TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 3 PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT

8.310.3.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.310.3.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2023; A, 7/1/2024; A, xx/xx/xxxx]

8.310.3.2 SCOPE: The rule applies to the general public.
[8.310.3.2 NMAC - Rp, 8.310.3.2 NMAC, 1/1/2023]

8.310.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2023; A, 7/1/2024]

8.310.3.4 DURATION: Permanent.
[8.310.3.4 NMAC - Rp, 8.310.3.4 NMAC, 1/1/2023]

8.310.3.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[8.310.3.5 NMAC - Rp, 8.310.3.5 NMAC, 1/1/2023]

8.310.3.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.3.6 NMAC - Rp, 8.310.3.6 NMAC, 1/1/2023]

8.310.3.7 DEFINITIONS: [RESERVED]

8.310.3.8 MISSION STATEMENT: [~~To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.310.3.8 NMAC - Rp, 8.310.3.8 NMAC, 1/1/2023; A, xx/xx/xxxx]

8.310.3.9 ELIGIBLE PROVIDERS:

A. Health care to eligible medical assistance program (MAP) recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by the [~~HSD~~] HCA medical assistance division (MAD). Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to a MAP eligible 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~~] HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by [~~HSD~~] HCA or its authorized agents, including MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives [~~instruction~~] instructions on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact [~~HSD~~] HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Upon approval of the New Mexico medical assistance PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) medical practitioners:

(a) a physician licensed to practice medicine or osteopathy;

(b) a licensed certified nurse practitioner under the supervision or in collaboration with a physician or as an independent practitioner;

(c) a licensed physician assistant certified by the national commission on certification of physician assistants under the supervision of a physician;

(d) a licensed pharmacist clinician under the supervision of a physician;

(e) a licensed clinical nurse specialist under the supervision or in collaboration with a physician or as an independent practitioner;

(f) a licensed nurse anesthetist certified by the American association of nurse anesthetists council on certification of nurse anesthetists;

(g) a licensed anesthesiologist assistant certified by the national commission for certification of anesthesiologist assistants (NCCAA);

(h) a licensed podiatrist;

(i) [~~a licensed and~~] certified nurse midwife;

(j) a licensed midwife;

(k) a licensed dietician or a licensed nutritionist under the direction of a licensed physician;

(l) a licensed optometrist;

(m) a licensed audiologist certified by the American speech and hearing association;

(n) a licensed chiropractor; or

(o) a licensed naturopathic doctor;

(2) dental practitioners:

(a) a licensed dentist; or

(b) a licensed dental hygienist certified for collaborative practice;

(3) therapists:

(a) a physical therapist licensed by the physical therapy board under the state of New Mexico regulations and licensing division (RLD);

(b) an occupational therapist licensed by the board of occupational therapy under RLD; or

(c) a speech pathologist licensed by the board of speech, language, hearing under RLD;

(4) clinical laboratory, radiology, and diagnostic facilities:

(a) an independent clinical laboratory having a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory;

(b) a licensed radiological facility; or

(c) a licensed diagnostic laboratory;

(5) transplant centers: practitioners and facilities licensed or certified to furnish specialized transplant medical or surgical services;

(6) other providers described in other rules found in NMAC rules eligible to provide services or receive reimbursement, such as behavioral health services, early and periodic screening, diagnostic and treatment (EPDST) services, institutional services, and other specialized services.

B. Upon approval of the New Mexico MAD PPA agreement by MAD or its designee, the clinic, professional association, or other legal entity may be enrolled as a MAD provider in order that payment may be made to the clinic, professional association, or other legal entity formed by one or more individual practitioners. The individual practitioners that are employed by or contracted by the clinic, professional practice or other legal entity must also be enrolled as individual providers. All requirements under state law and regulations or rules regarding supervision, direction, and approved supervisory practitioners must be met. Such entities include:

(1) professional components for inpatient and outpatient institutions;

(2) professional corporations and other legal entities;

(3) licensed diagnostic and treatment centers, including a birthing center licensed as a diagnostic and treatment center;

(4) licensed family planning clinics;

(5) public health clinics or agencies;

(6) Indian health services (IHS) facilities; and

(7) PL.93-638 tribal 638 facilities.

C. All services rendered must be within the legal scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD including meeting requirements for medical necessity.

D. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers outside of New Mexico, a provider's out of state license may be accepted in lieu of licensure in New Mexico if the out of state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

E. Additional licensure or certification requirements may be required for specialized services such as services provided to MAP special needs recipients. Transplantation providers are eligible for enrollment if licensed as state transplantation centers by the licensing and certification bureau of the New Mexico department of health (DOH); or if certified as transplantation centers by the centers for medicare and medicaid services (CMS).

F. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and NMAC rules or meet federal requirements for providing services to IHS facilities or tribal contract facilities.

[8.310.3.9 NMAC - Rp, 8.310.3.9 NMAC, 1/1/2023; A, xx/xx/xxxx]

8.310.3.10 COVERED SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of NMAC rules and benefits and within the scope and practice of the provider's professional standards.

[8.310.3.10 NMAC - Rp, 8.310.3.10 NMAC, 1/1/2023]

8.310.3.11 REIMBURSEMENT: Providers must submit claims for reimbursement on the CMS-1500, American dental association (ADA), or universal billing (UB) claim form or their successor or their electronic equivalents, as appropriate to the provider type and service.

A. A provider is responsible for following coding manual guidelines and CMS national correct coding initiatives, including not improperly unbundling or upcoding services, not reporting services together inappropriately, and not reporting an inappropriate number or quantity of the same service on a single day. Bilateral procedures and incidental [~~procedure~~] procedures are also subject to special billing payment policies. The payment for some services includes payment for other services. For example, payment for a surgical procedure may include hospital visits and follow up care or supplies which are not paid separately.

B. General reimbursement:

(1) reimbursement to professional service providers is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure;

(2) the billed charge must be the provider's usual and customary charge for the service or procedure.

(3) "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.

C. Reimbursement limitations:

(1) Nurses: Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

(2) Midwife services: Reimbursement for a certified nurse midwife or a licensed midwife for maternity services is: [~~based on one global fee which includes prenatal care, delivery, postnatal and postpartum care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at seventy-seven percent of the rate paid to physicians for furnishing the global services and at one hundred percent of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule.~~]

(a) based on care reported in four distinct phases:

(i) antepartum and postpartum care is reimbursed per visit using evaluation and management services with appropriate modifier(s) for pregnancy-related visits;

(ii) labor management is reimbursed for daily visits, distinguishing initial vs. subsequent days and straightforward vs. complex cases; and

(iii) delivery care is reimbursed separately for the delivery event.

(b) certified nurse midwives and licensed midwives are reimbursed according to the MAD fee schedule.

(3) Surgery: Surgical assistants are reimbursed at twenty percent of the allowed primary surgeon amount. Surgical assistants are paid only when the surgical code allows for assistants as determined by medicare, CMS, or MAD. Physician assistants (PA), pharmacist clinicians, CNP's, midwives, and CNS's can only be paid as surgical assistants when it is within the scope of their practice as determined by state statute and their licensing boards.

(4) Physician extenders: Physician assistants, pharmacist clinicians and other providers not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works.

(5) Hospital settings: Reimbursement for services provided in hospital settings that are ordinarily furnished in a provider's office is made at sixty percent of the fee schedule allowed amount. MAD follows medicare principles in determining which procedures and places of service are subject to this payment reduction. For services not covered by medicare, the determination is made by MAD. For facility-based providers, costs billed separately as a professional component must be identified for exclusion from the facility cost report prior to cost settlement or rebasing.

(6) Dietician and nutrition services: For nutritional counseling services, physicians, physician extenders and clinics must include the charges for nutritional services in the office visit code when services are furnished by physicians or physician extenders. The level of the office visit reflects the length and complexity of the visit. For services furnished as part of prenatal or postpartum care, nutritional counseling services are included in the reimbursement fees for prenatal and postpartum care and are not reimbursed separately. Nutritional assessment and counseling services can be billed as a separate charge only when services are furnished to a MAP eligible recipient under age 21 by licensed nutritionists or licensed dieticians who are employed by eligible providers. Reimbursement is made to eligible providers and not directly to the nutritionists or dieticians.

(7) Laboratory and diagnostic imaging reimbursement limitations:

(a) Use of medicare maximums: The MAD payment does not exceed the amount allowed by medicare for any laboratory service. Medicare notifies MAD on an annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums for reimbursement upon implementation by MAD.

(b) 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 their 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.

