

**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).  
[8.302.2.1 NMAC - Rp, 8.302.2.1 NMAC, xx-xx-17]

**8.302.2.2 SCOPE:** The rule applies to the general public.  
[8.302.2.2 NMAC - Rp, 8.302.2.2 NMAC, xx-xx-17]

**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 (HHS) under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.  
[8.302.2.3 NMAC - Rp, 8.302.2.3 NMAC, xx-xx-17]

**8.302.2.4 DURATION:** Permanent.  
[8.302.2.4 NMAC - Rp, 8.302.2.4 NMAC,]

**8.302.2.5 EFFECTIVE DATE:** January 1, 2014, unless a later date is cited at the end of a section.  
[8.302.2.5 NMAC - Rp, 8.302.2.5 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).  
[8.302.2.6 NMAC - Rp, 8.302.2.6 NMAC, xx-xx-17]

**8.302.2.7 DEFINITIONS:**

**A.** “Authorized representative” means the individual designated to represent and act on behalf of the eligible recipient or member’s behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient or member.

**B.** “Eligible recipient” means an individual who has met a medical assistance program (MAP) category of eligibility and receives his or her medical assistance division (MAD) services through the fee-for-service (FFS) program.

**C.** “Member” means a MAP eligible recipient and who receives his or her MAD services through a HSD contracted managed care organization (MCO).

**D.** “Co-payment” means a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be charged at the time of service or receipt of the item.  
[8.302.2.7 NMAC – Rp, 8.302.7 NMAC, xx-xx-17]

**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.~~] **RESERVED**  
[8.302.2.8 NMAC - Rp, 8.302.2.8 NMAC, 1-1-14]

**8.302.2.9 BILLING FOR MEDICAID SERVICES:** Health care for New Mexico medical assistance program MAP eligible recipients and members 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~~] HSD 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, service standards, 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] HSD 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, service standards, 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, rules, billing instructions, service standards, UR 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. See 8.308.14 NMAC for additional MCO provider responsibilities. [8.302.2.9 NMAC - Rp, 8.302.2.9 NMAC, xx-xx-17]

**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 MCO or the MAD (FFS) 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 MAP 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, member or his or her 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.

<b>time spent</b>	<b>number of 15-minute units that may be billed</b>	<b>number of 1-hour units that may be billed</b>
Less than 8 minutes	0	0
	<i>services that are in their</i>	<i>services that are in their</i>

	<i>entirety less than 8 minutes cannot be billed.</i>	<i>entirety less than 8 minutes cannot be billed</i>
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 or member 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 or member. 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 centers for medicare and medicaid services (CMS) national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to 8.310.3 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 requires co-payments for specific categories of medicaid beneficiaries for certain types of covered services. Some exemptions and limitations apply to the collection of co-payments as set forth in Subparagraphs (2) and (3) below.

(1) The chart below summarizes the medicaid co-payment requirements. These requirements are detailed by co-payment type in Subparagraphs (7) through (12) below.

	<b><u>children’s health insurance program (CHIP)</u></b>	<b><u>working disabled individuals (WDI)</u></b>	<b><u>other adult group – category of eligibility (COE) 100</u></b> Beneficiaries with income greater than 100% of the federal poverty level (FPL)	<b><u>other medicaid categories all federal poverty levels (FPLs) and most COEs</u></b>
<b><u>Outpatient office visits</u></b>	<u>\$5/visit</u>	<u>\$5/visit</u>	<u>\$5/visit</u>	<u>No co-payment</u>
<b><u>Inpatient hospital stays</u></b>	<u>\$50/entire stay</u>	<u>\$50/entire stay</u>	<u>\$50/entire stay</u>	<u>No co-payment</u>
<b><u>Outpatient surgeries</u></b>	<u>\$50/procedure</u>	<u>\$50/procedure</u>	<u>\$50/procedure</u>	<u>No co-payment</u>
<b><u>Prescription drugs, medical equipment, and medical supplies</u></b>	<u>\$2/prescription</u>	<u>\$2/prescription</u>	<u>\$2/prescription</u>	<u>No co-payment</u>
<b><u>Non-preferred prescription drugs</u></b>	<u>\$8/prescription</u>	<u>\$8/prescription</u>	<u>\$8/prescription</u>	<u>\$8/prescription</u>
<b><u>Non-emergency use of the hospital emergency department</u></b>	<u>\$8/visit</u>	<u>\$8/visit</u>	<u>\$8/visit</u>	<u>\$8/visit</u>

