INDEX

8.302.5 PRIOR AUTHORIZATION AND UTILIZATION REVIEW

This page intentionally left blank

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 5 PRIOR AUTHORIZATION AND UTILIZATION REVIEW

8.302.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.302.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 1/1/04]

8.302.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.302.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 1/1/04]

8.302.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.302.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 1/1/04]

8.302.5.4 DURATION: Permanent
[2/1/95; 8.302.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 1/1/04]

8.302.5.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.302.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 1/1/04]

8.302.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.302.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 1/1/04]

8.302.5.7 DEFINITIONS: [RESERVED]

8.302.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.302.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 1/1/04]

8.302.5.9 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: The New Mexico human services department's medical assistance division (MAD) has developed a utilization review process to regulate provider compliance with medicaid quality control and cost containment objectives. See 42 CFR Section 456, *Utilization Control*. This part describes medical necessity requirements, general utilization review processes and types of utilization reviews that may be used by MAD. Specific details pertinent to a service or a provider are contained in program policies or utilization review instructions for that specific service or provider type. Once enrolled, providers receive a packet of information including medicaid program policies, billing instructions, utilization review instructions, medical necessity criteria, and prior authorization forms. It is the provider's responsibility to understand the information provided and comply with the requirements.
[2/1/95, 11/1/96; 8.302.5.9 NMAC - Rn, 8 NMAC 4.MAD.705 & A, 1/1/04]

8.302.5.10 MEDICAL NECESSITY REQUIREMENTS: The New Mexico medicaid program (medicaid) reimburses providers for furnishing covered services to medicaid recipients only when the services are medically necessary. Medical necessity is required for the specific service, level of care, and service setting, if relevant to the service. Providers must verify that medicaid covers a specific service and that the services are medically necessary prior to furnishing services. Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service(s) that are reviewed and approved by MAD. Medicaid denies payment for services that are not medically necessary and for services that are not covered by medicaid. The process for determining medical necessity is called utilization review. Utilization review (UR) of medicaid services may be performed directly by MAD, another state agency designated by MAD, or as contracted by MAD.
[2/1/95, 11/1/96; 8.302.5.10 NMAC - Rn, 8 NMAC 4.MAD.705.1 & A, 1/1/04; A, 9/1/05]

8.302.5.11 TIMING OF UTILIZATION REVIEW:

A. Utilization review may be performed at any time during the service, payment, or post payment processes. In signing the medicaid provider agreement, providers agree 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:

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

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

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

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

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

B. **Prior authorization reviews:** Claims for services that require 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 recipient and the date(s) the service(s) must be provided.

(1) Prior authorization does not guarantee that individuals are eligible for medicaid benefits. Providers must verify that individuals are eligible for medicaid at the time services are furnished.

(2) Information on the specific service(s) or procedure(s) that require prior authorization for a specific provider type are contained in the applicable policy sections and/or the utilization review instructions for that provider type or service.

(3) Services that have 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.

(4) Prior authorization reviews are used to authorize service for eligible recipients before services are furnished. Requests for retroactive prior authorization may be approved only under the following circumstances.

(a) approval is made as part of the process of determining medicaid eligibility for certain categories, such as institutional care medicaid or home and community-based services waiver (HCBSW) programs. In these situations, the determination of medical necessity for an institutional care level of the service is a factor in establishing medicaid eligibility and may be made after the individual receives nursing facility or HCBSW services;

(b) the service is furnished before the determination of the effective date of the recipient's eligibility for medicaid or the servicing provider's medicaid participation agreement. Retrospective requests for prior authorization based on retrospective recipient or provider eligibility must be received in writing by MAD or its designee within thirty (30) calendar days of the date of the eligibility determination;

(c) 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.

(i) an individual's death;

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

(iii) serious impairment of bodily functions; or

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

(d) services that are furnished to a medicare recipient who is also eligible for medicaid and medicare has denied payment for a reason that is not based on medical necessity. Requests for retroactive prior authorization must be accompanied by a copy of the document from medicare that denied payment and states the reason(s) for denial. Services denied payment by medicare because of lack of medial necessity are not covered by medicaid.

C. **Concurrent reviews:** Concurrent reviews are conducted while the service is being furnished. Continued stay or continued service reviews are concurrent reviews for medical necessity.

D. **Prepayment reviews:** Prepayment reviews are conducted after services have been furnished and claims for payment have been filed by providers. If a service is not a covered medicaid benefit or not medically necessary, payment for that service will be denied.

E. **Retrospective review:** Retrospective reviews are conducted after the claim has been processed and payment is made. Information from the paid claim is compared with the provider records detailing the services and medical necessity.

(1) If MAD determines that the services specified on the claim were not performed or, were not a covered benefit or were not medically necessary, the MAD payments are recouped.

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

(3) Retrospective reviews 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 providers and/or the assignment of a recipient to a medical management designated provider.

(4) Selective or scheduled reviews are conducted to focus on the overutilization and underutilization of a specific service or provider. The services or procedures selected for this focused retrospective review are identified by MAD as potential or actual problems.

[2/1/95; 11/1/96; 8.302.5.11 NMAC - Rn, 8 NMAC 4.MAD.705.2 & A, 1/1/04]

8.302.5.12 DENIAL OF PAYMENT: If a service or procedure is not medically necessary or not a covered medicaid benefit, 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.

[2/1/95; 8.302.5.12 NMAC - Rn, 8 NMAC 4.MAD.705.3 & A, 1/1/04]

8.302.5.13 REVIEW OF DECISIONS: Providers who disagree with prior authorization request denials or other review decisions may request a re-review and a reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.* Providers who are not satisfied with a reconsideration determination may request an administrative hearing. See 8.353.2 NMAC, *Provider Hearings.*

[2/1/95; 8.302.5.13 NMAC - Rn, 8 NMAC 4.MAD.705.4 & A, 1/1/04]

HISTORY OF 8.302.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
SP-004.0400, Section 4, General Program Administration Medicaid Quality Control, filed 1/23/81.
SP-003.0103, Standards and Methods for Assuring High Quality Care, filed 1/27/81.
SP-004.1400, Section 4, General Program Administration Utilization Control, filed 3/3/81.

History of Repealed Material: [RESERVED]