

**STATE COVERAGE INSURANCE (SCI)
BENEFIT PACKAGE
Tribal Consultation Version 10.15.2013**

**TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 7 BENEFIT PACKAGE**

8.306.7.1 ISSUING AGENCY: Human Services Department
[8.306.7.1 NMAC - N, 7-1-05]

8.306.7.2 SCOPE: This rule applies to the general public.
[8.306.7.2 NMAC - N, 7-1-05]

8.306.7.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.7.3 NMAC - N, 7-1-05; A, 6-1-10]

8.306.7.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.7.4 NMAC - N, 7-1-05; A, 6-1-10]

8.306.7.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.7.5 NMAC - N, 7-1-05]

8.306.7.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.7.6 NMAC - N, 7-1-05]

8.306.7.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.7.7 NMAC - N, 7-1-05]

8.306.7.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.
[8.306.7.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.7.9 BENEFIT PACKAGE: This part defines the state coverage insurance (SCI) benefit package for which the MCO will be paid fixed payment rates. The MCO shall cover these services. The MCO shall not delete benefits from the SCI-defined benefit package. An MCO is encouraged to provide a value added benefit package, which could include health-related educational, preventive, outreach and value added physical and behavioral health benefits. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services.
[8.306.7.9 NMAC - N, 7-1-05; A, 6-1-08]

8.306.7.10 SCI HEALTH BENEFITS: This part contains a detailed explanation of the services covered by SCI, limitations and exclusions to covered services, and services that are not covered by SCI. The MCOs shall determine their own utilization management (UM) protocols, which are based on reasonable medical evidence and are not subject to the utilization management protocols in the medical assistance program manual. HSD may review the MCO's UM protocols.
[8.306.7.10 NMAC - N, 7-1-05]

8.306.7.11 SERVICES INCLUDED IN THE SCI BENEFIT PACKAGE: The SCI benefit package includes provider and consultation services and supplies that are reasonably required to maintain good health and are

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provided by or under the direction of the member's PCP. The following lists covered services and provides additional information.

A. Provider services:

- (1) office visits;
- (2) home visits;
- (3) hospital and inpatient physical rehabilitation facility visits by physician;
- (4) inpatient and outpatient surgery (includes assistant surgeon's charges);
- (5) office procedures;
- (6) inpatient professional care services, including pathologists, radiologists and anesthesiologists;
- (7) allergy testing;
- (8) allergy injections;
- (9) antigen serum;
- (10) injections in accordance with accepted medical practice to treat acute conditions, which are customarily administered in a provider's office;
- (11) injections in accordance with acceptable medical practice used to treat chronic conditions, including, but not limited to, diseases such as rheumatoid arthritis, crohn's disease, and hepatitis C; and
- (12) routine and diagnostic x-rays and clinical laboratory tests.

B. Inpatient hospital services: The benefit package includes inpatient hospital services as detailed below.

- (1) Hospital admissions must have prior authorization and are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP. Any service or procedure not outlined below requires a prior authorization.
- (2) Inpatient hospitalization coverage is limited to 25 days per benefit year. This 25-day limitation is combined with home health services and inpatient physical rehabilitation.
- (3) Inpatient hospital services include:
 - (a) semi-private room and board accommodations, including general duty nursing care;
 - (b) private room and board accommodations when medically necessary; prior authorization is required;
 - (c) in-hospital therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units;
 - (d) use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment;
 - (e) laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests performed in conjunction with a member's admission to a hospital;
 - (f) anesthetics, oxygen, pharmaceuticals, medications, and other biological;
 - (g) dressings, casts, and special equipment when supplied by the hospital for use in the hospital;
 - (h) inpatient meals and special diets;
 - (i) inpatient radiation therapy or inhalation therapy;
 - (j) rehabilitative services - physical, occupational, and speech therapy;
 - (k) administration of whole blood, blood plasma, and components;
 - (l) discharge planning and coordination of services; and
 - (m) maternity care.

