TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 2 DIALYSIS SERVICES

8.325.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.325.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11/1/04]

8.325.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.325.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11/1/04]

8.325.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, section 27-2-12 et. seq. (Repl. Pamp. 1991).
[2/1/95; 8.325.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11/1/04]

8.325.2.4 DURATION: Permanent
[2/1/95; 8.325.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11/1/04]

8.325.2.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.325.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11/1/04]

8.325.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.325.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11/1/04]

8.325.2.7 DEFINITIONS: [RESERVED]

8.325.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.325.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11/1/04]

8.325.2.9 DIALYSIS SERVICES: Dialysis services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients [42 CFR Sections 440.10, 440.20; 440.50]. This part describes eligible dialysis providers, covered services, service limitations, and general reimbursement methodology.
[2/1/95; 8.325.2.9 NMAC - Rn, 8 NMAC 4.MAD.761, 11/1/04]

8.325.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation applications licensed practitioners or facilities that meet applicable requirements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for furnishing dialysis services to medicaid recipients:

(1) individuals licensed to practice medicine or osteopathy;

(2) facilities certified by the licensing and certification bureau of the department of health to furnish renal dialysis services; and

(3) hospitals eligible to participate in the New Mexico medicaid program. See 8.311.2 NMAC, Hospital Services [MAD-721].

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, which includes medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they understand these materials. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superceded by federal law, or federal regulation. Providers must be enrolled as medicaid providers before submitting a claim for payment to the MAD claims processing contractor.
[2/1/95; 8.325.2.10 NMAC - Rn, 8 NMAC 4.MAD.761.1 & A, 11/1/04]

8.325.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to the MAD policies and instructions as specified in this manual and its appendices, as updated.

A. **Recipient eligibility verification:** Providers must verify that services they furnish are provided to eligible recipients. Providers must verify that recipients are eligible and remain eligible for medicaid through periods of continued and extended services. By verifying eligibility, a provider is informed of restrictions that may apply to recipient's eligibility. Providers may verify eligibility through several mechanisms, including using an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

B. **Requirements for updating information:** Providers must furnish in writing to MAD or the MAD claims processing contractor with complete information changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the health care provider group or individual.

C. **Documentation requirements:** Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 43.107(b)].

[2/1/95; 8.325.2.11 NMAC - Rn, 8 NMAC 4.MAD.761.2 & A, 11/1/04]

8.325.2.12 COVERED SERVICES: Medicaid covers renal dialysis services for the first three (3) months of dialysis pending the establishment of medicare eligibility. Medicare becomes the primary reimbursement source for individuals who meet the medicare eligibility criteria. Dialysis providers must assist medicaid recipients in applying for and pursuing final medicare eligibility determinations. Medicaid covers medically necessary dialysis supplies furnished to home-dialyzed recipients. Medicaid covers medically necessary renal dialysis services furnished by providers as required by the condition of the recipient. Medicaid covers the following specific renal dialysis services:

A. **Supplies, equipment and services included in the renal dialysis services composite rate:** The facility reimbursement fee includes all renal-related facility and home dialysis services, including supplies and equipment. The following are some of the drugs, items and supplies included in the facility fee:

(1) hypertonic saline;
(2) dextrose (glucose);
(3) mannitol or similar product used for volume control;
(4) heparin;
(5) protamine;
(6) antiarrhythmics;
(7) antihistamines;
(8) antihypertensives;
(9) pressor drugs;
(10) antiobiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis);
(11) oxygen;
(12) filters;
(13) bicarbonate dialysate;
(14) cardiac monitoring;
(15) catheters and catheter changes;
(16) suture removal kits and suture removal;
(17) dressing supplies;
(18) crash cart usage for cardiac arrest;
(19) declotting of shunt performed by facility staff in the dialysis unit;
(20) staff time to administer blood;
(21) staff time to administer separately billable parenteral items; and
(22) staff time used to collect all specimens for laboratory tests.

B. **Routine laboratory tests:** Routine laboratory tests are included in the facility fee. The following list specifies the covered routine tests and allowed frequencies. Routine tests at greater frequencies are reimbursable in addition to the facility fee, but require medical justification by a physician.

(1) For hemodialysis, peritoneal dialysis and continuous cyclic peritoneal dialysis (CCPD):

(a) **per dialysis:**
- (i) hematocrit;
- (ii) clotting time;
- (iii) hemoglobin.

