INDEX

8.233.600 BENEFIT DESCRIPTION

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MEDICAID ELIGIBILITY – LOSS OF AFDC – INCOME OR RESOURCES (CATEGORY 033)
BENEFIT DESCRIPTION

TITLE 8 SOCIAL SERVICES
CHAPTER 233 MEDICAID ELIGIBILITY - LOSS OF AFDC - INCOME OR RESOURCES (CATEGORY 033)
PART 600 BENEFIT DESCRIPTION

8.233.600.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.233.600.1 NMAC - Rn, 8 NMAC 4.IAF.000.1, 9-15-13]

8.233.600.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.233.600.2 NMAC - Rn, 8 NMAC 4.IAF.000.2, 9-15-13]

8.233.600.3 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 and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.233.600.3 NMAC - Rn, 8 NMAC 4.IAF.000.3, 9-15-13]

8.233.600.4 DURATION: Permanent
[2/1/95; 8.233.600.4 NMAC - Rn, 8 NMAC 4.IAF.000.4, 9-15-13]

8.233.600.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.233.600.5 NMAC - Rn, 8 NMAC 4.IAF.000.5, 9-15-13]

8.233.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[2/1/95; 8.233.600.6 NMAC - Rn, 8 NMAC 4.IAF.000.6, 9-15-13]

8.233.600.7 DEFINITIONS: [RESERVED]

8.233.600.8 [RESERVED]

8.233.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid-covered services.
[2/1/95; 8.233.600.9 NMAC - Rn, 8 NMAC 4.IAF.600, 9-15-13]

8.233.600.10 BENEFIT DETERMINATION: Application for this category is made on the assistance application form used for AFDC. No separate application is required for category 033.
[2/1/95; 8.233.600.10 NMAC - Rn, 8 NMAC 4.IAF.620, 9-15-13]

8.233.600.11 INITIAL BENEFITS: After the eligibility determination is made, the ISS sends notice to the applicant/applicant group. The denial notice contains information on the reason for the denial and explanation of appeal rights.
[2/1/95; 8.233.600.11 NMAC - Rn, 8 NMAC 4.IAF.623, 9-15-13]

8.233.600.12 ONGOING BENEFITS: Periodic review for eligibility must be made on an annual basis.
[2/1/95; 8.233.600.12 NMAC - Rn, 8 NMAC 4.IAF.624, 9-15-13]

8.233.600.13 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 [42 CFR Section 435.914].

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application/redetermination of eligibility for medicaid assistance (MAD 381) form or by checking "yes" to the question on "does anyone in your household have unpaid medical expenses in the last three (3) months?" on the application for assistance (ISD 100 S) form. Applications for retroactive medicaid benefits must be made by 180 days from the date of application for

assistance. Medicaid-covered services which were furnished more than two (2) years prior to application are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three (3) retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system (for categories programmed on that system) or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he/she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which 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 recipient is responsible for payment of the bill.

[2/1/95; 8.233.600.13 NMAC - Rn, 8 NMAC 4.IAF.625, 9-15-13]

HISTORY OF 8.233.600 NMAC: [RESERVED]