

MEDICAID POLICY-TO-PRACTICE GAP:



Understanding disparities in Substance Use Disorder testing standards, managed care coverage decisions, and State oversight in New Mexico.



AN EFFORT TO ADDRESS SYSTEMIC BEHAVIORAL HEALTH PRESSURES IN NEW MEXICO:



1



NM DRUG OVERDOSE RATE AND COST INCREASING

- 10% increase in New Mexico over National 14% decrease in Drug Overdose Deaths

2



PROVIDER LIABILITY EXPOSURE

- Restrictive coverage creates risk exposure in a high-risk population.

3



DENIALS & ADMINISTRATIVE BURDEN

- Many clinics lack resources to appeal denials.
- Revenue instability disproportionately impacts rural and independent providers.

4



POLICY USE FOLLOWING CMS AND NMAC

- Geographic barriers compound workforce shortages.
- Revenue reductions from denials contribute to rural site closures.

5



NM HCA ADMINISTRATIVE HANDLING

- Demonstrates MCO preference over provider and patient care.
- Lacking systemic resolution of policy discrepancies.

PROVIDER LIABILITY CONCERNS:

- **PATIENT SAFETY**
- **PROVIDER LIABILITY**
- **MALPRACTICE INSURANCE**



Ignoring established medical guidelines can impact
CLINICAL, REGULATORY, LEGAL, AND FINANCIAL CONSEQUENCES.



STATE GUIDELINES NEW MEXICO

- New Mexico Prescribing Guidelines
- New Mexico Medical Board
- NM Board of Pharmacy – PDMPs
- New Mexico Board of Nursing
- ASAM-NM
- NMAC – BHSD



CLINICAL | LEGAL | REGULATORY
ACCOUNTABILITY



NATIONAL GUIDELINES FEDERAL & NATIONAL

- CMS
- DEA
- CDC Guidelines
- ASAM Guidelines
- ACOEM Guidelines



MALPRACTICE & WRONGFUL DEATH



Providers can be held liable for fatal medication errors whether through overdose, dosage errors, or failure to assess a patient's capacity.



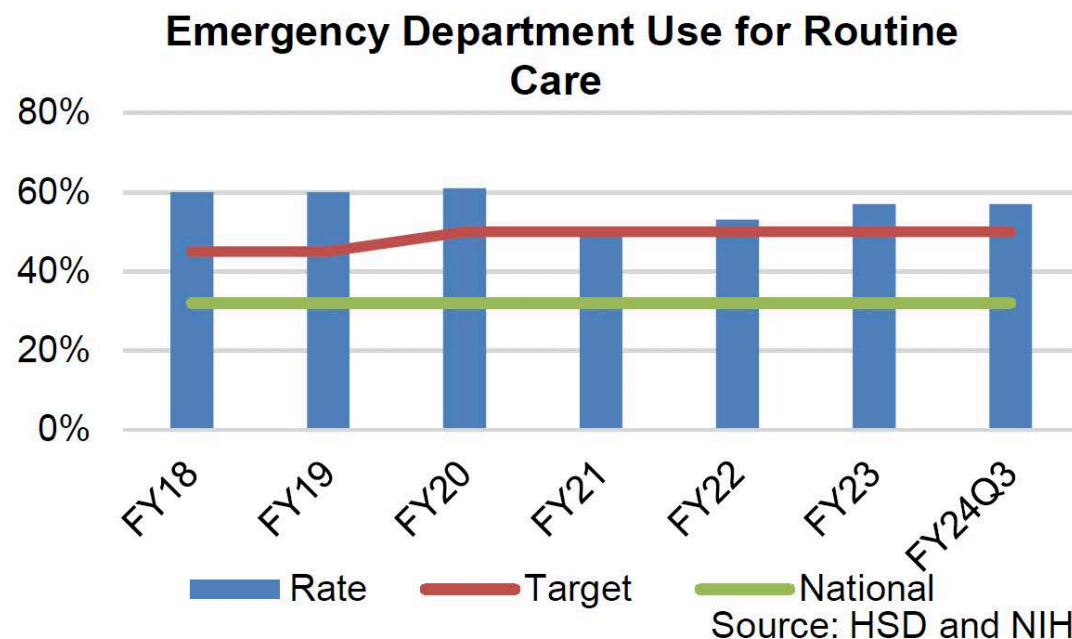
NEW MEXICO LAWSUIT EXAMPLE



New Mexico Lawsuit Against Provider / Pharmacy
In a **lawsuit** brought on behalf of a 19-year-old who died from overdosing on physician-prescribed medications.

