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TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 2 GENERAL BENEFIT DESCRIPTION

8.310.2.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.310.2.1 NMAC - Rp, 8.310.2.1 NMAC, 1/1/2014; A, 7/1/2024; A, 7/1/2025]

8.310.2.2 SCOPE: The rule applies to the general public.
[8.310.2.2 NMAC - Rp, 8.310.2.2 NMAC, 1/1/2014]

8.310.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.2.3 NMAC - Rp, 8.310.2.3 NMAC, 1/1/2014; A, 7/1/2024]

8.310.2.4 DURATION: Permanent.
[8.310.2.4 NMAC - Rp, 8.310.2.4 NMAC, 1/1/2014]

8.310.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.2.5 NMAC - Rp, 8.310.2.5 NMAC, 1/1/2014]

8.310.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.2.6 NMAC - Rp, 8.310.2.6 NMAC, 1/1/2014]

8.310.2.7 DEFINITIONS: [**RESERVED**]

8.310.2.8 MISSION STATEMENT: We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.310.2.8 NMAC - Rp, 8.310.2.8 NMAC, 1/1/2014; A, 8/10/2021; A/E, 1/1/2025; A, 7/1/2025]

8.310.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico medical assistance division (MAD) pays for medically necessary health care services furnished by a MAD enrolled medical provider. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991).

B. MAD pays for medically necessary behavioral health professional services including assessments, evaluations, and therapy required by the condition of the medical assistance program (MAP) eligible recipient. See 42 CFR Sections 440.40, 440.60(a) and 441.571.

C. MAD covers services which are medically necessary for the diagnosis or treatment of illnesses, injuries or conditions of a MAP eligible recipient, as determined by MAD or its designee. All services must be furnished within the limits of the MAD New Mexico administrative code (NMAC) rules policies and instructions within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. Any claim submitted for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service. All claims are subject to pre-payment or post-payment review and recoupment.

D. HCA, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to MAP eligible recipients.

E. A provider must be eligible for participation as a MAD approved provider at the time services are furnished. MAD does not cover services performed during a time period when the provider or facility did not meet required licensing or certification requirement.

F. If a MAP eligible recipient is enrolled with a MAD managed care organization (MCO), the provider must contact that member's MCO for specific reimbursement information. A MCO contracted with the state of New Mexico is not required to follow the MAD fee-for-service (FFS) fee schedules or reimbursement

methodologies unless otherwise instructed by MAD. Reimbursement arrangements are determined contractually between the MCO and the provider.
[8.310.2.9 NMAC - N, 1/1/2014; A, 7/1/2025]

8.310.2.10 RELATIONSHIP TO MEDICARE: MAD covers medically necessary health services furnished to a MAP eligible recipient who meets specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to MAP eligible recipient 65 years of age and older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other MAP eligible recipients as specified by other provisions of the Social Security Act.

A. New Mexico has entered into an agreement with the social security administration to pay a medicaid MAP eligible recipient's premium for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, MAD pays for the medicare co-insurance, deductible and copayment amounts for a MAP eligible recipient subject to the following reimbursement limitations.

(1) Medicaid payment for the co-insurance, deductible, copayment or other patient responsibility is limited such that the payment from medicare, plus the amount allowed by MAD for the co-insurance, copayment and deductible, shall not exceed the MAD allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance, copayment, deductible or other patient responsibility. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance, copayment or deductible from the MAP eligible recipient or their authorized representative. For services for which medicare part B applies a 50 percent co-insurance rate, medicare co-insurance, copayment and deductible amounts are paid at an amount that allows the provider to receive more than MAD allowed amount, not to exceed a percentage determined by HCA.

(2) MAD will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance, deductible and copayment together do not exceed the MAD allowable amount. MAD will pay the full medicare co-insurance and deductible when MAD does not have a specific amount allowed for the service. When MAD does not use an equivalent payment methodology for a service, the full coinsurance, deductible and copayment amounts will be paid. This occurs when providers are paid at encounter rates, percent of billed charges followed by cost settlements, or when providers are entitled to a full reimbursement rate such as for federally qualified health centers and hospital outpatient prospective payment system reimbursement.
[8.310.2.10 NMAC - Rp, 8.300.1.10 NMAC, 1/1/2014; A, 7/1/2025]

8.310.2.11 SERVICE LIMITATIONS AND RESTRICTIONS: MAD covers the following services with the frequency limits indicated. For purpose of this rule, a provider is considered part of the same provider group if they practice in the same office or clinic or has direct access to the MAP eligible recipient's medical or behavioral health records. Exceeding these limits requires prior authorization.

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

B. Physical medicine modalities in a professional practitioner's office: These modalities are limited to three-per-month. The limit is met when the same modality is performed three times during a calendar month, when three different modalities are performed during a month, or when three different modalities are performed during one visit.

C. Physical medicine procedures and kinetic activities in a professional practitioner's office: These services are limited to three-per-month from the same provider or provider group. The limit is met when the same procedure is performed three times during a calendar month, when three different procedures are performed during a month, or when three procedures are performed during one visit.

D. Manipulation, osteo-manipulative therapy, or myofacial release in a professional practitioner's office: These services are limited to three manipulations per calendar month, regardless of the area or areas manipulated. The limit is met when a manipulation of three different areas or of the same area at three different visits is performed during a month.

E. Medically necessary services: All services are limited to those that are medically necessary, including the length of time and the frequency of service.
[8.310.2.11 NMAC - Rp, 8.310.2.13 NMAC, 1/1/2014; A, 4/5/2022]

8.310.2.12 SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope of their practice board and licensure.

A. Medical practitioner services:

(1) Second surgical opinions: MAD covers second opinions when surgery is considered.

(2) Services performed in an outpatient setting: MAD covers 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.

(a) A MAP eligible recipient may be hospitalized if they have existing medical conditions that predispose them to complications even with minor procedures.

(b) Claims may be subject to pre-payment or post-payment review.

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

(3) Noncovered therapeutic radiology and diagnostic imaging services: MAD does not pay for kits, films or supplies as separate charges. All necessary materials and minor services are included in the service or procedure charge. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay an additional amount for contrast media except in the following instances:

(a) radioactive isotopes;

(b) non-ionic radiographic contrast material; or

(c) gadolinium salts used in magnetic resonance imaging.

(4) Midwives services: MAD covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and rules and within the scope of their practice board and licensure. Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postpartum care.

(a) Separate trimesters completed and routine vaginal delivery can be covered if a MAP eligible recipient is not under the care of one provider for the entire prenatal, delivery and postpartum periods.

(b) MAD covers laboratory and diagnostic imaging services related to pregnancy. These services can be billed separately.

(c) MAD covers gynecological or obstetrical ultrasounds without requiring a prior authorization of any kind.

(d) MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through the "Birthing Options Program" (BOP). MAD reimburses the birth center facility and the rendered services of a midwife separately. BOP services are provided by an eligible midwife that enrolls as a BOP provider with the health care authority/medical assistance division (HCA/MAD). The facility must comply with all DOH licensing requirements, including limiting licensure. The facility must maintain all clinical documentation, including schedules, for the period of time as required under 8.302.1 NMAC. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(e) Non-covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(i) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the MAP eligible recipient;

(ii) services furnished by an apprentice; unless billed by the supervising midwife;

(iii) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

B. Pharmaceutical, vaccines and other items obtained from a pharmacy: MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to a pharmacy is not a MAD allowed benefit with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release.

C. Laboratory and diagnostic imaging services: MAD covers medically necessary laboratory and diagnostic imaging services ordered by primary care provider (PCP), physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialists (CNS) and performed in the office by a provider or under their supervision by a clinical laboratory or a radiology laboratory, or by a hospital-based clinical laboratory or radiology laboratory that are a enrolled MAD provider. See 42 CFR Section 440.30.

