TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 12 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES

8.310.12.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.12.1 NMAC - N, 11-1-14]

8.310.12.2 SCOPE: This rule applies to the general public.
[8.310.12.2 NMAC - N, 11-1-14]

8.310.12.3 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 Section 27-2-12 et seq. NMSA 1978.
[8.310.12.3 NMAC - N, 11-1-14]

8.310.12.4 DURATION: Permanent.
[8.310.12.4 NMAC - N, 11-1-14]

8.310.12.5 EFFECTIVE DATE: November 1, 2014, unless a later date is cited at the end of a section.
[8.310.12.5 NMAC - N, 11-1-14]

8.310.12.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.12.6 NMAC - N, 11-1-14]

8.310.12.7 DEFINITIONS: [RESERVED]

8.310.12.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.310.12.8 NMAC - N, 11-1-14]

8.310.12.9 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES: HSD, through the medical assistance division (MAD), pays for medically necessary health services furnished to an eligible recipient, including American Indian and Alaska native (AI/AN) eligible recipients. The Indian health service (IHS) is a federal agency within the United States department of health and human services (DHHS) that is responsible for providing health services to AI/ANs based on the unique government-to-government relationship between federally recognized tribes and nations and the federal government. The IHS health care delivery system consists of health facilities owned and operated by IHS, facilities owned by IHS and operated by tribes or tribal organizations under Title I or Title III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) agreements, and facilities owned and operated by tribes or tribal organizations under such agreements, hereafter referred to as "IHS and tribal 638 facilities". Pursuant to Section 1911 of the Social Security Act; see 42 U.S.C. 1369j and the 1996 memorandum of agreement between IHS and the centers for medicare and medicaid services (CMS), IHS and tribal 638 facilities are eligible to be reimbursed by MAD for furnishing covered healthcare services to a MAP eligible AI/AN recipient (eligible recipient). Specific to this rule, an eligible recipient includes a member enrolled in a HSD contracted managed care organization (MCO).
[8.310.12.9 NMAC - N, 11-1-14]

8.310.12.10 ELIGIBLE PROVIDERS:

A. Health care to an eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to an eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing contractor. MAD makes available on the HSD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including

program rules, billing instructions, utilization review instructions, and other pertinent material. 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 therein and comply with the requirements. Providers must contact MAD for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to provisions of the MAD PPA and applicable statutes, regulations, rules and executive orders. MAD, or its selected claims processing contractor, issues payment to a provider using electronic funds transfer (EFT) only. Upon approval of the provider's PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) IHS facilities;
(2) Public Law 93-638 tribal facilities;
(3) urban Indian facilities (follows the rules for a federally qualified health center);
(4) IHS or tribal 638 facility pharmacies which follow 8.324.4 NMAC; and
(5) off site locations on federal land and facilities approved by MAD.

B. Practitioners contracted or employed by the above facilities are enrolled as individual providers for rendering services when appropriate.

C. Services rendered must be medically necessary and within the scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD.

D. For services provided under the federal public health service, including IHS, rendering providers must meet the requirements of the public health service corp.

E. Additional provider numbers or NPI numbers may be required when necessary to assure that claiming of federal matching funds by MAD is accurate as per federal requirements to distinguish between 100% federal match rates and other match rates.

[8.310.12.10 NMAC - N, 11-1-14]

8.310.12.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an eligible recipient must comply with all applicable laws, regulations, rules, standards, and the provisions of the MAD PPA. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include, but are not limited to, supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service. A provider must determine if an eligible recipient has other applicable health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act or regulatory authority, or as customarily provided under IHS or public health service administrative direction including the level of supervision required for services.

[8.310.12.11 NMAC - N, 11-1-14]

8.310.12.12 COVERED SERVICES: MAD covers medically necessary services and procedures for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition. Services must be furnished within the limits of MAD rules and within the scope of practice of the provider's professional standards. Public health services including services by public health nurses are covered to the same extent their services would be covered for non-IHS public health facilities. Limitations on covered services based on age and category of eligibility also apply to services rendered at an IHS or tribal 638 facility. Examples include enhanced benefits only available to early and periodic screening, diagnostic and treatment (EPSDT) eligible recipients, and limitations and enhanced services for alternative benefit plan (ABP) eligible recipients and eligible recipient pregnant women.

