INDEX

8.324.5 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

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TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 5 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

8.324.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.324.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 7/1/04]

8.324.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.324.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 7/1/04]

8.324.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Sections 27-2-12 et seq. NMSA 1978.
[2/1/95; 8.324.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7/1/04; A, 3/1/11]

8.324.5.4 DURATION: Permanent
[2/1/95; 8.324.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 7/1/04]

8.324.5.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.324.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7/1/04; A, 11/1/05]

8.324.5.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.324.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7/1/04; A, 3/1/11]

8.324.5.7 DEFINITIONS: [RESERVED]

8.324.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2/1/95; 8.324.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7/1/04; A, 3/1/11]

8.324.5.9 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES: The New Mexico medical assistance division (MAD) pays for medically necessary services furnished to eligible recipients, including durable medical equipment and medical supplies, as specified at 42 CFR Section 440.70 (c).
[2/1/95; 8.324.5.9 NMAC - Rn, 8 NMAC 4.MAD.754, 7/1/04; A, 3/1/11]

8.324.5.10 ELIGIBLE PROVIDERS: Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.
[2/1/95; 8.324.5.10 NMAC - Rn, 8 NMAC 4.MAD.754.1 & A, 7/1/04; A, 3/1/11]

8.324.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care programs eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

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

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.324.5.11 NMAC - Rn, 8 NMAC 4.MAD.754.2 & A, 7/1/04; A, 3/1/11]

8.324.5.12 COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES:

A. **Durable medical equipment:** MAD covers durable medical equipment (DME) that meets the definition of DME, the medical necessity criteria and the prior authorization requirements. MAD covers repairs, maintenance, delivery of durable medical equipment and disposable and non-reusable items essential for use of the equipment, subject to the limitations specified in this section. All items purchased or rented must be ordered by a provider who is currently enrolled with MAD. MAD coverage for DME is limited for an eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, nursing facility, intermediate care facility for the mentally retarded and a rehabilitation facility. An eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover multiple services. An eligible recipient is limited to one wheelchair, one hospital bed, one oxygen delivery system or one of any particular type of equipment. A back-up ventilator is covered.

(1) "Durable medical equipment" is defined as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

(2) Equipment used in an eligible recipient's residence must be used exclusively by the eligible recipient for whom it was approved.

(3) To meet the medical necessity criterion, durable medical equipment must be necessary for the treatment of an illness or injury or to improve the functioning of a body part.

(4) Replacement of equipment is limited to the same extent as it is limited by medicare policy. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in medical necessity or as otherwise indicated in policy.

B. **Medical supplies:** MAD covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items.

(1) A provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order to the eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement.

(2) Medicaid coverage for DME and medical supplies is limited for an eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, nursing facility, intermediate care facility for the mentally retarded and a rehabilitation facility.

C. **Covered services and items:** MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized eligible recipient:

(1) trusses and anatomical supports that do not need to be made to measure;

(2) family planning devices;

(3) repairs to DME and replacement parts if an eligible recipient owns the equipment for which the repair is necessary and the equipment being repaired is a covered MAD benefit; some replacement items used in repairs may require prior authorization; see Subsection C of 8.324.5.14 NMAC;

(4) repairs to augmentative and alternative communication devices require prior authorization;

(5) monthly rental includes monthly service and repairs; and

(6) replacement batteries and battery packs for augmentative and alternative communication devices owned by the eligible recipient.

D. **Covered services for non-institutionalized recipients:** MAD covers certain medical supplies, nutritional products and durable medical equipment provided to a non-institutionalized eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare policy. When medicare does not specify a limitation, an item is limited to reasonable amounts as defined by medicaid and published in the billing instructions for DME/medical supplies. MAD covers the following for a non-institutionalized eligible recipient:

(1) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings;

(2) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(3) gauze, bandages, dressings, pads, and tape;

(4) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(5) parenteral nutritional support products prescribed by a physician on the basis of a specific medical indication for an eligible recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet medical needs;

(6) apnea monitors: prior authorization is required if the monitor is needed for six months or longer; and

(7) disposable gloves (sterile or non-sterile) are limited to 200 per month.