(b) **weekly**:
- (i) prothrombin time for patients on anticoagulant therapy;
- (ii) creatinine; and
- (iii) BUN;

(c) **monthly**:
- (i) CBC;
- (ii) calcium;
- (iii) potassium;
- (iv) chloride;
- (v) alkaline phosphatase;
- (vi) SGOT;
- (vii) bicarbonate;
- (viii) phosphate;
- (ix) total protein;
- (x) albumin; or
- (xi) LDH.

(2) For continuous abdominal peritoneal dialysis when the facility bills a facility charge (CAPD): **Monthly:** BUN; magnesium; HCT; calcium; HGB; albumin; creatinine; phosphate; LDH; sodium; potassium; SGOT; CO_2; total protein; dialysate protein; alkaline phosphatase.

[2/1/95; 8.325.2.12 NMAC - Rn, 8 NMAC 4.MAD.761.3 & A, 11/1/04]

8.325.2.13 SERVICE LIMITATIONS: Tests that are listed as separately billable (not included in the composite rate) and are performed at a frequency greater than specified in the composite rate require medical justification and are covered when furnished at specified frequencies.

A. **Tests for hemodialysis, peritoneal dialysis and CCPD:** (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) **Monthly**
- (a) alkaline phosphatase;
- (b) alkaline phosphatase;
- (c) blood urea nitrogen (BUN);
- (d) serum bicarbonate (CO_2);
- (e) dialysis protein;
- (f) hematocrit;
- (g) hemoglobin;
- (h) lactic dehydrogenase (LDH);
- (i) magnesium;
- (j) serum albumin;
- (k) serum creatinine;
- (l) serum phosporus;
- (m) serum potassium;
- (n) SGOT;
- (o) sodium;
- (p) total protein;
- (q) serum calcium;
- (r) hepatitis test.

(2) **Once every three (3) months**
- (a) serum aluminum;
- (b) serum ferritin;

(c) nerve conductor velocity test;
(d) EKG.

(3) **Once every six (6) months:** chest x-ray

(4) **Once every year:** bone survey

B. **Tests for CAPD:** (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) **Once every three (3) months**
(a) white blood count (WBC);
(b) platelet count;
(c) red blood count.

(2) **Once every six (6) months:**
(a) 24-hour urine volume;
(b) residual renal function;
(c) chest x-ray;
(d) EKG;
(e) MNCV.

C. **Training:** Medicaid reimburses for hemodialysis, peritoneal dialysis, continuous cycling peritoneal dialysis and continuous abdominal peritoneal dialysis training sessions if furnished by a renal dialysis facility certified to provide these services. Dialysis training must be performed in the dialysis facility. Fifteen (15) training sessions are allowed without medical justification. To be reimbursed for additional training sessions, a medical justification must be attached to the claim.
[8.325.2.13 NMAC - N, 11/1/04]

8.325.2.14 NONCOVERED SERVICES: Dialysis services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]
[2/1/95; 8.325.2.14 NMAC - Rn, 8 NMAC 4.MAD.761.4, 11/1/04]

8.325.2.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review 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. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

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

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

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].
[2/1/95; 8.325.2.15 NMAC - Rn, 8 NMAC 4.MAD.761.5 & A, 11/1/04]

8.325.2.16 REIMBURSEMENT: Dialysis facilities must submit claims for reimbursement on the UB-92 claim form or its successor. Physicians must submit for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. The facility's composite rate reimbursement is a comprehensive payment for all in facility and home dialysis services. Providers cannot bill separately for services inclusive of the composite rate, as defined by medicare, even though payment is made at the medicaid fee schedule. Physicians services are not included in the facilities composite rate. Physicians may bill for their professional services according to the policies and procedures outlined in the 8.310.2 NMAC, *Medical Services Providers*. Laboratory procedures and radiology procedures that are not part of the facilities composite rate, as defined by medicare, may be billed separately.

A. Certified hospital-based dialysis facilities are reimbursed at a rate determined by the medicaid outpatient hospital reimbursement methodology.

B. Hospital providers are reimbursed for inpatient renal dialysis at a rate determined by the medicaid inpatient hospital reimbursement methodology.

C. Renal dialysis facilities acting as suppliers to a home-dialyzed recipient can bill medicaid for the necessary supplies furnished to the recipient only if the facility is not billing a facility fee. Facilities cannot bill for both a facility fee and supplies.
[2/1/95; 8.325.2.16 NMAC - Rn, 8 NMAC 4.MAD.761.6 & A, 11/1/04]

HISTORY OF 8.325.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD-Rule 310.2100, Dialysis Services, filed 4/8/85.

History of Repealed Material:
ISD-Rule 310.2100, Dialysis Services, filed 4/8/85 - Repealed effective 2/1/95.