C. Outpatient services: The benefit package includes outpatient services performed in a hospital or other approved outpatient facility. Outpatient services:

- (1) can reasonably be provided on an ambulatory basis;
- (2) are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred by the PCP;
- (3) require prior authorization, unless otherwise noted; and
- (4) the following provides additional information on covered outpatient services and associated co-payments:
 - (a) surgeries, including use of operating, delivery, recovery, treatment rooms, equipment and supplies, including anesthesia, dressings and medications;

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(b) radiation therapy and chemotherapy;
 (c) magnetic resonance imaging (MRI);
 (d) positron emission tomography (PET) tests;
 (e) CT scan;
 (f) holter monitors and cardiac event monitors;
 (g) routine and diagnostic x-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs);
 (h) cardiovascular rehabilitation; and
 (i) rehabilitative services - physical, occupational, and speech therapy; rehabilitative services for short-term physical, occupational, and speech therapies are covered; short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment; the member's PCP or other appropriate treating provider to whom the member has been referred shall determine in advance of rehabilitative services that these services can be expected to result in significant improvement in the member's physical condition within a period of two months; requests for rehabilitative services from therapists will not be approved; these services shall be requested by the ordering provider and require a prior authorization.

(i) Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, contingent on the approval of the MCO's medical director, only if such services can be expected to result in continued significant improvement of the member's physical condition within the extension period. Expectation of significant improvement will be established if the member has complied fully with the instructions for care and has met all therapy goals for the preceding two-month period as documented in the therapy record.

(ii) Therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered under SCI. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitative services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, muscular dystrophy, cerebral palsy, developmental delay, myofascial pain disorders, arthritis, autism, and syndromes of chromosomal abnormalities.

D. Emergency and urgently needed health services: The benefit package includes emergency and urgently needed health services. These services are available 24 hours a day, seven days a week. The benefit package includes inpatient and outpatient services meeting the definition of emergency services, which shall be provided without regard to prior authorization or the provider's contractual relationship with the MCO. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services shall be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type shall be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post-stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain the stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO; or
 (2) the hospital contacted the MCO but did not get instructions within an hour of the request; the following provides additional information on covered services and required co-payments.

(a) Emergency health services can be provided in or out of the service area. Coverage is provided for trauma services at an appropriately designated trauma center according to established emergency medical services triage and transportation protocols.

(i) Prior authorization is not required for emergency care.
 (ii) Coverage for trauma services and all other emergency health services from non-participating providers will continue at least until the member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending participating provider in consultation with the MCO. The MCO may transfer hospitalized members to the care of participating providers as soon as it is medically appropriate. Such members shall be stabilized and the transfer effected in accordance with federal law.

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(iii) The member is responsible for charges for non-covered services.

(b) Use of an urgent care center, where available, in or out of the service area for treatment of sudden unexpected acute illness or injury that requires prompt medical attention to prevent jeopardy to the member if such services were not received immediately.

(i) A non-participating urgent care center may be used only if the member cannot reasonably access a participating provider.

(ii) Routine or follow-up medical treatment shall be provided by or through a participating provider.

E. **Women's health services:** The benefit package includes any gynecological examinations or care related to pregnancy, for primary and preventive obstetrics, and gynecological services required as a result of any gynecological examination or condition. Covered women's health services may be obtained from the member's PCP, or a participating women's health care provider or a consulting provider to whom the member has been referred by her PCP. The following lists covered services and provides additional information:

(1) office visits;
(2) low-dose mammography screening for detection of breast cancer;
(3) cytological screening to determine the presence of pre-cancerous or cancerous conditions or other health problems; and

(4) services related to the diagnosis, treatment and appropriate management of osteoporosis.

F. **Prenatal and post-partum care:** Prenatal care includes a minimum of one prenatal office visit per month during the first two trimesters of pregnancy; two office visits per month during the seventh and eighth months of pregnancy; and one office visit per week during the ninth month until term as medically indicated, provided that coverage for each office visit shall include prenatal counseling and education.

(1) Following delivery of a newborn, a female member is entitled to either:

(a) post-partum care in the home consisting of up to three visits; or

(b) a minimum hospital stay of specified inpatient hours; the choice of either home care or inpatient care will be made based on discussion between the participating provider and the member.

(2) If post-partum home care is elected, the care shall be rendered in accordance with accepted maternal and neonatal physician assessments, and by a home care participating provider who is properly licensed, trained and experienced. A maximum of three home care visits are allowable.

(3) If inpatient care is elected, a mother and her newborn child in a health care facility will be entitled to a minimum stay of 48 hours following a vaginal delivery or 96 hours following a caesarian section.

(4) Non- hospital births - prior authorization is required.

G. **Preventive health services:** The benefit package includes preventive health services. Preventive health services are provided to a member when performed by or under the direction of the member's PCP or a participating provider to whom the member has been referred by his PCP, and are consistent with the MCO's preventive health guidelines. The following lists covered services and provides additional information.

(1) Physical exams, including health appraisal exams, laboratory and radiological tests, hearing and vision screenings, and early detection procedures.

(2) Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or a fractionated cholesterol level.