“A REDUCTION OF 1,072 PRESCRIBING PROVIDERS”

However, the work the state has done over the last several years to increase the number of behavioral health providers by increasing provider rates and other initiatives has not necessarily led to increased providers or access. The authority reported recently that in 2024 there was a reduction of 1,072 prescribing providers and 427 non-prescribing providers from the prior year. The authority said the decrease was likely the result of the pandemic unwinding. At the same time, the authority reported an increase in the number of behavioral health encounters suggesting fewer providers billed for more services. But this data does not shine a light on whether more people accessed services or whether the services they did access were evidence-based.



- Reducing emergency department (ED) use is important to reduce costs and improve quality.
- Routine care use of the ED may be a sign of a lack of access to primary care.
- New Mexico's rate is significantly higher than the national rate cited by the National Institutes of Health.

For every million cut from UDS spend, downstream cost roughly \$11M



A COMBINED \$190 Million increase against a \$17Million UDT Reduction.

NM Department of Health Vital Statistics; SAMHSA State Profiles; KFF Medicaid data; NM Sentencing Commission; CMS Medicaid SUD policy briefs; ASAM Clinical Practice Guidelines; SAMHSA Treatment Improvement Protocols. UDT cost range \$60–\$150 reflects standard presumptive and confirmatory testing reimbursement under NM Medicaid fee schedules. Hospital and incarceration cost estimates reflect documented ranges from peer-reviewed SUD economic literature and NM-specific DOH reports. Figures for 2024–2025 include projections based on trend extrapolation.

POLICY ORDER: From Federal to MCO



FEDERAL CMS / 42 C.F.R.

National Requirements
and Standards



Federal Requirements

- Medicare Coverage & Billing (CMS)
- 42 C.F.R. Regulations
- CPT / HCPCS Codes (e.g., G0480–G0483)
- National Coverage and Payment Standards



*Establishes
national coverage,
coding and
billing standards.*



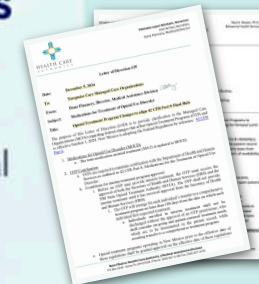
STATE HCA / NMAC

New Mexico Authority
and Regulations



New Mexico Medicaid Requirements

- HCA Medicaid State Plan
- NMAC Regulations
- Behavioral Health Services & Billing Manual
- **Letters of Direction (LODs)**
- Program Guidance and Memos

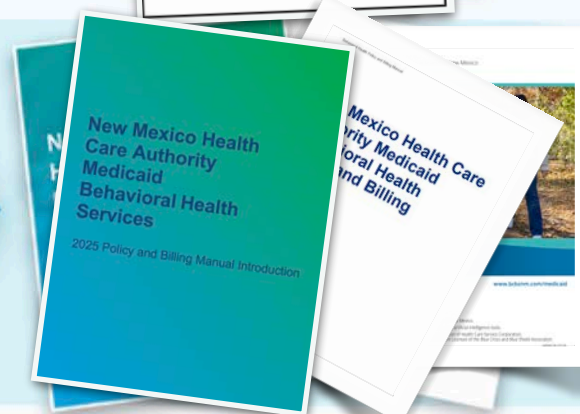


*Letters of Direction
(LODs) provide
additional guidance
to MCOs on specific
program requirements
(e.g., OTP, UDT, SUD).*



NM MEDICAID PLAN DOCUMENTS TURQUOISE CARE

Program Requirements
and Coverage



Turquoise Care Plan Documents

- Medicaid Program Requirements
- Behavioral Health Coverage Policies
- Billing and Reimbursement Guidance
- Service-Specific Requirements (e.g., SUD/OTP)
- Incorporates HCA LODs and NMAC

