INDEX

8.310.2 MEDICAL SERVICES PROVIDERS

This page intentionally left blank

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 2 MEDICAL SERVICES PROVIDERS

8.310.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.310.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/04]

8.310.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.310.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/04]

8.310.2.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.310.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/04]

8.310.2.4 DURATION: Permanent
[2/1/95; 8.310.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/04]

8.310.2.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.310.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/04]

8.310.2.6 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; 8.310.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/04]

8.310.2.7 DEFINITIONS: [RESERVED]

8.310.2.8 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; 8.310.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/04]

8.310.2.9 MEDICAL SERVICE PROVIDERS: Recipients who receive health care services under the New Mexico medicaid program (medicaid) Title XIX of the Social Security Act, are dependent on the participation and cooperation of New Mexico medical providers to secure access to health care. To allow recipients a choice of medical service providers, the New Mexico medical assistance division (MAD) reimburses a variety of eligible providers for furnishing care. Physicians who participate in medical training programs as students, interns, residents, fellows or any other training capacities may furnish medical services. These providers may not bill directly for services, unless they are licensed as physicians and are furnishing services within the scope of their medical education. Physicians, certified nurse practitioners (CNP), and clinical nurse specialists (CNS) licensed in New Mexico, see 8.310.2.10 NMAC and 8.310.2.13 NMAC for specific details, may furnish services independently and may be reimbursed directly for these services. Certified physician assistants (PAs) may furnish services to recipients, but may not bill directly for services. Pharmacist clinicians may furnish services to recipients under the direct supervision of a physician, but may not bill directly for services. Physicians or professional component providers who supervise physician assistants and pharmacist clinicians are allowed to bill for the services performed by PAs and pharmacist clinicians. This part describes eligible providers, covered services, service limitations, and general reimbursement methodologies.
[2/1/95; 4/30/97; 8.310.2.9 NMAC - Rn, 8 NMAC 4.MAD.711 & A, 3/1/04]

8.310.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of the New Mexico medical assistance provider program agreement by MAD, the following providers are eligible to bill and receive reimbursement for furnishing medical services:

(1) individuals licensed to practice medicine or osteopathy [42 CFR Section 440.50(a)(1)(2)]; practices or groups formed by these individuals may also receive direct reimbursement for medical services;

(2) facilities licensed as diagnostic and treatment centers by the licensing and certification bureau of the New Mexico department of health (DOH); the medical services performed in these facilities must be furnished by individual practitioners who are enrolled as medicaid providers;

(3) individuals licensed as certified nurse practitioners by the New Mexico board of nursing may provide services in collaboration with a physician or as independent providers within the scope of their practice. See Section 61-3-23.2(B)(2) NMSA 1978 (Cum. Supp. 1992);

(4) physician assistants certified by the national commission on certification of physician assistants, inc. and licensed by the New Mexico board of medical examiners may furnish services within the scope of their practice, as defined by state law; direction and supervision of physician assistants must be performed by the licensed physicians who are enrolled medicaid providers and are approved by the New Mexico board of medical examiners as supervisory physicians.

(5) pharmacist clinicians certified by the New Mexico board of pharmacy may furnish services within the scope of their practice, as defined by state law; direction and supervision of pharmacist clinicians must be performed by licensed physicians who are enrolled as medicaid providers and are approved by the New Mexico board of medical examiners as supervisory physicians; and

(6) individuals licensed as clinical nurse specialists by the New Mexico board of nursing may provide services in collaboration with a physician or as independent providers within the scope of their practice; see NMSA 1978, 61-3-1 to 61-3-30.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received and understand these materials and for updating their knowledge as new materials are provided by MAD.

[2/1/95; 4/30/97; 8.310.2.10 NMAC - Rn, 8 NMAC 4.MAD.711.1 & A, 3/1/04]

8.310.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that an individual is eligible for medicaid at the time services are rendered and determine if the medicaid recipient has other health care insurance. If the recipient has other insurance coverage in addition to medicaid, the provider must bill the other insurance, and receive payment or denial, prior to billing medicaid. Providers must maintain records that are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.310.2.11 NMAC - Rn, 8 NMAC 4.MAD.711.2 & A, 3/1/04]

8.310.2.12 COVERED SERVICES: Medicaid covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the recipient's condition. All services must be furnished within the limits of medicaid policy and within the scope and practice of the provider's professional standards.

