Benefits

Practitioners/providers who participate in Medicaid agree to accept the amount paid as payment in full (see 42 CRF 447.15) with the exception of co-payment amounts required in certain Medicaid categories (Native Americans are exempt from co-payment requirements). Co-pays are outlined in this section.

Aside from co-payments, a practitioner/provider may not bill a Molina Healthcare of New Mexico, Inc. (Molina Healthcare) Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- **Failure to follow managed care policies:** A Member must be aware of the practitioners/providers, pharmacies, facilities and hospitals, who are contracted with Molina Healthcare;
- **Denied emergency room claims:** A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided. The Member may only be billed for the emergency room charges if they have signed a waiver at the hospital stating they will be responsible for the charges if it is determined that an emergency did not exist. A Member cannot be billed for the ancillary charges (i.e. laboratory & radiology services); or
- **Other Member responsibilities:** 1) The Member has been advised by the practitioner/provider that the service is not a covered benefit; 2) The Member has been advised by the practitioner/provider that he/she is not contracted with Molina Healthcare; and 3) The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment.

As a managed care organization contracted with the State of New Mexico to administer the Salud! Program, Molina Healthcare is required to make available a specific list of services to its enrolled Members. These services are covered when medically necessary and must be directed by the Member's primary care practitioner. In some instances, Molina Healthcare will require a prior authorization.

The list on the following page is a summary of the Molina Healthcare Salud Program benefits. If there are questions as to whether a service is covered or requires prior authorization, contact Member Services (see Section B for information on how to contact Member Services).

Benefits (*continued*)

Selected Benefits

See Sections I for Services Requiring Referral and Prior Authorization

Service	PCP Directed
Professional Services ▪ **PCP Office Visits** ▪ **Inpatient Professional Services** ▪ **Injections** ▪ **Allergy Testing** ▪ **Allergy Injections** ▪ **Mammography Screening** ▪ **Cytological Screening (pap smear)** ▪ **Laboratory & Diagnostic Imaging**	 ▪ **Covered** ▪ **Covered** ▪ **Covered** ▪ **Covered** ▪ **Covered** ▪ **Covered** ▪ **Covered** ▪ **Covered**
Preventive Care ▪ **Physical Exams** ▪ **Well Child Care** ▪ **Immunizations**	 ▪ **Covered** ▪ ***See EPSDT Program Description*** ▪ **Reimbursement for administration only**
Prescription Drugs	▪ **Formulary**
Lab & X-Ray	▪ **Covered at contracted facility**
Obstetrics /Gynecological (OB/Gyn) ▪ **Maternity Care** ▪ **Gynecological Office Visits**	 ▪ **Notification Required** ▪ **No referral required**
Behavioral Health Services	▪ **Contact OptumHealth New Mexico – toll free (866) 660-7182**
Dental Services	▪ **Self-referral through DentaQuest (formerly Doral Dental)– toll free (800) 417-7140**
Vision Services	▪ **Self-referral for routine care through March Vision Care - toll free (800) 493-4070**
Transportation Services (Member required to obtain prior authorization) ▪ **48-72 hour notice required**	▪ **Self-referral through Integrated Transportation Management (ITM) – toll free (888) 593-2052**

Benefits (*continued*)

Children's Health Insurance Program Reauthorization Act (CHIPRA)

CHIPRA was implemented as a Medicaid expansion, covering children in families with income between 185% to 235% of federal poverty levels (FPLs). Cost sharing is considered to be an essential component of the CHIPRA Program for several reasons: to approach parity with privately-insured individuals in similar income ranges who pay significant amounts for less comprehensive coverage, to elicit and reinforce appropriate utilization of medical services, and to prevent crowd-out of private insurance.

IMPORTANT: THE NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD) REQUIRES FOR THE CHIPRA PROGRAM THAT CO-PAYMENTS BE COLLECTED FOR SERVICES AS OUTLINED BELOW (NATIVE AMERICAN MEMBERS ARE EXEMPT FROM MAKING CO-PAYMENTS IF CHIPRA ELIGIBILE). IF YOU CHOOSE TO COLLECT THE CO-PAYMENTS FROM THE COMPANY'S CHIPRA MEMBERS, YOU MAY RETAIN THEM FOR YOUR OWN PURPOSES.

Co-payments for CHIPRA services are as follows:

- **$25 per inpatient admission**
  (see exemptions list in this section)

- **$15 per emergency room visit**
  Emergency room co-payment is waived if patient is admitted. At such time, inpatient co-payment should be assessed instead (see exemptions list in this section).

- **$5 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session**
  Applies only if a "visit" or "therapy" code or equivalent code is billed (see code list in this section). Does not apply if service is rendered in an inpatient setting or in an emergency room. Those services have separate co-payments (see exemptions list in this section).

