State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
BILLING FOR MEDICAID SERVICES
and
PROVIDER HEARINGS

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY
The Human Services Department, Medical Assistance Division, is proposing amendments to 8.302.2 NMAC, *Billing for Medicaid Services* and 8.353.2 NMAC, *Provider Hearing* rules to clarify regulatory language, assure accuracy of existing rules and update the rules to include a shorter claim timely filing process, limitations against providers billing recipients, and clarifications for the provider hearing process.

8.302.2 NMAC, *Billing for Medicaid Services*

- New language directing providers to follow the instructions of the appropriate coordinated service contractors and claims processing contractors;
- Reducing the timely filing limits from 120 days to 60 calendar days from the date of service;
- New language limiting and clarifying exceptions to filing limit requirements;
- New language limiting the conditions under which HSD may waive timely filing limits;
- New language limiting and clarifying the conditions under which a provider may seek reimbursement from a recipient; and
- Clarifying other billing and payment limitations.

8.353.2 NMAC, *Provider Hearings*

- Clarifying Scope and Limits on Provider Hearings;
- Adding an Informal Resolution Conference; and
- Clarifying pre-hearing activities to include: informal and pre-hearing conferences, scheduling and continuations, timeliness, unresolved issues, written summaries, pre-

conference orders, points of law, summary of evidence, evidence from HSD and providers, and additional evidence submission.

VI. RULE

These proposed rule changes refer to 8.302.2 NMAC *Billing for Medicaid Services,* and 8.353.2 NMAC, *Provider Hearings,* of the Medical Assistance Program Policy Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers. 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 March 15, 2010.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed regulations will be held at 9:00 a.m., on January 11, 2010, in the ASD Conference Room, Plaza San Miguel, 729 St. Michael's Drive, Santa Fe, New Mexico.

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:

Kathryn Falls, Acting 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 January 11, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

KATHRYN FALLS, ACTING SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 2 BILLING FOR MEDICAID SERVICES

8.302.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.302.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 5/1/04; A, 3/15/10]

8.302.2.3 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~~] Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978 [~~(Repl. Pamp. 1991)~~].
[2/1/95; 8.302.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 5/1/04; A, 3/15/10]

8.302.2.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide [~~policies~~] instruction 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; 8.302.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 5/1/04; A, 3/15/10]

8.302.2.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[2/1/95; 8.302.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 5/1/04; A, 3/15/10]

8.302.2.9 BILLING FOR MEDICAID SERVICES: [~~Direct health care to New Mexico medicaid program (medicaid) eligible recipients is furnished by a variety of provider groups. The reimbursement and billing for these services is administered by the New Mexico medical assistance division (MAD) [NMSA 1978 Section 27-1-3(G)(Repl. Pamp. 1991)].~~ [~~Once enrolled, providers receive and are responsible for the maintenance of a packet of information from MAD which includes program policies, billing instructions, utilization review instructions, and information on purchasing billing forms. This part describes general provider billing information, interest rate computation, and reimbursement methodologies. Specific reimbursement methodologies for a particular type of provider or service are listed in subsequent sections of this manual.~~] Health care for New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, billing instructions and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.
[2/1/95; 8.302.2.9 NMAC - Rn, 8 NMAC 4.MAD.702, 5/1/04; A, 3/15/10]

8.302.2.10 BILLING INFORMATION:

[~~A. Some services in the medicaid program are managed by coordinated service contractors. Contracted services may include behavioral health services, dental services, transportation, pharmacy or other benefits as designated by the medical assistance division. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of~~

~~remittance advices and payments. Providers must submit claims to the appropriate coordinated service contractors as directed by the medical assistance division.~~

~~B. The most currently approved HCFA-1500 form is used by professional service providers, such as physicians, independent laboratories, imaging providers or certified nurse practitioners to bill medicaid for services.~~

~~C. The HCFA-UB-92 form is used by hospitals, home health agencies, and other institutional providers for billing. The New Mexico turn around document (TAD) is used by nursing facilities, intermediate care facilities for the mentally retarded, and other residential providers to bill medicaid.~~

~~(1) **Billing for referral services:** Servicing providers must submit all information necessary to bill medicaid within specified time limits, if their performance of direct health care services for a recipient is furnished at the request of another practitioner. Recipients and medicaid are not responsible for payment if servicing providers fail to get this information.~~

~~(2) **Billing for other services:** Medicaid pays only providers or the following individuals or organizations for services:~~

~~(a) government agencies or third parties with court orders, based on a valid provider payment assignment. See 42 CFR Section 447.10(d)(e); or~~

~~(b) business agents, such as billing services or accounting firms, that furnish statements and receive payment in the name of the provider; the agent's compensation must be related to the cost of processing the claims and not related on a percentage or other basis to the amount that is billed or collected or dependent upon collection of the payment.~~

~~(3) **Billing for individual practitioner services:** MAD may make payments to employers of individual practitioners, if the practitioners are required to turn over their fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2)(3). MAD may make payments to a facility where services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system, if the facility, foundation, plan, or organization is required by contract to submit claims for individual practitioners.~~

~~(a) **Payment not allowed:** MAD does not pay for services furnished to recipients by providers which are made to or through factors, either directly or by power of attorney [42 CFR Section 447.10(h)]. A factor is an individual or an organization, such as a collection agency or service bureau.~~

~~(b) **No reimbursement for the discharge day:** Institutional providers, such as nursing facilities, hospitals, and intermediate care facilities for the mentally retarded and providers of treatment foster care services are reimbursed for services furnished to eligible recipients on the day of admission but are not reimbursed for services furnished on day of discharge.~~]

A. **Billing for services:** MAD only makes payment to a provider or to the following individuals or organizations for services:

(1) a government agency or third party with a court order, based on a valid provider payment assignment. See 42 CFR Section 447.10(d)(e); or

(2) a business agent, such as billing service or accounting firm that provides statements and receives payment in the name of the provider. The agent's compensation must be related to the cost of processing the claims and not based on a percentage of the amount that is billed or collected or dependent upon collection of the payment.

B. **Billing for services from group practitioners or employers of practitioners:** MAD may make payments to a group practice and to an employer of an individual practitioner if the practitioner is required to turn over his fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2)(3). MAD may make payments to a facility where the services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system if the facility, foundation, plan, or organization is required by contract to submit claims for an individual practitioner.

C. **Billing for referral services:** A referred provider must submit to the provider receiving the referral, specimen, image, or other record, all information necessary for the provider rendering the service to bill MAD within specified time limits. An eligible recipient or their personal representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider.

D. Hospital-based services: For services that are hospital based, the hospital must provide MAD recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, their personal representative, or MAD is not responsible for payment if the hospital-based provider does not obtain this information from the hospital as necessary to bill MAD within the specified time limits.