(c) Reimbursement for collection costs: MAD does not reimburse an independent clinical laboratory separately for associated collection costs such as office visits, home visits or nursing home visits.

(d) 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. MAD cannot be billed for individual lab procedures that are considered included in a profile or panel.

(8) Radiology:

(a) Non-profit licensed diagnostic and treatment centers and state facilities: Non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center.

(b) Reimbursement for additional charges: Reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

(c) Reimbursement for inclusive procedures: Reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

(d) Reimbursement for the professional component of a radiology service does not exceed forty percent of the amount allowed for the complete procedure.

(i) A professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(ii) A claim for "supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

(9) Telemedicine providers: Reimbursement for services at the originating-site (where the MAP eligible recipient is located) and the distant-site (where the provider is located) are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

D. Reimbursement for services furnished by medical interns or residents: Reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in another hospital that participates in a teaching program is only made through an institutional reimbursement process. Medical or surgical services performed by an intern or a resident that are unrelated to educational services, internship, or residency, are reimbursed according to the MAD fee schedule for physician services when all of the following provisions are met:

(1) services are identifiable physician services that are performed by the physician in person;

(2) services must contribute to the diagnosis or treatment of the MAP eligible recipient's medical condition;

(3) an intern or resident is fully licensed as a physician;

(4) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and

(5) services are excluded from outpatient hospital costs; when these criteria are met the services are considered to have been furnished by the practitioner in their capacity as a physician and not as an intern or resident.

E. Services of an assistant surgeon in an approved teaching program:

(1) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since the resident is available to perform services unless the following exceptional medical circumstances exist:

(a) an assistant surgeon is needed due to unusual medical circumstances;

(b) the surgery is performed by a team of physicians during a complex procedure; or

(c) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the MAP eligible recipient's medical condition.

(2) This reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

F. Reimbursement for dental residents: Reimbursement can be made for dental residents in an approved teaching program when all the following conditions are met:

(1) the resident is fully licensed as a dentist for independent practice;

(2) the costs of the dental residency program is not included in the direct or graduate medical education payments to a provider operating the teaching program; and

(3) only one dental claim is submitted for the service; the supervising dentist and the rendering dentist will not be both paid for the service or procedure.

G. Non-independent practitioners: Reimbursement for services furnished by a physician assistant, a pharmacist clinician, or another practitioner whose license is not for independent practice, is made only to the billing supervising practitioner or entity rather than directly to the supervised practitioner.

H. Surgical procedures: Reimbursement for surgical procedures is subject to certain restrictions and limitations.

(1) When multiple procedures that add significant time or complexity to care are furnished during the same operative session, the major procedure is reimbursed at one hundred percent of the allowable amount, the secondary procedure is reimbursed at fifty percent of the allowable amount and any remaining procedures are reimbursed at twenty-five percent of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly. "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same MAP eligible recipient on the same date of service.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier. Reimbursement for bilateral procedures is one hundred fifty percent of the amount allowed for a unilateral procedure.

(3) Surgeons are not reimbursed for the performance of incidental procedures, such as incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias, or tubal ligations done in conjunction with cesarean sections.

(4) Providers are not reimbursed for performing complete physical examinations or histories during follow-up treatment after a surgical procedure.

(5) Other health care related to a surgery is considered to be reimbursed in the payment for the surgery and is not paid as a separate cost. Surgical trays and local anesthesia are included in the reimbursement for the surgical procedure.

(6) Under certain circumstances, the skills of two surgeons, usually with different surgical specialties may be required in the management of a specific surgical problem. The total allowed value of the procedure is increased by twenty-five percent and each surgeon is paid fifty percent of that amount.

I. Maternity services: [~~Reimbursement for maternity care is based on one global fee. Routine prenatal, delivery postnatal and postpartum care are included in the global fee. Services related to false labor and induced labor are also included in the global fee.~~]

(1) Reimbursement for maternity care is based on care reported in four distinct phases:

(a) antepartum care and postpartum care: is reimbursed per visit using evaluation and management services with appropriate modifier(s) for pregnancy-related visits;

(b) labor management: is reimbursed for daily visits, distinguishing initial vs. subsequent days and straightforward vs. complex cases; and

(c) delivery care: is reimbursed separately for the delivery event.