(2) Co-payments are not to be charged for the following exempt medicaid beneficiaries:

(a) native Americans who are active or previous users of the Indian health service (IHS), tribal 638 health programs, or urban Indian health programs, who are coded as native American in the eligibility and enrollment information technology (IT) system;

(i) the HSD income support division (ISD) identifies individuals as native American for purposes of co-payment exemptions.

(ii) self-attestation of these criteria is accepted by ISD without the requirement of additional verification.

(b) persons who are receiving care in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);

(c) persons who are enrolled only in the qualified medicare beneficiary (QMB), specified low-income medicare beneficiary (SLIMB), or qualified individuals program;

(d) persons who are covered only under the medicaid family planning program;

(e) persons who are enrolled in the program of all-inclusive care for the elderly (PACE);

(f) persons who are enrolled in the 1915(c) developmentally disabled waiver program; and

(g) persons who are receiving hospice care.

(3) Co-payments are not to be charged for the following exempt services:

(a) community benefit services, nursing facility (NF) stays, or home and community based (HCBS) waiver services;

(b) hospice care services;

(c) family planning services, procedures, surgeries, prescription drug items, supplies, and devices;

(d) pregnancy-related health care, including tobacco cessation treatment for pregnant women, prenatal drug items, and postnatal care;

(e) laboratory, radiology and diagnostic laboratory tests and measurements ordered by a practitioner;

(f) emergency services;

(g) preventive services, including well-child visits, immunizations, periodic health exams, and covered preventive care and screenings as advised by the united states preventive services task force A and B recommendations;

(h) preventive dental cleanings and exams, and covered routine vision care services;

(i) services provided to minors that are protected under minor consent laws;

(j) behavioral health outpatient visits, inpatient hospital stays, and psychotropic drug items;

(k) labor and delivery inpatient obstetric stays;

(l) services rendered to treat provider preventable conditions as defined at 42 CFR 447.26(b);

(m) services rendered before an individual's determination of medicaid eligibility, even if covered retroactively;

(n) services rendered under the medicaid school-based services (MSBS) program;

(o) services rendered under agreement with the department of health (DOH) children's medical services program; and

(p) services covered by medicare or a medicare advantage plan, or following payment by another primary insurer when the medicaid payment is made toward a deductible, co-insurance, or co-payment determined by the primary payer.

(4) A medicaid provider or provider who is contracted with a medicaid managed care organization (MCO) must adhere to the following responsibilities for charging, collecting, and reporting co-payments:

(a) Only one co-payment may be charged per visit or encounter.

(b) A provider may not impose more than one type of co-payment for any service.

(c) A provider may require individuals to pay co-payments as a condition for receiving items or services when the following conditions are met in accordance with 42 CFR 447.52(e):

(i) the individual has household income above 100% FPL;

(ii) the individual is not part of an exempted group as set forth in Subparagraph (2) above, and the service is not an exempted service as set forth in Subparagraph (3) above; and

(iii) for co-payments imposed for non-emergency services furnished in a hospital emergency department, the conditions set forth in Subparagraph (12) of this Section have been satisfied.

(d) A provider may not deny services to a beneficiary on account of the beneficiary's inability to pay the co-payment when the household has income at or below 100% FPL.

(e) Before charging a co-payment, the provider must confirm the beneficiary's eligibility information by checking the beneficiary's managed care organization (MCO) member card or information in the Medicaid provider portal to verify if a co-payment applies.

(f) If a service subject to co-payments is provided, the medicaid beneficiary remains liable for payment of the co-payment amount. The provider must apply the co-payment and may attempt to collect any unpaid charges at the time of service, at a later appointment, or by billing the medicaid beneficiary.

(g) A provider is required to report the applicable co-payment amount on the claim form or on the provider's corresponding electronic billing transactions. The co-payment amount is to be reported on the claim, regardless of whether the co-payment was collected.