(1) MAD covers interpretation of diagnostic imaging with payment as follows: when diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, payment is made only for the professional component of the service. This limitation does not apply if the hospital does not bill for any component of the radiology procedures and does not include the cost associated with furnishing these services in its cost reports.

(2) A provider 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.

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

(4) Radiology professional components are not paid 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 a pathologist who is not billing for global procedures and the service is for anatomic and surgical pathology only, including cytopathology, histopathology, and bone marrow biopsies, or as otherwise allowed by the medicare program.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless a MAP eligible recipient is an inpatient of a nursing facility or hospital.

(7) Noncovered laboratory services: MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from a MAP eligible recipient who is not a resident of a NF or hospital. MAD does not cover the following specific laboratory services:

(a) clinical laboratory professional components, except as specifically described under covered services above;

(b) specimens, including pap smears, collected in a provider's office or a similar facility and conveyed to a second provider's office, office laboratory, or non-certified laboratory;

(c) laboratory specimen handling or mailing charges;

(d) specimen collection fees other than those specifically indicated in covered services; and

(e) laboratory specimen collection fees for a MAP eligible recipient in NF or inpatient hospital setting.

D. Reproductive health services: MAD pays for family planning and other related health services (see 42 CFR Section 440.40(c)) and supplies furnished by or under the supervision of a MAD enrolled provider acting within the scope of their practice board or licensure.

(1) Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "*sterilization consent*" or a "*hysterectomy acknowledgment/consent*" form. MAD covers a medically necessary sterilization under the following conditions. See 42 CFR Section 441.251 et seq:

(a) a MAP eligible recipient 21 years and older at the time consent is obtained;

(b) a MAP eligible recipient is not mentally incompetent; mentally incompetent is a declaration of incompetency as made by a federal, state, or local court; a MAP eligible recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;

(c) a MAP eligible recipient is not institutionalized; for this section, institutionalized is defined as:

(i) an individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or an intermediate care facility for the care and treatment of mental illness;

(ii) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness;

(d) a MAP eligible recipient seeking sterilization must be given information regarding the procedure and the results before signing a consent form; this explanation must include the fact that sterilization is a final, irreversible procedure; a MAP eligible recipient must be informed of the risks and benefits associated with the procedure;

(e) a MAP eligible recipient seeking sterilization must also be instructed that their consent can be withdrawn at any time prior to the performance of the procedure and that they would not lose any other MAD benefits as a result of the decision to have or not have the procedure; and

(f) a MAP eligible recipient voluntarily gives informed consent to the sterilization procedure. See 42 CFR Section 441.257(a); and

(g) a MAP eligible recipient's informed consent to the sterilization procedure must be attached to the claim.

(2) Hysterectomies: MAD covers only a medically necessary hysterectomy. MAD does not cover a hysterectomy performed for the sole purpose of sterilization. See 42 CFR Section 441.253.

(a) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by the MAP eligible recipient prior to the operation.

(b) Acknowledgement of the sterilizing results of the hysterectomy is not required from a MAP eligible recipient who has been previously sterilized or who is past child-bearing age as defined by the medical community. In this instance, the PCP signs the bottom portion of the hysterectomy form which states the MAP eligible recipient has been formerly sterilized, and attaches it to the claim.

(c) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

(3) Birthing options services (BOP): MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through BOP. The BOP is an out-of-hospital birthing option for pregnant individuals enrolled in the medicaid program who are at low-risk for adverse birth outcomes. BOP services are provided by an eligible midwife that enrolls as a BOP provider with HCA/MAD. The BOP services are specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(4) Doula services: MAD covers doula services to prevent perinatal complication or promote the physical and mental health of the beneficiary. MAD covers only those services furnished by a doula certified by the department of health (DOH).

(a) Department of health certification of a doula will include the following:

(i) a uniform application process with timelines and procedures

(ii) a certification review committee; and

(iii) a uniform hearing process to allow for an applicant to appeal a decision by the department of health.

(b) in addition to DOH certification eligible doula service providers must:

(i) be at least 18 years old;

(ii) maintain a current adult and infant cardiopulmonary resuscitation (CPR) certification from the American Red Cross or American Heart Association; and

(iii) complete the basic Health Insurance Portability and Accountability Act of 1996 (HIPPA) training.

(c) Doula services include the following:

(i) prenatal and post-partum physical, emotional, and evidence-based education support and linkages to community-based resources;

(ii) non-medical labor and delivery (L&D) support; and

(iii) education related to pre-conception, pregnancy loss, infant loss, or termination of pregnancy.

(5) Other covered services: MAD covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy or contraception.

(6) Noncovered reproductive health care: MAD does not cover the following specific services:

(a) sterilization reversal services;

(b) fertility drugs;

(c) in vitro fertilization;

(d) artificial insemination;

(e) hysterectomies performed for the sole purpose of family planning;

(f) induced vaginal deliveries prior to 39 weeks unless medically indicated;

(g) caesarean sections unless medically indicated; and

(h) elective procedures to terminate a pregnancy.

E. Nutritional services: MAD covers medically necessary nutritional services which are based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the MAP eligible recipient. MAD covers only those services furnished by PCP, licensed nutritionists or licensed dieticians. MAD covers the following services:

(1) Nutritional assessments for a pregnant MAP eligible recipient and for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnosis and treatment (EPSDT) program. Nutritional assessment is defined as an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

(2) Nutrition counseling to or on behalf of a MAP eligible recipient under 21 years of age who has been referred for a nutritional need. Nutrition counseling is defined as advising and helping a MAP eligible recipient obtain appropriate nutritional intake by integrating information from the nutrition assessment with information on food, other sources of nutrients and meal preparation, consistent with cultural background and socioeconomic status.

(3) Noncovered nutritional services: MAD covers only those services furnished by a PCP, licensed nutritionist or licensed dietician. MAD does not cover the following specific services:

(a) services not considered medically necessary for the condition of the MAP eligible recipient as determined by MAD or its designee;

(b) dietary counseling for the sole purpose of weight loss;

(c) weight control and weight management programs; and

(d) commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management; see 8.324.4 NMAC.

F. Transplant services: Non-experimental transplant services are covered. MAD covered transplantation services include hospital, a PCP, laboratory, outpatient surgical, and other MAD covered services necessary to perform the selected transplantation for the MAP eligible recipient and donor.

(1) Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement.

(2) MAD covers the MAP eligible recipient's and donor's related medical, transportation, meals and lodging services for non-experimental transplantation.

(3) MAD does not cover transplant procedures, treatments, use of a drug, biological product, a product or a device which are considered unproven, experimental, investigational or not effective for the condition for which they are intended or used.

(4) A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment.

G. Dental services: Dental services are covered as an optional medical service for a MAP eligible recipient. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the MAP eligible recipient. See 42 CFR Section 440.100(a). MAD also covers dental services, dentures and special services for a MAP eligible recipient who qualifies for services under the EPSDT program. See 42 CFR Section 441.55.

(1) Emergency dental care: MAD covers emergency care for all MAP eligible recipients. Emergency care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For a MAP eligible recipient under 21 years of age, care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) Prior authorization requirements are waived for emergency care, but the claim can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

(2) Diagnostic services: MAD coverage for diagnostic services is limited to the following:

(a) for a MAP eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(b) one clinical oral examination every 12 months for a MAP eligible recipient 21 years and older; and

(c) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

(3) Radiology services: MAD coverage of radiology services is limited to the following:

(a) one intraoral complete series every 60 months per MAP eligible recipient; this series includes bitewing x-rays;

(b) additional bitewing x-rays once every 12 months per MAP eligible recipient; and

(c) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per MAP eligible recipient.

