State of New Mexico
Human Services Department
Human Services Register

HUMAN SERVICES DEPARTMENT

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)
8.302.2 NMAC BILLING FOR MEDICAID SERVICES, **8.308.14** NMAC COST SHARING, AND **8.309.4** MAD ADMINISTRATIVE BENEFITS AND LIMITATION OF SERVICES, **8.200.430** RECIPIENT RIGHTS AND RESPONSIBILITIES, AND **8.243.600** WORKING DISABLED INDIVIDUALS (WDI) BENEFIT DESCRIPTION

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to amend the following rules that are part of the New Mexico Administrative Code (NMAC): **8.302.2** *Billing for Medicaid Services,* **8.308.14** *Cost Sharing,* and **8.309.4** *MAD Administrative Benefits and Limitation of Services*, **8.200.430** *Recipient Rights and Responsibilities,* and **8.243.600** *Working Disabled Individuals (WDI) Benefit Description.* The Department's intent by amending these rules is to simplify the cost sharing process. Specifically the changes are:

1. Cost sharing for emergency department use will be removed for the Working Disabled Individuals (WDI) and Children's Health Insurance Program (CHIP) populations.

2. WDI copayment for pharmacy will be lowered to $3.00 from $5.00.

3. Alternative Benefit Plan (ABP) copayments will be removed except for the non-emergent use of the emergency department and unnecessary use of a brand name drug.

4. Non-emergent use of the emergency department co-payment will be set at $8.00 regardless of the federal poverty level (FPL). The unnecessary use of brand name drug co-payment will be $3.00.

5. Amended 8.243.600 NMAC Section 13 Subsection D Paragraph (2) to require a provider to submit a claim for reimbursement from 120 days to 90 calendar days which the standard timeframe for submission of MAD claims from a provider.

6. Amended 8.309.4 NMAC Section 10 Subsection M and N to provide clarifying language for these two covered benefits.

VI. RULES

These proposed rules will be contained in 8.302.2 NMAC, 8.308.14 NMAC, and 8.309.4, 8.200.430, and 8.243.600 NMAC. This register and the proposed changes are available on the HSD website at http://www.hsd.state.nm.us/LookingForInformation/registers.aspx . If you do not have internet access, a copy of the proposed rules may be requested by contacting MAD at 505-827-3118.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective October 1, 2014.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held in the Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road Santa Fe on Tuesday, September 2, 2014 at 1:30 p.m. Mountain Daytime Time (MDT).

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 MAD 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 10 working days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

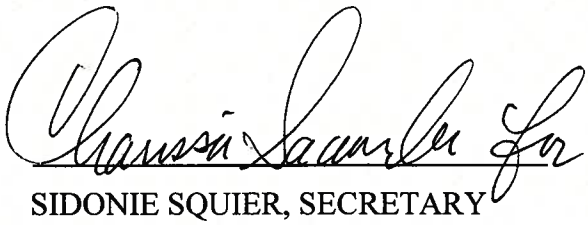
Interested persons may address written comments to:

Sidonie Squier, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5 p.m. on September 2, 2014, MDT. Written and recorded comments will be given the same consideration as oral testimony made at the public hearing. Recorded comments may be left at *(505) 827-3118*. Interested persons may also address comments via electronic mail to: JenniferL.Chavez1@state.nm.us.

X. PUBLICATIONS

Publication of these rules approved by:



SIDONIE SQUIER, 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).
[8.302.1 NMAC - Rp, 8.302.1 NMAC, 1-1-14]

8.302.2.2 SCOPE: The rule applies to the general public.
[8.302.2 NMAC - Rp, 8.302.2 NMAC, 1-1-14]

8.302.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services (HHS) under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.302.3 NMAC - Rp, 8.302.3 NMAC, 1-1-14; A, xx-xx-14]

8.302.2.4 DURATION: Permanent.
[8.302.4 NMAC - Rp, 8.302.4 NMAC, 1-1-14]

8.302.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.302.5 NMAC - Rp, 8.302.5 NMAC, 1-1-14]

8.302.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.302.6 NMAC - Rp, 8.302.6 NMAC, 1-1-14]

8.302.2.7 DEFINITIONS:

A. "Authorized representative" means the individual designated to represent and act on behalf of the eligible recipient or member's behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient or member.

B. "Eligible recipient" means an individual who has met a medical assistance program (MAP) category of eligibility and receives his or her medical assistance division (MAD) services through the fee-for-service (FFS) program.

C. "Member" means a MAP eligible recipient and who receives his or her MAD services through a HSD contracted managed care organization (MCO).
[8.302.7 NMAC - Rp, 8.302.7 NMAC, xx-xx-14]

8.302.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.302.8 NMAC - Rp, 8.302.8 NMAC, 1-1-14]

8.302.2.9 BILLING FOR MEDICAID SERVICES: Health care for New Mexico [~~medical assistance division (MAD) medical assistance program~~] MAP eligible recipients and members 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 (PPA) 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 (UR) instructions, and other pertinent material. 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. MAD makes available on the 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 instructions, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, 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. See 8.308.14 NMAC for additional MCO provider responsibilities.

[8.302.9 NMAC - Rp, 8.302.9 NMAC, 1-1-14; A, xx-xx-14]

8.302.2.10 BILLING INFORMATION:

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 referring 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 authorized representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider. Ordering, referring, prescribing, rendering and attending providers must participate in a [~~medicaid managed care plan~~] MCO or the [~~medicaid~~] MAD fee for service (FFS) program, or otherwise be identifiable as a participating, out-of-network, or in-network provider for services, as determined by MAD.

D. **Hospital-based services:** For services that are hospital based, the hospital must provide [~~MAD~~] MAP recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room (ER) physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, member or his or her [~~their~~] authorized 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 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 MAD. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, (UR), claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.

F. **Reporting of service units:** A provider must correctly report service units.

(1) For current procedural terminology (CPT) codes or healthcare common procedural coding system (HCPCS) codes that describe how units associated with time should be billed, providers are to follow those instructions.

(2) For CPT or HCPCS for services for which the provider is to bill 1 unit per 15 minute or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or one hour.

time spent	**number of 15-minute units that may be billed**	**number of 1-hour units that may be billed**
Less than 8 minutes	0 *services that are in their entirety less than 8 minutes cannot be billed.*	0 *services that are in their entirety less than 8 minutes cannot be billed.*
8 minutes through 22 minutes	1	.25
23 minutes through 37 minutes	2	.5

38 minutes through 52 minutes	3	.75
53 minutes through 67 minutes	4	1
68 minutes through 82 minutes	5	1.25
83 minutes through 97 minutes	6	1.5

(3) Only time spent directly working with an eligible recipient or member to deliver treatment services is counted toward the time codes.

(4) Total time spent delivering each service using a timed code must be recorded in the medical record of each eligible recipient or member. If services provided are appropriately described by using more than one CPT or HCPCS code within a single calendar day, then the total number of units that can be billed is limited to the total treatment time. Providers must assign the most units to the treatment that took the most time.

(5) The units for codes do not take precedence over centers for medicare and medicaid services (CMS) national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to 8.310.5 NMAC.

(7) Units billed by a home and community-based services waiver provider, a behavioral health provider, an early intervention provider, and all rehabilitation services providers must also follow the requirements of this section unless exceptions are specifically stated in published MAD program rules or provider billing instructions.

G. **Applying co-payments:** MAD has established co-payments for specified groups of eligible recipients and members for specific services. Exemptions and limits apply to the collection of co-payments.

(1) **Provider responsibilities for collection of co-payments:**

(a) The professional provider is responsible for collecting any applicable co-payments due for any outpatient visit or service provided, including a physician, other practitioner, clinic, urgent care, dental, outpatient therapy, or behavioral health session or visit.

(b) The hospital provider is responsible for collecting any applicable co-payments due for any emergency department (ED) or inpatient services provided.

(i) In the situation where there has been a non-emergent use of the ED by an eligible recipient or member, the hospital is responsible for determining if there is a co-payment due and, if so, collecting the co-payment. Before assessing a co-payment for non-emergent use of the ED, a hospital must consider the medical needs of the eligible recipient or member to judge whether care is needed immediately or if a short delay in treatment would be medically acceptable and any particular challenges the eligible recipient or member may face in accessing follow-up care, such as leave from employment, child care, ability to receive language assistance services, or accessible care for people with disabilities.

(ii) Before assessing a co-payment for non-emergent use of the ED, hospitals must first provide the eligible recipient or member with the name and location of an available and accessible provider that can provide the service at lesser or no cost sharing and provide a referral to coordinate scheduling for treatment by an alternative provider. If geographical or other circumstances prevent the hospital from meeting this requirement, the co-payment may not be imposed. If the eligible recipient or member chooses to receive services from the alternative provider, the co-payment may not be assessed. If, after being advised of the available alternative provider and of the amount of the co-payment due, the eligible recipient or member chooses to continue to receive treatment for a non-emergent condition at the hospital's ED, the hospital shall then assess and collect the co-payment.

(c) The pharmacy is responsible for collecting any co-payments due for drug items dispensed.

(i) When a brand name drug is prescribed, the co-payment for unnecessary use of a brand name drug does not apply when the brand name drug is medically necessary because the available therapeutically equivalent generic alternative would be less effective for treating the eligible [~~recipient's~~] recipient or member's condition, would have more side effects, or a higher potential for adverse reactions exists. If there is no medical justification for the use of the brand name drug, the co-payment for unnecessary use of a brand name drug applies and is collected by the pharmacy.

(ii) If the prescriber has stated that the brand name drug is medically necessary on the prescription and the claim is billed with a dispense as written indicator, the co-payment cannot be applied unless the pharmacy ascertains that the reason for the brand name drug is something other than the medical necessity. This co-payment does not apply to psychotropic drugs. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(d) The provider may not deny covered care or services to an eligible recipient or member because of the eligible [~~recipient's~~] recipient or member's inability to pay the co-payment amount at the time of service. The eligible recipient or member remains liable for the co-payment. The provider may attempt to collect the co-payment amount at a later appointment or by billing the eligible recipient or member.

(e) After an eligible [~~recipient's~~] recipient or member's assistance unit has reached the maximum out-of-pocket cost sharing limit (five percent of the eligible [~~recipient's~~] recipient or member's family's income, calculated on a quarterly basis), a provider shall reimburse any co-payments that it has collected from the eligible recipient or member in excess of the maximum out-of-pocket cost sharing limit. This includes anytime a provider receives a remittance advice indicating that the co-payment was not deducted from the reimbursement.

(f) A provider is required to report the co-payment amount charged on the CMS-1500, UB, or pharmacy claim form or their corresponding electronic billing transactions.

(g) [~~A provider shall accept the amounts paid by MAD or the MAD contracted managed care organization (MCO plus any applicable co-payment as payment in full.~~] When a co-payment is applied to a claim, a provider shall accept the amounts paid by MAD or the MCO plus the applicable co-payment as payment in full.

(h) A provider may not impose more than one type of cost sharing for any service.

(2) **Provider to understand the application of co-payments:** The provider is responsible for understanding and applying the rules for co-payment including when to contact the payer to determine if a co-payment is applicable for the service for the specific eligible recipient or member.

(a) Co-payments are not applied when one or more of the following conditions are met:

(i) the service is a medicare claim or medicare advantage claim, or follows other insurer payment, so the payment is therefore toward a deductible, co-insurance, or co-payment determined by the primary payer;

(ii) the eligible recipient or member is a native American;

(iii) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the eligible recipient or member;

(iv) the service is a provider preventable condition or is solely to treat a provider preventable condition;

(v) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;

(vi) the maximum family out-of-pocket cost sharing limit has been reached;

(vii) the service was rendered prior to any eligibility being established including when eligibility is retroactively established to the time period of the service; or

(viii) the eligible recipient, member or service is exempt from co-payment as otherwise described in these rules.