(h) When a co-payment is applied to a service, the provider shall accept the amounts paid by MAD or the amount negotiated with the department's contracted MCO, including the deducted co-payment amount, as payment in full. MAD and its contracted MCOs do not compensate providers for co-payments that are not collected.

(i) If a provider has charged co-payments that exceed the aggregate beneficiary household maximum, then the provider must refund any amount collected above the aggregate maximum to the beneficiary. The provider has 10 working days after receiving a notice of overcharged co-payments from MAD or the MCO to refund the co-payment to the beneficiary. Failure to refund an overcharged collected co-payment to the beneficiary may result in a credible allegation of fraud in accordance with 8.351.2 NMAC.

(5) Medicaid beneficiary rights and responsibilities:

(a) When a co-payment is assessed and charged in accordance with this Section, the beneficiary must make payment at the time of service or make arrangements with the provider to make payment at a later date.

(b) Medicaid co-payments incurred by all beneficiaries in the household may not exceed an aggregate limit of five percent of the household's income, as applied on a calendar quarter basis. If the beneficiary has a break in medicaid coverage within the quarter, co-payment accruals toward the household maximum continue to apply during the quarter and do not reset until the following calendar quarter.

(c) The beneficiary has the right to request from his or her MCO at any time an accounting of his or her household's accrued co-payment total(s) per quarter.

(d) If the beneficiary believes that he or she has met the household limit or disagrees with the MCO's accounting of accrued co-payments, the beneficiary may file an appeal through his or her MCO in accordance with NMAC 8.308.15.

(e) If the beneficiary household has been charged co-payments that exceed the aggregate maximum, the beneficiary household has a right to be repaid by the provider for any co-payment(s) collected above the aggregate amount in accordance with Subparagraph (4) above.

(f) ISD determines eligibility for most categories of medicaid, in accordance with 8.291.420.8 NMAC. If the beneficiary household disagrees with the household income calculation as determined by ISD, then the beneficiary household may request a fair hearing in accordance with 8.100.970.8 NMAC. The beneficiary household is required to report any change in income or household size to ISD in accordance with 8.291.400.12 NMAC.

(6) Responsibilities of the contracted MCOs for administering and tracking co-payments are detailed at NMAC 8.308.14.

(7) Co-payments for outpatient office visits:

(a) The co-payment for an outpatient office visit is \$5 per visit. This co-payment applies only for other adult group (COE 100) beneficiaries with income above 100% FPL, WDI beneficiaries, and CHIP beneficiaries. Certain beneficiaries are exempt from outpatient office visit co-payments, as defined in Subparagraph (2) above.

(b) The outpatient office visit co-payment is charged for non-preventive care outpatient office and clinic visits, hospital outpatient department visits for physician or other practitioner services, non-preventive dental visits, urgent care visits, and outpatient professional therapies. For a single service that requires multiple visits to complete, such as a crown, dentures, or orthodontia, a co-payment is applied only on the date of the initial service. Certain services are exempt from the outpatient office visit co-payment, as defined in Subparagraph (3) above.

(8) Co-payments for inpatient hospital stays:

(a) The co-payment for an inpatient hospital stay is \$50 for an entire stay. This co-payment applies only for other adult group (COE 100) beneficiaries with income above 100% FPL, WDI beneficiaries, and CHIP beneficiaries. Certain beneficiaries are exempt from inpatient hospital stay co-payments, as defined in Subparagraph (2) above.

(b) In accordance with Subparagraph (4) above, only one co-payment may be charged per inpatient stay, including when a patient is transferred from one hospital to another hospital. When an

inpatient medicaid beneficiary is transferred to another hospital, only the co-payment made to the original hospital is allowed.

(c) Certain types of inpatient hospital stays are exempt from co-payments, as defined in Subparagraph (3) above.

(9) Co-payments for outpatient surgeries:

(a) The co-payment for outpatient surgery is \$50 per primary surgical procedure performed. This co-payment applies only for other adult group (COE 100) beneficiaries with income above 100% FPL, WDI beneficiaries, and CHIP beneficiaries. Certain beneficiaries are exempt from outpatient surgery co-payments, as defined in Subparagraph (2) above.