(3) Periodic glaucoma eye tests for all persons 35 years of age and older.

(4) Periodic stool examination for the presence of blood for all persons 40 years of age or older.

(5) Periodic mammograms for detection of breast cancer as follows: one low dose baseline mammogram for women ages 35 through 39, one low dose mammogram biennially for women ages 40 through 49 and one low dose mammogram annually for women over age 50.

(6) All members may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. The consultation may include, but not be limited to:

(a) smoking control;

(b) nutrition and diet recommendations;

(c) exercise plans;

(d) lower back protection;

(e) immunization practices;

(f) breast self-examinations;

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- (g) testicular self-examinations; or
- (h) use of seat belts in motor vehicles.
- (7) Adult immunizations in accordance with the recommendations of the advisory committee on immunization practices (ACIP).
- (8) Periodic colon examination of 35 to 60 centimeters or barium enema for all persons 45 years of age or older.
- (9) Voluntary family planning services.
- (10) Insertion of contraceptive devices.
- (11) Removal of contraceptive devices.
- (12) Surgical sterilization.
- (13) Pregnancy termination procedures: The benefit package includes services for the termination of pregnancy and pre or post-decision counseling or psychological services as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures*.

H. Dialysis: The benefit package includes dialysis services. Long-term hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) is provided with a prior authorization and performed by or under the direction of the member's PCP or a consulting provider to whom the member has been referred by his PCP. The member shall advise the MCO of the date the treatment commenced.

I. Inpatient physical rehabilitation: The benefit package includes inpatient physical rehabilitation. The following lists covered services and provides additional information.

- (1) Inpatient physical rehabilitation services require prior authorization, and services are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP.
- (2) Inpatient physical rehabilitation facility coverage is limited to 25 days per benefit year. This 25-day limitation is combined with inpatient hospital and home health services.

J. Home health services/home intravenous services: The benefit package includes home health services, which are health services provided to a member confined to his home due to physical illness. The following lists covered services and provides additional information.

- (1) Home health services and home intravenous services are provided by a home health agency (HHA) at a member's home with a prior authorization and prescribed by the member's PCP or a consulting provider to whom the member is referred by his PCP.
- (2) Home health services in lieu of hospitalization are limited to 25 days per benefit year provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. This 25 day limitation is combined with inpatient hospitalization and inpatient physical rehabilitation.
- (3) Services provided by a registered nurse or a licensed practical nurse; by physical, occupational, and respiratory therapists; speech pathologists; or by a home health aide are covered.
- (4) Prescription supplies for the provision of home health services at the time of a home health visit are covered.
- (5) Home intravenous services are covered.
- (6) Tube feedings as the sole source of nutrition are covered.

K. Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices: The benefit package includes durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices. The following lists covered services and provides additional information.

- (1) Prior authorization is required.
- (2) Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices with allowable charges of \$200 or more per item, including tax and any shipping charges are covered. Rental price cannot exceed purchase price.
- (3) Durable medical equipment that requires a provider's prescription for purchase or rental is covered unless otherwise excluded.
- (4) Medical supplies that require a provider's prescription for purchase are covered unless otherwise excluded.
- (5) Orthotic appliances that require a provider's prescription for purchase are covered unless otherwise excluded.

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(6) Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal or when the body's growth or atrophy necessitates replacement, unless otherwise excluded.

(7) Breast prostheses and bras required in conjunction with reconstructive surgery are covered, except as limited.

(8) Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear or when necessitated by the body's growth or atrophy are covered.

L. **Ambulance services:** The benefit package includes emergency transport services identified below.

(1) When necessary to protect the life of the mother or infant, emergency transport includes transport for medically high-risk pregnant women with an impending delivery to the nearest tertiary care facility.

(2) The MCO will not pay more for air ambulance than it would have paid for transportation over the same distance by surface emergency medical transportation services unless the member's health condition renders the utilization of such surface services medically inappropriate.

(3) Emergency ground ambulance transportation to the nearest facility where emergency care and treatment can be rendered and when provided by a licensed ambulance service

(4) Emergency, trauma-related air ambulance transportation - prior authorization is required, when feasible.

M. **Oral surgery:** The benefit package includes limited oral surgery benefits with prior authorization. The following lists covered services and provides additional information. General dental and oral surgery services with a prior authorization only in conjunction with:

(1) Accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within 12 months of the date of injury. The MCO will require dental x-rays.

(2) Surgical procedures to correct non-dental, non-maxillo-mandibular physiologic conditions that produce demonstrable impairment of function are covered.

