State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
GENERAL PROGRAM DESCRIPTION

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY
The Human Services Department, Medical Assistance Division, is proposing amendments to 8.300.1 NMAC, *General Program Description;* 8.300.2 NMAC, *Health Insurance Portability and Accountability Act of 1996*, and 8.300.11 NMAC, *Confidentiality,* 8.301.2 NMAC, *General Benefit Description* and 8.302.1 NMAC, *General Provider Rules* to clarify regulatory language and accuracy with existing rules and provider participation agreements.

VI. RULES
These proposed rule changes refer to: 8.300.1 NMAC; 8.300.2 NMAC, 8.300.11 NMAC, 8.301.2 NMAC, and 8.302.1 NMAC of the Medical Assistance Program Rules Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at (505) 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these rules effective June 1, 2008.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed rules will be held at 10:00 a.m., on April 11, 2008, in the HSD Law Library at Pollon Plaza, 2009 S. Pacheco Street, Santa Fe, New Mexico. Parking accessible to persons with physical impairments will be available.

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.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Pamela S. Hyde, J.D., 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 April 11, 2008. 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:

PAMELA S. HYDE, J.D., SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID AND OTHER HEALTH CARE PROGRAMS GENERAL INFORMATION
PART 1 GENERAL PROGRAM DESCRIPTION

8.300.1.3 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. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.300.1.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 5/1/04; A, 6-1-08]

8.300.1.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of the section.
[2/1/95; 8.300.1.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 5/1/04; A, 6-1-08]

8.300.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico [~~medicaid program~~] medical assistance programs. [~~These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement~~.]
[2/1/95; 8.300.1.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 5/1/04; A, 6-1-08]

8.300.1.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of [~~medicaid eligible individuals~~] eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.300.1.8 NMAC - Rn, 8 NMAC 4.MAD.002, 5/1/04; A, 6-1-08]

8.300.1.9 GENERAL PROGRAM DESCRIPTION: [~~The New Mexico medicaid program (medicaid) is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended. State administrative authority is provided, pursuant to Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). The medical assistance division (MAD) of the New Mexico human services department is responsible for the administration of the medicaid program. This joint federal and state program provides payment for medically necessary health services furnished to eligible recipients.~~] Human services department (HSD) through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to eligible recipients.
[2/1/95; 8.300.1.9 NMAC - Rn, 8 NMAC 4.MAD.010, 5/1/04; A, 6-1-08]

8.300.1.10 RELATIONSHIP TO MEDICARE: [~~Medicaid~~] MAD covers medically necessary health services furnished to [~~individuals~~] eligible recipients who meet specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to [~~individuals~~] eligible recipients sixty-five (65) years of age or older, to those who have received disability benefits for twenty-four (24) consecutive months, to those who have end stage renal disease, and to other eligible [~~individuals~~] recipients, as specified by other provisions of the Social Security Act.

A. The state of New Mexico has entered into an agreement with the social security administration to pay medicaid [~~client~~] eligible recipient premiums for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, the medicaid program pays for the medicare co-insurance and deductible amounts for all eligible medicaid recipients subject to the following medicaid reimbursement limitations.

(1) Medicaid payment for the co-insurance and deductible is limited such that the payment from medicare, plus the amount allowed by medicaid for the co-insurance and deductible, shall not exceed the medicaid allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance and/or deductible.

The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance and/or deductible from the [~~client~~] eligible recipient or their personal representative. For services for which medicare part B applies a 50% co-insurance rate, medicare co-insurance and deductible amounts may be paid at an amount that allows the provider to receive more than medicaid allowed amount, not to exceed a percentage determined by [~~the department~~] HSD.

(2) The medicaid program will pay toward the medicare co-insurance and deductible [~~in full when the amount~~] to the extent that the amount paid by medicare and the allowed medicare co-insurance and deductible together do not exceed the medicaid allowed amount or when the medicaid program does not have a specific amount allowed for the service.

[2/1/95; 8.300.1.10 NMAC - Rn, 8 NMAC 4.MAD.011 & A, 5/1/04; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID AND OTHER HEALTH CARE PROGRAMS GENERAL INFORMATION
PART 2 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) POLICIES

8.300.2.3 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. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[8.300.2.3 NMAC – N, 7-1-03; A, 6-1-08]

8.300.2.6 OBJECTIVE: The objective of this regulation is to provide health insurance portability and accountability Act (HIPAA) policies for the New Mexico [~~medicaid program~~] medical assistance programs. [~~These policies describe eligible divisions, covered services, and noncovered services~~].
[8.300.2.6 NMAC - N, 7-1-03; A, 6-1-08]

8.300.2.7 DEFINITIONS: [~~This section contains the glossary for the New Mexico medicaid HIPAA policy.~~] The following definitions apply to terms used in this chapter.

A. **Alternate address:** A location other than the primary address on file with HSD for the eligible recipient or the eligible recipient's personal representative.

B. **Alternate means of communication:** A communication made other than in writing on paper, or made orally to the [~~individual~~] eligible recipient or their personal representative.

C. **Amend or amendment:** To make a correction to information that relates to the past, present, or future physical or mental health or condition of [~~a~~] an eligible recipient.

D. **Authorized HCC employee:** A person employed within the HCC workforce who is authorized by the immediate supervisor or by HCC policies to perform the task.

E. **Business associate:** A person or entity that performs certain functions or services on behalf of the HCC involving the use or disclosure of individually identifiable health information. These include claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, and practice management. They also include, other than in the capacity of a member of the HCC workforce, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the HCC.

F. **Covered entity:** A health plan, a health care clearinghouse, and/or a health care provider that transmits any health information in electronic form in connection with [~~a~~] an eligible recipient's health care transaction.

G. **Disclose or disclosure:** To release, transfer, provide access to, or divulge in any other manner (verbally, written, or electronic) protected health information outside the HCC workforce or to an HCC business associate.

H. **Health care component (HCC):** Those parts of the [~~human services department~~] HSD, which is a "hybrid entity" under HIPAA [45 CFR 164.105], that engage in covered health plan functions and business associate functions involving protected health information. HSD's health care component consists of the medical assistance division, supported by the income support division, the office of inspector general, the office of general counsel, and the office of the secretary.

I. **Health care operations:** Any of the following activities: quality assessment and improvement activities, credentialing activities, training, outcome evaluations, audits and compliance activities, planning, fraud and abuse detection and compliance activities, managing, and general administrative activities of the HCC, to the extent that these are related to covered health plan functions.

J. **Health oversight agency:** An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

K. **Health Insurance Portability and Accountability Act (HIPAA) privacy rule:** The federal regulation Section 45 CFR part 160 and Subparts A and E of Part 164.

L. **Health plan:** The medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., and the state children's health insurance program (SCHIP) under Title XXI of the Social Security Act, 42 U.S.C. 1397 et seq.

M. **HCC workforce:** Permanent, term, temporary and part-time employees (classified or exempt), university/federal government placements, volunteers, contractors and others conducting data entry tasks, and contractors and other persons whose conduct and work activities are under the direct control of HCC.

N. **Medical record or designated record set:** Any HCC item, collection, or grouping of information that includes PHI that is written or electronic and is used in whole or in part, by or for HCC to make decisions about the eligible recipient. This applies to:

(1) the medical records and billing records about the eligible recipient maintained by or for the HCC; and

(2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for HCC.

(3) this definition ***excludes*** HCC documents such as those related to accreditation compliance activities (e.g., JCAHO), quality assurance, continuous quality improvement, performance improvement, peer reviews, credentialing and incident reports, and investigations.

O. **Minimum necessary:** The least amount of information needed to accomplish a given task.

P. **Notice of privacy practices, notice or NPP:** The official HSD notice of privacy practices that documents for [~~recipients~~] an eligible recipient the uses and disclosures of PHI that may be made by HCC and the recipient's rights and HCC's legal duties with respect to PHI.

Q. **Payment:** All HCC activities undertaken in its role as a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; and HCC activities undertaken in its role as a health care provider to obtain or provide reimbursement for the provision of health care. Such activities include but are not limited to determination of eligibility or coverage; risk adjusting amounts due based upon health status or demographic characteristics; billing, claims management, collection activities, and related health care data processing; review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges; utilization review activities; and disclosure to consumer reporting agencies of lawful elements of PHI relating to collection of premiums or reimbursement.

R. **Personal representative:** A person who has the legal right to make decisions regarding [~~a~~] an eligible recipient's PHI, and includes surrogate decision makers, parents of unemancipated minors, guardians and treatment guardians, and agents designated pursuant to a power of attorney for health care.

S. **Privacy and security officer (PSO):** The individual appointed by HSD pursuant to HIPAA [45 CFR 164.530(a)] who is responsible for development, implementation, and enforcement of the privacy policies and procedures required by HIPAA.

T. **Protected health information (PHI):** Health information that exists in any form (verbal, written or electronic) that identifies or could be used to identify [~~a~~] an eligible recipient (including demographics) and relates to the past, present, or future physical or mental health or condition of that eligible recipient. It also includes health information related to the provision of health care or the past, present, or future payment for the provision of health care to [~~a~~] an eligible recipient.

U. **Psychotherapy notes:** Notes recorded (in any medium) documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the [~~individual's~~] eligible recipient's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

V. **Public health agency:** An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

W. **Requestor:** [~~A~~] An eligible recipient, personal representative of [~~a~~] an eligible recipient, or any other person making a request.

X. **Restrict or restriction:** To limit the use or disclosure of PHI for purposes of TPO, or for purposes of disclosing information to a spouse, personal representative, close family member or person involved

with the eligible recipient's care.

Y. **Standard protocols:** A process that details what PHI is to be disclosed or requested, to whom, for what purpose, and that limits the PHI to be disclosed or requested to the amount reasonably necessary to achieve the purpose of the disclosure or request.

Z. **TPO:** Treatment, payment or health care operations.

AA. **Treatment:** The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to [~~a patient~~] an eligible recipient; or the referral of [~~a patient~~] an eligible recipient for health care from one health care provider to another.