(4) Preventive services: MAD coverage of preventive services is subject to certain limitations.

(a) Prophylaxis: MAD covers for a MAP eligible recipient under 21 years of age one prophylaxis service every six months. MAD covers for a MAP eligible recipient 21 years of age and older who has a developmental disability, as defined in 8.314.6 NMAC, one prophylaxis service every six months. For a MAP eligible recipient 21 years of age and older without a developmental disability, as defined in 8.314.6 NMAC, MAD covers one prophylaxis service once in a 12 month-period.

(b) Fluoride treatment: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride treatment every six months. For a MAP eligible recipient 21 years of age and older MAD, covers one fluoride treatment once in a 12-month period.

(c) Fluoride varnish: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride varnish treatment every six months.

(d) Molar sealants: MAD only covers for a MAP eligible recipient under 21 years of age, sealants for permanent molars. Each MAP eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For a MAP eligible recipient 21 years of age and older, MAD does not cover sealant services.

(e) Space maintenance: MAD covers for a MAP eligible recipient under 21 years of age fixed unilateral and fixed bilateral space maintainers (passive appliances). For a MAP eligible recipient 21 years of age and older, MAD does not cover space maintenance services.

(5) Restorative services: MAD covers the following restorative services:

(a) amalgam restorations (including polishing) on permanent and deciduous teeth;

(b) resin restorations for anterior and posterior teeth;

(c) one prefabricated stainless steel crown per permanent or deciduous tooth;

(d) one prefabricated resin crown per permanent or deciduous tooth; and

(e) one recementation of a crown or inlay.

(6) Endodontic services: MAD covers therapeutic pulpotomy for a MAP eligible recipient under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

(7) Periodontic services: MAD covers for a MAP eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(a) a collaborative practice dental hygienist may provide periodontal scaling and root planning, per quadrant after diagnosis by a MAD enrolled dentist; and

(b) a collaborative practice dental hygienist may provide periodontal maintenance procedures with prior authorization.

(8) Removable prosthodontic services: MAD covers two denture adjustments per every 12 months per MAP eligible recipient. MAD also covers repairs to complete and partial dentures.

(9) Fixed prosthodontics services: MAD covers one recementation of a fixed bridge.

(10) Oral surgery services:

(a) simple and surgical extractions: MAD coverage includes local anesthesia and routine post-operative care; erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(b) autogenous tooth reimplantation of a permanent tooth: MAD covers for a MAP eligible recipient under 21 years of age; and

(c) the incision and the drainage of an abscess for a MAP eligible recipient.

(11) Adjunctive general services: MAD covers emergency palliative treatment of dental pain for a MAP eligible recipient. MAD also covers general anesthesia and intravenous sedation for a MAP eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. For a MAP eligible recipient under 21 years of age, MAD covers the use of nitrous oxide analgesia. For a MAP eligible recipient 21 years of age and older, MAD does not cover the use of nitrous oxide analgesia.

(12) Hospital care: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with a prior authorization, unless one of the following conditions exist:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified; or

(c) any service which requires a prior authorization in an outpatient setting must have a prior authorization if performed in an inpatient hospital.

(13) Behavioral management: Dental behavior management as a means to assure comprehensive oral health care for persons with developmental disabilities is covered. This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment of a special needs MAP eligible recipient. Dentists who have completed the training and received their certification from DOH are eligible for reimbursement.

(14) Noncovered dental services: MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. MAD covers orthodontic services only for a MAP eligible recipient under 21 years of age and only when specific criteria are met to assure medical necessary. MAD does not cover the following specific services:

(a) surgical tray is considered part of the surgical procedure and is not reimburse separately for tray;

(b) sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

(c) oral preparations, including topical fluorides dispensed to a MAP eligible recipient for home use;

(d) permanent fixed bridges;

(e) procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

(f) procedures for desensitization, re-mineralization or tooth bleaching;

(g) occlusal adjustments, disking, overhang removal or equilibration;

(h) mastique or veneer procedures;

(i) treatment of TMJ disorders, bite openers and orthotic appliances;

(j) services furnished by non-certified dental assistants, such as radiographs;

(k) implants and implant-related services; or

(l) removable unilateral cast metal partial dentures.

H. Podiatry and procedures on the foot: MAD covers only medically necessary podiatric services furnished by a provider, as required by the condition of the MAP eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and rules. MAD covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, post a hazard to a MAP eligible recipient with a medical condition. MAD 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 MAP eligible recipient's medical record. MAD covers the following specific podiatry services.

(1) Routine foot care: Routine foot care services that do not meet the coverage criteria of medicare part B are not covered by MAD. MAD covers services only when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination. A MAP eligible recipient with diagnoses marked by an asterisk(*) in the list below must be under the active care of a physician or physician assistant (PA). to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60-calendar days after the routine foot care service. A CNP, PA and a CNS do not satisfy the coverage condition of "active care by a PCP".

(2) Common billed diagnoses: The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;
(b) arteriosclerosis obliterans;
(c) buerger's disease;
(d) chronic thrombophlebitis*;
(e) neuropathies involving the feet associated with:
(i) malnutrition and vitamin deficiency*;
(ii) malnutrition (general, pellagra);
(iii) alcoholism;
(iv) malabsorption (celiac disease, tropical sprue);
(v) pernicious anemia;
(vi) carcinoma*;
(vii) diabetes mellitus*;
(viii) drugs or toxins*;
(ix) multiple sclerosis*;
(x) uremia (chronic renal disease)*;
(xi) traumatic injury;
(xii) leprosy or neurosyphilis;
(xiii) hereditary disorders;
(xiv) hereditary sensory radicular neuropathy;
(xv) fabry's disease; and
(xvi) amyloid neuropathy.

(3) Routine foot care services: MAD covers routine foot care services for a MAP eligible recipient who has a systemic condition and meets the severity in the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) class A findings: non-traumatic amputation of foot or integral skeletal portion thereof;
(b) class B findings:
(i) absent posterior tibial pulse;
(ii) absent dorsalis pedis pulse; and
(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness);
(c) class C findings:
(i) claudication;
(ii) temperature changes (e.g., cold feet);
(iii) edema;
(iv) paresthesias (abnormal spontaneous sensations in the feet); or
(v) burning.

(4) Subluxated foot structure: Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

(5) Foot warts: MAD covers the treatment of warts on the feet.

(6) Asymptomatic mycotic nails: MAD covers the treatment of asymptomatic mycotic nails in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care.

(7) Mycotic nails: MAD covers the treatment of mycotic nails in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(a) marked, significant limitation;
(b) pain; or
(c) secondary infection.

(8) Orthopedic shoes and other supportive devices: MAD only covers these items when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics who is a MAP eligible recipient.

(9) Hospitalization: If the MAP eligible recipient has existing medical condition that would predispose them to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered.

(10) Noncovered podiatric services: A provider is subject to the limitations and coverage restrictions that exist for other medical services. MAD does not cover the following specific services or procedures.

(a) Routine foot care is not covered except as indicated under "covered services" for a MAP eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(i) trimming, cutting, clipping and debriding toenails;

(ii) cutting or removal of corns, calluses, or hyperkeratosis;

(iii) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast MAP eligible recipient; and

(iv) any other service performed in the absence of localized illness, injury or symptoms involving the foot.

(b) Services directed toward the care or the correction of a flat foot condition are not covered. Flat foot is defined as a condition in which one or more arches of the foot have flattened out.

(c) Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to a diabetic MAP eligible recipient.

(d) Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

(e) MAD will not reimburse for services that have been denied by medicare for coverage limitations.