A. **Combined services:** Some services are considered medicaid benefits but the reimbursement for the service is considered made or encompassed within another procedure or service. Medicaid does not provide an additional payment for these services. For example, an additional payment is not made for an incidental appendectomy performed during a laparotomy, although an appendectomy is a covered service.

B. **Foot care:** Medicaid covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, pose a hazard to recipients with a medical condition. Medicaid covers the treatment of warts on the soles of the feet (plantar warts). Medical justification for the performance of routine care must be documented in the recipient's medical record.

C. **Laboratory and diagnostic imaging services:** Medicaid covers medically necessary laboratory and diagnostic imaging services ordered by physicians, CNPs, or CNSs and performed in the office by providers or under their supervision by clinical laboratories or radiology laboratories, or by hospital-based clinical laboratories or radiology laboratories that meet the requirements for medicaid participation. See 42 CFR Section 440.30.

(1) Medicaid covers interpretation of diagnostic imaging with payment as follows.

(a) When diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, performing providers or the associations they form are paid only for the professional component of the service. Neither providers nor associations are paid for the global services when the procedures are performed in hospital settings.

(b) If both the following conditions are met, this limitation does not apply:

(i) recipients are not served in inpatient or outpatient hospital facilities; and

(ii) hospitals did not bill for any component of the radiology procedures and did not include the cost associated with furnishing these services in their cost reports.

(2) Providers may bill for the professional components of imaging services performed at a hospital or independent radiology laboratory if the provider does not request an interpretation by the hospital radiologist. In this case, neither the hospital nor hospital radiology laboratory can bill for the professional component.

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

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

(5) Professional components associated with clinical laboratory services are payable only when the work is actually performed by pathologists who are not billing for global procedures and the work is for anatomic and surgical pathology only, including cytopathology, histopathology, and bone marrow biopsies.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless recipients are inpatients of nursing facilities or hospitals. See 8.324.2 NMAC [MAD-751], *Laboratory Services* and 8.324.3 NMAC [MAD-752], *Diagnostic Imaging and Therapeutic Radiology Services*.

D. **Pharmacy services:** Medicaid covers injectable medications administered by physicians or other health care providers furnishing services within their scope of practice. See 8.324.4 NMAC [MAD-753], *Pharmacy Services*. Medicaid covers flu and pneumococcal vaccines when one of the following conditions exists:

(1) acquired or congential heart disease, such as valve disease, congestive heart failure or pulmonary overload;

(2) conditions that compromise pulmonary function, renal function or immune mechanisms;

(3) metabolic disorders;

(4) severe anemia, including sickle cell diseases;

(5) age sixty-five (65) years or older; or

(6) conditions covered in the seasonal recommendations of the public health division.

E. **Procedures requiring consents or certifications:** Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "consent to sterilization" or a "hysterectomy acknowledgement" form. See 8.325.3 NMAC [MAD-762], *Reproductive Health Services*.

F. **Reproductive health services:** See 8.325.3 NMAC [MAD-762], *Reproductive Health Services*.

G. **Second surgical opinions:** Medicaid covers second opinions when surgery is considered.

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

(1) Recipients may be hospitalized if they have existing medical conditions that predispose them to complications even with minor procedures.

(2) All these claims may be subject to pre-payment or post-payment review.

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

[2/1/95; 8.310.2.12 NMAC - Rn, 8 NMAC 4.MAD.711.3 & A, 3/1/04]

8.310.2.13 SERVICE LIMITATIONS AND RESTRICTIONS: Medicaid covers the following services with the frequency limits indicated. For purpose of these provisions, providers are considered part of the same provider group if they practice in the same office or clinic or have direct access to the recipient's medical records.

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

B. Hospital inpatient and nursing home visits are limited to two (2) per day from the same provider or provider group.

C. Physical medicine modalities are limited to three (3) per month. The limit is met when the same modality is performed three (3) times during a month, when three (3) different modalities are performed during a month, or when three (3) different modalities are performed during one visit.