BB. **Valid authorization:** An authorization with all required elements, as specified in HIPAA privacy policy in Section 13 of 8.300.2 NMAC.

[8.300.2.7 NMAC - N, 7-1-03; A, 6-1-08]

8.300.2.8 MISSION STATEMENT: The mission of the [~~HSD~~] New Mexico medical assistance division (MAD) is to maximize the health status of [~~medicaid eligible individuals~~] eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.2.8 NMAC - N, 7-1-03; A, 6-1-08]

8.300.2.9 GENERAL HIPAA POLICIES: This part describes HIPAA policies including health plan responsibilities, disclosure requirements, minimum necessary, business associates, sanctions, reporting, and documentation requirements. The HCC shall meet all requirements in this chapter. [~~Specific information on the regulation requirement is contained in subsequent sections of this part.~~]

A. **Medicaid is a health plan and a covered entity under HIPAA:** The New Mexico medicaid program under title XIX of the Social Security Act qualifies as a health plan under HIPAA regulations at 45 CFR 160.103 and is considered a covered entity.

B. **Inconsistency between state and federal law:** In the event of any inconsistency between the federal HIPAA privacy rule and New Mexico statutes or regulations, the HIPAA privacy rule shall preempt state law, except where [45 CFR 160.203];

(1) a determination is made by the secretary of the United States department of health and human services pursuant to 45 CFR 160.204;

(2) the provision of state law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification under the HIPAA privacy rule;

(3) the provision of state law and procedures established thereunder provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation or intervention; or

(4) the provision of state law requires the HCC to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

[8.300.2.9 NMAC - N, 7-1-03; A, 6-1-08]

8.300.2.10 NOTICE OF PRIVACY PRACTICES: HSD shall establish policies protecting [~~a medicaid recipient's~~] an eligible recipient's rights regarding HIPAA privacy practices [45 CFR 164.520].

A. **Notice of privacy practices requirements:**

(1) HSD shall provide the HSD notice of privacy practices, update the notice as necessary, and distribute the notice and any revised notices to all [~~medicaid recipients~~] eligible recipients or their personal representatives.

(2) All notice of privacy practices required elements listed in the HIPAA privacy rule shall be contained in the HSD notice of privacy practices [45 CFR 164.520].

(3) The name of every eligible recipient, and as applicable, their personal representative to whom the HSD notice of privacy practices is sent shall be recorded.

B. **Notice schedule:**

(1) [~~For recipients enrolled in medicaid prior to July 1, 2003, a copy of the notice of privacy practices shall be sent to each medicaid recipient's last known address no later than July 1, 2003.~~] For an eligible recipient enrolled in medicaid prior to November 1, 2007, a copy of the notice of privacy practices shall be sent to each eligible recipient's or their personal representative's last known address no later than November 1, 2007.

(2) [~~For revisions made to the notice of privacy practices, a copy of the revised notice of privacy practices shall be mailed to each recipient enrolled in New Mexico medicaid within sixty (60) days of the effective date of the revision.~~] For revisions made to the notice of privacy practices, a copy of the revised notice of privacy practices shall be mailed to each enrolled MAD eligible recipient or their personal representative within 60 calendar days of the effective date of the revision.

(3) For [~~new medicaid recipients~~] a new eligible recipient approved after [~~July 1, 2003~~] November 1, 2007, a copy of the notice of privacy practices shall be mailed with the eligible recipient's new medicaid card and/or their eligibility determination notice.

(4) At least once every three years, HSD shall notify [~~medicaid~~] eligible recipients or their personal representatives by mail of the availability of the notice of privacy practices and how to obtain the notice of privacy practices.

[8.300.2.10 NMAC - N, 7-1-03; A, 6-1-08]

8.300.2.11 RECIPIENT'S RIGHTS: HSD shall establish policies protecting [~~a~~] an eligible recipient's rights regarding HIPAA privacy practices.

A. **Alternate means of communication:** [~~Medicaid recipients~~] An eligible recipient or their personal representative shall have the right to request an alternate means of communication and an alternative address to receive communications of protected health information (PHI) from the HCC. The HCC shall accommodate such requests when reasonable [45 CFR 164.522(b)].

(1) If the eligible recipient or their personal representative is unable to write the request, the eligible recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the eligible recipient or their personal representative sign and date the document, co-sign and retain the document in the medical record.

(2) The HCC staff may determine the reasonableness of a request. If an HCC staff member is unable to determine if the request is reasonable, the staff member may request a supervisor's assistance.

(3) If the recipient or the recipient's personal representative is present when the request is approved or denied, HCC staff shall notify the recipient or the recipient's personal representative verbally of the decision, and shall document the notification in the recipient's file.

(4) If the eligible recipient or their personal representative is not present when the request is approved or denied, HCC shall notify the eligible recipient or [~~the recipient's~~] their personal representative of the decision in writing and retain the copy of the decision in the eligible recipient's file.

(5) If the request is approved, an HCC staff member shall record the alternative method and/or address in the medical record and in the PSO's database.

B. **Inspect and copy:** [~~Medicaid recipients~~] An eligible recipient or their personal representative may inspect their own PHI in a medical file (designated record set) as maintained by the HCC. This does not include psychotherapy notes.

(1) For all requests received in writing, the HCC shall respond in writing to the request to inspect or to obtain a copy of HCC PHI no later than [~~sixty (60)~~] 60 calendar days after receipt of the request. The HCC shall then determine, using the criteria in HIPAA privacy rule, if the request will be granted in part, in full, or denied.

(a) If the request will be granted in full, the PSO shall provide a written response arranging with the eligible recipient or [~~the recipient's~~] their personal representative a convenient time and place to inspect or obtain a copy of the PHI, or may mail the copy of the PHI at the eligible recipient's or their personal representative's request; and shall discuss the scope, format, and other aspects of the eligible recipient's or their personal representative's request with the eligible recipient or [~~the recipient's~~] personal representative as necessary to facilitate timely provision.

(b) If the PSO is unable to gather the required data within the time period required, the PSO may extend the time for the action by no more than [~~thirty (30)~~] 30 calendar days so long as the eligible recipient or their personal representative is provided with a written statement of the reason(s) for the delay and the date by which the PSO shall complete the action on the request. However, only one such extension of time shall be allowed.

(c) The PSO shall provide a copy of the eligible recipient's PHI to the eligible recipient or [~~the recipient's~~] their personal representative in the format requested, if possible. If not, the PSO shall provide the PHI in a readable hard copy form or in another format mutually agreed upon by the PSO and the eligible recipient or [~~the recipient's~~] their personal representative.

(2) If the request is denied, in part or in full, the PSO shall either:

(a) give the eligible recipient or [~~the recipient's~~] their personal representative access to any permitted PHI requested to the extent possible; or

(b) provide a written denial to the eligible recipient or [~~the recipient's~~] their personal representative. The denial shall be written in plain language and contain:

(i) the basis for the denial,

(ii) if applicable, a statement of the eligible recipient's review rights, and

(iii) a description of how the eligible recipient or their personal representative may complain to the PSO or to the secretary of HSD. This description shall include the title and telephone number of the PSO and the secretary of HSD.

(3) If the HCC does not maintain the PHI that is the subject of the request for inspection or copying, the PSO shall inform the eligible recipient or [~~the recipient's~~] their personal representative where to direct the request, if known.

(4) **Exceptions:** A eligible recipient or their personal representative may not inspect the eligible recipient's own protected health information (PHI) in a medical record in connection with:

(a) psychotherapy notes;

(b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding;

(c) PHI maintained by the HCC that is subject to the clinical laboratory improvements amendments (CLIA) to the extent that access to the eligible recipient or their personal representative is prohibited by CLIA;

(d) when the access to the PHI requested is reasonably likely to endanger the life or physical safety of the [~~individual~~] eligible recipient or another person as determined by a licensed health care professional by using his/her professional judgment;

(e) when the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that granting the access requested is reasonably likely to cause substantial harm to such other person; or

(f) when the request for access is made by the eligible recipient's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the [~~individual~~] eligible recipient or another person [45 CFR 164.524].

(5) The PSO shall record all actions pertaining to access to inspect and copy in the PSO's database.

C. **Accounting of disclosures:** Accounting of all disclosures of [~~a~~] an eligible recipient's PHI shall be produced via written report by the PSO when the request is made in writing by the eligible recipient or their personal representative and sent to the PSO.

(1) All disclosures shall be reported except for those:

(a) made to carry out TPO [45 CFR 164.506];

(b) for a facility directory;

(c) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(d) for national security purposes;

(e) to correctional institutions or law enforcement officials having custody of an inmate;

(f) made prior to [~~July 1, 2003~~] November 1, 2007;

(g) made more than six years prior to the date the accounting is requested;

(h) made to the eligible recipient of the eligible recipient's own PHI; or

(i) made to individuals involved in the eligible recipient's care [45 CFR 164.528].

(2) If the HCC does not maintain the PHI that is the subject of the request for accounting, the PSO shall inform the eligible recipient or [~~the recipient's~~] their personal representative where to direct the request, if known.

(3) When [~~a~~] an eligible recipient or their personal representative requests in writing to the PSO an accounting of disclosures of PHI:

(a) within [~~sixty (60)~~] 60 calendar days of receiving [~~a~~] an eligible recipient's or [~~the recipient's~~] their personal representative's request, HCC prepares a report from the PSO's database that includes all required PHI disclosures that occurred during the six [~~(6)~~] years prior to the date of the request for an accounting, unless the eligible recipient or [~~the recipient's~~] their personal representative requested an accounting for a shorter period of time than six [~~(6)~~] years.

(b) the deadline for producing the disclosure report may be extended for up to [~~thirty (30)~~] 30 calendar days, provided that a written statement is sent to the eligible recipient citing the reasons for the delay and the date by which the accounting shall be received.

(c) the HCC must provide free of charge the first accounting report within any [~~twelve~~] 12-month period. If additional requests for an accounting are made within the same [~~twelve-month~~] 12-month period, the HCC shall notify the eligible recipient or their personal representative if a fee will be charged for the additional copies.