(b) Other than a co-payment for non-emergent use of the ED or for unnecessary use of a brand name drug, co-payments are not applied when the services are one of the following:

(i) family planning services, procedures drugs, supplies, or devices;

(ii) preventive services (well child checks, vaccines, preventive dental cleanings/exams, periodic health exams) unless treatment is rendered; or

(iii) prenatal and postpartum care and deliveries, and prenatal drug items.

(c) A hospital provider must determine the eligible recipient or member is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED if necessary

(3) **Payment of claims with applicable co-payment:**

(a) Payment to the provider will be reduced by the amount of an eligible [~~recipient's~~] recipient or member's applicable cost sharing obligation, regardless of whether the provider has collected the payment, unless the uncollected co-payment is for non-emergent use of the ED.

(b) A provider may not adopt a policy of waiving all [~~MAP~~] MAD co-payments or use such a policy to promote his or her practice.

(4) **Children's health insurance program (CHIP) co-payment requirement:** Eligible recipients or members whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients or members:

(a) $2 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $5 per dental visit, unless all the services are preventive services;

[~~(d) $15 per ED visit, unless a copayment for non-emergent use of the ED is assessed or if the eligible recipient or member is admitted as an inpatient in which case the inpatient hospital co-payment applies;~~]

[~~(e)~~] (d) $25 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;

[~~(f)~~] (e) [~~$5~~] $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

[~~(g)~~] (f) [~~$50~~]$8 for non-emergent use of the ED.

(5) **Working disabled individual's copayment requirements (WDI):** Eligible recipients or members whose benefits are determined using criteria for WDI are identified by their category of eligibility. The following co-payments apply to WDI eligible recipients or members:

(a) [~~$5~~] $3per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $7 per dental visit, unless all the services are preventive services;

(d) [~~$20 per ED visit, unless a co-payment for non-emergent use of the ED is assessed or if the eligible recipient is admitted as an inpatient in which case the inpatient hospital co-payment applies;~~]

(e) $30 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;

(f) [~~$8~~] $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(g) [~~$28~~] $8 for non-emergent use of the ED.

[~~(6) **Alternative benefit plan (ABP) co-payment requirements for federal poverty level (FPL) less than or equal to 100 percent and for ABP exempt recipients:** [When an eligible recipient's benefits are determined using criteria for ABP are identified by their category of eligibility and are at an FPL less than or equal to 100 percent or ABP exempt recipients, no co-payments apply except for unnecessary services. The following co-payments apply to these ABP eligible recipients:~~

~~(a) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and~~

~~(b) $8 for non-emergent use of the ED.~~

~~(7) **Alternative benefit plan co-payment requirements for FPL between 101 and 138 percent:** When eligible recipient's benefits are determined using criteria for ABP are those identified by their category of eligibility and at an FPL between 101 and 138 percent co-payments do apply. The following co-payments apply to these ABP eligible recipients:~~

~~(a) $3 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;~~

~~(b) $8 per outpatient physician or other practitioner, dental visit, rehabilitative or habilitative therapy session (does not apply to ER facility or ER professional charges; does apply to outpatient hospital clinic visits and urgent care visits, but is applied to the professional service, not the facility charge);~~

~~(c) $8 per dental visit, unless all the services are preventive services;~~

~~(d) $25 per inpatient hospital admission unless the hospital is receiving the recipient as a transfer from another hospital;~~

~~(e) $8 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply;~~

~~(f) $8 for non-emergent use of the ED; and~~

~~(g) a co-payment does not apply to exempt services meeting the definition at section 1932(b)(2) of the social security act and 42 CFR section 438.114 [a]), unless the co-payment is for non-emergent use of the ED or for unnecessary use of a brand name drug, including:~~

~~(i) conditions described in Paragraph (2), Subsection G of this section;~~

~~(ii) services for eligible recipients enrolled in hospice;~~

~~(iii) behavioral health and substance abuse services;~~

~~(iv) psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision);~~

~~[(v) recipients who have a disability type code of MH or PH on his or her eligibility file; and~~

~~(vi) emergency services.~~]

(6) Alternative benefit (ABP and APB exempt) co-payment requirements:

(a) $8 for non-emergent use of the ED; and

(b) a co-payment does not apply to exempt services meeting the definition at section 1932(b)(2) of the social security act and 42 CFR section 438.114 [a]), unless the co-payment is for non-emergent use of the ED or for unnecessary use of a brand name drug, including:

(i) conditions described in Paragraph (2), Subsection G of this section;

(ii) services for eligible recipients enrolled in hospice;

(iii) behavioral health and substance abuse services;

(iv) psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision);

(c) no co-payment is applied when the claim is for a co-insurance, deductible or co-payment following payment from a primary payer, including medicare;

(d) no co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility;

(e) the provider shall not charge these co-payments when:

(i) the eligible recipient or member is native American;

(ii) the eligible recipient or member is in foster care or has an adoption category of eligibility;

(iii) the service is not for a MAP category of eligibility such as being funded by the department of health children's medical services program; or

(iv) the eligible recipient or member reside in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has an institutional care category of eligibility.

[~~(8)~~](7) **All other MAD eligible recipients and members:** Providers shall charge the following co-payment amounts on other MAP eligible recipients or members only in the event of a non-emergent use of the ED or unnecessary uses of a brand name drug. No other co-payments apply.

(a) $3 for unnecessary use of a brand name drug;

(b) $8 for non-emergent use of the ED if the eligible recipient or member has an income of less than or equal to 150 percent of FPL;

(c) $50 for non-emergent use of the ED if the eligible recipient or member has an income over 150 percent of FPL;

(d) no co-payment is applied when the claim is for a co-insurance, deductable or co-payment following payment from a primary payer, including medicare;

(e) no co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility;

(f) the provider shall not charge these co-payments when:

(i) the eligible recipient or member is native American;

(ii) the eligible recipient or member is in foster care or has an adoption category of eligibility;

(iii) the eligible recipient or member does not have a MAP category of eligibility such as being eligible only for the department of health children's medical services program; or

(iv) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has an institutional care category of eligibility.

H. For purposes of this section, FPL [~~meant~~] means the poverty guidelines updated periodically in the federal register by [~~the U.S. department of health and human services~~] HHS under the authority of 42 U.S.C. 9902(2).

I. **Billing state gross receipts tax:** For providers subject to, and registered to pay, gross receipts tax and registered to pay gross receipts tax, the provider may include gross receipt tax in the billed amount when the tax applies to the item or service. The provider may only bill tax to the extent the tax is also charged to the general public. A provider may not include gross receipts tax in the billed amount when the provider is not obligated to pay gross receipts tax to the state.

[8.302.10 NMAC - Rp, 8.302.10 NMAC, 1-1-14; A, xx-xx-14]

8.302.2.11 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 90 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 90 calendar days of the date of the eligible [~~recipient's~~] recipient or member'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~~] a HSD contracted MCO, medicare replacement plans, or another insurer, the claim must be received within 90 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 210 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~~] MAD only considers payment for a claim denied by the other primary payer when under the primary payer's plan the [~~MAD~~] eligible recipient or ,member 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 also must be received within 90 calendar days of the date of the other payer's payment, not to exceed 210 calendar days from the date of service.

(4) For an eligible recipient or member 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~~] 90 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 90 calendar days of the date the provider is notified of the MAD approval of the PPA, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit a PPA 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~~] HSD contracted MCO from which the capitation payment is recouped resulting in recoupment of a provider's claim by the MCO, the claim must be received within 90 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 90 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 hard copy 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 90 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 90 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 90 calendar day grace periods are not allowed. However, within the 90 calendar day grace period the provider may continue to resubmit the claim or adjustment requests until the 90 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 90 calendar day allowed grace period.

C. The eligible recipient, member or [~~their~~] his or her authorized representative is responsible for notifying the provider of [~~MAD~~] MAP eligibility or pending eligibility and when retroactive [~~MAD~~] MAP eligibility is received. When any provider including an enrolled provider, a non-enrolled provider, a MCO provider, and an out-of-network provider is informed of a recipient's [~~MAD~~] MAP eligibility, the circumstances under which an eligible recipient, member or [~~their~~] his or her authorized representative can be billed by the provider are limited.

(1) When the provider is unwilling to accept the eligible recipient as a [~~MAD~~] fee-for-service (FFS) eligible recipient or a MCO [~~eligible recipient~~] member, the provider must provide the eligible recipient, member or [~~their~~] his or her authorized representative written notification that they have the right to seek treatment with another provider that does accept [~~MAD~~] a FFS eligible recipient or a MCO [~~eligible recipient~~] member. It is the provider's responsibility to have the eligible recipient, member or [~~their~~] his or her authorized representative receive and sign a statement that they are aware the proposed service may be covered by MAD if rendered by an approved MAD or [~~MAD~~] MCO provider and that by authorizing a non-approved provider to render the service, they agree to be held financially responsible for any payment to that provider. A provider may only bill or accept payment for services from an eligible recipient, member or [~~their~~] his or her authorized representative if all the following requirements are satisfied:

(a) The eligible recipient, member or [~~their~~] his or her authorized representative is advised by the provider before services are furnished that he or she does not accept patients whose medical services are paid for by MAD.

(b) The eligible recipient, member or [~~their~~] his or her authorized representative is advised by the provider regarding the necessity, options, and the estimated charges for the service, and of the option of going to a provider who accepts MAD payment.

(2) The eligible recipient or member is financially responsible for payment if a provider's claims are denied because of the eligible recipient, member or [~~their~~] his or her authorized 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.

(3) [~~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 authorized 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 authorized representative the service is not covered by the MAD program and obtain a signed statement from the eligible recipient or their authorized representative acknowledging such notice. It is the provider's responsibility to understand or confirm the benefits of the MAD program the benefits and to inform the eligible recipient or their authorized representative when the service is not a benefit of the program and to inform the eligible recipient or their authorized representative.~~] When a provider is informed of MAP eligibility or pending eligibility prior to rendering a benefit, the provider cannot bill the eligible recipient, member or his or her authorized representative for the benefit 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 MAP category of eligibility or the benefit, or item is not a MAD benefit. In order to bill the eligible recipient or member for an item or benefit that is not a MAD benefit, prior to rendering the benefit or providing the item the provider must inform the eligible recipient, member or his or her authorized representative the benefit is not covered by MAD and obtain a signed statement from the eligible recipient, member or his or her authorized representative acknowledging such notice. It is the provider's responsibility to understand or confirm the eligible recipient or member's MAD benefits and to inform the eligible recipient, member or his or her authorized representative when the benefit is not a MAD benefit and to inform the eligible recipient, member or his or her authorized representative.

(4) The provider must accept [~~medicaid~~] MAD payment as payment in full and cannot bill a remaining balance to the eligible recipient, member or [~~their~~] his or her authorized representative other than a MAD allowed copayment, coinsurance or deductible.

(5) If the provider claim is denied, the provider cannot use a statement signed by the eligible recipient, member or [~~their~~] his or her authorized representative to accept responsibility for payment 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, member or [~~their~~] his or her authorized 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, member or [~~their~~] his or her authorized 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.

(6) When a provider has been informed of [~~MAD~~] MAP 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, member or [~~their~~] his or her authorized 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 and to notify the eligible recipient or member.

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 any insurance plan, or other 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~~] MAD 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. For more details see 8.351.2 NMAC. 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) An eligible recipient or member for whom [~~MAD~~] MAP 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.

(7) The claim is from a federal IHS facility operating within [~~the federal department of health and human services~~] HHS which is responsible for native American health care or is a PL 93-638 tribally operated hospital and clinic which must be finalized within two years of the date of service.