(3) Removal or biopsy, when pathological examination is required of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth are covered.

(4) External incision and drainage of cellulitis; incision of infected accessory sinuses, salivary glands or ducts; and removal of stones from salivary ducts are covered.

(5) Surgical procedures to correct accidental injuries of the jaws and facial bones, cheeks, lips, tongue, roof and floor of mouth are covered.

N. **Reconstructive surgery:** The benefit package includes reconstructive surgery as provided below.

(1) Reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders - prior authorization is required. Functional disorder shall result from accidental injury or from congenital defects or disease.

(2) Prosthetic devices and reconstruction surgery of the affected breast or other breast to produce symmetry related to mastectomy. This coverage includes physical complications at all stages of mastectomy, including lymph edemas. A member is allowed at least 48 hours of inpatient care following mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

O. **Prescription drugs:** The benefit package includes all generic prescription drugs and brand name drugs included on the MCO's preferred drug list (PDL). Exceptions to the PDL depend on MCO policy.

P. **Diabetes treatment:** The benefit package includes diabetes treatment. The MCO will maintain an adequate PDL to provide resources to members with diabetes; and guarantee reimbursement or coverage for prescription drugs, insulin, supplies, equipment and appliances with a prior authorization described in this subsection within the limits of the MCO. The following lists covered services and provides additional information.

(1) Equipment, supplies and appliances to treat diabetes to include:

- (a) blood glucose monitors, including those for the legally blind;
- (b) test strips for blood glucose monitors;
- (c) visual reading urine and ketone strips;
- (d) lancets and lancet devices;
- (e) insulin (limit two vials per co-payment);

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- (f) injection aids, including those adaptable to meet the needs of the legally blind;
 - (g) syringes;
 - (h) prescriptive oral agents for controlling blood sugar levels;
 - (i) medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and
 - (j) glucagons emergency kits.
- (2) Diabetes self-management training by a certified, registered or licensed health care professional with recent education in diabetes management, which is limited to:
- (a) medically necessary visits upon the diagnosis of diabetes;
 - (b) visits following a provider diagnosis that represents a significant change in the member's symptoms or condition that warrants changes in the member's self-management;
 - (c) visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and
 - (d) medical nutrition therapy related to diabetes management.

Q. Behavioral health and substance abuse services: The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to 25 days per benefit year with prior authorization.

- (1) **Behavioral health service:**
- (a) Outpatient office visits for mental health evaluation and treatment; injectable forms of haloperidol or fluphenazine are included in the office visit co-payment. Prior authorization is required for over seven visits.
 - (b) Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital - *prior authorization is required.*
- (2) **Substance abuse service:**
- (a) outpatient substance abuse including visits, detoxification and intensive outpatient care limited to 42 days per benefit year; and
 - (b) inpatient substance abuse detoxification - *prior authorization is required.*

R. Annual limits on out-of-pocket expenditures: Out-of-pocket charges for all participants will be limited to five percent of maximum gross household income per benefit year.

S. Limitations on coverage: The benefit package is limited to \$100,000 in benefits payable per member per benefit year. The state may adjust the \$100,000 maximum per benefit year; however the maximum per benefit year cannot be decreased more than five percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than \$100,000. The state must notify CMS 60 days prior to any requested change in the maximum per benefit year.

T. Pregnancy termination procedures: The MCO shall provide coverage of pregnancy termination as allowed per 42 CFR 457.475. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 457.475 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC.
[8.306.7.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09; A, 6-1-10]

8.306.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: The SCI benefit package is limited to \$100,000 in benefits payable per member per benefit year. Covered services are subject to the following conditions and limitations:

- A. Medically necessary:** Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:
- (1) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
 - (2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;
 - (3) are provided within professionally accepted standards of practice and national guidelines; and
 - (4) are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

