State Supplement A to Attachment 3.1 A

Item 3 Other Laboratory and X-ray Services

a. A professional component associated with laboratory services is covered only when the work is actually by a pathologist who is not billing for the complete procedure and is covered only for anatomic and surgical pathology (includes cytopathology and histopathology).

b. Specimen collection fees are covered when drawn by venipuncture or collected by catheterization unless the patient is in a nursing home. Specimen collection fees are not payable for nursing home recipients.

c. Laboratory tests are not covered if the tests are conveyed from an ordering physician's office to a different physician's office, office laboratory, or non-certified laboratory. Physician and other private practitioners may not bill for laboratory tests which are sent to an outside laboratory or other facility.

d. Laboratory specimen handling or mailing charges are not a benefit of the program.

e. Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel.

f. Biomarker tests that are medically necessary are covered. These include biomarkers with an NDC or LDC, ones that are recommended by the FDA for pharmacologic monitoring, or ones recommended in a national guideline.

g. The following services require prior approval (or retrospective approval following an emergency or retrospective eligibility):
    1. Cryogenic service
    2. Outpatient Magnetic Resource Imaging

Item 4b ESDT Services in Excess of Federal Requirements

Nutritional assessment and nutritional counseling.

VL Clinical Diagnostic Lab Services

Laboratory services are covered under the laboratory benefit. Payment for clinical diagnostic laboratory services does not exceed payment levels specified by Section 1903(i) of the Social Security Act which is the Medicare fee schedule on a per test basis.

Beginning July 1, 2001, the Medicare fee schedule, as updated, is implemented as the Medicaid fee schedule.

For items and services for which there is not a Medicare fee schedule amount, the fee schedule is established by the state agency with consideration given to payment practices of other third-party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items, and/or the usual charges of the providers for services to non-Medicaid patients.

The agency's fee schedule rates for services and items for which there is not an established Medicare fee were set as of March 21, 2011, and are effective for services provided on or after that date.

All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Provider Enrollment and Program Policy, Fee for Service, under Fee Schedules, at: http://www.hsd.state.nm.us/mad/feeschedules.html

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Changes to the fee schedule are made with public notice, following the requirements of 42 CFR 447.205.

1.Biomarker Coverage (BC). Biomarker tests are reimbursed on a fee schedule basis when medically necessary. Except as otherwise noted in the state plan, The agency's fee schedule rates were set as of January 1, 2024 and are effective for services provided on or after that date. All rates are published at: https://www.hsd.state.nm.us/providers/fee-schedules/

VII. Prescribed dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist:

(1) Dentures

Dentures are covered under the service benefit of "Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses Prescribed by a Physician Skilled in Diseases of the Eye or by an Optometrist". Payment for dentures is made at the lesser of the provider's billed charge or the current Medicaid fee schedule.

The Medicaid fee schedule is established by the state agency with consideration given to payment practices of other third party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items and/or the usual charges of the providers for services to non-Medicaid patients,

The agency's fee schedule rates were set as of March 21, 2011, and are effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services.