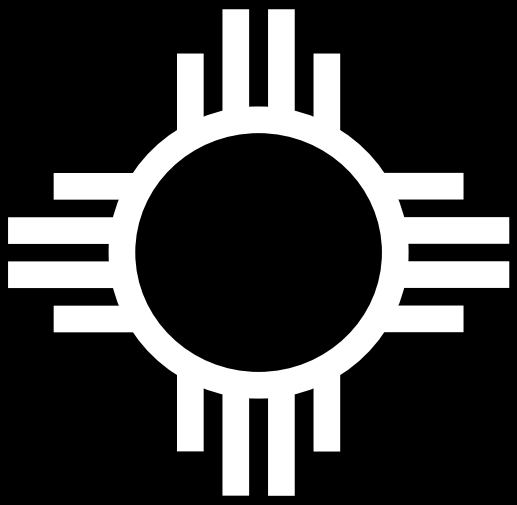
NEW MEXICO REGISTER



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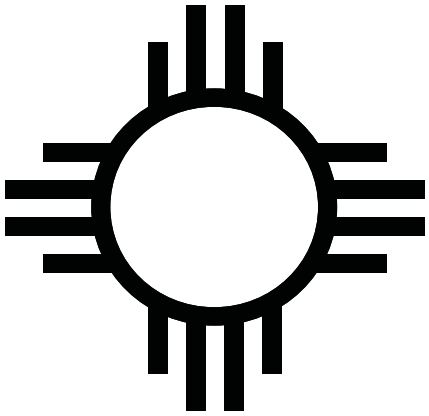

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2013

New Mexico Register

Volume XXIV, Number 24
December 30, 2013

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Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=***Amended***, E=***Emergency***, N=***New***, R=***Repealed***, Rn=***Renumbered***

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Notices of Rulemaking and Proposed Rules

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD NOTICE OF HEARING

On February 12, 2014, at 5:30 PM, the Albuquerque-Bernalillo County Air Quality Control Board (Air Board) is scheduled to hold a public hearing in the Vincent E. Griego Chambers located in the basement level of the Albuquerque-Bernalillo County Government Center, One Civic Plaza NW, Albuquerque, NM. The hearing will address:

* Proposal to amend 20.11.66 NMAC, *Process Equipment*, and Incorporate These Amendments into the New Mexico State Implementation Plan for Air Quality (SIP)

The Air Quality Division (AQD) of the City of Albuquerque Environmental Health Department is proposing these amendments for the following reasons:

1. Albuquerque-Bernalillo County regulations should be consistent with the State's regulations whenever possible [*See* NMSA § 74-2-4(C)]. The currently effective Sections 20.11.66.12 NMAC, *Emissions of Particulate Matter*, and 20.11.66.18 NMAC *Emissions of Particulate Matter: Table 1* are no longer consistent with the State's regulations. To resolve these inconsistencies, the City proposes to delete Sections 12 and 18 of 20.11.66 NMAC.

2. The language in the currently effective Section 20.11.66.12 NMAC, *Emissions of Particulate Matter*, is overbroad in scope, and inappropriately applies the same particulate matter emissions standards (i.e. 20.11.66.18 NMAC *Emissions of Particulate Matter: Table 1*) to disparate sources of particulate matter (PM) emissions, even though they each have unique operating and emissions characteristics. Therefore, Sections 12 and 18 of 20.11.66 NMAC are proposed to be deleted, and references to applicable New Source Performance Standards ("NSPS") and National Emissions Standards for Hazardous Air Pollutants ("NESHAPs") have been added to Sections 13, 14, and 15.

3. The process weight-based particulate matter emission limits for process equipment found in the currently effective Sections 20.11.66.12 NMAC, *Emissions of Particulate Matter*, and 20.11.66.18 NMAC, *Emissions of Particulate Matter: Table 1* are not practically enforceable. Sections 12 and 18 of 20.11.66 NMAC are proposed to be deleted for this reason.