(d) the accounting disclosure information is entered into the PSO's database.

D. **Setting restrictions:** [~~Recipients~~] An eligible recipient or their personal representative may request restrictions on the uses and disclosures of their own protected health information (PHI) by submitting a request in writing to the HIPAA privacy and security officer (PSO).

(1) The PSO shall approve or deny requests for restriction(s) in writing within [~~fifteen (15)~~] 15 calendar days.

(2) If the HCC does not maintain the PHI that is the subject of the request for setting restrictions, the PSO shall inform the eligible recipient or [~~the recipient's~~] their personal representative where to direct the request, if known.

(3) If a restriction is approved by the PSO, the information shall be entered into the PSO's database and the HCC shall not use or disclose the restricted PHI [45 CFR 164.522(a)].

(4) If the eligible recipient or their personal representative is unable to write the request, the eligible recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the eligible recipient or their personal representative sign and date the document, co-sign and retain the document in the eligible recipient's file.

(5) Limited use and disclosure of PHI is allowable when the eligible recipient or their personal representative's is not present for an emergency or because of the incapacity of the eligible recipient or their personal representative.

(6) The HCC shall approve or deny the request as appropriate and ensure that the approval or denial of the restriction is entered into the medical record.

(7) If the restriction would involve more than a single location, the HCC staff worker shall send the request to the HIPAA privacy and security officer.

(8) The PSO shall inform the eligible recipient or [~~the recipient's~~] their personal representative in writing of the approval or denial of the request to restrict use and disclosure.

(9) The PSO shall document the restriction(s) in the PSO's database.

E. **Amendments:** It is the policy of the HCC that the HCC shall allow [~~recipients~~] an eligible recipient to request that an amendment be made to the eligible recipient's own protected health information (PHI) contained in a designated record set as long as the PHI was originated by the HCC.

(1) A request for an amendment shall be submitted in writing to the PSO [45 CFR 164.526].

(2) If the HCC does not maintain the PHI that is the subject of the request for amending, the PSO shall inform the eligible recipient or [~~the recipient's~~] their personal representative where to direct the request, if known.

(3) Within five [~~(5)~~] working days of receiving the eligible recipient's or [~~the recipient's~~] their personal representative's written request for an amendment, the PSO shall forward the request to the possessor of the PHI requested to be amended for a determination on whether to grant or deny, in whole or in part, the eligible recipient's or their personal representative's request.

(4) The possessor of the PHI shall:

(a) review the eligible recipient's or their personal representative's request for an amendment;

(b) determine whether to grant or deny, in whole or in part, the eligible recipient's or their personal representative's request;

(c) within 45 calendar days of receiving the eligible recipient's or their personal representative written request for an amendment from the PSO, inform the PSO of the decision to grant or deny, in whole or in part, the eligible recipient's or their personal representative's request and the reason(s) for reaching the decision;

(d) within 60 calendar days of the original receipt of the eligible recipient's or their personal representative's request for an amendment, the PSO shall inform the eligible recipient or [~~the recipient's~~] their personal representative of the decision to grant or deny the requested amendment in whole or in part; and

(e) if the PSO is unable to act on the amendment within the required [~~60-day~~] 60 calendar day period, the time may be extended by no more that 30 calendar days, provided that the PSO provides the eligible recipient or their personal representative with a written statement of the reasons for the delay and the date the action on the request will be completed.

(5) If the eligible recipient's or their personal representative's request is granted in whole or in part:

(a) the possessor shall make the appropriate amendment to the recipient's PHI in the designated record set;

(b) the PSO shall inform the eligible recipient or their personal representative that the amendment is accepted;

(c) the PSO shall obtain the eligible recipient's or their personal representative's agreement and identification of persons that the HCC is to notify of the amendment; and

(d) the PSO shall provide the amendment to those persons identified by the eligible recipient or their personal representative, and to persons, including business associates, that the PSO knows have received the PHI that is the subject of the amendment, and who may have relied, or could predictably rely on such information to the detriment of the eligible recipient.

F. **Complaints and appeals:** It is the policy of the HCC to receive, investigate and resolve complaints made by [~~recipients~~] an eligible recipient or their personal representative of alleged violations of the HIPAA privacy rule. Complaints shall be made in writing, specifying how the eligible recipient's privacy rights have been violated, and submitted to the PSO or to the secretary of HSD [45 CFR 164.530(d)(1), (e), and (f)].

(1) Within five [~~(5)~~] working days of receipt of the complaint, the PSO shall initiate a HIPAA privacy investigation.

(2) The PSO shall enter the complaint into the PSO's database.

(3) Within [~~thirty (30)~~] 30 calendar days of contact by the PSO, the appropriate HCC staff shall conduct the HIPAA privacy investigation and prepares a written report to the PSO documenting the details of the HIPAA privacy investigation and the findings.

(4) Within [~~thirty (30)~~] 30 calendar days after receiving the written report from the appropriate HCC staff, the PSO shall determine the validity of the complaint and notify the eligible recipient or their personal representative, the HCC supervisor and the HCC staff of the action taken. In consultation with the HCC supervisor, the PSO shall take appropriate action to mitigate the adverse effects of any unauthorized disclosure.

(5) For valid complaints, the PSO shall ensure that the appropriate disciplinary action and training are applied as per 8.300.2.24 NMAC.

(6) The PSO shall enter the HIPAA privacy investigation results into the PSO's database.

(7) If the eligible recipient's or their personal representative's request pursuant to this section is denied in whole or in part, the PSO shall:

(a) provide eligible recipient or their personal representative with a timely, written denial, which includes the reason for the denial.

(b) inform the eligible recipient or their personal representative of his/her right to submit, and the procedure for submission of a written statement disagreeing with the denial and also inform the eligible recipient or their personal representative that if no statement of disagreement is submitted, the eligible recipient or their personal representative may request that the HCC provide the eligible recipient's or their personal representative's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment request.

(c) if necessary, prepare a written rebuttal to the eligible recipient's or their personal representative's statement of disagreement and provide a copy to the eligible recipient or their personal representative.

(d) identify the record or PHI and append to the designated record set the:

(i) eligible recipient's or their personal representative's request for an amendment;

(ii) the HCC's denial of the request;

(iii) the eligible recipient's or their personal representative's statement of disagreement, if any; and

(iv) the HCC's rebuttal, if any.

[8.300.2.11 NMAC - N, 7-1-03; a, 6-1-08]

8.300.2.12 USE AND GENERAL DISCLOSURES OF PROTECTED HEALTH INFORMATION: PHI shall be used or disclosed only by authorized HCC staff or contractors and only in accordance with HCC policies and procedures [45 CFR 164.502(a) and 45 CFR 164.530(i)].

A. **Making a disclosure when an authorization is required:** When PHI is requested, an authorized HCC employee shall:

(1) determine if a valid authorization is presented. See 8.300.2.13 NMAC;

(2) determine the identity and authority of the requestor as per 8.300.2.21 NMAC;

(3) if a valid authorization is presented and the identity and authority of the requestor is verified, the HCC is authorized to disclose the PHI in accordance with the valid authorization's instructions;

(4) HCC shall retain the valid authorization in the eligible recipient's file;

(5) the valid authorization and the disclosure shall be documented in the PSO's database;

(6) if the request is not accompanied by a valid authorization, the HCC shall determine if an exception to the authorization requirement applies; and

(7) if no exception applies, the HCC shall deny the request for disclosure of PHI, document the denial and instruct the requestor that a valid authorization shall be obtained from the eligible recipient or their personal representative before MAD will disclose PHI.

B. **Exceptions:** A valid written authorization shall be required from [~~recipients~~] an eligible recipient or their personal [~~representatives~~] representative before any use or disclosure of PHI, with the following exceptions:

(1) disclosures to the eligible recipient or personal representative pursuant to his/her request [45 CFR 164.502(a)(1)(i)];

(2) for purposes of TPO [45 CFR 164.502 and 506];

(3) when a consent, authorization, or other express legal permission in writing was obtained from the eligible recipient prior to [~~July 1, 2003~~] November 1, 2007, and is on file in an HCC location that permits the use or disclosure of PHI [45 CFR 164.532]; and

(4) when the use or disclosure of PHI is limited to the minimum necessary to or for the following:

(a) assisting disaster relief agencies [45 CFR 164.510(b)(4)];

(b) coroners, medical investigators, funeral directors, and organ procurement organizations as authorized by law [45 CFR 164.512(g) and (h)];

(c) averting a serious and imminent threat to the health or safety of a person or the public [45 CFR 164.512(j)];

(d) health oversight activities [45 CFR 164.512(d)];

(e) disclosures required by law pursuant to a legal duty to disclose or report, such as for law enforcement purposes, child abuse or neglect, judicial or administrative proceedings, or workers compensation proceedings pursuant to a subpoena [45 CFR 164.512(a), (c), (e) and (f)];

(f) public health activities [45 CFR 164.512(b)];

(g) correctional institutions or law enforcement officials who have custody of an inmate [45 CFR 164.512(k)(5)];

(h) government agencies which administer a government program that provides public benefits, where the disclosure is necessary to coordinate, improve, investigate, or manage the program [45 CFR 164.512(d)(1) and (3)]; or

(i) research purposes that have been granted a waiver of authorization by an appropriately constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes [45 CFR 164.512(i)].

[8.300.2.12 NMAC - N, 7-1-03; new; A, 6-1-08]

8.300.2.18 TERMINATION OF RESTRICTIONS:

A. **Termination requirements:** Restrictions on the uses and disclosures of PHI shall be terminated if:

(1) the recipient or the recipient's personal representative requests the termination in writing;

(2) the PSO informs the recipient or the recipient's personal representative in writing that the HCC agreement to a restriction has ended and that the termination of the restriction is effective with any PHI created or received after the recipient or the recipient's personal representative is notified of the termination [45 CFR 164.522(a)(2)]; or

(3) if the recipient is unable to write the request, the recipient may request assistance from HCC. If assistance is provided, HCC shall document that the assistance was given, have the recipient sign and date the document, co-sign and retain the document in the medical record.