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- B. Behavioral health and substance abuse services:
- (1) Inpatient mental health services/partial hospitalizations are limited to 25 days per benefit year.
 - (2) Inpatient substance abuse detoxification is limited to 72 hours per occurrence as part of the total 25 day benefit for inpatient mental health services.
 - (3) Outpatient substance abuse detoxification services are limited to 10 days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to 42 days per benefit year.
- C. **Cardiovascular rehabilitation:** Coverage for cardiovascular rehabilitation is limited to a maximum of 36 sessions per cardiac event.
- D. **Choice of provider:** For the purpose of coverage under this policy, the SCI MCO has the right to determine which provider may be used to provide the covered services.
- E. **Contact lenses or eyeglasses following cataract surgery:** One complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is not allowed for both contact lenses and eyeglasses. Coverage is limited to one set of contact lenses or eyeglasses per member per surgery. Coverage for materials (contact lenses or eyeglasses) is limited to \$300 per surgery. Coverage for contact lenses or eyeglasses is limited to 90 days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the 90 day period are not covered.
- F. **Dental services:** In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within 12 months of the date of injury. The MCO will require dental x-rays.
- G. **Detoxification:** Inpatient detoxification is limited to 72 hours of inpatient services per occurrence as part of the 25 day benefit for inpatient behavioral health services. Outpatient detoxification is limited to 10 days per benefit year.
- H. **Home health services:** Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation, may not exceed 25 days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review of the continuation of covered services. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.
- I. **Inpatient hospitalization, home health services, inpatient rehabilitation:** This policy is limited to maximum of 25 combined days per member per benefit year for inpatient hospitalization, home health services and inpatient rehabilitation.
- J. **Major disasters:** In the event of any major disaster, epidemic, or other circumstance beyond its control, the MCO will render or attempt to arrange covered services with participating providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include: complete or partial disruption of facilities; war; riot; civil uprising; disability of the MCO personnel; disability of participating providers; or act of terrorism.
- K. **Maximum benefit limits:** Maximum benefits allowed under SCI are limited to \$100,000 per member per benefit year. The state may adjust the \$100,000 maximum per benefit year; however the maximum per benefit year cannot be decreased more than five percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than \$100,000. The state must notify CMS 60 days prior to any requested change in the maximum per benefit year.
- L. **Maternity transport:** Coverage for transportation where medically necessary to protect the life of the infant or mother, including air transport if indicated for medically high risk pregnant women with an impending delivery of a potentially viable infant to the nearest available tertiary care center.
- M. **Mastectomy and lymph node dissection:** Length of inpatient stay: not less than 48 hours inpatient stay following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection when determined medically appropriate by physician and patient.
- N. **Orthotic appliances and prosthetic devices:** Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

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O. **Physical, speech and occupational therapy:** Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two consecutive months per member per condition.

P. **Post mastectomy supplies:** Bras required in conjunction with reconstructive surgery are limited to two per member, per benefit year.

Q. **Prescription drugs:** Prescription drugs are limited to generic drugs and name brand prescriptions on the preferred drug list (PDL) drugs as listed on the MCO PDL. The MCO shall ensure that Native American members accessing prescription drugs at IHS or tribal 638 facilities will be exempt from the MCO's PDL. For each co-payment amount, quantities are limited to a 30-day supply or 100 tablets; whichever is less, per prescription or refill. All other units will be dispensed in a 30 -day supply, with one co-payment required for each of the following quantities:

(1) **Topical products:** The lesser of 80 gm. of cream/ointment or 60 ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.

(2) **Oral liquids:** 480 ml. maximum per co-payment.

(3) **Inhalers and vials:** One co-payment per unit (diabetic insulin exception - two vials of the same type of insulin per co-payment).

(4) **Manufacturer's trade package:** One co-payment per trade package (i.e. imitrex, estrogen patches).

(5) **Mail order drugs** are limited to drugs available through the MCO's mail order distributor.

R. **Transplants - organ, bone marrow, or tissue:**

(1) Organ, bone marrow, or tissue transplants are limited to:

(a) heart;

(b) heart/lung;

(c) lung;

(d) liver;

(e) cornea;

(f) kidney;

(g) skin;

(h) bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, severe combined immunodeficiency disease, wiskott-aldrich syndrome, advanced hodgkin's or non-hodgkin's lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas); or

(i) pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

(2) No other transplant procedures are covered. The MCO has the right to require that transplants be performed at contracted centers of excellence if one is available.

(3) A member is eligible for coverage for up to two transplants per lifetime. Multiple organ, bone marrow, or tissue transplants performed at the same time are considered to be one procedure. All transplant services are limited by the \$100,000 annual benefit limitation per member per benefit year.

[8.306.7.12 NMAC - N, 7-1-05; A, 7-1-09; A, 6-1-10]

8.306.7.13 SERVICES EXCLUDED FROM THE SCI BENEFIT PACKAGE: SCI does not cover any service or supply not specifically listed in 8.306.7.12 NMAC as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well. The list of exclusions below is not intended to be exhaustive. If a service is not listed in 8.306.7.12 NMAC as a covered service, then it is not covered regardless of medical necessity. Other services excluded are:

A. **Services not coordinated through a member's PCP or lack of a prior authorization:** Health services and supplies if not provided by or under the direction of:

(1) the member's PCP or a provider to whom the member has been referred by his PCP;

(2) a non-participating provider to whom the member has been referred by his PCP, and a prior authorization is in place for those services; or

(3) any services or supplies that require a prior authorization if a prior authorization is not obtained.