(8) The claim is from a [~~medicaid~~] MAD school-based service program when providing services to a [~~MAD~~] eligible recipient or member through an individualized education plan or an individualized family service plan to which an initial filing limit of 90 calendar days is applied.

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

G. A provider may not bill an eligible recipient, member or [~~their~~] his or her authorized 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~~] MAP category of eligibility in which an eligible recipient or member 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, member or [~~their~~] his or her authorized 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, member or [~~their~~] his or her authorized 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~~] service; or if the service is not a MAD benefit [~~of the MAD program~~], prior to rendering the service the provider informed the eligible recipient, member or [~~their~~] his or her authorized representative that the specific service is not covered by[~~the MAD program~~] MAD and obtained a signed statement from the eligible recipient, member or [~~their~~] his or her authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient, member or [~~their~~] his or her authorized 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, member or [~~their~~] his or her authorized 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.

(4) The provider cannot bill the eligible recipient, or member or his or her authorized representative for office tasks such as billing claims, checking eligibility, making referrals calls, in the form of either routine charges or as penalties including missed appointments, failure to cancel an appointment, failure to show eligibility card or similar charges unless specifically allowed by MAD rules.

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 transaction 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.

[8.302.11 NMAC - Rp, 8.302.11 NMAC, 1-1-14; A, xx-xx-14]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS: To receive payment for services furnished to [~~a MAD~~] an eligible recipient or member who is also entitled to medicare, a provider must first bill the appropriate medicare payer. The medicare payer pays the medicare covered portion of the bill. After medicare payment, MAD pays the amount the medicare payer determines is owed for copayments, co insurance and deductibles, subject to [~~medicaid~~] MAD reimbursement limitations. If a medically necessary service is excluded from medicare and it is a [~~medicaid~~] MAD covered[~~services~~]benefit, MAD will pay for service. 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 authorized representative. For behavioral health professional services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at an amount that allows the provider to receive 80 percent of the medicare allowed amount even if such amount exceeds the MAD allowed amount for the service. A provider must accept assignment on medicare claims for MAD eligible recipients and members. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient, member or [~~their~~] his or her authorized representative that the provider is not a medicare provider or will not accept assignment; and because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the [~~MAD~~] eligible recipient, member or [~~their~~] his or her authorized representative of the estimated amount for which the eligible recipient member will be responsible, that service is available from other providers who will accept assignment on a medicare claim, and identify an alternative provider to whom the eligible recipient or member may seek services. The provider cannot bill a dually eligible [~~MAD~~] MAP recipient or member 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, member or [~~their~~] his or her authorized representative even when the medicare eligibility is established retro-actively and covers the date of service.

A. **Claim crossover:** If there is sufficient information for medicare to identify an individual as a [~~MAD~~] eligible recipient or member, medicare may send payment information directly to the MAD claims processing contractor in a form known as a "cross-over claim". 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. **Medicare replacement plan or other health maintenance organization (HMO) plan:** When a [~~MAD~~] eligible recipient or member 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~~] MAD 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, member or [~~their~~] his or her authorized representative. For behavioral health services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member 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~~] MAD to make payment on a claim.

[8.302.12 NMAC - Rp, 8.302.12 NMAC, 1-1-14; A, xx-xx-14]

8.302.2.13 BILLING FOR CONTRACTED 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. 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 NF, [~~intermediate care facilities (ICF) IID~~] ICF-IDD, residential treatment centers, a group home, a hospice agency, a federally qualified health center, a rural health clinic, and an IHS or tribal 638 facility.

B. 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 MAD provider participation applications are completed by the billing entity and the practitioner rendering the service or in their employ; and

(2) the practitioner is listed as the rendering provider on the claim form.

C. Transportation providers may bill for contracted personnel, equipment or vehicles.

D. 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 or orthotic supplier equipment dealer, or manufacturer to do work; and

(2) the contractor doing the work does not qualify as an eligible provider in his or 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 MAD provider must be billed at a rate based on direct and indirect costs, plus a reasonable administrative charge. The billing provider must ensure all 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:** A provider cannot enter into contracts that are used to restrict an eligible [~~recipient's~~] recipient or member'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)], or for providers whose enrollment is under a moratorium as identified or approved by the secretary of the federal HHS or by CMS.

[8.302.13 NMAC - Rp, 8.302.13 NMAC, 1-1-14; A, xx-xx-14]

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 NF, a hospital, an ICF-IID, and a provider of treatment foster care services are reimbursed for services furnished to an eligible recipient or member 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 or member; and

(3) an incorrect procedure performed on an eligible recipient or member.

D. **Payments for acquired conditions:** MAD may deny or limit payment on claims for services to treat [~~a MAD~~] an eligible recipient or member for a condition acquired during the course of a facility stay or in the rendering of other services.

[8.302.14 NMAC - Rp, 8.302.14 NMAC, 1-1-14; A, xx-xx-14]

8.302.2.15 INTERIM RATES ON COST SETTLEMENTS: 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 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 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 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 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 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 30 calendar days if granted for good cause, until the time the cost report is filed. Written requests for time extensions must be received for approval by MAD before cost reports due dates.

(5) Interest accrues on an underpayment owed by MAD to a provider beginning 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 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 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 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.

[8.302.15 NMAC - Rp, 8.302.15 NMAC, 1-1-14]

HISTORY OF 8.302.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

SP-004.1902, Methods and Standards of Establishing Payment Rates - Other Types of Care, filed 3-5-81.
SP-004.2000, Section 4, General Program Administration Direct Payments to Certain Recipients for Physician's or Dentist's Services, filed 3-5-81.
SP-004.2100, Section 4, General Program Administration Prohibition Against Reassignment of Provider Claims, filed 3-5-81.
SP-006.0100, Section 6, Financial Administration Fiscal Policies and Accountability, filed 3-5-81.
SP-006.0200, Section 6, Financial Administration Cost Allocation, filed 3-5-81.
SP-006.0300, Section 6, Financial Administration State Financial Participation, filed 3-5-81.
SP-004.1905, Definition of Timely Payment Requirement for the State of New Mexico, filed 6-10-81.
ISD 304.1000, Provider Reimbursement Responsibility, filed 1-7-80.
ISD 304.1000, Provider Reimbursement Responsibility, filed 9-9-81.
ISD 304.2000, Recipient Reimbursement Responsibility, filed 1-9-80.
ISD 304.3000, Reimbursement Limitations, filed 1-7-80.
ISD 304.3000, Reimbursement Limitations, filed 9-9-81.
ISD 304.3000, Reimbursement Limitations, filed 12-17-85.
ISD 304.4000, Billing Limitations, filed 1-7-80.
ISD 304.4000, Billing Limitations, filed 9-9-81.
ISD 304.7000, Reimbursement To Out-of-State Providers, filed 1-7-80.
ISD 304.7000, Reimbursement To Out-of-State Providers, filed 9-9-81.
ISD 304.8000, Third Party Liability, filed 1-7-80.
ISD 304.8000, Third Party Liability, filed 9-9-81.
ISD 304.9000, Usual and Customary, filed 1-7-80.
ISD 304.9000, Reasonable Charge Pricing, filed 9-9-81.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 2-17-84.
ISD Rule 304.9000, Reasonable Charge Price, filed 3-30-84.
MAD Rule 304.9, Reimbursement, filed 12-15-87.
MAD Rule 304.9, Reimbursement, filed 8-11-88.
MAD Rule 304, Billing and Reimbursement, filed 11-8-89.
MAD Rule 304, Billing and Reimbursement, filed 4-21-92.

History of Repealed Material:

MAD Rule 304, Billing And Reimbursement, filed 4-21-92 - Repealed effective 2-1-95.
8.302.2 NMAC, Billing for Medicaid Services, filed 4-16-04 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 14 COST SHARING

8.308.14.1 ISSUING AGENCY: New Mexico Human Services Department (HSD)
[8.308.14.1 NMAC - N, 1-1-14]

8.308.14.2 SCOPE: This rule applies to the general public.
[8.308.14.2 NMAC - N, 1-1-14]

8.308.14.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.14.3 NMAC - N, 1-1-14]

8.308.14.4 DURATION: Permanent.
[8.308.14.4 NMAC - N, 1-1-14]

8.308.14.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.14.5 NMAC - N, 1-1-14]

8.308.14.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.14.6 NMAC - N, 1-1-14]

8.308.14.7 DEFINITIONS:

A. **Co-payment:** A fixed dollar amount that must be paid at the time a MAD service is provided or a prescription is filled.

B. **Emergency medical condition:** A medical or behavioral health condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment of bodily functions;

(3) serious dysfunction of any bodily organ or part; or

(4) serious disfiguration to the member.

C. **Unnecessary utilization of services:**

(1) The unnecessary utilization of a brand name drug means using a brand name drug is not on the first tier of a preferred drug list (PDL) instead of a alternative lesser expensive drug item that is on the first tier of a PDL, unless in the prescriber's estimation, the alternative drug item available on the PDL would be less effective for treating the member's condition, or would likely have more side effects or a higher potential for adverse reactions for the member.

(2) The unnecessary utilization of an emergency department (ED) is when a member presents to an emergency room for service when the condition of the member is not an emergency medical condition and considered non-emergent after considering the medical presentation of the member, age, and other factors, but also alternative providers that may be available in the community at the specific time of day.
[8.308.14.7 NMAC - N, 1-1-14]

8.308.14.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.14.8 NMAC - N, 1-1-14]

8.308.14.9 COST SHARING IN MEDICAID MANAGED CARE PROGRAM: The medical assistance division (MAD) imposes cost-sharing (out-of- pocket) provisions on certain members, certain categories of eligibility and on certain services. Cost-sharing includes co-payments, coinsurance, deductibles, and other similar

charges. The member's HSD contracted managed care organization (MCO) is required to impose the following co-payments as directed by MAD and in accordance with federal regulations.

A. **General requirements regarding cost sharing:**

(1) The MCO or its contracted providers may not deny services for a member's failure to pay the co-payment amounts.

(2) The MCO must take measures to educate and train both its contracted providers and members on cost-sharing requirements, and must include, at a minimum:

(a) educating and working with the MCO's hospital providers on the requirements related to non-emergency utilization of the emergency department (ED); and

(b) for co-payments required in the case of a non-emergency utilization of an ED (an unnecessary use of services) the hospital is required, before imposing cost sharing, to provide the member with a name of and location of an available and accessible provider that can provide the service with lesser or no cost sharing and provide a referral to coordinate scheduling; if geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.

(3) The MCO shall not impose cost-sharing provisions on certain services that, in accordance with federal regulations, are always exempt from cost-sharing provisions. See CFR 447.56, *Limitations on Premiums and Cost Sharing,* 8.200.430 NMAC and 8.302.2 NMAC.

(4) The MCO shall not impose cost-sharing provisions on certain member categories of eligibility [populations] that, in accordance with federal and state regulations and rules, are exempt from cost-sharing provisions. The MCO and its contracted providers are required to impose co-payments on its members in the case of unnecessary utilization of specific services as outlined in Subsection B of Section 9 of this rule, unless the [~~eligible recipient~~] member is exempt from the copayments; see Subsection B of Section [~~10~~] 9of this rule.

(5) Payments to MCO contracted providers: In accordance with 42 CFR 447.56, *Limitations on Premiums and Cost Sharing* and New Mexico state statute 27-2-12.16:

(a) the MCO must reduce the payment it makes to a non-hospital contracted provider by the amount of the member's applicable cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing; and

(b) the MCO must not reduce the payment it makes to a contracted hospital provider by the amount of the member's cost sharing obligation if the contracted hospital provider is not able to collect the cost sharing obligation from the member.

(6) At the direction of MAD, the MCO must report all cost-sharing amounts collected.

(7) The MCO may not impose more than one type of cost sharing for any service, in accordance with 42 CFR 447.52.