D. Office visits for orthotic, prosthetic, activities of daily living assessment, or extremity or muscle testing are limited to one per month per recipient. The time allowed for each visit cannot exceed forty-five (45) minutes.

E. Physical medicine procedures and kinetic activities are limited to three (3) per month from the same provider or provider group. The limit is met when the same procedure is performed three (3) times during a

month, when three (3) different procedures are performed during a month, or when three (3) procedures are performed during one visit. The time allowed for each procedure cannot exceed forty-five (45) minutes.

F. Manipulation, osteo-manipulative therapy, or myofacial release is limited to three (3) manipulations per month, regardless of the area or areas manipulated. The limit is met when a manipulation of three (3) different areas or of the same area at three (3) different visits is performed during a month. Medicaid does not cover manipulations performed on recipients under fourteen (14) years of age, including manipulations to the feet.

G. Clinical nurse specialists are reimbursed directly for services rendered in federally qualified health centers (FQHCs), rural health centers (RHCs), and certain other free-standing clinical settings where a CNS is authorized to practice independently. A CNS will not be reimbursed directly by medicaid when providing services in a hospital setting, as these services are reimbursed under the diagnosis related group (DRG) methodology. The exception is CNSs certified in psychiatric nursing who provide psychiatric nursing services as mid-level providers in free-standing psychiatric hospitals or psychiatric units in acute care hospitals. These CNSs will be reimbursed directly.

[2/1/95; 8.310.2.13 NMAC - Rn, 8 NMAC 4.MAD.711.4 & A, 3/1/04]

8.310.2.14 NONCOVERED SERVICES: Medical service providers are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC [MAD-602], *General Noncovered Services*.

[2/1/95; 8.310.2.14 NMAC - Rn, 8 NMAC 4.MAD.711.5 & A, 3/1/04]

8.310.2.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services requiring prior authorization remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if a medicaid recipient has other health care insurance.

C. **Reconsideration:** Providers who disagree with denials of prior authorization requests or other review decisions may request a re-review and a reconsideration. See 8.350.2 NMAC [MAD-953], *Reconsideration or Utilization Review Decisions*.

[2/1/95; 8.310.2.15 NMAC - Rn, 8 NMAC 4.MAD.711.6 & A, 3/1/04]

8.310.2.16 GENERAL REIMBURSEMENT: Medical service providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC [MAD-702], *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. Reimbursement to providers is made at the lesser of the following:

(1) the provider's billed charge; or

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

B. The billed charge must be the provider's usual and customary charge for the service or procedure.

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

D. **Maximum allowed reimbursement amounts:** MAD establishes a maximum allowed reimbursement level for services which are not assigned relative value units. Established payment levels for new or infrequently billed procedures and services, such as tangible items, are contained in individualized billing sections of this manual.

[2/1/95; 8.310.2.16 NMAC - Rn, 8 NMAC 4.MAD.711.7 & A, 3/1/04]

8.310.2.17 REIMBURSEMENT FOR HOSPITAL-BASED SERVICES: Reimbursement for office visits, diagnostic procedures, or surgical services furnished in hospital settings that are ordinarily furnished in a provider's office is paid at sixty percent (60%) of the fee schedule allowed amount for each professional service. Medicaid follows medicare principles in determining which procedures are subject to this payment reduction. Providers must notify MAD when they intend to bill facility and professional components for services performed in a hospital

setting. Non-professional components for laboratory services performed in a hospital setting must be billed by the institutional provider.
[2/1/95; 8.310.2.17 NMAC - Rn, 8 NMAC 4.MAD.711.8 & A, 3/1/04]

8.310.2.18 REIMBURSEMENT FOR CERTIFIED NURSE PRACTITIONERS AND CERTIFIED CLINICAL SPECIALISTS: Reimbursement for CNPs and CNSs who bill under a physician's provider number is the same as the allowed amount if similar services are furnished by physicians. If a CNP or CNS bills independently, the paid amount is ninety percent (90%) of the amount allowed when similar services are furnished by physicians.
[2/1/95; 8.310.2.18 NMAC - Rn, 8 NMAC 4.MAD.711.9 & A, 3/1/04]

8.310.2.19 REIMBURSEMENT FOR SERVICES FURNISHED BY INTERNS OR RESIDENTS:

A. **Reimbursement in approved teaching programs:** Reimbursement for services furnished by interns or residents in hospitals with approved teaching programs or services furnished in other hospitals that participate in teaching programs is made through institutional reimbursement. Medicaid cannot be billed directly by interns or residents for these services.