I. Anesthesia: MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the MAP eligible recipient. All services must be provided within the limits of MAD benefit package, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and rules.

(1) When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

(2) An anesthesia service is not covered if the medical or surgical procedure is not a MAD covered service.

(3) Separate payment is not allowed for qualifying circumstances. Payment is considered bundled into the anesthesia allowance.

(4) Separate payment is not allowed for the anesthesia complicated by the physical status of the MAP eligible recipient.

J. Vision: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a MAP eligible recipient. MAD pays for the correction of refractive errors required by the condition of the MAP eligible recipient. All services must be furnished within the limits of the MAD benefits package, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules.

(1) Vision exam: MAD covers routine eye exams. Coverage for an eligible adult recipient 21 years of age and older of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the MAP eligible recipient's visual examination record and indicated by diagnosis on the claim. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

(2) Noncovered vision services: MAD does not cover vision services that are performed for aesthetic or cosmetic purposes. MAD covers orthoptic assessments and treatments only when specific criteria are met to assure medical necessity.

K. Hearing: All audiology screening, diagnostic, preventive or corrective services require medical clearance. Audiologic and vestibular function studies are rendered by an audiologist or a PCP. Hearing aid dealers

and dispensers are not reimbursed for audiological, audiometric or other hearing tests. Only licensed audiologists and PCPs are reimbursed for providing these testing services.

L. Client medical transportation: MAD covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MAP eligible recipient in or out of their home community. See 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment. MAD reimburses a MAP eligible recipient or the transportation provider for medically necessary transportation subject to the following.

(1) Free alternatives: Alternative transportation services which may be provided free of charge include volunteers, relatives or transportation services provided by a nursing facility (NF) or another residential center. A MAP eligible recipient must certify in writing that they do not have access to free alternatives.

(2) Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before the MAP eligible recipient can use more expensive transportation alternatives.

(3) Non-emergency transportation service:

(a) MAD covers non-emergency transportation services for a MAP eligible recipient who does not have primary transportation to a MAD covered service and who is unable to access a less costly form of public transportation.

(b) MAP eligible recipients released from incarceration at a correctional facility may be transported by a New Mexico medicaid transportation provider to a pharmacy to fill and retrieve prescribed medication. The eligible recipient must have a valid prescription that is qualified to be filled or re-filled at the time of their release from incarceration.

(4) Long distance common carriers: MAD covers long distance services furnished by a common carrier if the MAP eligible recipient must leave their home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the MAP eligible recipient's local county income support division (ISD) office.

(5) Ground ambulance services: MAD covers services for a MAP eligible recipient provided by ground ambulances when:

(a) an emergency which requires ambulance service is certified by the attending provider or is documented in the provider's records as meeting emergency medical necessity as defined as:

(i) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(ii) medical necessity for ambulance services is established if the MAP eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(b) Scheduled, non-emergency ambulance services: These services are covered when ordered by the MAP eligible recipient's attending provider who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's medical or behavioral condition.

(c) Reusable items and oxygen: MAD covers non-reusable items and oxygen required during transportation. Coverage for these items is included in the base rate reimbursement for a ground ambulance;

(6) Air ambulance services: MAD covers services for a MAP eligible recipient provided by an air ambulance, including a private airplane, if an emergency exists and the medical necessity for the service is certified by their attending provider.

(a) An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant individual, the health of

the individual or their unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(b) MAD covers the following services for air ambulances:

(i) non-reusable items and oxygen required during transportation;

(ii) professional attendants required during transportation; and

(iii) detention time or standby time up to one hour without provider documentation; if the detention or standby time is more than one hour, a statement from the attending provider or flight nurse justifying the additional time is required.

(7) Lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical or behavioral health services and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, in-state lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15-calendar days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the attending provider's statement of need. Authorization forms for direct payment to a MAD approved lodging provider by MAD are available through local county ISD offices. In addition, overnight lodging could include the following situations:

(a) a MAP eligible recipient who is required to travel more than four hours each way to receive medical or behavioral health services; or

(b) a MAP eligible recipient who is required to travel less than four hours each way and is receiving daily medical or behavioral health services and is not sufficiently stable to travel or must be near a facility because of the potential need for emergency or critical care.

(8) Meal services: MAD covers meals if a MAP eligible recipient is required to leave their home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to a meal provider by MAD are available through local county ISD offices.

(9) Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for a MAP eligible recipient for one attendant if the medical necessity for the attendant is certified in writing by the MAP eligible recipient's attending provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. MAD only covers transportation services or related expenses for a MAP eligible recipient and as certified, their attendant. Transportation services and related expenses will not be reimbursed by MAD for any other individual accompanying the MAP eligible recipient to a MAD covered medical or behavioral health service.

(10) Coverage for a MAP eligible waiver recipient: Transportation of a MAP eligible waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy or an outpatient behavioral health therapy.

(11) Out-of-state transportation and related expenses: All out-of-state transportation, meals and lodging must be prior approved by MAD or its designee. Out-of-state transportation is approved only if the out-of-state medical or behavioral health service is approved by MAD or its designee. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

(a) Requests for out-of-state transportation must be coordinated through MAD or its designee;

(b) Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30-calendar days by MAD or its designee. Re-evaluation authorizations are completed prior to expiration and every 30-calendar days, thereafter.

(c) Border cities: A border city is a city within 100 miles of a New Mexico border (Mexico excluded). Transportation to a border city is treated as in-state provider service. A MAP eligible recipient who receives a MAD reimbursable service from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, to determine when a provider is considered an out-of-state provider or a border area provider.

(12) Client medical transportation fund: In a non-emergency situation, a MAP eligible recipient can request reimbursement from the client medical transportation (CMT) fund through their local county ISD office for money spent on transportation, meals and lodging by the MAP eligible recipient; for reimbursement from the CMT fund, a MAP eligible recipient must apply for reimbursement within 30-calendar days from the date of appointment or the date they are discharged from the hospital.

(a) Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the MAD approved provider visit to receive reimbursement:

(i) submit a letter on the provider's stationary which indicates that the MAP eligible recipient kept the appointment for which the CMT fund reimbursement is requested; for medical or behavioral health services, written receipts confirming the date of service must be given to the MAP eligible recipient for submission to the local county ISD office;

(ii) proper referral with original signatures and documentation stating that the MAD services are not available within the community from the MAD requesting provider, when a referral is necessary;

(iii) verification of current eligibility of the recipient for a MAD service for the month the appointment and travel is made;

(iv) certification that free alternative transportation services are not available and that the MAP eligible recipient is not enrolled in a HCA contracted managed care organization (MCO);

(v) verification of mileage; and

(vi) documentation justifying a medical attendant.

(b) Preparation of referrals for travel outside the home community: If a MAP eligible recipient must travel over 65 miles from their home community to receive medical care, the transportation provider must obtain a written verification from the referring provider or from the service provider containing the following information for the provider to retain with their billing records:

(i) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(ii) the name of the out of community medical or behavioral health provider; and

(iii) justification that the medical or behavioral health care is not available in the home community.

(c) Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. An emergency is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical or behavioral health appointment.

(i) The ISD CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate utilization review (UR) contractor verifies that the recipient is eligible for a MAD service and has a medical or behavioral health appointment prior to advancing money from the CMT fund and that the MAP eligible recipient is not enrolled in a HCA contracted MCO;

(ii) written referral for out of community service must be received by the CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate UR contractor no later than 30-calendar days from the date of the medical or behavioral health appointment for which the advance funds were requested. If a MAP eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated; see Section OIG-900, Restitutions.

