State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
DENTAL SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department, Medical Assistance Division, is proposing a change to the Medicaid dental benefits for eligible recipients 21 years of age or older. Along with these proposed changes in benefits, the entire rule, 8.310.7 NMAC, *Dental Services*, was reviewed for clarity resulting in additional changes in the wording but not otherwise affecting the benefits of the program.

If implemented as proposed, the following changes to Medicaid dental benefits will affect recipients 21 years of age or older:

- Changing the allowed frequency of the dental radiology service "intraoral complete series or panoramic film" from one every three years to one every five years. For clarity, the five-year period is described as "60 months" in the proposed rule.

Other changes in the rule being proposed at this time include the following:

- Replacing outdated word usage, such as Medicaid with MAD, the Medical Assistance Division.
- Providing more instruction on the eligibility of providers and their responsibilities
- Directing providers to enroll and follow a managed care or coordinated care contractor's instructions for billing and authorization of services.
- Separating recipient benefit coverage by age: under 21 years of age or 21 years of age or older for more clarity.

- Adding one fluoride treatment once in a 12 month period for eligible recipients 21 years of age or older.
- Clarifying services covered under dental emergencies.
- Adding language instructing providers of their responsibility to determine if a proposed service has already been furnished by another provider.
- Clarifying when a provider may make arrangements for direct payment from an eligible recipient or their personal representative for non-covered dental services.
- Other grammatical and clarifying changes as necessary.

The changes in the dental benefits are being proposed because the Department believes the changes are more in line with the benefits typically available from other dental service insurers. Also, at this time there is a serious shortfall in state revenues which has resulted in reductions in many state agency budgets. The New Mexico Medicaid program budget is no exception. Program costs are outpacing available revenues. Therefore, the Department has looked at dental and other program benefits to determine changes that can be made while still providing medically appropriate services.

The reduction in payments for these services in the Medicaid fee-for-service program is estimated to be $192,000.

VI. RULES

These proposed rule changes refer to 8.310.7 NMAC of the Medical Assistance Program Policy Manual. This register is available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010 . The proposed rule changes are attached to the register. If you do not have Internet access, a copy of the rules may be requested by contacting the Medical Assistance Division at 505-827-3156.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective July 15, 2010.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 10:00 a.m. on Thursday, May 27, 2010, in the South Park Conference Room, 2055 S. Pacheco, Ste 500-590, Santa Fe, NM.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on May 27, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these rules approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 7 DENTAL SERVICES

8.310.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[1/1/95; 8.310.7.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 10/1/02; A, 7/15/10]

8.310.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program [~~is~~] 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 [~~and by the state human services department pursuant to state statute~~] or by state statute. See NMSA 1978, Sections 27-2-12 et seq. [~~(Repl. Pamp. 1991)~~].
[1/1/95; 8.310.7.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 10/1/02; A, 7/15/10]

8.310.7.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[1-1-95, 2-1-95; 8.310.7.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 10/1/02; A, 7/15/10]

8.310.7.6 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.~~] The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid program.
[1/1/95, 2/1/95; 8.310.7.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 10/1/02; A, 7/15/10]

8.310.7.8 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.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[2/1/95; 8.310.7.8 NMAC - Rn, 8 NMAC 4.MAD.002, 10/1/02; A, 7/15/10]

8.310.7.9 DENTAL SERVICES: Dental services are covered as an optional medical service [~~for New Mexico medicaid program (medicaid) recipients~~] for medical assistance division (MAD) eligible recipients. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the recipient [42 CFR Section 440.100(a)]. [~~Medicaid~~] MAD also covers dental services, dentures and special services for recipients who qualify for services under the early and periodic screening, diagnosis and treatment (EPSDT) program [~~42 CFR Section 440.120(3)(b); 42 CFR Section 441.55(c)(2). This section describes covered dental services, service requirements, covered services, service restrictions and general reimbursement methodology.~~] 42 CFR Section 441.55.
[2/1/95; 8.310.7.9 NMAC - Rn, 8 NMAC 4.MAD.716, 10/1/02; A, 7/15/10]

8.310.7.10 ELIGIBLE PROVIDERS:

A. [~~Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico human services department, medical assistance division (HSD/MAD) or its designee, individuals and those in professional corporations, associations or other types of group dental practices licensed to practice dentistry are eligible to participate as medicaid dental providers.~~] Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners of facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction 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 or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions and other pertinent material, and to obtain answers to questions related to the material or not covered by the material. To be eligible for

reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement 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. Providers must supply necessary information in order for payment to be made. Eligible providers include:

(1) Dental hygienists certified for collaborative practice as defined by NMSA 1978 Section 61-5A-4(D&E) may be enrolled to provide any of those services specified for collaborative practice dental hygienists in 8.310.7.12 NMAC. Certified collaborative practice dental hygienists must be in good standing with the New Mexico board of dental health care and the New Mexico dental hygienist committee and must verify their current certificate with the New Mexico board of dental health care annually.