B. **Services performed in outpatient and emergency room settings:** Medical or surgical services performed by interns or residents in hospital outpatient departments or emergency rooms, that are unrelated to educational services, are reimbursed according to the fee schedule for physician services when all of the following provisions are met:

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

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

(3) interns or residents are fully licensed as physicians;

(4) services are performed under the terms of a written contract or agreement and can be separately identified from services required as part of the training program; and

(5) services are excluded from outpatient hospital costs.

(6) when these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not as interns or residents.

C. **Services of assistant surgeons in approved teaching programs:**

(1) Medicaid does not pay for the services of assistant surgeons in facilities with approved teaching programs since residents are available to perform services, unless the following exceptional medical circumstances exist:

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

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

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

(2) This reimbursement policy cannot be circumvented by private contractors or agreements entered into by hospitals with physicians or physician groups.
[2/1/95; 8.310.2.19 NMAC - Rn, 8 NMAC 4.MAD.711.10 & A, 3/1/04]

8.310.2.20 REIMBURSEMENT LIMITATIONS:

A. **Assistants in surgery:** Physicians who assist during surgery are reimbursed at twenty percent (20%) of the allowed primary surgeon amount. Physician assistants, CNPs, midwives, and CNSs are not eligible to receive reimbursement for assisting during surgery.

B. **Critical care services:** Reimbursement for extensive physician care of a critically ill recipient is based on the fee schedule.

C. **Laboratory and diagnostic imaging:** Reimbursement for laboratory services is not made directly to providers unless the tests are performed in their offices. Laboratory services must be consistent with the provisions of the Clinical Laboratory Improvement Act (CLIA). Reimbursement for the professional component of diagnostic imaging services in inpatient, outpatient, or office settings may not exceed forty percent (40%) of the allowed amount payable for the global procedure in office settings. Nuclear medicine, radiation oncology, computer tomography (CT) scans, and arteriograms are excluded from this limitation. See 8.324.2 NMAC [MAD-751], *Laboratory Services* and 8.324.3 [MAD-752], *Diagnostic Imagining and Therapeutic Radiology Services*.

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

(1) If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code. Total payments made to all providers involved in furnishing services cannot exceed the total single global fee.

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

(3) Based on the eligibility category, medicaid pays only for pregnancy-related services. The determination of whether services are related or non-related to pregnancy is based on the diagnosis.

E. **Physician assistant services:** Reimbursement for services furnished by PAs is made to the billing supervisory physician or group.

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

(1) When multiple procedures, that add significant time or complexity to care, are furnished during the same operative session, the major procedure is reimbursed at one hundred percent (100%) of the allowable amount, the secondary procedure is reimbursed at fifty percent (50%) of the allowable amount and any remaining procedures are reimbursed at twenty-five percent (25%) of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly.

(a) "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same patient on the same date of service.

(b) Without specific indications from providers, the procedure for which providers bill the highest amount is considered the major procedure, the procedure for which providers bill the next highest amount is considered the secondary procedure. Any additional procedures are considered remaining procedures.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier of 50. Reimbursement for bilateral procedures is 150 percent (150%) of the amount allowed for a unilateral procedure.

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

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

(5) Hospital visits are included in the payment for surgical procedures and are not reimbursed separately.

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

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

G. **Pharmacist clinicians:** Reimbursement for services furnished by certified pharmacist clinicians is made to the billing supervisory physician or group.

[2/1/95; 4/30/97; 8.310.2.20 NMAC - Rn, 8 NMAC 4.MAD.711.11 & A, 3/1/04]

HISTORY OF 8.310.2 NMAC:

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

History of Repealed Material:
MAD Rule 310.01, Physician Services, filed 3/10/94 - Repealed effective 2/1/95.