the service is available 24-hours a day, seven days a week;

(b) the service is provided by an interdisciplinary ACT team that includes trained personnel as defined in of Section 6 Subsection A of this rule;

(c) an individualized treatment plan and supports are developed;

(d) at least 90 percent of services are delivered as community-based, non-office-based outreach services (in vivo);

(e) an array of services are provided based on the MAP eligible recipient's medical need;

(f) the service is MAP eligible recipient-directed;

(g) the service is recovery-oriented;

(h) following the ACT evidence-based model guidelines, the ACT team maintains a low staff-to-patient ratio;

(i) mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations; and

(j) the team is not just a consortium of mental health specialists, but includes collaborative assessment and treatment planning for each MAP eligible recipient; cross-training of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each MAP eligible

recipient's care and services; and the team will assist the MAP eligible recipient to access other appropriate services in the community that are not funded by MAD.

(2) Quality measurement: An ACT program's success is evaluated based on outcomes which may include but are not limited to: improved engagement by the MAP eligible recipient in medical and social services; decreased rates of incarceration; decreased rates of hospitalization; decreased use of alcohol or illegal drugs; increased housing stability; increased relationships of the MAP eligible recipient with his or her family (as appropriate); increased employment; and increased attainment of goals self-identified by the service MAP eligible recipient for his own life. Fidelity to the specific evidence-based ACT service model will also be measured to assure that ACT, rather than some other form of intensive case management, is being provided.

(3) ACT services must be provided to the MAP eligible recipient by the treatment team members.

(4) ACT program provides three levels of interaction with a MAP eligible recipient:

(a) a face-to-face encounters are at least 60 percent of all ACT team activities with approximately 90 percent of ACT encounters occurring outside of the IOP agency's office (in vivo);

(b) a collateral encounter where the collaterals are members of the MAP eligible recipient's family or household or significant others (e.g. landlord, criminal justice staff, and employer) who regularly interact with him or her and are directly affected by or have the capability of affecting the MAP eligible recipient's condition, and are identified in the service plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff that is assisting an ACT MAP eligible recipient in locating housing);

(c) assertive outreach consists of the ACT team being 'assertive' about knowing what is going on with a MAP eligible recipient and acting quickly and decisively when action is called for, while increasing the MAP eligible recipient's independence. The team must closely monitor the relationships that the MAP eligible recipient has within the community and intervene early if a difficulty arises;

(d) collateral encounters and assertive outreach combined must not exceed 40 percent of the total ACT team activities for each MAP eligible recipient; and

(e) all of the above activities must be indicated in the MAP eligible recipient's service plan.

E. **Noncovered services:** ACT services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for MAD general noncovered behavioral health services. MAD does not cover other psychiatric, mental health nursing, therapeutic, substance abuse or crisis services when billed in conjunction with ACT services to a MAP eligible recipient, except for medically necessary medications and hospitalizations.

F. **Reimbursement:** ACT agencies must submit claims for reimbursement on the CMS 1500 claim form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements. [8.321.2.12 NMAC - N, 1-1-14]

8.321.2.13 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: To help a MAP eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD furnishes these services as part of the EPSDT program and when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation [42 CFR Section 441.57]. MAD pays for medically necessary behavior management skills development services (BMS) which are services designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the MAP eligible recipient in his or her home or community. BMS services assist in preventing inpatient hospitalizations or out-of-home residential placement of the MAP eligible recipient through use of teaching, training and coaching activities designed to assist him or her in acquiring, enhancing and maintaining the life, social and behavioral skills needed to function successfully within his or her home and community settings. BMS is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the MAP eligible recipient's treatment or service plan.

A. **Eligible providers:**

(1) An agency must be certified by CYFD to provide BMS services; and

(2) See Section 9 Subsections A and B of this rule for MAD general provider requirements.

B. **Covered services:** MAD reimburses for services specified in the MAP eligible recipient's individualized treatment plan which are designed to improve his or her performance in targeted behaviors, reduces emotional and behavioral episodic events, increases social skills and enhances behavioral skills through a regimen of positive intervention and reinforcement.

(1) Implementation of a MAD eligible recipient's BMS treatment plan must be based on a relevant clinical assessment covering an integrated program of therapeutic services, as applicable. The following tasks must be identified in the MAP eligible recipient's BMS treatment plan:

(a) the treatment plan must identify all targeted behaviors that are to be addressed by the behavior management specialist;

(b) the treatment plan should include, when appropriate, a goal of working with the MAP eligible recipient's foster, adoptive, or natural family in order to assist with the achievement and maintenance of behavior management skills; and

(c) the treatment plan must identify the behavior management specialist who is responsible for implement of the plan, including but not limited to:

(i) assistance in achieving and maintaining appropriate behavior management skills through teaching, training and coaching activities; and

(ii) maintaining case notes and documentation of tasks as required by the agency and pursuant to the standards under which it operates in accordance with NMAC rules, including licensed professional standards.

(2) Supervision of behavioral management staff by an independent level practitioner is required for this service. See, Section 9 of this rule. The supervisor must ensure that:

(a) an assessment (within the past 12 months) of the MAP eligible recipient is completed which identifies the need for BMS;

(b) the assessment is signed by the recipient, his parent or legal guardian; and

(c) the BMS specialist receives supervision on a regular basis.

(3) An agency certified for BMS services must:

(a) develop a BMS treatment plan based on a relevant and recent clinical assessment (within the last 12 months), as part of a comprehensive treatment plan covering an integrated program of therapeutic services, as applicable;

(b) identify all targeted behaviors that are to be addressed by the behavioral management specialist;

(c) ongoing assessment of the MAP eligible recipient's progress in behavioral management skills by the BMS supervisor; and

(d) offer 24-hour availability or appropriate staff to respond to the MAP eligible recipient's crisis situations.

(4) A MAP eligible recipient's treatment plan must be reviewed at least every 30 calendar days and notation of this review must be maintained in the recipient's file

C. **MAP eligible recipients:** In order to receive BMS services, a MAP eligible recipient must be under the age of 21 years, be diagnosed with a behavioral health condition and:

(1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;

(2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) require behavior management support following an institutional or other out-of-home placement as a transition to maintain the MAP eligible recipient in his or her home and community.

D. **Noncovered services:** BMS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

(1) activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the BMS treatment plan;

(2) services provided in a residential treatment facilities; and

(3) as services provided in lieu of services that should be provided as part of the MAP eligible recipient's individual educational plan (IEP).

E. **Reimbursement:** A BMS agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and 8.302.2 NMAC.

[8.321.2.13 NMAC - N, 1-1-14]

8.321.2.14 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): To help a New Mexico MAP eligible recipient receive medically necessary services, MAD pays for covered CCSS. This culturally sensitive service coordinates and provides services and resources to a MAP eligible recipient and his or her family necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the MAP eligible recipient's community, as well as strengths that may aid the MAP eligible recipient and family in the recovery or resiliency process.

A. **Eligible providers:** In addition to the requirements of Section 9, Subsections A and B of this rule, in order to be eligible to be reimbursed for providing CCSS services, an agency must be: a FQHC; an IHS hospital or clinic; a PL 93-638 tribally operated hospital or clinic; or be a MAD enrolled CSA. CCSS services are certified by CYFD for MAP eligible recipients under 21 years of age and department of health (DOH) for those recipients over 21 years of age. For MAP eligible recipient ages 18 through 20, the CCSS certification or a license may be from either CYFD or DOH, as appropriate.

(1) Community support workers (CSW) (not a peer or family specialist), must possess the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the CSW must have:

(a) the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS;

(b) a bachelor's degree in a human service field from an accredited university and one year of relevant experience with the target population;

(c) an associate's degree and a minimum of two years of experience working with the target population;

(d) a high school graduation or general educational development (GED) test and a minimum of three years of experience working with the target population; or

(e) a New Mexico peer or family specialist certification and have completed 20 hours of documented training or continuing education, as identified in the CCSS service definition.

(2) CCSS agency supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the supervisory staff must hold:

(a) a bachelor's degree in a human services field from an accredited university or college;

(b) have four years of relevant experience in the delivery of case management or community support services with the target population;

(c) have at least one year of demonstrated supervisory experience; and

(d) completed 20 hours of documented training or continuing education, as identified in the New Mexico behavioral health collaborative CCSS service definition.

(3) CSA clinical supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the clinical supervisory staff must:

(a) be a licensed independent practitioner as detailed in Section 9 Subsection B and H of this rule; and

(b) have one year of documented supervisory training.

(4) Certified peer worker (CPW) must:

(a) be 18 years of age or older;

(b) have a high school diploma or GED;

(c) be self-identified as a current or former consumer of mental health or substance abuse services;

(d) have at least two years of mental health or substance abuse recovery; and

(e) be a currently certified New Mexico CPW.

(5) Certified family specialist (CFS) must:

(a) be 18 years of age or older;

(b) have a high school diploma or GED;

(c) have personal experience navigating any of the child and family-serving systems, advocating for family members who are involved with the child and family behavioral health systems; and must also have an understanding of how these systems operate in New Mexico;

(d) be a currently certified New Mexico CFS; and

(e) must be well-grounded in his or her symptom self-management if the family specialist is a current or former consumer of behavioral health services.

C. **Covered services:** The purpose of CCSS is to surround a MAP eligible recipient and his or her family with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community

support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, with at a minimum 60 percent face-to-face and in vivo (where the MAP eligible recipient is located). that address barriers that impede the development of skills necessary for independent functioning in the community.

(1) CCSS activities include:

(a) assistance to the MAP eligible recipient in the development and coordination of his or her treatment plan including a recovery or resiliency management plan, a crisis management plan, and, when requested, his or her advanced directives related to the MAP eligible recipient's behavioral health care; and

(b) assessment support and intervention in crisis situations, including the development and use of crisis plans that recognize the early signs of crisis or relapse, use of natural supports, alternatives to the utilization of emergency departments and inpatient services.

(2) Individualized interventions, with the following objectives:

(a) services and resources coordination to assist the MAP eligible recipient in gaining access to necessary rehabilitative, medical and other services;

(b) assistance in the development of interpersonal and community coping and functional skills (e.g., adaptation to home, school and work environments), including:

(i) socialization skills;
(ii) developmental issues;
(iii) daily living skills;
(iv) school and work readiness activities; and
(v) education on co-occurring illness;

(c) encouraging the development of natural supports in workplace and school environments;

(d) assisting in learning symptom monitoring and illness self-management skills (e.g. symptom management), relapse prevention skills, knowledge of medication and side effects, and motivational and skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms that interfere with the MAP eligible recipient's daily living and to support him or her in maintaining employment and school tenure;

(e) assisting the MAP eligible recipient in obtaining and maintaining stable housing; and

(f) any necessary follow-up to determine if the services accessed have adequately met the MAP eligible recipient's needs.

(3) At least 60 percent of non facility-based CCSS provided must be face-to-face and in vivo (where the MAP eligible recipient is located). The CSW must monitor and follow-up to determine if the services accessed have adequately met the MAP eligible recipient's specific treatment needs.

(4) The CSW will make every effort to engage the MAP eligible recipient and his or her family in achieving the member's treatment or recovery goals.

(5) When the service is provided by a CPS or CFS, the above functions and interventions should be performed with a special emphasis on recovery values and process, such as:

(a) empowering the MAP eligible recipient to have hope for, and participate in, his or her own recovery;

(b) helping the MAP eligible recipient to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;

(c) helping the MAP eligible recipient to identify and achieve his or her personalized recovery goals; and

(d) promoting the MAP eligible recipient's responsibility related to illness self-management.

(6) Limited CCSS services may be provided by a CSA during discharge planning while a MAP eligible recipient is receiving the following services:

(a) accredited residential treatment (ARTC);
(b) residential treatment (RTC);
(c) group home service;
(d) impatient hospitalization; or
(e) treatment foster care (TFC I and II).

(7) CCSS services may not be provided in conjunction with the following services:

(a) multi-systemic therapy (MST); or
(b) assertive community treatment (ACT).

D. **MAP eligible recipients:**

(1) CCSS is provided to a MAP eligible recipient 21 years and under who meets the criteria for or is diagnosed as either or both: (a) at risk of or experiencing serious emotional disturbances (SED); (b) has a chronic substance abuse disorder.

(2) MAD covers CCSS for a MAP eligible recipient 21 years and older diagnosed with a severe mental illness (SMI). A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from CCSS.

E. **Noncovered services:** CCSS are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.310.2 NMAC for a detailed description of MAD general noncovered services and Section 9 Subsection C of this rule for all noncovered MAD behavioral health services or activities. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST) or ACT services.

F. **Reimbursement:** CCSS agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives direction on how to access MAD NMAC rules, instructions for documentation, billing, and claims processing. General reimbursement instructions are found in this rule under Section 9 Subsection D. [8.321.2.14 NMAC - N, 1-1-14]

8.321.2.15 DAY TREATMENT: MAD pays for services furnished by a day treatment provider as part of the EPSDT program for eligible MAP recipients under 21 years of age [42 CFR section 441.57]. The need for day treatment services must be identified through an EPSDT tot-to-teen healthcheck or other diagnostic evaluation. Day treatment services include MAP eligible recipient and parent education, skill and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented utilizing a clinical model for service delivery and support.

A. **Eligible providers:** An agency must be certified by CYFD to provide day treatment services in addition to the meeting the general provider enrollment requirements in Section 9, subsection A and B.

B. **MAP eligible recipients:** MAD covers day treatment services for a MAP eligible recipient under age 21 who:

(1) is diagnosed with an emotional, behavioral, and neurobiological or substance abuse problems;

(2) may be at high risk of out-of-home placement;

(3) requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school;

(4) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services; or

(5) is able to benefit from this LOC.

C. **Covered services:**

(1) Behavioral health day treatment services are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include parent and MAP eligible recipient education, skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. Counseling services may be provided in addition to the BMS services. The goals of the service must be clearly documented, utilizing a clinical model for service delivery and support.

(2) The goal of day treatment is to maintain the MAP eligible recipient in his or her home or community environment.

(3) Day treatment services must be provided in a school setting or other community setting. However, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered. Programming is designed to complement and coordinate with the MAP eligible recipient's educational system.

(4) Services must be based upon the MAP eligible recipient's individualized BMS treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the MAP eligible recipient's adaptive functioning.

(5) The following services must be furnished by a day treatment service agency to receive reimbursement from MAD:

(a) the assessment and diagnosis of the social, emotional, physical and psychological needs of the MAP eligible recipient and his or her family for treatment planning ensuring that evaluations already performed are not unnecessarily repeated;

(b) development of individualized treatment and discharge plans and ongoing reevaluation of these plans;

(c) regularly scheduled individual, family, multi-family, group or specialized group sessions focusing on the attainment of skills, such as managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention, if applicable;

(d) family education and family outreach to assist the eligible recipient in gaining functional and behavioral skills;

(e) supervision of self-administered medication, as clinically indicated;

(f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each MAP eligible recipient's individualized treatment plan;

(g) availability of appropriate staff to provide crisis intervention during program hours;

(h) day treatment services are provided at a minimum of four hours of structured programming per day, two to five days per week based on acuity and clinical needs of the MAP eligible recipient and his or her family as identified in the treatment plan; and

(i) payment for performance of these services is included in the day treatment reimbursement rate.

(6) Only those activities of daily living and basic life skills that are assessed as being a clinical problem should be addressed in the treatment plan and deemed appropriate to be included in the MAP eligible recipient's individualized program.

(7) A family who is unable to attend the regularly scheduled sessions at the day treatment facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the day treatment agency.

D. **Noncovered services:** Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 subsection C of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

(1) educational programs;

(2) pre-vocational training;

(3) vocational training which is related to specific employment opportunities, work skills or work settings;

(4) any service not identified in the treatment plan;

(5) recreation activities not related to the treatment issues;

(6) leisure time activities such as watching television, movies or playing computer or video games;

(7) transportation reimbursement for the therapist who delivers services in the family's home; or

(8) a partial hospitalization program and all residential programs cannot be offered at the same time as day treatment services.

E. **Prior authorization:** See Section 9 Subsection F of this rule for the general behavioral health services prior authorization requirements.

F. **Treatment plan:** In addition to the General Treatment Plan requirements in Section 9, Subsection G of this rule, the treatment plan must be reviewed at least every 30 calendar days or more often when indicated based on the changing clinical needs.

G. **Reimbursement:** Day treatment providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Section 9, Subsection E of this rule for MAD general reimbursement requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how access documentation, billing and claims processing information.

[8.321.2.15 NMAC - N, 1-1-14]

8.321.2.16 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: To assist the MAP eligible recipient receive necessary mental health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program. If the MAP eligible recipient is receiving services immediately before he or she reaches the age of 21 years, services may continue based on the following conditions, whichever comes first: (1) up to the date the MAP eligible recipient no longer requires the services, or (2) the date the MAP eligible recipient reaches the age of 22 years. The need for inpatient psychiatric care in freestanding psychiatric hospital must be identified in the MAP eligible recipient's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

A. **Eligible providers:** An MAD eligible provider must be accredited by at least one of the following:

(1) the joint commission (JC);

(2) the council on accreditation of services for families and children (COA);
(3) the commission on accreditation of rehabilitation facilities (CARF);
(4) another accrediting organization recognized by MAD as having comparable standards;
(5) be licensed and certified by the New Mexico DOH or the comparable agency if in another state;
(6) have a written utilization review (UR) plan in effect which provides for the review of a MAP eligible recipient's need for the facility's services that meet federal requirements; see 42 CFR Sections 456.201 through 456.245; or
(7) be an approved MAD provider before it furnishes services; see 42 CFR Sections 456.201 through 456.245.

B. **Covered services:** MAD covers those inpatient psychiatric hospital services furnished in freestanding psychiatric hospitals which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the MAP eligible recipient. These services must be furnished by eligible providers within the scope and practice of his or her profession (see Section 9 of this rule) and in accordance with federal regulations; see 42 CFR Section 441 Subpart D. Services must be furnished under the direction of a physician.

(1) In the case of a MAP eligible recipient under 21 years of age these services:
(a) must be furnished under the direction of a board prepared, board eligible, board certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist; and
(b) the psychiatrist must conduct an evaluation of the MAP eligible recipient, in person within 24 hours of admission.

(2) In the case of a MAP eligible recipient under 12 years of age, the psychiatrist must be board prepared, board eligible, or board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for a MAP eligible recipient under age 12 and a MAP eligible recipient under 21 years of age can be waived when all of the following conditions are met:
(a) the need for admission is urgent or emergent and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;
(b) at the time of admission, a board prepared, board eligible, or board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located;
(c) another facility which is able to furnish a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and
(d) the admission is for stabilization only and transfer arrangement to the care of a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible under the understanding that if the MAP eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the MAP eligible recipient is stable for transfer in accordance with professional standards.

(3) The following services must be furnished by a freestanding hospital to receive reimbursement from MAD:
(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 MAP eligible recipient, group, family, or a multifamily group based on individualized needs, as specified in the MAP eligible recipient's 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 a MAP eligible recipient in his or her self administration of medication in compliance with state policies and procedures;
(e) appropriate staff available on a 24-hour basis to respond to crisis situations; determine the severity of the situation; stabilize MAP eligible recipient by providing support; make referrals, as necessary; and provide follow-up;
(f) a consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;
(g) non-medical transportation services needed to accomplish treatment objectives; and
(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of the MAP eligible recipient.

C. **Noncovered services:** Services furnished in a freestanding psychiatric hospital are subject to the limitations and coverage restrictions which exist for other MAD services; see Section 9 Subsection C of this rule for MAD general noncovered services. MAD does not cover the following specific services for a MAP eligible recipient in a freestanding psychiatric hospital in the following situations:

(1) conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM);

(2) services in freestanding psychiatric hospital for MAP eligible recipient 21 years of age or older;

(3) services furnished after the determination by MAD or its designee has been made that the MAP eligible recipient no longer needs hospital care;

(4) formal educational or vocational services related to traditional academic subjects or vocational training. MAD only covers non-formal education services if they are part of an active treatment plan for a MAP eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b); or

(5) drugs classified as "ineffective" by the FDA drug evaluation.

D. MAD covers "awaiting placement days" in a freestanding psychiatric hospital when the MAD utilization review (UR) contractor determines that a MAP eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the MAP eligible recipient requires a residential LOC which cannot be immediately located. Those days during which the MAP eligible recipient is awaiting placement to the lower LOC are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for ARTC services to a MAP eligible recipient classified as level III, IV, or IV+, plus five percent. A separate claim form must be submitted for awaiting placement days.

E. **Treatment plan:** The treatment plan must be developed by a team of professionals in consultation with a MAP eligible recipient, his or her parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days.

(1) The treatment team must consist of at a minimum (see CFR 42 441.156(c-d):

(a) either a:

(i) board eligible or board certified psychiatrist;

(ii) a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy;

(iii) a physician licensed to practice medicine;

(iv) osteopathy with specialized training and experience in the diagnosis and treatment of mental illness, or

(v) a psychologist who has a master's degree in clinical psychology or who has been certified by the state and his or her RLD practice board;

(b) the team must also include one of the following:

(i) a psychiatric social worker;

(ii) an occupational therapist who is licensed by the state and who has specialized training in treating a MAP eligible recipient under the age of 21 years of age with SED:

(iii) a RN with specialized training or one year's experience in treating a recipient under the age of 21 years; or

(iv) a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by his or her RLD practice board.

(2) The treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file. The following must be contained in the treatment plan or documents used in the development of the treatment plan:

(a) shall be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the MAP eligible recipient's situation and reflects the need for inpatient psychiatric care;

(b) shall be developed by a team of professionals as defined in Section E (1) above in consultation with the MAP eligible recipient and, his or her parent, legal guardian, or others in whose care he or she will be released after discharge;

(c) shall have stated treatment objectives;

(d) shall be prescribed in an integrated program of therapies, activities, and experiences designed to meet the objectives;

(e) include, at the appropriate time, a post-discharge plan and coordination of inpatient services with partial a discharge plan, and related community services to ensure continuity of care with the MAP eligible recipient's family, school, and community upon discharge;

(f) shall have a statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(g) shall have a description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

(h) shall have a statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including the provision for review and modification of the plan;

(i) shall have specification of staff responsibilities, description of proposed staff involvement, and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the MAP eligible recipient; and

(j) shall have the criteria for release to less restrictive settings for treatment and discharge plans, the criteria for discharge, and the projected date of discharge.

E. **Prior authorization and utilization review:** All MAD services are subject to UR 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. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

(1) All inpatient services for a MAP eligible recipient under 21 years of age in a freestanding psychiatric hospital 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.

(2) Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

(3) A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration; see 8.350.2 NMAC.

F. **Discharge planning:** Plans for discharge must begin upon admittance to the facility and be included in the MAP eligible recipient's treatment plan. Discharge must not be delayed because post-hospital planning is neglected. If the MAP eligible recipient will receive services in the community or in the custody of CYFD, the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the MAP eligible recipient, his or her family, and school and community.

G. **Reimbursement:** A freestanding psychiatric hospital service providers must submit claims for reimbursement on the UB04 claim form or its successor; see 8.302.2 NMAC. Once enrolled, providers receive instructions on how to access information on documentation, billing, and claims processing.

(1) Reimbursement rates for New Mexico freestanding psychiatric hospital is based on TEFRA provisions and principles of reimbursement; see 8.311.3 NMAC. Covered inpatient services provided in freestanding psychiatric hospital 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.

(2) 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 February 1, 2012. 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.

(3) Reimbursement rates for services furnished by a psychiatrist and licensed Ph.D. psychologist in a freestanding psychiatric hospital are contained in 8.311.3 NMAC. Services furnished by a psychiatrist and psychologist in a freestanding psychiatric hospital cannot be included as inpatient psychiatric hospital charges.

(4) When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the MAD coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

(5) The provider agrees to be paid by a HSD contracted managed care organization (MCO) at any amount mutually-agreed upon between the provider and MCO when the provider enters into contracts with MCO contracting with HSD for the provision of managed care services to a MAP eligible recipient.

(a) If the provider and the HSD contracted MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated 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.

(b) The "applicable reimbursement rate" is defined as the rate paid by HSD to the provider participating in the medical assistance programs administered by MAD and excludes disproportionate share hospital and medical education payments.

[8.321.2.16 NMAC - N, 1-1-14]

8.321.2.17 INTENSIVE OUTPATIENT PROGRAM SERVICES: To help a MAP eligible recipient receive medically necessary services, MAD pays for intensive outpatient program (IOP) services. IOP services provide a time-limited, multi-faceted approach to treatment service for a MAP eligible recipient who requires structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be delivered through a MAD approved agency, as specified in this section.

A. Eligible providers: See Section 9 Subsection A of this rule for MAD general provider requirements.

(1) Specific to IOP, the following types of agencies are eligible to be reimbursed for providing IOP services when they have a research-based model meeting the requirements of this Section Subsection C of this rule:

(a) a CMHC
(b) a RHC;
(c) a FQHC;
(d) an IHS facility;
(e) a PL.93-638 tribal 638 facility;
(f) a MAD CSA; or
(g) an agency approved by MAD after demonstrating that the agency meets all the requirements of IOP program services and supervision requirements. Such a MAD approved IOP agency is allowed to have services rendered by non-independent practitioners as listed in Section 9 Subsection J of this rule.

(2) Each IOP program must have a clinical supervisor. The clinical supervisor may also serve as the IOP program supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) be licensed as a MAD approved independent practitioner; see Section 9 Subsection H of this rule;
(b) two years relevant experience with an IOP program;
(c) one year demonstrated supervisory experience; and
(d) expertise in both mental health and substance abuse treatment.