(b) The outpatient surgery co-payment is charged for outpatient surgeries performed in office settings, outpatient facilities, and ambulatory surgical centers that are performed separately and distinct from an office clinic or outpatient visit. The co-payment applies only to the primary surgical procedure performed. Certain types of outpatient surgical procedures are exempt from co-payments, as defined in Subparagraph (3) above.

(10) Co-payments for prescription drugs, medical equipment, and medical supplies:

(a) The co-payment for prescription drugs, medical equipment, and medical supplies is \$2 per prescription, purchased item, or monthly rental. This co-payment applies only for other adult group (COE 100) beneficiaries with income above 100% FPL, WDI beneficiaries, and CHIP beneficiaries. Certain beneficiaries are exempt from the co-payment for prescription drugs, medical equipment, and medical supplies, as defined in Subparagraph (2) above.

(b) A prescription drug co-payment is not charged if the higher co-payment for non-preferred prescription drugs is applied, as described in Subparagraph (11) below. Certain types of prescription drug items, medical equipment, and medical supplies are exempt from co-payments, as defined in Subparagraph (3) above.

(11) Co-payments for non-preferred prescription drugs:

(a) The co-payment for non-preferred prescription drugs is \$8 per prescription. This co-payment applies to beneficiaries enrolled in any medicaid category of eligibility and at any income level, unless described as exempt in Subparagraph (2) above.

(b) A non-preferred prescription drug is a medicaid-covered prescription drug item that is not on the first tier of a preferred drug list (PDL). A name brand drug may be considered preferred in certain circumstances.

(c) The co-payment for non-preferred prescription drugs does not apply if the following conditions are met:

(i) in the prescriber's estimation, the lower-cost alternative drug item available on the PDL is either less effective for treating the beneficiary's condition or would have more side effects or a higher potential for adverse reactions; and

(ii) the prescriber has stated that the non-preferred drug is medically necessary on the prescription and the claim is billed with a "dispense as written" indicator.

(iii) In such cases, reimbursement to the pharmacy is based on the appropriate co-payment amount.

(d) If there is no medical justification for the use of a non-preferred drug, the co-payment is to be assessed by the pharmacy provider.

(e) Certain prescription drug items are exempt from the non-preferred prescription drug co-payment:

(i) items that are exempt as defined in Subparagraph (3) above, and

(ii) legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics, and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(12) Co-payments for non-emergency use of the hospital emergency department (ED):

(a) The co-payment for non-emergency use of the hospital ED is \$8 per visit. This co-payment applies to beneficiaries enrolled in any medicaid category of eligibility and at any income level, unless described as exempt in Subparagraph (2) above.

(b) Non-emergency care is defined as any health care service provided to evaluate and treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. If it is determined that the condition is not an emergency and that care could have been provided appropriately elsewhere, and the individual still opts to be treated in the hospital ED, then the individual will be required to pay the co-payment. This process does not limit a



hospital's obligations for screening and stabilizing treatment of an emergency medical condition under Section 1867 of the Social Security Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by MAD or any contracted MCO.

(c) Before providing non-emergency services and imposing co-payments for such services, the hospital providing care must:

(i) conduct an appropriate medical screening under 42 CFR 489.24, Subpart G, to determine that the individual does not need emergency services;

(ii) inform the individual of the amount of his or her co-payment obligation for non-emergency services provided in the ED;

(iii) provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

(iv) determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser co-payment or no co-payment if the individual is otherwise exempt from co-payments; and

(v) provide a referral to coordinate scheduling for treatment by the alternative provider.

(d) If the beneficiary chooses to receive services from the alternative provider, the co-payment may not be assessed.

(e) If the beneficiary has been advised of the available alternative provider and of the amount of the co-payment due, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital shall assess the co-payment.

~~[MAD has established co-payments for specified groups of eligible recipients and members 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 or member, 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 or member 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 or member 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 or member 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 or member 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 or member 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 or member'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 or member because of the eligible recipient or member's inability to pay the co-payment amount at the time of service. The eligible recipient or member remains liable for the co-payment. The provider may attempt to collect the co-payment amount at a later appointment or by billing the eligible recipient or member.