E. **Covered oxygen and oxygen administration equipment:**

(1) MAD covers the following oxygen and oxygen administration systems, within the specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase, with prior authorization: oxygen administration equipment may be supplied on a rental basis for one month without prior authorization; rental beyond the initial month requires prior authorization.

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems; medicaid approves the most economical oxygen delivery system available that meets the medical needs of the eligible recipient;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(2) MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If MAD pays rental charges for systems, tank rental is included in the rental payments. MAD follows the medicare rules for limiting or capping reimbursement for oxygen rental at 36 months, requirements for the provider to maintain and repair the equipment, and to provide ongoing services and disposable supplies after the capped rental.

(3) A nursing home is administratively responsible for overseeing oxygen supplied to the eligible recipient.

F. **Augmentative and alternative communication devices:** MAD covers medically necessary electronic or manual augmentative communication devices for an eligible recipient. Medical necessity is determined by MAD or its designee(s). Communication devices whose purpose is also educational or vocational are covered only when it has been determined the device meets medical criteria.

(1) An eligible recipient must:

(a) have the cognitive ability to use the augmentative communication device; and

(b) be able to functionally communicate verbally or through gestures.

(2) All of the following criteria must be met before an augmentative communication device can be considered for authorization. The communication device must be:

(a) a reasonable and necessary part of the eligible recipient's treatment plan;

(b) consistent with the symptoms, diagnosis or medical condition of the illness or injury under treatment;

(c) not furnished for the convenience of the eligible recipient, the family, the attending practitioner or other practitioner or supplier;

(d) necessary and consistent with generally accepted professional medical standards of care;

(e) established as safe and effective for the eligible recipient's treatment protocol;

(f) furnished at the most appropriate level suitable for use in the eligible recipient's home environment;

(g) augmentative and alternative communication devices are authorized every 60 months for an eligible recipient 21 years of age or older and every 36 months for an eligible recipient under 21 years of age, unless earlier authorization is dictated by medical necessity; and

(h) repairs to, and replacement parts for augmentative and alternative communication devices owned by the recipient.

G. **Rental of durable medical equipment:** MAD covers the rental of durable medical equipment.

(1) MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace equipment during the rental period.

(2) Low cost items, defined as those items for which the medicaid allowed payment is less than $150 dollars, may only be purchased. Purchased DME becomes the property of the eligible recipient for whom it was approved.

(3) MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

H. **Delivery of equipment and shipping charges:** MAD covers the delivery of DME only when the equipment is initially purchased or rented and the round trip delivery is over 75 miles. A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to those clients who are not recipients of MAD services. MAD does not pay delivery charges for equipment purchased by medicare, for which MAD is responsible only for the coinsurance and deductible. MAD covers shipping charges for DME and medical supplies when it is cost effective or practical to ship items rather than have an eligible recipient travel to pick up items. Shipping charges are defined as the actual cost of shipping items from a provider to an eligible recipient by a means other than that of provider delivery. MAD does not pay shipping charges for items purchased by medicare for which MAD is only responsible for the coinsurance and deductible.

I. **Wheelchairs and seating systems:**

(1) MAD covers customized wheelchairs and seating systems made for a specific eligible recipient, including an eligible recipient who is institutionalized. Written prior authorization is required. MAD or its designee cannot give verbal authorizations for customized wheelchairs/seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific eligible recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(2) Repairs to a wheelchair owned by an eligible recipient residing in an institution may be covered.

(3) Customized or motorized wheelchairs required by an eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, and will be reviewed on a case-by-case basis.

[2/1/95; 3/1/99; 8.324.5.12 NMAC - Rn, 8 NMAC 4.MAD.754.3 & A, 7/1/04; A, 12/1/04; A, 11/1/05; A, 3/1/11]

8.324.5.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's written instructions for authorization of services.

