State of New Mexico
Human Services Department
HUMAN SERVICES REGISTER

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
GENERAL PROGRAM RULES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY
The Human Services Department, Medical Assistance Division, is proposing amendments to *MAD 704, Out-of-State Providers* to clarify regulatory language and accuracy with existing rules and provider participation agreements.

VI. RULES
These proposed rule changes refer to 704 of the Medical Assistance Program Rules Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at (505) 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective June 1, 2008.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed rules will be held at 11:00 a.m., on April 11, 2008. in the HSD Law Library at Pollon Plaza, 2009 S. Pacheco Street, Santa Fe, New Mexico. Parking accessible to persons with physical impairments will be available.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:0o p.m., on April 11, 2008. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdelena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these rules approved by:

PAMELA S. HYDE, J.D., SECRETARY
HUMAN SERVICES DEPARTMENT

OUT OF-STATE PROVIDERS

[~~The New Mexico Medicaid program (Medicaid) pays for services furnished by border providers and out-of-state providers in instances when the needed services are not available in the State of New Mexico or when recipients are traveling out-of-state and need medical attention.~~
~~This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.~~]
Border area services are those that are rendered within one hundred (100) miles of the New Mexico state border (Mexico excluded). Out-of-state services are those that are rendered in an area more than 100 miles from the New Mexico borders (Mexico excluded). To help New Mexico eligible recipients receive medically necessary services, MAD pays for border area services to the same extent and subject to the same rules and requirements that such services are covered when provided within the state. MAD pays for out-of-state services as described under Covered Services, MAD 704.11

704.1 Eligible Providers

[~~Out-of-state providers and border providers must be licensed or certified by their respective states to be considered eligible to provide services to New Mexico recipients. To be reimbursed for furnishing services to New Mexico Medicaid recipients, out-of-state or border providers must complete the New Mexico Medical Assistance Program Provider Participation Application and have the application approved by the New Mexico Medical Assistance Division (MAD).~~

~~(A) Out-of-state providers are those providers who render services in an area more than 100 miles from the New Mexico border (Mexico excluded). Border providers, those providers located within 100 miles of the New Mexico border (Mexico excluded), are subject to the rules governing the provision of services for in-state providers.~~

~~(B) The claim filing limit for out-of-state and border providers is 120 days.~~]
A. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim

for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered HSD or its authorized agents, including program rules, billing instruction, utilization review instructions, and other pertinent materials. The following providers are eligible to apply for a provider participation agreement, bill and receive reimbursement for furnishing medical services:

(1) border area and out-of-state providers licensed or certified by their respective states to practice medicine or osteopathy [42 CFR Section 440.50(a)(1)(2)]; and other providers licensed and/or certified by their state to perform services equivalent to those covered by the Medical Assistance Program in New Mexico. Practices or groups formed by these individuals may also receive reimbursement for services;

(2 border providers within on hundred (100) miles of the New Mexico state border (Mexico excluded), are subject to the rules governing the provision of services for an in-state provider

(3) out-of-state providers are those providers who render services in an area more than 100 miles from the New Mexico borders (Mexico excluded).

B. Once enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program policy manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement a provider is bound by the provisions of the MAD provider participation agreement.

704.2 Provider Responsibilities

[~~Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES.~~

~~Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.~~

~~Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES.~~]

A provider who furnishes services to medicaid and other health care program eligible recipients agrees to comply with all federal and state laws and regulations relevant to the provision of services as specified in the MAD provider participation agreement. A provider also agrees to conform to MAD program rules and instructions as specified in this manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. A provider must verify that individuals are eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

704.3 Covered Out-of-State Services

[~~Medicaid covers medical services furnished by out-of-state providers only when:~~

1. ~~Recipients are out of the state at the time the services are needed and the delivery of services is on an emergency or urgent basis. Services must be medically necessary to stabilize the recipient's health or prevent significant adverse health effects, including preventable hospitalization;~~

2. ~~Care is medically necessary for eligible foster children placed by the State of New Mexico in out-of-state homes or institutions;~~

3. ~~Durable medical equipment, medical supplies, prosthetics or orthotics are purchased from out-of-state vendors;~~

4. ~~Clinical laboratory tests are performed by out-of-state laboratories; or~~

5. ~~Medical services or procedures considered medically necessary are not available in the State of New Mexico. Prior approval is required for all services which are not available in New Mexico.~~]

MAD covers services and procedures furnished by out-of-state providers when

medically necessary for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition only when one or more of the following conditions are met:

A. All services are furnished within the limits of the MAD provider program rules and within the scope and practice of the provider's professional standards.

B. An eligible recipient is out-of-state at the time the services are needed and the delivery of services is of an emergency or urgent nature. Services must be medically necessary to stabilize the eligible recipient's health or prevent significant adverse health effects, including preventable hospitalization. Claims for such services are subject to pre-payment or post-payment reviews to assure the emergency or urgent need of the services.