B. **If a termination of restriction is granted:**

(1) the PSO shall approve or deny the request within five [~~(5)~~] working days. If approved, the PSO shall notify the recipient or the recipient's personal representative in writing of the termination request and give the recipient or the recipient's personal representative ten [~~(10)~~] working days to disagree in writing. If denied, the PSO shall notify the requestor in writing.

(2) if the recipient or the recipient's personal representative disagrees, the PSO shall inform the requestor of the disagreement and require a response in three [~~(3)~~] working days to review the communication from

the recipient or the recipient's personal representative to ascertain if the disagreement by the recipient has bearing on the PSO final decision to terminate the restriction.

(3) the PSO shall issue a final decision within five [~~(5)~~] working days and notify the recipient or personal representative and the MAD requestor.

(4) the PSO shall record the termination of restriction in the PSO's database.

[8.300.2.18 NMAC - N, 7-1-03; new; A, 6-1-08]

8.300.2.21 VERIFYING IDENTITY AND AUTHORITY: If the identity or authority of a requestor of PHI is unknown, the identity and authority of that requestor shall be verified prior to any disclosure [45 CFR 164.514(h)].

A. **Identification:** Upon receipt of a request for PHI, an authorized HCC employee must determine whether the requestor is a recipient or personal representative of a recipient.

(1) If the requestor is unknown to the authorized HCC employee, the employee shall request proof of identity, such as a photograph ID, credit card issued to the requestor, or medicaid card issued to the requestor.

(2) If the request is made over the phone, the HCC employee shall require proof of identity by asking for a social security number or omnicaid system ID.

(3) If the requestor is the recipient, a valid signed authorization satisfies the authority requirement.

(4) If the requestor is the recipient's personal representative, the HCC employee shall require proof of authority to act on the recipient's behalf.

(5) If the request for PHI disclosure is by a government official, and the government official's identity is unknown, the HCC employee shall verify the identity of the government official by viewing an agency identification badge or other official credentials.

(6) The HCC employee shall forward all requests for PHI for research purposes to the PSO. See 8.300.2.14 NMAC.

B. **Authority:** Once the identity of the government official is verified (or if already known), the HCC employee shall verify the authority of the request. If the disclosure of PHI is required by law, the employee shall disclose the PHI and record the disclosure in the PSO's database. If there are questions as to whether PHI disclosure is required by law, the employee shall seek assistance from OGC prior to any PHI disclosure.

(1) HCC shall forward all requests for PHI from subpoenas, legal requests, or for law enforcement purposes to OGC within two [~~(2)~~] working days.

(2) For any requests for PHI received, OGC shall determine the identity of the requestor and the authority of the requestor. OGC then shall approve or deny the request and take the appropriate legal action.

C. **Restrictions or amendments**: If a valid authorization from an ISD location is received because a restriction or amendment is recorded in the PSO's database, the HCC shall take the following action.

(1) If a restriction is already documented, and the valid authorization from the recipient is asking for the restricted PHI to be disclosed, the HCC shall notify the recipient in writing within three [~~(3)~~] working days that a previously set restriction must be revoked in writing by the recipient before the disclosure can be made.

(2) If an amendment is requested, within three [~~(3)~~] working days the HCC shall determine if the PHI to be disclosed has been amended. If yes, the HCC shall disclose the amended PHI.

(3) The HCC shall record the disclosure in the PSO's database.

[8.300.2.21 NMAC - N, 7-1-03; A, 6-1-08]

8.300.2.23 STAFF TRAINING: All members of the HCC workforce shall be trained within appropriate timeframes on HIPAA privacy policies and procedures regarding the proper use and disclosure of PHI [45 CFR 164.530(b)].

A. **Initial training:** The HCC shall:

(1) develop a training plan with HCC supervisory staff involvement to determine the timing of and level of training appropriate to members of the HCC workforce;

(2) develop bureau-specific training curricula and materials. The training material shall be maintained for six years;

(3) provide bureau-specific training for the current HCC workforce no later than [~~July 1, 2003~~] September 1, 2007; and

(4) ensure documentation of initial training completion and forward documentation to the HSD office of human resources.

B. **Continuous training:** For HCC workforce members who begin employment or whose job functions change subsequent to [~~July 1, 2003~~] September 1, 2007, HCC shall:

(1) within one working day of start date, notify the PSO of the new HCC workforce member and schedule training for the new workforce member to be completed within ten [~~(10)~~] working days of the start date;

(2) for HCC workforce members whose job functions change, and who thus require a new level of training, notify the PSO and schedule the training prior to having the workforce member assume the new job duties. Employees must successfully complete training within ten [~~(10)~~] working days of their start date, and evidence of training must be provided to the HSD office of human resources; and

(3) the HSD office of human resources shall retain the original signed training documentation for six [~~(6)~~] years.

C. **Privacy policy changes:** When changes are made to HCC policies or procedures or when HCC changes its privacy practices [45 CFR 164.530(b)], HCC shall:

(1) prepare relevant changes to the bureau-specific curricula;

(2) prepare changes to training materials;

(3) retain the training material for six [~~(6)~~] years;

(4) after determining affected staff with supervisor involvement, develop a training plan;

(5) ensure that the HCC workforce successfully completes training and provide individual signed documentation of training to the PSO;

(6) the PSO shall forward the individual documentation of training to the HSD office of human resources; and

(7) the HSD office of human resources shall retain the original signed training documentation for six [~~(6)~~] years.

[8.300.2.23 NMAC - N, 7-1-03; new; A, 6-1-08]

8.300.2.24 WORKFORCE DISCIPLINARY ACTION: Any HCC employee who discloses protected health information (PHI) not allowed by HIPAA privacy policies and procedures shall be subject to appropriate disciplinary action.

A. **Knowingly inappropriate disclosure of protected health information:** Appropriate disciplinary action may be informal discipline, such as counseling, oral reprimands, written reprimands, and mandatory training or retraining; or formal discipline, such as suspension, demotion or dismissal from employment.

(1) A HCC supervisor shall notify the PSO immediately upon becoming aware of an alleged or suspected inappropriate disclosure(s) of PHI by a HCC employee.

(2) The PSO shall enter the date and name of the HCC employee into the PSO database.

(3) The PSO shall direct the supervisor to conduct a privacy investigation of the alleged inappropriate disclosure(s) within five [~~(5)~~] working days of being notified.

(4) The supervisor shall complete the privacy investigation of the alleged inappropriate disclosure(s) within ten (10) days of notification and shall prepare a written report of the privacy investigation findings.

(5) The supervisor shall send the written report to the PSO and shall retain a copy.

(6) If the findings of the privacy investigation show that the HCC employee did not disclose PHI inappropriately, the PSO shall enter "claim not substantiated" into the PSO database by the HCC employee's name.

(7) If the findings of the privacy investigation show that the HCC employee did knowingly disclose PHI inappropriately, the PSO shall share the findings of the privacy investigation with OGC and the HSD office of human resources.

(8) The employee's supervisor, with the advice of OGC, the PSO, and the office of human resources, as appropriate, shall determine appropriate disciplinary action to be applied in accordance with principles of progressive discipline, and shall notify the PSO of the determination. Such discipline may be either informal or formal.

(a) **Informal discipline:** Within three [~~(3)~~] working days of notifying the PSO of the determination of the level of disciplinary action to be applied, the supervisor shall meet with the HCC employee who knowingly disclosed PHI inappropriately to discuss the outcome of the investigation and to provide the employee with the informal disciplinary action. Any written documentation of the informal discipline that is placed in the employee's HSD personnel file shall be provided to the employee, and the employee may submit a written rebuttal for placement in the employee's HSD personnel file in accordance with Subsection A of 1.7.1.12 NMAC.

(b) **Formal discipline:** For an employee in career status (i.e., has completed the probationary period), within ten [~~(10)~~] working days of notifying the PSO of the determination of the level of disciplinary action to be applied, the supervisor shall initiate the discipline in accordance with the procedures required by the state personnel board as set out in 1.7.11 NMAC, or subsequent amendment, by preparing an appropriate notice of contemplated action in accordance with 1.7.11.13 NMAC, or subsequent amendment. For an employee not in career

status, such as a probationary, emergency, or temporary employee, written notice of the discipline shall be provided at least [~~twenty-four hours~~] 24-hours prior to the imposition of the discipline in accordance with 1.7.11.11 NMAC.

(9) The supervisor shall notify the PSO when the HCC employee that knowingly disclosed the PHI inappropriately has received the disciplinary action.

(10) The PSO shall enter the privacy investigation findings of "claim substantiated" along with the disciplinary action taken by the name of the HCC employee that knowingly disclosed PHI inappropriately into the PSO database.

B. **Inadvertent inappropriate disclosure of protected health information:** Appropriate disciplinary action for inadvertent inappropriate disclosure of PHI is generally informal discipline, such as counseling, oral reprimands, written reprimands, and mandatory training or retraining.

(1) An HCC supervisor shall notify the PSO immediately upon becoming aware of an alleged or suspected inappropriate disclosure(s) of PHI by an HCC employee.

(2) The PSO shall enter the date and name of the HCC employee into the PSO database.

(3) The PSO shall direct the supervisor to conduct a privacy investigation of the alleged inappropriate disclosure(s) of PHI by an HCC employee within five [~~(5)~~] working days of being notified.

(4) The supervisor shall complete the privacy investigation of the alleged inappropriate disclosure(s) of PHI within ten [~~(10)~~] working days of notification and prepares a written report of the privacy investigation findings.

(5) The supervisor shall send the written report to the PSO and retain a copy.

(6) If the findings of the privacy investigation show that the HCC employee did not disclose PHI inappropriately, the PSO shall enter "claim not substantiated" into the PSO database by the HCC employee's name.

(7) If the findings of the privacy investigation show that the HCC employee did inadvertently disclose PHI inappropriately, the PSO shall share the findings of the privacy investigation with OGC.