A. **Services that require prior authorization:** MAD covers certain medical supplies, nutritional products and durable medical equipment provided to an eligible recipient with prior authorization. Written requests for items not included in the categories listed above or for a quantity greater than that covered by MAD may be submitted by the eligible recipient's physician, with a prior authorization request, to MAD for consideration of medical necessity. Please refer to criteria in 8.301.3 NMAC, *General Noncovered Services,* for durable medical equipment or medical supplies that are not covered. Services for which prior authorization was obtained remain subject to review at any point in the payment process. Certain procedures or services may require prior authorization for MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment. See Subsection A of 8.311.2.16 NMAC, *emergency room services.* Prior authorization does not guarantee that an individual is eligible for medicaid. A provider must verify that the individual is eligible for medicaid at the time services are furnished and determine if the recipient has other health insurance. MAD covers the following benefits with prior authorization for non-institutionalized eligible recipients:

(1) enteral nutritional supplements and products provided to an eligible recipient who must be tube fed oral nutritional supplements when administered enterally are included;

(2) oral nutritional support products prescribed by a physician:

(a) on the basis of a specific medical indication for an eligible recipient who has a defined need for which nutritional support is considered therapeutic, and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet the medical needs;

(b) when medically necessary due to inborn errors of metabolism;

(c) medically necessary to correct or ameliorate physical illnesses or conditions in an eligible recipient under the age of 21; or

(d) coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance;

(3) either disposable diapers or underpads prescribed for an eligible recipient age three and older who suffers from neurological or neuromuscular disorders or who has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;

(4) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for specialized wheelchairs;

(5) protective devices, such as helmets and pads;

(6) bathtub rails and other rails for use in the bathroom;

(7) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(8) passive motion exercise equipment;

(9) decubitus care equipment;

(10) equipment to apply heat or cold;

(11) hospital beds and full length side rails;

(12) compressor air power sources for equipment that is not self-contained or cylinder driven;

(13) home suction pumps and lymph edema pumps;

(14) hydraulic patient lifts;

(15) ultraviolet cabinets;

(16) traction equipment;

(17) prone standers and walkers;

(18) trapeze bars or other patient helpers that are attached to bed or freestanding;

(19) home hemodialysis or peritoneal dialysis systems, replacement supplies or accessories;

(20) wheelchairs and functional attachments to wheelchairs: wheelchairs are authorized every 60 months; for an eligible recipient under 21 years of age, wheelchairs can be authorized every 36 months; earlier authorization is possible when dictated by medical necessity;

(21) wheelchair trays;

(22) whirlpool baths designed for home use;

(23) intermittent or continuous positive pressure breathing equipment; and

(24) manual or electronic augmentative and alternative communication devices;

(25) trusses and anatomical supports that require fitting or adjusting by trained individuals, including JOBST hose;

(26) custom-fitted compression stockings; and

(27) artificial larynx prosthesis.

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

[2/1/95; 3/1/99; 6/15/99; 8.324.5.13 NMAC - Rn, 8 NMAC 4.MAD.754.4 & A, 7/1/04; A, 11/1/05; A, 3/1/11]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS: Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to an eligible recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the eligible recipient for whom it was authorized.

(1) The provider assumes responsibility for correcting defects or deficiencies in wheelchair and seating systems that make them unsatisfactory for use by the eligible recipient.

(2) The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians, as necessary, to ensure that the wheelchair meets the eligible recipient's needs.

(3) Evaluations by a physical therapist or occupational therapist are required when ordering customized wheelchairs and seating systems. These therapists should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the eligible recipient and those consultants listed in Paragraph (2) of Subsection B of 8.324.5.14 NMAC to assure that the selected system matches physical seating needs. The physical or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

(4) MAD does not pay for special modifications or replacement of customized wheelchairs after the wheelchairs are furnished to the eligible recipient.

(5) When the equipment is delivered to the eligible recipient and the eligible recipient accepts the order, the provider will submit the claim for reimbursement.