C. On-going services being provided by a medical assistance program within the state continue to be necessary when the eligible recipient is traveling to another state to visit family members or for other purposes.

D. Care is medically necessary for eligible recipient foster children placed by the state of New Mexico in out-of-state homes or institutions.

E. Durable medical equipment, medical supplies, prosthetics or orthotics are purchased from out-of-state vendors.

F. Clinical laboratory tests, radiological interpretations, professional consultations or other services are performed by out-of-state laboratories but do not require the eligible recipient to leave the state.

G. Medical services or procedures considered medically necessary are not available in the state of New Mexico. All services that are not available in New Mexico require prior authorization when provided by an out-of- state provider.

~~[**704.31 Out-of-State Billing Offices** Services furnished within the state are subject to the regulations for in-state providers even if the billing office is outside the state.]~~

~~[**704.32 Out-of-State Hospital Services** All out-of-state hospital claims are subject to prepayment review by MAD or its designee for medical necessity and length of stay.]~~

705.4 Noncovered Services

Services furnished by an out-of-state or border [~~providers are~~] provider is subject to the limitations and coverage restrictions which exist for other [~~Medicaid~~] services renderedin-state as stated in the relevant administrative, provider, and services sections of the MAD program policy manual. [~~See Section MAD 602, GENERAL NONCOVERED SERVICES.~~] In addition, [~~Medicaid~~] MAD

programs [does] do not cover the following specific services when furnished by an out-of-state or border provider. . Medicaid does not cover the following specific services when furnished by an out-of-state and/or border provider:

1. Services furnished outside the boundaries of the United States; and

2. Services furnished in out-of-state or border area nursing facilities and intermediate care facilities for the mentally retarded, or outpatient rehabilitation services.

[3. ~~Psychosocial rehabilitation services provided to recipients under twenty-one (21) in non-accredited residential treatment centers or group homes.~~]

704.5 Prior Approval 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 Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, [~~providers receive~~] a provider receives instructions on how to access utilization review [~~and documentation forms~~] documents necessary for prior approval and claims processing.

704.51 Prior [~~Approval~~] Authorization Certain procedures or services can require prior approval from MAD or its designee. Services for which prior [~~approval~~] authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through an out-of state or border provider is subject to the same prior authorization and utilization review requirements, which exist for the service when not provided out-of-state.

704.52 Eligibility Determination Prior [~~approval~~] authorization of services does not guarantee that individuals are eligible for Medicaid. and other health care programs. [~~Providers~~] A provider must verify that an [~~individuals are~~] individual is eligible for [~~Medicaid~~] a specific program at the time services are furnished and must determine if [~~Medicaid~~] the eligible [~~recipients have~~] recipient has other health insurance.

704.53 Reconsideration [~~Providers~~] A provider who disagree with prior [~~approval~~] authorization request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953,

[~~704.14~~] 704.6 Out-of-State Billing Offices Services furnished within the state or border areas are subject to the regulations for in-state providers even if the billing or administrative office is outside the state.

[~~704.15~~] 704.7 Out-of-State Hospital Services All out-of-state hospital, and other residential service claims are subject to prepayment review or periodic re-authorization by MAD or its designee for medical necessity and length of stay, in addition to requiring authorization for the initial placement.

[~~704.6~~] 704.8 Reimbursement

[~~Out-of-state providers must submit claims for reimbursement on the claim form appropriate for the service type furnished to the recipient. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive billing instructions and other material from MAD for processing of claims.~~]

[~~Reimbursement for out-of-state providers is made at the lesser of the following:~~

~~1. The provider's billed charge; or~~

~~2. The MAD fee schedule for the specific services or procedure when performed by an in-state provider.~~

~~(A) The provider's billed charges must be their usual and customary charges for services.~~

~~(B) "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.~~

~~(C) Inpatient services furnished by out-of-state acute care hospitals are reimbursed at seventy percent (70%) of billed charges. All hospital billing must reflect the hospital's usual and customary charge for the furnished services. To be considered for reimbursement, inpatient claims must have a copy of the discharge summary attached.~~

~~(D) Outpatient services furnished by out-of-state hospitals, not subject to reimbursement limitations, are reimbursed at seventy-seven percent (77%) of billed charges. All hospital billings must reflect the hospital's usual and customary charge for the services furnished.~~

~~(E) Out-of-state hospital emergency room claims must have the emergency room report attached to the claim~~.]

A. Reimbursement to an out-of-state or border provider is made at the same rate as for an in-state provider except as otherwise stated in the relevant specific providers and services sections of the MAD program policy manual.

B. The billed charge must be the provider's usual and customary charge for the service or procedure.

C. "Usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.