E. Coordinated service contractors: Some MAD services are managed by a coordinated service contractor. Contracted services may include behavioral health services, dental services, physical health services,

transportation, pharmacy or other benefits as designated by the medical assistance division. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.
[2/1/95; 8.302.2.10 NMAC - Rn, 8 NMAC 4.MAD.702.1, 5/1/04; A, 7/1/05; A, 3/15/10]

8.302.2.11 [~~CLAIM FILING LIMITATIONS:~~ ~~Claims for services must be submitted to the MAD claims processing contractor within 120 calendar days of the date the service was furnished. Requests for adjustments to rejected or denied claims must be submitted to the MAD claims processing contractor within six (6) months of the date on the "remittance advice" form which accompanied the payment or denial of the claim. All claims must be finalized within two (2) years of the date of service. For purposes of claims filing limits, the date of submission is the date the original claim was submitted to the MAD claims processing contractor, as identified by the assigned "internal control number".~~

~~A. **Exceptions to general time limitations**: If a claim is submitted to medicare within the applicable medicare time limits, MAD pays a claim for the co-insurance and deductible for the service up to six (6) months of the medicare payment or denial, subject to medicaid reimbursement limitations. If [a] recipient has insurance or a third party is liable for the payment, the claim must be submitted within 365 days of the date of service.~~

~~(1) If claims are submitted more than 120 days after the date of service, the statement of benefits from the other insurance or the denial of benefits from the other insurance must be attached to the claim to verify that the other payment source has been pursued.~~

~~(2) If a provider receives payment from the other insurance or liable third party after receiving payment from MAD, an amount equal to the lower of either the insurance payment or the amount paid by MAD must be immediately remitted to the MAD third party liability unit (MAD-TPLU).~~

~~(3) Claims for services furnished by out-of-state providers must be submitted within 120 days of the date of service. In the event the out-of-state provider does not have a New Mexico medicaid provider number, the request for the provider number must also be submitted within the 120 day limit.~~

~~(4) Claims for services provided during a period for which retroactive eligibility has been established must be submitted within 120 days of the date the MAD claims processing contractor was notified of the retroactive eligibility.~~

~~(a) Recipients must notify providers of pending eligibility and the date eligibility is received. Recipients are financially responsible for payment if the provider's claims are denied because of the recipient's representative's failure to notify the provider of the retroactive coverage within the 120 day filing limit.~~

~~(b) Documents certifying the retroactive eligibility must be attached to the claim or on any correspondence concerning the claim. Documents include printed copy of the eligibility computer screen, copy of the court ordered retroactive eligibility, or a signed statement from an income support specialist from a local county income support division office.~~

~~B. **Corrected claims:** Corrected claims which are originally submitted within the 120 day filing limit and need corrections or additions must be completed and submitted to MAD or its claims processing contractor within 365 days of the date of service.~~

~~C. **Duplicate claims:** Duplicate claims which are used to replace lost or unprocessed claims must be submitted within 120 days of the date of service. Providers are responsible for submitting duplicate claims within the applicable time periods.~~]

BILLING AND CLAIMS FILING LIMITATIONS:

A. Claims must be received within the MAD filing limits as determined by the date of receipt by MAD or its selected claims processing contractor.

(1) Claims for services must be received within 60 calendar days of the date of service unless an alternative filing limit is stated within this section.

(2) Inpatient hospital and other inpatient facility claims must be received within 60 calendar days of the date of the eligible recipient's discharge, transfer, or otherwise leaving the facility.

(3) When the provider can document that a claim was filed with another primary payer including medicare, medicaid managed care organizations, medicare replacement plans, or another insurer, the claim must be received within 60 calendar days of the date the other payer paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payer, not to exceed 180 calendar days from the date of service. It is the provider's responsibility to submit the claim to another primary payer within a sufficient timeframe to reasonably allow the primary payer to complete the processing of the claim and also meet the MAD timely filing limit. Denials by the primary payer due to the provider not meeting administrative requirements in filing the claim must be

appealed by the provider to the primary payer. The MAD program only considers payment for a claim denied by the other primary payer when under the primary payer's plan the MAD recipient is not eligible, the diagnosis, service or item is not within the scope of the benefits, benefits are exhausted, pre-existing conditions are not covered, or out-of-pocket expenses or the deductibles have not been met. MAD will evaluate a claim for further payment including payment toward a deductible, co-insurance, co-payment or other patient responsibility. Claims for payment towards a deductible, co-insurance, co-payment or other patient responsibility must also be received within 60 calendar days of the date of the other payer's payment, not to exceed 180 calendar days from the date of service.

(4) For an eligible recipient for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within 120 calendar days of the date the eligibility was added to the eligibility record of MAD or its selected claims processing contractor.

(5) For a provider of services not enrolled as a MAD provider at the time the services were rendered, including a provider that is in the process of purchasing an enrolled MAD provider entity such as a practice or facility, claims must be received within 60 calendar days of the date the provider is notified of the MAD approval of the provider participation agreement, not to exceed 180 calendar days from the date of service. It is the provider's responsibility to submit a provider participation agreement within a sufficient timeframe to allow completion of the provider enrollment process and submission of the claim within the MAD timely filing limit.

(6) For claims that were originally paid by a medicaid managed care organization from which the capitation payment is recouped resulting in recoupment of a provider's claim by the managed care organization, the claim must be received within 60 calendar days of the recoupment from the provider.

(7) For claims that were originally paid by MAD or its selected claims processing contractor and subsequently recouped by MAD or its selected claims processing contractor due to certain claims conflicts such as overlapping duplicate claims, a corrected claim subsequently submitted by the provider must be received within 60 calendar days of the recoupment.

B. The provider is responsible for submitting the claim timely, for tracking the status of the claim and determining the need to resubmit the claim.

(1) Filing limits are not waived by MAD due to the providers inadequate understanding of the filing limit requirements or insufficient staff to file the claim timely or failure to track pending claims, returns, denials, and payments in order to resubmit the claim or request an adjustment within the specified timely filing limitation.

(2) A provider must follow up on claims that have been transmitted electronically or on paper in sufficient time to resubmit a claim within the filing limit in the event that a claim is not received by MAD or its selected claims processing contractor. It is the provider's responsibility to re-file an apparently missing claim within the applicable filing limit.

(3) In the event the provider's claim or part of the claim is returned, denied, or paid at an incorrect amount the provider must resubmit the claim or an adjustment request within 60 calendar days of the date of the return, denial or payment of an incorrect amount, that was submitted in the initial timely filing period. This additional 60 calendar day period is a one-time grace period following the return, denial or mis-payment for a claim that was filed in the initial timely filing period and is based on the remittance advice date or return notice. Additional 60 calendar day grace periods are not allowed. However, within the 60 calendar day grace period the provider may continue to resubmit the claim or adjustment requests until the 60 calendar day grace period has expired.

(4) Adjustments to claims for which the provider feels additional payment is due, or for which the provider desires to change information previously submitted on the claim, the claim or adjustment request with any necessary explanations must be received by MAD or its selected claims processing contractor with the provider using a MAD-approved adjustment format and supplying all necessary information to process the claim within the one-time 60 calendar day allowed grace period.

C. The eligible recipient or their personal representative is responsible for notifying the provider of MAD eligibility or pending eligibility and when retroactive MAD eligibility is received. When a provider is informed of a recipient's MAD eligibility, the circumstances under which an eligible recipient or their personal representative can be billed by the provider are limited.

(1) The eligible recipient is financially responsible for payment if a provider's claims are denied because of the eligible recipient's or their personal representative's failure to notify the provider of established eligibility or retroactive eligibility in a timely manner sufficient to allow the provider to meet the filing limit for the claim.