(8) The PSO and the supervisor shall meet jointly with the HCC employee who inadvertently disclosed PHI within three [~~(3)~~] working days of receipt of the written notification from the PSO to discuss the outcome of the investigation and to provide the employee with the informal disciplinary action.

(9) At a minimum, the supervisor shall take the following informal disciplinary action:

(a) give the HCC employee who inadvertently disclosed PHI inappropriately copies of the HSD HIPAA privacy policies and procedures with which the employee did not comply;

(b) require the HCC employee to read the applicable HSD HIPAA privacy policies and procedures in the presence of the supervisor;

(c) explain to the HCC employee the potential implications to HCC when PHI is disclosed inappropriately and is in conflict with HSD HIPAA privacy policies and procedures;

(d) answer any questions the HCC employee has regarding the HSD HIPAA privacy policies and procedures; and

(e) require the HCC employee to sign and date a document stating that counseling was provided regarding the failure to comply with HSD HIPAA privacy policies and procedures.

(10) The supervisor shall give the original of the document signed and dated by the HCC employee to the HSD office of human resources, and shall also maintain a copy and immediately forward a copy to the PSO. Any written documentation of the informal discipline that is placed in the employee's personnel file shall be copied and provided to the employee, and the employee may submit a written rebuttal for placement in the employee's personnel file in accordance with Subsection A of 1.7.1.12 NMAC.

(11) Upon receiving a copy of the document, the PSO shall enter "claim substantiated" along with the disciplinary action taken by the name of the HCC employee into the PSO database.

C. **Repeated inadvertent inappropriate disclosure of protected health information:** If the findings of the privacy investigation show that a repeat inappropriate, inadvertent disclosure of PHI was made by an HCC employee, and the employee has received informal or formal discipline as provided in these HIPAA privacy procedures, the PSO in consultation with the employee's supervisor shall recommend an appropriate disciplinary action to be applied. Such discipline may be either informal or formal. Informal discipline includes counseling, oral reprimands, written reprimands, and mandatory training or retraining. Formal discipline is suspension, demotion, or dismissal.

(1) An HCC supervisor shall notify the PSO immediately upon becoming aware of an alleged or suspected inappropriate disclosure(s) of PHI by an HCC employee.

(2) The PSO shall enter the date and name of the HCC employee into the PSO database.

(3) The PSO shall direct the supervisor to conduct a privacy investigation of the alleged inappropriate disclosure(s) of PHI within five [~~(5)~~] working days of being notified.

(4) The supervisor shall complete the privacy investigation of the alleged inappropriate disclosure(s) of PHI within ten (10) days of notification and shall prepare a written report of the privacy investigation findings.

(5) The supervisor shall send the written report to the PSO and retain a copy.

(6) If the findings of the privacy investigation show that the HCC employee did not disclose PHI inappropriately, the PSO shall enter "claim not substantiated" into the PSO database by the employee's name.

(7) If the findings of the privacy investigation show that a repeat inappropriate, inadvertent disclosure of PHI was made by a HCC employee, and the employee has received informal or formal discipline as provided in these HIPAA privacy procedures, the PSO in consultation with the employee's supervisor shall recommend an appropriate disciplinary action to be applied. Such discipline may be either informal or formal. Informal discipline includes counseling, oral reprimands, written reprimands, and mandatory training or retraining. Formal discipline is suspension, demotion, or dismissal.

(8) The PSO and the supervisor shall meet jointly with the HCC employee who inadvertently disclosed PHI within three [~~(3)~~] working days of receipt of the written notification from the PSO to discuss the outcome of the investigation and to provide the employee with the informal disciplinary action.

(9) At a minimum, the supervisor shall take the following informal disciplinary action:

(a) give the HCC employee who inadvertently disclosed PHI inappropriately copies of the HSD HIPAA privacy policies and procedures with which the employee did not comply;

(b) require the employee to read the applicable HSD HIPAA privacy policies and procedures in the presence of the supervisor;

(c) explain to the employee the potential implications to HSD when PHI is disclosed inappropriately and is in conflict with HSD HIPAA privacy policies and procedures;

(d) answer any questions the employee has regarding the HSD HIPAA privacy policies and procedures; and

(e) require the employee to sign and date a document stating that counseling was provided regarding the failure to comply with HSD HIPAA privacy policies and procedures.

(10) The supervisor shall give the original document, signed and dated by the HCC employee, to the office of human resources, maintain a copy and immediately forward a copy to the PSO. Any written documentation of the informal discipline that is placed in the employee's HSD personnel file shall be copied and provided to the employee, and the employee may submit a written rebuttal for placement in the employee's personnel file in accordance with Subsection A of 1.7.1.12 NMAC.

(11) Upon receiving a copy of the document, the PSO shall enter "claim substantiated" along with the disciplinary action taken by the name of the HCC employee into the PSO database.

D. **Non-employee inappropriate disclosure of protected health information:** Appropriate disciplinary action may include requiring a corrective action plan with mandatory retraining, or severance of the working relationship with the HCC.

(1) The supervisor shall notify the PSO immediately upon becoming aware of an alleged or suspected inappropriate disclosure(s) of PHI by a non-employee member of the HCC workforce and shall conduct a privacy investigation within five [~~(5)~~] working days of becoming aware of the situation.

(2) The supervisor shall notify the PSO of the results of the investigation (substantiated or not substantiated) and of the discipline that occurred (a corrective action plan with retraining or severed working relationship).

(3) The PSO shall enter into the PSO database the date and name of the non-employee member of the HCC workforce with the findings and action taken.

[8.300.2.24 NMAC - N, 7-1-03; A, 6-1-08]

HISTORY OF 8.300.2 NMAC: [RESERVED]

MEDICAID AND OTHER HEALTH CARE PROGRAMS GENERAL INFORMATION
CONFIDENTIALITY

EFF:proposed

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID AND OTHER HEALTH CARE PROGRAMS GENERAL INFORMATION
PART 11 CONFIDENTIALITY

8.300.11.3 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. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.300.11.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7/1/03; A, 6-1-08]

8.300.11.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of the section.
[2/1/95; 8.300.11.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7/1/03; A, 6-1-08]

8.300.11.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico [~~medicaid program~~] medical assistance programs. [~~These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.~~]
[2/1/95; 8.300.11.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7/1/03; A, 6-1-08]

8.300.11.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of [~~medicaid-eligible individuals~~] eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.300.11.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7/1/03; A, 6-1-08]

8.300.11.9 CONFIDENTIALITY: The following [~~applicant/recipient~~] applicant and eligible recipient information is confidential and is safeguarded by the human services department (HSD), all state agencies, their contractors and other [~~designees,~~] authorized agents and all providers of [~~medicaid~~] MAD services. See 42 CFR 431.305(b) and 45 CFR 164.530(c):

A. name, address and social security number;
B. medical services furnished to the applicant and eligible recipient;
C. social and economic conditions or circumstances;
D. agency evaluation of personal information;
E. medical data, including diagnosis and past history of disease or disability;
F. information received to verify income eligibility and the amount of medical payments, including information received from the social security administration and the internal revenue service;
G. information received in connection with the identification of legally liable third parties;
H. telephone numbers;
I. fax numbers;
J. electronic mail addresses;
K. medical record numbers;
L. health plan beneficiary numbers;
M. account numbers; and
N. certificate/license numbers.

[2/1/95; 4/30/97; 8.300.11.9 NMAC - Rn, 8 NMAC 4.MAD.030 & A, 7/1/03; A, 6-1-08]

8.300.11.10 CONFIDENTIALITY OF APPLICANT/RECIPIENT INFORMATION:

A. Safeguarding of confidential [~~applicant/recipient~~] applicant and eligible recipient information includes the methods of receiving, maintaining, and communicating individually identifiable health information. See 45 CFR Section 164.530(c).

B. **Confidentiality of medical information:** Confidential information regarding applicants or eligible recipients will be available to those identified in 8.300.11.9 NMAC for use only in connection with the administration of the New Mexico [~~medicaid program (medicaid)~~] medical assistance programs and other health care programs and only on a need-to-know basis. See 42 CFR Section 431.300-307. Those using confidential information will only use the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. See 45 CFR Section 164.502(b).

(1) **Use of confidential medical information:** The following individuals have access to medical information:

(a) employees of private firms, other divisions within HSD or other state agencies who are performing work or providing services for MAD under contract or business associate agreement or who are providing services, as required by federal law;

(b) employees or agents of the federal department of health and human services; and

(c) providers of health care services to [~~medicaid~~] eligible recipients.

(2) **Sanctions for the improper use of confidential information:** Improper disclosure or use of confidential information by a MAD employee or designee is grounds for immediate dismissal, demotion or suspension (see 8.300.2.24 NMAC). Employees or designees are solely liable for all damages resulting from their improper use of confidential information.

[2/1/95; 4/30/97; 8.300.11.10 NMAC - Rn, 8 NMAC 4.MAD.031 & A, 7/1/03; A, 6-1-08]

8.300.11.11 CONFIDENTIALITY OF ELECTRONIC DATA:

A. **Electronic transmission/reception of confidential information:** To ensure that the confidential medical information of eligible recipients and applicants is kept confidential, transmission and reception of this information is limited to those individuals allowed to have access to medical information as stated in the use of confidential medical information policy (Paragraph (1) of Subsection B of 8.300.11.10 NMAC) and safeguarding protected health information policy 8.300.2.22 NMAC).

B. **Provider participation:** Providers who choose to send and/or receive confidential medical information via fax must have a dedicated fax line and/or fax machine. Confidential medical information should not be received at a commercial fax center where employees or customers may have access to the information. Providers who choose to send and/or receive confidential medical information via fax or email must follow the minimum necessary standard. See 45 CFR Section 164.502.

C. **Responsibility for failure to follow policy:** Providers who fail to adhere to this policy are solely liable for any consequences resulting from the use of this method of transmitting confidential medical information, including any attorney fees, costs or damages. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f).