[~~**(1)** If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code.~~]

(2) MAD pays based on a modifier for high-risk pregnancies or for complicated pregnancies. The determination of high risk is based on a claims review.

[~~**(3)** If partial services are furnished by a certified nurse midwife or licensed midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code.~~

~~**(4)** If the services furnished include a combination of services performed by a certified nurse midwife or licensed midwife, and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.~~]

[~~**(5)**~~] **(3)** MAD pays supply fees only when a MAP eligible recipient is accommodated for two hours or more in the home or a birthing center prior to delivery. Payment for use of a licensed birthing center includes supplies.

[~~**(6)** MAD covers postnatal and postpartum care by a certified nurse midwife or licensed midwife, as a separate service only when the midwife does not perform the delivery.~~]

[~~**(7)**~~] **(4)** Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.

[~~**(8)**~~] **(5)** Reimbursement for cesarean sections and inductions is made only when the service is medically necessary. These services are not covered as elective procedures.

[~~**(9)**~~] **(6)** MAD covers laboratory and diagnostic imaging services related to an essentially normal pregnancy. These services can be billed separately.

(7) MAD covers doula services provided as described in NMAC 8.310.2 for MAP eligible recipients. MAD covers only those services furnished by a doula certified by the Department of Health (DOH).

(8) MAD covers lactation care services provided by lactation care providers (LCP) or non-physician provider-certified nurse assistant (CNA), certified nurse midwife (CNM), licensed midwife (LM) or physician assistant (PA) as described in NMAC 8.310.2 for MAP eligible recipients. LCP's must be licensed and maintain licensure through the New Mexico Board of Nursing (NMBON).

[~~**(10)**~~] **(9)** Non/covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(a) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self/administered by the MAP eligible recipient;

(b) services furnished by an apprentice, unless billed by the supervising midwife;

(c) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

[~~(11)~~] (10) Birthing options program (BOP): The BOP is specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(a) The BOP out-of-hospital birth locations include a pregnant member's home or a licensed birth center.

(b) A BOP participant may elect to have a home birth or birth in a licensed birth center when she has BOP services provided by an eligible midwife that enrolls as a BOP provider with the [~~Human Services Department/medical assistance division (HSD/MAD)~~] Health Care Authority/medical assistance division (HCA/MAD) and the New Mexico Department of Health/maternal health division (NMDOH/MHC).

J. Services limited by frequency:

(1) services furnished by another provider: where coverage of services provided to MAP eligible recipient is restricted or limited by frequency of services, procedures or materials, it is a provider's responsibility to determine if a proposed service has already been furnished by another provider, such that the MAP eligible recipient has exhausted the benefit. Examples include but are not limited to dental services, vision exams and eyeglasses.

(2) direct MAP eligible recipient payment for services: a provider can make arrangements for direct payment from a MAP eligible recipient or their authorized representative for noncovered services. A MAP eligible recipient or their authorized representative can only be billed for noncovered services if:

(a) a MAP eligible recipient or their authorized representative is advised by a provider of the necessity of the service and the reasons for the non-covered status;

(b) a MAP eligible recipient or their authorized representative is given options to seek treatment at a later date or from a different provider;

(c) a MAP eligible recipient or their authorized representative agrees in writing to be responsible for payment; and

(d) the provider fully complies with the NMAC rules relating to billing and claims filing limitations.

(3) services considered part of the total treatment: a provider cannot bill separately for the services considered included in the payment for the examination, another service, or for routine post-operative or follow-up care.

K. Anesthesia services:

(1) Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time.

(a) Each anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the conversion factor allowed for each unit.

(b) The reimbursement per anesthesia unit may vary depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) and a non-directed CRNA.

(c) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiologist assistant, one time unit is allowed for each 15-minute period a MAP eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15-minute period.

(2) Medical direction: Reimbursement is made at fifty percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA). Reimbursement is made at fifty percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a MAP eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-MAP eligible recipients and the remaining is a MAP eligible recipient, this represents three concurrent cases.

(a) Time units for medical direction are allowed at one time unit for each 15-minute interval.

(b) Anesthesia claims are not payable if the surgery is not a MAD benefit or if any required documentation was not obtained.