(8) The MCO must track, by month, all co-payments collected from each individual member in the household family to ensure that the family does not exceed the aggregate limit (cap). The cap is five percent of countable family income for all individual members in a household family calculated as applicable for a quarter. The MCO must be able to provide each member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

(9) The MCO must report to the provider when a copayment has been applied to the provider's claim and when a copayment was not applied to the provider's claim. The MCO shall be responsible for assuring the provider is aware that:

(a) the provider shall be responsible for refunding to the member any copayments the provider collects after the [~~eligible recipient~~] member has reached the co-payment cap (five percent of the [~~eligible recipient's~~] member's family's income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from copayment due to the timing of claims processing;

(b) the provider shall be responsible for refunding to the member any copayments the provider collects for which the MCO did not deduct the payment from the provider's payment whether the discrepancy occurs because of provider error or MCO error; and

(c) failure to refund a collected copayment to a member and to accept full payment from the MCO may result in a credible allegation of fraud, see 8.351.2 NMAC.

B. **Unnecessary utilization of services co-payments:** The use of a brand name prescription drug in place of a generic [~~therapeutic~~]therapeutically equivalent on the PDL and the utilization of the emergency room for non-ED services are both considered to be unnecessary utilization of services. [~~Some members are exempt from copayments for unnecessary utilization of services.~~] Providers shall charge the following co-payment amounts on other MAP eligible recipients or members, including ABP, only in the event of a non-emergent use of the ED or unnecessary uses of a brand name drug. No other co-payments apply.

(a) $3 for unnecessary use of a brand name drug;

(b) $8 for non-emergent use of the ED if the eligible recipient or member has an income of less than or equal to 150 percent of FPL;

(c) no co-payment is applied when the claim is for a co-insurance, deductible or co-payment following payment from a primary payer, including medicare;

(d) no co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility;

(e) the provider shall not charge these co-payments when:

(i) the eligible recipient or member is native American;

(ii) the eligible recipient or member is in foster care or has an adoption category of eligibility;

(iii) the eligible recipient or member does not have a MAP category of eligibility such as being eligible only for the department of health children's medical services program; or

(iv) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has an institutional care category of eligibility.

(1) When a member obtains a brand name prescription drug in place of a generic therapeutic equivalent on his or her MCO's PDL, the MCO and dispensing pharmacy must impose a co-payment in the amount specified by MAD for the member, unless the member is exempt from copayments for unnecessary utilization of services or the use of the drug does not meet the definition for unnecessary utilization of a brand name drug as defined in this section. The MCO is responsible for determining when this unnecessary utilization of service has taken place and if so, the dispensing pharmacy is responsible for collecting the co-payment from the member.

(2) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(3) The MCO shall develop a co-payment exception process, to be prior approved by MAD, for legend drugs when generic alternatives are not tolerated by a member.

[8.308.14.9 NMAC - N, 1-1-14; A, 6-1-14; A, xx-xx-14]

8.308.14.10 CO-PAYMENT AMOUNTS IN MANAGED CARE PROGRAMS: The copayment amounts, the application and exemptions of copayments are determined by MAD. See CFR 447.56, *Limitations on Premiums and Cost Sharing*, 8.200.430 NMAC and 8.302.2 NMAC.

[8.308.14.10 NMAC - N, 1-1-14]

HISTORY OF 8.308.14 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 309 ALTERNATIVE BENEFIT PROGRAM
PART 4 MAD ADMINISTERED BENEFITS AND LIMITATION OF SERVICES

8.309.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.309.4.1 NMAC - N, 1-1-14]

8.309.4.2 SCOPE: This rule applies to the general public.
[8.309.4.2 NMAC - N, 1-1-14]

8.309.4.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.309.4.3 NMAC - N, 1-1-14]

8.309.4.4 DURATION: Permanent.
[8.309.4.4 NMAC - N, 1-1-14]

8.309.4.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.309.4.5 NMAC - N, 1-1-14]

8.309.4.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.309.4.6 NMAC - N, 1-1-14]

8.309.4.7 DEFINITIONS: [RESERVED]

8.309.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.309.4.8 NMAC - N, 1-1-14]

8.309.4.9 ALTERNATIVE BENEFITS PLAN SERVICES WITH LIMITATIONS (ABP): The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). MAD covers ABP specific services for an ABP eligible recipient. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP eligible recipient: (1) has limitations on specific benefits; (2) does not have all standard medicaid state plan benefits available; and (3) has some benefits, primarily preventive services, that are available only to an ABP eligible recipient. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP eligible recipient under 21 years. ABP services for an ABP eligible recipient under the age of 21 years not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MAD ABP provider and ABP eligible recipient have rights and responsibilities as described in chapters 349 through 352 of Title 8 NMAC, Social Services. Long term care in a nursing facility (NF), mi via and community benefits are not available to an ABP eligible recipient.
[8.309.4.9 NMAC - N, 1-1-14]

8.309.4.10 ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP-EXEMPT ELIGIBLE RECIPIENTS (ABP-exempt): An ABP eligible recipient who self-declares he or she has a qualifying condition is evaluated by the MAD utilization review (UR) contractor for determination of whether he or she meets the qualifying condition. An ABP-exempt eligible recipient may select to no longer utilize his or her ABP benefits package. Instead, the ABP-exempt eligible recipient would then utilize the standard medicaid state plan benefit package. See Section 19 of this rule for detailed descriptions of the standard medicaid state plan benefits. Long term care in a nursing facility (NF), mi via and community benefits are available to an eligible ABP-exempt recipient when all conditions for accessing those services are met.
[8.309.4.10 NMAC - N, 1-1-14]

8.309.4.11 MAD ABP GENERAL PROGRAM DESCRIPTION: The ABP benefits and services are detailed in Sections 12 through 17 of this rule. The ABP-exempt benefits and services are detailed in Section 19 of this rule.
[8.309.4.11 NMAC - N, 1-1-14]

8.309.4.12 GENERAL ABP COVERED SERVICES:

A. **Ambulatory surgical services:** The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. **Anesthesia services:** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. **Audiology services:** The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP eligible recipient 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are not covered as a separate service. Audiologist services, hearing aids and other aids are not covered for an ABP recipient.

D. **ABP eligible recipient transportation:** The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health services for an ABP eligible recipient in or out of his or her home community as detailed in 8.310.2 NMAC.

E. **Dental Services:** The benefit package includes dental services as detailed in 8.310.2 NMAC.

F. **Diagnostic, imaging and therapeutic radiology services:** The benefit package includes medically necessary diagnostic tests and studies, and imaging and radiology services as detailed in 8.310.2 NMAC.

G. **Dialysis services:** The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. A dialysis provider shall assist an ABP eligible recipient in applying for and pursuing final medicare eligibility determination.

H. **Durable medical equipment and medical supplies:** The benefit package includes:

(1) durable medical equipment as detailed in 8.310.2 NMAC;

(2) covered prosthetic and orthotic services as detailed in 8.310.2 NMAC and 8.324.5 NMAC; and

(3) medical supplies as detailed in 8.310.2 NMAC with some limitations; for an ABP eligible recipient 21 years of age and older the [~~the~~] only medical supplies that are covered:

(a) diabetic supplies, such as reagents, test strips, needles, test tapes, and alcohol swabs; and

(b) medical supplies that are a necessary component of durable medical equipment, medical supplies applied as part of a treatment in a practitioner's office, outpatient hospital, residential facility, as a home health service and in other similar settings are covered as part of a service (office visit), which are not reimbursed separately; and

(c) family planning supplies.

I. **Emergency and non-emergency transportation services:** The benefit package includes transportation service such as ground ambulance, or air ambulance in an emergency and when medically necessary, taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services as detailed in 8.324.7 NMAC. Non-emergency transportation is covered only when an ABP eligible recipient does not have a source of transportation available and when the ABP eligible recipient does not have access to alternative free sources. MAD or its UR contractor shall coordinate efforts when providing transportation services for an ABP eligible recipient requiring physical or behavioral health services.

J. **Home health services:** The benefit package for an ABP eligible recipient as detailed in 8.325.9 NMAC with some limitations. For an ABP eligible recipient 21 years of age and older, home health services are limited to 100 visits annually that do not exceed four hours-per-visit.

K. **Hospice services:** The benefit package for an ABP eligible recipient as detailed in 8.325.4 NMAC.

L. **Hospital outpatient service:** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 and 8.321.2 NMAC.

M. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services for the eligible recipient as detailed in 8.311.2 NMAC and inpatient rehabilitation hospitals detailed in 8.311.2 NMAC. Extended care hospitals are covered only as a temporary step-down level of care (LOC) following the eligible recipient's discharge from a hospital prior to being discharged to home.

N. **Laboratory services:** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC. Additionally,

ABP diagnostic testing coverage includes physical measurements and performance testing, such as cardiac stress tests and sleep studies.

O. **Physical health services:** The benefit package includes primary, primary care in a school-based setting, family planning and specialty physical health services provided by a licensed practitioner performed within the scope of practice; see 8.310.2 and 8.310.3 NMAC. Benefits also include:

(1) an out of hospital birth and other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC; and

(2) bariatric surgery is limited to one per lifetime; meeting additional criteria to assure medical necessity may be required prior to accessing services.

P. **Rehabilitation and habilitation services:** The benefit package includes rehabilitative and habilitative services as detailed in 8.323.5 NMAC. For an eligible recipient 21 years and older there are service limitations listed below:

(1) cardiac rehabilitation is limited to 36 visits per cardiac event;

(2) pulmonary rehabilitation is limited to short-term therapy as defined in Paragraph (3) below; and

(3) physical and occupational therapies and speech and language pathology:

(a) are short-term therapies that produce significant and demonstrable improvement within the two-month period of the initial date of treatment; and

(b) the short-term therapy may be extended beyond the initial two month period for one additional period of up to two months dependent upon the MAD UR contractor, only if such services can be expected to result in continued significant improvement of the ABP eligible recipient's physical condition within the extension period.

(4) nursing facility (NF) and acute long term care facility stays only as a temporary step-down LOC from a hospital prior to the eligible recipient's discharge to home.

Q. **Private duty nursing:** For an eligible recipient under 21 years of age, private duty nursing services are covered under EPSDT program. See Section 18 of this rule for a detailed description. For recipients age 21 and older, private duty nursing is only available through the home health benefit. See Subsection J of this section and 8.325.9 NMAC.

R. **Tobacco cessation services:** The benefit package includes cessation sessions as described in 8.310.2 NMAC but is not limited to EPSDT or pregnant women.

S. **Transplant services:** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants. For an ABP eligible recipient 21 years or older, there is a lifetime limitation two transplants. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

T. **Vision:** The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for an ABP eligible recipient as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years or older, the service limitations are:

(1) coverage is limited to one routine eye exam in a 36-month period; and

(2) MAD does not cover refraction or eyeglasses other than for aphakia following removal of the lens.

[8.309.4.12 NMAC - N, 1-1-14; A, xx-xx-14]

8.309.4.13 PHARMACY SERVICES: The benefit package includes pharmacy and related services, as detailed in 8.324.4 NMAC.

[8.309.4.13 NMAC - N, 1-1-14]

8.309.4.14 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC.

[8.309.4.14 NMAC - N, 1-1-14]

8.309.4.15 PREVENTATIVE PHYSICAL HEALTH SERVICES: The benefit package includes the current national standards for preventive health services including behavioral health preventive services. Standards are derived from several sources, including the United States preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Unless an ABP eligible recipient refuses and the refusal is documented, MAD shall make available the preventive health services or screens or document that the services (with the results) were provided by other means. The MAD provider shall document medical reasons not to perform these services for an individual ABP eligible recipient. ABP eligible recipient refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** A MAD ABP provider may assist the ABP eligible recipient with inquires to the MAD UR contractor for a NF assessment.