(3) The IOP agency is required to develop and implement a program evaluation system.

(4) The agency must maintain the appropriate state facility licensure if offering medication treatment or medication replacement services.

(5) The agency must hold a MAD IOP approval letter and be enrolled by MAD to render IOP services to a MAP eligible recipient. A MAD IOP agency will be provisionally approved for a specified timeframe to render IOP services to a MAP eligible recipient. During this provisional approved time, MAD or its designee will determine if the IOP agency meets MAD IOP requirements and if so, the agency will receive an approval letter for IOP full enrollment.

B. **Coverage criteria:** The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. Treatment services should address co-occurring mental health disorders, as well as substance use disorders, when indicated. The IOP services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MAD enrolled behavioral health providers, with the intent that the IOP service shall not exclude a MAP eligible recipient with co-occurring disorder.

C. **Covered services:**

(1) MAD covers services and procedures that are medically necessary for the evaluation, assessment, diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. See Section 9 of Subsection C of this rule for general behavioral health provider requirements. Also see 8.310.2 NMAC.

(2) IOP core services include:

(a) individual therapy;

(b) group therapy (group membership may not exceed 15 in number); and

(c) psycho-education for the MAP eligible recipient and his or her family.

(3) A MAP eligible recipient youth or transition-age young adult is defined for this service as 17 years of age and under. This population should engage in IOP treatment in an environment separate from recipients 18 years of age and older who are receiving IOP services.

(4) Co-occurring mental health and substance use disorders: IOP must accommodate the needs of the MAP eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated multi-disciplinary approach or coordinated, concurrent services with MAD behavioral health providers. Medication management services are available to oversee the use of psychotropic medications.

(5) The duration of a MAP eligible recipient's IOP intervention is typically three to six months. The amount of weekly services per MAP eligible recipient is directly related to the goals and objectives specified in his or her treatment or service plan.

(6) IOP services must be rendered through one of the following research-based models:

(a) matrix model adult treatment model;

(b) matrix model adolescent treatment model;

(c) Minnesota treatment model;

(d) integrated dual disorder treatment; or

(e) other researched-based models than those identified in (a)-(d) above must be approved by MAD or its designee.

(7) IOP services not provided in accordance with the conditions for coverage as specified in this rule are not a MAD covered service and are subject to recoupment.

D. **IOP MAP Eligible recipients:**

(1) IOP services are provided to a MAP eligible recipient, 13 through 17 years of age diagnosed with substance abuse disorder or with co-occurring disorder (SED and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

(2) IOP services are provided to a MAP eligible recipient 18 years of age and over diagnosed with substance abuse disorder or with a co-occurring disorder (SMI and substance abuse) or that meets the ASAM patient placement criteria for level two (II) - intensive outpatient treatment.

(3) Before engaging in an IOP program, the MAP eligible recipient must have a treatment file containing:

(a) one diagnostic evaluation; and

(2) one individualized treatment or service plan that includes IOP as an intervention.

E. **Noncovered services:** IOP services are subject to the limitations and coverage restrictions which exist for other MAD services see Section 9, Subsection C of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, and transitional living services);

(3) ACT;

(4) partial hospitalization;

(5) outpatient therapies (individual, family and group therapy may be billed only if there are clinical issues beyond the scope of IOP services);

(6) multi-systemic therapy (MST);

(7) activity therapy; or

(8) psychosocial rehabilitation (PSR) group services.

F. **Reimbursement:** See Section 9 Subsection E of this rule for MAD behavioral health general reimbursement requirements and Subsection F for general prior authorization requirements. Specifically for IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

[8.321.2.17 NMAC - N, 1-1-14]

8.321.2.18 MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION: MAD provides coverage for medication assisted treatment for opioid addiction (MAT) to a MAP eligible recipient through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment Programs.

A. **Eligible providers:** An opioid treatment center agency is a public or private facility operating a federally certified program to dispense methadone, other narcotic replacement, or narcotic agonist drug items, as part of a detoxification treatment or maintenance treatment as defined in 42 CFR Part 8 Certification of Opioid Treatment Programs. In addition to the requirements found in Section 9 Subsections A and B of this rule, the following are requirements of an opioid treatment facility:

(1) The agency must maintain documentation supporting the medical necessity of MAT services in the MAP eligible recipient's medical record per the requirements in 42 CFR Part 8, Certification of Opioid Treatment Programs; and

(2) A MAT agency must provide the following:

(a) its DEA certification to operate an opioid treatment program (OTP);

(b) a copy of substance abuse and mental health services administration (SAMHSA), center for substance abuse treatment (CSAT) approval to operate an OTP;

(c) a copy of accreditation by the joint committee (JC) or a copy of the commission on accreditation of rehabilitation facilities (CARF) accreditation; and

(d) its HSD behavioral health services division (BHSD) approval letter as a methadone provider.

B. **Covered services:** MAT services use a drug or biological that is recognized in the treatment of substance use disorder and provided as a component of a comprehensive treatment program. MAT is also a benefit as a conjunctive treatment regimen for a MAP eligible recipient who is addicted to a substance that can be abused and who meets the DSM-IV-TR and subsequent editions' criteria for a substance use disorder diagnosis.

C. **MAT MAP eligible recipients:**

(1) The agency must ensure through its internal policies and procedures that a MAP eligible recipient is treated for opioid dependency only after the agency's physician determines and documents that:

(a) the MAP eligible recipient meets the definition of opioid dependence using generally accepted medical criteria, such as those contained in DSM-IV-TR and subsequent editions;

(b) the MAP eligible recipient has received an initial medical examination as required by 7.32.8.19 NMAC, *Opioid Treatment Program Admissions*;

(c) if the MAP eligible recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting MAT services unless the MAP eligible recipient receives a waiver of this requirement from the agency's physician because the MAP eligible recipient:

(i) was released from a penal institution within the last six months;

(ii) is pregnant, as confirmed by the agency's physician;

(iii) was treated for opioid dependence within the last 24 months; or

(iv) meets any other requirements specified in 7.32.8 NMAC, *Opioid Treatment Program* regarding waivers, consent, and waiting periods.

(2) The agency must ensure that a MAP eligible recipient requesting long-term or short-term opioid withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period be assessed by the agency's medical director or physician to determine if other forms of treatment may be more appropriate.

D. **Noncovered services:** MAT services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services.

E. **Reimbursement:** See Section 9 Subsection E of this rule for MAD general reimbursement requirements. Specifically:

(1) the MAT agency, except an IHS or a 638 tribal facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor; see 8.302.2 NMAC and 8.310.12 NMAC for IHS reimbursement details;

(2) the coverage of services provided to a MAP eligible recipient can be greater than the services required under 42 CFR Part 8 or its successor, *Certification of Opioid Treatment Programs*. MAD recognizes it is beneficial to the MAP eligible recipient to receive necessary comprehensive medical and behavioral health services when they can be rendered by the MAT agency at the same time as MAT services.

(a) The reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, other narcotic replacement or agonist drug items, and substance abuse and HIV counseling as well as other services performed by the agency, unless otherwise described as separately reimbursed are required by 42 CFR Part 8.12 (f), or its successor.

(b) The following additional MAD reimbursements will be made for the specific drug item if separately reimbursed service payable to the MAT agency:

(i) a narcotic replacement or agonist drug item other than methadone is administered or dispensed;

(ii) outpatient therapy other than the substance abuse and HIV counseling required by 42 CFR Part 8.12 (f) is reimbursable when rendered by a MAD approved independently licensed provider that meets Section 9 Subsection H of this rule requirements;

(iii) a MAP eligible recipient's initial medical examination when rendered by a MAD approved medical provider who meets 8.310.2 and 8.310.3 NMAC requirements;

(iv) laboratory services provided by a certified laboratory facility when billed by the offsite laboratory, see 8.310.2 and 8.310.3 NMAC;

(v) full medical examination, prenatal care and gender specific services for a pregnant MAP eligible recipient. If she is referred to a provider outside the agency, payment is made to the provider of the service; or

(vi) medically necessary services provided beyond those required by CFR 42 CFR Part 8.12 (f), to address the medical issues of the MAP eligible recipient; see 8.310.2 and 8.310.3 NMAC;

(c) the quantity of service billed for administering or dispensing for each day cannot exceed the combined total of the drug items administered that day plus the number of drug items dispensed on that day; and

(d) for an IHS and a tribal 638 facility, MAD does not consider MAT services to be outside the IHS all inclusive rate and CCSS is therefore reimbursed at the MAT fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC.

(3) Claims billed for MAT services must include the MAP eligible recipient's substance use disorder diagnosis.

[8.321.2.18 NMAC - N, 1-1-14]

8.321.2.19 MULTI-SYSTEMIC THERAPY (MST): To help a MAP eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter his or her home and community, MAD pays for MST services as part of EPSDT program. MAD covers medically necessary MST required by the condition of the MAP eligible recipient. MST provides an intensive home, family and community-based treatment for a MAP eligible recipient who is at risk of out-of-home placement or is returning home from an out of home placement and his or her family. The need for MST services must be identified in the MAP eligible recipient's tot to teen healthcheck screen or another diagnostic evaluation. MST provides an intensive home, family and community-based treatment for MAP eligible recipients ages 10 to 18 and their families who are at risk of out of home placement or are returning home from placement.

A. **Eligible providers:** In addition to the requirements of Section 9 Subsection A and B of this rule, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST licensure by MST Inc, of Mt. Pleasant, South Carolina, or any of its approved subsidiaries. MST Inc is a national organization located in Mt. Pleasant, South Carolina, deemed by MAD to be the primary authority on licensure of New Mexico MST programs.

(1) The MST program shall include an assigned MST team for each MAP eligible recipient. The MST team must include at minimum:

(a) a master's level independently licensed behavioral health professional clinical supervision; see Section 9 Subsection H of this rule);

(b) a licensed master's and bachelor's level behavioral health staff able to provide 24 hour coverage, seven days per week; see Section 9 Subsection J of this rule);

(c) a licensed master's level behavioral health practitioner that is required to perform all therapeutic interventions. A bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of his or her RLD practice board licensure or practice (see Section 9 Subsection B of this rule);

(d) a bachelor's level staff that has a degree in social work, counseling, psychology or a related human services field and must have at least three years' experience working with the target population of children, adolescents and their families; and

(e) staffing for MST services shall be comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Section 9 Subsection H) who is MST trained; this supervision, following the MST supervisory

protocol, is provided to team members on topics directly related to the needs of the MAP eligible recipient and his or her family on an ongoing basis; and

(b) one hour of local group supervision per week and one-hour of telephone consultation per week with the MST systems supervisor, provided to team members on topics directly related to the needs of MAP eligible recipient and his or her family on an ongoing basis.

(3) All clinical staff are required to participate in and complete a prescribed five-day MST introductory training and subsequent quarterly trainings.

B. **MAP eligible recipients:**

(1) MST is provided to a MAP eligible recipient 10 to 18 years of age who is diagnosed SED, involved in or at serious risk of involvement with the juvenile justice system; have antisocial, aggressive, violent, and substance-abusing behaviors; is at risk for an out-of-home placement; or is returning from an out-of-home placement where the above behaviors were the focus of his or her treatment and family.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from the program.

C. **Covered services and service limitations:** MST is a culturally sensitive service, provided by a MST team, provides an intensive home, family and community-based treatment for a MAP eligible recipient who is at risk of an out-of-home placement or is returning home from an out-of-home placement and his or her family. MST services are primarily provided in the MAP eligible recipient's home, but a MST worker may also intervene at the MAP eligible recipient's school and other community settings. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance abuse, delinquency and violent behavior.

(1) The following services must be furnished as part of the MST service to be eligible for reimbursement:

(a) an initial assessment to identify the focus of the MST intervention;

(b) therapeutic interventions with the MAP eligible recipient and his or her family;

(c) case management; and

(d) crisis stabilization.

(2) MST services are conducted by practitioners using the MST team approach. The MST team must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. MST services shall:

(a) promote the family's capacity to monitor and manage the MAP eligible recipient's behavior;

(b) involves the MAP eligible recipient's family and other systems, such as the school, probation officers, extended families and community connections;

(c) provide access to a variety of interventions 24 hours a day, seven days a week, by staff that will maintain contact and intervene as one organizational unit; and

(d) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains, such as adaptive, communication, psychosocial, problem solving, and behavior management.

(3) The duration of MST intervention is typically three to six months. Weekly interventions may range from three to 20 hours a week; less as a MAP eligible recipient nears discharge.

D. Noncovered services: MST services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered specialized behavioral health services.

E. **Reimbursement:** MST agencies must submit claims for reimbursement on the CMS-1500 form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the provider agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.19 NMAC - N, 1-1-14]

8.321.2.20 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS (RTC) AND GROUP HOMES: MAD covers those medically necessary services for a MAP eligible recipient under 21 years of age which are designed to develop skills necessary for successful reintegration into his or her family or transition into his or her community. A LOC determination must indicate that the MAP eligible recipient's needs this LOC services furnished in a RTC or group home. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. MAD pays for services furnished in a RTC or group home as part of EPSDT program. The need for RTC and group home services must be identified in the MAP

eligible recipient's tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.

A. **Eligible providers:** In addition to the requirements of Section 9 Subsections A and B of this rule, in order to be eligible to be reimbursed for providing RTC or group home services to a MAP eligible recipient, an agency must meet the following requirements:

(1) a RTC and group home must be certified by CYFD. If the provider is certified by CYFD as a RTC, that certification will suffice if all other CYFD group home certification requirements are met; or

(2) if the RTC or group home is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD certifying requirements but is not required to be certified by CYFD. In lieu of receiving a certificate, CYFD will provide MAD copies of the facility review and recommendations. MAD will work with the provider to address the recommendations.

B. **Covered services:** MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient. The following are covered services:

(1) performance of necessary evaluations and psychological testing of the MAP eligible recipient for the development of his or her treatment plan, while ensuring that evaluations already performed are not repeated;

(2) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the MAP eligible recipient's treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the MAP eligible recipient;

(4) assistance to the MAP eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, making referrals, as necessary, and provide follow-up;

(6) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective; and

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the MAP eligible recipient.

C. **Noncovered services:** RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to a MAP eligible recipient:

(1) CCSS except by a CCSS agency when discharge planning with the MAP eligible recipient from the RTC or group home facility;

(2) services not considered medically necessary for the condition of the MAP eligible recipient, as determined by MAD or its designee;

(3) room and board;

(4) services for which prior approval was not obtained; or

(5) services furnished after the a MAD or its designee determination that the recipient no longer meets the LOC for RTC or group home care.

D. **Treatment plan:** The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a RTC or group home. In addition to the requirements of Section 9 Subsection G of this rule, the interdisciplinary team must review the treatment plan at least every 14 days. The MAP eligible recipient's file must contain the treatment plan and the documents used in the development of the treatment plan and all other supporting documentation.

E. **Prior authorization:** Before a RTC or group home service is furnished to a MAP eligible recipient, a prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. **Reimbursement:** A RTC or group home agency must submit claims for reimbursement on the UB-04 form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements

and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility, MAD considers RTC services to be outside the IHS all inclusive rate and RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

(1) The fee schedule is based on actual cost data submitted by the RTC or group home agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The MAD fee schedule reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include:

(i) direct services furnished by a psychiatrist or licensed Ph.D. psychologist. These services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) other MAD services that a MAP eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of the MAD NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD-covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home agency cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

[8.321.2.20 NMAC - N, 1-1-14]

8.321.2.21 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN A FREESTANDING PSYCHIATRIC HOSPITAL: To help a MAP eligible recipient under 21 years of age receive the level of services needed, MAD pays for outpatient hospital and partial hospitalization services furnished in a freestanding psychiatric hospital as part the EPSDT program. These services are provided upon release of an inpatient stay to address follow-up care. 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.

A. **Eligible providers:** In addition to the requirements found in Section 9 Subsection A and B of this rule, an eligible provider includes a facility JO accredited, and licensed and certified by DOH or the comparable agency in another state.

B. **Coverage criteria:** MAD covers only those services which meet the following criteria:

(1) Services that are prescribed by a psychiatrist or licensed Ph.D. psychologist and furnished under an individualized written treatment plan established by the MAD enrolled 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, indicate the diagnoses, anticipated goals and must be developed with the MAP eligible recipient and his or her parent or guardian. The treatment plan must be developed within 14 calendar days of admission to the partial hospitalization or outpatient program.

(2) Treatment is supervised and periodically evaluated by a MAD enrolled psychiatrist or licensed Ph.D. psychologist to determine the extent to which treatment goals are being realized. The psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any behavioral health practitioner involved in the MAP eligible recipient's treatment. The psychiatrist or licensed Ph.D. psychologist must see the MAP 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.

(3) Treatment must be reasonably expected to improve the MAP eligible recipient's condition or designed to reduce or control the MAP eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the MAP 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.

C. **Covered services and service limitations:** The following services must be furnished by a MAD enrolled provider delivering outpatient hospital or a partial hospitalization as part of the freestanding psychiatric hospital services to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

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

(2) regularly scheduled structured counseling and therapy sessions for a MAP eligible recipient, his or her family, group or multifamily group based on individualized needs furnished by social workers, trained psychiatric nurses, other behavioral health professionals who are employed by the hospital, as specified in the treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management;

(4) assistance to the MAP eligible recipient in his or her self-administration of medication in a manner that complies with state policies and procedures;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, provide follow-up for crisis situation and schedule follow-up appointments;

(6) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective;

(8) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(9) non-medical transportation services needed to accomplish the treatment objective;

(10) discharge planning and referrals as necessary to community programs as part of the planning.

D. **Noncovered services:** Outpatient and partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for all general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services with outpatient and partial hospitalization:

(1) meals;

(2) transportation;

(3) activity therapies, group activities or other services which are primarily recreational or divisional in nature;

(4) programs which provide social and recreational activities to recipients who need some supervision during the day

(5) programs which are generally community support groups in non-medical settings for a SED individual for the purpose of social interaction;

(6) outpatient hospital program consisting entirely of social activities;

(7) 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 the MAP eligible recipient; see 42 CFR Section 441.13(b);

(8) hypnotherapy or biofeedback; or

(9) services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

E. Treatment plan: An individualized treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge within 14 calendar days of the MAP eligible recipient's admission. The interdisciplinary team must participate in the treatment planning at least every 30 calendar days. See Section 9, Subsection G of this rule for MAD general treatment plan requirements.

F. **Prior authorization:** All outpatient and partial hospitalization services furnished in a freestanding psychiatric hospital must be prior authorization (PA) from MAD or its UR contractor; see Section 9 Subsection F this rule for MAD general prior authorization requirements.

G. **Reimbursement:** A provider of outpatient and partial hospitalization services must submit claims for reimbursement on the UB 04 claim form or its successor. See 8.302.2 NMAC and Section 9 Subsection E of this rule for MAD general reimbursement requirements. Specific to outpatient and partial hospitalization services:

(1) are reimbursed at an interim rate established by HSD 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, MAD 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 February 1, 2012. 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; and

(2) 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.

[8.321.2.21 NMAC - N, 1-1-14]

8.321.2.22 OUTPATIENT BEHAVIORAL HEALTH PROFESSIONAL SERVICES:

A. Psychological, counseling and social work: These services mean diagnostic or active treatments with the intent to reasonably improve a MAP eligible recipient's physical, social, emotional and behavioral health or substance abuse condition. Services are provided to a MAP eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling and social work services are performed by licensed psychological, counseling and social work staff acting within their scope of practice (see Section 9 subsections B, H-J or this rule). These services include, but are not limited, to testing and evaluation that appraise cognitive, emotional and social functioning and self concept. Therapy and treatment includes the planning, managing and providing a program of psychological services to the MAP eligible recipient with diagnosed behavioral health condition and may include consultation with his or her family and other professional staff.

B. An assessment or evaluation must be conducted at least annually or more frequently if indicated by the MAP eligible recipient's condition or applicable federal or state statute, regulation, rule or law. The assessment must be signed by the practitioner operating within his or her scope of licensure (see Section 9, Subsection B of this rule). Based on the MAP eligible recipient's annual assessment, the MAP eligible recipient's treatment file must document the extent to which his or her treatment goals are being met and whether changes in direction or emphasis of the treatment are needed.

[8.321.2.22 NMAC - N, 1-1-14]

8.321.2.23 PSYCHOSOCIAL REHABILITATION SERVICES: To help adult MAP eligible recipient with SMI receive a range of psychosocial services, MAD pays for psychosocial rehabilitation services (PSR). The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore his or her best possible level of functioning.

A. **Eligible providers:**

(1) The following psychosocial rehabilitation agencies are eligible to be reimbursed for furnishing PSR to a MAP eligible recipient:

(a) an IHS facility;

(b) a CMHC licensed by DOH; or

(c) a CSA with CMHC licensure;

(2) An agency which furnishes PSR services must have direct experience in successfully serving individuals with SMI.

(3) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services. See Section 9 Subsection A of this rule for MAD general provider requirements. A PSR agency must have the following:

(a) its copy of DOH licenses as a CMHC if so enrolled; and

(b) a copy of its New Mexico behavioral health collaborative letter of approval as a CSA if so enrolled;

B. **Coverage criteria:** MAD covers only those PSR services which comply with DOH mental health standards and are medically necessary to meet the individual needs of the MAP eligible recipient, as delineated in his or her treatment plan. Medical necessity is based upon the MAP eligible recipient's level of functioning as affected by his or her SMI. The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore the recipient to his or her best possible level of functioning.

C. **Covered services:** MAD covers PSR services which include a cadre of services designed to reduce symptomatology and restore basic skills necessary to function independently in the MAP eligible recipient's community. MAD covers the following PSR services detailed below for a MAP eligible recipient. These services are further defined by current procedure terminology (CPT) and healthcare common procedure coding system (HCPCS) identified for PSR.

(1) Psychosocial therapy interventions designed to address the functional limitations, deficits, and behavioral excesses through capitalizing on personal strengths and developing coping strategies and supportive environments.

(2) Community-based crisis intervention which must include:

(a) the availability of appropriate staff to respond to a crisis situation on a 24-hour a day basis;

(b) determining the severity of the crisis situation;

(c) stabilizing the MAP eligible recipient; and

(d) making referrals to appropriate agency(ies) and provider follow-up.

(3) Psychosocial clinical consultations by professionals to assess the MAP eligible recipient's status, if applicable.

(4) Therapeutic interventions designed to meet the MAP eligible recipient's clinically determined needs through scheduled structured sessions.

(5) Medication services that are goal-directed interventions such as the evaluation of the need for psychotropic medication and subsequent assessment and management of the MAP eligible recipient's pharmacologic treatment.

(6) Services must be individualized for each MAP eligible recipient and identified in his or her treatment plan.

D. **MAP eligible recipients:** A MAP eligible recipient is 21 years or older diagnosed with SMI and for whom the medical necessity for PSR services was determined. A resident in an institution for mental illness is not eligible for this service.

E. **Noncovered services:** PSR services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 9 Subsection C of this rule for all general noncovered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. **Prior authorization:** For PSR, reviews are retrospective.

(1) Retrospective review: An assessment, diagnostic summary formulation and a treatment plan determine the type of PSR services rendered to a MAP eligible recipient. An agency's staff determines medical necessity of services based upon the service guidelines included in the DOH manual for evidencing medical necessity. All plans are subject to retrospective review to determine whether services provided met the service guidelines.

(2) Reviews for crisis intervention: When crisis intervention services are required, the claim is subject to retrospective review in accordance with the definition and requirements of the service criteria. Reviews must be submitted to DOH.

G. **Treatment plan:** See Section 9 Subsection G of this rule for MAD general treatment plan requirements. The following must be contained in the treatment plan and documents used in the development of the MAP eligible recipient's treatment plan. The treatment plan and all supporting documentation must be available for review by HSD, DOH or their agents in the MAP eligible recipient's file:

H. **Reimbursement:** A PSR agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC.

[8.321.2.23 NMAC - N, 1-1-14]

8.321.2.24 SMOKING CESSATION COUNSELING: See 8.310.2 NMAC for a detailed description of tobacco cessation services and approved behavioral health providers.

[8.321.2.24 NMAC - N, 1-1-14]

8.321.2.25 TREATMENT FOSTER CARE I: MAD pays for medically necessary services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level I (TFC I) and meets this LOC as part of the EPSDT program. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into the community. TFC I agency provides therapeutic

services to a MAP eligible recipient who is experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a TFC I setting. The need for TFC I services must be identified in the tot to teen healthcheck or other diagnostic evaluation furnished through the MAP eligible recipient's healthcheck referral.

A. **Eligible agencies:** In addition to the requirements of Section 9 Subsection A and B of this rule, in order to be eligible to be reimbursed for providing TFC I services to a MAP eligible recipient, the agency must be certified as provider of TFC by CYFD. A MAP eligible recipient has the right to receive services from any MAD TFC enrolled agency of his or her choice.

B. **Covered services:** The family living experience is the core treatment service to which other individualized services can be added, as appropriate to meet the MAP eligible recipient's needs.

(1) A TFC I parent is either employed or contracted by the TFC I agency and receives appropriate training and supervision by the TFC I agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when the MAP eligible recipient is normally at home, and is able to be physically present to meet the MAP eligible recipient's emotional and behavioral needs. The treatment foster parent responsibilities include, but are not limited to:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in the MAP eligible recipient's treatment plan;

(c) recording the MAP eligible recipient's information and documentation of activities, as required by the TFC I agency and the standards under which it operates;

(d) assisting the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals;

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan; and

(g) work with all appropriate and available community-based resources to secure services for and to advocate for the MAP eligible recipient.