B. **Services not medically necessary, not standard medical practice, or experimental:** The following services are not covered:

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(1) any treatment, procedure, facility, equipment, drug, drug use, device, or supply that is not medically necessary; SCI pays only for medically necessary services furnished by approved providers to eligible recipients; SCI does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, other products or devices except routine patient costs associated with certain Phase I, II III and IV cancer clinical trials;

(2) drugs and devices that are not FDA approved, not FDA approved for the proposed use, or that have been voluntarily removed from the market; and

(3) medical, surgical, or behavioral health procedures, pharmacological regimes, or associated health services if they are experimental, under investigation, or generally not standard medical practice.

C. **Acupuncture and chiropractic services:** Acupuncture and chiropractic services are not covered.

D. **Assistant surgeon services:** Assistant surgeon services are not covered if not approved by the MCO.

E. **Behavioral health:** The following behavioral health services are not covered: behavioral health services that are rendered in connection with disorders not classified in the international classification of diseases, 9th revision, clinical modification (ICD-9-CM). Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, treatment foster care, day treatment, and neurobehavioral programs.

F. **Cosmetic services:** Cosmetic services are not covered, including but not limited to: surgery, services, or procedures to change family characteristics or conditions due to aging; dermabrasion; scar reconstruction or revision; acne surgery (including excision of scarring and cryotherapy); tattoo removal; orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body; surgical excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy; sclerotherapy; liposuction; rhinoplasty; otoplasty; services related to a cosmetic service, or required as a result of a noncovered cosmetic service; surgery required as a result of a noncovered procedure (such as a noncovered organ/tissue transplant or a sex change operation) or additional surgery or treatment required to care for or correct a complication due to a previous cosmetic service; or breast augmentation, reduction mammoplasty, or nipple reconstruction except as related to reconstructive surgery.

G. **Court ordered care:** Court-mandated evaluations and treatment that would not be in compliance with the terms and conditions of the MCO contract are not covered.

H. **Coverage out of the service area:** Coverage while away from service area, except for emergency health services and urgently needed health services, is not included unless otherwise covered.

I. **Custodial care:** Custodial or home (domestic) care, including services and supplies that can be performed by non-licensed medical personnel to help a member meet the normal activities of daily living are not covered. Examples of custodial care that are not covered services are:

- (1) bathing;
- (2) feeding;
- (3) preparing meals; and
- (4) performing housekeeping tasks.

J. **Dental services:** The following dental services are not covered:

- (1) All general dental services and dental x-rays, including but not limited to:
 - (a) anesthesia and facility services for dental restoration;
 - (b) removal of impacted teeth;
 - (c) removal of tori or exostoses;
 - (d) procedures involving orthodontic care, the teeth, dental implants and periodontal disease;
 - (e) artificial devices, surgery on the supporting structures of the teeth, and bone grafts to prepare the mouth for denture wear;
 - (f) personalized restorations, cosmetic replacement of serviceable restorations, or materials that are more expensive than necessary to restore damaged teeth; or
 - (g) surgical realignment of the jaw structures for functional malocclusion.
- (2) Orthodontics, endodontics, and dental prosthetics.
- (3) Orthotic and orthodontic appliances or treatment, crowns, bridges, or dentures used for the treatment of craniomandibular and temporomandibular joint disorders.

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K. **Donor services:** Medical and hospital services of a donor when the recipient of an organ, bone marrow, or tissue transplant is not a member, or when the transplant procedure is not a covered service are not included in the benefit package.

L. **Durable medical equipment, medical supplies; prosthetic devices; orthotic appliances:** The following are not included in the benefit package:

(1) **Durable medical equipment, medical supplies:**

(a) equipment that is non-medical in nature such as voice synthesizers or other communication devices, waterbeds, jacuzzi units, hot tubs, whirlpools, swimming pools, exercise equipment, heating pads, or hot water bottles;

(b) air conditioners, humidifiers, purifiers, or self-help devices, biofeedback equipment, and tens units;

(c) deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds, when standard equipment is available and adequate to meet functional requirements;

(d) repairs to equipment that is not owned by the member, or repairs to equipment that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;

(e) comfort or safety items such as bed boards, hospital beds or mattresses, flotation mattresses, bathtub lifts, grab bars, over bed tables, adjustable beds, telephone arms, diapers, under pads;

(f) sphygmomanometers, stethoscopes, and blood pressure monitors; or

(g) medical supplies and equipment that can be purchased over the counter such as shower chairs, elevated toilet seats, alcohol pads, and dressing supplies.