B. **Special requirements for purchase of augmentative and alternative communication devices:**

(1) The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by a physician, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the eligible recipient's ability to use the communication device must be provided showing that the eligible recipient's ability to use the device is improving and that the eligible recipient is motivated to continue to use this device.

(3) MAD does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to, paper, printer ribbons and computer discs.

(4) Prior authorization is required for equipment repairs.

(5) A provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement.

[2/1/95; 3/1/99; 8.324.5.14 NMAC - Rn, 8 NMAC 4.MAD.754.5 & A, 7/1/04; A, 3/1/11]

8.324.5.15 NONCOVERED SERVICES: MAD does not cover certain durable medical equipment and medical supplies. See 8.301.3 NMAC, *General Noncovered Services*, for an overview of the criteria used to assess whether equipment and supplies are not covered.

[2/1/95; 3/1/99; 8.324.5.15 NMAC - Rn, 8 NMAC 4.MAD.754.6 &A, 7/1/04; A, 3/1/11]

8.324.5.16 REIMBURSEMENT:

A. **Reimbursement for purchase or rental**: Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for DME and medical supplies and nutritional products is made at the lesser of:

(1) the provider's billed charges or the MAD fee schedule; or

(2) when applicable; alternatively, when there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows:

(a) durable medical equipment, medical supplies and nutritional products;

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000 dollars, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(b) custom specialized wheelchairs and their customized related accessories: payment is limited to the provider's actual acquisition cost plus 15 percent.

B. **Rental payments must be applied towards the purchase with the exception of ventilators:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for rental of DME is made at the lesser of:

(1) the provider's billed charges; or

(2) the MAD fee schedule, when applicable; payment for the month of rental is limited to the provider's acquisition invoice cost plus a percentage, as follows: a provider must keep a running total of rental payments for each piece of equipment; a provider must consider the items sold and the item becomes the property of the eligible recipient when 13 rental payments have been made for the item, or earlier when the rental payments total the lesser of the provider's usual and customary charge for the purchase of the item or the MAD fee schedule for the purchase of the item; or for an item for which a fee schedule purchase price has not been established by MAD when the provider has received rental payments equal to one of the following:

(a) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000 dollars, payment is limited to the provider's actual acquisition cost plus 20 percent;

(b) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(3) MAD follows medicare rules regarding capped rental; for rental months one through three, the full fee schedule rental fee is allowed; for rental months four through 13, the rental fee schedule rental fee is reduced by 25 percent; no additional rental payments are made following the month 13 or to the most current schedule determined by medicare; the provider may only bill for routine maintenance and for repairs, and oxygen contents, to the extent as allowed by medicare;

(4) oxygen is paid using the medicare billing, capped rental period, and payment rules;

(5) a provider must retain a copy of their acquisition invoice showing the provider's purchase of an item and make it available to MAD upon request;

(6) 'set-up fees" are considered to be included in the payment for the equipment or supplies and are not reimbursed as separate charges.

C. **Reimbursement for home infusion drugs:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Home infusion drugs are reimbursed as follow at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee;

(3) for home infusion drugs for which a fee schedule price has not been established by MAD, or for which the description associated with the appropriate billing code is too broad to establish a reasonable payment level, payment is limited to the provider's acquisition cost plus 20 percent; a provider must retain a copy of their acquisition invoice showing the provider's purchase of an item and make it available to MAD upon request.

D. **Reimbursement for delivery and shipping charges:** Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method of shipping. MAD does not pay for charges for shipping items from suppliers to the providers. [2/1/95; 12/30/95; 3/1/01; 8.324.5.16 NMAC - Rn, 8 NMAC 4.MAD.754.7 & A, 7/1/04; A, 3/1/11]

HISTORY OF 8.324.5 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0800, Medical Supplies, filed 2/29/80.
MAD Rule 310.08, Medical Supplies, filed 12/1/87.
MAD Rule 310.08, Medical Supplies, filed 5/31/88.
MAD Rule 310.08, Medical Supplies, filed 4/3/92.
MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4/21/92.

History of Repealed Material:
MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4/21/92 Repealed effective 2/1/95.