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8.302.4 OUT-OF-STATE AND BORDER AREA PROVIDERS

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

8.302.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.302.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1 & A, 8/14/08]

8.302.4.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.302.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 8/14/08]

8.302.4.3 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 the Social Security Act as amendedor by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[2/1/95; 8.302.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3 & A, 8/14/08; A, 11/1/10]

8.302.4.4 DURATION: Permanent
[2/1/95; 8.302.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 8/14/08]

8.302.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.302.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 8/14/08]

8.302.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.302.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6 & A, 8/14/08; A, 11/1/10]

8.302.4.7 DEFINITIONS: [RESERVED]

8.302.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2/1/95; 8.302.4.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 8/14/08; A, 11/1/10]

8.302.4.9 OUT-OF-STATE AND BORDER AREA PROVIDERS: Border area services are those that are rendered within 100 miles of the New Mexico state border (Mexico excluded). Out-of-state services are those that are rendered in an area more than 100 miles from the New Mexico border (Mexico excluded). To help New Mexico eligible recipients receive medically necessary services, the medical assistance division (MAD) pays for border area services to the same extent and subject to the same rules and requirements that such services are covered when provided within the state. MAD pays for out-of-state services as described under 8.302.4.12 NMAC, *covered out-of-state services.*
[2/1/95; 8.302.4.9 NMAC - Rn, 8 NMAC 4.MAD.704 & A, 8/14/08; A, 11/1/10]

8.302.4.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic

funds transfer (EFT) only. The providers listed in Subsections A-C of 8.302.4.10 NMAC, *eligible provider*, are eligible for a provider participation agreement, bill and receive reimbursement for furnishing medical services:

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

B. Eligible providers include border area providers within 100 miles of the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider.

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

[2/1/95; 8.302.4.10 NMAC - Rn, 8 NMAC 4.MAD.704.1 & A, 8/14/08; A, 11/1/10]

8.302.4.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicaid and medicare (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[2/1/95; 8.302.4.11 NMAC - Rn, 8 NMAC 4.MAD.704.2 & A, 8/14/08; A, 11/1/10]

8.302.4.12 COVERED OUT-OF-STATE SERVICES: MAD covers services and procedure furnished by a provider located within 100 geographical miles of the New Mexico border, even though the road miles may be greater than 100 miles, to the same extent and using the same coverage rules as for an in-state provider. See 8.302.4.9 NMAC, *out of state and border area providers*. When it is the general practice for an eligible recipient in a New Mexico locality to access medical services in a location more than 100 geographical miles from the New Mexico border, MAD will treat that out-of-state location as a border area. MAD covers services and procedures furnished by a provider more than 100 geographical miles from the New Mexico border, excluding Mexico, to the extent and using the same coverage rules as for in-state provider when one or more of the following conditions are met.

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

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

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

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

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

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

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

[2/1/95; 8.302.4.12 NMAC - Rn, 8 NMAC 4.MAD.704.3 & A, 8/14/08; A, 11/1/10]

8.302.4.13 NONCOVERED SERVICES: Services furnished by an out-of-state or border provider are subject to the limitations and coverage restrictions which exist for other services rendered in-state as stated in the relevant administrative, provider, and other services sections of the MAD program policy manual. In addition, MAD programs do not cover the following specific services when furnished by an out-of-state or border provider:

A. services furnished outside the boundaries of the United States; and

B. services furnished in an out-of-state or border area nursing facility or intermediate care facility for the mentally retarded.

[2/1/95; 8.302.4.13 NMAC - Rn, 8 NMAC 4.MAD.704.4 & A, 8/14/08]

8.302.4.14 OUT-OF-STATE HOSPITAL SERVICES: All out-of-state hospital, and other residential service claims are subject to prepayment review or periodic re-authorization by MAD or its designee for medical necessity and length of stay, in addition to requiring authorization for the initial placement.

[2/1/95; 8.302.4.14 NMAC - Rn, 8 NMAC 4.MAD.704.32 & A, 8/14/08]

8.302.4.15 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, *Prior Authorization and Utilization Review*. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. Prior authorization: Certain procedures or services can require prior approval from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through an out-of-state or border provider is subject to the same prior authorization and utilization review requirements, which exist for the service when not provided out-of-state.

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

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

[2/1/95; 8.302.4.15 NMAC - Rn, 8 NMAC 4.MAD.704.5 & A, 8/14/08]

8.302.4.16 OUT-OF-STATE BILLING OFFICES: Services furnished within the state or border areas are subject to the rules for in-state providers even if the billing or administrative office is outside the state.

[2/1/95; 8.302.4.16 NMAC - Rn, 8 NMAC 4.MAD.704.5 & A, 8/14/08]

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

A. Unless payment for a service is made using a diagnosis related group or outpatient prospective payment system rate, reimbursement to a provider for covered services is made at the lesser of the following:

(1) the billed change which must be the provider's usual and customary charge for service; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service; or

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

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

[2/1/95; 8.302.4.17 NMAC - Rn, 8 NMAC 4.MAD.704.6 & A, 8/14/08; A, 11/1/10]

HISTORY OF 8.302.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 303.1000, Covered Services, filed 1/7/80.
ISD 303.1000, Covered Services, filed 4/2/82.
MAD Rule 303, Benefits, filed 11/8/89.
MAD Rule 303, Benefits, filed 4/17/92.
MAD Rule 303, Benefits, filed 3/10/94.
SP-004.1700, Section 4, General Program Administration Liens and Recoveries, filed 3/5/81.

History of Repealed Material:
MAD Rule 303, Benefits, filed 3/10/94 - Repealed effective 2/1/95.