(2) The following services must be furnished by the TFC I agency. Payment for performance of these services is included in the TFC I agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC I foster parents initial and ongoing training;

(b) providing support, assistance and training to the TFC I foster parents;

(c) assessment, pre placement and placement to determine the MAP eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC I and assessment of family interactions and stress;

(e) treatment planning as defined Section 9 Subsection G of this rule and treatment team meetings;

(f) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group setting for the MAP eligible recipient;

(g) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the MAP eligible recipient;

(h) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations;

(i) when a MAP eligible recipient's return to his or her family is planned, assessment of the family's strengths, needs and the development of a family service plan.

(j) for TFC I, the treatment coordinator must conduct a private face to face visit with the MAP eligible recipient within the first two weeks of placement and at least twice monthly thereafter;

(k) for TFC I, the treatment coordinator has a face to face interview with the MAP eligible recipient's treatment foster parents within the first two weeks of placement and at least twice monthly thereafter;

(l) for TFC I, the treatment coordinator must have a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week as the face to face contact.

C. **Noncovered service:** TFC I services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for all noncovered MAD behavioral health services or activities. Specific to TFC I services MAD does not cover:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS except when planning a discharge from the MAP eligible recipient's TFC I placement.

D. **Prior authorization:** Before any TFC I service is furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. **Treatment plan:** The treatment plan must be developed by MAP eligible recipient's treatment team in consultation with the MAP eligible recipient, family or legal guardian, primary care provider, if applicable, and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC I program.

(1) The treatment team must review the treatment plan every 30 calendar days.

(2) In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

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

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

(i) substance abuse assessment;

(ii) educational assessment; and

(iii) vocational 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 review and modification of the plan;

(f) specification of staff and TFC I foster parent responsibilities and the description and frequency of the following components: (a) proposed staff involvement, (b) orders for medication, (c) treatments, restorative and rehabilitative services, (d) activities, therapies, social services, (e) special diet, and (f) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for his or her release to less restrictive settings for treatment, including TFC II.

F. **Reimbursement:** A TFC I agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.25 NMAC - N, 1-1-14]

8.321.2.26 TREATMENT FOSTER CARE II: MAD pays for behavioral health services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level II (TFC II) and meets this LOC as part of the EPSDT. The therapeutic family living experience is the core treatment service to which other individualized services can be added. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into his or her community. The need for TFC II services must be identified in the MAP eligible recipient's tot to teen healthcheck or other diagnostic evaluation furnished through a health check referral.

A. **Eligible agencies:** In addition to the requirements of Section 9 Subsection A and B of this rule, in order to be eligible to be reimbursed for providing TFC II services to a MAP eligible recipient, the agency must be certified as provider of TFC by CYFD. A MAP eligible recipient has the right to receive services from any MAD enrolled TFC agency of his or her choice.

B. **Covered services:** All services covered in TFC I are required in TFC II. TFC II allows for a step down from TFC I when the MAP eligible recipient's symptoms improve and allow for less intensive supervision by the family, age appropriate activities are allowed with some degree of independence or gains have been met in TFC

I; however,t continued monitoring is required to maintain these achievements as identified in the treatment plan. TFC II also allows for entry into this LOC for those MAP eligible recipients who would benefit optimally from a treatment foster care placement but who do not have the severity of symptoms and behaviors as required for TFC I.

(1) A TFC II parent is either employed or contracted by the TFC II agency and receives appropriate training and supervision by the TFC II agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when the MAP eligible recipient is normally at home, and is able to be physically present to meet the MAP eligible recipient's emotional and behavioral needs. The treatment foster parent responsibilities include:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in the MAP eligible recipient's treatment plan;

(c) recording the MAP eligible recipient's information and documentation of activities, as required by the TFC I agency and the standards under which it operates;

(d) assisting the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals;

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan; and

(g) work with all appropriate and available community-based resources to secure services for and to advocate for the MAP eligible recipient.

(2) The following services must be furnished by the TFC II agency. Payment for performance of these services is included in the TFC II agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC II foster parents initial and ongoing training;

(b) providing support, assistance and training to the TFC II foster parents;

(c) assessment, pre placement and placement to determine the MAP eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC II and assessment of family interactions and stress;

(e) treatment planning as defined Section 9 Subsection G of this rule and treatment team meetings;

(f) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group setting for the MAP eligible recipient;

(g) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the MAP eligible recipient;

(h) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations; and

(i) when a MAP eligible recipient's return to his or her family is planned, assessment of the family's strengths, needs and the development of a family service plan.

(j) for TFC II, the treatment coordinator must conduct a private face to face visit with the MAP eligible recipient within the first two weeks of placement and at least once monthly thereafter;

(k) for TFC I, the treatment coordinator has a face to face interview with the MAP eligible recipient's treatment foster parents within the first two weeks of placement and at least once monthly thereafter;

(l) for TFC II, the treatment coordinator must have a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week as the face to face contact.

C. **Noncovered service:** TFC II services are subject to the limitations and coverage restrictions that exist for other MAD services. See Section 9 Subsection C of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with TFC II services to a MAP eligible recipient:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS, except when planning discharge from the TFC II placement

D. **Prior authorization:** Before any TFC II services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. **Treatment plan:** The treatment plan must be developed by treatment team in consultation with the MAP eligible recipient, his or her family or legal guardian, primary care provider, if applicable, and others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC II program. The treatment plan must meet all requirements found in Section 9 Subsection G of this rule.

(1) The treatment coordinator must review the treatment plan every 30 calendar days;

(2) In addition to the requirements of Section 9 Subsection G of this rule, the following must be contained in the treatment plan and documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) a statement of the nature of the specific problem and the specific needs and strengths of the MAP eligible recipient;

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

(i) mental status assessment;
(ii) intellectual function assessment;
(iii) psychological assessment;
(iv) educational assessment;
(v) vocational assessment;
(vi) social assessment;
(vii) medication assessment; and
(vii) 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;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and TFC II foster parent responsibilities and the description and frequency of the following components: (a) proposed staff involvement, (b) orders for medication, (c) treatments, restorative and rehabilitative services, (d) activities, therapies, social services, (e) special diet, and (f) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge and projected date of discharge of the MAP eligible recipient.

F. **Reimbursement:** A TFC II agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Section 9 Subsection E of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.26 NMAC - N, 1-1-14]

HISTORY OF 8.321.2 NAMC: [RESERVED]

History of Repealed Material: [Reserved]

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 4 PHARMACY SERVICES, PRESCRIBING, AND PRACTITIONER ADMINISTERED DRUG ITEMS

8.324.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.324.4.1 NMAC - Rp, 8.324.4.1 NMAC, 1-1-14]

8.324.4.2 SCOPE: The rule applies to the general public.
[8.324.4.2 NMAC - Rp, 8.324.4.2 NMAC, 1-1-14]

8.324.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.324.4.3 NMAC - Rp, 8.324.4.3 NMAC, 1-1-14]

8.324.4.4 DURATION: Permanent.
[8.324.4.4 NMAC - Rp, 8.324.4.4 NMAC, 1-1-14]

8.324.4.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.4.5 NMAC - Rp, 8.324.4.5 NMAC, 1-1-14]

8.324.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.324.4.6 NMAC - Rp, 8.324.4.6 NMAC, 1-1-14]

8.324.4.7 DEFINITIONS: [RESERVED]

8.324.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.4.8 NMAC - Rp, 8.324.4.8 NMAC, 1-1-14]

8.324.4.9 PHARMACY SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to MAP eligible recipients, including covered pharmacy services and practitioner administered drugs [42 CFR Section 440.120(a)]. Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by MAD.
[8.324.4.9 NMAC - Rp, 8.324.4.9 NMAC, 1-1-14]

8.324.4.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAP 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 MAP 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 (PPA), an agreement with a HSD contracted managed care organization (MCO) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Eligible providers include:

(1) pharmacies licensed by the New Mexico pharmacy board;
(2) clinics licensed for outpatient dispensing by the New Mexico pharmacy board;
(3) institutional pharmacies licensed for outpatient dispensing by the New Mexico pharmacy board;
(4) family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico pharmacy board;
(5) prescribing practitioners practicing in communities more than 15 miles from a licensed pharmacy;
(6) Indian health service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care; and
(7) mail order pharmacies licensed to dispense in New Mexico.

B. When services are billed to and paid by a MAD 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.

C. Properly licensed practitioners and facilities may also be enrolled for the purpose of being reimbursed for practitioner administered drug items that cannot be self-administered by the medical assistance program (MAP) eligible recipient.

[8.324.4.10 NMAC - Rp, 8.324.4.10 NMAC, 1-1-14]

8.324.4.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include but are not limited to supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if an MAP 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 MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.310.3 NMAC.

D. Retention and storage of the original prescription, electronic prescription, and records of phone or fax orders must meet all pharmacy board requirements and must be retained for six years. If the prescriber certifies that a specific brand is medically necessary, by handwriting "brand medically necessary" or "brand necessary" on the face of the prescription, the allowed ingredient cost is the estimated acquisition cost (EAC) of the brand drug. The documentation of the provider's handwritten certification must be maintained by the pharmacy provider and furnished upon request. Checked boxes, rubber stamps and requests by telephone do not constitute appropriate documentation, pursuant to 42 CFR 447.512. "Brand necessary" prescriptions may be subject to prior authorization. Any claim for which "brand necessary" is claimed must be supported with documentation in the prescriber's medical records. Electronic alternatives approved by the secretary of the federal department of health and human services are acceptable.

E. A pharmacy provider must discuss any matters with the MAP eligible recipient or their personal representative that in the provider's professional judgment are significant. See 42 USC 1396r-8(g)(2)(A)(ii)(I) of the Social Security Act. Pharmacy counseling services are subject to the standards for counseling established under the state Pharmacy Practice Act. Counseling must be furnished unless declined by the MAP eligible recipient or his or her authorized representative.

F. A pharmacy must follow all federal and state laws, regulations and rules regarding management of pain with controlled substances, use of the drug monitoring program database, limiting dispensing of controlled substances, and reporting dispensing of controlled substances to state monitoring programs.

[8.324.4.11 NMAC - Rp, 8.324.4.11 NMAC, 1-1-14]

8.324.4.12 COVERED SERVICES: MAD covers medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated in this section of this rule. Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications may be reviewed for medical necessity before or after reimbursement. Providers must consult MAD, or its designated

contractor, before supplying items not specifically listed in this policy or billing instructions. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards are considered.

A. For a MAP eligible recipient 21 years of age and older not in an institution, coverage of over-the-counter items is limited to insulin, diabetic test strips, prenatal vitamins, electrolyte replacement system, ophthalmic lubricants, pediculosides and scabicides, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. MAD, or its designee, may expand the list of covered over-the-counter items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over the counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is incorporated as part of the generic-first coverage provisions. Otherwise, the MAP eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item. Prior authorization for coverage of other over the counter products may be requested when a specific regimen of over the counter drugs is required to treat chronic disease conditions.

B. When drugs are provided through a preferred drug list, drugs are subject to generic-first coverage provisions. The MAP eligible recipient must first use one or more generic items available on the preferred drug list to treat a condition before MAD covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD, or its designee, including HSD contracted managed care organization (MCO), based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items.

[8.324.4.12 NMAC - Rp, 8.324.4.12 NMAC, 1-1-14]

8.324.4.13 COVERAGE REQUIREMENTS:

A. **Legal requirements:** All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. A prescription must meet all federal and state laws, regulations and rules. A pharmacy provider and a prescriber must fulfill all the requirements of federal and state laws relating to his or her practice and ethics.

B. **Rebate requirements:** MAD pays only for the drugs of pharmaceutical manufacturers that have entered into and have in effect a rebate agreement with the federal department of health and human services. This limitation does not apply to dispensing a single-source or innovator multiple-source drug if MAD has determined that the availability of the drug is essential to the health of a MAP eligible recipient.

C. **Prescribing:** A prescriber must be enrolled as a MAD provider in order to prescribe drug items for a MAP eligible recipient. A provider who has been terminated or suspended by MAD or is not enrolled as a provider must notify his or her MAP eligible recipients that he or she cannot prescribe drug items for them.

[8.324.4.13 NMAC - Rp, 8.324.4.13 NMAC, 1-1-14]

8.324.4.14 NONCOVERED SERVICES OR SERVICE RESTRICTIONS: Pharmacy services are subject to the limitations and coverage restrictions that exist for other MAD services.

A. MAD does not cover the following specific pharmacy items:

(1) medication supplied by state mental hospitals to a MAP eligible recipient on convalescent leave from the center;

(2) methadone for use in drug treatment programs except as part of a MAD approved medication assisted treatment program (MAT);

(3) personal care items such as non-prescription shampoos, soaps;

(4) cosmetic items, such as retin-A for aging skin, rogaine for hair loss;

(5) drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the federal food and drug administration (FDA), known as DESI (drug efficacy study implementation) drugs;

(6) fertility drugs;

(7) antitubercular drug items available from the New Mexico department of health (DOH) or the United States public health service;

(8) weight loss/weight control drugs;

(9) barbiturate hypnotic drugs whose primary action is to induce sleep unless the MAP eligible recipient resides in a nursing home;

(10) drug items used to treat sexual dysfunction;

(11) compounded drug items which lack an ingredient approved by the federal food and drug administration (FDA) for the indication for which the drug is intended;

(12) compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and

(13) cough and cold preparations for a MAP eligible recipient under the age of four.

B. MAD covers non-prescription drug items without prior authorization when prescribed by a licensed practitioner authorized to prescribe for a MAP eligible recipient who resides in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), when such items are not routinely included in the facility's reimbursable cost and a specific prescription for the item is dispensed based on a practitioner's order. The following cannot be charged to the MAP eligible recipient or billed to MAD, or a HSD contracted managed care organization, by a provider:

(1) diabetic testing supplies and equipment;

(2) aspirin and acetaminophen;

(3) routine ointments, lotions and creams, and rubbing alcohol; and

(4) other non-prescription items stocked at nursing stations and distributed for use individually in small quantities.

C. MAD does not cover drug items for a MAP eligible recipient who is eligible for medicare Part D when the drug item or class of drug meets the federal definition of a medicare Part D covered drug. MAD does not cover any copayment due from the MAP eligible recipient towards a claim paid by medicare Part D nor any medicare Part D covered drug or class of drug where the MAP eligible recipient has a gap in medicare Part D coverage due to a medicare coverage limit. Items or drug classes specifically excluded by medicare Part D are covered, non-covered or limited to the same extent that MAD covers the excluded drug items for a MAP eligible recipient who is not dually-eligible.

[8.324.4.14 NMAC - Rp, 8.324.4.14 NMAC, 1-1-14]

8.324.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and, before payment is made or after payment is made; see 8.302.5 NMAC. Once enrolled, providers receive directions on how to access instructions and documentation forms necessary for prior authorization and claims processing. Review or prior authorization may be required for items for which a less expensive or therapeutically preferred alternative should be used first. In addition to the generic-first coverage provisions, applicable therapeutic "step" requirements will be based on published clinical practice guidelines, professional standards of health care and economic considerations.

A. **Prior authorization:** MAD or its designee reviews all requests for prior authorizations. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request reconsideration; see 8.350.2 NMAC.

D. **Drug utilization review:** The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the MAP eligible recipient's service providers or governmental entities legally authorized to receive such information.

(1) **Prospective drug use review:** Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interactions, clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system

detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

(2) **Counseling:** Pursuant to 42 CFR 456.705, each dispensing pharmacist must offer to counsel each MAP eligible recipient or his or her authorized representative receiving services who presents a new prescription, unless the MAP eligible recipient or his or her authorized representative refuses such counsel. Pharmacists must document these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review has taken place. A reasonable effort must be made to record and maintain the pharmacist's comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide a MAP eligible recipient access to a toll-free number.
[8.324.4.15 NMAC - Rp, 8.324.4.15 NMAC, 1-1-14]

8.324.4.16 REIMBURSEMENT: Pharmacy providers must submit claims for reimbursement on the separate pharmacy claim form or its successor, see 8.302.2 NMAC and Section 17 of this rule.

A. **General reimbursement methodology:** The estimated ingredient cost will not exceed the lowest of the estimated acquisition cost (EAC), the maximum allowable cost (MAC), the actual acquisition cost of a 340B drug, or the federal upper limit (FUL).

(1) **Estimated acquisition cost (EAC).** MAD determines EAC as follows:

(a) MAD establishes EAC, defined as MAD's approximation of the net or actual acquisition costs of such drugs;

(b) the factors MAD considers in setting rates for drugs under this subparagraph include:

(i) product cost, which may vary among purchasing contracts;

(ii) clinical concerns;

(iii) MAD's budget limits;

(iv) the actual package size dispensed; and

(v) payments by other payers in New Mexico and other state MAD and medicare pricing policies;

(c) MAD uses the EAC as its reimbursement for a drug when the EAC, plus a dispensing fee established by MAD, is the lowest of the rates calculated under the methods listed in general reimbursement methodology.

(d) EAC is calculated using the current published average wholesale price (AWP) of a drug less a percentage established by MAD, the average manufacturer price (AMP) plus a percentage established by MAD, or the wholesale acquisition cost (WAC) plus a percentage established by HSD, and other pricing limits determined by other pricing information sources selected by MAD; and

(e) MAD uses the ingredient cost indicated in the ingredient cost field on the billing transaction as the EAC when that indicated ingredient cost is lower than the MAD EAC.

(2) **Maximum allowable cost (MAC) MAC methodology.** MAD establishes a MAC applicable for certain multiple-source drugs with FDA rated therapeutic equivalents and for certain over-the-counter drugs and non-drug items on the following basis:

(a) at least one A-rated generic (as listed in the FDA orange book) is readily available to New Mexico pharmacies;

(b) the MAC for the brand name drug products and for all A-rated therapeutic equivalents shall be determined by arraying costs for the A-rated therapeutic equivalent drugs regardless of manufacturer, and selecting a reasonable price from the arrayed list in a manner consistent with the state plan or any waiver approved by CMS subjecting that price to cost factors and tests for reasonableness;

(c) when a state MAC price has not been calculated by MAD, a baseline price calculated by a national supplier of drug pricing information is used as the state MAC;

(d) MAC will not be applied if a specific brand has been determined to be medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's billed usual and customary charge; and

(e) for over-the-counter drugs and non-drug items, MAC may be established using the pricing sources in this Section Subsection B of this rule.

(3) **Federal upper limit (FUL) methodology:**

(a) MAD adopts the FUL that is set by CMS or recommended by the federal department of justice.

(b) MAD's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAD under the dispensing fee determination.

(c) MAD will not use the individual drug FUL as MAD's reimbursement rate when the prescribing practitioner has certified that a specific brand is medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's usual and customary billed charge.

(4) **340B drug discount actual acquisition cost:**

(a) The actual ingredient cost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must placed in the ingredient cost field and indicated on the billing transaction as a 340B drug item.

(b) Drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must be billed at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item. If a MAP eligible recipient with a prescription written at a 340B entity requests the item to be dispensed by a 340B pharmacy under contract to the 340B entity then the pharmacist must dispense 340B purchased items when filling the prescription.

(5) **Usual and customary charge:**

(a) The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

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

(c) Usual and customary charges must reflect discounts given to a MAP recipient for certain reasons, such as age or NF resident, when a MAP eligible recipient meets the standards for the discount. MAD must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-MAP recipient.

(d) Providers cannot add additional costs for their time, paperwork, or anticipated turnaround time for payment.

(6) **Medicare reimbursement:** Reimbursement may be limited to medicare reimbursement limits where the total of the medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in this Section Subsection A of this rule.

(7) Practitioner administered drug items are reimbursed according to the MAD fee schedule.

B. **Pricing information to set EAC and MAC:** MAD selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers, manufacturers, federal agencies, drug data information clearinghouses and pharmacy invoices.

C. **Assistance in establishing EAC and MAC:** MAD may solicit assistance from pharmacy providers, pharmacy benefit managers (PBMs), other government agencies, actuaries, or other consultants when establishing EAC or MAC.

D. **Pharmacy price reductions:** If the pharmacy provider offers a discount, rebate, promotion or other incentive that results in a reduction of the price of a prescription to the individual non- MAP recipient, the provider must similarly reduce its charge to MAD for the prescription.

E. **No claims for free products:** If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a MAP eligible recipient.

F. **Solutions:** Solutions, such as saline for nebulizers, intravenous (IV) solutions without additives, electrolyte and irrigation solutions, and diluents are considered medical supply items for reimbursement purposes; see 8.310.2 NMAC.

G. **Non-drug items:** Urine test reagents, electrolyte replacement and nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies, see 8.310.2 NMAC.

[8.324.4.16 NMAC - Rp, 8.324.4.16 NMAC, 1-1-14]

8.324.4.17 POINT OF SALE: The point-of-sale system provides relevant drug utilization information that the pharmacist must consider before dispensing a drug. If utilization information indicates that a MAP eligible recipient has an adequate supply of the drug item or that the quantity being dispensed is excessive, the claim will initially be denied. The pharmacist is responsible for resolving the issue and obtaining an authorization to dispense the drug, if necessary.

A. **General requirements:** All MAD in-state and border area pharmacy providers are required to submit claims through the point-of-sale system.

B. **Exceptions to general requirements:** The following are exceptions to this general requirement:

(1) the provider is out-of-state and is not a border area provider;

(2) the provider is a family planning clinic dispensing prescriptions;

(3) the provider submitted on average less than 50 claims per month to MAD for the preceding six-month period;

(4) the claim requires an attachment or explanation; or

(5) a required data element on the claim cannot be entered in the current standard point-of-sale format.

[8.324.4.17 NMAC - Rp, 8.324.4.17 NMAC, 1-1-14]

8.324.4.18 PRESCRIPTIONS AND REFILLS:

A. **Dispensing frequencies:** MAD limits the frequency for which it reimburses the same pharmacy for dispensing the same drug to the same MAP eligible recipient.

(1) The limitation is established individually for each drug.

(2) Maintenance drugs are subject to a maximum of three times in 90 days with a 14-calendar day grace period to allow for necessary early refills.

(3) Certain drugs are given more flexibility due to their specific dosage forms, packaging or clinical concerns.

(4) The excessive dispensing limitation applies regardless of whether the claim is for a new prescription or refill.

(5) Schedule II controlled substances are limited to a maximum 34-day supply. Initial use of controlled substances may also be further limited by state law.

B. **Refill requirements:** Refills must be consistent with the dosage schedule prescribed and with all applicable federal and state laws, regulations and rules. Consistent use of early refills will result in a calculation that the MAP eligible recipient has sufficient stock of the drug item on hand and allowed refill dates will be adjusted accordingly.

C. **Quantities dispensed:** Maintenance drugs are those on the MAD-approved maintenance drug list.

(1) For a MAP eligible recipient with likely continuous eligibility due to age, disability or category of eligibility, prescriptions for maintenance drugs may be dispensed in amounts up to a 90-day supply.

(2) Prescriptions for non-maintenance drugs are limited to 34-day supplies.

(3) Oral contraceptives may be dispensed for up to a one-year supply if the appropriate contraceptive for the MAP eligible recipient has been established.

(4) Controlled substances may not be refilled until 75 percent of the drug has been used based on the days supply of the previous prescription unless the prescriber has been notified and given approval. A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or other dispensing of drugs through a point-of-sale system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database. Dispensed drug items which do not meet these criteria are subject to recoupment.

(5) Pharmacy providers shall not reduce prescriptions for maintenance drugs that are written for quantities larger than a 34-day supply and may dispense up to a 90-day supply. MAD considers prescription splitting to be fraudulent. Pharmacies that do not have the entire prescribed amount on hand may dispense a partial fill.

(6) Coverage may be limited by the end date of the MAP eligible recipient's span of eligibility at the time of dispensing.

(7) Pharmacists are encouraged to consult with prescribers to achieve optimal drug therapy outcomes, consistent with NMSA 1978, Section 61-11-2(V).

(8) Controlled substances may have specific controls on the quantities dispensed.

D. **Unit dose packaging:** MAD does not pay additional for unit dose packaging.

E. **Prevention of abuse:** Drug items are to be dispensed for legitimate medical needs only. If the pharmacist suspects the MAP eligible recipient of over-utilizing or abusing drug services, the pharmacist must contact the provider and MAD so that the MAP eligible recipient's use of medications can be reviewed. Excessively high doses and overlapping use of multiple drug items with the same therapeutic uses that are potentially abusive or

otherwise dangerous may result in subjecting the prescriptions to the prior authorization process or recoupment from the pharmacy if the prescriber is not contacted and the contact documented.

F. **Mail service pharmacy:** MAD may provide a mail service pharmacy for a MAP eligible recipient use.

(1) The mail service pharmacy is available as an option to all MAP eligible recipients.

(2) Retail pharmacies may mail, ship or deliver prescriptions to all MAP eligible recipients consistent with applicable state and federal statutes, rules and regulations.

[8.324.4.18 NMAC - Rp, 8.324.4.18 NMAC, 1-1-14]

HISTORY OF 8.324.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0700, Pharmacy Services, filed 2-29-80.
ISD 310.0700, Drug Services, filed 2-10-81.
ISD 310.0700, Drug Services, filed 7-8-82.
ISD Rule 310.0700, Drug Services, filed 3-1-83.
ISD Rule 310.0700, Drug Services, filed 2-15-89.
ISD Rule 310.0700, Drug Services, filed 7-9-84.
MAD Rule 310.07, Drug Services, filed 3-31-89.
MAD Rule 310.07, Drug Services, filed 1-3-92.
MAD Rule 310.07, Drug Services, filed 4-20-92.
MAD Rule 310.07, Drug Services, filed 12-8-94.