(d) MAP Eligible recipients enrolled in a HCA contracted MCO: A member enrolled in HCA contracted MCO on the date of service is not eligible to use the client medical transportation fund for services that are the responsibility of the MAP eligible recipient's MCO.

(13) Noncovered transportation services: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a non-covered MAD service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

(a) an attendant where there is not the required certification from the MAP eligible recipient's medical or behavioral health provider;

(b) minor aged children of the MAP eligible recipient that are simply accompanying them to medical or behavioral health services;

(c) transportation to a non-covered MAD service;

(d) transportation to a pharmacy provider with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release; see 8.324.7 NMAC.

M. Telehealth services:

(1) Telemedicine visits: An interactive HIPAA compliant telecommunication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant sites. If

real-time audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person as a face to face encounter. Coverage for services rendered through telemedicine shall be determined in a manner consistent with medicaid coverage for health care services provided through in person consultation. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities. Provision of telemedicine services does not require that a certified medicaid healthcare provider be physically present with the MAP eligible recipient at the originating site unless the telemedicine consultant at the distant site deems it necessary.

(a) Telemedicine originating-site: The location of a MAP eligible recipient at the time the service is being furnished via an interactive telemedicine communications system. The origination-site can be any of the following medically warranted sites where services are furnished to a MAP eligible recipient.

(i) The office of a physician or practitioner.

(ii) A critical access hospital (as described in section 1861 (mm)(1) of the Act).

(iii) A rural health clinic (as described in 1861 (mm)(2) of the Act).

(iv) A federally qualified health center (as defined in section 1861 (aa)(4) of the Act).

(v) A hospital (as defined in section 1861 (e) of the Act).

(vi) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(vii) A skilled nursing facility (as defined in section 1819(a) of the Act).

(viii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Act).

(ix) A renal dialysis facility (only for the purposes of the home dialysis monthly ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(x) The home of an individual (only for purposes of the home dialysis ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(xi) A mobile stroke unit (only for the purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke provided in accordance with section 1834(m)(6) of the Act).

(xii) The home of an individual (only for the purposes of treatment of a substance use disorder or a co-occurring mental health disorder), furnished on or after July 1, 2019, to an individual with a substance use disorder diagnosis.

(xiii) The home of an individual when an interactive audio and video telecommunication system that permits real-time visit is used between the eligible provider and the MAP eligible recipient.

(xiv) A School Based Health Center (SBHC) as defined by section 2110(c)(9) of the Act.

(b) Telemedicine distant-site: The location where the telemedicine provider is physically located at the time of the telemedicine service. All services are covered to the same extent the service and the provider are covered when not provided through telemedicine. For these services, use of the telemedicine communications system fulfills the requirement for a face-to-face encounter.

(c) Telemedicine reimbursement: MAD covers both distant (where the eligible provider is located) as well as the originating sites (where the MAP eligible recipient is located, if another eligible provider accompanies the patient). If audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person and no additional reimbursement is made.

(d) Telemedicine providers: Reimbursement for professional services at the originating-site and the distant-site are made at the same rate as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for a real-time interactive audio/video technology telemedicine system fee (where the MAP eligible recipient is located, if another eligible provider accompanies the patient) at the lesser of the provider's billed charge, or the maximum allowed by MAD for the specific service of procedure. If the originating site is the patient's home, the originating site fee should not be billed if the eligible provider does not accompany the MAP eligible recipient. The MAP eligible recipient is not reimbursed for their computer/internet.

(e) A telemedicine originating-site communication system fee is covered if the MAP eligible recipient was present at and participated in the telemedicine visit at the originating-site and the system that is used meets the definition of a telemedicine system.

(2) Telephone visits: MAD will reimburse eligible providers for limited professional services delivered by telephone without video. No additional reimbursement is made to the originating-site for an interactive telemedicine system fee.

(3) MAD will reimburse for services delivered through store-and-forward. To be eligible for payment under store-and-forward, the service must be provided through the transference of digital images, sounds, or previously recorded video from one location to another; to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation. Store-and-forward telemedicine includes encounters that do not occur in real time (asynchronous) and are consultants that do not require face-to-face live encounter between patient and telemedicine provider.

(4) Noncovered telemedicine services: A service provided through telemedicine is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine. Telemedicine services are not covered when audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting.

N. Pregnancy termination services: MAD does not cover the performance of 'elective' pregnancy termination procedures. MAD will only pay for services to terminate a pregnancy when certain conditions are met.

(1) Prior to performing pregnancy termination services providers must complete and file in the MAP eligible recipient medical record, a consent for pregnancy termination that includes written certification of a provider that the procedure meets one of the following conditions:

(a) the procedure is necessary to save the life of the MAP eligible recipient as certified in writing by a provider;

(b) the pregnancy is a result of rape or incest, as certified by the treating provider, the appropriate reporting agency, or if not reported, the MAP eligible recipient is not physically or emotionally able to report the incident; or

(c) the procedure is necessary to terminate an ectopic pregnancy; or

(d) the procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient.

(2) Psychological services: MAD covers behavioral health services for a pregnant MAP eligible recipient.

(3) Oral medications: MAD covers oral medications approved by the FDA have been determined a benefit by MAD for pregnancy termination. MAD will cover oral medications when administered by a provider acting within the scope of their practice board and licensure.

(4) Informed consent: Under New Mexico law, the provider may not require any MAP eligible recipient to accept any medical service, diagnosis, or treatment or to undergo any other health service provided under the plan if the MAP eligible recipient objects on religious grounds or in the case of a non-emancipated MAP eligible recipient, the legal parent or guardian of the non-emancipated MAP eligible recipient objects.

(a) Consent: Voluntary, informed consent by a MAP eligible recipient 18 years of age and older, or an emancipated minor MAP eligible recipient must be given to the provider prior to the procedure to terminate pregnancy, except in the following circumstances:

(i) in instances where a medical emergency exists; a medical emergency exists in situations where the attending PCP certifies that, based on the facts of the case presented, in their best clinical judgment, the life or the health of the MAP eligible recipient is endangered by the pregnancy so as to require an immediate pregnancy termination procedure;

(ii) in instances where the MAP eligible recipient is unconscious, incapacitated, or otherwise incapable of giving consent; in such circumstances, the consent shall be obtained as prescribed by New Mexico law;

(iii) in instances where pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the MAP eligible recipient;

(iv) consent is valid for 30-calendar days from the date of signature, unless withdrawn by the MAP eligible recipient prior to the procedure.

(b) Required acknowledgements: In signing the consent, the MAP eligible recipient must acknowledge that they have received, at least, the following information:

(i) alternatives to pregnancy termination;

(ii) medical procedure(s) to be used;

(iii) possibility of the physical, mental, or both, side effects from the performance of the procedure;

(iv) right to receive pregnancy termination behavioral health services from an independent MAD provider; and

(v) right to withdraw consent up until the time the procedure is going to be performed.

(c) Record retention: A dated and signed copy of the consent, with counseling referral information, if requested, must be given to the MAP eligible recipient. The provider must keep the original signed consent with the MAP eligible recipient's medical records.