(e) After an eligible recipient or member's assistance unit has reached the maximum out-of-pocket cost sharing limit (five percent of the eligible recipient or member's family's income, calculated on a quarterly basis), a provider shall reimburse any co-payments that it has collected from the eligible recipient or member 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) When a co-payment is applied to a claim, a provider shall accept the amounts paid by MAD or the MCO plus the 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 eligible recipient or member.

(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 eligible recipient or member 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 or member;

(iv) the service is for an eligible recipient enrolled in hospice;

(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;

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

(ix) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID), has a level of care determination or nursing facility care, or other residential care, or for community benefits, or for a home and community based services waiver;

(x) the service is not for a MAP category of eligibility such as the department of health children's medical services program;

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

(xii) the eligible recipient, member 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) Unnecessary use of a brand named drug: the unnecessary utilization of a brand name drug means using a brand name drug that is not on the first tier of a preferred drug list (PDL) instead of an alternative lesser expensive drug item that is on the first tier of a PDL, unless in the prescriber's estimation, the



alternative drug item available on the PDL would be less effective for treating the eligible recipient's condition, or would likely have more side effects or a higher potential for adverse reactions for the eligible recipient.

~~(i) If in the prescriber's estimation, the alternative drug item available on the PDL is either less effective for treating the eligible recipient's condition, or would have more side effects or higher potential for adverse reactions, the cop payment is not applied.~~

~~(ii) If the prescriber has stated the brand name is medically necessary and therefore the claim is billed with a dispense as written indicator, the co payment is not applied unless the reason for the brand being medically necessary is something other than the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the eligible recipient.~~

~~(iii) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.~~

~~(d) Unnecessary use of the ED: the unnecessary utilization of an ED is when an eligible recipient presents to an emergency room for service when the condition of the eligible recipient is not an emergency medical condition and the hospital determines the condition does not require emergency treatment after considering the medical presentation of the eligible recipient, the age of the eligible recipient, alternative providers that may be available in the community at the specific time of day, and other relevant factors. The co payment is assessed when the eligible recipient is told that the condition does not require emergency treatment and the eligible recipient still chooses to continue with the treatment in the ED. A hospital provider must determine the eligible recipient is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED according to the definition as stated in this paragraph.~~

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

~~(a) Payment to the provider will be reduced by the amount of an eligible recipient or member'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 MAD 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 or members whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients or members:~~

~~(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; and~~

~~(d) \$25 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital.~~

~~(e) \$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~~

~~(f) \$8 for non-emergent use of the ED.~~

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

~~(a) \$3 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) \$30 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;~~

~~(e) \$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~~

~~(f) \$8 for non-emergent use of the ED.~~

~~(6) All other MAD eligible recipients and members: Providers shall charge the following co-payment amounts on other MAP eligible recipients or members 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) \$8 for non-emergent use of the ED;~~

~~(b) \$3 per prescription for the unnecessary use of a brand name drug;~~

~~(c) unless the co-payment is for non-emergent use of the ED and the unnecessary use of a brand name drug, the co-payment does not apply to services meeting the definition at section 1932(b)(2) of the Social Security Act and 42 CFR section 438.114 [a]); and~~

~~(d) The co-payment for non-emergent use of the ED and for unnecessary use of a brand name drug does not apply to conditions described in Paragraph (2), Subsection G of this section.]~~

**H. Billing state gross receipts tax:** For providers subject 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. [8.302.2.10 NMAC - Rp, 8.302.2.10 NMAC, xx-xx-17]

### **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 or member'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, a HSD contracted MCO, 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. MAD only considers payment for a claim denied by the other primary payer when under the primary payer's plan the eligible recipient or member 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 or member for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within 90 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 HSD contracted 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, member or his or her authorized representative is responsible for notifying the provider of MAP eligibility or pending eligibility and when retroactive MAP 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 MAP eligibility, the circumstances under which an eligible recipient, member or his or her authorized representative can be billed by the provider are limited.