(2) When a provider is informed of MAD eligibility or pending MAD eligibility prior to rendering a service, the provider cannot bill the eligible recipient or their personal representative for the service even if the claim is denied by MAD or its selected claims processing contractor unless the denial is due to the recipient not being

eligible for the MAD program or the service or item is not a benefit of the MAD program. In order to bill the eligible recipient for an item or service that is not a benefit of the program, prior to rendering the service or providing the item the provider must inform the eligible recipient or their personal representative that the service is not covered by the MAD program and obtain a signed statement from the eligible recipient or their personal representative acknowledging such notice. It is the provider's responsibility to understand or confirm the benefits of the MAD program and to inform the eligible recipient or their personal representative when the service is not a benefit of the program and to inform the eligible recipient or their personal representative.

(3) The provider must accept medicaid payment as payment in full and cannot bill a remaining balance to the eligible recipient or their personal representative other than a MAD allowed copayment, coinsurance or deductible.

(4) The provider cannot use a statement signed by the eligible recipient or their personal representative to accept responsibility for payment if the claim is denied as the basis to bill an eligible recipient or their personal representative unless such billing is allowed by MAD rules. It is the responsibility of the provider to meet the MAD program requirements for timely filing and other administrative requirements, to provide information to MAD or its selected claims processing contractor regarding payment issues on a claim, and to accept the decision of MAD or its selected claims processing contractor for a claim. The eligible recipient or their personal representative does not become financially responsible when the provider has failed to met the timely filing and other administrative requirements in filing a claim. The eligible recipient or their personal representative does not become financially responsible for payment for services or items solely because MAD or its selected claims processing contractor denies payment for a claim.

(5) The provider cannot bill the eligible recipient or their personal representative for charges that are denied for lack of medical necessity or not being an emergency unless the provider determined prior to rendering the service that medical necessity requirements or emergency requirements were not met and informed the eligible recipient that MAD will not pay for the services and the eligible recipient or their personal representative has signed a statement of the choice to proceed with the service or item.

(6) When a provider has been informed of MAD eligibility or pending MAD eligibility of a recipient, the provider cannot turn an account over to collections or to any other entity intending to collect from the eligible recipient or their personal representative. If a provider has turned an account over for collection, it is the provider's responsibility to retrieve that account from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor.

D. The filing limit does not apply to overpayments or money being returned to MAD or its selected claims processing contractor.

(1) If a provider receives payment from another source, such as an indemnity insurance plan, HMO, or responsible third party, after receiving payment from MAD, an amount equal to the lower of either the insurance payment or the amount paid through the medicaid program must be remitted to MAD or its selected claims processing contractor third party liability unit, properly identifying the claim to which the refund applies.

(2) For claims for which an over-payment was made to the provider, the provider must return the overpayment to MAD or its selected claims processing contractor. The timely filing provisions for payments and adjustments to claims do not apply when the provider is attempting to return an overpayment.

E. MAD or its selected claims processing contractor may waive the filing limit requirement in the following situations:

(1) An error or delay on the part of MAD or its selected claims processing contractor prevented the claim from being filed correctly within the filing limit period. In considering waiver of a filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim in a timely manner and the follow up efforts made to secure payment in a timely manner from the other payer.

(2) The claim was filed within the filing limit period but the claim is being reprocessed or adjusted for issues not related to the filing limit.

(3) The claim could not be filed timely by the provider because another payer or responsible party could not or did not process the claim timely or provide other information necessary to file the claim timely. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim and to follow up on the payment from another payer or responsible party in order to attempt to meet the MAD filing limit.

(4) A recipient for which MAD or Medicare eligibility was established by hearing, appeal, or court order. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the hearing or court decision.

(5) The claim is being reprocessed by MAD or its selected claims processing contractor for issues not related to the provider's submission of the claim. These circumstances may include when MAD is implementing retroactive price changes, or reprocessing the claim for accounting purposes.

(6) The claim was originally paid but recouped by another primary payer. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the recoupment.

F. The medicaid program is jointly funded through state and federal sources. Claims will not be processed when the federal timely filing standards are not met, thereby precluding federal financial participation in payment of the claim.

G. A provider may not bill an eligible recipient or their personal representative for a service or item when a claim is denied due to provider error in filing the claim or failing to meet the timely filing requirements. It is the provider's responsibility to understand or verify the specific MAD program in which an eligible recipient is enrolled, the covered or non-covered status of a service or item, the need for prior authorization for a service or item, and to bill the claim correctly and supply required documentation. The eligible recipient or their personal representative cannot be billed by the provider when a claim is denied because these administrative requirements have not been met.

(1) The provider cannot bill the eligible recipient or their personal representative for a service or item in the event of a denial of the claim unless the denial is due to the recipient not being eligible for the MAD program or the service is not a benefit of the MAD program and prior to rendering the service the provider informed the eligible recipient or their personal representative that the specific service or time is not covered by the MAD program and obtained a signed statement from the eligible recipient or their personal representative acknowledging such.

(2) The provider cannot bill the eligible recipient or their personal representative for the service in the event that a payment is recouped by another primary payer and MAD or its selected claims processing contractor determines that the claim will not be reimbursed by MAD or its selected claims processing contractor.

(3) The provider cannot turn an account over to collections or to any other factor intending to collect from the eligible recipient or their personal representative. If a provider has turned an account over to a collection agency, it is the provider's responsibility to retrieve that account back from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor.

H. When documentation is required to show the provider met applicable filing limits, the date a claim is received by MAD or its selected claims processing contractor will be documented by the date on the claim control number (TCN) as assigned by MAD or its selected claims processing contractor. Documentation of timely filing when another third party payer, including medicare, is involved will be accepted as documented on explanation of benefits payment dates and reason codes from the third party. Documentation may be required to be submitted with the claim.

[2/1/95; 8.302.2.11 NMAC - Rn, 8 NMAC 4.MAD.702.2 & A, 5/1/04; A, 3/15/10]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS: To receive payment for services furnished to [~~medicaid recipients who are~~] a MAD eligible recipient who is also entitled to medicare, [~~providers~~] a provider must first bill the appropriate medicare [~~intermediary or carrier.~~] payer. The medicare [~~intermediary or carrier~~] payer pays the medicare covered portion of the bill. After medicare payment, [~~the medicaid program~~] MAD pays the amount the medicare payer determines is owed for copayments, co-insurance and deductibles, subject to medicaid reimbursement limitations. When the medicare payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the coinsurance, deductible, or copayment. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare coinsurance, deductible, or copayment from the eligible recipient or their personal representative. For professional services for which medicare part B applies a 50 percent coinsurance rate, medicare coinsurance and deductible amounts are paid at an amount that allows the provider to receive up to 80 percent of the medicare allowed amount even if such amount exceeds the MAD allowed amount for the service. [~~Providers~~] A provider must accept assignment on medicare claims for MAD eligible recipients [~~before MAD will process payments~~]. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient or their personal representative that the provider is not a medicare provider or will not accept assignment; and that because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the MAD eligible recipient or their personal representative that the service is available from other providers who will accept assignment on a medicare claim. The provider cannot bill a dually eligible MAD recipient for a service that medicare cannot pay because the provider chooses not to participate in medicare, or which MAD cannot pay

because the provider chooses not to accept assignment on a claim, without the expressed consent of the MAD eligible recipient or their personal representative.

