TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 4 FEDERALLY QUALIFIED HEALTH CENTER SERVICES

8.310.4.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.310.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11/1/04]

8.310.4.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.310.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11/1/04]

8.310.4.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.310.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11/1/04]

8.310.4.4 DURATION: Permanent
[2/1/95; 8.310.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11/1/04]

8.310.4.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.310.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11/1/04]

8.310.4.6 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; 8.310.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11/1/04]

8.310.4.7 DEFINITIONS: [RESERVED]

8.310.4.8 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; 8.310.4.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11/1/04]

8.310.4.9 FEDERALLY QUALIFIED HEALTH CENTER SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible clients. To help New Mexico clients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered outpatient services provided at federally qualified health centers (FQHC's). This part describes eligible providers, covered services, service limitations, and general reimbursement methodology. MAD intends to follow federal regulation applicable to medicare where and if there are any omissions in these regulations with respect to covered services.
[2/1/95; 1/1/00; 8.310.4.9 NMAC - Rn, 8 NMAC 4.MAD.713, 11/1/04]

8.310.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following entities are eligible to be reimbursed for furnishing medical services as FQHCs:

(1) entities which receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(2) entities which receive funding from such a grant under a contract with the recipient of such a grant indicated above which meet the requirements to receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(3) entities which the secretary of the federal department of health and human services determines meet the requirements for receiving such a grant or entities which qualify through waivers authorized by the secretary of the department of health and human services; and

(4) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organizations receiving funds under the Indian Health Care Improvement Act for the provision of primary health services.

B. Individual providers employed by or under contract with FQHCs must be enrolled with New Mexico medicaid.

C. 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; 1/1/00; 8.310.4.10 NMAC - Rn, 8 NMAC 4.MAD.713.1, 11/1/04]

8.310.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid clients 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 clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to clients. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.310.4.11 NMAC - Rn, 8 NMAC 4.MAD.713.2, 11/1/04]

8.310.4.12 COVERED SERVICES: All services provided by the FQHC must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid-covered benefits. If not specified in this section, MAD adopts definitions of coverage delineated in the FQHC sections of medicare statutes. "Other ambulatory services" offered by the FQHC are subject to the same medicaid limitations, utilization review requirements, and coverage restrictions that exist for other providers rendering the delineated service.

A. **Physician services:**

(1) Physician services are professional services that are performed by a physician, including psychiatrists, employed by or under contract with the FQHC.

(2) Services and supplies incident to a physician's professional service are covered if the service or supply meets delineated requirements. Services and supplies include the professional component of radiology services, laboratory services performed by the FQHC and specimen collection for laboratory services furnished by an off-site laboratory. To meet the definition of "incident to" a professional service, the service and supplies must be:

(a) of a type commonly furnished in a physician's office; [within the meaning of the Code of Federal Regulations (CFR) page 128 Section 405.2413 (a)(1) 10-01-98 edition]

(b) of a type commonly rendered either without charge or included in the FQHC encounter rate;

(c) furnished as an incidental, although integral, part of a physician's professional service;

(d) furnished under direct, personal supervision of a physician; and

(e) in the case of a service, furnished by a member of the FQHC's health care staff who is an employee of the FQHC or under contract with the FQHC.

(3) Inpatient hospital visits are those services furnished to an individual as a "patient" of the FQHC. Therefore, FQHC services furnished off-site (including those furnished to a person who is an inpatient of a hospital or nursing facility) will be considered FQHC services only if the physician's agreement with the FQHC requires that he or she seek compensation from the FQHC. (Section 4704 c of OBRA '90, amended Section 1905 1,2.) (HCFA Letter #91-18 dated March 1991.)

B. **Mid-level practitioners:** Services furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner are covered as an FQHC core service if the service is:

(1) furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner who is employed by or under contract with the FQHC;

(2) furnished in accordance with FQHC policies and individual treatment plans developed by FQHC personnel for a given client;

(3) a type which the nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who furnished the service is permitted by licensure and/or certification;

(4) furnished under the supervision of a physician, if required by New Mexico law.