(1) When the provider is unwilling to accept the eligible recipient as a (FFS) eligible recipient or a MCO member, the provider must provide the eligible recipient, member or his or her authorized representative written notification that they have the right to seek treatment with another provider that does accept a FFS eligible recipient or a MCO member. It is the provider's responsibility to have the eligible recipient, member or his or her 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 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, member or his or her authorized representative if all the following requirements are satisfied:

(a) The eligible recipient, member or his or her 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, member or his or her 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 or member is financially responsible for payment if a provider's claims are denied because of the eligible recipient, member or his or her 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 MAP eligibility or pending eligibility prior to rendering a benefit, the provider cannot bill the eligible recipient, member or his or her authorized representative for the benefit 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 MAP category of eligibility or the benefit, or item is not a MAD benefit. In order to bill the eligible recipient or member for an item or benefit that is not a MAD benefit, prior to rendering the benefit or providing the item the provider must inform the eligible recipient, member or his or her authorized representative the benefit is not covered by MAD and obtain a signed statement from the eligible recipient, member or his or her authorized representative acknowledging such notice. It is the provider's responsibility to understand or confirm the eligible recipient or member's MAD benefits and to inform the eligible recipient, member or his or her authorized

representative when the benefit is not a MAD benefit and to inform the eligible recipient, member or his or her authorized representative.

(4) The provider must accept MAD payment as payment in full and cannot bill a remaining balance to the eligible recipient, member or his or her authorized representative other than a MAD allowed co-payment [eopayment], coinsurance or deductible.

(5) If the provider claim is denied, the provider cannot use a statement signed by the eligible recipient, member or his or her 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, member or his or her authorized representative does not become financially responsible when the provider has failed to meet the timely filing and other administrative requirements in filing a claim. The eligible recipient, member or his or her 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 MAP eligibility or pending 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, member or his or her 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 or member.

**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 MAD 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) An eligible recipient or member for whom MAP 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 HHS 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 MAD school-based service program when providing services to [an](#) eligible recipient or member through an individualized education plan or an individualized family service plan to which an initial filing limit of 90 calendar days is applied.

F. MAD 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, member or his or her 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 MAP category of eligibility in which an eligible recipient or member 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, member or his or her 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, member or his or her 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 service; or if the service is not a MAD benefit, prior to rendering the service the provider informed the eligible recipient, member or his or her authorized representative that the specific service is not covered by MAD and obtained a signed statement from the eligible recipient, member or his or her authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient, member or his or her 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, member or his or her 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, or member or his or her authorized representative 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.

[8.302.2.11 NMAC - Rp, 8.302.2.11 NMAC, xx-xx-17]

**8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS:** To receive payment for services furnished to an eligible recipient or member 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 [co-payments](#) [[eopayments](#)], co-insurance and deductibles, subject to MAD reimbursement limitations. If a medically necessary service is excluded from medicare and it is a MAD covered benefit, MAD will pay for service. 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 [co-payment](#) [[eopayment](#)]. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare coinsurance, deductible, or [co-payment](#) [[eopayment](#)] 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 or member 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 and members. A provider who chooses not to



participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient, member or his or her 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 eligible recipient, member or his or her authorized representative of the estimated amount for which the eligible recipient or member 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 or member may seek services. The provider cannot bill a dually eligible MAP recipient or member 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 eligible recipient, member or his or her 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 [an \[a\]](#) eligible recipient or member, 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 [an \[a\]](#) eligible recipient or member belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for [co-payment \[eopayment\]](#), coinsurance or deductible, subject to MAD 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 [co-payment \[eopayment\]](#), coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer [co-payment \[eopayment\]](#), coinsurance or deductible from the eligible recipient, member or his or her 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 or member 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 MAD to make payment on a claim.  
[8.302.2.12 NMAC - Rp, 8.302.2.12 NMAC, xx-xx-17]

**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, ICF-IDD, 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 or member'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)], or for providers whose enrollment is under a moratorium as identified or approved by the secretary of the federal HHS or by CMS.

[8.302.2.13 NMAC - Rp, 8.302.2.13 NMAC, xx-xx-17]

#### **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 or member 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 or member; and
- (3) an incorrect procedure performed on an eligible recipient or member.

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

[8.302.2.14 NMAC - Rp, 8.302.2.14 NMAC, xx-xx-17]

**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.
- [8.302.2.15 NMAC - Rp, 8.302.2.15 NMAC, xx-xx-17]

**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 4-16-04 - Repealed effective 1-1-14.