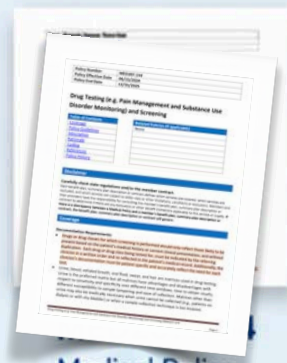


*Defines Medicaid
benefits, coverage
and billing expectations
for Turquoise Care
based on HCA guidance,
NMAC and LODs.*



MCO POLICIES e.g., BCBSNM

Plan Implementation
and Claims Adjudication



Medical Policy



Coverage Policy



BCBSNM (Avalon)



*Implements state
and federal requirements
through plan-specific
policies, prior authorization
criteria, claims logic
and medical necessity
review.*

LETTER OF DIRECTION # 35

Opioid Treatment Program Changes to align with Federal 42 CFR



Letter of Direction #35

Date: December 5, 2024
To: Turquoise Care Managed Care Organizations
From: Dana Flannery, Director, Medical Assistance Division
Subject: Medications for Treatment of Opioid Use Disorder
Title: Opioid Treatment Program Changes to align 42 CFR Part 8 Final Rule

The purpose of this Letter of Direction (LOD) is to provide clarification to the Managed Care Organizations (MCOs) regarding federal changes that affect Opioid Treatment Programs (OTP) and is effective October 1, 2024. New Mexico is adopting the Federal Regulation by reference: [42 CFR Part 8](#).

1. Medications for Opioid Use Disorder (MOUD)
 - a. The term medication assisted treatment (MAT) is updated to MOUD.
2. OTP Certification
 - a. OTPs are required to maintain certification with the Department of Health and Human Services as outlined in 42 CFR Part 8, Medications for the Treatment of Opioid Use Disorder.
 - b. Conditions for interim treatment program approval.
 - i. Before an OTP may provide interim treatment, the OTP must receive the approval of both the Secretary of Health and Human Services (HHS) and the Secretary of Health and Human Services (SOTA). The OTP shall not provide interim treatment until it has received approval from the Secretary of Health and Human Services.

Testing: “For commonly used and misused substances that may impact patient safety, at frequency that is in the accordance with generally accepted in clinical practice”

42 CRF Alignment:

Implementation

MCOs are directed to implement changes associated with these instructions, including system changes and provider contract negotiations as needed no later than 90 days from the date of issuance of this directive. HCA directs the MCOs to provide biweekly updates to HCA on the status of implementation every other Friday beginning November 1, 2024, until otherwise directed by HCA. This LOD will sunset upon inclusion in 8.321.2 and 8.321.10 NMAC and the Behavioral Health Policy and Billing Manual.

Enforced NMAC, the Behavioral Health Policy and Billing Manual?

will required to offer counseling services to all patient's access to MOUD cannot be contingent upon receipt of counseling services. Supervision of MOUD must be delivered in overall treatment based upon a treatment plan that is made in making between the patient and health care provider, to include the availability of counseling, drug testing, and medication monitoring. Adequate medical, counseling, vocational, and treatment services either onsite or by practitioner with a documented agreement to

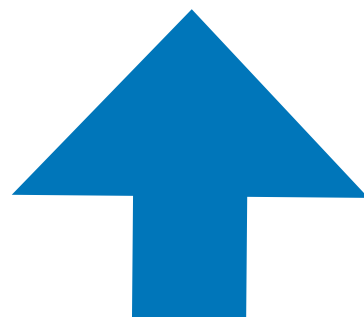
as well as available lab testing results, with applicable privacy laws, to the practitioner. Examination, including the results of laboratory tests, shall be considered to be clinically appropriate, and shall be completed within 30 calendar days following a patient's admission to the OTP. The examination can be completed by a non-OTP practitioner as long as it is performed by a licensed OTP practitioner as permitted in accordance with applicable regulations. Deemed medically appropriate by the OTP, may form part of the patient's history and physical examination, and shall be completed within 30 days prior to admission to the OTP, may form part of

7 Drug Classes MAY be reimbursable:

Definitive Drug Testing

2. Confirmatory/definitive qualitative or quantitative drug testing up to seven (7) drug classes **may be reimbursable** when laboratory-based definitive drug testing is specifically requested, the rationale is documented by the individual's treating physician and **ANY** of the following conditions is met:
 - a. The result of the presumptive drug screen is different than that suggested by the individual's medical history, clinical presentation or individual's own statement; (e.g., test was negative for prescribed
3. When laboratory-based definitive drug testing is requested for larger than seven drug class panels, confirmatory/definitive qualitative or quantitative drug testing **is not reimbursable**.