[2/1/95; R 5/31/97; Re-pr, 3/1/99; 8.300.11.11 NMAC - Rn, 8 NMAC 4.MAD.034 & A, 7/1/03; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 301 MEDICAID AND OTHER HEALTH CARE PROGRAMS GENERAL BENEFIT DESCRIPTION
PART 2 GENERAL BENEFIT DESCRIPTION

8.301.2.3 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. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[1-1-95; 8.301.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3-1-06; A, 6-1-08]

8.301.2.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[1-1-95, 2-1-95; 8.301.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3-1-06; A, 6-1-08]

8.301.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico [~~medicaid program~~] medical assistance programs. [~~These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement~~.]
[1-1-95, 2-1-95; 8.301.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3-1-06; A, 6-1-08]

8.301.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of [~~medicaid eligible individuals~~] eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[2-1-95; 8.301.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3-1-06; A, 6-1-08]

8.301.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico [~~medicaid program (medicaid)~~] MAD pays for medically necessary health care services furnished by medical providers who participate in medicaid and other health care programs.. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991). [~~Medicaid~~] MAD covers a range of medical services, including acute care services, transportation, physician services, home health care, durable medical equipment and medical supplies, tot to teen healthchecks, pharmacy services, behavioral health services and institutional and community-based long-term care services.

B. [~~Medicaid~~] MAD covers services which are medically necessary for the diagnosis and/or treatment of illnesses, injuries or conditions of [~~recipients, as determined by the medical assistance division (MAD)~~] an eligible recipient, as determined by the MAD or its designee.. All services must be furnished within the limits of medicaid benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local laws and regulations. Any claim submitted to MAD for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service.
[2-1-95; 8.301.2.9 NMAC - Rn, 8 NMAC 4.MAD.601 & A, 3-1-06; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID AND OTHER HEALTH CARE PROGRAMS GENERAL PROVIDER POLICIES
PART 1 GENERAL PROVIDER POLICIES

8.302.1.3 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 Title XIX of the Social Security Act, as amended and by [~~the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq.~~] state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[1-1-95; 8.302.1.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7-1-01; A, 6-1-08]

8.302.1.5 EFFECTIVE DATE: February 1, 1995, unless a late date is cited at the end of a section.
[1-1-95, 2-1-95; 8.302.1.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7-1-01; A, 6-1-08]

8.302.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico [~~Medicaid program~~] medical assistance programs.
[1-1-95, 2-1-95; 8.302.1.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7-1-01; A, 6-1-08]

8.302.1.7 DEFINITIONS: Medically necessary services

A. Medically necessary services are clinical and rehabilitative physical[~~,~~] or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an [~~the individual~~] an eligible recipient to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical[~~, mental~~] and behavioral health care needs of the [~~individual~~] eligible recipient;

(3) are provided within professionally accepted standards of practice and national guidelines;

(4) are required to meet the physical[~~, mental~~] and behavioral health needs of the [~~individual~~] eligible recipient and are not primarily for the convenience of the [~~individual~~] eligible recipient, the provider or the payer.

B. Application of the definition:

(1) A determination that a [~~health care~~] service is medically necessary does not mean that the [~~health care~~] service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

(2) The department or its [~~designee~~] authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the [~~Medicaid~~] specific program's benefit package applicable to an eligible [~~individual~~] recipient shall do so by:

(a) evaluating [~~individual~~] the eligible recipient's physical[~~, mental~~] and behavioral health information provided by qualified professionals who have personally evaluated the [~~individual~~] eligible recipient within their scope of practice, who have taken into consideration the [~~individual's~~] eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the [~~individual or the individual's legal guardian, agent or surrogate decision maker~~] eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems.

(3) Physical[~~, mental~~] and behavioral health services shall not be denied solely because the [~~individual~~] eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible [~~individual~~] recipient solely because of the diagnosis, type of illness or condition.

(4) Decisions regarding medicaid benefit coverage for children shall be governed by the [~~EPSDT~~] early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

(5) Medically necessary service requirements apply to all medical assistance program policies.
[8.302.1.7 NMAC - N, 12-1-03; A, 6-1-08]

8.302.1.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of [~~medicaid eligible individuals~~] eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[2-1-95; 8.302.1.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7-1-01; A, 6-1-08]

8.302.1.9 GENERAL PROVIDER POLICIES: [~~Medical services are reimbursed by the New Mexico medicaid program (medicaid) under Title XIX of the Social Security Act, as amended. Direct health care services are provided by a variety of provider groups. This section describes general provider participation requirements eligible recipients, provider responsibilities, payment restrictions, and reporting and documentation requirements. Specific information by provider type is contained in subsequent sections of this manual.~~] Medically necessary services are reimbursed by the MAD under Title XIX of the Social Security Act as amended, or by state statute.
[2-1-95; 2-1-99; 8.302.1.9 NMAC - Rn, 8 NMAC 4.MAD.701, 7-1-01; A, 6-1-08]

8.302.1.10 ELIGIBLE PROVIDERS: [~~Upon approval of a New Mexico medical assistance program provider participation application by the New Mexico medical assistance division (MAD), licensed practitioners or facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to Medicaid recipients. Providers must be enrolled as Medicaid providers before submitting a claim for payment to the MAD claims processing contractor. Once enrolled, providers receive and are responsible for maintenance of, a packet of information which includes Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. To be eligible for rmedicaid reimbursement, provides are bound by MAD policies, procedures, billing instruction, reimbursement rates, and all audit, recoupment and withholding provisions unless superseded by federal law, federal regulation or by specific written approval by the MAD director.~~] Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. 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 policies, billings instructions, utilization review instructions, and other pertinent materials. Once enrolled, providers receive instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, 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 policy manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement.
[2-1-95, 2-1-99; 8.302.1.10 NMAC - Rn, 8 NMAC 4.MAD.701.1, 7-1-01; A, 6-1-08]

8.302.1.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS: [~~Providers who furnish services to medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, the Health Insurance Portability and Accountability Act (HIPAA), and the state Medicaid Fraud Act. Providers also agree to conform t MAD policies and instructions as specified in this manual and its appendices, as updated.~~] A provider who furnishes services to a medicaid and other health care program eligible recipient agrees to comply with all federal and state laws and regulations relevant to the provision of services as specified in the MAD provider participation agreement. A provider also agrees to conform to MAD program policies and instructions as specified in this manual, its appendices, and 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.

A. **Eligibility determination:** [~~Providers must verify that services they furnish are provided to eligible recipients.~~] A provider must verify that services he furnishes are provided to an eligible recipient.

(1) [~~Providers may verify eligibility through several mechanisms, including using an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor. Providers must verify that recipients are eligible and remain eligible for medicaid throughout periods of continued or extended services. By verifying client eligibility, a provider is informed of restrictions that may apply to a recipient's eligibility.~~] A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting the medical assistance division or designated contractor eligibility help desks,

contracting with an eligibility verification system vendor, or contracting with a magnetic swipe card vendor. A provider must verify that a recipient is eligible and remains eligible throughout periods of continued or extended services.

(2) [~~A recipient becomes financially responsible for a provider claim if the recipient fails to furnish identification before service and MAD denies payment because the resulting administrative error. Settlement of these claims is between the provider and recipient.~~] An eligible recipient becomes financially responsible for a provider claim if the eligible recipient fails to identify himself as a medicaid or other health care program recipient, that an eligibility determination is pending, or fails to furnish medicaid or other health care program identification before the service is rendered and MAD denies payment because of the resulting inability of the provider to be able to file a claim timely or because of the lack of provider enrollment, provider eligibility, or provider participation. Settlement of these claims is between the provider and the eligible recipient.

B. **Requirements for updating information:** [~~Providers~~] A provider must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in [~~their~~] his address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the [~~health care~~] provider or person. MAD or the appropriate MAD claims processing contractor must receive this information at least 60 calendar days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment or provider repayment.

C. **Additional requirements:** [~~Providers~~] A provider must meet all other requirements stated in this manual, the billing instructions, manual revisions, supplements, and signed application forms or re-verification forms, as updated. MAD may require a letter of credit, a surety bond, or a combination thereof, from the [~~health care~~] provider. The letter of credit, surety bond or combination thereof may be required if any one of the following conditions is met:

(1) the [~~health care~~] provider is the subject of a state or federal sanction or of a criminal, civil, or departmental proceeding in any state;

(2) a letter of credit, surety bond, or any combination thereof is required for each [~~health care~~] provider [~~in that category of health care provider; or~~] of a designated provider type;

(3) the [~~health care~~] provider cannot reasonably demonstrate that they have assumed liability and are responsible for paying the amount of any outstanding recoveries to MAD as the result of any sale, merger, consolidation, dissolution, or other disposition of the [~~health care~~] provider or person;

(4) the MAD provider participation agreement must be updated by the provider with information on the conviction of delineated criminal or civil offenses against the provider or parties with direct or indirect ownership or controlling interest within ten calendar days after the conviction.

[~~(4)~~] (5) the secretary determines that it is in the best interest of [~~the medical assistance programs~~] MAD to do so, specifying the reasons.

[2-1-95, 2-1-99; 8.302.1.11 NMAC - Rn, 8 NMAC 4.MAD.701.2 & A, 7-1-01; A, 7-1-03; A, 6-1-08]

8.302.1.12 ELIGIBLE MEDICAID AND OTHER HEALTH CARE PROGRAM RECIPIENTS: To comply with Title XIX of the Social Security Act, as amended, [~~medicaid~~] MAD is required to serve certain groups of eligible recipients and has the option of paying for [~~medical~~] services provided to other eligible recipient groups [42 CFR 435.1]. [~~Medicaid~~] MAD is also required to pay for emergency services furnished to undocumented aliens residing in New Mexico who are not lawfully admitted for permanent residence but who otherwise meet the eligibility requirements [~~for medicaid~~]. Coverage is restricted to those services necessary to treat an emergency medical condition, which includes labor and delivery services. See 8.325.10.3 NMAC.

