TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 2 HOSPITAL SERVICES

8.311.2.1 ISSUING AGENCY: Health Care Authority.
[8.311.2.1 NMAC - Rp 8.311.2.1 NMAC, 7/01/2024]

8.311.2.2 SCOPE: This rule applies to the general public.
[8.311.2.2 NMAC - Rp 8.311.2.2 NMAC, 7/01/2024]

8.311.2.3 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 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.
[8.311.2.3 NMAC - Rp 8.311.2.3 NMAC, 7/01/2024]

8.311.2.4 DURATION: Permanent
[8.311.2.4 NMAC - Rp 8.311.2.4 NMAC, 7/01/2024]

8.311.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.311.2.5 NMAC - Rp 8.311.2.5 NMAC, 7/01/2024]

8.311.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.311.2.6 NMAC - Rp 8.311.2.6 NMAC, 7/01/2024]

8.311.2.7 DEFINITIONS: [**RESERVED**]

8.311.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.311.2.7 NMAC - Rp 8.311.2.7 NMAC, 7/01/2024]

8.311.2.9 HOSPITAL SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for inpatient, outpatient, and emergency services furnished in general hospital settings.
[8.311.2.8 NMAC - Rp 8.311.2.8 NMAC, 7/01/2024]

8.311.2.10 ELIGIBLE PROVIDERS: Health care to 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, facilities and other providers of services 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 HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, 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 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 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. Eligible providers include:

A. a general acute care hospital, rehabilitation, extended care or other specialty hospital:

(1) licensed by the New Mexico department of health (DOH), and

(2) participating in the Title XVIII (medicare) program or accredited by the joint commission (previously known as JCAHO accreditation);

B. a rehabilitation inpatient unit or a psychiatric unit in an inpatient hospital (referred to as a prospective payment system exempt unit (PPS-exempt));

C. a free-standing psychiatric hospital may be reimbursed for providing inpatient and outpatient services to an eligible recipient under 21 years of age; see 8.321.2 NMAC*, Inpatient Psychiatric Care in Free-Standing Psychiatric Hospitals;*

D. a border area and out-of-state hospital is eligible to be reimbursed by MAD if its licensure and certification to participate in its state medicaid or medicare program is accepted in lieu of licensing and certification by MAD; and

E. a hospital certified only for emergency services is reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.

[8.311.2.10 NMAC - Rp 8.311.2.10 NMAC, 7/01/2024]

8.311.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an 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, as well as current program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HCA 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. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed between the provider and MCOs when the provider enters into contracts with MCOs contracting with HCA for the provision of managed care services to the MAD population.

(1) If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(2) The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, 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.

[8.311.2.11 NMAC - Rp 8.311.2.11 NMAC, 7/01/2024]

8.311.2.12 COVERED SERVICES: MAD covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis, the treatment of an illness or injury or as required by the condition of the eligible recipient. MAD covers items or services ordinarily furnished by a hospital for the care and treatment of an eligible recipient. These items or services must be furnished under the direction of an enrolled MAD physician, podiatrist, or dentist with staff privileges in a hospital which is an enrolled MAD provider. Services must be furnished within the scope and practice of the profession as defined by state laws and in accordance with applicable federal and state and local laws and regulations.

[8.311.2.12 NMAC - Rp 8.311.2.12 NMAC, 7/01/2024]

8.311.2.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews may 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*. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain

answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. A procedure that requires prior authorization is primarily one for which the medical necessity may be uncertain, which may be for cosmetic purposes, or which may be of questionable effectiveness or long-term benefit.

(1) All transfers from one acute care DRG reimbursed hospital to another DRG reimbursed hospital.

(2) All inpatient stays for a PPS-exempt psychiatric unit of a general acute care hospital requires admission and continued stay reviews.

(3) All inpatient stays in a rehabilitation hospital, a PPS-exempt rehabilitation unit in a general acute care hospital, and an extended care or other specialty hospital requires admission and continued stay reviews.

(4) Outpatient physical, occupational, and speech therapies services require prior authorization.

(5) Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. A provider must verify that an individual is eligible for the MAD services at the time services are furnished and determine if an eligible recipient has other health insurance.