[~~(2) Certified collaborative practice dental hygienists must be in good standing with the New Mexico board of dental health care and the New Mexico dental hygienist committee and must reverify their certificate with the New Mexico board of dental health care annually.~~]

[~~(3)~~] (2) Individuals who are licensed and those in professional corporations, associations or other types of group dental practices licensed to practice dentistry are eligible to participate as medicaid dental providers.

B. [~~Once enrolled, providers receive a packet of information; including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from HSD/MAD or its designee. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from HSD/MAD or its designee.~~] When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[2/1/95; 8.310.7.10 NMAC - Rn, 8 NMAC 4.MAD.716.1 & A, 10/1/02; A, 11/1/06; A, 7/15/10]

8.310.7.11 PROVIDER RESPONSIBILITIES:

[~~A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See Part 8.302.1 NMAC, *General Provider Policies*.~~

~~B. 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. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Part 8.302.1 NMAC, *General Provider Policies*, for documentation requirements.~~]

A. A provider who furnishes services to a MAD eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and centers for medicaid and medicare services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies*.

C. Services must be provided within the scope of practice, licensure and must be in compliance with the statues, rules and regulations of the applicable practice act.

[2/1/95; 8.310.7.11 NMAC - Rn, 8 NMAC 4.MAD.716.2, 10/1/02; A, 7/15/10]

8.310.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: [~~Medicaid~~] MAD covers the following types of dental services with the specified limitations.

A. **Emergency services:** [~~Medicaid~~] MAD covers emergency care for all eligible recipients. "Emergency" care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For eligible recipients under the age of 21 years care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(1) Routine restorative procedures and root canal therapy are not emergency procedures.

(2) Prior authorization requirements are waived for emergency care, but the claims can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

B. **Diagnostic services:** [~~Medicaid~~] MAD coverage for diagnostic services is limited to the following:

[~~(1) for recipients under twenty-one (21) years of age, diagnostic services are limited to one clinical oral examination every six (6) months; medicaid covers one additional clinical oral examination by a second dental provider for recipients under twenty-one (21) years of age; for recipients twenty-one (21) years of age and over, coverage is limited to one clinical oral examination per year; and~~

~~(2) Medicaid covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.~~]

(1) for an eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(2) one clinical oral examination every 13 months for an eligible recipient 21 years and over; and

(3) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

C. **Radiology services**: [~~Medicaid~~] MAD coverage of radiology services is limited to the following:

(1) [~~One (1) intraoral complete series every three (3) years per recipient. This series includes bitewing x-rays. Collaborative practice dental hygienists may provide this service.~~] One intraoral complete series every 60 months per eligible recipient. This series includes bitewing –x-rays.

(2) Additional bitewing x-rays once every [~~twelve (12)~~] 12 months per eligible recipient. [~~Collaborative practice dental hygienists may provide this service.~~]

(3) Panoramic films performed can be substituted for an intraoral-complete series, which is limited to one every [~~three (3) years~~] 60 months per eligible recipient. [~~Collaborative practice dental hygienists may provide this service.~~]

D. **Preventive services:** [~~Medicaid~~] MAD coverage of preventive services is subject to certain limitations.

(1) **Prophylaxis:** [~~Medicaid covers one prophylaxis service per recipient every six (6) months for recipients under twenty-one (21) years of age. For recipients twenty-one (21) years of age or older, medicaid covers one prophylaxis per recipient per year. Medicaid covers one prophylaxis service per recipient every six (6) months for recipients twenty-one (21) years of age or older who have developmental disabilities as defined in 8.314.5.12 NMAC, *Eligible Recipients*. Collaborative practice dental hygienists may provide this service after diagnosis by a dentist~~]. MAD covers for an eligible recipient under the age of 21 years, one prophylaxis service every six months. MAD covers for an eligible recipient 21 years of age or older who has a developmental disability as defined in 8.314.12 NMAC, *Eligible Recipients*, one prophylaxis service every six months. For an individual 21 years of age or older without a developmental disability as defined in 8.314.12 NMAC, *Eligible Recipients*, MAD covers one prophylaxis service once in a 12 month-period.