A. **Outpatient encounters and visits:** An outpatient encounter or visit is face-to-face contact between a practitioner and an eligible recipient as documented in the eligible recipient's physical or behavioral health record. An encounter or visit can occur at an IHS facility, tribal 638 facility, or a MAD recognized offsite location including IHS or tribal facility-based services that are provided in the home or in community centers or other locations but the medical records and the supervision or direction of the service comes from the eligible facility. To be billable as an encounter, the eligible recipient must be seen by a level of practitioner who would be eligible to be enrolled as a MAD provider or a practitioner comparable to that required by other service and provider rules or the service must be supervised by a level of practitioner who would be eligible to be enrolled as a MAD

provider or a practitioner comparable to that required by other service and provider rules. Examples include but are not limited to the following: audiologist, behavioral health professional, certified nurse midwife, certified nurse practitioner, clinical nurse specialist, clinical pharmacy specialist, dentist, dental hygienist, licensed dietician, occupational therapist, optometrist, pharmacist clinician, physician assistant, physician, physical therapist, podiatrist, speech therapist and other provider types within their scope of practice as designated by MAD; see 8.310.2 NMAC, 8.310.3 NMAC and 8.321.2 NMAC.

(1) Visits to the same facility, on the same day, for the same or related diagnosis constitutes a single encounter.

(2) Multiple encounters can occur on the same date of service when the services are distinct. The following are examples of types of separate encounters:

(a) an eligible recipient receives a service that is not associated with the initial encounter and the service provided is for a different principal diagnosis; or

(b) an eligible recipient is seen at two different facilities (different provider numbers) and one of the facilities is unable to provide the necessary services for the diagnosis or treatment of the eligible recipient's condition.

(3) An outpatient encounter may be billed when a visit consists of services that could be provided in a physician's office such as instructions to a diabetic, medication management, and anticoagulant management, when provided by a qualified individual as part of a facility-based outpatient program if no other related encounter occurs that day, similar to how services would be covered for other providers and clinics in other MAD service rules.

(4) An outpatient encounter may be billed when an eligible recipient returns at a later date for a follow up MAD service such as a laboratory, radiology, or therapy service which does not require an additional physician visit if no other related visit occurs that day.

(5) When a MAD service typically requires multiple visits such as orthodontia services, crowns, and dentures, the provider may bill an amount for the initial service that includes the standard number of encounters for the service are for the standard number of visits, similar to how services would be covered for other providers in other MAD service rules, or be paid at a fee schedule amounts that closely approximates the appropriate payment for multiple services.

B. **Inpatient hospital stays:** An inpatient hospital stay occurs when an eligible recipient is admitted and stays overnight.

C. **Services not subject to office of management and budget (OMB) codes or rates:** Some services are covered by MAD when occurring within an IHS or a tribal facility but are not included or billed at the OMB rate. These services are covered to the extent described under applicable rules for the service, and include:

(1) anesthesia (professional charges);

(2) ambulatory surgical center facility services;

(3) targeted case management;

(4) hearing appliances (hearing testing is reimbursed at the OMB rate);

(5) physician inpatient hospital visits and surgeries;

(6) smoking cessation;

(7) vision appliances, including frames, lenses, dispensing, and contacts (vision exams are at the OMB rate); and

(8) telemedicine's originating site facility fee; a telemedicine originating site fee is covered when the requirements of 8.310.2 NMAC are met; both the originating and distant sites may be IHS or tribal facilities at two different locations or if the distant site is under contract to the IHS or tribal facility and would qualify to be an enrolled provider; a telemedicine originating site fee is not payable if the telemedicine technology is used to connect an employee or staff member of a facility to the eligible recipient being seen at the same facility; however, even if the service does not qualify for a telemedicine originating site fee, the use of telemedicine technology may be appropriate thereby allowing the service provided to meet the standards to qualify as an encounter by providing the equivalent of face-to-face contact.