C. Consideration: A provider who disagrees with a prior authorization request denial or another review decision may request a re-review and a reconsideration. See *MAD-953, Reconsideration of Utilization Review Decisions.*

[8.311.2.13 NMAC - Rp 8.311.2.13 NMAC, 7/01/2024]

8.311.2.14 INPATIENT SERVICES: MAD coverage of some inpatient services may be conditional or limited.

A. Medically warranted days: A general hospital is not reimbursed for days of acute level inpatient services furnished to an eligible recipient as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

B. Awaiting placement days:

(1) When the MAD utilization review (UR) contractor determines that an eligible recipient no longer meets the care criteria in a rehabilitation, extended care or other specialty hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement in a lower level of care facility are termed "awaiting placement days". Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for the level of nursing facility services required by the eligible recipient (high NF or low NF).

(2) When the MAD UR contractor determines that a recipient under 21 years of age no longer meets acute care criteria and it is verified that an appropriate reviewing authority has made a determination that the eligible recipient requires a residential level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement to the lower level of care are termed "awaiting placement days". MAD does not cover residential care for individuals over 21 years of age.

(3) Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for residential services that may have different levels of classification based on the medical necessity for the placement of the eligible recipient. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. A separate claim form must be submitted for awaiting placement days.

(4) MAD does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits or**,** in the case of the eligible recipient under 21 years of age requiring residential services, licensed Ph.D. psychologist visits, are not included in this limitations.

C. Private rooms: A hospital is not reimbursed for the additional cost of a private room unless the private room is medically necessary to protect the health of the eligible recipient or others.

D. Services performed in an outpatient setting: MAD covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.

(1) An eligible recipient may be hospitalized if there is an existing medical condition which predisposes the eligible recipient to complications even with minor procedures.

(2) All claims for one- or two-day stays for hospitalization are subject to pre-payment or post-payment review.

E. Observation stay: If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

(1) The following are exemptions to the general observation stay definition:

(a) the eligible recipient dies;

(b) documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by their legal guardian against medical advice;

(c) an eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or

(d) an inpatient admission results in delivery of a child.

(2) MAD or its designee determines whether an eligible recipient's admission falls into one of the exempt categories or considers it to be a one- or two-day stay.

(a) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

(b) A hospital must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

(3) The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. See MAD 953*, Reconsideration of Utilization Review Decisions.*

(4) The observation stay review does not replace the review of one- and two-day stays for medical necessity.

(5) MAD does not cover medically unnecessary admissions, regardless of length of stay.

F. Review of hospital admissions: All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different hospital, and readmission are reviewed by MAD or its designee. MAD or its designee performs a medical review to verify the following:

(1) admission to acute care hospital is medically necessary;

(2) all hospital services and surgical procedures furnished are appropriate to the eligible recipient's condition and are reasonable and necessary to the care of the eligible recipient;

(3) patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected; hospitals are not reimbursed for inappropriate admissions or transfers; and

(4) the method of payment and its application by a hospital does not jeopardize the quality of medical care.

G. Non-covered services: MAD does not cover the following specific inpatient benefits:

(1) a hospital service which is not considered medically necessary by MAD or its designee for the condition of the eligible recipient;

(2) a hospital service that requires prior authorization for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) a hospital service which is furnished to an individual who was not eligible for MAD services on the date of service;

(4) an experimental or investigational procedure, technology or therapy and the service related to it, including hospitalization, anesthesiology, laboratory tests, and imaging services; see MAD-765*, Experimental or Investigational Procedures or Therapies*;

(5) a drug classified as "ineffective" by the federal food and drug administration;

(6) private duty or incremental nursing services;

(7) laboratory specimen handling or mailing charges; and

(8) formal educational or vocational training services which relate to traditional academic subjects or training for employment.

H. Covered services in hospitals certified for emergency services-only: Certain inpatient and outpatient services may be furnished by a hospital certified to participate in the Title XVIII (medicare) program as an emergency hospital. MAD reimburses a provider only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the eligible recipient which necessitates the use of the most accessible hospital equipped to furnish emergency services.

(1) MAD covers the full range of inpatient and outpatient services furnished to an eligible recipient in an emergency situation in a hospital which is certified for emergency services-only.

(2) MAD reimbursement for emergency services furnished in a hospital certified for an emergency services-only is made for the period during which the emergency exists.