B. **Prenatal care and screenings:** The benefit package includes prenatal care and related services, as detailed in 8.310.2 NMAC.

C. **Preventive medicine and supplements:**

(1) An ABP eligible recipient can receive supplements detailed below as medically indicated:

(a) aspirin to prevent cardiovascular disease for a female between the ages of 45 to 79 years when the potential benefit of a reduction of ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage;

(b) aspirin to prevent cardiovascular disease for a male between the ages of 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage;

(c) vitamin D supplementation to prevent falls in a community-dwelling for an ABP eligible recipient 65 years of age and older who is at increased risk for falls;

(d) folic acid supplementation for all female ABP eligible recipients who are planning or are capable of pregnancy to take a daily supplement containing 0.4 to 0.8 mg of folic acid;

(e) iron supplementation for all asymptomatic ABP eligible recipients between the ages of six to 12 months who are at increased risk for iron deficiency anemia; and

(f) breast cancer preventive medication, such as chemoprevention, is made available.

(2) The MAD provider will discuss with a female ABP eligible recipient who is at high risk for breast cancer and at low risk for adverse effects of chemoprevention. The PCP will provide information to the ABP eligible recipient of the potential benefits and harms of chemoprevention.

D. **Screens and preventative screens:** screens and preventative screens include in the recommendation of the United States preventative services task force A and B recommendations are included in the benefit package.

[8.309.4.15 NMAC - N, 1-1-14]

8.309.4.16 TELEMEDICINE SERVICES: The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.

[8.309.4.16 NMAC - N, 1-1-14]

8.309.4.17 BEHAVIORAL HEALTH SERVICES: The benefit package includes the behavioral health services as detailed in 8.321.2 NMAC.

[8.309.4.17 NMAC - N, 1-1-14]

8.309.4.18 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES (EPSDT): The benefit package includes the delivery of the federally mandated EPSDT program services [42 CFR Section 441.57] provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. These include the ABP benefit services found in Sections 12 through 17 of this rule.

A. **General physical health EPSDT services:** MAD makes available access to early intervention programs and services for an ABP eligible recipient identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, ESPDT services are for an ABP eligible recipient under 21 years of age. For detailed description of each service, see 8.320.2 and for school based health services, see 8.320.6 NMAC. Additional NMAC citations may be included as reference.

B. **Behavioral health EPSDT services:** The benefit package includes services provided by a behavioral health practitioner for an ABP eligible recipient. See 8.321.2 NMAC for a detailed description of each service. MAD makes available access to early intervention programs and services for an ABP eligible recipient

identified in his or her EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.
[8.309.4.18 NMAC - N, 1-1-14]

8.309.4.19 ABP-EXEMPT ELIGIBLE RECIPIENT GENERAL BENEFIT DESCRIPTION: An ABP eligible recipient with a qualifying condition may select ABP-exempt [~~utilizing~~] to utilize the standard medicaid state plan benefits. All services, services limitations and co-payments that apply to full benefit medicaid recipients [~~are available~~] apply to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that are only apply to ABP recipients. [~~The ABP co-payments do not apply to an ABP-exempt recipient.~~] The limitations on services that apply only to ABP-recipients do not apply to ABP-exempt recipients. The following chapters of Title 8 Social Services NMAC provide more detailed descriptions of services.

A. Chapter 301 *medicaid general benefit description*;
B. Chapter 302 *medicaid general provider policies*;
C. Chapter 310 *health care professional services*;
D. Chapter 311 *hospital services*;
E. Chapter 312 *long term care-nursing services*, with the exceptions detailed in Section 10 of this rule);
F. Chapter 313 *long-term care facilities -intermediate care facilities*;
G. Chapter 314 *long-term care services-waivers*;
H. Chapter 320 *early and periodic screening, diagnosis and treatment (EPSDT)*;
I. Chapter 321 *behavioral health services*;
J. Chapter 324 *adjunct services*;
K. Chapter 325 *specialty services*; and
L. Chapter 326 *case management services*.

[8.309.4.19 NMAC - N, 1-1-14]

8.309.4.20 ABP AND ABP-EXEMPT ELIGIBLE PROVIDERS: Health care to an ABP eligible recipient is furnished by a variety of providers and provider groups. Refer to the MAD NMAC specific service rules for detailed description of unique provider requirements. For general information, see 8.310.2 and 8.310.3 NMAC.
[8.309.4.20 NMAC - N, 1-1-14]

8.309.4.21 ABP AND ABP-EXEMPT NONCOVERED SERVICES: MAD does not cover certain procedures, services, or miscellaneous items. Refer to the NMAC specific service rules for detailed description of unique noncovered services. For general information, see 8.310.2 NMAC for physical health noncovered services, 8.320.2 NMAC for EPSDT noncovered services, 8.320.6 for noncovered school-based health services, and 8.321.2 NMAC for behavioral health noncovered services.
[8.309.4.21 NMAC - N, 1-1-14]

8.309.4.22 ABP AND ABP-EXEMPT PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to UR for medical necessity and program compliance. Refer to the NMAC specific service rule for detailed description of the service's prior authorization and utilization review requirements. For general information, see 8.310.2 and 8.310.3 NMAC.
[8.309.4.22 NMAC - N, 1-1-14]

8.309.4.23 ABP AND ABP-EXEMPT RECIPIENT RESPONSIBILITIES: Services provided may be subject to cost sharing requirements. Please see 8.302.2 NMAC for more information on any required recipient co-payments.
[8.309.4.23 NMAC - N, 1-1-14]

HISTORY OF 8.309.4 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 430 RECIPIENT RIGHTS AND RESPONSIBILITIES

8.200.430.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.430.1 NMAC - Rp, 8.200.430.1 NMAC, 1-1-14]

8.200.430.2 SCOPE: The rule applies to the general public.
[8.200.430.2 NMAC - Rp, 8.200.430.2 NMAC, 1-1-14]

8.200.430.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.~~] 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.

[8.200.430.3 NMAC - Rp, 8.200.430.3 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.4 DURATION: Permanent.
[8.200.430.4 NMAC - Rp, 8.200.430.4 NMAC, 1-1-14]

8.200.430.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.430.5 NMAC - Rp, 8.200.430.5 NMAC, 1-1-14]

8.200.430.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility [~~policy~~] rule manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining [~~MAD~~] medical assistance programs (MAP) eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.430.6 NMAC - Rp, 8.200.430.6 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.7 DEFINITIONS: [RESERVED]

8.200.430.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.200.430.8 NMAC - N, 1-1-14]

8.200.430.9 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A. An individual has the right to apply for medicaid and other health care programs HSD administers regardless of whether it appears he or she may be eligible.

(1) Income support division (ISD) determines MAP eligibility [~~for medicaid health care~~] unless otherwise determined by another entity as stated in 8.200.400 NMAC. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130[~~H~~] NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. Application: A paper or electronic application is required from the applicant, or his or her [~~an~~] authorized representative.[~~, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.~~] The applicant may complete a joint [~~medicaid~~] MAP, cash assistance, supplemental nutrition assistance program (SNAP) and low income home energy assistance (LIHEAP) application or a [~~medicaid~~]MAP-only application.

(1) The following do not require an application unless a re-determination is due in that month or the following month, as applicable:

(a) switching from one [~~of the medical assistance~~] MAP category of eligibility for women,

children (MAWC) and families [~~medical assistance division (MAD) categories~~] to another MAP category of eligibility;

(b) switching between medicaid and refugee medical assistance MAP categories of eligibility; and

(c) switching to or from one of the long term care [~~medicaid~~] MAP categories of eligibility.

(2) Medicare savings programs (MSP):

(a) A [~~medicaid~~] MAP eligible recipient receiving full benefits is automatically deemed eligible for MSP when she or he receives free medicare Part-A hospital insurance; the MAP eligible recipient does not have to apply for medicare MSP;

(b) When an individual is not eligible for free medicare Part A hospital insurance, a separate application for the MAP qualified medicare beneficiary (QMB) eligibility category 040 is required. Individuals must apply for medicare Part A with the SSA. This is called, "conditional Part A" because they will receive medicare Part A on the condition that the MAP QMB category of eligibility is approved. When QMB is approved, the cost of the premium for Part A will be covered by [~~medicaid~~] MAD.

C. Responsibility in the application or recertification process: The applicant or the re-determining MAP eligible recipient is responsible for providing verification of eligibility. Refer to 8.100.130 NMAC.

(1) An applicant or [~~an~~] a MAP eligible recipient's failure to provide necessary verification results in [~~medicaid~~] MAP ineligibility.

(2) An applicant or a re-determining MAP eligible recipient must give HSD permission to contact other individuals, agencies, or sources of information which are necessary to establish MAP eligibility.

[8.200.430.9 NMAC - Rp, 8.200.430.9 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.10 FREEDOM OF CHOICE: Except when specifically waived from MAD, [~~an~~] a MAP eligible recipient has the freedom to obtain [~~medical~~] physical and behavioral health services from a MAD provider of his or her choice.

[8.200.430.10 NMAC - Rp, 8.200.430.10 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.11 RELEASE OF INFORMATION: By signing the [~~medicaid~~] MAP application, an applicant or a re-determining MAP eligible recipient gives HSD explicit consent to release information to applicable state or federal agencies, [~~medical~~] physical or behavioral health providers, or an HSD designee when the information is needed to provide, monitor, or approve [~~medicaid~~] MAD services. [~~Medical~~] Physical and behavioral health information is confidential and is subject to the standards for confidentiality per 8.300.11 NMAC.

[8.200.430.11 NMAC - Rp, 8.200.430.11 NMAC, 1-1-14, A, xx-xx-14]

8.200.430.12 RIGHT TO HEARING: [~~An applicant or an eligible recipient is entitled to adequate notice of state agency actions and for an opportunity to have an impartial review of those decisions at an administrative hearing. This includes any action to deny or terminate medicaid or another health care program's eligibility or deny, terminate, suspend or reduce a medicaid covered service [42 CFR Section 431.220(a)(1)(2)].~~

~~A. Adequate notice rules regarding medicaid eligibility are detailed at 8.100.180 NMAC. Fair hearing rules regarding medicaid eligibility are detailed at 8.100.970 NMAC.~~

~~B. Adequate notice and recipient hearing rules regarding MAD covered services are detailed in 8.352.2 NMAC.~~] An applicant or a MAP eligible recipient is entitled to adequate notice of a HSD adverse action regarding his or her termination or re-categorization of his or her MAP category of eligibility. The applicant or re-determining MAP eligible recipient has specific rights and responsibilities when requesting a HSD administrative hearing. A HSD administrative hearing affords the applicant or re-determining MAP eligible recipient the opportunity to have an impartial review of these decisions. See 8.352.2 NMAC, 8.100.180 NMAC and 8.100.970 NMAC for a detailed description of these rights, responsibilities and the HSD administrative hearing process. 8.352.2 NMAC further details the rights, responsibilities and the HSD administrative hearing process for other adverse actions MAD, its utilization review contractor or a HSD contracted managed care organization (MCO) may initiate [42 CFR Section 431.220(a)(1)(2)].

[8.200.430.12 NMAC - Rp, 8.200.430.12 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.13 ASSIGNMENT OF SUPPORT: As a condition of [~~MAD~~] MAP eligibility, HSD requires an applicant or a re-determining MAP eligible recipient to assign his or her medical care support rights to HSD for medical support and any third party payments. The assignment authorizes HSD to pursue and make recoveries from

liable third parties [42 CFR 433.146; NMSA 1978 27-2-28 (G)].

A. **Assigning medical support rights**: The assignment to HSD of [~~an~~] a MAP eligible recipient's rights to medical support and payments occurs automatically under New Mexico law when the applicant or the re-determining MAP eligible recipient signs the application.