(a) The physician supervision requirement is met if the conditions specified in Section 491.8 (b) of the Social Security Act and any pertinent requirements specified under New Mexico law are satisfied.

(b) To be covered, the services provided by mid-level practitioners must comply with New Mexico law.

(c) Services and supplies are covered as incident to the provision of services by a mid-level practitioner if the requirements specified in Paragraph (2) of Subsection A of 8.310.4.12 NMAC are met.

(d) The direct personal supervision requirement for mid-level practitioners is met if the mid-level practitioner is permitted to supervise under the written policies governing the FQHC and as defined under New Mexico law.

C. **Outpatient mental health services:** Diagnosis and treatment of mental illness are covered services when the service is provided by an individual licensed as a physician by the board of medical examiners or board of osteopathy and who is board-eligible or board-certified in psychiatry, a licensed clinical psychologist (Ph.D., Psy. D., or Ed. D.), a licensed independent social worker (LISW), a licensed professional clinical mental health counselor (LPCC), a licensed marriage and family therapist (LMFT), or a clinical nurse specialist certified in psychiatric nursing (CNP) who is employed by or under contract with the FQHC. An FQHC is reimbursed for services furnished by licensed master's level social workers, licensed psychology associates and master's level licensed counselors who are graduates of an accredited program when the services are furnished under the direction and supervision as addressed under Subsection C of 8.310.8.10 NMAC.

D. **Visiting nurse services:** Visiting nurse services are covered if the FQHC is located in an area identified by the secretary of health and human services as having a shortage of home health agencies. No additional certification is required beyond the FQHC certification. To be covered, visiting nurse services must be:

(1) rendered to clients who meet criteria for home health services;

(2) furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or under contract with the FQHC; and

(3) furnished under a written plan of treatment that is established and signed by a supervising physician; the plan may also be established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner employed by or under contract with the FQHC; the plan must be reviewed every 60 days by the supervising physician and revised as the client's condition warrants;

(4) visiting nurse services do not include household and housekeeping services or other services that constitute custodial care.

E. **Preventive services:**

(1) Preventive primary services that an FQHC may provide are those services as defined in the 42 CFR 405.2448 and include:

(a) medical social services;

(b) nutritional assessment and referral;

(c) individual preventive health education;

(d) well-child care, including periodic screening, to include children's eye and ear examinations;

(e) prenatal and postpartum care;

(f) immunizations for children and adults, including tetanus-diptheria booster and influenza vaccine;

(g) family planning services;

(h) physical examinations targeted to risk, to include blood pressure measurement, weight, and client history;

(i) visual acuity screening;

(j) hearing screening;

(k) cholesterol screening;

(l) stool testing for occult blood;

(m) dipstick urinalyses;

(n) risk assessment and initial counseling regarding risks;

(o) tuberculosis testing for high risk clients;

(p) preventive dental services;

(q) for women only: PAP smears; clinical breast exams; referral for mammography; and thyroid function tests.

(2) Documentation of any service provided by the FQHC must be available in the client's record.

(3) Preventive primary services do not include eyeglasses, hearing aids, group or mass information programs, health education classes, or group education activities, including media productions and publications.

F. **Pharmacy services:** Pharmacy services and medical supplies are covered services and are included as an allowable cost if dispensed from an FQHC. An FQHC encounter for the provision of medical, behavioral health, and dental services includes related pharmacy services. The FQHC shall not bill a separate

encounter for the provision of pharmacy services. To dispense medications, the FQHC must be licensed as a licensed drug clinic under the Pharmacy Practice Act.

G. **Dental services:** See 8.310.7 NMAC, *Dental Services*, for benefit coverage and service limitation. Dentists and dental hygienists providing services for an FQHC must provide services within the scope of their license as defined in the New Mexico Dental Health Care Act.

H. **Case management:** Targeted case management services are covered services and are subject to the same requirements that apply to providers who furnish case management services. See 8.326.2 NMAC through 8.326.8 NMAC [MAD-771 - MAD-779].