A. **Recipient eligibility determination:** To be eligible to receive [~~medicaid benefits, applicants/recipients~~] benefits, an applicant/recipient must meet general eligibility and/or resource and income requirements. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on eligibility requirements.

(1) [~~Individuals who are~~] An otherwise eligible recipient who is under the jurisdiction or control of the correctional system or resides in a public institution [~~are~~] is not eligible for medicaid.

(2) Medicaid eligibility determinations are made by the following agencies:

(a) the staff of the income support division (ISD) county offices determines eligibility for aid to families with dependent children, pregnant women and children and other general medicaid categories;

(b) the staff of the New Mexico children, youth and families department (CYFD) determines eligibility for child protective services, adoptive services and foster care children;

(c) the staff of the social security administration determines eligibility for social security income (SSI); and

(d) the staff of a federally qualified health [~~centers,~~] center, a maternal and child health services block grant program [~~or~~], the Indian health [~~services,~~] service, and other designated agents make presumptive eligibility determinations [~~for pregnant women~~].

B. **Recipient freedom of choice:** [~~Eligible recipients have the freedom of choice to obtain medical services from in-state providers who meet the requirements for participation in medicaid.~~] Unless otherwise restricted by specific health care program policies, an eligible recipient has the freedom of choice to obtain services from in-state and border providers who meet the requirements for MAD provider participation. Some restrictions to this freedom of choice may apply to recipients who are assigned provider(s) in the medical management program. Some restrictions to this freedom of choice apply to an eligible recipient who is assigned to a provider or providers in the medical management program [42 CFR 431.54(e)]. See 8.301.5 NMAC, MEDICAL MANAGEMENT. Some restrictions to this freedom of choice may also apply to purchases of medical devices, and laboratory and radiology tests and other services and items as allowed by federal law [42 CFR 431.54 (d)].

C. **Recipient identification: [**~~Medicaid clients receive a medicaid card. The card must be presented by or on behalf of the individual recipient or family members before receiving medical services, or with each visit in the case of continued or extended services.~~] An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

(1) [~~Providers should~~] A provider must verify the eligibility of the [~~client~~] recipient to assure the [~~client~~] recipient is eligible on the date the services are provided. Verification of eligibility also permits the provider to be informed of any restrictions or limitations on services associated with the [~~client's~~] recipient's eligibility; of the applicability of co-payments on services; of the need for the [~~client's~~] eligible recipient's care to be coordinated with or provided through a Salud!, [~~medicaid~~] managed care organization, a hospice provider, a PACE provider, a medical management provider, or similar health care [~~plans or providers~~] plan or provider. Additionally, information on medicare eligibility and other insurance coverage may be provided.

(2) [~~Recipients whose medicaid coverage may be limited include qualified medicare beneficiary (QMB) recipients, and recipients entitled to receive pregnancy only benefits or family planning benefits.~~] An eligible recipient whose health care program coverage or benefits may be limited include qualified medicare beneficiary (QMB) recipient and recipient entitled to receive only pregnancy-related benefits or family planning benefits.

[2-1-95; 2-1-99; 8.302.1.12 NMAC - Rn, 8 NMAC 4.MAD.701.3 & A, 7-1-01; A, 6-1-08]

8.302.1.13 PATIENT SELF DETERMINATION ACT: [~~Medicaid certified hospitals, nursing facilities, intermediate care facilities for the mentally retarded, hospice agencies, and home health agencies are required to give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. Individuals are~~] A hospital, nursing facility, intermediate care facility for the mentally retarded, hospice agency and home health agency are required to give an eligible recipient or personal representative information about his right to make his own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. An eligible recipient is not required by this legislation to execute advance directives. Advance directives, such as living wills or durable power of attorney documents, must be established in a manner which is recognized under New Mexico state law. See applicable state law. A health care [~~providers~~] provider cannot object on the basis of conscience when [~~a recipient~~] an eligible recipient or personal representative wishes to implement an advance directive. However, [~~providers~~] a provider may decline to participate in the care if the [~~recipient's care is transferred to other qualified physicians.~~] eligible recipient's care is transferred to other qualified providers.

A. **Information requirements:** [~~Providers are required to provide written information to all adults concerning their right to do the following at the time of admission:~~] A provider is required to provide written information to an adult eligible recipient or personal representative concerning his right to do the following at the time of admission:

(1) make decisions about [~~their~~] his medical care;

(2) accept or refuse medical or surgical treatment;

(3) execute advance directives;

(4) execute [~~their~~] his rights under HIPAA; and

(5) [~~if recipients who are already incapacitated are admitted, providers must provide recipients' families or authorized representatives with this information. If recipients are no longer incapacitated, providers must~~

~~discuss these rights with recipients.~~] if an eligible recipient who is already incapacitated is admitted, the provider must provide their personal representatives with this information. If an eligible recipient is no longer incapacitated, provider must discuss these rights with the eligible recipient.

B. **Policies and procedures:** [~~Providers must give written information to all recipients over eighteen (18) years of age about provider policy and procedures concerning advance directives rights. Providers~~] A provider must give written information to an eligible adult recipient or their personal representative about provider policy and procedures concerning advance directive rights. A provider must verify that the advance directive complies with state law.

C. **Documentation requirements:** [~~Providers must document in each recipient's medical record whether he/she has established an advance directive. If the recipient or his/her family or representative presents an advanced directive, providers must comply with the terms of the document, as directed by law. If recipients are incapacitated, unable to communicate, or family members or representatives do not present an advance directive, providers must document that recipients were unable to receive information or communicate whether advance directives exist. Providers must inform recipients that it furnishes information and proper forms for completion of advance directives.~~] A provider must document in each eligible recipient's medical record whether he or their personal representative has established an advance directive. If the eligible recipient or their personal representative presents an advanced directive, a provider must comply with the terms of the document, as directed by state law. If an eligible recipient is incapacitated, unable to communicate, or their personal representative does not present an advance directive, the provider must document that the eligible recipient was unable to receive information or communicate whether advance directives exist. A provider must inform the eligible recipient or their personal representative that it furnishes information and proper forms for completion of advance directives.

D. **Provision of care:** [~~Providers~~] A provider must not condition the provision of care or discriminate against [~~a recipient~~] an eligible recipient based on whether [~~he/she~~] he has established advance directives. If [~~a recipient~~] an eligible recipient is entitled to necessary care ordered by a physician, which providers under normal procedures must furnish, care cannot be delayed while waiting for the execution of an advance directive. Once the existence of an advance directive is documented, the directive takes precedence over normal procedures.

E. **Changing the advanced directives:** [~~Providers~~] A provider must inform [~~a recipient that he/she~~] an eligible recipient or their personal representative that he has a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements.

[2-1-95; 8.302.1.13 NMAC - Rn, 8 NMAC 4.MAD.701.4, 7-1-01; A, 7-1-03; A, 6-1-08]

8.302.1.14 NONDISCRIMINATION: [~~Providers must furnish covered services to recipients in the same scope, quality and manner as provided to the general public. Within the limits of medicaid, providers may not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment.~~] A provider must furnish covered services to an eligible recipient in the same scope, quality and manner as provided to the general public. Within the limits of medical assistance programs, a provider may not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, marital status, political belief, or source of payment, [45 CFR 80.3 (a)(b); 45 CFR 84.52 (a); 42 CFR 447.20; and PL 101-366, 104 Stat. 327 (1990)].

[2-1-95; 2-1-99; 8.302.1.14 NMAC - Rn, 8 NMAC 4.MAD.701.5, 7-1-01; A, 6-1-08]

8.302.1.15 BILLING AND CLAIMS PROCESSING: Reimbursement to [~~providers~~] a provider for services or procedures is based on the MAD reimbursement fee schedule, reimbursement rate, or reimbursement methodology in place at the time the services were furnished by the provider. [~~Providers who furnish services to medicaid recipients agree to accept the amount paid my MAD as payment in full.~~] A provider who furnishes services to an eligible recipient agrees to accept the amount paid by MAD as payment in full, except as otherwise allowed by regulation [42 CFR 447.15].

A. **Requirements for reimbursement:** [~~Providers are~~] A provider is reimbursed for performing a service or procedure only if any required prior [~~approval, documentation, or acknowledgement~~] authorization, documentation, certifications, or acknowledgements are submitted with the claim and the claim is received by the appropriate claims processing contractor within the filing limits.

[~~B. **Responsibility for claims:** Providers are responsible for all claims submitted under his/her medicaid provider number.~~]

B. **Electronic Billing Requirements:** Effective October 1, 2008, electronic billing of claims is mandatory unless an exemption has been allowed by MAD. Electronic billing improves the accuracy of claims

submission and payment; provides consistency in billing information; and improves the speed of payment. Exemptions will be given on a case by case basis with consideration given to barriers the provider may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which paper attachments must accompany the claim form.

[~~C. **No billing of recipients or third parties:** With the exception of WDI and SCHIP copayments as defined in 8.243.600.9 NMAC, providers may not bill or accept payment from recipients or other third parties determined to be legally responsible for the balance of a claim. Following medicaid payment, providers cannot seek additional payment from a recipient or other legally responsible party in addition to the amount paid by medicaid.~~]

C. **Responsibility for claims:** A provider is responsible for all claims submitted under his national provider identifier or other provider number including responsibility for accurate coding that represents the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, the CMS correct coding initiative, and provider standards.

D. **No billing of recipients or third parties:** With the exception of WDI and SCHIP or other specified program co-payments or cost-sharing, a provider may not bill, turn over to collection, or accept payment from an eligible recipient, their personal representative or other third parties determined to be legally responsible for the balance of a claim except as specifically allowed by MAD regulations. Following MAD payment, a provider cannot seek additional payment from an eligible recipient or their personal representative in addition to the amount paid by MAD. Following MAD denial of payment due to provider administrative error in filing a claim, a provider cannot seek payment from an eligible recipient or their personal representative or turn the balance over to collection. See 8.302.3 NMAC, *Third Party Liability Provider Responsibilities*.