(2) **Prosthetic devices:**

(a) prosthetic devices unless they replace a limb or other part of the body after accidental or surgical removal or when the body's growth or atrophy necessitates replacement;

(b) external prosthetic devices that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;

(c) cosmetic coverings for external prosthetic devices;

(d) repairs of prosthetic devices that are not owned by the member; or

(e) cochlear implants.

(3) **Orthotic appliances:**

(a) accommodative orthotic appliances; orthopedic shoes and shoe orthotic appliances (except when the shoes are attached and an integral part of the brace), arch supports, shoe inserts, special-ordered shoes, custom shoes, built up shoes of any type, and other supportive devices for the feet, except for the management of diabetes as required by law;

(b) orthopedic appliances that can be purchased over-the-counter;

(c) cranial banding services; or

(d) penile prosthesis.

M. **Eyeglasses and vision services:** The following eyeglasses and vision services are not included in the benefit package:

(1) eye refractions, eyeglasses, and contact lenses, or the fitting thereof, and routine vision services, except for contact lenses or eyeglasses following cataract surgery; and

(2) surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses, except for intraocular lenses in connection with cataract removal.

N. **Genetic testing:** Genetic testing, screening (other than by triple serum test only) and counseling, with the exception of genetic testing for the diagnosis or treatment of a current illness are not included in the benefit package.

O. **Health clubs:** Fees for health clubs, spas and exercise programs are not included in the benefit package.

P. **Hearing aids:** The purchase of hearing aids, or the fitting thereof, associated hearing aid testing, and other artificial aids, is not included except as specifically defined in subsection G of 8.306.7.11 NMAC, *preventive health services*.

Q. **Hospice care:** Hospice care is not included in the benefit package.

R. **Illegal acts or crimes:** The following is not covered: Injury or illness sustained during the voluntary participation in a riot or the commission of an illegal act or crime, or while under the influence of alcohol

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or other drug or controlled substance, which is not prescribed by a provider. For purposes of this Subsection, a person will be presumed to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the MCO. The limitations of this subsection will not apply unless there is a direct causal relationship between the activity described above and the illness or injuries sustained.

S. **Infertility treatment:** Infertility treatment services are not covered.

T. **Learning disorders:** Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance, are not included in the benefit package.

U. **Marital therapy or counseling:** Marital therapy or counseling is not covered.

V. **Missed appointments:** Costs incurred in conjunction with missed appointments are not included in the benefit package.

W. **Modifications, improvements, equipment:** Home, workplace, and automobile modifications, improvements, or equipment are not included in the benefit package.

X. **No legal obligation to pay:** The following are not included in the benefit package:

(1) services a member is eligible to receive and has received under any governmental program which, in the absence of any health services or insurance plan, no charge would be made to the member; and

(2) services or supplies for which the member has no legal obligation to pay or for which no charge would be made if the member were not eligible for SCI.

Y. **Paternity tests:** Diagnostic tests to establish paternity of a child or unborn child are not included in the benefit package.

Z. **Physical examinations:** The following physical examinations are not included in the benefit package:

(1) routine physical examinations, vaccinations, or immunizations if given for:

(a) the purpose of obtaining employment, insurance, passports, or travel; or

(b) for the purpose of medical research.

(2) sports and school physicals, unless done in conjunction with periodic health assessments.

AA. **Physical, speech, occupational therapy - long term:** All long-term physical, speech and occupational therapy services are not included in the benefit package.

BB. **Physical, speech, occupational therapies:** Physical, speech, occupational therapies for the following conditions are not covered:

(1) psychosocial speech delay including delayed language development and developmental apraxia;

(2) mental retardation, down's syndrome, autism, autism spectrum disorders, or dyslexia;

(3) syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions;

(4) learning disabilities, developmental articulation and language disorders, and stuttering; and

(5) sensory disorders (oral and tactile aversions).

CC. **Podiatry and foot care:** The benefit package does not include podiatry or foot care, including but not limited to: bunion treatment, callus treatment, corn paring or excision, toenail trimming, except in the treatment of insulin-dependent diabetics. Foot massage of any type, treatment of fallen arches, flat or pronated feet, and shock wave treatment are not included in the benefit package.

DD. **Prenatal, delivery, post-partum services:**

(1) **All services related to the prenatal period:** Delivery and post-partum services shall be received in the MCO service area with the exception of a pregnant woman in the third trimester of pregnancy who has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not participating with the MCO.