(2) **Fluoride treatment:** [~~Medicaid covers one fluoride treatment per recipient per provider every six (6) months furnished in the office to recipients under twenty-one (21) years of age. For recipients twenty-one (21) years of age or older, medicaid does not reimburse providers for fluoride treatments unless it is deemed medically necessary by MAD or its designee. Collaborative practice dental hygienists may provide this service.~~] MAD covers for an eligible recipient under the age of 21 years, one fluoride treatment every six months. For an individual 21 years of age or older. MAD covers one fluoride treatment once in a 12-month period.

(3) **Molar sealants:** [~~Medicaid only covers sealants for permanent molars for recipients under twenty-one (21) years of age. Each eligible recipient can receive one treatment per tooth every five (5) years. Medicaid does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the five (5) year periods requires prior authorization. Collaborative practice dental hygienists may provide this service after diagnosis by a dentist.~~] MAD only covers for an eligible recipient under the age of 21 years, sealants for permanent molars. Each eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For an individual 21 years of age or older, MAD does not reimburse sealant services.

(4) **Space maintenance:** [~~Medicaid covers fixed unilateral and fixed bilateral space maintainers (passive appliances).~~] MAD covers for an eligible recipient under the age of 21 years fixed unilateral and fixed bilateral space maintainers (passive appliances). For an individual 21 years of age or older, MAD does not reimburse for space maintenance services.

E. **Restorative services:** [~~Medicaid~~] MAD covers the following restorative services:

(1) amalgam restorations (including polishing) on permanent and deciduous teeth;

(2) resin restorations for anterior and posterior teeth;

(3) one prefabricated stainless steel crown per permanent or deciduous tooth;

(4) one prefabricated resin crown per permanent or deciduous tooth; and

(5) one recementation of a crown or inlay.

F. **Endodontic services:** [~~Medicaid~~] MAD covers therapeutic pulpotomy for [~~recipients~~] an eligible recipient if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

G. **Periodontic services:** [~~Medicaid~~] MAD covers for an eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(1) collaborative practice dental hygienists may provide periodontal scaling and root planning, per quadrant after diagnosis by a dentist; and

(2) collaborative practice dental hygienists may provide periodontal maintenance procedures with prior authorization.

H. **Removable prosthodontic services:** [~~Medicaid covers two denture adjustments per calendar year per recipient.~~] MAD covers two denture adjustments per every 12 months per an eligible recipient. MAD also covers repairs to complete and partial dentures.

I. **Fixed prosthodontics services:** [~~Medicaid~~] MAD covers one recementation of a fixed bridge.

J. **Oral surgery services:** [~~Medicaid~~] MAD covers the following oral surgery services:

(1) **simple and surgical extractions for [~~all recipients:~~] an eligible recipient:** coverage includes local anesthesia and routine post-operative care; "erupted surgical extractions" are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, [~~and/or~~] or section of tooth and closure;

(2) autogenous tooth reimplantation of a permanent tooth for [~~recipients~~] an eligible recipient under [~~twenty-one (21)~~] 21 years of age; and

(3) incision and drainage of an abscess for [~~all recipients~~] an eligible recipient.

K. **Adjunctive general services:** [~~Medicaid~~] MAD covers emergency palliative treatment of dental pain for [~~all recipients~~] an eligible recipient. [~~Medicaid~~] MAD covers general anesthesia and intravenous sedation for [~~medicaid recipients~~] an eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. [~~Medicaid~~] MAD covers nitrous oxide analgesia for [~~recipients~~] an eligible recipient under [~~twenty-one (21)~~] (21) years of age. For an individual 21 years of age or older, MAD does not reimburse for nitrous oxide analgesia.

[2/1/95; 8.310.7.12 NMAC - Rn, 8 NMAC 4.MAD.716.3 & A. 10/1/02; A, 7/1/04; A, 11/1/06; A, 7/15/10]

8.310.7.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: [~~Dental services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See Part 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which assist in the receipt of prior authorization and claims processing from HSD/MAD or its designee.~~] All MAD 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, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. **Prior authorization:** [~~Medicaid~~] MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when prior authorization is received from MAD or its designee. [~~Medicaid~~] MAD covers medically necessary orthodontic services to treat handicapping malocclusions for [~~recipients~~] an eligible recipient under [~~twenty-one (21)~~] 21 years of age with prior authorization.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for [~~Medicaid~~] MAD services. [~~Dental providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.~~] A dental provider must verify that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** [~~Providers or recipients who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration.~~] A provider who disagrees with prior authorization denials

or other review decisions can request a re-review and a reconsideration. See Part 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.*
[2/1/95; 8.310.7.13 NMAC - Rn, 8 NMAC 4.MAD.716.4, 10/1/02; A, 7/1/04; A, 11/1/06; A, 7/15/10]

8.310.7.14 HOSPITAL CARE: [~~Medicaid~~] MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with prior authorization, unless one [~~(1)~~] of the following conditions exist:

A. the eligible recipient is under [~~twenty-one (21)~~] 21 years of age; or

B. the eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified;

C. any service which requires prior authorization in an outpatient setting must be prior authorized if performed in an inpatient hospital.

