This is an amendment to 8.302.2 NMAC, Sections 7 and 10, effective 1/1/2019.

8.302.2.7 DEFINITIONS:

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

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

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

D. "Co-payment" means a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be [~~paid~~] charged at the time of service or receipt of the item.

[8.302.2.7 NMAC – Rp, 8.302.7 NMAC, 10/1/2017; A, 1/1/2019]

8.302.2.10 BILLING INFORMATION:

A. Billing for services: MAD only makes payment to a provider or to the following individuals or organizations for services:

(1) a government agency or third party with a court order, based on a valid provider payment assignment; see 42 CFR Section 447.10(d)(e); or

(2) a business agent, such as billing service or accounting firm that provides statements and receives payment in the name of the provider; the agent's compensation must be related to the cost of processing the claims and not based on a percentage of the amount that is billed or collected or dependent upon collection of the payment.

B. Billing for services from group practitioners or employers of practitioners: MAD may make payments to a group practice and to an employer of an individual practitioner if the practitioner is required to turn over his fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2) (3). MAD may make payments to a facility where the services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system if the facility, foundation, plan, or organization is required by contract to submit claims for an individual practitioner.

C. Billing for referral services: A referring provider must submit to the provider receiving the referral, specimen, image, or other record, all information necessary for the provider rendering the service to bill MAD within specified time limits. An eligible recipient or their authorized representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider. Ordering, referring, prescribing, rendering and attending providers must participate in a MCO or the MAD (FFS) program, or otherwise be identifiable as a participating, out-of-network, or in-network provider for services, as determined by MAD.

D. Hospital-based services: For services that are hospital based, the hospital must provide MAP recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room (ER) physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, member or his or her authorized representative, or MAD is not responsible for payment if the hospital-based provider does not obtain this information from the hospital as necessary to bill within the specified time limits.

E. Coordinated service contractors: Some MAD services are managed by a coordinated service contractor. Contracted services may include behavioral health services, dental services, physical health services, transportation, pharmacy or other benefits as designated by the MAD. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, (UR), claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.

F. Reporting of service units: A provider must correctly report service units.

(1) For current procedural terminology (CPT) codes or healthcare common procedural coding system (HCPCS) codes that describe how units associated with time should be billed, providers are to follow those instructions.

(2) For CPT or HCPCS for services for which the provider is to bill 1 unit per 15 minute or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or one hour.

time spent	**number of 15-minute units that may be billed**	**number of 1-hour units that may be billed**
Less than 8 minutes	0 *services that are in their entirety less than 8 minutes cannot be billed*.	0 *services that are in their entirety less than 8 minutes cannot be billed*
8 minutes through 22 minutes	1	.25
23 minutes through 37 minutes	2	.5
38 minutes through 52 minutes	3	.75
53 minutes through 67 minutes	4	1
68 minutes through 82 minutes	5	1.25
83 minutes through 97 minutes	6	1.5

(3) Only time spent directly working with an eligible recipient or member to deliver treatment services is counted toward the time codes.

(4) Total time spent delivering each service using a timed code must be recorded in the medical record of each eligible recipient or member. If services provided are appropriately described by using more than one CPT or HCPCS code within a single calendar day, then the total number of units that can be billed is limited to the total treatment time. Providers must assign the most units to the treatment that took the most time.

(5) The units for codes do not take precedence over centers for medicare and medicaid services (CMS) national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to 8.310.3 NMAC.

(7) Units billed by a home and community-based services waiver provider, a behavioral health provider, an early intervention provider, and all rehabilitation services providers must also follow the requirements of this section unless exceptions are specifically stated in published MAD program rules or provider billing instructions.

G. MAD [~~has established~~] requires co-payments [~~for specified groups of eligible recipients and members~~] for specific services under the medicaid managed care program. [~~Exemptions and limits apply to the collection of co-payments.~~] The rules for medicaid managed care co-payments, including the co-payment amounts, co-payment exemptions, provider responsibilities, and member rights and responsibilities, are detailed at 8.308.14 NMAC.