[2/1/95; 1/1/00; 8.310.4.12 NMAC - Rn, 8 NMAC 4.MAD.713.3 & A, 11/1/04]

8.310.4.13 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 Approval and Utilization Review*. Once enrolled, providers receive instruction and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures and 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 the individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients 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 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[2/1/95; 1/1/00; 8.310.4.13 NMAC - Rn, 8 NMAC 4.MAD.713.4, 11/1/04]

8.310.4.14 NON-COVERED SERVICES AND SERVICE LIMITATION: FQHC services are covered when provided in outpatient settings only, including a client's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a client's home. FQHC services are not covered in a hospital as defined in section 1861(e)(1) of the Act.

A. **Service limitations:** An FQHC may be compensated for provision of other "ambulatory services" covered in the medicaid fee-for-service program (per the Balanced Budget Act of 1997). However, an FQHC must meet licensing and certification requirements for those services as specified in the applicable MAD policy manual section for the specific service.

B. **Location of clinic:**

(1) Permanent unit: Objects, equipment, and supplies necessary for the provision of services furnished directly by the FQHC must be housed in a permanent structure. Each unit must have individual FQHC certification.

(2) Mobile unit: The objects, equipment, and supplies necessary for the provision of services furnished by the FQHC must be housed in an FQHC mobile structure which has fixed, scheduled locations.

C. **Other restrictions:** FQHC service providers are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Non-covered Services* [MAD-602].

[2/1/95; 1/1/00; 8.310.4.14 NMAC - Rn, 8 NMAC 4.MAD.713.5, 11/1/04]

8.310.4.15 REIMBURSEMENT: FQHCs must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services* [MAD-702]. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Interim reimbursement for services provided by an FQHC is made by MAD based on submitted claims.

A. **Initial rates:** The initial interim rate for new FQHC providers will be the interim rate set by medicare.

B. **Cost settlement:**

(1) FQHCs must submit cost reports on an annual basis to MAD or its designee within the time frames specified by medicare. FQHCs will not be granted an extension to the cost report filing time frames.

(2) A final cost settlement based on the audit data will be made in accordance with delineated medicaid requirements and/or applicable medicare cost reimbursement principles when medicaid requirements are

not specified. Final cost settlements are based on the allowable cost as audited or desk reviewed costs by MAD or its designee. "Allowable costs" are costs incurred by an FQHC which are reasonable in amount, proper and necessary for the efficient delivery of services by the FQHC (MAD or its designee will follow the HCFA Pub. 15-1 in determining allowable costs). The supporting documentation for "allowable costs" must be available upon request from MAD or its designee.

(3) MAD or its designee may reopen cost reports per HCFA Pub. 15-1 Section 2931 through 2932.1. Providers will be notified on a case-by-case basis thirty (30) days prior to any reopening. MAD uses the productivity standards used in the medicare cost report. However, MAD does not use the costs limits imposed by medicare. If an FQHC disagrees with an audit settlement, the provider can request a reconsideration. See 8.350.4 NMAC, *Reconsideration of Audit Settlement* [MAD-955].

(4) HSD or its designee will complete their initial review of cost settlement materials within 150 days of the receipt of all required information.

C. **What constitutes a visit:** A visit is a face-to-face encounter between a center client and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, qualified clinical psychologist or qualified clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(1) after the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment;

(2) the client has a dental visit, or medical visit and another health visit (e.g., a face-to-face encounter between the client and a clinical psychologist, clinical social worker, or other health professional for mental health services listed in Subsection C of 8.310.4.12 NMAC [MAD 713.33].

D. **Supplemental agreements:** FQHCs which executed specific agreements with HSD will receive supplemental payments for services rendered to clients enrolled in managed care in the manner and amount specified under the terms of that agreement.

E. **Termination or change of ownership:** The human services department (HSD) reserves the right to withhold payment on all current and pending claims until HSD rights to recoup all or portions of such payments is determined from final cost reports when a change of ownership occurs. Payment will not be withheld if HSD is informed in writing the current (new) owner or the previous owner agrees to be responsible for any potential recoupment.

[2/1/95; 1/1/00; 8.310.4.15 NMAC - Rn, 8 NMAC 4.MAD.713.6, 11/1/04]

HISTORY OF 8.310.4 NMAC:

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

MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/91.

History Of Repealed Material:

MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/91 - Repealed effective 2/1/95.