A. **Claim crossover:** If there is sufficient information for medicare to identify an individual as [~~medicaid recipients~~] a MAD eligible recipient, medicare may send payment information directly to the MAD claims processing [~~contractor~~] contractor in a form known as a "cross-over claim". [~~In all cases where claims fail to crossover automatically to MAD, providers must forward a copy of the medicare claim and medicare "explanation of benefits" (EOB) forms to the MAD claims processing contractor. This information must also be included when filing claims, if payments have not been made by MAD within six (6) weeks of the medicare payment.~~] In all cases where claims fail to crossover automatically to MAD, a provider must bill the appropriate MAD claims processing contractor directly, supplying the medicare payment and medicare "explanation of benefits" (EOB) information and meet the MAD filing limit.

B. [**~~Health maintenance organization plan coverage:~~**[~~When a medicaid eligible recipient belongs to a medicare HMO plan , the medicaid program limits payment for the claim to the medicaid allowed amount less the third party payment amount, not to exceed the copayment amount calculated by the HMO plan. If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment and the claim is considered paid in full. The provider may not collect any portion of the unpaid co-payment, co-insurance, or deductible from the client. All other HMO requirements, including servicing provider restrictions, apply to the provision of services.~~] **Medicare replacement plan or other health maintenance organization (HMO) plan:** When a MAD eligible recipient belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for copayments, coinsurance or deductible, subject to medicaid reimbursement limitations. When the payer payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the copayment, coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer copayment, coinsurance or deductible from the eligible recipient or their personal representative. For services for which medicare part B applies a fifty percent coinsurance rate, medicare coinsurance and deductible amounts are paid at the amount that allows the provider to receive up to 80 percent of the payer amount allowed even if the amount exceeds the MAD allowed amount for the services.

C. All other HMO and medicare replacement plan requirements, including provider network restrictions must be met for medicaid to make payment on a claim.

[2/1/95; 8.302.2.12 NMAC - Rn, 8 NMAC 4.MAD.702.3 & A, 5/1/04; A, 3/15/10]

8.302.2.13 BILLING FOR CONTRACTED SERVICES: [~~Medicaid reimburses only providers who actually furnish the services. However, in the following instances medicaid providers can bill and be paid for contractor services:~~] MAD only makes payment to a provider who actually rendered the services. However, in the following instances a MAD provider can bill and be paid for covered contracted services:

A. [~~Hospitals, nursing homes, intermediate care facilities for the mentally retarded, home health agencies, residential treatment centers, group homes, hospice agencies, federally qualified health centers, and rural health clinics can bill for contracted services if these costs appear in their cost reports.~~] A provider is reimbursed at encounter rates or other all-inclusive rates that may have some contracted services built into those rates. These providers include nursing facilities, intermediate care facilities for the mentally retarded, residential treatment centers, a group home, a hospice agency, a federally qualified health center, a rural health clinic, and an Indian health service or 638 facility.

B. [~~Physician groups, clinics, individual physicians, hospital professional components, nursing home professional components, fee-for-service providers, and other professional service providers can bill for services furnished by physicians under contract if the following apply:~~] A practitioner group, a clinic, an institutional professional component, and providers of professional services may bill for services furnished by practitioners under contract when the provider applications are approved by MAD, and the following apply:

(1) [~~the New Mexico medical assistance program provider participation application is completed by the contractor and approved by MAD; and~~] the MAD provider participation applications are completed by the billing entity and the practitioner rendering the service or in their employ; and

(2) [~~the physician contractor is listed as the servicing provider on the claim form.~~] The practitioner is listed as the rendering provider on the claim form.

C. Transportation providers may bill for contracted personnel, equipment or [~~vehicles if the services are covered medicaid benefits~~] vehicles.

D. [~~Providers may bill MAD directly for contracted services, such as the construction or assembly of prosthetic devices, dental, hearing and vision prosthesis, orthotics, equipment and repairs, when:~~] A provider may

bill MAD directly for contracted services for the construction or assembly of equipment or prosthetic devices, construction of dental devices and prosthetics, hearing and vision prosthesis, orthotics, and repairs, when:

(1) the provider customarily uses the dental laboratory, optical supplier, hearing aid supplier, [~~prosthetic, orthotic, equipment dealer~~] prosthetic or orthotic supplier equipment dealer, or manufacturer to do [~~the~~] work; and

(2) the contractor doing the work does not qualify as an eligible provider in his/her own right.

E. For all other contracted services not specified above, written prior approval must be obtained from MAD or its designee before the provision of services.

F. **Billing rates for contracted services:** All services provided by a contractor and billed through a participating [~~medicaid~~] MAD provider must be billed at a rate based on direct and indirect costs, plus a reasonable administrative charge. The billing provider [~~ensures that~~] must ensure all [~~medicaid~~] MAD requirements are met by the contractor furnishing the service, including prior approval requirements, if applicable. Reimbursement for contracted services is included in the fee paid to the provider. For example, the amount paid to a dentist for a crown includes the dentist's work fitting the crown and the dental lab fees for making the crown.

G. **Recipient freedom of choice:** [~~Providers~~] A provider cannot enter into contracts that are used to restrict [~~a~~] an eligible recipient's freedom of choice. Some restrictions to this freedom of choice may apply to the purchases of medical devices and laboratory and radiology tests, and transportation [42 CFR Section 431.54(e)].
[2/1/95; 8.302.2.13 NMAC - Rn, 8 NMAC 4.MAD.702.4, 5/1/04; A, 3/15/10]

8.302.2.14 BILLING AND PAYMENT LIMITATIONS:

A. **Payment not allowed:** MAD does not pay factors either directly or by power of attorney [42 CFR Section 447.10(h)]. A factor is an individual or an organization, such as a collection agency or service bureau.

B. **No reimbursement for the discharge day:** An institutional or other residential provider, such as a nursing facility, a hospital, an intermediate care facility for the mentally retarded, and a provider of treatment foster care services are reimbursed for services furnished to an eligible recipient on the day of admission but are not reimbursed for services furnished on day of discharge.

C. **No payment made for wrong services:** A provider shall not bill MAD for:

(1) services provided to the wrong patient

(2) a service performed on the wrong body part of an eligible recipient; and

(3) an incorrect procedure performed on an eligible recipient

D. Payments for acquired conditions: MAD may deny or limit payment on claims for services to treat a MAD eligible recipient for a condition acquired during the course of a facility stay or in the rendering of other services.
[2/1/95; 8.302.2.14 NMAC - Rn, 8 NMAC 4.MAD.702.5, 5/4/04' 8.302.2 NMAC - N, 3/15/10]

[~~8.302.2.14~~] 8.302.2.15 INTERVEST RATES ON COST SETTLEMENTS: [~~Medicaid~~] MAD charges interest on overpayments and pays interest on underpayments as a result of year-end cost settlements, unless waived.

A. **Interest periods:** Interest accrues from the date of the final determination of costs or from a date required by a subsequent administrative reversal. Interest is charged on the overpayment balance or paid on the underpayment balance for each [~~thirty (30)~~] 30 calendar day period that payment is delayed.

(1) For purposes of this provision, a final determination is considered to occur when:

(a) MAD, the MAD selected claims processing contractor, or the MAD audit contractor makes a written demand for payment or a written determination of underpayment; or

(b) a cost report which was filed in a timely manner indicates that an amount is due MAD and the amount due is not included with the report.

(2) The date of final determination for an additional overpayment or underpayment, as determined by the MAD audit contractor, is considered to occur if any of the previously mentioned events occur.