(c) Medical direction is a covered service only if the physician:

(i) performs a pre-anesthesia examination and evaluation; and

(ii) prescribes the anesthesia plan; and

(iii) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(iv) ensures that any procedures in the anesthesia plan that they do not perform are performed by a qualified anesthetist; and

(v) monitors the course of anesthesia administration at frequent intervals; and

(vi) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) provides indicated post-anesthesia care.

(d) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(e) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(f) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(g) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

(3) Monitored anesthesia care: Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(a) "Monitored anesthesia care" is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the MAP eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological MAP eligible recipient reaction to the surgical procedure and includes:

(i) performance of a pre-anesthetic examination and evaluation;

(ii) prescription of the anesthesia care required;

(iii) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the MAP eligible recipient's physiological signs;

(iv) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(v) provision of indicated postoperative anesthesia care.

(b) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

(c) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

(4) Medical supervision: If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed anesthesia services. The MAD payment to the CRNA will be fifty percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.

(5) Obstetric anesthesia: Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

(6) Unusual circumstances: When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the MAP eligible recipient's record.

(7) Pre-anesthetic exams and cancelled surgery: A pre-anesthetic examination and evaluation of a MAP eligible recipient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

(8) Performance of standard procedures: If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units or units for time.

(9) Add-on codes for anesthesia: Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

(10) Anesthesia services furnished by the same physician providing the medical and surgical service:

(a) A physician who both performs and provides moderate sedation for medical or surgical services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who performs and provides local or minimal sedation for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

(i) local or topical anesthesia; to

(ii) moderate (conscious) sedation; to

(iii) regional anesthesia; to

(iv) general anesthesia.

(b) Moderate sedation is a drug-induced depression of consciousness during which a MAP eligible recipient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines. However, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

(L) Chiropractic services: MAD covers chiropractor services provided by a licensed chiropractor and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the state to perform. Chiropractic services are covered when medically necessary for all individuals who have a primary diagnosis of neck pain, back pain, musculoskeletal pain, or headaches. Payments to New Mexico chiropractic licensed providers are reimbursed at one hundred percent.

[8.310.3.11 NMAC - Rp, 8.310.3.11 NMAC, 1/1/2023; A, xx/xx/xxxx]

HISTORY OF 8.310.3 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0100, Physician Services, filed 1/9/1980.
ISD 310.0100, Physician Services, filed 6/16/1980.
ISD 310.0100, Physician Services, filed 4/2/1982.
ISD-Rule-310.0100, Physician Services, filed 9/2/1983.
ISD-Rule-310.0100, Physician Services, filed 3/30/1984.
ISD Rule-310.0100, Physician Services, filed 4/26/1984.
ISD Rule-310.0100, Physician Services, filed 2/25/1986.
MAD Rule 310.01, Physician Services, filed 12/15/1987.

MAD Rule 310.01, Physician Services, filed 4/27/1988.
MAD Rule 310.01, Physician Services, filed 4/20/1992.
MAD Rule 310.01, Physician Services, filed 3/10/1994.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990.

History of Repealed Material:
MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990 - Repealed effective 2/1/1995.
8.310.2 NMAC, Medical Services Providers, filed 2/16/2004 - Repealed effective 1/1/2014.
8.310.3 NMAC, Rural Health Clinic Services, filed 2/7/2012 - Repealed effective 1/1/2014. Replaced by 8.310.9 NMAC, Rural Health Clinic Services, effective 1/1/2014.
8.310.5 NMAC, Anesthesia Services, filed 5/12/2003 - Repealed effective 1/1/2014.
8.310.13 NMAC, Telehealth Services, filed 7/17/2007 - Repealed 1/1/2014.
8.324.2 NMAC, Laboratory Services, filed 2/7/2012 - Repealed 1/1/2014.
8.324.3 NMAC, Diagnostic Imaging and Therapeutic Radiology Services, filed 2/7/2012 - Repealed 1/1/2014.
8.324.9 NMAC, Nutrition Services, filed 2/7/2012 - Repealed 1/1/2014.
8.325.3 NMAC, Reproductive Services, filed 1/18/1995 - Repealed 1/1/2014.
8.310.3 NMAC, Professional Providers, Services And Reimbursement filed 12/17/2013 - Repealed 1/1/2023.

Other History: 8.310.3 NMAC, Professional Providers, Services And Reimbursement filed 12/17/2013, Replaced by 8.310.3 NMAC, Professional Providers, Services And Reimbursement effective 1/1/2023.