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TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 2 LABORATORY SERVICES

8.324.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.324.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.324.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.324.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.324.2.3 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 Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.324.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.324.2.4 DURATION: Permanent
[2/1/95; 8.324.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.324.2.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.324.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.324.2.6 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; 8.324.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.324.2.7 DEFINITIONS: [RESERVED]

8.324.2.8 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; 8.324.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.324.2.9 LABORATORY SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including laboratory services [42 CFR Section 440.30]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[2/1/95; 8.324.2.9 NMAC - Rn, 8 NMAC 4.MAD.751, 3/1/12]

8.324.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of medical assistance program provider participation agreements by MAD, the following providers are eligible to furnish laboratory services:

(1) Independent clinical laboratories qualified to participate under Title XVIII (medicare) of the Social Security Act; Participation is limited to those facilities which have a Clinical Laboratory Improvement Act (CLIA) identification number and either a CLIA certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory.

(2) Clinics and individual physicians licensed to practice medicine or osteopathy, podiatrists, certified nurse practitioners, and groups formed by providers, who have office laboratories which have a CLIA identification number and either a CLIA certificate or waiver of a certificate of registration applicable to the category of procedures performed by the office laboratory; and

(3) Hospital clinical laboratories. See 8.311.2 NMAC, *Hospital Services*. The professional component of clinical laboratory for hospitals is subject to the limitations specified in this section.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, 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.

[2/1/95; 8.324.2.10 NMAC - Rn, 8 NMAC 4.MAD.751.1, 3/1/12]

8.324.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *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 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.324.2.11 NMAC - Rn, 8 NMAC 4.MAD.751.2, 3/1/12]

8.324.2.12 COVERED SERVICES: Medicaid covers medically necessary laboratory services ordered by physicians or other licensed medicaid providers which are either performed by ordering providers or under their supervision in an office laboratory or furnished by a clinical laboratory which meets the requirements for medicaid participation.

A. **Professional component:** A professional component associated with clinical laboratory services is payable only when the work is actually performed by a pathologist who is not billing for the complete procedure and is covered only for anatomic and surgical pathology including cytopathology, histopathology, bone marrow biopsy and pathology consultation.

B. **Specimen collection fees:** Medicaid covers specimen collection fees when drawn by venipuncture, arterial stick or collected by urethral catheterization, unless the recipient is in a nursing home or is a hospital inpatient.

[2/1/95; 8.324.2.12 NMAC - Rn, 8 NMAC 4.MAD.751.3, 3/1/12]

8.324.2.13 NONCOVERED SERVICES: Laboratory services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific laboratory services:

A. clinical laboratory professional components, except as specifically described under covered services above;

B. specimens, including pap smears, collected in a physician's office or a similar facility and conveyed to a second physician's office, office laboratory, or non-certified laboratory;

C. laboratory specimen handling or mailing charges;

D. specimen collection fees other than those specifically indicated in covered services; and

E. laboratory specimen collection fees for recipients in nursing facilities or inpatient hospital settings.

[2/1/95; 8.324.2.13 NMAC - Rn, 8 NMAC 4.MAD.751.4, 3/1/12]

8.324.2.14 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 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services 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.

B. **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.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.324.2.14 NMAC - Rn, 8 NMAC 4.MAD.751.5, 3/1/12]

8.324.2.15 REIMBURSEMENT: Laboratory providers must submit claims for reimbursement on the either the HCFA-1500 or UB-92 claim form or their successor based on the provider type. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

- A. Reimbursement to non-institutional providers is made at the lesser of the following:
- (1) the provider's billed charge; or
 - (2) the MAD fee schedule for the specific service or procedure.
- B. The provider's billed charge must be their usual and customary charge for services.
- C. "Usual and customary charge" refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.
- D. Reimbursement to institutional providers is based on medicare reimbursement principles.
[2/1/95; 8.324.2.15 NMAC - Rn, 8 NMAC 4.MAD.751.6, 3/1/12]

8.324.2.16 REIMBURSEMENT LIMITATIONS:

- A. **Use of medicare maximums:** Medicaid payment does not exceed the amount allowed by medicare for any given service. Medicare notifies MAD on an annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums upon implementation by MAD.
- B. **Referrals from clinical laboratories:** Clinical laboratories can bill for laboratory tests which are referred to an outside laboratory or other facility, if the outside lab is appropriately certified and registered according to the provisions of CLIA.
- C. **Referrals from providers:** Physicians and other private practitioners cannot bill for laboratory tests which are sent to an outside laboratory or other facility. Payment for laboratory services cannot be made directly to a practitioner, unless the tests were performed in his or her own office. Laboratories can bill for tests sent to other laboratories only if the CLIA number of the other laboratory is identified on the claim form. State facilities which contract for services with other state operated laboratories, such as the state health laboratory, can bill for those services providing the amount billed for the service does not exceed the amount paid by the state facility to the contractor.
- D. **Reimbursement for collection costs:** Medicaid does not reimburse an independent clinical laboratory separately for associated collection costs, such as office visits, home visits and nursing home visits. Reimbursement for performance of a laboratory procedure is considered payment in full for the service.
- E. **Services performed as profile or panel:** Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel. Medicaid cannot be billed for individual lab procedures that are considered in a profile or panel.
- F. **Services performed in freestanding and hospital-based renal dialysis facilities:** Medicaid does not reimburse freestanding and hospital-based renal dialysis facilities for performance of non-routine laboratory studies and blood services.
- G. **Professional components for specific procedures:** For services furnished in a hospital setting, the technical component of clinical laboratory services and surgical pathology are considered paid in the payment to the hospital. For inpatients, the professional components of these services are the only services for which Medicaid makes separate payment. Professional components can only be billed by the non-institutional provider. Non professional components for laboratory services performed within a hospital setting can only be billed by the institutional provider.
[2/1/95; 8.324.2.16 NMAC - Rn, 8 NMAC 4.MAD.751.7, 3/1/12]

HISTORY OF 8.324.2 NMAC: [RESERVED]