(d) Consent for a MAP eligible recipient under 18 years of age who is not an emancipated minor, in instances not involving life endangerment, rape or incest: Informed written consent for an non-emancipated minor to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or another adult acting 'in loco parentis' to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating PCP shall note the minor's objections or the unavailability of the parent or guardian in the minor's chart, and:

(i) certify in their best clinical judgment, the minor is mature enough and well enough informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, certify that the procedure is in the minor's best interests based on the information provided to the treating PCP by the minor; or

(ii) refer the minor to an independent MAD behavioral health provider in circumstances where the treating PCP believes behavioral health services are necessary before a clinical judgment can be rendered on the criteria established in Paragraph (1) above; the referral shall be made on the same day of the visit between the minor and the treating PCP where consent is discussed; the independent MAD behavioral health provider shall meet with the minor and confirm in writing to the treating PCP whether or not the minor is mature enough and sufficiently informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, that the procedure is in the minor's best interests based on the information provided to the independent MAD behavioral health provider by the minor; this provider's written report is due to the treating PCP within 72 hours of initial referral;

(iii) a minor shall not be required to obtain behavioral health services referenced in Paragraph (2) above; however, if the treating PCP is unable or unwilling to independently certify the requirements established in Paragraph (1) above, the minor must be informed by the treating PCP that written consent must be obtained by the parent, legal guardian or parent 'in loco parentis' prior to performing the procedure; or, that the minor must obtain a court order allowing the procedure without parental consent.

O. Behavioral health professional services: Behavioral health services are addressed specifically in 8.321.2 NMAC.

P. Experimental or investigational services: MAD covers medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD. MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices, except the following:

(1) Phase I, II, III or IV: MAD may approve coverage for routine patient care costs incurred as a result of the MAP eligible recipient's participation in a phase I, II, III, or IV cancer trial that meets the following criteria. The cancer clinical trial is being conducted with the approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the FDA in the form of an investigational new drug application;

(e) the federal department of veteran affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

(2) Review and approval: The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research risks of the federal national institutes of health.

(3) Experimental or investigational interventions: Any medical, surgical, or other healthcare procedure or treatment, including the use of a drug, a biological product, another product or device, is considered experimental or investigational if it meets any of the following conditions:

(a) current, authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of a drug, a biological product, another product or device for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting;

(b) the drug, biological product, other product, device, procedure or treatment (the "technology") lacks final approval from the FDA or any other governmental body having authority to regulate the technology;

(c) the medical, surgical, other health care procedure or treatment, including the use of a drug, a biological product, another product or device is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting.

(4) Review of conditions: On request of MAD or its designee, a provider of a particular service can be required to present current, authoritative medical and scientific evidence that the proposed technology is not considered experimental or investigational.

(5) Reimbursement: MAD does not reimburse for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products or devices that are considered experimental or investigational, except as specified as follows. MAD will reimburse a provider for routine patient care services, which are those medically necessary services that would be covered if the MAP eligible recipient were receiving standard cancer treatment, rendered during the MAP eligible recipient's participation in phase I, II, III, or IV cancer clinical trials.

(6) Experimental or investigational services: MAD does not cover procedures, technologies or therapies that are considered experimental or investigational.

Q. Smoking/Tobacco cessation: MAD covers tobacco cessation services for all MAP eligible recipients.

(1) Eligible medical, dental, and behavioral health practitioner: Cessation counseling services may be provided by one of the following:

(a) by or under the supervision of a physician; or

(b) by any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law;

(c) generally, eligible practitioners would be medical practitioners, including independently enrolled CNPs, behavioral health and dental practitioners; physician assistants and CNPs not enrolled as independent MAD providers, and registered nurses and dental hygienists may bill for counseling services through the enrolled entity under which their other services are billed, when under the supervision of a dentist or physician;

(d) counseling service must be prescribed by a MAD enrolled licensed practitioner.

(2) Eligible pharmacy providers: For rendering tobacco cessation services, eligible pharmacists are those who have attended at least one continuing education course on tobacco cessation in accordance with the federal public health guidelines found in the United States department of health and human services; public health services' *quick reference guide for clinicians*, and *treating tobacco use and dependence*.

(3) Tobacco cessation drug items: MAD covers all prescribed tobacco cessation drug items for a MAP eligible recipient as listed in this section when ordered by a MAD enrolled prescriber and dispensed by a MAD enrolled pharmacy. MAD does not require prior authorization for reimbursement for tobacco cessation products, but the items must be prescribed by a MAD enrolled practitioner. Tobacco cessation products include, but are not limited to the following:

(a) sustained release buproprion products;

(b) varenicline tartrate tablets; and

(c) prescription and over-the-counter (OTC) nicotine replacement drug products, such as lozenges, patches, gums, sprays and inhalers.

(4) Covered services: MAD makes reimbursement for assessing all MAP eligible recipient's tobacco dependence including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, and may bill using the E&M codes. MAD covers face-to-face counseling when rendered by an appropriate provider. The effectiveness of counseling is comparable to pharmacotherapy alone. Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of

tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session refers face-to-face MAP eligible recipient contact of either

(a) intermediate session (greater than three minutes up to 10 minutes); or

(b) intensive session (greater than 10 minutes).

(5) Documentation for counseling services: Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered, which may consist of documentation of tobacco use. The rendering practitioner must maintain documentation that face-to-face counseling was prescribed by a practitioner, even if the case is a referral to self, consistent with other NMAC rules and other materials.

(6) Limitations on counseling sessions: The services do not have any limits on the length of treatment or quit attempts per year. The program also allows participants to try multiple treatments and does not impose any requirement to enroll into counseling. During the 12-month period, the practitioner and the MAP eligible recipient have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

R. Screening, brief intervention and referral to treatment (SBIRT) service: SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with physical health care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for behavioral health treatment, the certified SBIRT staff, with the eligible recipient's approval, assists in securing behavioral health services. Only a physical health office, clinic, or facility who has been certified by a HCA approved SBIRT trainer and uses the approved healthy lifestyle questionnaire (HLQ) can complete the screen. The physical office, clinic or facility must be the billing provider, not the individual practitioner. All practitioners must be SBIRT certified and are employees or contractors of a SBIRT physical health office, clinic or facility. See the SBIRT policy and billing manual for detailed description of the service and billing requirements.

S. Other services: Other covered and noncovered services including hospitalization and other residential facilities, devices for hearing and vision correction, behavioral health services, home and community based services, EPSDT services, case management and other adjunct and specialty services are described in other NMAC rules.

[8.310.2.12 NMAC - Rp, 8.310.2.12 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022; A/E, 1/1/2025; A, 7/1/2025]

8.310.2.13 GENERAL NONCOVERED SERVICES

A. General noncovered services: MAD does not cover certain procedures, services, or miscellaneous items. See specific provider or service rules or sections of this rule for additional information on service coverage and limitations. A provider cannot turn an account over to collections or to any other factor intending to collect from the MAP eligible recipient or their authorized representative; see 8.302.2 NMAC. A provider cannot bill a MAP eligible recipient or their authorized representative for the copying of the MAP eligible recipient's records, and must provide copies of the MAP eligible recipient's records to other providers upon request of the MAP eligible recipient.

B. Appointment, interest and carrying charges: MAD does not cover penalties on payments for broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts. A provider may not bill a MAP eligible recipient or their authorized representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of CHIP or WDI who may be charged up to $5 for a missed appointment.

C. Contract services: Services furnished by a contractor, an organization, or an individual who is not the billing provider must meet specific criteria for coverage as stated in MAD or its designee's NMAC rules, billing instructions, policy manuals; see 8.302.2 NMAC.

D. Cosmetic services and surgeries: MAD does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, for hair loss, and personal care items such as non-prescription lotions, shampoos, soaps or sunscreens. MAD does not cover cosmetic surgeries performed for aesthetic purposes. "*Cosmetic surgery*" is defined as a procedure performed to improve the appearance of physical features that may or may not improve the functional ability of the area of concern. MAD covers only a surgery that meets specific criteria and is approved as medically necessary reconstructive surgery.

