



State of New Mexico
Medical Assistance Program Manual
Supplement



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TO: PROVIDERS PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAMS

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SUBJECT: CO-PAYMENT CHANGES RESULTING FROM THE BEHAVIORAL HEALTH PARITY ANALYSIS FOR RECIPIENTS IN THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) AND WORKING DISABLED INDIVIDUALS (WDI)

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that applies requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid Managed Care Organization (MCO) members' benefits, Medicaid alternative benefit plans (ABPs), and the Children's Health Insurance Program (CHIP).

After conducting the parity analysis, the Medical Assistance Division (MAD) decided to remove all co-payments on behavioral health services.

Effective January 1, 2018, co-payments for behavioral health services were eliminated. Specifically, CHIP and WDI recipients are exempt from co-payments whenever:

- The service provided is a behavioral health service;
- The provider of the service is a behavioral health provider;
- Any diagnosis on the claim is a behavioral health diagnosis; or
- If a drug item, including those on pharmacy claims, is an item used primarily for behavioral health.

A description of behavioral health services is described in more detail in the chart below.

For future reference, the chart posted on the HSD website at:

<http://www.hsd.state.nm.us/LookingForInformation/cost-sharing-chart.aspx>

NEW MEXICO MEDICAID PROGRAM CO-PAYMENT COST SHARING CHART- Effective 1/1/2018

APPLICATION OF CO-PAYMENT: Co-payments only apply to two different categories of recipients.

- **CHIP RECIPIENTS** - Children's Health Insurance Program, Categories of Eligibility 0420 or 0421. Co-payment only applies when the federal match code is 1 (meaning that the eligibility is not just "presumptive eligibility").
- **WDI RECIPIENTS** - Working Disabled Individuals, Category of Eligibility 074.

When the eligibility of a recipient is checked on the MAD/Conduent web portal, if a recipient is one of the categories of eligibility above and is NOT a Native American, the web portal information will state that a co-payment may apply.

Web portal for providers: <https://nmmedicaid.portal.conduent.com/>

A provider is not able to refuse services to the recipient when the recipient is unable to pay the co-payment at the time of service. However, the provider is still required to apply the co-payment by billing the recipient or trying to collect it at a future visit.

LIMITATION OF CO-PAYMENTS: Co-payments are applied to claims only if the claim meets one of the following conditions and is not otherwise exempted by the additional criteria below.

Only one co-payment is applied to any visit or session.

Practitioner and Therapy Claims

\$5.00 for CHIP RECIPIENTS

\$7.00 for WDI RECIPIENTS

Co-payments are applied only to claims that have a procedure code typically thought of as an "office visit" or their equivalents:

Outpatient and Other Visits 99201 – 99215

Home Visits 99341 – 99350

Osteopathic Manipulations 98925 - 98929

Eye Evaluations and Ophthalmic Medical Services 92002 – 92014

Physical Therapy Treatment and Assessments 97001 – 97039

Assessments and Training 97750 – 97799

Treatment of Speech and/or Auditory Disorders 92507 – 92508

For the above codes, the co-payment is only charged when the place of service is one of the following: 11 office, 12 home, 20 urgent care, 33 custodial facility, 50 FQHC, 72 rural health, and 19 and 20 outpatient hospitals.

Note that if the "visit" takes place in an outpatient hospital which typically involves both a facility component claim as well as a professional (physician) component claim, the co-payment is applied to the professional services, not to the facility charges.

Exempt from co-payments are emergency room visits, inpatient visits, nursing facility visits, visits to a behavioral health practitioner and claims from any practitioner for which any diagnosis on the claim is a behavioral health diagnosis (the entire section of codes beginning with "F" in ICD-10, and some Y and Z codes). See the complete list of exemptions from co-payment below in the chart.

Dental Claims

\$5.00 FOR CHIP RECIPIENTS

\$7.00 FOR WDI RECIPIENTS

Co-payments are applied to any dental claim that has a code other than a preventive care code. A dental claim with ONLY preventive care services is EXEMPT from co-payments. If a dental claim has any services other than the following, then the dental co-payment is applied:

- Oral evaluations, periodic and comprehensive
- Orthodontic treatment
- Sealants & fluoride applications with or without varnish
- Space maintainers, all types, including re-cementing of dentures

Admissions to Inpatient Hospitals (does not apply to psychiatric hospitals or units)

\$25.00 FOR CHIP RECIPIENTS

\$30.00 FOR WDI RECIPIENTS

The co-payment is only applied to the inpatient admission and is applied to the hospital charge, not the professional physician or other practitioner services. No other services rendered during the inpatient stay are subject to co-payments.

The co-payment is not applied when the recipient is admitted as a transfer from another hospital or when the level of care changes.

Pharmacy Claims including prescription and non-prescription drugs, and medical supplies

\$2.00 FOR CHIP RECIPIENTS

\$5.00 FOR WDI RECIPIENTS

The co-payment is not applied to family planning drugs and devices including contraceptive items, prenatal drugs, or any drug whose primary use is to treat a behavioral health condition.

GENERAL EXEMPTIONS FROM ALL CO-PAYMENTS

Exempt recipients:

- Native Americans (race code 3, A, D, or E)
- All services rendered by an IHS, 638 Tribal Facility, or Urban Indian Facility regardless of race code
- Any recipient who is not classified as a CHIP category of eligibility or a WDI category as described above
- Any CHIP category of eligibility with a federal match code of 3 on the date of service, which means that the recipient is "presumptively eligible"
- Services rendered prior to eligibility being established, even if later retroactive eligibility covers the time period during which the service was rendered

Exempt due to prior payer:

- Claims on which Medicare or Medicare Advantage Plans have made payment
- Claims on which other insurance has paid for the service and the amount being paid to the provider is for the co-insurance and deductible or co-payments

Exempt due to the service or diagnosis:

- Prenatal and postpartum care, delivery services and prenatal drug items
- Family planning services, procedures, drugs, supplies, and devices
- Behavioral health services (any claim with a diagnosis code beginning with "F", or with any behavioral health service procedure code or from a behavioral health provider)
- Preventive services regardless of age (EPSDT well child checks, vaccines, preventive dental cleanings, exams, etc.)
- Services to treat provider preventable conditions - these are services being provided to a recipient whose condition is due to a provider error
- Emergency services
- Co-payments are applied only to the limited procedure codes at the beginning of the chart. Co-payments are never applied to Home and Community Based services waiver claims or to services considered as Community Benefits billed by Community Benefits providers

Exempt due to setting:

- Emergency room services (the facility and the practitioner services)
- Services rendered in an inpatient hospital by a physician or other practitioner

Exempt when the maximum family out-of-pocket expense has been reached:

- When the co-payments applied have exceeded 5% of the family income on a quarterly basis.
- The recipient's managed Care Organization maintains a record of when the maximum has been reached.