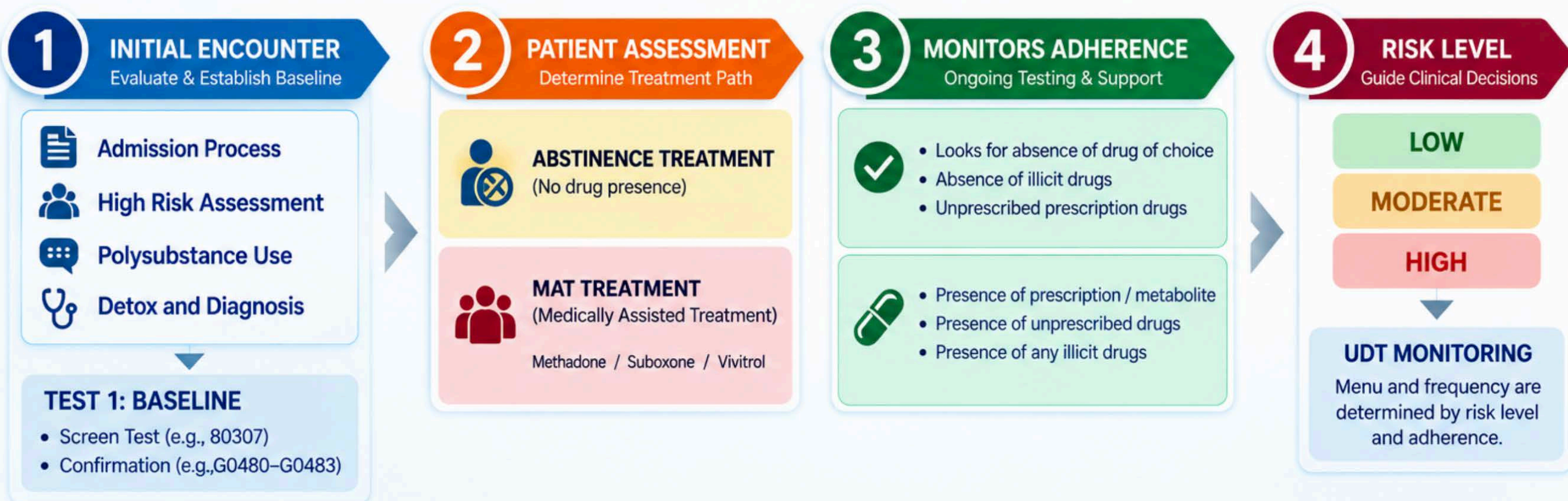
3



Larger than seven drug class panels,
drug testing is **NOT REIMBURSABLE**.

UNDERSTANDING SUD INTAKE PROCESS

SCREEN → ASSESS → MONITOR → IMPROVE LIVES



CONFIRMATION TESTING CODES

CPT Code	Drug Class	NM FFS
G0480	Classes 1–7	\$171.65
G0481	Classes 8–14	\$234.89
G0482	Classes 15–22	\$298.11
G0483	Classes 22+	\$370.38

KEY CONSIDERATIONS



Provider deems medically necessary to test for Benzodiazepines, Amphetamines, or Barbiturates.
To avoid risk of respiratory depression or overdose.



Provider must also confirm that the patient is not using illicit substances within regional trends.
For patient safety and treatment adherence.



Testing and frequency should be individualized based on clinical judgment, risk level and adherence to treatment.

UNTESTED or MISSED DRUG CLASSES

A 7 class panel may not detect the full scope of substance use



As a licensed provider...

How would you **GUESS** your limited drug class selection?

While balancing patient care and provider liability?

Sample Limited Selection G0480: 1–7 Drug Classes



Opioids & Analogs



Methadone



Amphetamines



Cocaine



Barbiturates



Benzodiazepines



Fentanyl

Many commonly used drugs fall outside these 7 classes.