(3) The date of final determination for an unfiled cost report occurs the day after the date the cost report was due. A single extension of time not to exceed [~~thirty (30)~~] 30 calendar days is granted for good cause. A written request for the time extension must be received and approved by MAD before the cost report due date. When the cost report is filed, a second final determination date is calculated based on the occurrence of either of the aforementioned events.

B. **Interest rates:** The interest rate on overpayments and underpayments is based on the prevailing rate specified in bulletins issued under article 8020.20 of the treasury fiscal requirement manual. When [~~providers sign~~] a provider signs a repayment agreement with MAD for an overpayment, the following provisions apply:

(1) the rate of interest specified in the agreement is binding unless a default in the agreement occurs; or

(2) the rate of interest on the balance may change to the prevailing rate if the provider or supplier defaults on an installment and the prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

C. **Accrual of interest:** Even though a filed cost report does not show an overpayment, interest begins to accrue on the date of final determination, if MAD, the MAD audit contractor, or the MAD selected claims processing contractor determines that providers have been overpaid.

(1) Interest continues to accrue during administrative and/or judicial appeals and until final disposition of claims.

(2) If a cost report is filed which indicates that an amount is due MAD, interest on the amount due accrues from the date the cost report is filed unless:

(a) the full payment on the amount due accompanies the cost report; or

(b) the provider and the MAD audit contractor agree in advance to liquidate the overpayment through a reduction in interim payments over the next [~~thirty (30)~~] 30 calendar day period.

(3) If the MAD audit contractor determines that a further overpayment exists, interest accrues from the date of final determination.

(4) If the cost report is not filed, interest accrues from the day following the date the report was due, plus a single extension of time not to exceed [~~thirty (30)~~] 30 calendar days if granted for good cause, until the time the cost report is filed. Written requests for time extensions must be received [~~and approved~~] for approval by MAD before cost reports due dates.

(5) Interest accrues on an underpayment owed by MAD to [~~providers~~] a provider beginning [~~thirty (30)~~] 30 calendar days from the date of MAD's notification of the underpayment by the MAD audit contractor.

D. **Interest charge waivers:** MAD may waive the interest charges when:

(1) the overpayment is liquidated within [~~thirty (30)~~] 30 calendar days from the date of the final determination; or

(2) MAD determines that the administrative cost of collection exceeds the interest charges; interest is not waived for the period of time during which cost reports are due but remain unfiled for more than [~~thirty (30)~~] 30 calendar days.

E. **Interest charges with installment or partial payments:** If an overpayment is repaid in installments or recouped by withholding from several payments due to [~~billing providers~~] a billing provider, the amounts are applied in the following manner:

(1) each payment or recoupment is applied first to accrued interest and then to the principle; and

(2) after each payment or recoupment, interest accrues on the remaining unpaid balance; if an overpayment or an underpayment determination is reversed following an administrative hearing, appropriate adjustments are made on the overpayment or underpayment and the amount of interest charged.

F. **Allowable interest cost:** Allowable interest cost is the necessary and proper interest on both current and capital indebtedness. An interest cost is not allowable if it is one of the following:

(1) an interest assessment on a determined overpayment; or

(2) interest on funds borrowed to repay an overpayment; following an administrative review and favorable provider decision, interest paid on funds borrowed to repay an overpayment or the interest assessed on an overpayment becomes an allowable cost.

[8.302.2.15 NMAC - Rn, & A, 8.302.2.14 NMAC, 3/15/10]

TITLE 8 SOCIAL SERVICES
CHAPTER 353 PROVIDER HEARINGS
PART 2 PROVIDER HEARINGS

8.353.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[1-1-95; 8.353.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 7-1-01; A, 3-15-10]

8.353.2.3 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~~] Act as amended or by state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).
[1-1-95; 8.353.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7-1-01; A, 3-15-10]

8.353.2.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide [~~policies~~] instruction 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; 8.353.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7-1-01; A, 3-15-10]

8.353.2.8 MISSION STATEMENT: [~~The mission of the New Mexico Medical Assistance Division (MAD) is to maximize the health status of Medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the lives of their communities.
[2-1-95; 8.353.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7-1-01; A, 3-15-10]

8.353.2.9 PROVIDER HEARINGS: [~~The Human Services Department (HSD)~~] HSD has established a hearing process for medicaid fee-for-service (FFS) providers who disagree with HSD decisions concerning their participation in the New Mexico medicaid program, recoupment of overpayments due to provider billing error, and imposition of sanctions. For the hearing process [~~for~~] concerning decisions on noncompliance with nursing facility (NF) or intermediate care facility (ICF-MR) provider certification requirements, see hearing regulations promulgated by the department of health (DOH). This section describes the hearing process for [~~Medicaid fee-for-service~~] MAD FFS providers. See 8.311.3 NMAC, *Methods and Standards for Establishing Payment– Rates Inpatient Hospital Services*, 8.312.3 NMAC, *Cost Related Reimbursement for Nursing Facilities*, and [~~8.313.2~~] 8.313.3 NMAC, *Cost Related Reimbursement for Intermediate Care Facilities for the Mentally Retarded*for a description of the appeals process for audit settlements. [~~See 8.305.12 NMAC, MCO Member Grievance Resolution~~] See 8.305.12.16 NMAC, *mco/se provider appeal process*, 8.306.12.16 NMAC, *mco provider grievance process*, and 8.307.12.15 NMAC, *provider grievance appeal process*, for a description of the grievance process for resolving provider disputes between a New Mexico medicaid [~~MCO~~] managed care organizations (MCO) and [~~its~~] their contractors or subcontractors.

A. **Hearing rights:** The right to a hearing includes the right to:
(1) be advised of the nature and availability of a hearing;
(2) be represented by counsel or [~~other~~] its representative of the provider's choice;
(3) have a hearing which safeguards the provider's opportunity to present a case;
(4) have prompt notice and implementation of the hearing decision; and
(5) be advised that judicial review may be invoked to the extent such review is available under state law.

B. **Notice of rights:** Upon enrollment, [~~Medicaid~~] MAD providers receive written notice of hearing rights along with any HSD action notice concerning provider agreement termination, recoupment of overpayment due to provider billing error, or notice of sanction. This information includes a description of the method by which a hearing may be requested and a statement that the provider's presentation may be made by the provider or by [~~a~~] its representative.
[11-1-96; 8.353.2.9 NMAC – Rn, 8 NMAC 4.MAD.980 & A, 7-1-01; A, 3-15-10]

8.353.2.10 INITIATION OF HEARING PROCESS:

A. **Notice:** The hearing process is initiated by a provider's request for hearing made in response to an HSD action notice. See Section 8.351.2 NMAC, *Sanctions and Remedies*, for information concerning notice requirements.

B. **Time limits:** [~~General Medicaid fee-for-service provider have~~] A MAD FFS provider has 30 calendar days from the date of the HSD action notice to request a hearing. To be considered timely, the request must be received by HSD no later than the close of business of the specified day. Hearings are conducted and a written decision is issued to the provider within 120 calendar days from the date HSD receives the hearing request, unless the parties otherwise agree to an extension. If HSD seeks to impose a sanction or remedy or take another action against a provider, the provider may submit a written request for a stay of the effective date of imposition of the sanction, remedy, or action to [~~the Medical Assistance Division (MAD)~~] MAD. Granting of a stay is at the discretion of the MAD [~~Director~~] director.