History of Repealed Material:

MAD Rule 310.07, Drug Services, filed 12-8-94 - Repealed effective 2-1-95.
8 NMAC 4.MAD.753, Pharmacy Services, filed 1-18-95 - Repealed effective 8-13-04.
8.324.4 NMAC, Pharmacy Services, filed 8-2-04 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 5 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS

8.324.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.324.5.1 NMAC - N, 1-1-14]

8.324.5.2 SCOPE: The rule applies to the general public.
[8.324.5.2 NMAC - N, 1-1-14]

8.324.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.324.5.3 NMAC - N, 1-1-14]

8.324.5.4 DURATION: Permanent.

8.324.5.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.5.5 NMAC - N, 1-1-14]

8.324.5.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.324.5.6NMAC - N, 1-1-14]

8.324.5.7 DEFINITIONS: [RESERVED]
[8.324.5.7 NMAC - N, 1-1-14]

8.324.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.5.8 NMAC - N, 1-1-14]

8.324.5.9 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to a medical assistance program (MAP) eligible recipient, including covered vision appliances, hearing aids and related services [42 CFR Section 440.60(a) and Section 440.110(c)], durable medical equipment and medical supplies, [42 CFR Section 440.70 (c)] and covered prosthetic and orthotic services [42 CFR Section 440.120(c)].
[8.324.5.9 NMAC - N, 1-1-14]

8.324.5.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient 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 (PPA), a licensed practitioner of a facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, utilization review (UR) 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, to comply with the requirements and to update his or her knowledge as new material is provided by MAD. The provider must contact HSD or its authorized agents to request hard copies of any MAD New Mexico administrative code (NMAC) program rules, MAD billing and UR instructions and other pertinent material, and 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 his or her MAD PPA and all applicable statutes, regulations, rules and executive orders. MAD or its selected claims processing contractor

issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made. Upon approval of his or her MAD PPA, the following practitioners and facilities may be enrolled as MAD providers:

A. Vision appliance provider:

(1) an ophthalmologist licensed to practice medicine in New Mexico, who limits his or her practice to ophthalmology (ophthalmologist) and the groups, corporations, and professional associations they form;

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

(3) an optician qualified to provide eyeglasses, contact lenses, supplies, and other vision-related materials; or

(4) Indian health service (IHS) or a tribal facility operating under Public Law 93-638.

B. **Hearing appliances providers:**

(1) an individual licensed to practice medicine or osteopathy; or

(2) a hearing aid dealer registered and licensed by the New Mexico regulations and licensing division (RLD) practice boards for speech language pathology, audiology, and hearing aid dispensing.

C. **Durable medical equipment (DME), oxygen and medical supplies provider:** A DME, oxygen and medical supplies provider must hold a current PPA with MAD.

D. **Prosthetics and orthotics provider:** A prosthetics or orthotics provider must hold a current PPA with MAD.

[8.324.5.10 NMAC - N, 1-1-14]

8.324.5.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of his or her PPA. A provider must adhere to the MAD NMAC program rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service, as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP 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 the MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.302.2 NMAC.

D. **Vision appliances providers:** A provider must ensure that a prescription for eyeglasses or contact lenses is accurate to the extent that the prescription corrects the MAP eligible recipient's vision to the degree of acuity indicated on his or her vision examination record. An eyeglass and contact lens supplier is responsible for verifying that the correct prescription is provided.

(1) If a prescription is inaccurate and the MAP eligible recipient is unable to use his or her eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

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

[8.324.5.11 NMAC - N, 1-1-14]

8.324.5.12 COVERED SERVICES:

A. **Vision appliances:** MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases. MAD pays a provider for the correction of refractive errors that are required by the condition of the MAP eligible recipient. All services must be furnished within the limits of MAD benefits, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and his or her New Mexico regulation and licensing division's (RLD) practice board.

(1) **Exam:** MAD covers routine eye exams. Coverage for a MAP eligible recipient over 22 years of age is limited to one routine eye exam in a 36-month period. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period. If a MAP eligible recipient has transitioned

from the early, periodic screening, diagnosis and treatment (EPSDT) program at age 21, the date of service for his or her last exam starts the 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma will be covered for required follow-up and treatment. The medical condition must be clearly documented on his or her visual examination record and indicated by diagnosis on the claim form.

(2) **Corrective lenses:** MAD covers one set of corrective lenses for a MAP eligible recipient 21 years of age and older not more frequently than once in a 36-month period. For a MAP eligible recipient under 21 years of age, one set of corrective lenses is covered no more frequently than once every 12 months. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service for his or her last corrective lenses starts the 36-month period. For either age group, MAD covers corrective lenses more frequently when an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the MAP eligible recipient's visual examination record and indicated by a diagnosis on the claim.

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

(i) -1.00 myopia (nearsightedness);

(ii) + 1.00 for hyperopia (farsightedness);

(iii) 0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal 0.75 will be accepted;

(iv) ±1.00 for presbyopia (farsightedness of aging); or

(v) diplopia (double vision) - prism lenses.

(b) When a MAP eligible recipient's existing prescription is updated and the frequency of replacement lenses meets the requirements in Paragraph (2) above, the lenses may be replaced when there is a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal 0.75 will be accepted. An exception is considered for the following:

(i) a MAP eligible recipient over 21 years of age with cataracts;

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

(iii) a MAP eligible recipient is under 21 years of age.

(3) Bifocal lenses: MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

(4) Tinted lenses: MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the comments section of the visual examination record, and the prescription meets the dioptic correction purchase criteria:

(a) aniridia;

(b) albinism, ocular;

(c) traumatic defect in iris;

(d) iris coloboma, congenital;

(e) chronic keratitis;

(f) sjogren's syndrome;

(g) aphakia, U.V. filter only if intraocular lens is not U.V. filtered;

(h) rod monochromaly;

(i) pseudophakia; or

(j) other diagnoses confirmed by ophthalmologist or optometrist that is documented in the MAP eligible recipient's visual examination form.

(5) Polycarbonate lenses: MAD covers polycarbonate lenses for:

(a) a MAP eligible recipient for medical conditions which require prescriptions for high power lenses;

(b) a MAP eligible recipient with monocular vision;

(c) a MAP eligible recipient who works in a high-activity physical job;

(d) a MAP eligible recipient under 21 years of age; or

(e) a MAP eligible recipient 21 years and older that has a developmental or intellectual disability.

(6) Balance lenses: MAD covers balance lenses for a MAP eligible recipient under 21 years of age without a prior authorization in the following situations:

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

(b) a MAP eligible recipient under 21years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

(7) Frames: MAD covers frames for corrective lenses. Coverage for a MAP eligible recipient 21 years of age and older is limited to one frame in a 36-month period. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service of his or her last frames starts the 36-month period. Coverage for a MAP eligible recipient under 21 years of age is limited to one frame in a 12-month period unless:

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

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

(8) Contact lenses: MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient 21 years of age and older is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. If a MAP eligible recipient is transition from the EPSDT program at age 21, the date of service for his or her last contact lenses starts as the 24-month period. A request for prior authorization will be evaluated on dioptic criteria or visual acuity, the MAP eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

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

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

(9) Replacement: Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the MAP eligible recipient, may be replaced. Two items must be documented in the provider's request for the replacement in addition to being found in the MAP eligible recipient's visual examination record: the MAP eligible recipient's eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion; and an explanation of the loss, deterioration or breakage is provided. The following are the criteria that an MAP eligible recipient must be meet for the replacement of his or her eyeglasses or contact lenses:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient is 21 years of age and older and has a developmental or intellectual disability.

(10) Prisms: Prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the MAP eligible recipient's visual examination record.

(11) Lens tempering: MAD covers lens tempering only on new glass lenses.

(12) Lens edging: MAD covers lens edging and lens insertion.

(13) Minor repairs: MAD covers minor repairs to eyeglasses.

(14) Dispensing fee: MAD pays a dispensing fee to an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames at the same time. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not approved by MAD to prescribe and fit contact lenses.

(15) Eye prosthesis: MAD covers eye prostheses (artificial eyes); see Subsection D below.

B. Hearing Appliances:

(1) Within specified limitations, MAD covers the following services when furnished by primary care provider (PCP), licensed audiologists or by licensed hearing aid dealers:

(a) hearing aid purchase, rental repairs, hearing aid repair and handling, replacements, and the loan of equipment while repairs or replacements are made:

(i) binaural hearing aid fitting will be covered for a MAP eligible recipient with bilateral hearing loss who is attending an educational institution, seeking employment, is employed, or for a MAP eligible recipient with a current history of binaural fitting; or

(ii) binaural hearing aid fitting will be considered on a case-by-case basis for a MAP eligible recipient determined to be legally blind.

(b) hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed; and

(c) hearing aid insurance against loss and breakage for up to four years for all purchased hearing aids. Hearing aid insurance is required when the aid is dispensed. Four years of hearing aid insurance is required for: (1) a MAP eligible recipient under 21 years of age; (2) a MAP eligible recipient residing in a nursing facility (NF); or (3) a MAP eligible recipient who has a developmental or intellectual disability.

(d) Replacement of hearing aids is limited to the provisions of the MAP eligible recipient's hearing aid insurance. The provider is responsible for obtaining insurance for every hearing aid purchased for a MAP eligible recipient.

C. DME, oxygen and medical supplies: MAD covers DME that meets the MAD definition of DME, the medical necessity criteria, and MAD prior authorization requirements. MAD covers the repair, maintenance, delivery of durable medical equipment, and the disposable and non-reusable items essential for the use of the equipment, subject to the limitations specified in this rule. All items purchased or rented must be ordered by a provider who has an approved MAD PPA. Coverage for DME is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, intermediate care facility for individuals with intellectual disabilities (ICF-IID), and a rehabilitation facility. A MAP eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover duplicates of items, for example, a MAP eligible recipient is limited to one wheelchair, one hospital bed, one oxygen delivery system, or one of any particular type of equipment. A back-up ventilator is covered.

(1) DME is defined by MAD as: (1) equipment that can withstand repeated use; (2) primarily and customarily used to serve a medical purpose; (3) not useful to an eligible recipient in the absence of an illness or injury; and (4) appropriate for use at home.

(2) Equipment used in a MAP eligible recipient's residence must be used exclusively by the MAP eligible recipient for whom it was approved.

(3) To meet the medical necessity criterion, DME must be necessary for the MAP eligible recipient's treatment of an illness, injury, or to improve the functioning of a specific body part.

(4) Replacement of equipment is limited to the same extent as it is limited by medicare regulation. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in the MAP eligible recipient's medical necessity or as otherwise indicated in this rule.

(5) Medical supplies: MAD covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items.

(a) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order. A provider must keep documentation in its files available for auditing that shows compliance with this requirement.

(b) MAD coverage for DME and medical supplies is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, ICF-IID, and a rehabilitation facility.

(6) Covered services and items: MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized MAP eligible recipient:

(a) trusses and anatomical supports that do not need to be made to measure;

(b) family planning devices;

(c) repairs to DME and replacement parts if a MAP eligible recipient owns the equipment for which the repair is necessary and the equipment being repaired is a covered MAD benefit. Some replacement items used in repairs may require prior authorization; see Section 13 of this rule;

(d) repairs to augmentative and alternative communication devices require prior authorization;

(e) monthly rental includes monthly service and repairs; and

(f) replacement batteries and battery packs for augmentative and alternative communication devices owned by the MAP eligible recipient.

(7) Covered services for a non-institutionalized MAP eligible recipient: MAD covers certain medical supplies, nutritional products and DME provided to a non-institutionalized MAP eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare regulation. When medicare does not specify a limitation, an item is limited to a reasonable amount as defined by MAD and published in its DME and medical supplies billing instructions which are available on the HSD/MAD website. MAD covers the following for a non-institutionalized MAP eligible recipient:

(a) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings;

(b) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(c) gauze, bandages, dressings, pads, and tape;

(d) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(e) parenteral nutritional support products prescribed by a PCP on the basis of a specific medical indication for a MAP eligible recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet the MAP eligible recipient's medical needs;

(f) apnea monitors: prior authorization is required if the monitor is needed for six months or longer; and

(g) disposable gloves (sterile or non-sterile) are limited to 200 per month.

(8) Covered oxygen and oxygen administration equipment: MAD covers the following oxygen and oxygen administration systems, within these specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase with prior authorization. Oxygen administration equipment may be supplied on a rental basis for one month without prior authorization. Rental beyond the initial month requires a prior authorization.

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems. MAD approves the most economical oxygen delivery system available that meets the medical needs of the MAP eligible recipient;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(g) MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If MAD pays rental charges for a system, tank rental is included in the rental payments. MAD follows the medicare rules for: (1) limiting or capping reimbursement for oxygen rental at 36 months; (2) requirements for the provider to maintain and repair the equipment; and (3) to providing ongoing services and disposable supplies after the capped rental.

(h) A NF is administratively responsible for overseeing oxygen supplied to the MAP eligible recipient resident.

(9) Augmentative and alternative communication devices: MAD covers medically necessary electronic or manual augmentative communication devices for a MAP eligible recipient. Medical necessity is determined by MAD or its designee. Communication devices whose purpose is also educational or vocational are covered only when it has been determined the device meets medical criteria. A MAP eligible recipient must have the cognitive ability to use the augmentative communication device, and be able to functionally communicate verbally or through gestures.

(a) All of the following criteria must be met before an augmentative communication device can be considered for prior authorization. The communication device must be:

(i) a reasonable and necessary part of the MAP eligible recipient's treatment plan;

(ii) consistent with the MAP eligible recipient's symptoms, diagnosis or medical condition of the illness or injury under treatment;

(iii) not furnished for the convenience of the MAP eligible recipient, the family, the attending practitioner or other practitioner or supplier;

(iv) necessary and consistent with generally accepted professional medical standards of care;

(v) established as safe and effective for the MAP eligible recipient's treatment protocol;

(vi) furnished at the most appropriate level suitable for use in the MAP eligible recipient's home environment;

(vii) augmentative and alternative communication devices are authorized every 60 months for a MAP eligible recipient 21 years of age and older and every 36 months for a MAP eligible recipient under 21 years of age, unless earlier authorization is dictated by medical necessity; and

(viii) repairs to, and replacement parts for augmentative and alternative communication devices owned by the MAP eligible recipient.

(10) Rental of DME: MAD covers the rental of DME.

(a) MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace the MAP eligible recipient's equipment during the rental period.

(b) Low cost items, defined as those items for which the MAD allowed payment is less than $150 dollars, may only be purchased. For these items, the purchased DME becomes the property of the MAP eligible recipient for whom it was approved.

(c) MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

(11) Delivery of equipment and shipping charges: MAD covers the delivery of a DME item only when the equipment is initially purchased or rented and the round trip delivery is over 75 miles. A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to its clients who are not a MAP eligible recipient of the service. MAD does not pay delivery charges for equipment purchased by medicare, for which MAD is responsible only for the coinsurance and deductible. MAD covers the shipping charges for DME and medical supplies when it is more cost effective or practical to ship items to the MAP eligible recipient rather than have him or her travel to pick up items. Shipping charges are defined as the actual cost of shipping an item from a provider to a MAP eligible recipient by a means other than that of provider delivery. MAD does not pay shipping charges for an item purchased by medicare for which MAD is only responsible for the coinsurance and deductible.

(12) Wheelchairs and seating systems:

(a) MAD covers customized wheelchairs and seating systems made for a specific MAP eligible recipient, including a MAP eligible recipient who is institutionalized. Written prior authorization is required by MAD or its designee. MAD or its designee cannot give verbal authorizations for customized wheelchairs and seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific MAP eligible recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(b) Repairs to a wheelchair owned by a MAP eligible recipient residing in an institution are covered.

(c) A customized or motorized wheelchair required by a MAP eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, but must be reviewed on a case-by-case basis by MAD or its designee.

D. Prosthetics and orthotics supplies: MAD covers medically necessary prosthetics and orthotics supplied by a MAD provider to a MAP eligible recipient only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. MAD covers prosthetics and orthotics only when all the following conditions are met:

(1) the device has been ordered by the MAP eligible recipient's PCP or other appropriate practitioner and is medically necessary for MAP eligible recipient's mobility, support or physical functioning;

(2) the need for the device is not satisfied by the existing device the MAP eligible recipient currently has;

(3) the device is covered by MAD and all prior approval requirements have been satisfied;

(4) coverage of compression stockings for a MAP eligible recipient 21 years and older is limited to stockings that are custom-fabricated to meet his or her medical needs;

(5) coverage of orthopedic shoes for a MAP eligible recipient 21 years and older is limited to the shoe that is attached to a leg brace;

(6) replacement of items is limited to one item every three years, unless there is a change in the MAP eligible recipient's medical necessity; and

(7) therapeutic shoes furnished to a diabetic is limited to one of the following within one calendar year:

(a) no more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; and

(b) no more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

[8.324.5.12 NMAC - N, 1-1-14]

8.324.5.13 UTILIZATION REVIEW AND PRIOR AUTHORIZATION: All MAD services are subject to UR 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. MAD

makes available on its website and other websites UR instructions. It is the provider's responsibility to access these instructions or ask for hard 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. Prior authorization does not guarantee that an individual is eligible for a MAD service.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. When services are billed to and paid by a coordinated services contractor authorized by MAD, the provider must follow that contractor's instructions for the authorization of a service. Written requests for items not included in the categories listed or for a quantity greater than that covered by MAD in this rule may be submitted by the MAP eligible recipient's PCP, with a prior authorization request to MAD or its designee for consideration of medical necessity.

B. Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance.

C. Reconsideration: A provider who disagrees with a prior authorization denial or another review decision may request a reconsideration; see 8.350.2 NMAC.

D. Prior authorization for specific services: The following services and procedures require prior authorization from MAD or its designee:

(1) hearing appliances:

(a) hearing aid dispensing, purchase, rental and replacement;

(b) hearing aid repairs for which the provider's billed charge exceeds $100;

(c) services for which prior authorization was obtained remain subject to review at any point in the payment process; and

(d) medical clearance: PCP medical approval is required on any request for prior authorization for hearing aids. The MAP eligible recipient's PCP must certify that her or she is a suitable candidate for hearing aids by signing the hearing aid evaluation and information MAD prior authorization form. Documentation must be on the PCP's letterhead or prescription pad. This documentation must be submitted with the prior approval request. A MAP eligible recipient under 16 years of age, must be examined by a physician who is board certified in the diagnosis and treatment of diseases and conditions of the ear for all hearing aid fittings.

(2) DME, oxygen and medical supplies: MAD covers certain medical supplies, nutritional products and DME provided to a MAP eligible recipient with prior authorization. Please refer to criteria in 8.301.3 NMAC for DME or medical supplies that are not covered. MAD covers the following benefits with prior authorization for a non-institutionalized MAP eligible recipient:

(a) enteral nutritional supplements and products for a MAP eligible recipient who must be tube fed oral nutritional supplements;

(b) oral nutritional support products prescribed by the MAP eligible recipient's PCP:

(i) on the basis of a specific medical indication for a MAP eligible recipient who has a defined need for which nutritional support is considered therapeutic, and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet his or her medical needs;

(ii) when medically necessary due to inborn errors of metabolism;

(iii) medically necessary to correct or ameliorate physical illnesses or conditions in a MAP eligible recipient under 21 years of age; or

(iv) coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance;

(c) either disposable diapers or underpads prescribed for a MAP eligible recipient age three years and older who suffers from neurological or neuromuscular disorders or who has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;

(d) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for a specialized wheelchair;

(e) protective devices, such as helmets and pads;

(f) bathtub rails and other rails for use in the bathroom;

(g) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(h) passive motion exercise equipment;

(i) decubitus care equipment;
(j) equipment to apply heat or cold;
(k) hospital bed and full length side rails;
(l) compressor air power sources for equipment that is not self-contained or cylinder driven;
(m) home suction pump and lymph edema pump;
(n) hydraulic patient lift;
(o) ultraviolet cabinet;
(p) traction equipment;
(q) prone stander and walker;
(r) trapeze bar or other patient-helpers that are attached to bed or freestanding;
(s) home hemodialysis or peritoneal dialysis system and its replacement supplies or accessories;
(t) wheelchair and functional attachments to a wheelchair. A wheelchair is authorized every 60 months for a MAP eligible recipient 21 years and older. For a MAP eligible recipient under 21 years of age, a wheelchair can be authorized every 36 months; and earlier authorization is possible when dictated by his or her medical necessity;
(u) wheelchair tray;
(v) whirlpool bath designed for home use;
(w) intermittent or continuous positive pressure breathing equipment;
(x) manual or electronic augmentative and alternative communication device;
(y) truss and anatomical supports that require fitting or adjusting by trained individuals, including a JOBST hose;
(z) custom-fitted compression stockings; and
(aa) artificial larynx prosthesis.

(3) Prosthetics and Orthotics: All prosthetic devices require prior authorization from MAD or its designee. The only prior authorization requirement exception is for a prosthetic limb attached immediately following a surgery for a traumatic injury while the MAP eligible recipient is a hospital inpatient. Prior authorization is required for orthotic devices for the foot or for shoes. Services for which prior authorization was obtained remain subject to UR at any point in the payment process.

[8.324.5.13 NMAC - N, 1-1-14]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

A. Special requirements for the purchase of wheelchairs: Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to a MAP eligible recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the MAP eligible recipient for whom it was authorized.

(1) The provider assumes responsibility for correcting defects or deficiencies in the wheelchair and seating systems that make them unsatisfactory for use by the MAP eligible recipient.

(2) The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians as necessary to ensure that the wheelchair meets the MAP eligible recipient's needs.

(3) Evaluations by a physical therapist or occupational therapist are required when ordering customized wheelchair and seating system. The therapist should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the MAP eligible recipient and those consultants listed in Paragraph (2) above to assure that the selected system matches physical seating needs. The physical or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

(4) MAD does not pay for special modifications or replacement of a customized wheelchair after the wheelchair is furnished to the MAP eligible recipient.

(5) When the equipment is delivered to the MAP eligible recipient and the MAP eligible recipient accepts the order, the provider will submit the claim for reimbursement.

B. Special requirements for purchase of augmentative and alternative communication devices:

(1) The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by the MAP eligible recipient's PCP, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech

pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the MAP eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the MAP eligible recipient's ability to use the communication device must be provided showing that the MAP eligible recipient's ability to use the device is improving and that the MAP eligible recipient is motivated to continue to use this device.

(3) MAD does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to: paper, printer ribbons, and computer discs.

(4) Prior authorization is required for equipment repairs.

(5) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the MAP eligible recipient. A provider must keep documentation in his or her files available for audit that show compliance with this requirement.
[8.324.5.14 NMAC - N, 1-1-14]

8.324.5.15 NONCOVERED SERVICES: The following services are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.302.1 NMAC and 8.310.2 NMAC. The provider must notify the MAP eligible recipient of the coverage limitations prior to providing services.

A. Vision appliances: MAD does not cover the following specific vision services:

(1) orthoptic assessment and treatment;

(2) photographic procedures, such as fundus or retinal photography and external ocular photography;

(3) polycarbonate lenses other than those listed in Section 13 Subsection A of this rule;

(4) ultraviolet (UV) lenses;

(5) trifocals;

(6) progressive lenses;

(7) tinted or photochromic lenses, except in cases of documented medical necessity; see Section 12 Subsection D of this rule;

(8) oversize frames and oversize lenses;

(9) low vision aids;

(10) eyeglass cases;

(11) eyeglass or contact lens insurance; and

(12) anti-scratch, anti-reflective, or mirror coating.

B. Hearing appliances: Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and will not be reimbursed separately.

C. DME, oxygen and medical supplies: MAD does not cover certain DME and medical supplies. See 8.301.3 NMAC for an overview of which DME or supply item is not covered by MAD.

D. Prosthetic and orthotics: The following services are not covered:

(1) orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics; and

(2) prosthetic devices or implants that are used primarily for cosmetic purposes.
[8.324.5.15 NMAC - N, 1-1-14]

8.324.5.16 REIMBURSEMENT: Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following: (1) the provider's billed charge; or (2) the MAD fee schedule for the specific service or procedure.

A. The provider's billed charge must be his or her usual and customary charge for services.

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

C Vision appliances: A vision service provider, except an IHS facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor.

D. Hearing appliances: A hearing aid or related service provider must submit claims for reimbursement on the CMS 1500 claim form or its successor. Reimbursement for hearing aids is made at the lesser

of the provider's billed charge, at the cost to the billing provider as indicated by the manufacturer's, the distributor's or wholesaler's invoice, which shall not exceed MAD's maximum reimbursement limitation amounts.

(1) Reimbursement for rental of hearing aids includes the following:

(a) rental charge for hearing aid; and

(b) hearing aid mold and batteries.

(2) Rental payments apply to the allowed amount for purchase. When the rental payments equal the amount allowed for purchase, the aid is considered purchased and owned by the MAP eligible recipient.

(3) Reimbursement for repairs to hearing aids is based on the MAD fee schedule. Reimbursement for repairs to hearing aids done by a manufacturer is the lesser of the provider's billed charge or the manufacturer's charge for the repairs plus a predetermined handling fee. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.

(4) Reimbursement is made for additional accessories and supplies, including batteries, when required. Reimbursement is made for an additional mold when a single aid type is used for both ears.

(5) Reimbursement is made for replacement ear molds.

(6) Reimbursement for insurance for hearing aid loss and accidental damage is paid at the lesser of the provider's billed charge or the maximum fee allowed by MAD. If the insurance policy cost exceeds the maximum fee established by MAD, reimbursement can be made at the actual policy rate if the actual cost is documented.

(7) Hearing appliances reimbursement limitations:

(a) Hearing aid purchase: Hearing aid purchase is limited to one monaural or binaural purchase per four year period with the following exceptions:

(i) a MAP eligible recipient under 21 years of age and is subject to prior approval;

(ii) progressive hearing loss, such as otosclerosis;

(iii) changes due to surgical procedures;

(iv) traumatic injury; and

(v) replacement of lost hearing aid in accordance with his or her insurance coverage.