(a) Documentation of the eligible recipient's condition, the physician's statement that emergency services were necessary, and the date when, in the physician's judgment, the emergency ceased, must be attached to the claim form.

(b) An emergency no longer exists when it becomes safe from a medical standpoint to move the eligible recipient to a certified inpatient hospital or to discharge the eligible recipient.

(c) Reimbursement for services in an emergency hospital is made at a percentage of reasonable charges as determined by HCA. No retroactive adjustments are made.

I. Patient self determination act: An adult eligible recipient must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC*, General Provider Policies*.

J. Psychiatric services furnished to an eligible recipient under 21 years of age in PPS-exempt units of acute care hospitals: Services furnished to an eligible recipient must be under the direction of a physician. In the case of psychiatric services furnished to an eligible recipient under 21 years of age, these services must be furnished under the direction of board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of an eligible recipient under 12 years of age, the psychiatrist must be board eligible/board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and under 21 years of age may be waived when all of the following conditions are met:

(1) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes; and

(2) at the time of admission, a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located; and

(3) another facility which is able to furnish a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(4) the admission is for stabilization only and transfer arrangements to the care of a board eligible/ board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible with the understanding that if the eligible recipient needs to transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

K. Reimbursement for inpatient services: MAD reimburses for inpatient hospital services using different methodologies. See 8.311.3 NMAC, *Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services.*

(1) All services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider may bill for services or supplies; an exception to this general rule applies to durable medical equipment delivered for discharge and ambulance transportation.

(2) A physician’s services are not reimbursed to a hospital under hospital services regulations, but may be payable as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*, for information on the professional component of services.

(3) Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.

(a) Transportation is included in a DRG payment when an eligible recipient is transported to a different facility for procedure(s) not available at the hospital where the eligible recipient is a patient.

(b) Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See 8.324.7 NMAC, *Transportation Services.*

L. Reimbursement limitations for capital costs: Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

(1) The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a MAD provider.

(2) The cost of construction is expected to include only the cost of buildings and fixed equipment.

(3) A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

[8.311.2.14 NMAC - Rp 8.311.2.14 NMAC, 7/01/2024]

8.311.2.15 OUTPATIENT SERVICES: MAD covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of an eligible recipient. Services must be furnished within the scope and practice of a professional provider as defined by state laws and regulations.

A. Outpatient covered services: Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. A partial hospitalization program in a general hospital psychiatric unit is considered under outpatient services. See 8.321.5 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.

B. Outpatient noncovered services: MAD does not cover the following specific outpatient benefits:

(1) outpatient hospital services not considered medically necessary for the condition of the eligible recipient;

(2) outpatient hospital services that require prior approval for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) outpatient hospital services furnished to an individual who was not eligible for MAD services on the date of service;

(4) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(5) drugs classified as "ineffective" by the federal food and drug administration;

(6) laboratory specimen handling or mailing charges; and

(7) formal educational or vocational services which relate to traditional academic subjects or training for employment.

C. MCO payment rates: If a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obliged to pay, and the provider shall accept, one hundred percent of the “applicable reimbursement rate” based on the provider type for services rendered under both emergency and non-emergency situations. The “applicable reimbursement rate” is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. Prior authorization: Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, and speech therapies services require prior authorization.

E. Reimbursement for outpatient services: Effective November 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates. The OPPS rules for payment for packaged services, separately reimbursed services are based on the medicare ambulatory payment classification (APC) methodology.

(1) Reimbursement for laboratory services, radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals must identify drugs items purchased at 340B prices.

(2) Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on approved methods. See 8.302.2 NMAC, *Billing For Medicaid Services.*

(3) For critical access hospital providers, the MAD outpatient prospective payment system (OPPS) fee-for-service rate will be set based on the provider’s reported cost to charge ratio reported in the provider’s most recently filed cost report prior to February 1, 2012.

(4) For services not reimbursed using the outpatient prospective payment system (OPPS) methodology or fee schedule, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent. An interim rate of payment is established by MAD. A rate of payment for providers not subject to the cost settlement process is also established

by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If the provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.
[8.311.2.15 NMAC - Rp 8.311.2.15 NMAC, 7/01/2024]

8.311.2.16 EMERGENCY ROOM SERVICES: MAD covers emergency room services which are medically necessary for the diagnosis and treatment of medical or surgical emergencies to an eligible recipient and which are within the scope of the MAD program.