C. [~~**Eligibility**~~**] Scope and limits on provider hearings:**

(1) A hearing is available to all [~~Medicaid fee-for-service~~] MAD FFS providers who submit a request in accordance with this section in a timely manner. A provider can request a hearing if:

(a) a provider application or renewal of an application is denied;

(b) the provider's participation is suspended or terminated; or

(c) the provider disagrees with a decision of MAD or its designee with respect to [~~utilization review, overpayment, recoupment, claims adjustment,~~] recovery of overpayments due to provider billing error including incorrect billing, or lack of documentation to support the medical necessity of a service, or that the service was provided, or imposition of a sanction or other remedy.

(2) **Denial or dismissal of request for hearing:** HSD may deny or dismiss a request for a provider hearing when:

(a) the request is not received in a timely manner or within the time period stated in the notice;

(b) the request is withdrawn[~~,~~] or canceled in writing by the provider or the provider's authorized representative;

(c) the sole issue presented concerns a federal or state law which requires an adjustment of compensation for all or certain classes of providers or services[~~,~~] unless the reason for the hearing request involves an alleged error in the computation of provider compensation;

(d) the provider fails to appear at a scheduled hearing without good cause; or

(e) the same issue has already been appealed or decided upon as to this provider and fact situation.

(f) the matter presented for hearing is outside the scope of issues which are subject to the provider hearing process. See Subsection C of 8.353.2.10 NMAC, *initiation of provider hearings*; and

[~~(f)~~] (g) the sole issue presented concerns [~~Medicaid~~] MAD MCO utilization management decisions, such as a decision to terminate, suspend, reduce, or deny services to members, untimely utilization reviews, [~~and/or~~] and provider payment issues, raised by a contracted or subcontracted MCO provider.

(3) A request for a hearing may be considered abandoned and therefore dismissed if neither the provider nor representative appears at the time and place of the hearing, unless, within [~~ten~~] 10 calendar days after the date of the scheduled hearing, the provider presents good cause for failure to appear. "Good cause" includes death in the family, disabling personal illness, or other significant emergencies.

(4) At the discretion of the hearing officer, other exceptional circumstances may be considered good cause.

D. **Method:** A request for hearing must be made in writing and must identify the provider and the underlying action.

E. **Acknowledgment of request:** The HSD hearing bureau sends acknowledgment of its receipt of a hearing request to the provider.

[~~F. **Scope of Appeal:** Medicaid providers may appeal the denial of their application to participate in the Medicaid program and all other matters which may be relevant to the action or imposition of sanctions or remedies by HSD.~~]

[11-1-96; 8.353.2.10 NMAC – Rn, 8 NMAC 4.MAD.981 & A, 7-1-01; A, 3-15-10]

8.353.2.11 PRE-HEARING PROCEDURE:

A. **Notice of hearing:** Not less than 30 calendar days before the hearing, written notice is given to all parties involved of the time, date, and place of the hearing. If an accommodation is necessary, the party must notify the hearing officer at least ten calendar days prior to the hearing. The provider is also given an explanation of the

hearing process and procedures and informed that HSD does not pay fees or costs incurred by the provider as a result of the hearing or appeal of the hearing decision.

B. **Postponement:** A provider may request, and is entitled to receive, one postponement of the scheduled hearing, as long as it does not interfere with the decision time frames. Requests for more than one postponement are considered, at the hearing officer's discretion, on a case-by-case basis.

C. **Expedited hearing:** The parties may request an expedited hearing in cases involving eligible recipient health, safety, or service availability issues. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. Granting an expedited hearing is at the discretion of the hearing officer.

D. **Group hearing:** A hearing officer may respond to a series of individual requests for hearings by conducting a single group hearing. Group hearing procedures apply only to cases where individual issues of fact are not disputed and where related issues of [~~state and/or federal law, regulation or policy~~] federal and state law, rules and policies or any combination of these are the sole issues being raised. In all group hearings, the regulations governing individual hearings are followed. Each provider is permitted to present his own case or to be represented by his own attorney or other person. If a group hearing is arranged, any provider has the right to withdraw from the group hearing in favor of an individual hearing.

~~[E. **Pre-Hearing Conference:** Upon receipt of a request for hearing, the hearing officer assigned to a case schedules a pre-hearing conference to be held within 30 calendar days of the receipt of the request.~~

~~(1) **Purpose of Conference:** The purposes of the pre-hearing conference include, but are not limited to:~~

~~(a) clarification, formulation and simplification of issues;~~
~~(b) resolution of some or all issues;~~
~~(c) exchange of documents and information;~~
~~(d) review of audit findings;~~
~~(e) reconsideration of a suspension or withholding of payments;~~
~~(f) establishing stipulations of fact to avoid unnecessary introduction of evidence at the hearing;~~
~~(g) identification of witnesses; and~~
~~(h) discussion of other matters that might help dispose of any of the issues.~~

~~(2) **Continuing and/or Rescheduling the Conference:** A pre-hearing conference may be continued or rescheduled with the consent of all parties, after the 30 calendar day time limit.~~

~~(3) **Matters Resolved at Conference:** The hearing officer may request the parties to submit a written summary of all issues resolved at the pre-hearing conference.~~

~~(4) **Matters Left Unresolved:** If all matters in controversy are not resolved at the pre-hearing conference, the hearing officer sets a hearing date within 30 calendar days of the last conference date, or at a later time agreed to by the parties, recognizing the 120 calendar day time constraints.~~

~~(5) **Pre-Hearing Order:** The hearing officer may, at his sole discretion, prepare or ask the parties to prepare a pre-hearing order. The pre-hearing order may contain:~~

~~(a) statements of any contested facts and issues;~~
~~(b) stipulation of matters not in dispute;~~
~~(c) list of witnesses to be called and the subject of their testimony;~~
~~(d) list of exhibits;~~
~~(e) discovery directives; or~~
~~(f) other matters relevant to the issues.~~

~~(6) **Pre-Hearing Memoranda:** The hearing officer or either of the parties may request submission of memoranda on points of law. The hearing officer may approve submission and set any limitations, in his discretion, and decide such points of law in summary judgment.~~

~~F. **Summary of Evidence:** A summary of evidence is a document prepared by HSD staff involved in the action or proposed action, or HSD counsel, that provides preliminary information to the hearing officer concerning the basis of an HSD action. The summary of evidence must be forwarded to the HSD Hearings Bureau within seven (7) calendar days of the receipt of the notice of a hearing request and must contain at least the following information:~~

~~(1) identifying information, including but not limited to the provider's name, telephone and address;~~
~~(2) the action or proposed action being appealed;~~
~~(3) the question or issue that must be decided at the hearing;~~
~~(4) information on which the action or proposed action is based with copies of any determination letters or notices concerning the action; and~~

~~(5) applicable state and federal regulations.~~

~~G. **Availability of Information:** The provider must be provided the information upon which the underlying action was based, HSD must:~~

~~(1) provide, on request, in a timely manner and without charge, any documents in its possession concerning the underlying action, that are not already in the provider's possession, and that are necessary for a provider or his representative to decide whether to request a hearing or to prepare for a hearing;~~

~~(2) allow the provider or his representative to examine all documents to be used at the hearing at a reasonable time before the date of the hearing and during the hearing. Confidential information protected from release, and other documents or records which the provider would not otherwise have an opportunity to challenge or contest, may not be introduced at the hearing or affect the hearing officer's decision; and~~

~~(3) present the provider with a copy of the summary of evidence.~~]

E. **Informal resolution conference:** The parties are encouraged to hold an informal resolution conference before the hearing to discuss the issues involved in the hearing. The informal resolution conference is optional and does not delay or replace the hearing process. Conference participants may include the provider or their personal representative, HSD or other responsible agency representatives, and the selected claims processing contractor. The purpose of the informal resolution conference is to informally review HSD's action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the hearing may also be clarified or further defined. Regardless of the outcome of the informal resolution conference, a hearing is still held, unless the provider makes a written withdrawal of the request of the hearing.