[~~**(1) Provider responsibilities for collection of co-payments:**~~

~~**(a)** The professional provider is responsible for collecting any applicable co-payments due for any outpatient visit or service provided, including a physician, other practitioner, clinic, urgent care, dental, outpatient therapy, or behavioral health session or visit.~~

~~**(b)** The hospital provider is responsible for collecting any applicable co-payments due for any inpatient services provided.~~

~~**(c)** The pharmacy is responsible for collecting any co-payments due for drug items dispensed.~~

~~**(d)** The provider may not deny covered care or services to an eligible recipient or member because of the eligible recipient or member's inability to pay the co-payment amount at the time of service. The eligible recipient or member remains liable for the co-payment. The provider may attempt to collect the co-payment amount at a later appointment or by billing the eligible recipient or member.~~

~~**(e)** After an eligible recipient or member's assistance unit has reached the maximum out-of-pocket cost sharing limit (five percent of the eligible recipient or member's family's income, calculated on a quarterly basis), a provider shall reimburse any co-payments that it has collected from the eligible recipient or member in excess of the maximum out-of-pocket co-payment limit. This includes anytime a provider receives a remittance advice indicating that the co-payment was not deducted from the reimbursement.~~

~~**(f)** A provider is required to report the co-payment amount charged on the CMS-1500, UB, or pharmacy claim form or their corresponding electronic billing transactions.~~

(g) When a co-payment is applied to a claim, a provider shall accept the amounts paid by MAD or the MCO plus the applicable co-payment as payment in full.

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

(2) Provider to understand the application of co-payments: The provider is responsible for understanding and applying the rules for co-payments, including when to contact the payer to determine if a co-payment is applicable for the service for the specific eligible recipient or member.

(a) Co-payments are not applied when one or more of the following conditions are met:

(i) the service is a medicare claim or medicare advantage claim, or follows other insurer payment, so the payment is therefore toward a deductible, co-insurance, or co-payment determined by the primary payer;

(ii) the eligible recipient or member is a native American;

(iii) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the eligible recipient or member;

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

(v) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;

(vi) the maximum family out-of-pocket cost sharing limit has been reached;

(vii) the service was rendered prior to any eligibility being established including when eligibility is retroactively established to the time period of the service;

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

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

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

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

(xii) the eligible recipient, member or service is exempt from co-payment as otherwise described in these rules.

(b) Co-payments are not applied when the services are one of the following:

(i) family planning services, procedures drugs, supplies, or devices;

(ii) preventive services (well child checks, vaccines, preventive dental cleanings/exams, periodic health exams) unless treatment is rendered; or

(iii) prenatal and postpartum care and deliveries, and prenatal drug items.

(3) Payment of claims with applicable co-payments:

(a) Payment to the provider will be reduced by the amount of an eligible recipient or member's applicable cost sharing obligation, regardless of whether the provider has collected the payment.

(b) A provider may not adopt a policy of waiving all MAD co-payments or use such a policy to promote his or her practice.

(4) Children's health insurance program (CHIP) co-payment requirement: Eligible recipients or members whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients or members:

(a) $2 per prescription; applies to prescription and non-prescription drug items;

(b) $5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $5 per dental visit, unless all the services are preventive services; and

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

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

(a) $3 per prescription; applies to prescription and non-prescription drug items;

(b) $7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

~~**(c)** $7 per dental visit, unless all the services are preventive services; and~~

~~**(d)** $30 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital.~~]

H. Billing state gross receipts tax: For providers subject and registered to pay, gross receipts tax, the provider may include gross receipt tax in the billed amount when the tax applies to the item or service. The provider may only bill tax to the extent the tax is also charged to the general public. A provider may not include gross receipts tax in the billed amount when the provider is not obligated to pay gross receipts tax to the state. [8.302.2.10 NMAC - Rp, 8.302.2.10 NMAC, 10/1/2017; A, 1/1/2019]