(b) Dispensing fees: The hearing aid dispensing fee includes payment for the services listed below. If a binaural dispensing fee is paid, it includes payment for all services listed below for both hearing aids:

(i) hearing aid selection and the fitting of the aids;

(ii) testing of the hearing aids;

(iii) one ear mold per hearing aid;

(iv) one package of batteries per hearing aid;

(v) any other accessories required to fit the aid;

(vi) all follow-up visits and adjustments necessary for a successful fitting;

(vii) cleaning and adjustments for the life of the aid; and

(viii) shipping and handling.

(c) Hearing aid evaluation: MAD covers the evaluation of a MAP eligible recipient for the hearing aid, subject to the following limitations:

(i) the evaluation for hearing aid is not payable to the same billing provider who bills for the hearing aid dispensing fee incidental to the purchase of a hearing aid;

(ii) the evaluation for hearing aid is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incidental to the purchase of the hearing aid; therefore,

(iii) physicians and audiologists can be reimbursed for audiologic and vestibular function studies in addition to a dispensing fee.

[8.324.5.16 NMAC - N, 1-1-14]

8.324.5.17 REIMBURSEMENT OF DME, MEDICAL SUPPLIES AND NUTRITIONAL PRODUCTS:

A. Reimbursement for purchase or rental: Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for DME, medical supplies and nutritional products is made at the lesser of:

(1) the provider's billed charges or the MAD fee schedule; or

(2) when there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows.

(a) DME, medical supplies and nutritional products:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(b) for a custom specialized wheelchair and its customized related accessories, payment is limited to the provider's actual acquisition cost plus 15 percent.

B. Rental payments must be applied towards the purchase with the exception of ventilators: Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. Reimbursement for rental of DME is made at the lesser of (1) or (2):

(1) the provider's billed charges; or

(2) the MAD fee schedule, when applicable. Payment for the month of rental is limited to the provider's acquisition invoice cost plus a percentage as follows:

(a) the provider must keep a running total of rental payments for each piece of equipment;

(b) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when 13 rental payments have been made for the item;

(c) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when the rental payments total the lesser of the provider's usual and customary charge for the purchase of the item or the MAD fee schedule for the purchase of the item;

(d) or for an item for which a fee schedule purchase price has not been established by MAD when the provider has received rental payments equal to one of the following:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent.

(3) MAD follows medicare regulations regarding capped rental. For rental months one through three, the full fee schedule rental fee is allowed. For rental months four through 13, the rental fee schedule rental fee is reduced by 25 percent. No additional rental payments are made following the 13th month or to the most current schedule determined by medicare. The provider may only bill for routine maintenance and for repairs, and oxygen contents to the extent as allowed by medicare.

(4) Oxygen is paid using the medicare billing, capped rental period, and payment rules.

(5) The provider must retain a copy of his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request.

(6) Set-up fees are considered to be included in the payment for the equipment or supplies and are not reimbursed as a separate charge.

C. Reimbursement for home infusion drugs: Unless otherwise specified in this rule, the provider's billed charges must be the usual and customary charge for the item or service. Home infusion drugs are reimbursed at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee schedule.

(3) For home infusion drugs for which a fee schedule price has not been established by MAD, or for which the description associated with the appropriate billing code is too broad to establish a reasonable payment level, payment is limited to the provider's acquisition cost plus 20 percent. A provider must retain a copy of his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request.

D. Reimbursement for delivery and shipping charges: Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method. MAD does not pay for charges for shipping items from a supplier to the provider.

E. Reimbursement limitations: MAD does not cover DME or medical supplies that do not meet the definition of DME as described in Section 12 of this rule. The following criteria are applied to each request as part of the determination of non-coverage:

(1) items that do not primarily serve a therapeutic purpose or are generally used for comfort or convenience purposes;

(2) environment-control equipment that is not primarily medical in nature;

(3) institutional equipment that is not appropriate for home use;

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

(5) items that are hygienic in nature;

(6) hospital or physician diagnostic items;

(7) instruments or devices manufactured for use by PCP;

(8) exercise equipment not primarily medical in nature or for the sole purpose of muscle strengthening or muscle stimulation without a medically necessary purpose;

(9) support exercise equipment primarily for institutional use;

(10) items that are not reasonable or necessary for monitoring the pulse of a homebound MAP eligible recipient with or without a cardiac pacemaker;

(11) items that are used to improve appearance or for comfort purposes;

(12) items that are precautionary in nature except those needed to prevent urgent or emergent events; and

(13) a provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have an excess of a 15 calendar day supply of the item before releasing the next supply to the MAP eligible recipient.

[8.324.5.17 NMAC - N, 1-1-14]

8.324.5.18 REIMBURSEMENT FOR PROSTHETICS AND ORTHOTICS:

A. A prosthetic and orthotic service provider must submit claims for reimbursement on the CMS-1500 claim form or its successor. Reimbursement for repairs made by the provider is made at the actual repair cost plus 50 percent. Repairs made by the manufacturer are reimbursed to the provider at the actual manufacturer's repair cost plus a handling fee of $20.00. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented. Reimbursement for additional accessories and supplies is made at the lower of the actual cost of the supply or accessory or the MAD fee schedule for the particular item.

B. Reimbursement limitations: The amount billed for the item includes all minor attachments, adjustments, additions, modifications, fittings and other services necessary to make the device functional. These items cannot be billed separately.

(1) MAD does not cover an additional charge for a hospital visit or home visit if fittings or measurements take place away from the provider's office.

(a) If the place of service is outside the provider's city limits, mileage can be billed for travel to the place of service.

(b) A prosthetic or orthotic device for a MAP eligible recipient hospitalized in a diagnostic related group (DRG) reimbursed hospital is reimbursed by the DRG methods described in 8.311.3 NMAC.

(2) Date of service: The date of service declared on a claim is the date when the device is supplied to the MAP eligible recipient, not the fitting date or measuring date.

(3) No specification of brand or quality: When an ordering provider requests an item and does not specify the brand or quality of the item to be dispensed, the item chosen must be of a quality and minimal cost which adequately serves the purpose for which the device is required.

[8.324.5.18 NMAC - N, 1-1-14]

HISTORY OF 8.324.5 NMAC:

History of Repealed Material:

8.324.5 NMAC, Durable Medical Equipment and Supplies, filed xx-xx-xx - Repealed effective, 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 7 TRANSPORTATION SERVICES AND LODGING

8.324.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, 1-1-14]

8.324.7.2 SCOPE: The rule applies to the general public.
[8.324.7.2 NMAC - Rp, 8.324.7.2 NMAC, 1-1-14]

8.324.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.324.7.3 NMAC - Rp, 8.324.7.3 NMAC, 1-1-14]

8.324.7.4 DURATION: Permanent.
[8.324.7.4 NMAC - Rp, 8.324.7.4 NMAC, 1-1-14]

8.324.7.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.7.5 NMAC - Rp, 8.324.7.5 NMAC, 1-1-14]

8.324.7.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.324.7.6 NMAC - Rp, 8.324.7.6 NMAC, 1-1-14]

8.324.7.7 DEFINITIONS: [RESERVED]

8.324.7.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.7.8 NMAC - Rp, 8.324.7.8 NMAC, 1-1-14]

8.324.7.9 TRANSPORTATION SERVICES: The New Mexico medical assistance division (MAD) covers expenses for transportation and other related expenses that MAD or its coordinated services contractor determines are necessary to secure covered medical and behavioral health examinations and treatment for a medical assistance program (MAP) eligible recipient in or out of his or her home community [42 CFR Section 440.170]. Travel expenses include the cost of transportation by long distance common carriers, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. Related travel expenses include the cost of meals and lodging made necessary by receipt of medical or behavioral health care away from the MAP eligible recipient's home community. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment.
[8.324.7.9 NMAC - Rp, 8.324.7.9 NMAC, 1-1-14]

8.324.7.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) 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 a MAP eligible recipient. Providers 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 (UR) instructions, and other pertinent material. 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. Providers must contact HSD, or its authorized agents, for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere

to the provisions of the MAD PPA and applicable statutes, regulations, rules, 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. The following providers are eligible to be reimbursed for providing transportation or transportation related services to MAP eligible recipients:

A. air ambulances certified by the state of New Mexico department of health (DOH), emergency medical services bureau;

B. ground ambulance services certified by the New Mexico public regulation commission (NMPRC) or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the NMPRC;

C. non-emergency transportation vendors (taxicab, vans and other vehicles) and certain bus services certified by the NMPRC, within those geographic regions in the state specifically authorized by the NMPRC;

D. long distance common carriers, that include buses, trains and airplanes;

E. certain carriers exempted or warranted by the NMPRC within those geographic regions in the state specifically authorized by the NMPRC;

F. lodging and meal providers; and

G. when services are billed to and paid by a MAD MAP 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.

[8.324.7.10 NMAC - Rp, 8.324.7.10 NMAC, 1-1-14]

8.324.7.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in the New Mexico MAD administrative code (NMAC) rules, and policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP 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 a MAP eligible recipient.

C. MAD services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. See 8.302.1 NMAC.

[8.324.7.11 NMAC - Rp, 8.324.7.11 NMAC, 1-1-14]

8.324.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: MAD reimburses a transportation provider for transportation only when the transport is of a MAP eligible recipient and is subject to the following conditions.

A. **Free alternatives:** Alternative transportation services that can be provided free of charge include volunteers, relatives or transportation services provided by nursing facilities (NF) or other residential centers. A MAP eligible recipient must certify in writing that they do not have access to free alternatives.

B. **Least costly alternatives:** MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before a MAP eligible recipient can use more expensive transportation alternatives.

C. **Non-emergency transportation service:** MAD covers non-emergency transportation services for a MAP eligible recipient who has no primary transportation and who is unable to access a less costly form of public transportation except as described under non-covered services, see 8.324.7.13 NMAC.

D. **Long distance common carriers:** MAD covers long distance services furnished by a common carrier if a MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through local county income support division (ISD) offices.

E. **Ground ambulance services:** MAD covers services provided by ground ambulances when:

(1) an emergency that requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity criteria: terms are defined as follows:

(a) "emergency" is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part;

(b) "medical necessity" is established for ambulance services if the MAP eligible recipient's physical, or behavioral health condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(2) Scheduled, non-emergency ambulance services are ordered by a primary care provider (PCP) who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's physical, or behavioral health condition. MAD covers non-reusable items and oxygen required during transportation, if needed; coverage for these items is included in the base rate reimbursement for ground ambulance.

F. **Air ambulance services:** MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the PCP certifies the medical necessity for the service.

(1) An emergency that would require air over ground ambulance services is defined as a medical or behavioral health condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

(a) a MAP eligible recipient's death;

(b) placement of a MAP eligible recipient's health is in serious jeopardy (or with respect to a pregnant woman, the health of the woman or her unborn child);

(c) serious impairment of bodily functions; or

(d) serious dysfunction of any bodily organ or part.

(2) Coverage for the following is included in the base rate reimbursement for air ambulance:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation;

(c) detention time or standby time; and

(d) use of equipment required during transportation.

G. **Lodging services:** MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical or behavioral health provider's statement of need. Authorization forms for direct payment by MAD to its lodging providers are available through local county ISD offices.

H. **Meal services:** MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to MAD meal providers by MAD are available through local county ISD offices.

I. **Coverage for attendants:** MAD covers transportation, meals and lodging for one attendant if the medical necessity for the attendant is certified in writing justified by the MAP eligible recipient's medical provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. The attendant for a child under 18 years of age should be the parent or legal guardian. If the medical appointment is for an adult MAP eligible recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult MAP eligible recipient.

J. **Coverage for medicaid home and community-based services waiver recipients:** Transportation of a medicaid waiver recipient to or from a provider of waiver service is only covered when the service is a physical therapy, occupational therapy, speech therapy or a behavioral health service.

[8.324.7.12 NMAC - Rp, 8.324.7.12 NMAC, 1-1-14]

8.324.7.13 NONCOVERED SERVICES: Transportation services are subject to the same limitations and coverage restrictions that exist for other MAD services. See 8.301.3 NMAC. Payments for transportation for any non-covered service is subject to retroactive recoupment.

A. MAD does not pay to transport a MAP eligible recipient to a medical or behavioral health service or provider that is not covered under the MAD program.

B. A provider will not be eligible to seek reimbursement from a MAP eligible recipient if the provider fails to notify the MAP eligible recipient or his or her authorized representative that the service is not covered by MAD. See 8.302.1 NMAC.

C. MAD does not pay for transportation to a pharmacy; see 8.310.2 for detailed description for alternative.

[8.324.7.13 NMAC - Rp, 8.324.7.13 NMAC, 1-1-14]

8.324.7.14 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES: Out-of-state transportation and related expenses require prior authorization by MAD or its designee. Out-of-state transportation is authorized only if the out-of-state medical or behavioral health service is approved by MAD or its designated contractor. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in New Mexico.

A. Requests for out-of-state transportation must be coordinated through MAD.

B. Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30 days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, is defined as those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as an in-state provider service. See 8.302.4 NMAC.

[8.324.7.14 NMAC - Rp, 8.324.7.14 NMAC, 1-1-14]

8.324.7.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject toUR 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. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or request hard copies to be provided, to understand the information, 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 MAD fee-for-service coordinated services contractor, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization is received remain subject to UR at any time during the payment process.

B. **Referrals for travel outside the home community:**

(1) If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical or behavioral health care, the transportation provider must obtain and retain in its billing records written verification from the referring provider or the service provider containing the following:

(a) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(b) the name of the out of community provider; and

(c) justification that the medical or behavioral health care is not available in the home community.

(2) Referrals and referral information must be obtained from a MAD provider. For continued out of community non-emergency transportation, the required information must be obtained every six months.

C. **Eligibility determination:** Prior authorization does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

[8.324.7.15 NMAC - Rp, 8.324.7.15 NMAC, 1-1-14]

8.324.7.16 REIMBURSEMENT:

A. Transportation providers must submit claims for reimbursement on the CMS-1500 form or its successor. See 8.302.2 NMAC. Reimbursement to transportation, meal or lodging providers for covered services is made at the lesser of the following:

(1) the provider's billed charge:

(a) the billed charge must be the provider's usual and customary charge for services; for a provider with a tariff, the billed charge must be the lesser of the charges allowed by the provider's tariff or the provider's usual and customary charge.

(b) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure; reimbursement by the MAD program to a transportation provider is inclusive of gross-receipts taxes and other applicable taxes; an air ambulance provider is exempt from paying gross receipts tax; therefore, the rates paid for air ambulance service do not include gross receipts tax.

B. **Ground ambulance:** A provider of ground ambulance services is reimbursed at the lesser of their billed charge for the service or the MAD maximum allowed amount.

(1) The MAD maximum allowed amount for transports up to 15 miles is limited to the base rate amount. The allowable base rate for advanced life support (ALS) or basic life support (BLS) includes reimbursement for the ALS or BLS equipped service, oxygen, disposable supplies and medications used in transport. The base rate reimbursement includes mileage reimbursement for the first 15 miles of transport.

(2) The allowable base rate for a scheduled non-emergency transport includes reimbursement for oxygen, disposable supplies and medications used in transport. The base rate includes mileage reimbursement for the first 15 miles of transport.

C. **Air ambulance:** A provider of air ambulance services is reimbursed at the lesser of billed charges or the MAD maximum allowed rate.

D. **Non-emergency transportation services:**

(1) A provider of non-emergency transportation is reimbursed at the lesser of their approved tariff or the MAD rate for one or multiple MAP eligible recipient transports not meeting the "additional passenger" criteria below.

(2) Reimbursement will be limited to the MAD reimbursement limitation per one-way trip for a MAP eligible recipient being transported for medical care. MAD does not provide reimbursement for any portion of the trip for which the MAP eligible recipient is not in the vehicle.

(3) An "additional passenger transport" is a non-emergency transport of two or more MAP eligible recipients who are picked up at the same location and are being transported to the same provider. Additional passenger transport services will not be covered. When more than one MAP eligible recipient is being transported from the same location to the same provider and each MAP eligible recipient has a scheduled MAD-covered medical or behavioral health appointment, MAD will allow coverage for one MAP eligible recipient.

(4) MAD covers transportation for one attendant when the MAP eligible recipient is a child 10 years of age or younger not meeting the additional passenger criteria if the medical necessity for the attendant is justified in writing by the MAP eligible recipient's medical or behavioral health provider for each transport. In cases where the MAP eligible recipient's condition is ongoing and the need for a medical attendant will not change, the attestation must be renewed every six months, unless the MAP eligible recipient who is receiving medical or behavioral health service is under 18 years of age. If the medical or behavioral health appointment is for a MAP eligible recipient 21 years of age and older, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the MAP eligible recipient.

(5) MAD covers transportation to scheduled, structured counseling and therapy sessions for a MAP eligible recipient, family, or multi-family groups, based on individualized needs as specified in the treatment plan. Claims for services are to be filed under the name of the MAP eligible recipient being primarily treated through these sessions.

[8.324.7.16 NMAC - Rp, 8.324.7.16 NMAC, 1-1-14]

HISTORY OF 8.324.7 NMAC:

History of Repeals Material:

8.324.7 NMAC, Transportation Services, filed xx-xx-xx - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 351 SANCTIONS OR REMEDIES
PART 2 SANCTIONS AND REMEDIES

8.351.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.351.2.1 NMAC - Rp, 8.351.2.1 NMAC, 1-1-14]

8.351.2.2 SCOPE: The rule applies to the general public.
[8.351.2.2 NMAC - Rp, 8.351.2.2 NMAC, 1-1-14]

8.351.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.351.2.3 NMAC - Rp, 8.351.2.3 NMAC, 1-1-14]

8.351.2.4 DURATION: Permanent.
[8.351.2.4 NMAC - Rp, 8.351.2.4 NMAC, 1-1-14]

8.351.2.5 EFFECTIVE DATE: January 1, 2014,
[11/1/96; 8.351.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7/1/03]

8.351.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[2/1/95; 8.351.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7/1/03]

8.351.2.7 DEFINITIONS: [RESERVED]

8.351.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[2/1/95; 8.351.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7/1/03]

8.351.2.9 SANCTIONS AND REMEDIES: The medical assistance division (MAD) is required to impose sanctions or penalties against providers for fraud, violations of federal or state law, violations of HIPAA regulations, failure to meet professional standards of conduct, non-compliance with the medical assistance division's New Mexico administrative code (NMAC) rules, violations of the Medicaid Provider Act, and other misconduct. See 42 CFR Part 455; Section 30-44-3 NMSA 1978 (Repl. Pamp. 1998). HSD recovers overpayments made to MAD enrolled providers, to include HSD contracted managed care organizations (MCO) contracted providers; and to a MCO's out-of-network providers who have billed and received payments from a HSD contracted MCO. For applying sanctions and remedies, any of the following are considered a MAD enrolled provider.

A. Any individual or other entity who has signed a provider participation agreement (PPA) with MAD, or who has signed an agreement or contract with a HSD contracted MCO.

B. Any individual or other entity who has otherwise received payment for treating or providing services to a medical assistance program (MAP) eligible recipient as an out-of-network provider, a participating or non participating provider, a subcontracted provider, or who participates in an entity contracted by HSD or a HSD contracted MCO, including but not limited to, pharmacy benefit managers, dental benefit administrators, and contracted transportation services.

C. Any individual or other entity that provides a service to a MAP eligible recipient which results in a claim for payment by MAD, the HSD contracted fiscal agent, or by a HSD contracted MCO or coordinated care organization with or without a contractual basis for the claim submission.

D. Any individual or other entity who submits a claim to medicare or to a medicare advantage plan for a MAP eligible recipient, for which a copayment, coinsurance, or deductible is applied.

E. An employee, owner, or contractor to any of the above.
[11/1/96; 8/1/99; 8.351.2.9.9 NMAC - Rn, 8 NMAC 4.MAD.960 & A, 7/1/03]

8.351.2.10 SANCTIONS: MAD is required to impose sanctions against a provider for violation of the

provisions outlined in the MAD New Mexico administrative code (NMAC) rules and federal and state laws and regulations. MAD has discretion to impose monetary or non-monetary sanctions against providers for fraud or other forms of misconduct.

A. **Provider fraud:** Fraud is the intentional misappropriation, deception or misrepresentation made by a provider with the knowledge that the deception could result in some unauthorized benefit to the provider, other entity or some other person. The term includes any act that constitutes fraud under applicable federal or state law or regulation.

B. **Misconduct defined:** Provider misconduct includes, but is not limited to, any of the following:

(1) engaging in a course of conduct or performing an act that violates any provision of federal or state statutes, laws, regulation, and rules, to include HIPAA, or the continuation of his or her conduct after the receipt of the notice that the conduct should cease;

(2) failure to meet federal or state licensing or certification standards required of the provider or other entity, including the revocation or suspension of his or her license. The provider or other entity must notify MAD of such failure;

(3) failure to correct deficiencies in provider or other entity operations within time limits specified by HSD or its authorized agent after receiving written notice of these deficiencies;

(4) failure to maintain and retain any medical, behavioral health or business records as are necessary to:

(a) verify the treatment or care of a MAP eligible recipient for which the provider or other entity received payment from MAD or a HSD contracted MCO to provide the benefit or service;

(b) services or goods provided to any MAP eligible recipient for which the provider or other entity received payment from MAD or a HSD contracted MCO;

(c) amounts paid by MAD or a HSD contracted MCO on behalf of a MAP eligible recipient;

(d).....identify the practitioners and qualifications of practitioners providing the service, and

(e) other records required by MAD for at least six years from the date of creation or until ongoing audits are settled, whichever is longer;

(5) furnishing services to a MAP eligible recipient or billing MAD or a HSD contracted MCO for services which fall outside the scope of the provider's practice board or outside the scope of his or her prescribed practice or as limited by MAD's NMAC rules;

(6) failure to comply with the terms of the provider certification, electronic signature, or terms of submission for the claim form;

(7) failure to provide complete, accurate, and current information on his or her MAD provider participation agreement (PPA);

(8) breach of the terms of the provider's MAD PPA;

(9) failure to provide or maintain services which meet professionally recognized standards of care and quality;

(10) engaging in negligent or abusive practices which result in death or physical, emotional, or psychological injury to a MAP eligible recipient;

(11) failure to repay or make arrangements to repay identified overpayments;

(12) failure to make records available upon request to HSD or its delegated agent;

(13) violation of any laws, regulations or code of ethics governing the conduct of providers;

(14) conviction of crimes relating to the neglect or abuse of any of his or her patients;

(15) conviction of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(16) conviction of program-related crimes under medicare to include any other programs administered by the federal government or any state health care program or the suspension or termination of a provider's participation by this or another state's medicaid agency;

(17) seeking payment for a furnished service or for work related charges and penalties from a MAP eligible recipient or his or her personal or authorized agent, except as allowed and specifically delineated by HSD;

(18) refusing to furnish services to a MAP eligible recipient because he or she has third-party coverage; or

(19) advising a MAP eligible recipient to terminate his or her third-party coverage;

(20) failing to follow federal or state regulations and rules regarding the management of pain with controlled substances, the prescription monitoring program, and prescribing controlled substances;

(21) injudicious or excessive prescribing;

(22) failing to maintain a practitioner-to-patient relationship while prescribing controlled substances;

(23) failure of a provider or other entity to report overpayments identified by the provider or other entity within 60 calendar days of identification which, at that point, are presumed to be false claims and are subject to determination as credible allegations of fraud.

C. **Violation of Medicaid Provider Act:** Violations of the Medicaid Provider Act include the following:

(1) a material breach of a provider's obligation to furnish services to a MAP eligible recipient or any other duty specified under the terms of his or her PPA;

(2) a violation of any provision of the Public Assistance Act or the Medicaid Provider Act or any regulations and rules issued pursuant to those acts;

(3) the provider or other entity intentionally or with reckless disregard made false statements with respect to any report or statement required by the Public Assistance Act, Medicaid Provider Act or rules issued pursuant to either of act;

(4) the provider or other entity intentionally or with reckless disregard advertised or marketed or attempted to advertise or market, services to a MAP eligible recipient in a manner to misrepresent its service or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing;

(5) the provider or other entity hindered or prevented the HSD secretary, MAD director, or HSD's authorized agent from performing any duty imposed by the Public Assistance Act, the Human Services Act, the Medicaid Provider Act or any regulations and rules issued pursuant to those acts; or

(6) the provider or other entity fraudulently procured or attempted to procure any benefit from MAD or a HSD contracted MCO.

[11/1/96; 8/1/99; 8.351.2.10 NMAC - Rn, 8 NMAC 4.MAD.961 & A, 7/1/03]

8.351.2.11 TYPES OF SANCTIONS: HSD is allowed to impose monetary or non-monetary sanctions against any provider or other entity for misconduct. HSD is required to impose certain sanctions against a provider or other entity for fraud, HIPAA violations, and other actions. Sanctions may be applied to any provider or other entity receiving payment for services either directly through MAD or through its managed care contractor, subcontractor, or other provider.

A. **Prior approval:** As a condition of payment, MAD or a HSD contracted MCO can require a provider to obtain prior approval before delivering all or certain services including prior to prescribing or ordering services. The prior approval request must be submitted to the HSD's contracted MCO or the MAD UR contractor in a manner prescribed for general utilization review. Failure to obtain prior approval prior to furnishing a service may result in imposition of sanctions. In addition, MAD may sanction a provider or other entity by requiring him or her to obtain prior approval before furnishing all or certain services, including prior to prescribing or ordering services, even if other providers may furnish that service without the requirement of obtaining prior approval; see 8.302.5 NMAC.