F. **Pre-hearing conference:** Upon receipt of a request for hearing, the hearing officer assigned to a case schedules a pre-hearing conference to be held within 30 calendar days of the receipt of the request. A pre-hearing conference is an informal proceeding and may occur telephonically.

(1) **Purpose of conference:** The purposes of the pre-hearing conference include, but are not limited to:

(a) expediting the disposition of the action;

(b) identification, clarification, formulation and simplification of issues;

(c) resolution of some or all issues;

(d) exchange of documents and information;

(e) preparing stipulations of fact to avoid unnecessary introduction of evidence at the hearing;

(f) review of audit findings;

(g) reconsideration of a suspension or withholding of payments;

(h) identifying the number of witnesses; and

(i) facilitating the settlement of the case.

(2) **Scheduling:** A scheduling order shall be entered into, which shall set the due date for the summary of evidence, due date for exhibits, and sets the date for the hearing. The order shall issue as soon as practicable but in any event within 30 days of the request for hearing.

(3) **Continuations and rescheduling:** A pre-hearing conference may be continued or rescheduled with the consent of all parties, after the 30 calendar days time limit.

(4) **Settlements, stipulations and admissions:** No offer of settlement made in a pre-hearing conference is admissible as evidence at a later hearing. Stipulations and admissions are binding and may be used as evidence at the hearing. Any stipulation, settlement or consent order reached between the parties is written and signed by the hearing officer and the parties or their representatives.

(5) **Timeliness:** The pre-hearing conference will not delay or replace the hearing itself. Pre-hearing conferences may include the provider or their personal representative, HSD or other responsible agency representatives, and the selected claims processing contractor. Subsequent to the conference or in the event that any of the parties to the hearing fail to participate, the scheduled hearing is still held, unless the provider submits a written request for withdrawal.

(6) **Unresolved issues:** If all matters in controversy are not resolved at the pre-hearing conference, the hearing officer sets a hearing date within 30 calendar days of the last conference date, or at a later time agreed to by parties, recognizing the 120 calendar day time constraints.

(7) **Written summaries:** The hearing office may request the parties to submit a written summary of all issues resolved at the pre-hearing conference.

(8) **Pre-hearing order:** The hearing officer may, at his sole discretion, prepare or ask the parties to prepare a pre-hearing order. The pre-hearing order may contain:

(a) statements of any contested facts and issues;

(b) stipulation of matters not in dispute;

(c) list of witnesses to be called and the subject of their testimony;
(d) list of exhibits;
(e) discovery directives; or
(f) other matters relevant to the issues.

(9) **Points of law:** The hearing officer or either of the parties may request submission of memoranda on points of law. The hearing officer may approve submission and set any limitations, in his discretion, and decide such points of law in summary judgment.

G. **Summary of evidence:** A summary of evidence is a document prepared by HSD staff involved in the action or proposed action or HSD counsel that provides preliminary information to the hearing officer concerning the basis of an HSD action.

(1) The summary will be completed as soon as practicable but in any event within five working days of the hearing and will be forwarded to the HSD hearing officer and all parties involved.

(2) The summary must be prepared and submitted within the time frame even if the informal resolution conference has not been completed.

(3) Failure to provide the summary of evidence may result in its exclusion or a continuance of the hearing at the discretion of the hearing officer pursuant to Subsection D of 8.353.2.13 NMAC, *conducting the hearing.*

(4) MAD staff or other responsible agency representatives is responsible for preparation of the summary of evidence and coordination of parties and witnesses when the MAD selected claims processing contractor is party to the fair hearing.

(5) The summary of evidence will contain:

(a) identifying information, including but not limited to the provider's name, telephone and address and the status of any previous or concurrent grievance through the MAD selected claims processing contractor;
(b) the action, proposed action or inaction being appealed;
(c) the issue or issues to be decided at the hearing;
(d) information on which the action or proposed action is based, and facts and findings related to the hearing issues, along with supporting documentation and correspondence. Some or all of the involved documentation may be provided by the MAD selected claims processing contractor; and
(e) applicable federal and state law, rules and policies or any combination of these.

H. **Availability of provider evidence:**

(1) The provider or his personal representative shall make any evidence that is planned to be introduced at the hearing available to HSD/hearings bureau at least three days prior to the hearing. The hearings bureau will forward to MAD copies of any evidence. MAD will then make these available to its selected claims processing, contractor if appropriate.

(2) All measures should be taken to ensure that this evidence is received with sufficient time to review before the hearing.

(3) Failure to provide the documentary evidence may result in its exclusion or a continuance of the hearing at the discretion of the hearing officer pursuant to Subsection D of 8.353.2.13 NMAC, *conducting the hearing.*

I. **Availability of information: HSD must:**

(1) provide, on request, in a timely manner and without charge, any documents in its procession concerning the underlying action, that are not already in the provider's possession, and that are necessary for a provider or his personal representative to decide whether to request a hearing or to prepare for a hearing;

(2) allow the provider or his personal representative to examine all documents to be used at the hearing at a reasonable time before the date of the hearing and during the hearing. Confidential information protected from release, and other documents or records which the provider would not otherwise have an opportunity to challenge or contest, may not be introduced at the hearing or affect the hearing officer's decision or become part of the hearing record; and

(3) present the provide with a copy of the summary of evidence.

[11-1-96; 8.353.2.11 NMAC – Rn, 8 NMAC 4.MAD.982 & A, 7-1-01; A, 3-15-10]

8.353.2.12 HEARING STANDARDS:

A. **Rights at hearing:** The parties are given an opportunity to:

(1) present their case or have it presented by a representative; bring witnesses to present information relevant to the case; and submit evidence to establish all pertinent facts and circumstances in the case;

(2) advance arguments without undue interference; and

(3) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

B. **Hearing officer:** Hearings are conducted by an impartial official who: 1) does not have any personal stake or involvement in the case; and 2) was not involved in the determination or the action which is being contested; if the hearing officer had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, he must disqualify himself as the hearing officer for that case.

(1) **Authority and duties of the hearing officer:** The hearing officer must:

(a) explain how the hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence considered necessary to decide the issues raised;

(d) regulate the conduct and the course of the hearing and any pre-hearing conference to ensure an orderly hearing;

(e) request, if appropriate, an independent medical assessment or professional evaluation from a source mutually satisfactory to the parties; and

(f) [~~provide~~] produce the hearing report and recommendation for review and final decision.

(2) **Appointment of hearing officer:** The hearing officer is appointed by the HSD hearings bureau chief upon receipt of the request for hearing. All communications are to be addressed to the assigned officer.