- **$5 per dental visit**
  Does not apply if the only services rendered are considered "preventive" "diagnostic" or "orthodontic;"

- **$2 per prescription**
  Applies to dispensed drug items whether it is a prescription drug or a nonprescription drug item. Does not apply to medical supplies (see exemptions list in this section).

Benefits (*continued*)

Preventive care and prenatal care are exempt from the co-payment requirement. In addition, services provided by Indian Health Services (IHS) facilities, urban Indian practitioners/providers, and tribal 638s are exempt. Native American children are excluded from the co-payment requirements.

The State of New Mexico also imposed a maximum co-payment amount for families, using a sliding scale based on gross income ranges. Once the maximum co-payment amount is met, the family ceases to have a co-payment requirement for the remainder of that calendar year. The imposed maximum amounts are: 3% for families with incomes between 185-200% of FPL, 4% for families with incomes between 201-215% of FPL, and 5% for families between 216-235% of FPL. As an example, a family of four with income at 200% of FPL would be capped at $1,417. For a family with income at 235% of FPL, the maximum amount would be $1,933. The family should notify the State once the maximum payment level has been reached.

As a condition of eligibility, the individual must be uninsured. If health insurance coverage has been voluntarily dropped, the individual will be ineligible for CHIPRA coverage for twelve (12) months subsequent to the month of termination of the health care coverage. Exceptions to the twelve (12) month period of ineligibility can be requested if the child has an urgent health care need. Such exception requests will be subject to review and approval by the State.

The regulation also allows presumptive eligibility determinations for the CHIPRA population. A copy of the CHIPRA regulations may be requested by contacting the State Medical Assistance Division (MAD) directly at **(505) 827-3153.**

CHIPRA Co-payments Code List

Molina Healthcare practitioners/providers may apply co-payment to the following codes unless there is an exemption:

Physician and Other Professional Services	**Codes**
Evaluation and management codes:	99201-99215, 99341-99350
Ophthalmology services:	92002-92014

Practitioner and Other Professional Services	**Codes**
Osteo-manipulative procedures:	98925-98929
Physical medicine and rehabilitation:	97001-97039, 97110-97140, 97532-97533, 97799

Benefits (*continued*)

Therapies and Evaluations	Codes
If more than one therapy is rendered in one session, only one co-payment can be applied.	
Occupational:	97003, 97110
Physical:	97001, 97010, 95831-95904 97750
Speech:	92506, 92507
Miscellaneous therapy:	92507, 97110, G0154, G0155

Therapies and Evaluations, Revenue Codes	Codes
If more than one therapy is rendered in one session, only one co-payment can be applied.	
Physical:	420-424, 429
Occupational:	430-434, 439
Speech:	440-444, 449

Rural Health Clinic, Revenue Codes	Codes
Type of Bill 71X:	520, 521 (clinic), 522, and 523

FQHC	Codes
Type of Bill 79X, revenue codes:	520, 522, 523, 529 (clinic)

CHIPRA Co-payments Exceptions List

Prenatal Care, Contraception Management, and Preventive Medical Care are **NOT** subject to co-payments. This definition includes well child visits, routine health exams, routine vision exams, routine hearing tests, and EPSDT screening.

Family Planning and Pre-Natal Care Drug Items exempt from co-payment

Therapeutic categories of drugs associated with family planning and prenatal care are exempt from co-payment. Identification of these categories is dependent on the therapeutic category system used.

Pre-Natal Vitamins C6F
Folic Acid C6M
Iron Replacement C3B
Multivitamins C6Z
Contraceptive Agents G8A, G8B, and G9A

Benefits (*continued*)

Medical Supplies exempt from co-payment Drug Codes

Exempt Drug Code Ranges — These are state codes for paying HMO co-payments and for medical supplies using the pharmacy claim form and may not be applicable to other payers.

HMO Co-payments 00888000000-00888001000
Medical Supplies 00999900000-00999999999

Services at IHS Facilities

Co-payment is NOT applied to services rendered at IHS facilities, by Urban Indian practitioners/providers, and by Tribal 638 Compact practitioners/providers.

Place of Service Exemptions for Co-payment

Because the following places of service are considered inpatient, the co-payment is NOT applied when billed with the following place of service:

Inpatient Hospital 21 (equivalent one digit code 1)
Emergency Room 23
Skilled Nursing Facility 31 (equivalent one digit code 8)
Nursing Facility 32 (equivalent one digit code 7)
Custodial Care Facility 33
Hospice 34
Inpatient Psychiatric Facility 51
ICF-MR 54
Comprehensive Inpatient Rehab Facility 61

Other Exemptions

Inpatient practitioner services, consultation, lab, x-ray, ambulatory surgical center, dialysis services, transportation, meals, lodging, DME, medical supplies, home health agency, hospice and Home and Community Based Waiver (HCBW) services, early intervention services.