E. Postmortem examinations: MAD does not cover postmortem examinations.

F. Education or vocational services: MAD does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for a MAP eligible recipient under 21 years of age, as part of the EPSDT program and for a pregnant MAP eligible recipient. MAD does not cover formal educational or vocational training services, unless those services are included as active treatment services for a MAP eligible recipient in intermediate care facility for individuals with intellectual disabilities (ICF-IID)or for a MAP eligible recipient under 21 years of age receiving inpatient psychiatric services. See 42 CFR 441.13(b). "*Formal educational services*" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of a MAP eligible recipient for paid or unpaid employment.

G. Hair or nail analysis: MAD does not cover hair or nail analysis.

H. Preparations dispensed for home use: MAD does not cover oral, topical, otic, or ophthalmic preparations dispensed to a MAP eligible recipient by a PCP, a CNP, a P.A., or an optometrist for home use or self administration unless authorized by MAD to assure the availability of medications.

I. Routine physical examinations: MAD only covers a routine physical examination for:

(1) a MAP eligible recipient residing in a NF or an ICF-IID facility.

(2) a MAP eligible recipient under 21 years of age through the tot to teen health check screen, New Mexico's EPSDT screening program. Included in the coverage is the physical examinations, screenings and treatment.

J. Screening services: MAD does not cover screening services that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. MAD covers screening services for a MAP eligible recipient under 21 years of age through the tot to teen healthcheck program. MAD covers screening services ordered by a provider for cancer detection such as pap smears and mammograms for a MAP eligible recipient when medically appropriate.

K. Services not covered by medicare: MAD does not cover services, procedures, or devices that are not covered by medicare due to their determination that the service is not medically necessary or that the service is experimental or not effective.

L. Bariatric surgery services: Bariatric surgery services are covered only when medically indicated and alternatives are not successful.

M. Services and tests which are not routinely warranted due to the MAP eligible recipient's age: MAD does not reimburse for routine screening, tests, or services which are not medically necessary due to the age of the MAP eligible recipient:

(1) Papanicolaou test (pap smear) for women under 21 years of age unless prior history or risk factors make the test medically warranted; and

(2) prostate specific antigen (PSA) test for men under age 40 unless prior history or risk factors make the test medically warranted.

N. Services for surrogate mothers: MAD does not pay for services for pregnancy, complications encountered during pregnancy related conditions, prenatal care and postpartum care, or delivery for services to a surrogate mother for which an agreement or contract between the surrogate mother and another party exists.
[8.310.2.13 NMAC - Rp, 8.310.2.14 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022; A, 7/1/2025]

8.310.2.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for hard 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 HCA, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization was obtained remain subject to UR at any point in the payment process, including after payment has been made. It is the provider's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

(1) Dental services: MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when a prior authorization is received from MAD or its designee. MAD covers medically

necessary orthodontic services to treat handicapping malocclusions for a MAP eligible recipient under 21 years of age by prior authorization.

(2) Transplantation services**:** A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

(3) Pregnancy termination services: Services to terminate a pregnancy do not require a prior authorization from MAD or its designee.

(4) Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for MAD or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if a MAP eligible recipient has other health insurance.

(5) Reconsideration: A provider who disagrees with a prior authorization -request denial or another review decision can request reconsideration; see 8.350.2 NMAC.

B. Prior authorization and UR: MAD has developed a UR process to regulate provider compliance with MAD quality control and cost containment objectives. See 42 CFR Section 456. Specific details pertinent to a service or a provider are contained in NMAC rules or UR instructions for that specific service or provider type. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instruction, UR 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 HCA 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 their MAD provider participation agreement (PPA) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made.

C. Medical necessity requirements: MAD reimburses a provider for furnishing MAD covered service to a MAP eligible recipient only when the service is medically necessary. Medical necessity is required for the specific service, level of care (LOC), and service setting, if relevant to the service. A provider must verify that MAD covers a specific service and that the service is medically necessary prior to furnishing the service. Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service that are reviewed and approved by MAD. MAD denies payment for services that are not medically necessary and for services that are not covered by MAD. The process for determining medical necessity is called UR. The UR of a MAD service may be performed directly by MAD or its designee, or another state agency designated by MAD.

D. Timing of UR:

(1) A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements. The following are examples of the reviews that may be performed:

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

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

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

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

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

(2) Prior authorization reviews: A claim for a service that requires a prior authorization are paid only if the prior authorization was obtained and approved by MAD or MAD's UR contractor, prior to services being furnished. A prior authorization specifies the approved number of service units that a provider is authorized to furnish to a MAP eligible recipient and the date the service must be provided.

(a) A prior authorization does not guarantee that an individual is eligible for a specific MAD service. A provider must verify that individuals are eligible for a specific MAD service at the time the service is furnished.

(b) Information on the specific service or procedure that requires a prior authorization for a specific provider type are contained in the applicable MAD rules and the UR instructions for that provider type or service.

(c) A service that has been approved by MAD or its designee does not prevent a later denial of payment if the service has been determined to be not medically necessary or if the individual was not eligible for the service.

(d) A prior authorization review is used to authorize service for a MAP eligible recipient before a service is furnished. A request for a retroactive prior authorization may be approved only under the following circumstances:

(i) approval is made as part of the process of determining MAD eligibility for certain categories, such as a MAD institutional care or home and community-based services waiver (HCBSW) programs. In these situations, the determination of medical necessity for an institutional LOC of the service is a factor in establishing MAD eligibility and may be made after the MAP eligible recipient receives NF or HCBSW services;

(ii) the service is furnished before the determination of the effective date of the recipient's MAP eligibility for a MAD service or the servicing provider's MAD PPA; a retrospective request for a prior authorization is based on retrospective recipient or provider eligibility must be received in writing by MAD or its designee within 30 calendar days of the date of the eligibility determination;

(iii) in cases of medical emergency; a medical emergency is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in one of the following: an individual's death; placement of an individual's health in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part;

(iv) a service that is furnished to a medicare recipient who is also eligible for a MAD service and medicare has denied payment for a reason that is not based on medical necessity; requests for a retroactive prior authorization must be accompanied by a copy of the document from medicare that denied payment and states the reason for denial; a service denied payment by medicare because of lack of medical necessity is not covered by MAD.

(3) Concurrent review: A concurrent review is conducted while the service is being furnished. A continued stay or continued service review is concurrent review for medical necessity.

(4) Prepayment review: A prepayment review is conducted after a service has been furnished and a claim for payment has been filed by the provider. If a service is not a covered MAD benefit or not medically necessary, payment for that service will be denied.

(5) Retrospective review: A retrospective review is conducted after the claim has been processed and payment is made. Information from the paid claim is compared with the provider records detailing the service and medical necessity.

(a) If MAD determines the service specified on the claim was not performed or, was not a covered benefit or was not medically necessary, the MAD payment is recouped.

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

(c) A retrospective review may be conducted by MAD or its designee on a random or selective basis. In addition to reviews performed by a MAD staff or its designee, MAD analyzes statistical data to determine utilization patterns. Specific areas of overutilization may be identified that result in recoupment or repayment from either or both a provider or the assignment of a MAP eligible recipient to a MAD medical management designated provider.

(d) A selective or scheduled review is conducted to focus on the overutilization and underutilization of a specific service or provider. The service or procedure selected for this focused retrospective review is identified by MAD as potential or actual problems.