Additional Drug Classes Commonly Used but **Not Detected** in a 7-Class Panel



Cannabinoids (THC)



Synthetic Cannabinoids



Heroin Metabolites (6-MAM)



Methylenedioxymphetamine (MDMA / Ecstasy)



Phencyclidine (PCP)



Stimulants (e.g., methylphenidate)



Alcohol Biomarkers (EtG, EtS)



Non-Opioid Analgesics (e.g., acetaminophen)



Antidepressants (SSRI/SNRI) (e.g., sertraline, venlafaxine)



Tricyclic Antidepressants (e.g., amitriptyline, nortriptyline)



Sedative Hypnotics (e.g., zolpidem, zopiclone)



Tapentadol



Tramadol



Skeletal Muscle Relaxants (e.g., cyclobenzaprine, carisoprodol)



Other Opioids (e.g., hydrocodone, oxycodone)



Propoxyphene



Gabapentin / Pregabalin



Ketamine



Methylphenidate (other formulations)



Antipsychotics (e.g., aripiprazole, quetiapine)



And More... (including emerging synthetic drugs)

“

Limiting testing to 7 drug classes is clinically **inadequate**.
Many of our patients use multiple substances, including synthetics and emerging drugs that **fall outside standard panels**.

”

HOW PROVIDERS EXCEED PAYOR LIMITATION

OTP patient is prescribed Rx: **Methadone**

(Following the Recommended New Mexico Guidelines:)

- New Mexico Prescribing Guidelines
- **LOD- HCA-NMAC 7.32.8.19 (D)(4)(c)-Admission**
- **LOD #35 Alignment with 42 CFR NMAC 7.32.8.22 (B)(7) & (E)-Drug Screening**
- CMS / ASAM

- ✓ **HCA-NMAC 7.32.8.19 (D)(4)(c)-Admission-initiating the following laboratory tests:**
a laboratory drug detection test for **at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines and other substances as may be appropriate, based upon patient history and prevailing patterns of availability and use in the local area; AND Required Fentanyl Confirmation Testing** (Memorandum to OTP: Required Fentanyl Confirmation Testing)

- ✗ **As part of thorough medical due diligence and guideline recommendations:**
Provider has ordered 8-14 drug classes (G0481) Exceeding payor policy- over utilization.

NM Medicaid Fee-for-Service HCPCS

HCPCS Code	NM FFS Rate	Drug Classes Covered
G0480	\$171.65	1-7 Drug Classes
G0481	\$234.89	8-14 Drug Classes
G0482	\$298.11	15-21 Drug Classes
G0483	\$370.38	22+ Drug Classes



NOT "MEDICALLY NECESSARY"
Following payer policy.

Prescribed

Medications the patient is legally prescribed.

Required

Required based on guidelines, regulations or policy (e.g., OTP, fentanyl).

Local area use patterns

Additional testing based on local drug trends and patient history.

CONFIRMATION LCMS/MS URINE INDIVIDUAL ORDER (EACH BOX SELECTION REPRESENTS A BILLING DRUG CLASS)

IN OFFICE SCREEN POSITIVES

☐ Check if performing and billing in-office screens

- ☐ Amphetamine
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Buprenorphine
- ☐ Cocaine
- ☐ Heroin (6-AM)
- ☐ Ecstasy (MDMA)
- ☐ Marijuana (THC)
- ☐ Methadone
- ☐ Opiates
- ☐ Oxycodone
- ☐ Phencyclidine

☐ **ALCOHOL BIOMARKERS**
ETG
ETS

☐ **ANALGESICS, NON-OPIOID**
Acetaminophen

☐ **ANTIDEPRESSANTS, NOT OTHERWISE SPECIFIED**
Venlafaxine

☐ **ANTIDEPRESSANTS, SEROTONERGIC CLASS**
Duloxetine
Fluoxetine
Paroxetine

☐ **ANTIDEPRESSANTS, TRICYCLIC & OTHER CYCLICALS**
Amitriptyline
Clomipramine
Desipramine
Doxepin
Imipramine
Nortriptyline