D. **Behavioral health services:**

(1) Outpatient behavioral health services billed using the outpatient OMB codes include assessments and evaluations, outpatient therapies, comprehensive community support services (CCSS), and other services as approved by MAD.

(2) Other specialized behavior health services may be reimbursed at the MAD fee for service (FFS) rate or at an OMB rate, as agreed between the facility and MAD.

(3) Prior to billing specialized behavioral health services including CCSS, the IHS or tribal 638 facility must submit documentation to MAD demonstrating the ability to adhere to the service definitions and standards for the specific service; see 8.321.2 NMAC.

E. **Pharmacy services:** See 8.324.4 NMAC for an IHS and a tribal 638 facility enrolled as a pharmacy. Pharmacy services are not part of the OMB rate. Pharmacy claims are not limited to a 30 or 90 day supply when the prescriber has written for a larger days' supply of medication. Pharmacy claims may exceed the days' supply limitations if the amounts dispensed at one time is reasonable. IHS and tribal 638 facility pharmacy claims are not subject to formularies or preferred drug lists or authorization as the facility maintains its own formulary.

F. **Transportation services:** For a detailed description of transportation services, see 8.324.7 NMAC.

[8.310.12.12 NMAC - N, 11-1-14]

8.310.12.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: IHS and tribal 638 facilities need not obtain prior authorization for services, but must continue to follow standards of care within its scope of practice and retain documentation in the eligible recipient's physical and behavioral health record. MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before or after services are furnished.

[8.310.12.13 NMAC - N, 11-1-14]

8.310.12.14 NON-COVERED SERVICES: For a detailed description of general non-covered MAD services, see 8.310.2 NMAC and 8.321.2 NMAC. Other MAD service rules may have additional non-covered MAD service restrictions.

[8.310.12.14 NMAC - N, 11-1-14]

8.310.12.15 REIMBURSEMENT: OMB rates are published annually in the federal register and are applicable to an IHS and a tribal 638 facility. These rates are applied retroactively to their effective date.

A. IHS OMB outpatient and inpatient reimbursement rates include facility fees and professional fees except as described in this rule.

(1) Outpatient encounters and visits: MAD reimburses outpatient encounters and visits at the OMB outpatient encounter rate. Reimbursement at OMB rates is retroactive to the dates of service for which the OMB rates are applicable.

(2) Inpatient hospital service: MAD reimburses covered inpatient hospital stays at the federally published OMB hospital inpatient per diem rate. The inpatient OMB rate applies when an eligible recipient has been under outpatient care observation or is receiving extended outpatient medical services, and the time period has been for 24 hours or more whether the eligible recipient has been formally admitted or not. Risk factors such as distance of the facility from the eligible recipient's residence for potential emergency follow up care, as well as lack of availability of step-down care providers (home health services, nursing facilities, and acute long term care hospital facilities) may be considered in making discharge decisions regarding the eligible recipient. Alternatively, the facility may elect to bill a daily outpatient OMB rate for an eligible recipient under observation. Reimbursement at OMB rates is retroactive to the date of service for which the federal OMB rates are applicable.

(3) Reimbursement following medicare payment is made at the full copayment, deductible and co-insurance amounts determined by medicare. Reimbursement following payment by other insurance is made at the OMB rate, is applicable, less the payment received from the other insurer.

B. Services not subject to the OMB rates are reimbursed according to MAD rules for the specific service. For services not reimbursable the facility at 100% federal matching funds, the facility may be enrolled additionally for services to be paid at standard federal matching rates.

C. **Electronic billing requirements:** Electronic billing of claims is required unless an exemption has been allowed by MAD. Exemptions will be given on a case-by-case basis with consideration given to barriers faced by the provider in electronic billing, such as small volume for which developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply when paper attachments must accompany the claim form.

D. **Responsibility for claims:** A provider is responsible for all claims submitted under his or her national provider identifier (NPI) or provider number, including responsibility for accurate coding representing the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, CMS correct coding initiatives, and NMAC MAD rules.

[8.310.12.15 NMAC - N, 11-1-14]

HISTORY OF 8.310.12 NMAC: [RESERVED]