B. **Third party liability (TPL):** This section describes [~~HSD~~] HSD's responsibility to identify and collect from primarily responsible third parties and [~~recipient~~] the eligible recipient's responsibility to cooperate with HSD to uncover such payments. [~~Medicaid~~] MAD is the payer of last resort. If other third party resources are available, these health care resources must be used before [~~medicaid~~] MAD makes a reimbursement. As a condition of [~~medicaid~~] MAP eligibility, an applicant assigns his or her rights to [~~medical~~] physical and behavioral health support and payments to HSD and promises to cooperate in identifying, pursuing, and collecting payments from these resources. Third party resources include the gross recovery by [~~a~~] MAP eligible recipient, including personal injury protection benefits, before any reduction in attorney's fees or costs, obtained through settlement or verdict, for personal injury negligence or intentional tort claims or actions, up to the full amount of [~~medicaid~~] MAD payments for treatment of injuries causally related to the occurrence that is the subject of the claim or action.

(1) Required TPL information: During the initial determination or [~~re-determination~~] re-determination of eligibility for [~~medicaid services~~] MAP enrollment, ISD must obtain information about TPL from either the applicant or the re-determining MAP eligible recipient.

(a) HSD is required to take all reasonable measures to determine the legal liability of third parties, including health insurers in paying for the [~~medical~~] physical and behavioral health services furnished to [~~an~~] a MAP eligible recipient [42 CFR 433.138(a)].

(b) HSD uses the information collected at the time of determination in order for [~~medicaid~~] MAD to pursue claims against third parties.

(2) Availability of health insurance: If an applicant or [~~an~~] a MAP eligible recipient has health insurance, the applicant or the MAP eligible recipient shall notify ISD. ISD must collect all relevant information, including name and address of the insurance company; individuals covered by the policy, effective dates, covered services, and appropriate policy numbers.

(a) An applicant or [~~an~~] a MAP eligible recipient with health insurance coverage or coverage by a health maintenance organization (HMO) or other managed care plan (plan) must be given a copy of the TPL recipient information letter.

(b) If there is an absent parent, ISD may request the absent parent's name and social security number (SSN).

(c) ISD must determine if an absent parent, relative, applicant or any member of the household is employed and has health insurance coverage.

(3) [~~Eligible~~] MAP eligible recipients with health insurance coverage: An applicant or [~~an~~] a MAP eligible recipient must inform [~~medicaid~~] his or her MAD providers of his or her TPL. An applicant or [~~an~~] a MAP eligible recipient must report changes to or terminations of insurance coverage to ISD. If an applicant or [~~an~~] a MAP eligible recipient has health coverage through an HMO or plan, payment from [~~medicaid~~] MAD is limited to applicable copayments required under the HMO or plan and to [~~medicaid~~] MAD covered services documented in writing as exclusions by the HMO or plan.

(a) If the HMO or plan uses a drug formulary, the medical director of the HMO or plan must sign and attach a written certification for each drug claim to document that a pharmaceutical product is not covered by the HMO or plan. The signature is a certification that the HMO or plan drug formulary does not contain a therapeutic equivalent that adequately treats the [~~medical~~] physical or behavioral health condition of the HMO or plan subscriber.

(b) [~~Medical~~] Physical and behavioral health services not included in the HMO or plan are covered by MAD only after review of the documentation and on approval by MAD.

(c) An applicant or [~~an~~] a MAP eligible recipient covered by an HMO or plan is responsible for payment of medical services obtained outside the HMO or plan and for medical services obtained without complying with the rules or policies of the HMO or plan.

(d) An applicant or [~~an~~] a MAP eligible recipient living outside an HMO or plan coverage area may request a waiver of the requirement to use HMO or plan providers and services. The applicant or the MAP eligible recipient for whom a coverage waiver is approved by MAD may receive reimbursement for expenses which allow him or her to travel to an HMO or plan participating provider, even when the provider is not located near the applicant or the MAP eligible recipient's residence.

(4) Potential health care resources: ISD must evaluate the presence of a TPL source if certain factors

are identified during the [~~medicaid~~] MAP eligibility interview.

(a) When the age of the applicant or the MAP eligible recipient is over 65 years old medicare must be explored. A student, especially a college student, may have health or accident insurance through his or her school.

(b) An application on behalf of deceased individual must be examined for "last illness" coverage through a life insurance policy.

(c) Certain specific income sources are indicators of possible TPL which include:

(i) railroad retirement benefits and social security retirement or disability benefits indicating eligibility for Title XVIII (medicare) benefits;

(ii) workers' compensation (WC) benefits paid to employees who suffer an injury or accident caused by conditions arising from employment; these benefits may compensate employees for [~~medical~~] physical and behavioral health expenses and lost income; payments for [~~medical~~] physical and behavioral health expenses may be made as [~~medical~~] physical and behavioral health bills are incurred or as a lump sum award;

(iii) black lung benefits payable under the coal mine workers' compensation program, administered by the federal department of labor (DOL), can produce benefits similar to railroad retirement benefits if the treatment for illness is related to the diagnosis of pneumoconiosis; beneficiaries are reimbursed only if services are rendered by specific providers, authorized by the DOL; black lung payments are made monthly and [~~medical~~] physical and behavioral health expenses are paid as they are incurred; and

(iv) Title IV-D support payments or financial support payments from an absent parent may indicate the potential for [~~medical~~] physical and behavioral health support; if a custodial party does not have health insurance that meets a minimum standard, the court in a divorce, separation or custody and support proceeding may order the parent(s) with the obligation of support to purchase insurance for the MAP eligible recipient child [45 CFR 303.31(b)(1); NMSA 1978, Section 40-4C-4(A)(1)]; insurance can be obtained through the parent's employer or union [NMSA 1978, Section 40-4C-4(A)(2)]; parents may be ordered to pay all or a portion of the [~~medical~~] physical and behavioral health [~~or dental~~] expenses; for purposes of [~~medical~~] physical and behavioral health support, the minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico; see New Mexico insurance code.

(d) An applicant or [~~an~~] a MAP eligible recipient has earned income: Earned income may indicate [~~medical~~] physical, behavioral health and health insurance made available by an employer.

(e) Work history or military services: Work history may indicate eligibility for other cash and [~~medical~~] physical and behavioral benefits. Previous military service suggests the potential for veterans administration (VA) or department of defense (DOD) health care, including the civilian health and the medical program of the United States (CHAMPUS), for individuals who reside within a 40-mile radius of a military health care facility. An applicant or [~~an~~] a MAP eligible recipient who is eligible for DOD health care must obtain certification of non-availability of medical services from the base health benefits advisor in order to be eligible for CHAMPUS.

(f) An applicant or [~~an~~] a MAP eligible recipient's expenses show insurance premium payments: Monthly expense information may show that the applicant or the MAP eligible recipient pays private insurance premiums or is enrolled in an HMO or plan.

(g) The applicant or the MAP eligible recipient has a disability: Disability information contained in applications or brought up during interviews may indicate casualties or accidents involving legally responsible third parties.

(h) The applicant or the MAP eligible recipient has a chronic disease: Individuals with chronic renal disease are probably entitled to medicare. Applications for social security disability may be indicative of medicare coverage.

(5) Communicating TPL information: Information concerning health insurance or health plans is collected and transmitted to MAD by ISD, child support enforcement division (CSED), SSA, and the children, youth and families department (CYFD).

[8.200.430.13 NMAC - Rp, 8.200.430.13 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.14 MAP ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS:

A. **Cooperation:** As a condition of [~~medicaid~~] MAP eligibility, an applicant or [~~an~~] a MAP eligible recipient must cooperate with HSD to:

(1) obtain [~~medical~~] physical and behavioral health support and payments for his or herself and other individuals for whom he or she can legally assign rights;

(2) pursue liable third parties by identifying individuals and providing information to HSD;

(3) cooperate with CSED to establish paternity and medical support as appropriate, see 8.50.105.12 NMAC;

(4) appear at a state or local office designated by HSD to give information or evidence relevant to the case, appear as a witness at a court or other proceeding or give information or attest to lack of information, under penalty of perjury;

(5) refund HSD any money received for [~~medical~~] physical or behavioral health care that has already been paid; this includes payments received from insurance companies, personal injury settlements, and any other liable third party; and

(6) respond to the trauma inquiry letter that is mailed to [~~an~~] a MAP eligible recipient [42 CFR 433.138(4)]; the letter asks [~~an~~] a MAP eligible recipient to provide more information about possible accidents, causes of accidents, and whether legal counsel has been obtained [42 CFR 433.147; 45 CFR 232.42, 232.43; NMSA 1978 27-2-28(G)(3)].

B. **Good cause waiver of cooperation:** The requirements for cooperation may be waived by HSD if it decides that the applicant or the MAP eligible recipient has good cause for refusing to cooperate. Waivers can be obtained for cooperating with CSED. The applicant or the MAP eligible recipient should request a good cause waiver from CSED per 8.50.105.14 NMAC.

C. **Penalties for failure to cooperate:**

(1) When the parent, the specified relative or legal guardian fails or refuses to cooperate, the parent or specified relative will not be eligible for [~~medicaid~~] MAD services. The MAP eligible recipient child maintains [~~medicaid~~] MAP eligibility provided all other eligibility criteria are met.

(2) When the parent or the specified relative fails or refuses to refund payments received from insurance or other settlement sources, such as personal injury case awards, he or she is not eligible for [~~medicaid~~] MAD services for one year and until full restitution has been made to HSD. The MAP eligible recipient child maintains [~~medicaid~~] MAP eligibility provided all other eligibility criteria are met.

[8.200.430.14 NMAC - Rp, 8.200.430.14 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.15 MAP ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES:

A. [A~~n~~] A MAP eligible recipient is responsible for presenting a current [~~medicaid~~] MAP eligibility card and evidence of any other health insurance to a [~~medicaid~~] MAD provider each time service is requested.

(1) [A~~n~~] A MAP eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current [~~medicaid~~] MAP eligibility identification before the receipt of a service and as a result the provider fails to adhere to MAD rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the MAP eligible recipient and the provider. An individual is financially responsible for services received if he or she was not eligible for [~~medicaid~~] MAD services on the date services are furnished.

(2) When a provider bills [~~medicaid~~] MAD and the claim is denied, the provider cannot bill the MAP eligible recipient. Exceptions exist for denials caused by [~~medicaid~~] MAP ineligibility or by [~~an~~] a MAP eligible recipient's failure to furnish [~~medicaid~~] MAP identification in a timely manner.

(3) If [~~an~~] a MAP eligible recipient fails to notify the provider that he or she has received services that are limited by time or amount, the MAP eligible recipient is responsible for payment of the service prior to rendering the service if the provider made reasonable efforts to verify whether the MAP eligible recipient has already received services.

B. Notification of providers following retroactive eligibility determinations: If an eligibility determination is made, the MAP eligible recipient is responsible for notifying MAD providers of this eligibility determination. When an individual receives retro [~~medicaid~~] MAP eligibility, the now-MAP eligible recipient must notify all of his or her [~~medicaid~~] MAD providers of his or her change of eligibility. If the MAP eligible recipient fails to notify the provider and the provider can no longer file a claim for reimbursement, the MAP eligible recipient becomes the responsible payer for those services.

C. Notification if [~~an~~] a MAP eligible recipient has private insurance: If [~~an~~] a MAP eligible recipient is covered under a private health insurance policy or health plan, he or she is required to inform his or her [~~medicaid~~] MAD providers of the private health coverage, including applicable policy numbers and special claim forms.

[8.200.430.15 NMAC - Rp, 8.200.430.15 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.16 MAP ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

A. A [~~medicaid~~] MAD provider agrees to accept the amount paid as payment in full with the exception of co-payment amounts required in certain [~~medicaid~~] MAP eligibility categories [42 CFR 447.15]. Other than the co-payments, a provider cannot bill [~~an~~] a MAP eligible recipient for any unpaid portion of the bill (balance billing) or for a claim that is not paid because of a provider administrative error or failure of multiple providers to communicate eligibility information. A native American MAP eligible recipient is exempt from co-payment requirements.