A. Covered emergency services: An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

B. Retrospective review: An emergency room service may be subject to prepayment or post-payment review. A provider, including an enrolled provider, a non-enrolled provider, a managed care organization provider, or an out of network provider cannot bill an eligible recipient for emergency room services including diagnostic and ancillary services which have been denied due to lack of medical necessity or lack of being an emergency except as specifically allowed by 8.302.2 NMAC, *Billing for Medicaid Services*. When an eligible recipient has identified himself or herself to a provider as a medicaid eligible recipient and is enrolled in a managed care organization, the provider of services must accept and adhere to the provisions of 42 CFR 438 Subpart C Enrollee Rights and Protections which state the administrative and payment responsibilities of a managed care organization and limit the financial responsibilities that can be passed on to an eligible recipient. Payment may be limited to medically necessary diagnostic and treatment services to sufficiently assess the recipient's condition and need for emergency services, the duration of a condition, and available alternatives to emergency room services.

C. Prior authorization: Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non-emergency settings also require prior approval in emergency settings.

D. Noncovered emergency services: MAD does not cover the following specific emergency services:

(1) diagnostic and other ancillary services which are not considered medically necessary as emergency services;

(2) emergency services furnished to individuals who were not eligible for MAD services on the date of service;

(3) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(4) drugs classified as "ineffective" by the federal food and drug administration; and

(5) laboratory specimen handling or mailing charges.

E. Reimbursement for emergency room service: An emergency service furnished by an eligible provider is reimbursed as outpatient hospital services. See Subsection D of 8.311.2.15 NMAC, *reimbursement for outpatient services*.

(1) An emergency room service furnished in a DRG-reimbursed hospital in conjunction with an inpatient admission is included with the charges for inpatient care. In this case, a payment for an emergency room service is included in the DRG rate.

(2) A physician's service furnished in an emergency room is not reimbursed to a hospital but may be paid as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*.

(3) A service furnished in an urgent care center of a hospital which does not meet the definition of an emergency, may not be submitted as an emergency room service.
[8.311.2.16 NMAC - Rp 8.311.2.16 NMAC, 7/01/2024]

HISTORY OF 8.311.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0200, Hospital Services, filed 1/9/1980.
ISD 310.0200, Hospital Services, filed 12/8/1990.

ISD 310.0200, Hospital Services, filed 12/30/1981.
ISD 310.0200, Hospital Services, filed 4/2/1982.
ISD 310.0200, Hospital Services, filed 7/8/1982.
ISD Rule 310.0200, Hospital Services, filed 4/5/1983.
ISD Rule 310.0200, Hospital Services, filed 2/15/1984.
ISD Rule 310.0200, Hospital Services, filed 4/26/1984.
ISD Rule 310.0200, Hospital Services, filed 2/21/1986.
MAD Rule 310.02, Hospital Services, filed 12/1/1987.
MAD Rule 310.02, Hospital Services, filed 4/27/1988.
MAD Rule 310.02, Hospital Services, filed 5/23/1988.
MAD Rule 310.02, Hospital Services, filed 8/18/1988.
MAD Rule 310.02, Hospital Services, filed 3/20/1989.
MAD Rule 310.02, Hospital Services, filed 7/2/1990.
MAD Rule 310.02, Hospital Services, filed 3/27/1992.
MAD Rule 310.02, Hospital Services, filed 4/21/1992.
MAD Rule 310.02, Hospital Services, filed 5/1/1992.
MAD Rule 310.02, Hospital Services, filed 7/14/1993.
MAD Rule 310.02, Hospital Services, filed 3/10/1994.
MAD Rule 310.02, Hospital Services, filed 6/15/1994.
MAD Rule 310.02, Hospital Services, filed 12/8/1994.

History of Repealed Material:
MAD Rule 310.02, Hospital Services, filed 12/8/1994 - Repealed effective 2/1/1995.
8 NMAC 4.MAD.721, Hospital Services, filed 1/18/1995 - Repealed effective 1/1/2009.
8.311.2 NMAC, Hospital Services, filed 12/24/2008 - Repealed effective 7/1/2024.

Other: 8.311.2 NMAC, Hospital Services, filed 12/24/2008 Replaced by 8.311.2 NMAC, Hospital Services effective 7/1/2024.