☐ **ANTIPSYCHOTICS**
Aripiprazole
Clozapine
Haloperidol
Olanzapine
Quetiapine
Risperidone
Ziprasidone
Paliperidone

1 ☒ **BARBITURATES**
Butalbital
Phenobarbital

2 ☒ **BENZODIAZEPINES**
Alprazolam
Lorazepam
Nordiazepam
Oxazepam
Temazepam
Flunitrazepam
Clonazepam
Flurazepam
Midazolam
Diazepam

3 ☒ **BUPRENORPHINE**
Buprenorphine
Norbuprenorphine

4 ☒ **FENTANYL**
Fentanyl
Norfentanyl
AcetylFentanyl

☐ **GABAPENTIN, NON-BLOOD**
Gabapentin

☐ **KETAMINE & NORKETAMINE**
Ketamine
Norketamine

5 ☒ **METHADONE**
EDDP
Methadone

☐ **METHYLPHENIDATE**
Ritalinic Acid

☐ **OPIATES**
Codeine
Hydrocodone
Hydromorphone
Morphine
Norhydrocodone

6 ☒ **OPIOIDS & OPIATE ANALOGS**
Dextrophan
Meperidine
Naloxone
Normeperidine

7 ☒ **OXYCODONE**
Noroxycodone
Oxycodone
Oxymorphone

☐ **PREGABALIN**
Pregabalin

☐ **PROPOXYPHENE**
Propoxyphene

☐ **SKELETAL MUSCLE RELAXANTS**
Carisoprodol
Cyclobenzaprine
Meprobamate

12 ☒ **SEDATIVE HYPNOTICS**
Zaleplon
Zolpidem
Xylazine

☐ **TAPENTADOL**
Tapentadol

8 ☒ **TRAMADOL**
Tramadol

ILLICIT DRUGS

☐ **ALKALOIDS**
Mitragynine

9 ☒ **AMPHETAMINES**
Amphetamine
Methamphetamine
Phentermine
☐ Perform D/L sample analysis on methamphetamine positives

☒ **CANNABINOIDS, NATURAL**
THCA

10 ☒ **COCAINE**
Benzoylcegonine

11 ☒ **HEROIN METABOLITE**
6-MAM (Heroin)