E. Denial of payment: If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

F. Review of decisions: A provider who disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial

review and issued the initial decision; see 8.350.2 NMAC. A provider who is not satisfied with the reconsideration determination may request a HCA provider administrative hearing; see 8.352.3 NMAC.
[8.310.2.14 NMAC - Rp, 8.310.2.15 NMAC, 1/1/2014; A, 7/1/2025]

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 1/9/1980.
ISD 310.0100, Physician Services, filed 6/16/1980.
ISD 310.0100, Physician Services, filed 4/2/1982.
ISD-Rule-310.0100, Physician Services, filed 9/2/1983.
ISD-Rule-310.0100, Physician Services, filed 3/30/1984.
ISD-Rule-310.0100, Physician Services, filed 4/26/1984.
ISD-Rule-310.0100, Physician Services, filed 2/25/1986.
MAD Rule 310.01, Physician Services, filed 12/15/1987.
MAD Rule 310.01, Physician Services, filed 4/27/1988.
MAD Rule 310.01, Physician Services, filed 4/20/1992.
MAD Rule 310.01, Physician Services, filed 3/10/1994.
SP-004.0400, Section 4, General Program Administration Medicaid Quality Control, filed, 1/23/1981
SP-003.0103, Standards and Methods for Assuring High Quality Care, filed 1/27/1981.
SP-004.1400, Section 4, General Program Administration Utilization Control, filed 3/3/1981.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990.
ISD 310.1000, Vision Care Services, filed 2/13/1980.
ISD 310.1000, Vision Care Services, filed 7/8/1982.
ISD Rule 310.1000, Vision Care Services, filed 2/28/1983.
ISD Rule 310.1000, Vision Care Services, filed 8/23/1984.
MAD Rule 310.10, Vision Care Services, filed 12/15/1987.
MAD Rule 310.10, Vision Care Services, filed 10/26/1988.
MAD Rule 310.10, Vision Care Services, filed 4/20/1992.
ISD 310.0900, Dental Services, filed 2/13/1980.
ISD 310.0900, Dental Services, filed 6/8/1981.
ISD 310.0900, Dental Services, filed 10/14/1983.
MAD Rule 310.09, Dental Services, filed 4/20/1992.
MAD Rule 310.09, Dental Services, filed 11/12/1993.
ISD 310.1500, Psychiatric and Psychological Services, filed 2/13/1980.
ISD Rule 310.1500, Psychiatric and Psychological Services, filed 2/7/1986.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12/15/1987.
ISD Rule 310.1900, Certified Nurse Midwife Services, filed 9/19/1983.
MAD Rule 310.19, Certified Nurse Midwife Services, filed 12/15/1987.
MAD Rule 310.19, Midwife Services, filed 8/31/1989.
ISD 310.1100, Podiatry Services, filed 2/13/1980.
ISD 310.1100, Podiatry Services, filed 10/14/1981.
ISD Rule 310.1100, Podiatry Services, filed 2/28/1983.
ISD Rule 310.1100, Podiatry Services, filed 2/21/1986.
MAD Rule 310.11, Podiatry Services, filed 12/15/1987.
MAD Rule 310.11, Podiatry Services, filed 4/27/1988.
MAD Rule 310.11, Podiatry Services, filed 4/20/1992.
ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985.
SP-003.0400, Section 3, Services: General Provisions Special Requirements Applicable to Sterilization Procedures, filed 1/23/1981.
ISD 310.1300, Family Planning Services, filed 2/18/1980.
MAD Rule 310.13, Family Planning Services, filed 12/15/1987.
ISD 310.0200, Hospital Services, filed 1/9/1980.
ISD 310.0200, Hospital Services, filed 12/8/1980.
ISD 310.0200, Hospital Services, filed 12/30/1981.
ISD 310.0200, Hospital Services, filed 4/2/1982.

ISD 310.0200, Hospital Services, filed 7/8/1982.
ISD Rule 310.0200, Hospital Services, filed 4/5/1983.
ISD Rule 310.0200, Hospital Services, filed 2/15/1984.
ISD Rule 310.0200, Hospital Services, filed 4/26/1984.
ISD Rule 310.0200, Hospital Services, filed 2/21/1986.
MAD Rule 310.02, Hospital Services, filed 12/1/1987.
MAD Rule 310.02, Hospital Services, filed 4/27/1988.
MAD Rule 310.02, Hospital Services, filed 5/23/1988.
MAD Rule 310.02, Hospital Services, filed 8/18/1988.
MAD Rule 310.02, Hospital Services, filed 3/20/1989.
MAD Rule 310.02, Hospital Services, filed 7/2/1990.
MAD Rule 310.02, Hospital Services, filed 3/27/1992.
MAD Rule 310.02, Hospital Services, filed 4/21/1992.
MAD Rule 310.02, Hospital Services, filed 5/1/1992.
MAD Rule 310.02, Hospital Services, filed 7/14/1993.
MAD Rule 310.02, Hospital Services, filed 3/10/1994.
MAD Rule 310.02, Hospital Services, filed 6/15/1994.
MAD Rule 310.02, Hospital Services, filed 12/8/1994.
MAD Rule 766, Pregnancy Termination Procedures, filed 11/30/1994.

History of Repealed Material:
MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995.
MAD Rule 310.27, Anesthesia Services, field 7/2/1990 - Repealed effective 2/1/1995.
MAD Rule 310.10, Vision Care Services, filed 4/20/1992 - Repealed effective 2/1/1995.
MAD Rule 310.09, Dental Services, filed 11/12/1993 - Repealed effective 1/8/1985.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12/15/1987 - Repealed effective 2/1/1995.
MAD Rule 310.11, Podiatry Services, filed 4/20/1992 - Repealed effective 2/1/1995.
ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985 - Repealed effective 2/1/1995.
MAD Rule 310.13, Family Planning Services, filed 12/15/1987 - Repealed effective 2/1/1995.
MAD Rule 310.02, Hospital Services, filed 12/8/1994 - Repealed effective 2/1/1995.
MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995 and 5/1/1995.
8 NMAC 4.MAD.718.1, Midwife Services, filed 1/8/1985 - Repealed effective 1/1/2014.
8 NMAC 4.MAD.718.2, Podiatry Services, filed 1/8/1985 - Repealed effective 7/1/2004.
8 NMAC 4.MAD.762, Reproductive Health Services, filed 1/8/1985 0 Repealed effective 1/1/2014.
8.310.2 NMAC, Medical Services Providers, filed 2/16/2004 - Repealed effective 1/1/2014.
8.301.2 NMAC, General Benefit Description, filed 2/13/2006 - Repealed effective 1/1/2014.
8.301.3 NMAC, General Noncovered Services, filed 2/13/2006 - Repealed effective 1/1/2014.
8.301.6 NMAC, Client Medical Transportation, filed 2/14/2011 - Repealed effective 1/1/2014.
8.302.5 NMAC, Prior Authorization and Utilization Review, filed 12-11-03 - Repealed effective 1/1/2014.
8.310.5 NMAC, Anesthesia Services, filed 5/12/2003 - Repealed effective 1/1/2014.
8.310.6 NMAC, Vision Care Services, filed 11/2/2003 - Repealed effective 1/1/2014.
8.310.7 NMAC, Dental Services, filed 9/16/2002 - Repealed effective 1/1/2014.
8.310.8 NMAC, Behavioral Health Professional Services, filed 10-12-04 - Repealed effective 1/1/2014.
8.310.11 NMAC, Podiatry Services, field 6/16/2004 - Repealed effective 1/1/2014.
8.310.13 NMAC, Telehealth Services, filed 7/17/2007 - Repealed effective 1/1/2014.
8.324.9 NMAC, Nutrition Services, filed 2/17/2012 - Repealed effective 1/1/2014.
8.325.2 NMAC, Dialysis Services, filed 10/15/2004 - Repealed effective 1/1/2014.
8.325.5 NMAC, Transplant Services, filed 2/17/2012 - Repealed effective 1/1/2014.
8.325.6 NMAC, Experimental or Investigational Procedures, Technologies or Non-Drug Therapies, filed 5/12/2003 - Repealed effective 1/1/2014.
8.325.7 NMAC, Pregnancy Termination Procedures, filed 10/16/2003 - Repealed effective 1/1/2014.