B. **Education:** As a condition of payment, MAD or a HSD contracted MCO can require a provider or other entity to attend an educational program if misconduct could be remedied with the provision of identified education. MAD or a HSD contracted MCO may also require a provider or other entity who is seeking reinstatement to attend a specific educational program prior to the approval of his or her new PPA application. Provider education programs may include, but are not limited to, the following:

(1) claim form completion;
(2) use and format of the MAD NMAC rules;
(3) use of procedure codes;
(4) substantive provisions of MAD's NMAC rule, policy, and requirement;
(5) reimbursement rates;
(6) assistance in claims coding and billing; and
(7) continuing medical or behavioral health education.

C. **Closed-end agreements:** MAD can transfer the provider to a closed-end PPA. A closed-end PPA is for a specified period of time which terminates on a defined date not to exceed 12 months. At the end of this term, a new PPA must be executed for continued MAD participation.

D. **Suspension:** "Suspension" is an exclusion from participation in MAD or a HSD contracted MCO for a specified period of time.

(1) MAD suspension: MAD may suspend a provider from MAD or a HSD contracted MCO participation for misconduct or fraud.

(a) HSD is permitted to suspend a provider for up to 36 months. The period of suspension is

not less than the term of any court-imposed suspension.

(b) If the suspension is imposed by MAD, the effective date of the suspension is the date on the notice of suspension. If the suspension is concurrent with a court-imposed suspension, the effective date is the date of the court-imposed suspension.

(c) MAD is permitted to suspend a provider when the provider's license is terminated, suspended, or moved to an inactive status whether the action is voluntary on the part of the provider or is an action of his or her practice or licensing board. When a provider is reinstated by his or her practice or licensing board, the provider may reapply to MAD. Approval of the provider's PPA will be based on the history, nature, and financial magnitude of the provider's prior misconduct and not solely on the basis of reinstatement of the provider's license.

(2) Medicare suspension: MAD must suspend a provider or other entity that is suspended by medicare or any other federal or state-funded health program. When a MAD suspension is concurrent with a medicare suspension, the effective date of the MAD suspension is the same date of the medicare suspension.

(3) Special exception for health manpower shortage areas: After assessing the nature of the violation or misconduct, MAD has the option of requesting action from the secretary of the federal department of health and human services (DHHS) if the suspension of a provider would result in the lack of adequate medical or behavioral health services for MAP eligible recipients in a given area. The secretary of DHHS can be asked to:

(a) designate the community as a health manpower shortage area and place national health services corps personnel in the community; or

(b) waive the provider's suspension based upon submission of adequate documentation that the suspension would deprive the provider's community of needed medical or behavioral health services because of a shortage of practitioners in the area.

(4) Submission of claims following suspension:

(a) If a provider is suspended from MAD or a HSD contracted MCO participation, the provider is prohibited from submitting claims for payment to MAD, its MAD claims processing contractor, or to a HSD contracted MCO.

(b) MAD or a HSD contracted MCO will not pay claims submitted by clinics, groups, corporations, associations or other entities associated with a provider who is suspended from MAD participation for services furnished by such provider after the effective date of the suspension.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the suspension can be submitted. The claims may be subject to pre-payment review.

(5) Reinstatement: A provider can apply for reinstatement at the end of a suspension period. Reinstatement is not automatic or guaranteed. A provider must furnish written documentation that he or she meets all relevant licensing, certification, or registration requirements as specified by MAD, HSD's behavioral health services division (BHSD), the children, youth and families department (CYFD), or the department of health (DOH).

E. **Termination:** Termination is the ending of the provider's MAD PPA for a specified period of time. MAD must terminate the provider's PPA in certain specified instances and is permitted to terminate the PPA in other instances.

(1) Mandatory termination: MAD must terminate the PPA when any of the following events occur:

(a) provider is convicted of MAP or medicare fraud;

(b) provider has a previous suspension from MAD with failure to correct identified deficiencies; or

(c) provider is terminated from participation in the medicare program or another federal or state-funded health program.

(2) Discretionary termination: MAD may terminate the provider's PPA when the violation is so egregious, in the discretionary opinion of MAD, that other sanctions are not sufficient to address, reduce or eliminate the violation or when the identified deficiency or violation reflects a pattern of violation.

(3) Effective date of termination: The effective date of the MAD PPA termination is the date of a MAD or a medicare fraud conviction or the date of the provider's medicare termination. If termination follows a prior suspension from MAD or the termination is discretionary, the date of termination is set by MAD.

(4) Termination of a NF or intermediate care facility's PPA:

(a) MAD or a HSD contracted MCO can terminate a NF or an intermediate care facility for individuals with intellectual disabilities (ICF-IID) PPA instead of or in addition to other alternative remedies. Termination can occur in the instances which include, but are not limited to, the following:

(i) immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident's health and safety which have not been removed;

(ii) the provider is not in substantial compliance with participation requirements

regardless of whether immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident is present;

(iii) the provider fails to submit an acceptable plan of correction within the specified timeframes;

(iv) provider fails to relinquish control to temporary manager; or

(v) DOH recommends termination as the most appropriate remedy.

(b) Termination of the provider's PPA ends payment to the NF or ICF-IID provider.

(c) Notwithstanding other sections of this rule, payment to the NF or ICF-IID provider can be continued for up to 30 calendar days after the effective date of his or her PPA termination if the following conditions are met:

(i) the payment is for a NF or ICF-IID MAP eligible recipient resident admitted to the NF or ICF-IID before the effective date of the provider's PPA termination; and

(ii) MAD or a HSD contracted MCO is making reasonable efforts to transfer a MAP eligible recipient resident to another MAD enrolled facility or to alternate care;

(iii) for purposes of this provision, the 30 calendar day period begins on the effective date of the provider's PPA termination by CMS, MAD, or by the NF or ICF-IID provider.

(d) Before termination of a provider's NF or ICF-IID PPA, MAD or a HSD contracted MCO must notify the provider and the public at least 15 calendar days before the effective date of the termination with non-immediate jeopardy deficiencies that constitute the noncompliance. For termination due to deficiencies that pose immediate jeopardy to a MAP eligible recipient resident, MAD or a HSD contracted MCO must notify the provider and the public at least two working days before the effective date of the termination.

(e) If the termination of the provider's PPA is selected due to immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident, the effective date of the termination is within 23 calendar days of the last date of its DOH survey.

(5) Submission of claims following termination:

(a) If a provider is terminated from MAD participation, the provider is prohibited from submitting claims for payment to a HSD contracted MCO or to the MAD claims processing contractor.

(b) MAD or an HSD contracted MCO will not pay claims submitted by clinics, groups, corporations, associations, or other entities associated with a provider who is terminated from MAD participation for services furnished by such provider after the effective date of the termination.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the termination can be submitted. The claims may be subject to pre-payment review.

(6) Re-application for MAD participation: A provider or other entity must submit a new PPA application after the end of the termination period to MAD, before requesting enrollment in one of HSD's contracted MCOs. A provider must meet certification and licensing requirements specified by MAD, CYFD or DOH to be eligible to once again become a provider.

F. **Civil monetary penalties:** MAD is permitted to impose civil monetary penalties in addition to other penalties, and in accordance with the federal and state laws, regulations and rules.

(1) Amount of penalty: The provider or other entity is liable for the following:

(a) payment of interest on the amount received by the provider or other entity from MAD or a HSD contracted MCO in excess of payment at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to HSD;

(b) a civil monetary penalty in an amount of up to the maximum allowable under federal or state law, regulations or rules;

(c) a civil monetary penalty of $500 for each false or fraudulent claim submitted for furnishing treatment, services, or goods; and

(d) payment of legal fees and costs of investigation and enforcement of civil remedies.

(2) Payment of penalty amounts: Penalties and interest amounts must be remitted to the state of New Mexico (the state). Any legal fees, costs of investigation and costs of enforcement of civil remedies recovered on behalf of the state must also be remitted to the state.

(3) **Criminal action:** The filing of a criminal action is not a condition precedent to MAD's imposition of civil monetary penalties.

G. **Reduction of payment:** MAD may reduce the amount of any payment due a provider or other entity, in addition to other sanctions, if the provider or other entity seeks to collect an amount in excess of the MAD or a HSD contracted MCO's allowable amount from a MAP eligible recipient, his or her family, his or her authorized agent or any other source. See 42 CFR Section 447.20 - 447.21.

(1) The reduction may be equal to up to three times the amount that the provider sought to collect.

(2) For purposes of this provision, the MAD allowable amount is equal to the amount payable under the state plan or MAD NMAC rules, a MAD or a HSD contracted MCO fee schedule. The provider may not charge a MAP eligible recipient for any effort or penalties such as researching eligibility, not having cards, completing paper work or billing forms, missed appointments, or any other add-on cost unless specifically allowed in a MAD NMAC rule.

H. **Sanctions and remedies for noncompliance with nursing facility or intermediate care facility certification requirements:** MAD is required to impose additional remedies against a NF provider who fails to comply with federal medicaid and state MAD participation requirements with respect to his or her licensing and certification. One or more of the following remedies can be imposed by MAD for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance: termination of the NF provider's MAD PPA and all provider contracts with the HSD contracted MCO; temporary management; denial of payment for new admissions; civil money penalties; NF closure or the transfer of MAP eligible recipient residents or both; state monitoring; directed plan of correction; directed inservice training; and other state remedies approved by CMS. MAD is also required to impose remedies against an ICF-IID provider who fail to comply with federal medicaid and state MAD licensing and certification requirements. MAD may terminate an ICF-IID provider's certification or deny payment for new admissions if the provider fails to meet the conditions for participation or certain deficiencies are identified by DOH.

(1) Authority of survey agency: DOH is the survey agency designated by MAD. When the rationale for imposition of the remedies is tied to DOH's licensing and certification responsibilities, criteria for imposition of remedies and description of these specific remedies are based on NMAC rules promulgated by the DOH.

(2) Recommendations for imposition of additional remedies: Following completion of a survey, DOH may recommend that specified remedies be imposed against a NF or an ICF-IID provider for failure to meet certification or licensing requirements which are based on the type, extent and seriousness of an identified deficiency. MAD has five working days from receipt of DOH's recommendations to impose remedies or to oppose the recommendations. Unless a response from MAD is received in writing prior to the expiration of the time period, the recommendations are accepted by MAD as submitted and the recommended remedy is imposed.

(3) Informal reconsideration for an ICF-IID provider: An ICF-IID provider can request an informal reconsideration of the decision to deny, terminate or not renew his or her MAD PPA when the HSD administrative hearing final decision will not be completed prior to the effective date of the termination. The informal reconsideration must be completed prior to the effective date of the termination. The informal reconsideration includes the following:

(a) written notice to the ICF-IID provider of the denial, termination or nonrenewal of his or her MAD PPA;

(b) reasonable opportunity for the ICF-IID provider to refute the findings upon which the decision was based; and

(c) a written affirmation or reversal of the denial, termination or nonrenewal of the provider's MAD PPA.

I. **Sanction for violation of the Medicaid Provider Act:** MAD may take any or any combinations of the following delineated actions against a provider or other entity for a violation of the Medicaid Provider Act.

(1) imposition of an administrative penalty of not more than $5,000 for engaging in any practice that violates the Act. Each separate occurrence of such practice constitutes a separate offense;

(2) MAD issues an administrative order requiring the provider or other entity to:

(a) cease or modify any specified conduct or practices engaged in by the provider or other entity or his or her employees, subcontractors, or agents;

(b) fulfill its contractual obligations in the manner specified in the order;

(c) provide any service that has been denied;

(d) take steps to provide or arrange for any service that it has agreed to or is otherwise obligated to make available; or

(e) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by the opposing parties.

(3) suspend or terminate the provider's MAD PPA and the provider contracts with a HSD contracted MCO.

[11/1/96; 8/1/99; 8.351.2.11 NMAC - Rn, 8 NMAC 4.MAD.962 & A, 7/1/03]

8.351.2.12 IMPOSITION OF SANCTIONS:

A. **Mandatory sanctions:** MAD must impose sanctions when a provider receives a formal

reprimand or censure for unethical practice by a professional association of the provider's peers or when a provider is suspended or terminated from participation in medicare or any federal or state-funded health care program. Imposition of sanctions are applied to any provider or other entity receiving payment for services either directly through MAD, its contractor, or through any HSD contracted MCO, subcontractor, or provider.

B. **Permissive sanctions:** MAD can impose monetary or non-monetary sanctions against a provider or other entity for fraud or other forms of misconduct.

C. **Criteria used in assessment of permissive sanctions:** MAD uses the following criteria to determine the type of permissive or mandatory sanction to impose:

(1) seriousness of the violation;
(2) number and nature of a violation;
(3) history of a prior violation or prior sanction;
(4) action or recommendation of peer review group or licensing board;
(5) nature and degree of adverse impact of the sanction upon a MAP eligible recipient;
(6) cost to MAD or a HSD contracted MCO of the violation;
(7) mitigating circumstances; and
(8) other relevant facts.

[11/1/96; 8.351.2.12 NMAC - Rn, 8 NMAC 4.MAD.963, 7/1/03]

8.351.2.13 RECOVERY OF OVERPAYMENTS: MAD can seek recovery of overpayments through the recoupment or repayment process. Overpayments are amounts paid to a MAD provider or other entity in excess of the MAD allowable amount. Overpayment amounts must be collected within 24 months of the initiation of recovery. Overpayment includes, but is not limited to, payment for any claim for which the provider or other entity was not entitled to payment because an applicable MAD NMAC rule and its requirements were not followed. Payment made to a pharmacy for a controlled substance or another prescribed drug item for which the prescriber did not follow all state and federal regulations, laws or rules may be subject to recoupment from the prescriber or entity to which the prescriber is associated. Recovery of overpayments through a HSD contracted MCO is also subject to the provisions of 8.308.22 NMAC.

A. **AUDITING PROCEDURES**

(1) **Prima facie evidence:** The audit findings generated through the audit procedure shall constitute prima facie evidence in all MAD proceedings of the number and amount of requests for payment as submitted by the provider or other entity.

(2) **Use of statistical sampling techniques:** MAD's procedures for auditing a provider or other entity may include the use of random sampling and extrapolation. When this procedure is used, all sampling will be performed using generally accepted statistical methods and will yield statistically significant results at a confidence level of at least 90 percent. Findings of the sample will be extrapolated to the universe for the audit period.

(3) **Burden of proof:** When MAD's final audit findings have been generated through the use of sampling and extrapolation, and the provider or other entity disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider or other entity. The provider or other entity may present evidence to show that the sample was invalid. The evidence must include a 100 percent audit of the universe of provider records used by MAD in the drawing of its sample. Any such audit must:

(a) be arranged and paid for by the provider or other entity;
(b) be conducted by a certified public accountant;
(c) demonstrate that a statistically significantly higher number of claims and records not reviewed in MAD sample were in compliance with MAD NMAC rules, and
(d) be submitted to MAD with all supporting documentation.

B. **Repayment process:** A provider or other entity can repay all or part of an overpayment with a lump sum payment or a series of payments based on a schedule developed and mutually agreed to by MAD and the provider or other entity. If a provider or other entity fails to comply with the schedule, HSD will recover the overpayment and interest or initiate other collection efforts.

C. **Recoupment process:** Upon written notice, MAD may withhold all or a portion of a provider or other entity's payment on pending and subsequently received claims in order to recover an overpayment, or it may suspend payment on all pending or subsequently submitted claims, pending a final determination of the amount of overpayment. All amounts must be recouped within 24 months. Recoupments may be applied to other providers owned by the same entity when necessary to recoup overpayments timely.

D. **Combination of processes:** MAD can use both recoupment and repayment process to collect an

overpayment if:

(1) the provider is unlikely to remain a MAD provider long enough for full recovery using recoupment alone;

(2) the provider is not enrolled through a MAD PPA or contract; or

(3) the average monthly payment to a provider or other entity is so low that recoupment within 12 months is not feasible.

E. **Prepayment review:** MAD may require pre-payment review of claims submitted during a recoupment or repayment process to ensure that subsequent claims are not inflated to compensate for amounts recovered during the recoupment or repayment process. Prepayment review may also be conducted as part of MAD's administrative responsibilities.

[11/1/96; 8.351.2.13 NMAC - Rn, 8 NMAC 4.MAD.964, 7/1/03; A, 9/1/04]

8.351.2.14 NOTICE REQUIREMENTS:

A. **Content of provider notice:** With the exception of a referral based on a credible allegation of fraud, as that term is defined in federal statute or regulation or both, when MAD seeks overpayment recovery, or to impose sanctions or remedies, written notice is sent to the provider or other entity. The notice sent to a non-nursing facility provider or other entity contains the following information:

(1) nature of the violation or misconduct;

(2) dollar value, if applicable, the method, criteria or both used for determining the overpayment, intended sanction, or amount of civil monetary penalty to be imposed;

(3) provider's right to a HSD provider administrative hearing, the right to be represented by counsel at the hearing proceeding, and the process necessary to request a HSD provider administrative hearing.

(4) statement notifying the provider that if he or she does not request a HSD provider administrative hearing, the action proposed by MAD will be deemed final for purposes of collection of overpayment and imposition of sanctions; and

(5) a statement that provider has 30 calendar days from the date of the notice to request a HSD provider administrative hearing.

B. **Notice requirements for credible allegations of fraud:**

(1) The notice for contains the following information; see 42 CFR Section 455.23 (b):

(a) a statement that payments are being withheld on a temporary basis and delineate which types or type of MAD claim to which the termination applies, when appropriate;

(b) a statement informing the provider of his or her right to submit written information for MAD's consideration regarding release of payments, in whole or in part, for a good cause exception; and

(c) the information listing the conditions or circumstances under which the withholding is terminated.

(2) Time limits for withholding for fraud or misrepresentation: If payments are to be withheld in instances of credible allegations of fraud, the notice is sent to the provider within five calendar days of taking such action.

(3) The provider is not afforded any HSD administrative hearing for temporary payment suspension based on refunds or denial of a partial or in whole good cause exception for a credible allegation of fraud.

C. **Notice to other organizations:** When a MAD provider or other entity is sanctioned, MAD notifies the applicable professional society, board of certification, licensing or registration, and state or federal agencies of the sanctions imposed and rationale for imposition of sanctions. If MAD learns that a provider or other entity is convicted of a MAD-related offense, MAD also notifies the federal secretary of DHHS of the conviction.

D. **Notice to a MAP eligible recipient:** When MAD terminates or suspends a provider from participation, it notifies each MAP eligible recipient for whom the provider has submitted claims for services after the date of the alleged fraud or misconduct.

E. **Notice deadlines for a NF or ICF-IID provider:** The notice period begins on the date of the MAD notice. In no event will the effective date of the action be later than 20 calendar days after MAD sends the notice.

(1) The notice informing the NF or ICF-IID provider of MAD's intent to impose remedies is given at least two calendar days before the effective date of the action in instances where there is immediate jeopardy to a NF or ICF-IID MAP eligible resident.

(2) The notice informs the NF or ICF-IID provider of MAD's intent to impose remedies is given at least 15 calendar days before the effective date of the remedies in instances where immediate jeopardy to a NF or ICF-IID MAP eligible resident is not involved.

F. **Exceptions to the notice requirements:** Notice is not sent and a HSD provider administrative hearing is not available if the basis for the provider sanction is the non-nursing facility provider's failure to meet standards for licensing, certification, or registration required by federal or state laws and rules for MAD participation Additional notice is not required if MAD has notified the provider in writing of the failure to meet standards and has given the provider 30 calendar days notice to correct or produce necessary documentation curing the failure and the provider fails to respond.
[11/1/96; 8.351.2.14 NMAC - Rn, 8 NMAC 4.MAD.965, 7/1/03]

8.351.2.15 REQUEST FOR PROVIDER HEARING: A provider can request a hearing if he or she disagrees with any of the aforementioned actions taken or sanctions or remedies imposed by MAD, as applicable. Requests for a HSD provider administrative hearing must be made within 30 calendar days or within the time limit specified on the notice of MAD action. A NF or ICF-IID provider must submit the request to DOH within 60 calendar days of the notice of the proposed imposition of remedies related to noncompliance with certification or licensing requirements. If a provider fails to request a HSD provider administrative hearing during this time frame, the provider waives its right to an appeal. See 8.353.2 NMAC for information on the MAD provider administrative hearing process and a provider rights and responsibilities.

A. **Imposition of remedies:** MAD can impose all remedies on a MAD enrolled provider after notifying the provider in a timely manner of the deficiencies an impending sanction, or remedy. Except for the imposition of civil monetary penalties against a NF provider, imposition of sanctions for violation of the Medicaid Provider Act and referrals based on credible allegations of fraud, any applicable sanctions or remedy may be imposed prior to the HSD provider administrative hearing.

B. **Stay granted:** As applicable, the provider can request that the imposition of sanctions or remedies be stayed while the HSD provider administrative hearing process is pending by submitting such request in writing to MAD. Granting of a stay is at the discretion of the MAD director upon consideration of health service available and other related concerns. Interest on civil money penalties or overpayments accrues from the date of the initial determination.

C. **Collection of civil monetary penalties for noncompliance:** MAD may not collect a civil money penalty against a NF provider until a final decision is made that supports the imposition of the penalty. In instances where imposition of civil money penalties are proposed due to noncompliance with certification requirements, a NF provider may waive its right to a HSD provider administrative hearing by submitting a written request to DOH. Waiver of the right to such a hearing reduces the amount of the specified penalty by 35 percent. A NF provider may submit a plan of correction or request a resurvey without prejudicing its position during the hearing.
[11/1/96; 8/1/99; 8.351.2.15 NMAC - Rn, 8 NMAC 4.MAD 966, 7/1/03]

HISTORY OF 8.351.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 305.3000, Provider Sanctions, filed 1/7/80.
ISD 305.4000, Provider Notification and Right to Review, filed 1/7/80.
ISD 305.5000, Repayment of Medicaid Funds, filed 1/7/80.
ISD 305.6000, Periods of Suspension, filed 1/7/80.
SP-004.0500, Section 4, General Program Administration Medicaid Agency Fraud Detection and Investigation Program, filed 1/23/81.
SP-004.3000, Section 4, General Program Administration Suspension of Practitioners Convicted of Crimes Related to Medicare or Medicaid, filed 3/17/81.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 352 ADMINISTRATIVE HEARINGS
PART 2 CLAIMANT ADMINISTRATIVE HEARINGS

8.352.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.352.2.1 NMAC - Rp, 8.352.2.1 NMAC, 1-1-14]

8.352.2.2 SCOPE: The rule applies to the general public.
[8.352.2.2 NMAC - Rp, 8.352.2.2 NMAC, 1-1-14]

8.352.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.352.2.3 NMAC - Rp, 8.352.2.3 NMAC, 1-1-14]

8.352.2.4 DURATION: Permanent.
[8.352.2.4 NMAC - Rp, 8.352.2.4 NMAC, 1-1-14]

8.352.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.352.2.5 NMAC - Rp, 8.352.2.5 NMAC, 1-1-14]

8.352.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.352.2.6 NMAC - Rp, 8.352.2.6 NMAC, 1-1-14]

8.352.2.7 DEFINITIONS:

A. *"Administrative law judge (ALJ)"* means the HSD Fair Hearings Bureau's appointed judge to oversee the claimant's administrative hearing process and render a recommendation to the medical assistance division direction.

B. "*Authorized representative*" means an individual that has been legally appointed by the appropriate court to act on behalf of the claimant.

C. "*Date of action*" means the date on which an adverse action becomes effective.

D. "*Denial*" means the decision not to authorize the claimant's requested service, prior approval, utilization review request, or level of care (LOC).

E. "*Hearing*" or "*administrative hearing*" or "*fair hearing*" means an evidentiary hearing that is conducted so that evidence may be presented as it relates to the denial or an adverse action by HSD, the MAD UR contractor, or the HSD managed care organization(MCO). This hearing is conducted by the HSD Fair Hearings Bureau (FHB).

F. "*HSD*" or "*the Department*" means the New Mexico human services department.

G. "*MAD*" means the medical assistance division which administers medicaid and medical assistance programs under HSD.

H. "*MAP*" means the medical assistance programs administered by MAD.

I. "*MCO final decision*" means the HSD managed care organization (MCO) final decision regarding an appealed adverse action it intends to take or has taken against its member.

J. "*Parties to the hearing*" are HSD and as appropriate its designee and the claimant. If the hearing issue is a decision made by a HSD contractor, the parties are then HSD and as appropriate its designee, the contractor, and the claimant.

K. "*Request for an administrative hearing*" means a clear expression by the claimant or his or her authorized representative that the claimant wants the opportunity to present his or her case to the FHB.

L. "*State coverage insurance (SCI)*" means the SCI- health insurance flexibility and accountability waiver program for coverage of uninsured working adults. Effective January 1, 2014, only adverse actions that occurred prior to this date may a claimant file a request for an administrative hearing.

M. "*Utilization review (UR) contractor*" is a HSD contractor responsible for medical and behavioral health level of care reviews and medical necessity reviews for only medical assistance programs services, prior approvals, LOC or other UR actions.