(1) [~~An~~] A MAP eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current [~~medicaid~~] MAP eligibility identification before the receipt of a [~~medicaid~~] MAP service and as a result the provider fails to adhere to [~~medicaid~~] MAD reimbursement rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the MAP eligible recipient and the MAD provider. An individual is financially responsible for services received if he or she was not eligible for [~~medicaid~~] MAD services on the date services are furnished.

(2) When a provider bills [~~medicaid~~] MAD and the claim is denied, the provider cannot bill the MAP eligible recipient. Exceptions exist for denials caused by [~~medicaid~~] MAP ineligibility or by [~~an~~] a MAP eligible recipient's failure to furnish [~~medicaid~~] MAP identification at the time of service.

(3) If [~~an~~] a MAP eligible recipient fails to notify a provider that he or she has received services that are limited by time or amount, the MAP eligible recipient is responsible to pay for services if, before furnishing the services, the provider makes reasonable efforts to verify whether the MAP eligible recipient has already received services.

B. Failure of [~~an~~] a MAP eligible recipient to follow his or her privately held health insurance carrier's requirements: [~~An~~] A MAP eligible recipient must be aware of the physician, pharmacy, hospital, and other providers who participate in his or her HMO or other managed care plan. [~~An~~] A MAP eligible recipient is responsible for payment for services if he or she uses a provider who is not a participant in his or her plan or if he or she receives any services without complying with the rules, policies, and procedures of his or her plan.

C. Other MAP eligible recipient payment responsibilities: If all the following conditions are met before a MAD service is furnished, the MAP eligible recipient can be billed directly by a [~~medicaid~~] MAD provider for services and is liable for payment:

(1) the MAP eligible recipient is advised by a provider that the particular service is not covered by [~~medicaid~~] MAD or is advised by a provider that he or she is not a [~~medicaid~~] MAD provider;

(2) the MAP eligible recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to another provider who is a [~~medicaid~~] MAD provider; and

(3) the MAP eligible recipient agrees in writing to have the service provided with full knowledge that he or she is financially responsible for the payment.

D. Children's health insurance program (CHIP) and working disabled individuals (WDI) co-payments: It is the MAP eligible recipient's responsibility to pay the co-payment to the [~~medicaid~~] MAD provider.

~~[(1) WDI co-payment requirements are the following:~~

~~(a) $7 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;~~

~~(b) $20 per emergency room (ER) visit;~~

~~(c) $28 for non-emergent use of the ER;~~

~~(d) $30 per inpatient hospital admission;~~

~~(e) $5 per drug item (does not apply if the $8 co-payment for a brand name drug is assessed); and~~

~~(f) $8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the preferred drug list (PDL) unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.~~

~~(2) CHIP co-payment requirements are the following:~~

~~(a) $5 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;~~

~~(b) $15 per ER visit;~~

~~(c) $50 for non-emergent use of the ER;~~

~~(d) $25 per inpatient hospital admission;~~

~~(e) $2 per drug item (does not apply if the $5 co-payment for a brand name drug is assessed); and~~

~~(f) $5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.~~

~~E. The following exemptions from co-payment responsibilities for WDI and CHIP eligible recipients apply:~~

~~(1) native Americans;~~

~~(2) family planning services, procedures, drugs, supplies, and devices;~~

~~(3) medicare cross over claims including claims from medicare advantage plans;~~

~~(4) preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc.);~~

~~(5) prenatal and postpartum care and deliveries, and prenatal drug items;~~

~~(6) provider preventable conditions;~~

~~(7) psychotropic drug items are exempt from the brand name co-payment (only the regular pharmacy co-payment applies);~~

~~(8) when the maximum family limit has been exceeded;~~

~~(9) all services rendered by an Indian health services facility (IHS), 638 facility, or urban Indian facility regardless of race code; and~~

~~(10) federal match 3 for categories 071 and 400 through 421 are exempt because these are presumptively eligible children.~~

~~F. Brand name drug: A $3 co-payment for a brand name drug applies to MAD eligible recipients, except for WDI and CHIP, which have higher co-payment amounts, when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.~~

~~G. Non emergent use of the ER: For non emergent use of the ER, the co-payment varies by the federal poverty level (FPL). These co-payment amounts apply to MAD eligible recipients except for WDI which has a higher co-payment amount. The co-payments for non emergent use of the ER are the following:~~

~~(1) $8 if 150 percent of the FPL or below; and~~

~~(2) $50 if greater than 150 percent of the FPL.~~

~~H. The following are exempt from the non emergent use of the ER and brand name drug co-payment:~~

~~(1) native Americans;~~

~~(2) medicare cross over claims including claims from medicare advantage plans;~~

~~(3) psychotropic drug items;~~

~~(4) foster care and adoption categories (Categories 014, 017, 037, 046, 047, 066, and 086); and~~

~~(5) institutional care categories (Categories 081, 083, and 084).~~

~~I. Co-payment maximum: The aggregate amount of cost sharing imposed for all individuals in the family as applied during the quarterly period is five percent of countable family income.~~]

(1) **Children's health insurance program (CHIP) co-payment requirement:** MAP eligible recipients whose benefits are determined using criteria for CHIP are identified by their MAP category of eligibility. The following co-payments apply to a CHIP eligible recipient:

(a) $2 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $5 per dental visit, unless all the services are preventive services;

(d) $25 per inpatient hospital admission unless the hospital is receiving the CHIP eligible recipient as a transfer from another hospital;

(e) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(f) $8 for non-emergent use of the ED.

(2) **Working disabled individual's copayment requirements (WDI):** A MAP eligible recipient whose benefits are determined using criteria for WDI are identified by his or her MAP category of eligibility. The following co-payments apply to WDI eligible recipient:

(a) $3 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $7 per dental visit, unless all the services are preventive services;

(d) $30 per inpatient hospital admission unless the hospital is receiving the WDI eligible recipient as a transfer from another hospital;

(e) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(f) $8 for non-emergent use of the ED.

E. Co-payment amounts on other MAP eligible recipients, including ABP, apply only in the event of a non-emergent use of the ED or unnecessary uses of a brand name drug. Co-payments are not applied when one or more of the following conditions are met:

(i) the MAD service is a medicare claim or medicare advantage claim, or follows other insurer payment;

(ii) the MAP eligible recipient is a native American;

(iii) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the MAP eligible recipient;

(iv) the service is a provider preventable condition or is solely to treat a provider preventable condition;

(v) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;

(vi) the maximum family out-of-pocket cost sharing limit has been reached;

(vii) the MAD service was rendered prior to any MAP eligibility being established including when MAP eligibility is retroactively established to the time period of the service;

(viii) the MAP eligible recipient or MAD service is exempt from co-payment as otherwise described in these rules;

(xi) the MAP eligible recipient is in foster care or has a MAP adoption category of eligibility;

(x) the recipient does not have a MAP category of eligibility such as being eligible only for the department of health children's medical services program; or

(xi) the MAP eligible recipient resides in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has a MAP institutional care category of eligibility.

(b) Other than a co-payment for non-emergent use of the ED or for unnecessary use of a brand name drug, co-payments are not applied when the services are one of the following:

(i) family planning services, procedures drugs, supplies, or devices;

(ii) preventive services (well child checks, vaccines, preventive dental cleanings/exams, periodic health exams) unless treatment is rendered; or

(iii) prenatal and postpartum care and deliveries, and prenatal drug items.

[8.200.430.16 NMAC - Rp, 8.200.430.16 NMAC, 1-1-14; A, xx-xx-14]

8.200.430.17 RESTITUTION:

A. A [~~medicaid~~] MAP eligible recipient must return overpayments or medical payments received from liable third parties to the applicable medical service provider or to MAD. If payments are not returned or received, recoupment proceedings against the MAP eligible recipient will be initiated.

B. The restitution bureau of HSD is responsible for the tracking and collection of overpayments made to [~~medicaid~~] MAP eligible recipients, vendors, and [~~medicaid~~] MAD providers. See Section OIG-940, RESTITUTIONS. The MAD third party liability unit is responsible for monitoring and collecting payments received from liable third parties. See 8.302.3 NMAC.

[8.200.430.17 NMAC - Rp, 8.200.430.17 NMAC, 1-1-14; A, xx-xx-14]

~~[8.200.430.18 ELIGIBLE RECIPIENT RESPONSIBILITY TO ENROLL IN AVAILABLE EMPLOYER-BASED GROUP HEALTH PLAN OR OTHER INSURANCE PLANS: Effective July 01, 1998, HSD no longer accepts referrals to the health insurance premium payment (HIPP) program. HIPP is only available to participants active on HIPP as of July 01, 1998 who have continued to maintain their eligibility for the program. This program~~

~~will end January 31, 2014.~~
~~[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1-1-14; A, 1-31-14]~~]

8.200.430.[~~19~~]18 REPORTING REQUIREMENTS: [~~A medicaid~~] A MAP eligible recipient is required to report certain changes which might affect his or her eligibility. The following changes must be reported to ISD within 10 calendar days from the date the change occurred pursuant to 8.200.400 NMAC, 8.200.410 NMAC, and 8.200.420 NMAC.

A. **Living arrangements or change of address**: Any change in where [~~an~~] a MAP eligible recipient lives or gets his or her mail must be reported.

B. **Household size:** Any change in the household size must be reported. This includes the death of an individual included in the either or both the assistance unit and budget group.

C. **Enumeration:** Any new social security number must be reported.

D. **Income:** Except for continuous eligibility in 8.200.400 NMAC any increase or decrease in the amount of income or change in the source of income must be reported.

E. **Resource:** Any change in what [~~an~~] a MAP an eligible recipient owns must be reported. This includes any property the MAP eligible recipient owns or has interest in, cash on hand, money in banks or credit unions, stocks, bonds, life insurance policies or any other item of value.

[8.200.430.18 NMAC - N, 1-1-14; A, xx-xx-14]

8.200.430. [~~20~~]19 MAD ESTATE RECOVERY: HSD is mandated to seek recovery from the estates of certain individuals up to the amount of medical assistance payments made by the HSD on behalf of the individual. See Social Security Act Section 1917 [42 USC 1396p(b) and NMSA 1978, Section 27-2A-1 et seq. "Medicaid Estate Recovery Act"].

A. **Definitions used in MAD estate recovery:**

(1) Authorized representative: The individual designated to represent and act on the MAP eligible recipient's behalf. The MAP eligible recipient or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the MAP eligible recipient.

[~~(1)~~](2) Estate: Real and personal property and other assets of an individual subject to probate or administration pursuant to the New Mexico Uniform Probate Code.

[~~(2)~~](3) Medical assistance: Amounts paid by HSD for long term care services including related hospital and prescription drug services.

[~~(3) Personal representative: An adult designated in writing who is authorized to represent the estate of the eligible recipient.~~]

B. **Basis for defining the group:** A [~~medicaid~~]MAP eligible recipient who was 55 years of age or older when medical assistance payments were made on his or her behalf for nursing facilities services, home and community based services, and related hospital and prescription drug services are subject to estate recovery.

C. **The following exemptions apply to estate recovery:**

(1) Qualified medicare beneficiaries, specified low-income beneficiaries, qualifying individuals, and qualified disabled and working individuals, are exempt from estate recovery for the receipt of hospital and prescription drug services unless they are concurrently in a MAP nursing facility category of eligibility or on a home and community based services waiver; this provision applies to medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the medicare savings programs.