[2/1/95; 8.310.7.14 NMAC - Rn, 8 NMAC 4.MAD.716.5, 10/1/02; A, 11/1/06; A, 7/15/10]

8.310.7.15 NONCOVERED SERVICES: Dental services are subject to the limitations and coverage restrictions, which exist for other [~~medicaid~~] MAD services. See Part 8.301.3 NMAC, *General Noncovered Services.* [~~Medicaid~~] MAD does not cover the following specific dental services:

A. [~~**Surgical trays:**~~] Surgical trays are considered part of the surgical procedure. [~~Medicaid~~] MAD does not reimburse separately for trays;

B. [~~**Sterilization of dental instruments and equipment:**~~] Sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization.

C. oral preparations, including topical fluorides dispensed to [~~recipients~~] an eligible recipient for home use;

D. permanent fixed bridges [~~for recipients twenty-one (21) years of age and over~~];

E. procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

F. procedures for desensitization, re-mineralization or tooth bleaching;

G. occlusal adjustments, disking, overhang removal or equilibration;

H. mastique or veneer procedures;

I. treatment of TMJ disorders, bite openers and orthotic appliances;

J. services furnished by non-certified dental assistants, such as radiographs;

K. implants and implant-related services; or

L. removable unilateral cast metal partial dentures.

[2/1/95; 8.310.7.15 NMAC - Rn, 8 NMAC 4.MAD.716.6, 10/1/02; A, 7/15/10]

8.310.7.17 REIMBURSEMENT:

A. Dental providers must submit claims for reimbursement on the dental claim form. See Part 8.302.2 NMAC, *Billing for Medicaid Services*. [~~Upon enrolled, providers receive information on billing, documentation requirements, and claims processing from HSD/MAD or its designee.~~

~~B. Reimbursement for dental covered services is made at the lesser of the following:~~] Upon enrollment, a provider receives instructions on documentation, billing, and claims processing. Reimbursement to a provider for covered services 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;~~

~~(3) the provider's billed charge must be their usual and customary charge for services;~~

~~(4) "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.~~]

(1) the billed charge which must be the provider's usual and customary charge for service; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure.

[2/1/95; 8.310.7.17 NMAC - Rn, 8 NMAC 4.MAD.716.8, 10/1/02; A, 11/1/06; A, 7/15/10]

8.310.7.18 REIMBURSEMENT RESTRICTIONS:

A. **Services performed in violation of dental rules:** [~~Providers are~~] A provider is not reimbursed for services performed in violation of the New Mexico Dental Health Care Act, or the rules of the New Mexico

board of dental health care, code of ethics of the American dental association or the American dental hygienists' association or accepted principles of good dental and dental hygienist practices.

B. **Services furnished by another provider:** Coverage of dental services can be restricted or limited. [~~Dental providers must try~~] It is a dental provider's responsibility to determine if a proposed service has already been furnished by another provider.

C. **Direct recipient payment for services:** [~~If dental providers believe that a service is medically necessary but limits or restrictions apply to the proposed service, dentists must advise recipients of the limitation. Providers can make arrangements for direct payment from recipients for noncovered or limited services. Recipients can be billed for services if:~~] A provider can make arrangements for direct payment from an eligible recipient or their personal representative for noncovered services. An eligible recipient or their personal representative can only be billed for noncovered services if:

(1) [~~recipients are~~] an eligible recipient or their personal representative is advised by [~~dental providers~~] a dental provider of the necessity of the service;

(2) [~~recipients are~~] an eligible recipient or their personal representative is given options to seek treatment at a later date or from a different provider; [~~and~~]

(3) [~~recipients agrees~~] an eligible recipient or their personal representative agrees in writing to be responsible for payment; and

(4) the provider fully complies with the requirements as stated in Subsection C of 8.302.2.11 NMAC, *claim filing limitations* .

D. **Services considered part of the total treatment:** [~~Providers~~] A provider cannot bill separately for the services included in the payment for the examination, another service, or routine post-operative or follow-up care. See 8.310.7 BI, *Billing Instructions For Dental Services*, for the list of these services.

[2/1/95; 8.310.7.18 NMAC - Rn, 8 NMAC 4.MAD.716.9 & A, 10/1/02; A, 7/15/10]