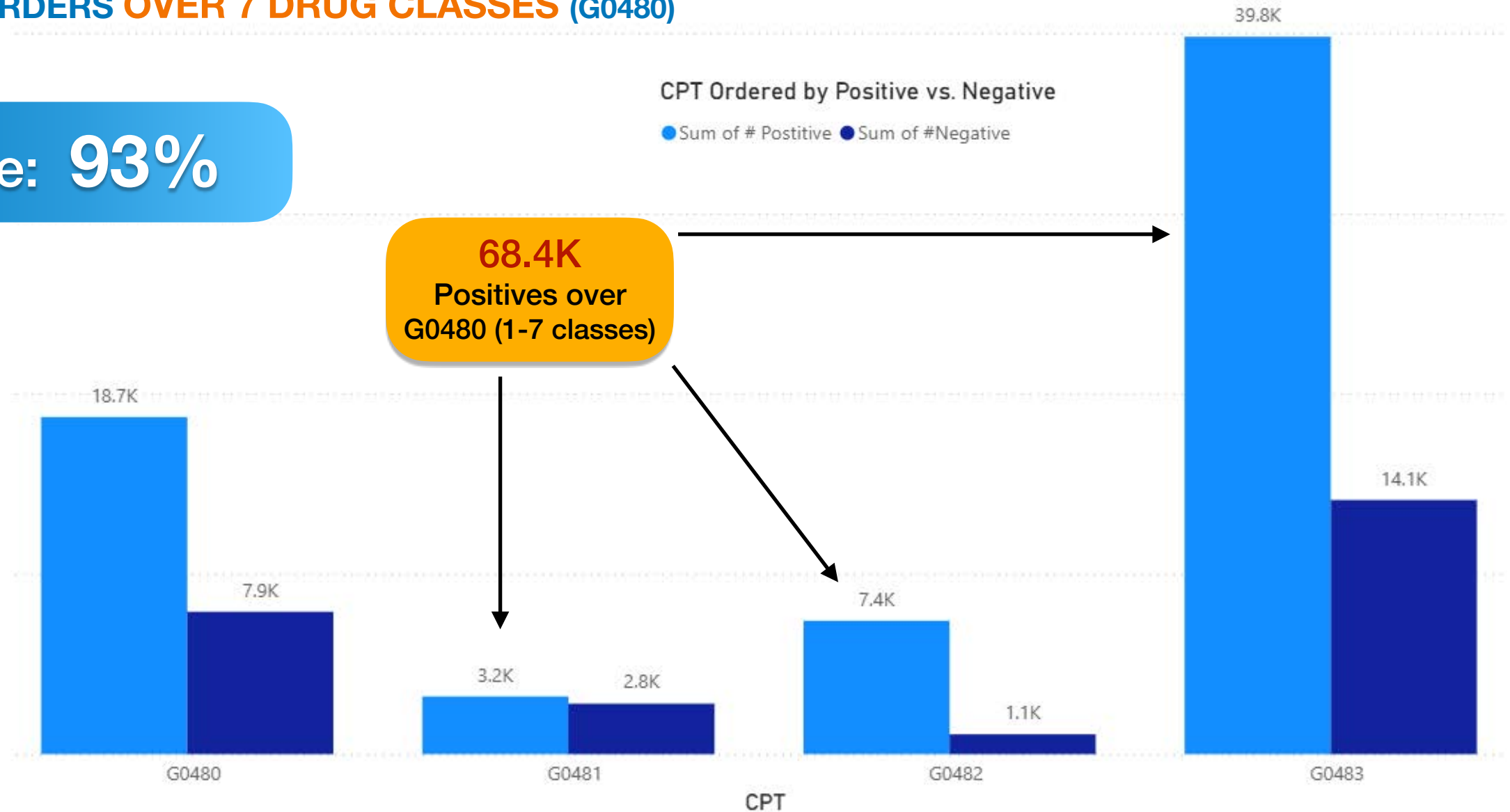
☐ **METHYLENEDIOXYAMPHETAMINES**
MDA
MDMA
☐ **PHENCYCLIDINE**
PCP
☐ **STIMULANTS, SYNTHETIC**
MDPV

CLINICAL REALITY vs. PAYOR POLICY LIMITATIONS

Emerging Clinical Data, 2025

POSITIVE TEST ORDERS OVER 7 DRUG CLASSES (G0480)

SUD Rate: 93%



NM PARITY REQUIREMENTS

PROHIBIT DISCRIMINATORY LIMITS on behavioral health coverage, testing frequency, and access.

Testing **POSITIVITY RATES** over **51%** should signal a **Human Health Concern** and warrant **HCA policy alignment**.

Sample of common SUD provider concerns

Shared perspective of over 200 New Mexican Providers



Limiting testing to 7 drug classes is clinically inadequate.

Many of our patients use multiple substances, including synthetics and emerging drugs that **fall outside standard panels.**



Clinical judgment and patient history must guide the scope of testing for **patient safety.**



This is not only the **MEDICAL STANDARD OF CARE** but also a matter of **patient safety and treatment accountability.**



UDT provides **objective data** that **detects relapses, prevents diversion of prescribed medications,** and allows us to make well-informed treatment decisions that **protect all** —

**my practice,
my patients,
and the public.**

KEY CONSIDERATIONS



Many substances fall outside the payor covered panels.



SUD treatment is subject to higher complexity of testing.



UDT is a critical component in **patient safety** and **accountability.**



Frequency needs to take metabolism into account.



Frequency limitations disrupt early recovery treatment.



UDT is an **objective data tool** in substance use settings.



100+

**Local Provider
Support**

The point of this presentation has been to raise collective concern and policy clarity.

1. What oversight mechanisms does HCA have to ensure MCO compliance with contractual obligations and mechanisms to enforce?
2. Are those mechanisms functioning effectively (i.e., Letters of Direction)?
3. Where are those limits formally defined (e.g., State Plan, MCO contract, or HCA-issued policy that differs from CMS/Medicaid guidelines)?
4. Are Medicaid recipients with SUD being denied access to adequate care as a result of MCO-imposed practices and policies?
5. Will HCA issue a clear letter of direction to MCO and providers identifying SUD drug testing policy for Turquoise Medicaid members?