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8.252.600 BENEFIT DESCRIPTION

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TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAID ELIGIBILITY – BREAST AND CERVICAL CANCER (BCC) (CATEGORY 052)
PART 600 BENEFIT DESCRIPTION

8.252.600.1 ISSUING AGENCY: Human Services Department.
[8.252.600.1 NMAC – N, 7-1-02]

8.252.600.2 SCOPE: This rule applies to the general public.
[8.252.600.2 NMAC – N, 7-1-02]

8.252.600.3 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 1978 27-2-12 et seq. (Repl. Pamp. 1991).
[8.252.600.3 NMAC – N, 7-1-02]

8.252.600.4 DURATION: Permanent
[8.252.600.4 NMAC – N, 7-1-02]

8.252.600.5 EFFECTIVE DATE: July 1, 2002, unless a later date is cited at the end of a section.
[8.252.600.5 NMAC – N, 7-1-02]

8.252.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the Medicaid program.
[8.252.600.6 NMAC – N, 7-1-02]

8.252.600.7 DEFINITIONS: [RESERVED]

8.252.600.8 [RESERVED]

8.252.600.9 GENERAL BENEFIT DESCRIPTION: A woman who is determined eligible for Medicaid coverage under the Breast and Cervical Cancer program can receive the full range of Medicaid covered services under fee-for-service provisions, and is exempt from SALUD, New Mexico's Managed Care program.
[8.252.600.9 NMAC – N, 7-1-02]

8.252.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within forty-five (45) days of the date of application. A woman will have time limits explained, and be informed of the date by which the application should be processed.
[8.252.600.10 NMAC – N, 7-1-02]

8.252.600.11 INITIAL BENEFITS: Eligibility is always prospective and begins the month of application. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, the notice shall include reason for denial and the woman's right to request a fair hearing.
[8.252.600.11 NMAC – N, 7-1-02]

8.252.600.12 ONGOING BENEFITS: A woman is responsible to report changes affecting eligibility within ten (10) days in which the change took place. Changes in eligibility status will be effective the first day of the following month. A redetermination of eligibility is made every twelve (12) months.
[8.252.600.12 NMAC – N, 7-1-02]

8.252.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three (3) months of retroactive Medicaid coverage can be furnished to applicants who have received Medicaid-covered 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 prior to the BCC program implementation date of July 1, 2002.

A. **Application for Retroactive Benefit Coverage:** Application for retroactive Medicaid is made by indicating the existence of medical expenses in the three (3) months prior to the month of application on the Medicaid application form.

B. **Approval Requirements:** To establish retroactive 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 services. Eligibility for each month is approved or denied on its own merits.

C. **Notice:**

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

(2) **Recipient Responsibility to Notify Provider:** After the retroactive eligibility has been established, the recipient is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the individual does not inform all providers and furnish verification of eligibility that can be used for billing, and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the individual is responsible for payment of the bill.

[8.252.600.13 NMAC – N, 7-1-02]

8.252.600.14 CHANGES IN ELIGIBILITY: A woman's eligibility ends when the department receives information from the treating physician or the woman that her course of treatment is completed. A case is closed, with provision of advance notice, when the recipient becomes ineligible. If a recipient dies, the case is closed the following month.

[8.252.600.14 NMAC – N, 7-1-02]

HISTORY OF 8.252.600 NMAC: [RESERVED]