C. **Evidence:** Formal rules of evidence and civil procedure do not apply. A free, orderly exchange of relevant information is necessary for the decision-making process. The hearing officer may question any witness in order to clarify testimony. All relevant evidence is admissible subject to the hearing officer's authority to limit repetitive or unduly cumulative evidence and his ability to conduct an orderly hearing. The hearing officer must admit evidence: 1) relevant to those allegations against the provider included in the notice of recovery of overpayment, sanction or other remedy, application denial, or application termination; and 2) which pertains to contested issues set forth in the pre-hearing order[~~; or 3) Which the hearing officer believes, in his opinion, is the sort of evidence upon which responsible persons may reasonably rely in the course of serious affairs~~] .

(1) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the hearing in the presence of the provider or provider's representative and HSD representative [~~available to the provider~~] may not be [~~presented to the hearing officer nor~~] used by the hearing officer in making the hearing recommendation, except as allowed by Subsection E of 8.353.2.13 NMAC, *conducting the hearing*.

(2) **Administrative notice:** The hearing officer may take administrative notice of any matter in which courts of this state may take judicial notice.

(3) **Privilege:** The rules of privilege apply to the extent that they are required to be recognized in civil actions in the District Courts of New Mexico.

(4) **Medical issues:** In a case involving medical issues, the parties may submit expert testimony, reports, affidavits or medical records into record as necessary. Admission of this evidence is at the discretion of the hearing officer. All parties to the hearing have the right to examine any documents which may influence the decision.

D. **Burden of proof:** HSD has the burden of proving the basis to support its proposed action by a preponderance of the evidence. HSD must prove allegations of fraud by clear and convincing evidence. In cases involving the imposition of civil money penalties against a nursing facility provider, HSD's conclusion about the nursing facility's level of noncompliance must be upheld unless clearly erroneous.

E. **Record of the hearing:** A hearing is electronically recorded. The recording is placed on file at the hearings bureau and is available to the parties for 60 calendar days following the decision. In addition to the recorded proceedings, the record of the hearing includes any pleadings, documents, or other exhibits admitted into evidence. If a hearing decision is appealed, a written transcript of the hearing is prepared by HSD and a copy of the transcript is supplied to the provider. Either party may request copies of the recording in addition to the transcript. [11-1-96; 8.353.2.12 NMAC – Rn, 8 NMAC 4.MAD.983 & A, 7-1-01; A, 3-15-10]

8.353.2.13 CONDUCTING THE HEARING: A hearing is conducted in an orderly manner and in an informal atmosphere. The hearing is conducted in person and is not open to the public. The hearing officer has the authority to limit the number of persons in attendance if space or other considerations dictate.

A. **Opening the hearing:** The hearing is opened by the hearing officer. Individuals present must identify themselves for the record. The hearing officer explains his role in the proceedings, and that the final decision on the appeal will be made by the MAD Director after review of the proceedings and the hearing officer's recommendation. The order of testimony is described, and the oath is administered to all who will testify at the hearing.

B. **Order of testimony:** The order of testimony at the hearing is as follows:

(1) opening statements of parties or representatives;

(2) presentation of HSD's case. If witnesses are called, the order of examination of each witness is:

(a) examination by HSD representative;

(b) cross examination by the provider or representative; and

(c) further questions or clarification by the hearing officer or, if requested, the HSD representative or the provider or provider representative.

(3) presentation of the provider's case. If witnesses are called, the order of examination of each witness is:

(a) examination by provider or representative;

(b) cross examination by HSD or its representative; and

(c) further questions or clarification by the hearing officer or, if requested, provider or its representative, or HSD.

(4) presentation of rebuttal evidence by HSD and provider, respectively;

(5) the hearing officer may direct further questions to HSD representative, the provider, or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the hearing officer may ask both parties to summarize and present closing arguments.

C. **Written closing argument:** At the discretion of the hearing officer, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

D. **Continuance:** The hearing officer may continue the hearing upon the request of either party or on his own motion, for admission of additional testimony or evidence. The granting of a continuance is at the discretion of the hearing officer and can only be allowed when the timeliness of a decision is not jeopardized by the continuance or the parties have agreed to an extension of the decision time frame. The reasons for the continuance must be stated for the record. Written notice of the date, time, and place of the continued hearing is sent to the parties if these are not set at the time of the continuance.

E. **Additional evidence:** [~~If the hearing officer needs further documentary evidence, he may close the hearing but keep the record open and direct the parties to submit such further evidence. Each party receives a copy of the documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within ten calendar days of its receipt.~~] If the hearing officer needs additional evidence to further clarify documentary evidence presented during the hearing, he may close the hearing but keep the record open and, if agreed by all parties at the hearing, direct the parties to submit such clarifying evidence. Each party receives a copy of the direction for further evidence and the documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within 10 calendar days of its receipt. The additional evidence and responses become part of the hearing record.

F. **Re-opening a hearing:** The hearing officer, at his discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision time frames. Written notice of the date, time and place of the re-opened hearing is sent to the parties not less than ten calendar days before the re-opened hearing.

[11-1-96; 8.353.2.13 NMAC – Rn, 8 NMAC 4.MAD.984 & A, 7-1-01; A, 3-15-10]

8.353.2.14 HEARING DECISION: The final decision concerning the hearing is made by the MAD [~~Director~~] director after review of the record and the hearing officer's report and recommendation.

A. **Decision based on the record:** [~~The MAD Director's decision and the~~] The hearing officer's recommendation must be based on the record created by the hearing. This includes the record of the testimony, all reports, documents, forms, and other appropriate materials[~~,~~] made available at the hearing, provided that both parties were given an opportunity to examine them as part of the hearing [~~process.~~] and the additional evidence allowed. See Subsection E of 8.353.2.13 NMAC, *conducting the hearing*.

B. **Hearing officer recommendation:** The hearing officer reviews the record of the hearing and all appropriate regulations, and evaluates the evidence submitted. The hearing officer submits the complete record of the hearing, along with his written recommendation to the MAD [~~Director~~] director.

(1) Content of recommendation. The hearing officer specifies the reasons for his conclusions, identifies the supporting evidence, references the pertinent [~~Medicaid regulation(s)~~] MAD rules, and responds to the arguments of the parties in a written report and recommendation.

(2) The hearing officer recommends:

(a) in favor of the provider if HSD's action or proposed action is not supported by a preponderance of the evidence available as a result of the hearing. With respect to allegations of fraud, the hearing officer recommends in favor of the provider if the allegation is not supported by clear and convincing evidence;

(b) in favor of HSD, if the preponderance of the evidence available supports the action or proposed action. Allegations of fraud must be supported by clear and convincing evidence; or

(c) any other result supported by the record.

C. **Review of recommendation:** The hearing file and recommendation are reviewed by the MAD [~~Director~~] director or designee to ensure conformity with applicable federal and state law, regulations, and policy.

D. **Final decision:** The hearing officer's recommendation may be adopted or rejected in a final written decision by the MAD [~~Director~~] director on issues that were the subject of the hearing. The MAD [~~Director~~] director specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the [~~decision~~] decision, including the record created by the hearing, applicable federal and state law, rules and policies or any combination of these. No person who participated in the original action under appeal or in the hearing may participate in arriving at a final decision.

E. **Notice to parties:** The parties receive the written decision, including the effective date of sanctions, terms of sanctions, and amounts of overpayment to be recovered by HSD. When the provider is represented by legal counsel, counsel must receive the decision. The notice of the decision includes an explanation that the parties have exhausted all administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.

[11-1-96; 8.353.2.14 NMAC – Rn, 8 NMAC 4.MAD.985 & A, 7-1-01; A, 3-15-10]