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762 REPRODUCTIVE HEALTH SERVICES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients, including certain reproductive health services [42 CFR § 440.40(c)].

This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

762.1 Eligible Providers

Upon approval of the Provider Participation contracts by the New Mexico Medical Agreement Division (MAD), the following providers are eligible to be reimbursed for furnishing reproductive health services to Medicaid recipients:

1. Family planning clinics duly licensed to do business and operated to furnish family planning services; and

2. Other medical providers eligible under sections of this manual to furnish family planning services.

Once enrolled, providers receive a packet of information, including Medicaid program regulations and procedures, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

762.2 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 furnished to recipients. See Section MAD-701, GENERAL PROVIDER

POLICIES.

762.3 Covered Services and Service Limitations

Medicaid covers medically necessary reproductive health services and supplies furnished by or under the supervision of physicians. All services must be furnished within the limits of Medicaid benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local laws and regulations.

Covered services must be offered and furnished promptly to a recipient.

762.31 Sterilization Services Medicaid covers medically necessary sterilizations only under the following conditions. See 42 CFR § 441.251 et. seq.:

1. Recipients are at least twenty-one (21) years old at the time consent is obtained;

2. Recipients are not mentally incompetent. "Mentally incompetent" is a declaration of incompetency as made by a federal, state, or local court. A recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization.

3. Recipients are not institutionalized. For this section, "institutionalized" is defined as:

   A. An individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or an intermediate care facility for the care and treatment of mental illness; or

   B. Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

4. Recipients seeking sterilization must be given information regarding the procedure and the results before signing a consent form. This explanation must include the fact that sterilization is a final, irreversible procedure. Recipients must be informed of the risks and benefits

associated with the procedure;

5. Recipients seeking sterilization must also be instructed that their consent can be withdrawn at any time prior to the performance of the procedure and that they do not lose any other Medicaid benefits as a result of the decision to have or not have the procedure; and

6. Recipients voluntarily give informed consent to the sterilization procedure. See 42 CFR § 441.257(a):

   (A) The consent to sterilization form is signed by the recipient at least thirty (30) days before performance of the operation, except in the case of premature deliveries or emergency abdominal surgery when the consent form must be signed not less than seventy-two (72) hours before the time of the premature delivery.

   (B) A consent form is valid for 180 days from the date of signature.

   (C) Consent is not valid if obtained during labor or childbirth, while the recipient is under the influence of alcohol or other drugs, or is seeking or obtaining a procedure to terminate pregnancy.

   (D) Providers obtaining the consent for sterilization must certify that to the best of their knowledge that the recipient is eligible, competent, and voluntarily signed the informed consent.

   (E) Providers must provide an interpreter if needed to ensure that the recipient understands the information furnished.

   (F) The recipient is given a copy of the completed, signed consent form and the original is placed in the recipient's medical record.

762.32 Hysterectomies Medicaid covers only medically necessary hysterectomies. Medicaid does not cover hysterectomies performed for the sole purpose of sterilization. See 42 CFR § 441.253.

(A) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by recipients prior to the operation.

(B) Acknowledgement of the sterilizing results of the hysterectomy is not required from recipients who have been previously sterilized or who are past child-bearing age as defined by the medical community.

(C) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

762.33 Other Covered Services Medicaid covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy, or contraception including oral contraceptives, condoms, intrauterine devices (IUD), Depoprovera injections, diaphragms, and foams.

762.4 Noncovered Services

Reproductive health care services are subject to the same limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. In addition, Medicaid does not cover the following specific services:

1. Sterilization reversals;

2. Fertility drugs;

3. In vitro fertilization;

4. Artificial insemination;

5. Elective procedures to terminate pregnancy; and

5. Hysterectomies performed for the sole purpose of family planning.

762.5 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 instructions and documentation forms necessary for prior approval and claims processing.

762.51 Prior Approval Certain procedures or services identified in the utilization review instructions can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

762.52 Eligibility Determination Prior approval 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.

762.53 Reconsideration Providers who disagree with prior approval denials or any other review decisions can request a re-review and a reconsideration. See Section MAD-953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

762.6 Reimbursement

Providers furnishing reproductive health services must submit claims for reimbursement on the HCFA-1500 or UB-92 claim form or its successor, depending on the provider type. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

Reimbursement for reproductive health services is made at the lesser of the following:

1. The provider's billed charge; or

2. The MAD fee schedule of the specific service or procedure.

(A) The provider's billed charge must be their usual and customary charge for the service furnished.

(B) "Usual and customary charge" refers to the amount which an individual provider charges the general public in the majority of cases for a

specific procedure or service.

(C) Medicaid reimburses family planning clinics for family planning supplies at cost.

Reimbursement to hospitals, ambulatory surgical centers, outpatient facilities, or other providers for furnishing reproductive health services is made at the rate specified in the relevant service section of this manual.