N. "*Premium assistance*" is a premium assistance program for children and pregnant women who are ineligible for other federally and state funded public assistance programs. Effective January 1, 2014, only adverse actions that occurred prior to this date may a claimant file a request for an administrative hearing.
[8.352.2.7 NMAC - Rp, 8.352.2.7 NMAC, 1-1-14]

8.352.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.352.2.8 NMAC - Rp, 8.352.2.8 NMAC, 1-1-14]

8.352.2.9 CLAIMANT: A claimant is a MAP enrolled recipient or an individual not currently a MAP enrolled recipient. When a MCO member requests a HSD administrative hearing, he or she is referred to as a claimant. The claimant may have an authorized representative act on behalf of him or her. To assist a claimant to whom an adverse action is intended or has been taken by MAD or its MAD UR contractor resulting in a denial of service, prior approval, UR action, or a specific level of care (LOC), MAD has established the process for a claimant to:

A. request a HSD administrative hearing;

B. request continuation of a benefit; and

C. present evidence on behalf of the claimant's request for approval of a specific services, prior approval, UR action, or LOC.
[8.352.2.9 NMAC - Rp, 8.352.2.9 NMAC, 1-1-14]

8.352.2.10 ADVERSE ACTION: The following listings are adverse actions.

A. The termination, modification, reduction, or suspension of a covered MAD service.

B. The denial or limiting of a MAD authorized service, including type or level of service (with the exception of a HSD contracted manvalue-added service); request for a prior authorization of such service; or a utilization review (UR) decision or the UR's reconsideration decision.

C. The denial in whole or in part of the claimant's provider claim by MAD, its UR contractor, or a HSD MCO which results in the claimant becoming liable for the payment.

D. The failure of MAD, its UR contractor or a HSD MCO to approve a service in a timely manner.

E. The failure of a MAP UR contractor to act on an appeal within the timeframes specified in 42 CFR 438.408 (b).

F. A claimant's MCO final decision upholding its denial or limitation of a MAD authorized service, with the exception of the MCO's value-added services.
[8.352.2.10 NMAC - Rp, 8.352.2.10 NMAC, 1-1-14]

8.352.2.11 RIGHT TO AN ADMINISTRATIVE HEARING: An administrative hearing is an evidentiary hearing that is conducted so that evidence may be presented as it relates to an adverse action by MAD, its UR contractor, or a HSD MCO. The hearing is conducted by the HSD fair hearing bureau (FHB). MAD, its UR contractor, or the claimant's MCO must grant a claimant the opportunity for a HSD administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and New Mexico Statutes Annotated 1978, 27-3-3.

A. A claimant or the claimant's authorized representative may request a HSD administrative hearing based on his or her belief that MAD, its UR contractor or the claimant's MCO has taken an adverse action erroneously.

B. A claimant or the claimant's authorized representative may request a HSD administrative hearing when the service, prior approval, UR action or LOC of a claimant is terminated, modified, reduced, suspended, or denied. A member of a HSD MCO shall have the right to request a HSD administrative hearing after the member has exhausted his or her MCO's appeal process. See 8.100.970 NMAC for hearings procedures on MAP eligibility determination issues.

C. A MCO member may request a HSD administrative hearing when:

(1) the member has exhausted his or her internal MCO appeal process;

(2) the member does not agree with his or her MCO's final decision;

(3) the member has requested a HSD administrative hearing within 90 calendar days of his or her MCO's final decision; and

(4) the member's request for a HSD administrative hearing meets one of the definitions of an adverse action in Section 10 of this rule.
[8.352.2.11 NMAC - Rp, 8.352.2.11 NMAC, 1-1-14]

8.352.2.12 HEARING PROCESS REFERENCE: HSD has established a hearing process for a claimant who meets the criteria described above in Section 10 of this rule and who disagrees with a MAD decision concerning his or her MAD or MCO services or his or her LOC determination.

A. See 8.354.2 NMAC for rules on HSD administrative hearings requests that may be made by a resident of a nursing facility: (1) who believes the facility's determination that he or she be transferred or discharged is erroneous; or (2) for requests by the claimant who believes that the HSD determination with regard to the preadmission and annual resident review requirements is erroneous.

B. See 8.308.15 NMAC for a detailed description of a member's MCO appeal process for resolving a member's dispute with his or her MCO, its contractors or subcontractors.

C. See 8.349.2 NMAC for a detailed description for services and level of care determinations made through a MAD coordinated service contractor.

D. Issues of late premium payment or failure to pay the premium addressed through the MCO appeal process which is not resolved at that level may be appealed to the New Mexico (the State) district court at the appellant's (member's) expense. Effective January 1, 2014, only eligibility determination actions that occurred prior to this date for an applicant or a recipient of MAD premium assistance may file an appeal through the HSD administrative hearing process.

[8.352.2.12 NMAC - Rp, 8.352.2.12 NMAC, 1-1-14]

8.352.2.13 NOTICES, TIME LIMITS, POSTPONEMENTS, AND DISMISSAL OF ADMINISTRATIVE HEARINGS:

A. **Notices:** MAD issues two separate types of notices to a claimant when it or its UR contractor intends to take an adverse action, deny prior authorization request or an UR action leading to the termination, modification, reduction, or suspension of a MAD service or LOC.

(1) A *Notice of Action* is issued within three working days of HSD or its contractor's determination of its intent to take action.

(2) An *Advance Notice of Action* is issued 13-calendar days prior to MAD's or its contractor's intended date to take the action.

B. **Exceptions to advance notice:** MAD or its contractor will mail an *Advance Notice of Action* to terminate, modify, reduce, or suspend a MAD service, denial of a prior authorization request, an UR action, or a change in the claimant's LOC no later than the actual date the action will take place by MAD or its contractor:

(1) has factual information that confirms the death of the claimant;

(2) receives a clear written statement signed by the claimant that the service is no longer wanted, or he or she provides information which requires a termination, modification, reduction or suspension of a MAD service, prior authorization request or an UR action which indicates the claimant's understanding that such information may result in the termination, modification, reduction or suspension of a service, the denial of a prior authorization request or an UR adverse action;

(3) learns the claimant is residing in a public institution which makes the claimant ineligible for MAP enrollment and MAD services while he or she resides in such an institution;

(4) does not know the claimant's whereabouts and the claimant's United States postal office returns mail directed to the claimant indicating he or she has no known forwarding address;

(5) has established the fact the claimant has been accepted for medicaid services outside of the State; or

(6) the primary care provider for the claimant has prescribed a change in his or her LOC.

C. **Time limits:** There are two specific time limits to which a claimant must adhere. One is for a request for a continuation of a benefit and the second is for a request for a HSD administrative hearing.

(1) Continuation of a benefit: A continuation of a benefit may be provided to a claimant who requests a hearing within 13 calendar days of issuance of MAD or its UR contractor's *Advance Notice of Action.* The notice will include information on the rights to continued benefits and on the claimant's responsibility for repayment if the hearing decision is not in his or her favor. The continuation of a benefit is only available to a claimant that is currently receiving the appealed service. In order to receive a continuation of a benefit while the hearing process goes forward, this request must be received by the claimant's MAD UR contractor no later than the close of business on the 13th calendar day of the date of the *Advance Notice of Action.* His or her MAD UR contractor is responsible for the determination to either approve or deny the request for the continuation of a claimant's benefit. The continuation of a benefit will be the same as the claimant's current allocation, budget or LOC.

(2) A claimant has 90 calendar days from the date of the *Notice of Action* to request a HSD administrative hearing. To be considered timely, the request must be received by the FHB or the claimant's local income support division (ISD) office or by MAD's director's office no later than the close of business on the 90th calendar day.

(3) The HSD administrative hearing is conducted within the 90 calendar day requirement unless the claimant or the claimant's authorized agent agrees to extend the administrative hearing in order facilitate the process.

(4) For a MCO member, the time limit to request a HSD administrative hearing is within 90 calendar days of his or her MCO's final decision.

(a) Upon requesting a HSD administrative hearing within this time limit, the member is referred to as the claimant and is governed by the remaining sections of this rule.

(b) The member may request a continuation of benefits from his or her MCO within 13 calendar days of the MCO's final decision.

D. **Dismissal of a hearings request:** The FHB may recommend to the MAD director or designee a dismissal of a request for hearing when:

(1) the request is not received in a timely manner or within the time period set out in the *Notice of Action* or the claimant's MCO final decision;

(2) the request is withdrawn or cancelled in writing, by the claimant or the claimant's authorized agent;

(3) the sole issue presented concerns a federal or state statue, regulation or rule requiring an adjustment of benefits for all or certain classes of individuals, including, but not limited to, a termination, modification, reduction, or suspension of a service;

(4) the same issue has already been appealed or decided upon as to this claimant and fact situation;

(5) the sole issue presented is regarding a MAD New Mexico administrative code (NMAC) rule rather than the application of the rule to the claimant; or

(6) the claimant fails to appear at a scheduled hearing without good cause. A request for a hearing may be considered abandoned and therefore dismissed if the claimant or the claimant's authorized representative appears at the time and place of the hearing, unless, within 10 calendar days after the date of the scheduled hearing, the claimant, or the claimant's authorized representative presents good cause for failure to appear. Good cause includes a death in the family, a disabling personal illness, or another significant emergency, or at the discretion of the ALJ for another exceptional circumstance is considered good cause.

[8.352.2.13 NMAC - Rp, 8.352.2.13 NMAC, 1-1-14]

8.352.2.14 INFORMAL RESOLUTION CONFERENCE: Any party may request an informal resolution conference by contacting the FHB. The parties are encouraged to hold an informal resolution conference before the administrative hearing to discuss the issues in dispute. The informal resolution conference is optional and does not delay or replace the hearing process. Conference parties may include the claimant or the claimant's authorized representative, MAD, its UR contractor, or the claimant's MCO. The purpose of the informal resolution conference is to informally review MAD or the MCO's action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the administrative hearing may also be clarified or further defined. Regardless of the outcome of the informal resolution conference, an administrative hearing is still held, unless the claimant or the claimant's authorized representative makes a written withdrawal of the request of the hearing.

[8.352.2.14 NMAC - Rp, 8.352.2.14 NMAC, 1-1-14]

8.352.2.15 NOTICE OF PRE-HEARING AND ADMINISTARTIVE HEARING DATES:

A. **Scheduling:**

(1) Pre-hearing: Not less than 30 calendar days before the pre-hearing, the assigned ALJ provides written notice to all parties involved detailing the time, date, and place of the both pre-hearing and administrative hearing. If an accommodation is necessary, the party must notify the ALJ at least 10 calendar days prior to the pre-hearing or administrative hearing. The claimant or the claimant's authorized representative is provided in the notice an explanation of the hearing process and procedures, and informed that MAD, its UR contractor or his or her MCO does not pay fees or costs incurred by the claimant or the claimant's authorized representative as a result of the hearing or if he or she files an appeal of the hearing decision to a state district court.

(2) Administrative hearing: If all matters in the request for a hearing are not resolved at the pre-hearing conference, the ALJ sets an administrative hearing date within 30 calendar days of the last conference date, or at a later time agreed to by the parties, recognizing the 90-calendar-day time constraint.

B. **Rescheduling:** Any party may request, and is entitled to receive, one postponement of the scheduled pre-hearing and administrative hearing, as long as it does not interfere with the decision time frames. A request for more than one postponement is at the ALJ's discretion on a case-by-case basis.

C. **Expedited hearing:** Any party may request an expedited hearing in cases involving a claimant's health, safety, or service availability issues. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. The granting of an expedited hearing is at the discretion of the ALJ.

D. **Group hearing:** An ALJ may respond to a series of individual requests for hearings by conducting a single group hearing. In all group hearings, the rules governing individual hearings are followed. Each claimant or the claimant's representative is permitted to present his or her own case. If a group hearing is arranged, any claimant or a claimant's representative has the right to withdraw from the group hearing in favor of an individual hearing.

[8.352.2.15 NMAC - Rp, 8.352.2.15 NMAC, 1-1-14]

8.352.2.16 PRE-HEARING CONFERENCE: Within 30 calendar days of the receipt of a request for an administrative hearing, the ALJ assigned to a case schedules a pre-hearing conference. A pre-hearing conference is an informal proceeding and may occur telephonically.

A. **Purpose of conference:** The purposes of the pre-hearing conference include, but are not limited to:

(1) expediting the disposition towards a final decision;
(2) identification, clarification, formulation and simplification of issues;
(3) resolution of some or all issues;
(4) exchange of documents and information;
(5) preparing stipulations of fact to avoid unnecessary introduction of evidence at the hearing;
(6) review of audit findings;
(7) review of MAD, its UR contractor, or the MCO's adverse action of termination, modification, reduction, or suspension of a covered service or a LOC;
(8) identification the number of witnesses; and
(9) facilitation towards a settlement of the case.

B. **Settlements, stipulations and admissions:** No offer of settlement made in a pre-hearing conference is admissible as evidence at a later hearing. Stipulations and admissions are binding and may be used as evidence at the hearing. Any stipulation, settlement or consent order reached between the parties is written and signed by the ALJ and the parties or their authorized representatives or agents.

C. **Written summaries:** The ALJ may request the parties to submit written summaries of all issues resolved at the pre-hearing conference.

D. **Pre-hearing order:** The ALJ may, at his or her sole discretion, prepare or ask the parties to prepare a pre-hearing order after the pre-hearing is completed. The pre-hearing order may contain:

(1) statements of any contested facts and issues;
(2) stipulation of matters not in dispute;
(3) list of witnesses to be called and the subject of their testimony;
(4) list of exhibits;
(5) discovery directives; or
(6) other matters relevant to the issues.

E. **Points of law:** The ALJ may direct the parties to submit memoranda on points of law to inform the final decision, and may dictate the length and scope of these submissions.

F. **Summary of evidence:** A summary of evidence (SOE) is a document submitted by MAD that provides preliminary information concerning the basis of its, its contractor or the HSD MCO's action. The SOE may be amended by MAD at any point prior to the pre-hearing if the ALJ and the claimant or the claimant's authorized representative receives copies of the amended SOE at least 2 working days of the pre-hearing conference.

(1) The SOE must be provided at least 10 working days prior to the pre-hearing conference or if the pre-hearing conference is not held, within 10 working days prior to the administrative hearing.

(2) The failure of MAD to timely provide the SOE may at the ALJ's discretion, result in its exclusion or a continuance of the hearing.

(3) MAD staff or its designee is responsible for preparation of the SOE and coordination of parties and witnesses. MAD is responsible for the submission of the SOE to all parties.

(4) The summary of evidence shall contain:

(a) the claimant's name, telephone number and address and the status of any previous or concurrent appeal through the MAD UR contractor;

(b) the action, proposed action or inaction being appealed;

(c) information on which the action or proposed action is based with supporting documentation and correspondence; and

(e) applicable federal and state statutes, regulations, rules or any combination of these.

G. **Availability of claimant evidence:**

(1) The claimant or the claimant's authorized representative will provide at least ten calendar days prior to the hearing to the FHB assigned ALJ any document to be introduced as evidence at the pre-hearing conference. The SOE may be amended by the claimant or the claimant's authorized representative at any point prior to the pre-hearing if the ALJ and HSD receive copies of the amended SOE at least within two working days of the pre-hearing conference. The FHB will forward to the MAD administrative hearings unit copies of such evidence. MAD will then make these available to its MAP UR contractor or the claimant's MCO as appropriate.

(2) Failure of the claimant or the claimant's authorized representative to timely provide the documentary evidence may result in its exclusion or a continuance of the hearing at the discretion of the ALJ.

H. **Availability of information to the claimant or the claimant's representative:** HSD must:

(1) provide, on request, in a timely manner and without charge, any documents in its possession concerning the underlying action, that are not already in the claimant or the claimant's authorized representative's possession, and that are necessary for him or her to decide whether to request a hearing or to prepare for a hearing;

(2) allow the claimant or the claimant's authorized representative to examine all documents to be used at the pre-hearing and administrative hearing at least 10 working days before the date of the hearing and at the pre-hearing and administrative hearing. HSD documents or records which the claimant or the claimant's authorized representative would not otherwise have an opportunity to challenge or contest may not be introduced at the hearing or be considered by the ALJ.

[8.352.2.16 NMAC - Rp, 8.352.2.16 NMAC, 1-1-14]

8.352.2.17 ADMINISTRAIVE HEARING STANDARDS:

A. **Administrative Law Judge:** Hearings are conducted by an impartial official who:

(1) does not have any personal stake or involvement in the case; and

(2) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, he must disqualify himself as the ALJ for that case.

(3) **Authority and duties of the hearing officer:** The ALJ must:

(a) explain how the hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence considered necessary to decide the issues raised;

(d) regulate the conduct and the course of the hearing and any pre-hearing conference to ensure an orderly hearing;

(e) request, if appropriate, an independent medical assessment or professional evaluation from a source mutually satisfactory to the parties; and

(f) produce the hearing report that includes findings of fact and his or her recommendation for resolution of the hearing.

(4) **Appointment of ALJ:** The ALJ is appointed by HSD upon receipt of the request for hearing. All communications are to be addressed to the assigned ALJ.

B. **Record of the hearing:** The administrative hearing is electronically recorded. The recording is placed on file at the FHB and is available to the parties for 60 calendar days following the final decision. In addition to the recorded proceedings, the record of the administrative hearing includes the SOEs of HSD, the MCO or MAD UR contractor and the claimant, pleadings, documents, or other exhibits admitted into evidence. Any of the parties to the hearing may request one digital copy of the recordings without charge. Subsequent copies will be charged at a rate HSD sets for any other digital request.

C. **Rights at administrative hearing:** The parties are given an opportunity to:

(1) present his or her case or have it presented by the authorized representative;

(2) bring witnesses to present information relevant to the case;

(3) submit evidence to establish all pertinent facts and circumstances in the case;

(4) advance arguments without undue interference; and

(5) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

D. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply to a HSD administrative hearing. A free, orderly exchange of relevant information is necessary for the decision-making process. The ALJ will provide HSD a copy of the claimant's SOE and any amendments to the SOE within one working day of his or her receipt. HSD will provide the MCO or MAD UR contractor a copy of the claimant's SOE within one working day of receipt. The HSD or claimant's SOE may be amended at any point prior to the pre-hearing if the all parties receive a copy of the amended SOE at least within two working days of the pre-hearing conference.

(1) **Admissibility:** All relevant evidence is admissible subject to the ALJ's authority to limit repetitive or unduly cumulative evidence and his or her ability to conduct an orderly hearing. The ALJ must admit evidence that is relevant to the contemplated action or the action taken by HSD, the MAD UR contractor, or the HSD MCO.

(2) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the hearing in the presence of the claimant or the claimant's authorized representative and HSD representative may not be used by the ALJ in making the hearing recommendation except as allowed by Section 13 Subsection E of this rule.

(3) **Administrative notice:** The ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(4) **Privilege:** The rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(5) **Medical issues:** In a case involving medical issues, the parties may submit expert testimony, reports, affidavits or medical records into record as necessary. Admission of this evidence is at the discretion of the ALJ. All parties to the hearing have the right to examine any documents which may influence the decision.

E. **Burden of proof:** HSD has the burden of proving the basis to support its proposed action by a preponderance of the evidence.

[8.352.2.17 NMAC - Rp, 8.352.2.17 NMAC, 1-1-14]

8.352.2.18 CONDUCTING THE HEARING: An administrative hearing is conducted in an orderly manner and in an informal atmosphere. The hearing is conducted telephonically and is not open to the public. The ALJ has the authority to limit the number of persons in attendance as necessary for the ALJ to control the hearing.

A. **Opening the hearing:** The hearing is opened by the ALJ. Individuals present must identify themselves for the record. The ALJ explains his or her role in conducting the hearing, that he or she will submit the record of the hearing and a recommendation, and that the final decision on the hearing will be made by the MAD director after review of the proceedings and the ALJ's recommendation. The order of testimony is described, and the oath is administered to all who will testify at the hearing.

B. **Order of testimony:** The order of testimony at the hearing is as follows:

(1) opening statements of parties or authorized representatives;

(2) presentation of HSD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by HSD authorized representative;

(b) cross examination by the claimant or the claimant's authorized representative; and

(c) opportunity to redirect the witness;

(3) presentation of the claimant's case; if witnesses are called, the order of examination of each witness is:

(a) examination by claimant or the claimant's authorized representative;

(b) cross examination by HSD or its authorized representative; and

(c) opportunity to redirect the witness;

(4) presentation of rebuttal evidence by HSD and the claimant or the claimant's authorized representative, respectively;

(5) the ALJ may direct further questions to the HSD authorized representative, claimant or the claim representative, or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask both parties to summarize and present closing arguments.

C. **Written closing argument:** At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

D. **Continuance:** The ALJ may continue the hearing upon the request of either party or on his or her own motion, for admission of additional testimony or evidence. The granting of a continuance is at the discretion of the ALJ and can only be allowed when the timeliness of a decision is not jeopardized by the continuance or the parties have agreed to an extension of the decision time frame. The reasons for the continuance must be stated for the record. Written notice of the date, time, and place of the continued hearing is sent to the parties if these are not set at the time of the approved continuance.

E. **Additional evidence:** If the ALJ needs additional evidence to further clarify documentary evidence presented during the hearing, he or she may close the hearing but keep the record open and direct the parties to submit such clarifying evidence. Each party receives a copy of the direction for further evidence and the documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within 10 calendar days of its receipt. The additional evidence and responses become part of the hearing record.

F. **Re-opening a hearing:** The ALJ, at his or her discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision time frames. Written notice of the date, time and place of the re-opened hearing is sent to the parties not less than 10 calendar days before the re-opened hearing.

[8.352.2.18 NMAC - Rp, 8.352.2.18 NMAC, 1-1-14]

8.352.2.19 HEARING DECISION: The final decision concerning the hearing is made by the MAD director after review of the record and the ALJ's report and recommendation.

A. **Decision based on the record:** The ALJ's recommendation must be based on the record created by the hearing. This includes the record of the testimony, all reports, documents, forms, and other appropriate material made available at the hearing, provided that all parties were given an opportunity to examine them as part of the hearing and the additional evidence allowed; see Section 13 Subsection E of this rule.

B. **ALJ recommendation:** The ALJ reviews the record of the hearing and all appropriate rules, and evaluates the evidence submitted. The ALJ submits the complete record of the hearing, along with his or her written recommendation to the MAD director.

(1) Content of recommendation: The ALJ specifies the reasons for his or her conclusions, identifies the supporting evidence, references the pertinent MAD rules, and responds to the arguments of the parties in a written report and recommendation.

(2) The ALJ recommends:

(a) in favor of the eligible recipient if HSD's action or proposed action is not supported by a preponderance of the evidence available as a result of the hearing. The ALJ will provide specific recommendations to each appealed adverse action.

(b) in favor of HSD, if the preponderance of the evidence available supports the adverse action or proposed adverse action; or

(c) any other result supported by the record. The ALJ will provide specific recommendations to each appealed adverse action.

C. **Review of recommendation:** The hearing file and recommendation are reviewed by the MAD director or designee to ensure conformity with applicable federal and state statutes, regulations, and rules.

D. **Final decision:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director on issues that were the subject of the hearing. The MAD director specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the hearing, applicable federal and state law, rules and policies or any combination of these. No person who participated in the original action under appeal or in the hearing may participate in arriving at a final decision.

E. **Notice to parties:** The parties receive the written decision. When the claimant is represented by legal counsel or another authorized representative, each must receive a copy of the final decision. The decision letter includes an explanation that the parties have exhausted all HSD administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.

[8.352.2.19 NMAC - Rp, 8.352.2.19 NMAC, 1-1-14]

8.352.2.20 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL OF HEARING DECISION:

A. A continuation of a benefit may be provided to a claimant who requests a hearing within 13 calendar days of issuance of HSD's *Advance Notice of Action* or within 13 calendar days of the claimant's MCO

final decision. The notice will include information on the rights to the continued benefit and on the claimant's responsibility for repayment if the hearing decision is not in his or her favor. The continuation of a benefit is only available to a claimant that is currently receiving the appealed service. The continuation of a benefit will be the same as the claimant's current allocation or LOC.

B. Repayment responsibility:

(1) When a claimant or the claimant's authorized representative appeals an issue of medical assistance program eligibility as described in 8.100.970 NMAC, has requested a continued of a benefit pursuant to timely appeal, and the hearing decision upholds HSD, the MCO or the involved contractor's proposed action, the repayment amounts will be calculated as follows:

(a) MAD month: The paid amount (paid claims amount) is owed to HSD.

(b) MCO enrolled month: HSD is owed the capitation amount plus the paid claim amount for any carved-out services.

(2) When a claimant or the claimant's authorized representative appeals a termination, modification, reduction, or suspension of a service as described in this rule, and has requested a benefit continuation pursuant to timely appeal, and the hearing decision upholds HSD, the MCO or the contractor's proposed action, the amount owed by the claimant will be calculated as follows:

(3) HSD will be owed the reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision. The MCO will be owed and is responsible to collect the reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision when the service was provided by the MCO. The repayment amount must be used by the MCO to benefit its members.

C. For SCI-enrolled claimant only: If the claimant is granted a continuation of a benefit, the notice will include information about the rights to continued benefits and about the claimant's responsibility for repayment if the hearing decision is not in the claimant's favor. If the SCI enrolled claimant has met his or her claim benefit maximums (dollars or bed days or prescriptions for the month) or has not paid premiums or paid premiums late, he or she will not be granted a continuation of a benefit. Effective January 1, 2014, a SCI enrolled claimant may only be granted a continuation of benefits if:

(1) the *advance notice of nction* was issued on or before December 31, 2013 and the claimant or the claimant's authorized representative requests a continuation of benefits within his or her 13 calendar day requirement; or

(2) the claimant or the claimant's authorized representative filed a request for an administrative hearing within 90 calendar days of the notice of action.

[8.352.2.20 NMAC - Rp, 8.352.2.20 NMAC, 1-1-14]

8.352.2.21 IMPLEMENTATION OF DECISION: The MAD director's final decision is binding on all issues that have been the subject of a hearing as to that claimant unless stayed by court order. HSD is responsible for ensuring that the final decision is fulfilled.