(2) Certain income, resources, and property are exempted from [~~medicaid~~] MAD estate recovery for native Americans:

(a) interest in and income derived from tribal land and other resources held in trust status and judgment funds from the Indian claims commission and the United States claims court;

(b) ownership interest in trust or non-trust property, including real property and improvements;

(i) located on a reservation or near a reservation as designated and approved by the bureau of Indian affairs of the U.S, department of interior; or

(ii) for any federally-recognized tribe located within the most recent boundaries of a prior federal reservation; and

(iii) protection of non-trust property described in Subparagraphs (a) and (b) is limited to

circumstances when it passes from a native American to one or more relatives, including native Americans not enrolled as members of a tribe and non-native Americans such as a spouse and step-children, that their culture would nevertheless protect as family members; to a tribe or tribal organization; or to one or more native Americans;

(c) income left as a remainder in an estate derived from property protected in Paragraph (2) above, that was either collected by a native American, or by a tribe or tribal organization and distributed to native Americans that the individual can clearly trace the income as coming from the protected property;

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a tribe or tribal organization and distributed to native Americans derived from these sources as long as the individual can clearly trace the ownership interest as coming from protected sources; and

(e) ownership interest in or usage of rights to items, not covered by Subparagraphs (a) through (d) above, that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

D. **Recovery process:** Recovery from [~~an~~] a MAP eligible recipient's estate will be made only after the death of the MAP eligible recipient's surviving spouse, if any, and only at a time that the MAP eligible recipient does not have surviving child who is less than 21 years of age, blind, or who meet the SSA definition of disability.

(1) Estate recovery is limited to payments for applicable services received on or after October 1, 1993; except that recovery also is permitted for pre-October 1993 payments for nursing facility services received by a [~~medicaid~~]MAP eligible recipient who was 65 years of age or older when such nursing facility services were received.

(2) A recovery notice will be mailed to the [~~personal~~] authorized representative or next of kin upon the MAP eligible recipient's death informing him or her about the amount of claim against the estate and provide information on hardship waivers and hearing rights.

(3) It is the family or [~~personal~~] authorized representative's responsibility to report the MAP eligible recipient's date of death to the ISD office within 10 calendar days after the date of death.

E. [~~Eligible~~] **MAP eligible recipient rights and responsibilities:**

(1) At the time of application or re-certification, [~~a personal~~] the authorized representative must be identified or confirmed by the applicant or the MAP eligible recipient. [~~or his or her designee~~].

(2) Information explaining estate recovery will be furnished to the applicant or the MAP eligible recipient, his or her [~~personal representative, or designee~~] authorized representative during the application or re-certification process. Upon the death of the [~~medicaid~~]MAP eligible recipient, a notice of intent to collect (recovery) letter will be mailed to the MAP eligible recipient's [~~personal~~] authorized representative with the total amount of claims paid by [~~medicaid~~]MAD on behalf of the MAP eligible recipient. The [~~personal~~] authorized representative must acknowledge receipt of this letter in the manner prescribed in the letter within 30 calendar days of the date on the letter.

(3) During the application or re-certification process for [~~medicaid~~]MAP eligibility, the local county ISD office will identify the assets of an applicant or the MAP eligible recipient. This includes all real and personal property which belongs in whole or in part to the applicant or the MAP eligible recipient and the current fair market value of each asset. Any known encumbrances on the asset should be identified at this time by the applicant or the MAP eligible recipient or his or her [~~personal~~] authorized representative.

(4) MAD, or its designee, will send notice of recovery to the probate court, when applicable, and to the MAP eligible recipient's [~~personal~~] authorized representative or successor in interest. The notice will contain the following information:

(a) statement describing the action MAD, or its designee, intends to take;

(b) reasons for the intended action;

(c) statutory authority for the action;

(d) amount to be recovered;

(e) opportunity to apply for the undue hardship waiver;

(f) procedures for applying for a hardship waiver and the relevant timeframes involved;

(g) explanation of the MAP eligible recipient's personal representative's right to request [~~an~~] a HSD administrative hearing; and

(h) the method by which an affected person may obtain a HSD administrative hearing and the applicable timeframes involved.

(5) Once notified by MAD, or its designee, of the decision to seek recovery, it is the responsibility of the MAP eligible recipient's [~~personal~~] authorized representative or successor in interest to notify other individuals

who would be affected by the proposed recovery.

(6) The [~~personal~~] authorized representative will:

(a) remit the amount of medical assistance payments to HSD or its designee;

(b) apply for an undue hardship waiver; (see Paragraph (2) of Subsection F below); or

(c) request an administrative hearing.

F. **Waivers:**

(1) For a general waiver, HSD may compromise, settle, or waive recovery pursuant to the Medicaid Estate Recovery Act if it deems that such action is in the best interest of the state or federal government.

(2) Hardship provision: HSD, or its designee, may waive recovery because recovery would work an undue hardship on the heirs. The following are deemed to be causes for hardship:

(a) the deceased recipient's heir would become eligible for a needs-based assistance program such as medicaid or temporary assistance to needy families (TANF) or be put at risk of serious deprivation without the receipt of the proceeds of the estate;

(b) the deceased eligible recipient's heir would be able to discontinue reliance on a needs-based program (such as medicaid or TANF) if he or she received the inheritance from the estate;

(c) the deceased recipient's assets which are subject to recovery are the sole income source for the heir;

(d) the homestead is worth 50 percent or less than the average price of a home in the county where the home is located based on census data compared to the property tax value of the home; or

(e) there are other compelling circumstances as determined by HSD or its designee.

[8.200.430.19 NMAC - N, 1-1-14; A, xx-xx-14]

HISTORY OF 8.200.430 NMAC: The material in this part was derived from that previously filed with the State Records Center:
8 NMAC 4.MAD.430, Recipient Policies, Recipient Rights and Responsibilities, filed 12-30-94.

History of Repealed Material:
8.200.430 NMAC, Recipient Rights and Responsibilities, filed 12-13-2000 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 243 MEDICAID ELIGIBILITY - WORKING DISABLED INDIVIDUALS (WDI) (CATEGORY 043)
PART 600 BENEFIT DESCRIPTION

8.243.600.1 ISSUING AGENCY: Human Services Department (HSD).

8.243.600.2 SCOPE: This rule applies to the general public.
[8.243.600.2 NMAC - N, 1-1-01]

8.243.600.3 STATUTORY AUTHORITY: [~~The New Mexico medicaid program 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 by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).~~] 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.243.600.3 NMAC - N, 1-1-01; A, xx-xx-14]

8.243.600.4 DURATION: Permanent
[8.243.600.4 NMAC - N, 1-1-01]

8.243.600.5 EFFECTIVE DATE: January 1, 2001, unless a later date is cited at the end of a section.
[8.243.600.5 NMAC - N, 1-1-01]

8.243.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.243.600.6 NMAC - N, 1-1-01]

8.243.600.7 DEFINITIONS: [RESERVED]

8.243.600.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.243.600.8 NMAC - N, xx-xx-14]

8.243.600.9 GENERAL BENEFIT DESCRIPTION: [~~An individual who is eligible for medicaid coverage under the working disabled individuals program is eligible to receive the full range of medicaid covered services.~~]An individual who meets a medical assistance programs (MAP) category of eligibility for the working disabled individual program (WDI) is eligible to receive full state plan benefits.

[~~A. **Co-payment responsibility for WDI recipients:** Eligible recipients have co-payment requirements as follows:~~

~~(1) $5 per prescription, applies to covered prescription and non-prescription drug items;~~

~~(2) $7 per dental visit;~~

~~(3) $7 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;~~

~~(4) $20 per emergency room visit;~~

~~(5) $30 per inpatient hospital admission.~~

~~B. **Co-payment maximum:**~~

~~(1) The co-payment maximum varies depending on the recipient's income. Once the recipient has reached his/her co-payment maximum on covered medicaid services, co-payments cease for the rest of that calendar year, only after the recipient has fulfilled the required steps listed below.~~

~~(2) Co-payment maximum amounts for WDI recipients are calculated at initial determination, based on the income received in the first month of eligibility, and every twelve months thereafter. The co-payment maximum amount calculated at the initial determination is prorated for the rest of the calendar year and is also determined for the following calendar year. At each annual periodic review, the co-payment maximum will be calculated for the following calendar year.~~

~~(a) Recipients with earned and unearned income below 100% FPL - maximum is $600.~~

~~(b) Recipients with earned and unearned income between 100-250% FPL - maximum is $1500.~~
~~(3) It is the responsibility of the recipient to track and total the co-payments paid.~~
~~(4) Once the yearly maximum amount has been paid on co-payment for medicaid covered services, the recipient must notify the medical assistance division that the maximum amount has been met~~
~~(5) Verification must be provided to the medical assistance division that the co-payment maximum has been paid.~~
~~(6) The first month that co-payments will no longer be required by the WDI recipient is the month following the month in which it has been verified by the medical assistance division that the maximum amount has been met.~~
~~(7) If the determination is made after the twenty-fifth (25th) of the month, the change is made effective the second month after the request.~~
~~(8) No retroactive eligibility for the "met co-payment maximum" criteria is allowed.~~]
[8.243.600.9 NMAC - N, 1-1-01; A, 1-1-02; A, 6-1-04; A, 12-15-04; A, xx-xx-14]

8.243.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within [~~sixty~~] 60 days of the date of application. Individuals will have time limits explained, and be informed of the date by which the application should be processed.
[8.243.600.10 NMAC - N, 1-1-01]

8.243.600.11 INITIAL BENEFITS: Eligibility begins the month of approval. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, this notice includes the individual's right to request a hearing.
[8.243.600.11 NMAC - N, 1-1-01]

8.243.600.12 ONGOING BENEFITS: A re-determination of MAP eligibility is made every [~~twelve~~] 12 months or at such time the MAP eligible recipient begins receiving medicare benefits.
[8.243.600.12 NMAC - N, 1-1-01; A, 6-1-04; xx-xx-14]

8.243.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three [~~(3)~~] months of retroactive [~~medicaid coverage~~] MAP eligibility can be furnished to applicants who have received [~~medicaid-covered~~] MAD services during the retroactive period and would have met applicable eligibility criteria had they applied during the three [~~(3)~~] months prior to the month of application. There is no retroactive [~~medicaid coverage~~] MAP eligibility prior to WDI program implementation.

A. **Application for retroactive benefit coverage:** Application for retroactive [~~medicaid~~] MAP eligibility is made by indicating the existence of medical expenses in the three [~~(3)~~] months prior to the month of application on the [~~medicaid~~] MAP application form.

B. **Approval requirements:** To establish retroactive MAP eligibility, verification must be provided to demonstrate that all conditions of eligibility were met for each of the three [~~(3)~~] retroactive months, and that the individual received [~~medicaid-covered~~] MAD services. Eligibility for each month is approved or denied on its own merits.

C. **Disability determination required:** If a disability determination is needed for the date of onset of blindness or disability, a referral will be made to the disability determination contractor.

D. **Notice:**

(1) **Notice to applicant:** The applicant must be informed of the disposition of each retroactive month.

(2) [~~**Recipient**~~] **MAP eligible recipient responsibility to notify provider:** After the retroactive MAP eligibility has been established, the MAP eligible recipient is responsible for informing all MAD providers with outstanding bills of the retroactive MAP eligibility determination. If the individual does not inform all MAD providers and furnish verification of MAP eligibility which can be used for billing, and the MAD provider consequently does not submit the billing within [~~120~~] 90 calendar days from the date of approval of retroactive [~~coverage~~] MAP eligiblity, the [~~individual~~] MAP eligible recipient is responsible for payment of the bill.
[8.243.600.13 NMAC - N, 1-1-01; xx-xx-14]

8.243.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, when the MAP eligible recipient becomes ineligible. If a MAP eligible recipient dies, the case is closed the following month.
[8.243.600.14 NMAC - N, 1-1-01; A, xx-xx-14]

HISTORY OF 8.243.600 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]