[2-1-95; 2-1-99; 8.302.1.15 NMAC - Rn, 8 NMAC 4.MAD.701.6, 7-1-01; A, 1-1-02; A, 6-1-08]

8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS: [~~Providers may bill recipients~~] A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:

A. [~~Recipients are~~] the eligible recipient is advised by the provider before services are furnished that a particular service is not covered by medicaid or other health care program, or that the particular provider does not accept patients whose medical services are paid for by [~~medicaid~~] MAD;

B. [~~Recipients are provided with information by providers about the necessity, options, charges for service, and the option of going to a provider who furnishes services to medicaid recipients; and~~] the eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment; and

C. [~~Recipients agree in writing to have specific services provided with knowledge that they are financially responsible for payment. The provider may bill the recipient, if an administrative error resulting in MAD's denial of payment was caused by the failure of the recipient to furnish identification before receiving services.~~] the eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.

[2-1-95; 2-1-99; 8.302.1.16 NMAC - Rn, 8 NMAC 4.MAD.701.7, 7-1-01;A, 6-1-08]

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: [~~Providers~~] A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to [~~recipients who are~~] an eligible recipient who is currently receiving or who [~~have~~] has received [~~medical~~] services in the past. [42 CFR 431.107(b)]. Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a crime punishable by fine. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. **Detail required in records:** Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, [~~servicing provider, level of services,~~] rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. **Services billed by units of time:** Services billed on the basis of time units spent with [recipients must be] an eligible recipient must be sufficiently detailed to document the actual time spent with [~~recipients~~] the eligible recipient and the services provided during that time unit.

D. **Recipient funds accounting systems:** If [~~a recipient~~] an eligible recipient entrusts [~~his/her~~] his personal funds to a nursing facility, intermediate care facility for the mentally retarded, or swing bed hospital, or any other facility, the facility [~~providers~~] provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. **Record retention:** [~~Providers who receive~~] A provider who receives payment for treatment, services, or goods [~~from MAD~~] must retain all medical and business records relating to any of the following for a period of at least [~~five (5) years~~] six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of medicaid.

(5) failure to maintain records for the required time period is a crime punishable by fine [NMSA 1978 30-44-5 (Repl. Pamp. 1989)].

[2-1-95; 2-1-99; 8.302.1.17 NMAC - Rn, 8 NMAC 4.MAD.701.8, 7-1-01; A, 6-1-08]

8.302.1.18 PATIENT CONFIDENTIALITY: [~~Providers are~~] A provider is required to comply with the HIPAA Privacy regulations. Confidential medical information regarding medicaid [~~applicants/recipients~~] or other health care program information on the applicant and/or eligible recipient must be released by providers to MAD, and to other state, or federal agencies, or their employees at no cost when:

A. the agency is involved in the administration of medicaid or other health information programs;

B. the information is to be used to establish eligibility, determine the amount of assistance or provide services related to medicaid or other health care programs;

C. the agency is subject to the same standards of confidentiality as MAD; and

[~~D. the agency has the actual consent of applicants or recipients for release of the information; and~~

~~E.~~]D. [~~consent is obtained when a recipient~~] the agency has the actual consent of applicant or eligible recipient or their personal representative for release of the information or consent is obtained when an eligible recipient or their personal representative or a member of the assistance group makes application for benefits or services with the human services department.

[2-1-95; 2-1-99; 8.302.1.18 NMAC – Rn, 8 NMAC 4.MAD.701.9, 7-1-01; A, 7-1-03; A, 6-1-08]

8.302.1.19 PROVIDER DISCLOSURE: [~~Providers~~] A provider must furnish MAD with the following information: See 42 CFR 431.107(b)(2)(3). 1) Name and address of each person with an ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent (5%) or more, and any relationship (spouse, child or sibling) of these persons to another; 2) Name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest; 3) Name of any person with an ownership or controlling interest in the entity who has been convicted of a criminal offense related to that person's involvement in any program established under the medicare or [~~medicaid~~] medical assistance programs; and 4) Name of any provider who employs or uses the services of an individual who, at any time during the year preceding this employment, was employed in a managerial, accounting, auditing or similar capacity, by an agency or organization which currently serves or at any time during the preceding year served as a medicare or [~~medicaid~~] MAD fiscal intermediary or carrier for the provider.

A. **Reports furnished by providers:** [~~Providers~~] Provider must give MAD, the appropriate MAD claims processing contractor, MAD audit contractor, MAD utilization review contractor or MAD designated representative financial reports, audits, certified cost statements, medical and other records, or any other data needed to establish a basis for reimbursement at no cost.

(1) All information regarding any claim for services must be provided. See 42 CFR 431.107(b)(2).

(2) Required cost statements must be furnished no later than [~~ninety (90)~~] 150 calendar days of the close of the provider's fiscal accounting period.

(3) Medicaid records and other documentation needed by MAD or its designee must be available within a defined period, upon request.

B. **Penalties:** MAD suspends payment for services until the required statements are furnished by the provider.

C. **Conflict of interest:** MAD does not enter into a [~~contract~~] provider participation agreement or other contract with a public officer, employee of the state, legislator, or business in which the individual has a substantial interest, unless the individual discloses his/her substantial interest and [~~the~~] provider participation agreement is accepted by MAD and any other contract is awarded pursuant to the state procurement code [NMSA 10-16-7 (Repl. Pamp. 1993)].

[2-1-95; 2-1-99; 8.302.1.19 NMAC - Rn, 8 NMAC 4.MAD.701.10, 7-1-01; A, 6-1-08]

8.302.1.20 TERMINATION OF PROVIDER STATUS:

A. Provider status may be terminated if the provider or MAD gives the other written notice of termination at least [~~thirty (30)~~] 60 calendar days before the effective termination date.

(1) Facility provider must also give at least [~~fifteen (15)~~] 15 calendar days notice to the public by publishing a statement of the date services are no longer available at the facility in one or more newspapers of general circulation within the affected county or region.

(2) Normal termination and notice limits do not apply if the state survey agency or health care financing administration determines that the health and safety of residents in a nursing [~~facilities~~] facility or intermediate care [~~facilities~~] facility for the mentally retarded or the children, youth and families department determines that the health and safety of children or adolescents in a residential treatment [~~centers~~] center, group [~~homes~~] home, or treatment foster care are in jeopardy.

B. **Grounds for denial or revocation of enrollment:** [~~The medical assistance division may deny or revoke enrollment in its medical assistance programs,~~] MAD may deny or terminate, for cause with a 30 calendar days notice, enrollment in its medical assistance programs, including but not limited to; medicaid (Title XIX of the Social Security Act) and other health insurance programs funded by the department, if any of the following are found to be applicable to the health care provider, his agent, a managing employee, or any person having an ownership interest equal to [~~five percent (5%)~~] 5 percent or greater in the health care provider:

(1) misrepresentation by commission or omission of any information on the MAD provider participation agreement enrollment form.

(2) previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in New Mexico medical assistance programs or health care programs, any other states medicaid program, medicare, or any other public or private health or health insurance program.

(3) conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under New Mexico medical assistance programs or health care programs, any other states medicaid program, medicare, or any other public or private health or health insurance program.

(4) conviction under federal or state law of a criminal offense relating to the neglect, or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(5) conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(6) conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(7) conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude, or acts against the elderly, children, or infirmed.

(8) conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this subsection.

(9) sanction pursuant to a violation of federal or state laws or rules relative to New Mexico medical assistance programs or health care programs, any other states medicaid program, medicare, or any other public health care or health insurance program.

(10) violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided.

(11) failure to pay recovery properly assessed or pursuant to an approved repayment schedule under New Mexico medical assistance programs.

(12) see 8.351.2 NMAC, *Sanctions And Remedies*. and 8.353.2 NMAC, *Provider Hearings*.

[2-1-95, 2-1-99; 8.302.1.20 NMAC - Rn, 8 NMAC 4.MAD.701.11, 7-1-01; A, 6-1-08]

8.302.1.21 CHANGE IN OWNERSHIP: As soon as possible, [~~and not less than thirty (30)~~] but at least (60) calendar days after a change in ownership, MAD reserves the right to withhold payment on all pending or current claims until any right MAD has to recoup portions or all of those payments is determined. Payment will not be withheld if MAD received written confirmation that the new owner or previous [~~medicaid~~] medical assistance program provider agrees to be responsible for any potential recoupment.
[2-1-95; 2-1-99; 8.302.1.21 NMAC - Rn, 8 NMAC 4.MAD.701.12, 7-1-01; A, 6-1-08]

8.302.1.22 PUBLIC DISCLOSURE OF SURVEY INFORMATION: The findings of a medicaid survey used to determine the ability of facility [~~providers~~] provider to begin or continue as medicaid participating [~~providers are~~] provider is available to the public within [~~ninety (90)~~] 90 calendar days of completion.

A. **Documents subject to disclosure:** Documents subject to public disclosure include:

(1) current survey reports prepared by the survey agency;

(2) official agency notifications of findings based on these reports, including statements of deficiencies;

(3) pertinent parts of written statements furnished by providers to the survey agency related to these reports and findings, including any corrective action taken or planned; and

(4) information regarding the ownership of nursing [~~facilities~~] facility. See 42 CFR 455.104(a).

B. **Release of performance reports:** Reports on [~~providers'~~] provider's or contractors' performance reviews and formal performance evaluations are not available to the public until [~~providers or contractors~~] provider or contractor have a reasonable opportunity (not to exceed 30 calendar days) to review the reports and offer comments. These comments become part of the reports.

C. **Availability of cost reports:** Provider cost reports used as a basis for reimbursement are available to the public upon receipt of a written request by the MAD audit contractor.

(1) Information disclosure is limited to cost report documents required by social security administration regulations, and in the case of a settled cost report, the notice of medicaid settlement.

(2) The request for information must identify the provider and the specific reports requested.

(3) The cost for supplying copies of the cost reports is billed to the requester.

[2-1-95; 2-1-99; 8.302.1.22 NMAC - Rn, 8 NMAC 4.MAD.701.13, 7-1-01; A, 6-1-08]