A. **Decision favorable to HSD, the MCO, or the involved MAD UR contractor:** If assistance or a benefit has been continued while the hearing decision was pending, and the decision is favorable to HSD, the MCO, or the involved MAD UR contractor, it will take action to file an overpayment claim to the claimant for the service received while the hearing decision was pending. A request for a hearing concerning the overpayment claim is limited to alleged computation errors. The hearing decision serves as the claimant's *Advance Notice of Action* for the resulting benefit termination, modification, reduction, or suspension. If the hearing decision is that the claimant received a benefit to which he or she was not entitled, HSD, the MCO, or the MAD UR contractor will start collection proceedings.

B. **Decision favorable to claimant:** When an administrative hearing decision is favorable to the claimant, HSD, the MCO or the MAD UR contractor will authorize the service and coverage approved in the final decision letter.

[8.352.2.21 NMAC - Rp, 8.352.2.21 NMAC, 1-1-14]

8.352.2.22 JUDICIAL APPEAL: If the final hearing decision upholds the HSD, MCO, or MAD UR contractor's original action or proposed action, the claimant or the claimant's authorized representative has the right to pursue judicial review of the decision and is so notified of that right in the HSD final decision letter. Judicial appeals for the final decision letter are governed by New Mexico statutes and court rules. While the following subsections highlight applicable procedures, they should not be considered a substitute for examining the statutes and rules themselves.

A. **Jurisdiction:** Administrative appeals for a claimant are governed by the NMSA 1978 Section 39-3-1.1 and by Rule 1-074, Rules of Civil Procedures for the District Courts. The appropriate venue for such appeals is the first judicial district court, or the state district court having jurisdiction over the location the claimant's participated in the hearing in person or telephonically.

B. **Timeliness:** Unless otherwise provided by law, a claimant or the claimant's authorized representative must appeal the final decision letter within 30 calendar days by filing a notice of appeal with the clerk of the appropriate state district court, and sending a copy to the HSD office of general counsel (OGC).

C. **Jurisdiction and standard of review:** All judicial appeals are based on the record made at the administrative hearing, and in accordance with state statute and court rules. The HSD OGC files a copy of the hearing record with the court clerk and furnishes one copy to the claimant within 30 calendar days after receipt of the notice of appeal. The court may set aside the HSD hearing decision if it finds the decision is: (1) arbitrary, capricious, or an abuse of discretion; (2) is not supported by substantial evidence in the record as a whole; or (3) is otherwise not in accordance with the applicable law.

D. **Benefits pending appeal:** The filing of a notice of appeal shall not stay the enforcement of the HSD decision, but the claimant or the claimant's authorized representative may seek a stay upon motion to the court. If the court orders a stay, HSD, the MCO or the MAD UR contractor will maintain the service at issue in accordance with the court's order. If the final decision is in favor of HSD, and a termination, modification, reduction, or suspension of service was pending the decision on appeal, see Section 19 of this rule for the repayment process.
[8.352.2.22 NMAC - Rp, 8.352.2.22 NMAC, 1-1-14]

HISTORY OF 8.352.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records-State Records Center and Archives:
SP-004.0200 Section 4, General Program Administration Hearing For Applicants, 1/23/81
SP-004.2800 Section 4, General Program Administration Appeals Process For Skilled Nursing Facilities And Intermediate Care Facilities, 3/5/81
NMAC History: 8 NMAC 4.MAD.970 Oversight Policies, Recipient Hearing Policies, Recipient Hearings, 10/16/96
8 NMAC 4.MAD.970 Oversight Policies, Recipient Hearing Policies, Recipient Hearings; 12/15/99.

History of Repealed Material: [RESERVED]
8.352.2 NMAC, Recipient Hearings, filed xx-xx-xx - Repealed effective, 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 352 ADMINISTRATIVE HEARINGS
PART 3 PROVIDER HEARINGS

8.352.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.352.3.1 NMAC - N, 1-1-14]

8.352.3.2 SCOPE: The rule applies to the general public.
[8.352.3.2 NMAC - N, 1-1-14]

8.352.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.352.3.3 NMAC - N, 1-1-14]

8.352.3.4 DURATION: Permanent.
[8.352.3.4 NMAC - N, 1-1-14]

8.352.3.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.352.3.5 NMAC - N, 1-1-14]

8.352.3.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.352.3.6 NMAC - N, 1-1-14]

8.352.3.7 DEFINITIONS: [RESERVED]

8.352.3.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.352.3.8 NMAC - N, 1-1-14]

8.352.3.9 PROVIDER ADMINISTRATIVE HEARINGS: With the exception of referrals for credible allegations of fraud, HSD has established a hearing process for MAD fee-for-service (FFS) providers who disagree with its decision concerning his or her participation as a MAD provider, recoupment of overpayments due to a provider billing error, and the imposition of MAD sanctions. For the provider administrative hearing process concerning decisions on noncompliance with nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) provider certification requirements also see hearing regulations promulgated by the department of health (DOH) and specific MAD New Mexico administrative code (NMAC) rules applicable to the provider. See 8.311.3 NMAC, 8.312.2 NMAC, and 8.313.3 NMAC for a detailed description of the appeals process for audit settlements. See 8.308.14 NMAC for a detailed description of the grievance and appeal process for resolving provider disputes between a HSD contracted managed care organization (MCO) and its contractor or subcontractor. For applicable rules for services and items provided through a MAD coordinated service contractor, see 8.349.2 NMAC.

A. **Provider administrative hearing rights:** The right to a provider administrative hearing includes the right to:

(1) be advised of the nature and availability of a provider administrative hearing;
(2) be represented by his or her authorized representative or legal counsel;
(3) have a provider administrative hearing which safeguards the provider's opportunity to present a case;
(4) have prompt notice and implementation of the final provider administrative hearing decision; and
(5) be advised that judicial review may be invoked to the extent such review is available under state law.

B. **Notice of rights:** Upon enrollment, a MAD provider receives written notice of provider administrative hearing rights along with any MAD action notice concerning provider participation agreement (PPA) termination, recoupment of overpayment due to provider billing error, or notice of sanction. This information

includes a description of the method by which a provider administrative hearing may be requested and a statement that the provider's presentation may be made by the provider or by his or her authorized representative or legal counsel.
[8.352.3.9 NMAC - N, 1-1-14]

8.352.3.10 INITIATION OF FFS PROVIDER ADMINISTRATIVE HEARING PROCESS:

A. **Notice:** When applicable, the provider administrative hearing process is initiated by a provider's request for hearing made in response to a MAD action notice. See Section 8.351.2 NMAC-for a detailed description of notice requirements when the action is a MAD sanction.

B. **Time limits:** A MAD FFS provider has 30 calendar days from the date of the MAD action notice to request a provider administrative hearing. To be considered timely, the request must be received by the HSD fair hearings bureau (FHB) no later than the close of business of the 30th day. Provider administrative hearings are conducted and a written decision is issued by the MAD director or designee to the provider within 120 calendar days from the date the FHB receives the provider administrative hearing request, unless the parties otherwise agree to an extension. See 8.351.2 NMAC for information concerning time limits when the action is a MAD sanction. The right to request a stay is cited in 8.351.2.15 NMAC.

C. **Scope and limits on provider administrative hearings:**

(1) A provider administrative hearing is available to all MAD FFS providers, including providers applying for electronic health record incentive payments, who submit a request in accordance with all sections of this rule. A provider can request a hearing if:

(a) his or her PPA or renewal of his or her PPA is denied;

(b) the provider's MAD participation is suspended or terminated; or

(c) the provider disagrees with a decision of MAD or its designee with respect to recovery of overpayments due to provider billing error including incorrect billing, or lack of documentation to support the medical necessity of a service, or that the service was provided, or imposition of a sanction or other remedy, with the exception of a temporary payment suspension for credible allegations of fraud; or

(d) the provider believes the requirements for timely filing of a claim as stated in 8.302.2 NMAC were met but a decision by MAD has been made that the timely filing requirements were not met.

(2) **Denial or dismissal of request for provider administrative hearing:** The assigned fair hearing FHB's administrative law judge (ALJ) may recommend to the MAD director in writing to deny or dismiss a provider's request for an administrative hearing when:

(a) the request is not received within the time period stated in the notice;

(b) the request is withdrawn or canceled in writing by the provider, the provider's authorized representative or legal counsel;

(c) the sole issue presented concerns a federal or state [~~law~~] statute, regulation or rule which requires an adjustment of compensation for all or certain classes of FFS providers or services unless the reason for the provider administrative hearing request involves an alleged error in the computation of a provider's compensation;

(d) the provider fails to appear at a scheduled provider administrative hearing without good cause. A request for a provider administrative hearing may be considered abandoned and therefore dismissed if the provider, his or her authorized representative or legal counsel fails to appear at the time and place of the hearing, unless, within 10 calendar days after the date of the scheduled provider administrative hearing, the provider presents good cause for failure to appear. Good cause includes death in the family, disabling personal illness, or other significant emergencies. At the discretion of the ALJ, other exceptional circumstances may be considered good cause;

(e) the same issue has already been appealed or decided upon as to this provider and fact situation;

(f) the matter presented for the provider administrative hearing is outside the scope of issues which are subject to the HSD provider administrative hearing process;

(g) the sole issue presented concerns a HSD contracted MCO or its subcontractor's utilization management decision, such as a decision to terminate, suspend, reduce, or deny services to its member, untimely utilization review, and provider payment issues raised by the MCO or its subcontractor; or

(h) the sole issue presented is regarding a MAD New Mexico administrative code (NMAC) rule rather than the application of the MAD NMAC rule to that provider.

D. **Method:** A request for a provider administrative hearing must be made in writing and must identify the provider and the one or more of the actions stated in Subsection C of this Section and rule.

E. **Acknowledgment of request:** The FHB sends acknowledgment of its receipt of a provider administrative hearing request to the provider in writing, as well as sends an electronic copy via email to the MAD designated administrative hearing staff.
[8.352.3.10 NMAC - N, 1-1-14]

8.352.3.11 PRE-HEARING PROCEDURE:

A. **Notice of hearing:** Not less than 30 calendar days before the provider administrative hearing, written notice is given to all parties involved of the time, date, and place of the hearing. If an accommodation is necessary, the party must notify the assigned ALJ at least 10 calendar days prior to the hearing. The FHB includes in its written notice to the provider an explanation of the HSD provider administrative hearing process and procedures, and informs the provider HSD does not pay fees or costs incurred by the provider as a result of the provider administrative hearing or district court appeals of the final HSD provider administrative hearing decision.

B. **Postponement:** A provider may request, and is entitled to receive, one postponement of the scheduled provider administrative hearing, as long as it does not interfere with the 120 calendar day timeframe. Requests for more than one postponement are considered on a case-by-case basis at the ALJ's discretion.

C. **Expedited hearing:** The parties may request an expedited hearing in cases involving a medical assistance program (MAP) eligible recipient's health, safety, or service availability concerns. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. Granting an expedited hearing is at the discretion of the ALJ.

D. **Group hearing:** The ALJ may respond to a series of individual requests for hearings by conducting a single group hearing. In all group hearings, the HSD administrative hearing process governing an individual hearing is followed. Each provider, his or her authorized representative or legal counsel may present his or her case individually. If a group hearing is arranged, each affected provider has the right to withdraw from the group hearing in favor of an individual HSD provider administrative hearing.

E. **Informal resolution conference:** The parties are encouraged to hold an informal resolution conference before the provider administrative hearing to discuss the issues involved in the hearing. The informal resolution conference is optional and does not delay or replace the provider administrative hearing process. Conference participants may include the provider, his or her authorized representative or legal counsel, MAD or other responsible agency representatives, and the MAD selected claims and provider enrollment processing contractor. The purpose of the informal resolution conference is to informally review MAD's action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the provider administrative hearing may also be clarified or further defined. Regardless of the outcome of the informal resolution conference, a provider administrative hearing is still held, unless the provider submits a written withdrawal of the request of the provider administrative hearing.

F. **Pre-hearing conference:** The assigned ALJ schedules a pre-hearing conference within 30calendar days of the receipt of the provider's request for a HSD provider administrative hearing. A pre-hearing conference is an informal proceeding and may occur telephonically.

(1) **Purpose of conference:** The purposes of the pre-hearing conference include, but are not limited to:

(a) expediting the disposition of the action;
(b) identification, clarification, formulation and simplification of issues;
(c) resolution of some or all issues;
(d) exchange of documents and information;
(e) preparing stipulations of fact to avoid unnecessary introduction of evidence at the hearing;
(f) review of audit findings;
(g) reconsideration of a suspension or withholding of payments;
(h) identifying the number of witnesses; and
(i) facilitating the settlement of the case.

(2) **Scheduling:** A scheduling order shall be entered into, which shall set the due date for the summary of evidence (SOE), due date for exhibits, and sets the date for the provider administrative hearing. The order shall be issued as soon as practicable, but in any event within 30 calendar days of the request for provider administrative hearing.

(3) **Continuations and rescheduling:** A pre-hearing conference may be continued or rescheduled with the consent of all parties after the 30 calendar day time limit.

(4) **Settlements, stipulations and admissions:** No offer of settlement made in a pre-hearing conference is admissible as evidence at the later provider administrative hearing. Stipulations and admissions are

binding and may be used as evidence at the provider administrative hearing. Any stipulation, settlement or consent order reached between the parties is written and signed by the ALJ and all parties to the provider administrative hearing.

(5) **Timeliness:** The pre-hearing conference will not delay or replace the provider administrative hearing itself. Pre-hearing conferences may include the provider, his or her authorized representative or legal counsel, MAD or other responsible agency representatives, and the MAD selected claims and provider enrollment processing contractor. Subsequent to the conference or in the event that any of the parties to the provider administrative hearing fail to participate, the scheduled hearing is still held, unless the provider submits a written request for withdrawal.

(6) **Unresolved issues:** If all matters in controversy are not resolved at the pre-hearing conference, the ALJ sets a provider administrative hearing date within 30 calendar days of the last conference date, or at a later time agreed to by all parties, recognizing the 120 calendar day timeframes.

(7) **Written summaries:** The ALJ may request the parties to submit a written summary of all issues resolved at the pre-hearing conference.

(8) **Pre-hearing order:** The may, at his or her sole discretion, prepare or ask the parties to prepare a pre-hearing order. The pre-hearing order may contain:

(a) statements of any contested facts and issues;
(b) stipulation of matters not in dispute;
(c) list of witnesses to be called and the subject of their testimony;
(d) list of exhibits;
(e) discovery directives; or
(f) other matters relevant to the issues.

(9) **Points of law:** The ALJ may direct the parties to submit memoranda on points of law to inform the final decision, and may dictate the length and scope of the submissions.

G. **Summary of evidence (SOE):** A summary of evidence (SOE) is a document submitted by MAD that provides preliminary information concerning the basis of its or its selected claims and provider enrollment processing contractor's action. The SOE may be amended by MAD at any point prior to the pre-hearing if the ALJ and the provider, his or her authorized representative or legal counsel receives copies of the amended SOE at least two working days of the pre-hearing conference.

(1) The SOE must be provided at least 10 working days prior to the pre-hearing conference or if the pre-hearing conference is not held, within 10 working days prior to the scheduled provider administrative hearing date.

(2) The failure of MAD to timely provide the SOE may, at the ALJ's discretion, result in its exclusion or a continuance of the hearing.

(3) MAD staff or its designee is responsible for the preparation of the SOE and coordination of parties and witnesses. MAD is responsible for the submission of the SOE to all parties.

(4) The summary of evidence shall contain:

(a) the provider's name, telephone number and address and the status of any previous or concurrent appeal through the MAD or its selected claims and provider enrollment processing contractor;
(b) the action, proposed action or inaction being appealed;
(c) information on which the action or proposed action is based with supporting documentation and correspondence; and
(d) applicable federal and state law, regulations, statutes, rules or any combination of these.

H. **Availability of provider evidence:**

(1) The provider, his or her authorized representative or legal counsel will provide at least ten calendar days prior to the hearing to the FHB assigned ALJ any document to be introduced as evidence at the pre-hearing conference. The SOE may be amended by the provider, his or her authorized representative or legal counsel at any point prior to the pre-hearing if the ALJ and MAD receive copies of the amended SOE at least within two working days of the pre-hearing conference. The FHB will forward to the MAD administrative hearings unit copies of such evidence. MAD will then make these available to its selected claims and provider enrollment processing contractor.

(2) Failure of the provider, his or her authorized representative or legal counsel to timely provide the documentary evidence may result in its exclusion or a continuance of the provider administrative hearing at the discretion of the ALJ.

I. **Availability of information:** MAD must:

(1) provide, on request, in a timely manner and without charge, any documents in its possession concerning the underlying action, that are not already in the provider's possession, and that are necessary for a provider to decide whether to request a hearing or to prepare for a provider administrative hearing; and

(2) allow the provider, his or her authorized representative or legal counsel to examine all documents to be used at the provider administrative hearing at a reasonable time before the date of the h provider administrative hearing and during such hearings. Documents or records which the provider would not otherwise have an opportunity to challenge or contest, may not be introduced at the provider administrative hearing or be taken inot considered by the ALJ.

[8.352.3.11 NMAC - N, 1-1-14]

8.353.3.12 HEARING STANDARDS:

A. **Rights at hearing:** The parties are given an opportunity to:

(1) present their case or have it presented by his or her authorized representative or legal counsel;

(2) bring witnesses to present information relevant to the case;

(3) submit evidence to establish all pertinent facts and circumstances in the case;

(4) advance arguments without undue interference; and

(5) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

B. **ALJ:** Hearings are conducted by an impartial official, the ALJ, who:

(1) does not have any personal stake or involvement in the case; and

(2) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify him or herself as the ALJ for that specific case.

(3) **Authority and duties of the ALJ:** The ALJ must:

(a) explain how the provider administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence considered necessary to decide the issues raised;

(d) regulate the conduct and the course of the provider administrative hearing and any pre-hearing conference to ensure an orderly hearing;

(e) request, if appropriate, an independent medical assessment or professional evaluation from a source mutually satisfactory to the parties; and

(f) produce the provider administrative hearing report and recommendation for review and final decision by the MAD director or designee.

(4) **Appointment of ALJ:** The ALJ is appointed by the HSD FHB chief upon receipt of the request for hearing. All communications are to be addressed to the assigned ALJ.

C. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) **Admissibility:** All evidence is admissible subject to the ALJ's authority to limit irrelevant, repetitive or unduly cumulative evidence and his or her ability to conduct an orderly hearing. The ALJ must admit evidence that is relevant to those allegations against the provider included in the notice of recovery of overpayment, sanction or other remedy, application denial, or application termination.

(2) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the provider administrative hearing in the presence of the provider, his or her authorized representative or legal counsel, and the MAD representative may not be used by the ALJ in making the provider administrative hearing recommendation except as allowed by Section 13 Subsection E of this rule.

(3) **Administrative notice:** The ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(4) **Privilege:** The rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(5) **Medical issues:** In a case involving medical and behavioral health issues, the parties may submit expert testimony, reports, affidavits or medical and behavioral health records into record as necessary. Admission of this evidence is at the discretion of the ALJ. All parties to the provider administrative hearing have the right to examine any documents which may influence the decision.

D. **Burden of proof:** MAD has the burden of proving the basis to support its proposed action by a preponderance of the evidence. In cases involving the imposition of civil money penalties against a NF provider, MAD's conclusion about the NF's level of noncompliance must be upheld unless clearly erroneous.

E. **Record of the provider administrative hearing:** A hearing is electronically recorded. The recording is placed on file at the FHB and is available to the parties for 60 calendar days following the decision. In addition to the recorded proceedings, the record of the provider administrative hearing includes any pleadings, documents, or other exhibits admitted into evidence. Any of the parties to the provider administrative hearing may request one digital copy of the recordings without charge. Subsequent copies will be charged at a rate HSD sets for any other digital request.

[8.352.3.12 NMAC - N, 1-1-14]

8.352.3.13 CONDUCTING THE HEARING: A provider administrative hearing is conducted in an orderly manner and in an informal atmosphere. The provider administrative hearing is conducted in person or telephonically and is not open to the public. The ALJ has the authority to limit the number of persons in attendance if space or other considerations dictate.

A. **Opening the provider administrative hearing:** The hearing is opened by the ALJ. Individuals present must identify themselves for the record. The ALJ explains his or her role in the proceedings, and that the final decision on the appeal will be made by the MAD director after review of the proceedings and the ALJ's recommendation. The order of testimony is described, and the oath is administered to all who will testify at the hearing.

B. **Order of testimony:** The order of testimony at the provider administrative hearing is as follows:

(1) opening statements of parties or their representatives;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by the MAD representative;

(b) cross examination by the provider, his or her authorized representative or legal counsel; and

(c) opportunity to redirect the witness;

(3) presentation of the provider's case; if witnesses are called, the order of examination of each witness is:

(a) examination by provider, his or her authorized representative or legal counsel;

(b) cross examination by MAD or its selected claims and provider enrollment processing contractor; and

(c) opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD and provider, respectively;

(5) the ALJ may direct further questions to the MAD representative, the provider, or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask parties to summarize and present closing arguments.

C. **Written closing argument:** At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

D. **Continuance:** The ALJ may continue the provider administrative hearing upon the request of either party or on his or her own motion, for admission of additional testimony or evidence. The granting of a continuance is at the discretion of the ALJ and can only be allowed when the timeliness of a decision is not jeopardized by the continuance or the parties have agreed to an extension of the decision time frame. The reasons for the continuance must be stated for the record. Written notice of the date, time, and place of the continued hearing is sent to the parties if these are not set at the time of the continuance.

E. **Additional evidence:** If the ALJ needs additional evidence to further clarify documentary evidence presented during the hearing, he may close the hearing but keep the record open and direct the parties to submit such clarifying evidence. Each party receives a copy of the direction for further evidence and the documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within 10 calendar days of its receipt. The additional evidence and responses become part of the hearing record.

F. **Re-opening a hearing:** The ALJ, at his or her discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a provider administrative hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision timeframes. Written notice of the date, time and place of the re-opened hearing is sent by the FHB to the parties not less than 10 calendar days before the date of the re-opened provider administrative hearing.

[8.352.3.13 NMAC - N, 1-1-14]

8.352.3.14 HEARING DECISION: The final HSD provider administrative hearing decision concerning the hearing is made by the MAD director or designee after review of the record and the ALJ's report and recommendation.

A. **Decision based on the record:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director or designee specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, regulations and MAD NMAC rules, policies and instructions or any combination of these. No person who participated in the original action under appeal or in the provider administrative hearing may participate in arriving at a final decision.

B. **ALJ recommendation:** The ALJ reviews the record of the provider administrative hearing and all applicable federal and state law, regulations and MAD NMAC rules, policy and instructions or any combination of these, and evaluates the evidence submitted. The ALJ submits the complete record of the hearing, along with his or her written recommendation to the MAD director.

(1) Content of recommendation. The ALJ specifies the reasons for his or her conclusions, identifies the supporting evidence, references the applicable federal and state law, regulations and MAD NMAC rules, policies and instructions or any combination of these, and responds to the arguments of the parties in a written report and recommendation.

(2) The ALJ recommends:

(a) in favor of the provider if MAD's action or proposed action is not supported by a preponderance of the evidence available as a result of the provider administrative hearing;

(b) in favor of MAD, if the preponderance of the evidence available supports the action or proposed action; or

(c) any other result supported by the record.

C. **Review of recommendation:** The provider administrative hearing file and recommendation are reviewed by the MAD director or designee to ensure conformity with applicable federal and state law, regulations and MAD NMAC rules, policies and instructions or any combination of these.

D. **Final decision:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, rules and policies or any combination of these. No person who participated in the original action under appeal or in the hearing may participate in arriving at a final decision.

E. **Notice to parties:** The parties receive the written decision, including the effective date of sanctions, terms of sanctions, and amounts of overpayment to be recovered by MAD. When the provider is represented by legal counsel, counsel must receive the decision. The notice of the decision includes an explanation that the parties have exhausted all administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.

[8.352.3.14 NMAC - N, 1-1-14]

8.352.3.15 IMPLEMENTATION OF DECISION: The final HSD provider administrative hearing decision is binding on all issues that were the subject of a hearing, as to the provider, unless stayed by court order pending appeal. The decision is implemented within the time frames specified below.

A. **Decision favorable to HSD:** Decisions favorable to MAD are implemented immediately, unless stayed by court order.

B. **Decision favorable to provider:** If the decision is in favor of the provider, MAD must immediately lift any sanctions in place and remit to the provider any funds being held pending the decision.

[8.352.3.15 NMAC - N, 1-1-14]

8.352.3.16 JUDICIAL REVIEW:

A. **Right of appeal:** If the final HSD provider administrative hearing decision upholds MAD's original action or proposed action, the provider has the right to pursue judicial review of the decision and is so notified of that right in the decision.

B. **Timeliness:** The provider has 30 calendar days from the date of the provider administrative hearing decision to appeal that decision by filing an appropriate action for judicial review with the clerk of the first judicial district court and sending a copy of the notice of action to HSD and the ALJ.

C. **Jurisdiction and standard:** All appeals to the district court are based on a review of the record made at the hearing. The HSD office of general counsel files one copy of the hearing record with the clerk of the first judicial district court and furnishes one copy to the provider and his or her counsel within 20 calendar days after receipt of the notice of appeal.

D. **Stay pending appeal:** The district court decides, upon motion duly filed, whether the filing of the appeal will operate as a stay of the HSD final provider administrative hearing decision. If a stay is granted, the office of general counsel notifies appropriate staff concerning any necessary action.

[8.352.3.16 NMAC - N, 1-1-14]

HISTORY OF 8.352.3 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]