(2) Tests to determine the gender of an unborn child are excluded from coverage.

EE. **Prescription drugs:** The following are excluded from coverage:

(1) brand name non-PDL prescription drugs without prior approval;

(2) drugs that do not require a physician's prescription; except insulin;

(3) contraceptive jellies, creams, foams, devices or implants (except legend contraceptive devices);

(4) therapeutic devices or appliances;

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- (5) drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or for cosmetic purposes only (e.g., Renova®);
- (6) biologicals, blood or blood plasma products;
- (7) drugs labeled “caution - limited by federal law to investigational use” or experimental drugs, even though a charge is made to the individual;
- (8) medication for which the cost is recoverable under any workers’ compensation or occupational disease law or from any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member;
- (9) medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution, which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- (10) any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order; and
- (11) charges for the administration or injection of any drug.
- FF. **Pulmonary rehabilitation:** Pulmonary rehabilitation is not included in the benefit package.
- GG. **Recovery:** Services and supplies that are otherwise covered, to the extent that a member realizes a recovery from any source, are not included in the benefit package.
- HH. **Repair or replacement for lost, stolen, or damaged items:** Repair or replacement for lost, stolen, or damaged items listed below are not included in the benefit package:
- (1) durable medical equipment;
 - (2) medical supplies;
 - (3) orthotic appliances;
 - (4) prosthetic devices; and
 - (5) prescription drugs.
- II. **Services, supplies for excluded services:** Services, supplies, or drugs used for non-covered or excluded procedures or treatment, or used for any related complication(s) are not included in the benefit package.
- JJ. **Services, supplies not primarily medical:** Services, supplies, and self-help items that are not primarily medical in nature, for personal comfort or safety, convenience or beautification during an inpatient stay, or in the home setting are not covered. Examples include but are not limited to: facial tissues, shampoo, diapers, under pads, grab bars, and exercise equipment.
- KK. **Sex transformation:** Sex transformation surgery and all expenses in connection with such surgery are not included in the benefit package.
- LL. **Sexual dysfunction:** Treatment for sexual dysfunction, including medication, counseling, and clinics, is not included in the benefit package.
- MM. **Sterilization reversal:** Any service related to reversal of sterilization is not included in the benefit package.
- NN. **Substance abuse or tobacco use:** Treatment to prevent the following is not included in the benefit package:
- (1) inpatient substance abuse treatment other than detoxification; and
 - (2) nicotine medications, gums, services, or supplies to aid in the treatment of addiction to tobacco or tobacco products; nicotine withdrawal treatments, including hypnosis, biofeedback, guided imagery, and other forms of relaxation training or subliminal suggestions used to modify tobacco use.
- OO. **Therapies:** Therapies including, but not limited to: exercise, massage, hypnotherapy, sensory, hippo, aquatic, oral aversion, visual training, recreational, sleep, stress management, scream, and myotherapy are not included in the benefit package.
- PP. **Travel/lodging expenses:** Travel and lodging expenses are not included in the benefit package.
- QQ. **Vocational rehabilitation services:** Vocational rehabilitation services are not included in the benefit package.
- RR. **War, terrorism, armed forces:** Any illness or injury resulting from war, act of terrorism, or an act of war or service in the armed forces of any country are not included in the benefit package, to the extent covered services of such illness or injury are provided through any governmental plan or program.

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SS. **Weight loss:** Surgery, medications, and related services for the purpose of weight reduction or control are not included in the benefit package.

TT. **Worker's compensation:** Industrial, work-related, or occupational illnesses, injuries, or conditions subject to federal, state, or other workers' compensation or liability law or other legislation of similar purpose are not included in the benefit package, unless the group is an employer not subject to the New Mexico Workers' Compensation Act or similar legislation.

UU. **Miscellaneous:** The following miscellaneous items are not included in the benefit package:

- (1) charges associated with copying or transferring of health information;
- (2) consultations by environmental engineers;
- (3) devices, medications, and treatments to remove hair due to excessive hair growth;
- (4) holistic medicine or biofeedback;
- (5) treatments, medications, prosthetic devices, and orthotic appliances to treat hair loss;
- (6) bone density screening with ultrasound devices; and
- (7) telephone visits by a provider or environmental intervention or consultation by telephone for

which a charge is made to the member, and getting acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.

[8.306.7.13 NMAC - N, 7-1-05; A, 7-1-09]

HISTORY OF 8.306.7 NMAC: [RESERVED]