4. The emissions standards in Sections 12 and 18 of 20.11.66 NMAC could potentially conflict with established federal NSPS and NESHAPs. To resolve these inconsistencies, the City proposes to delete Sections 12 and 18 of 20.11.66 NMAC, and language is proposed in Sections 13, 14 and 15 of 20.11.66 NMAC, to make it clear which NSPS or NESHAPs applies to each specific type of process equipment.

5. To clarify which standards apply to Cement Kilns, the City proposes to add language to Section 20.11.66.13 NMAC, *Cement Kilns*, that would impose different standards on cement kilns constructed or modified on or before August 17, 1971 versus those constructed or modified after that date. Both of these federal rules referenced in the proposed amended Section 20.11.66.13 NMAC are at least as stringent as Sections 12 and 18 of 20.11.66 NMAC, proposed to be deleted.

6. To clarify which standards apply to gypsum cookers (proposed title: "gypsum calciners"), the City proposes to add language to Section 20.11.66.14 NMAC, *Gypsum Cookers*, which would impose different standards on gypsum processing equipment, constructed, modified or reconstructed on or before April 23, 1986 versus that constructed, modified or reconstructed after that date. Also, the City proposes to change the title from "*Gypsum Cookers*" *to* "*Gypsum Caliners*" to more accurately reflect the types of sources that are affected.

7. Because the current rule could potentially be less stringent than existing federal standards, the City proposes to add clarifying language to Section 20.11.66.15 NMAC, *Asphaltic Batch Plants*, so that if any asphalt process equipment is subject to a federal PM emissions standard that is more stringent than that prescribed by currently effective Section 20.11.66.19 NMAC, *Asphaltic Batch Plants – Table 2*, then the federal rule shall govern. The City proposes to add citations for these federal standards in order to make it easier for the source to determine which standard is more stringent, and thus is applicable to their particular source. In addition the City is proposing to change the title of Section 20.11.66.15 NMAC, from "*Asphaltic Batch Plants*" to "*Asphalt Process Equipment*" and the title of 20.11.66.19 NMAC from "*Asphaltic Batch Plants – Table 2*" to "*Asphalt Process Equipment Allowable Emission Rates For Particulate Matter: Table 2*", to more accurately reflect the types of sources and emissions that are affected.

Under the currently effective Section 20.11.66.15 NMAC, asphaltic batch plants are not subject to Sections 12 or 18 of 20.11.66 NMAC, therefore the proposed deletion of these two sections will have no effect on Section 20.11.66.15 NMAC.

8. "Other" Process Equipment should be regulated by more specific PM emissions limits. The City contends that currently effective Sections 20.11.66.12 and 18, are overly broad and overly general. Under the proposed rule, these emission limits are eliminated and instead the process equipment is subject to specific PM emissions limits already set out in Air Board regulations and by enforceable permit conditions, which are at least as stringent as Sections 12 and 18 of 20.11.66 NMAC.

9. Currently effective 20.11.66 NMAC could inadvertently require sources with a Registration Certificate issued pursuant to 20.11.40 NMAC, *Source Registration*, to apply for a Construction Permit pursuant to the new 20.11.41 NMAC, *Construction Permits*, instead. To resolve these inconsistencies, the City proposes to delete Sections 12 and 18 of 20.11.66 NMAC, and language is proposed in Sections 13, 14 and 15 of 20.11.66 NMAC, to make it clear which specific types of sources are subject to **"an equipment emission limitation"**, and thus potentially subject to 20.11.41 NMAC.

Following the hearing, the Air Board will hold its regular monthly meeting during which the Air Board is expected to consider adopting the proposed amendments to 20.11.66 NMAC, *Process Equipment*.

The Air Quality Control Board is the federally-delegated air quality authority for Albuquerque and Bernalillo County. Local delegation authorizes the Air Board to administer and enforce the Clean Air Act and the New Mexico Air Quality Control Act, and to require local air pollution sources to comply with air quality standards and regulations.

Hearings and meetings of the Board are open to the public and all interested persons are encouraged to participate. All persons who wish to testify regarding the subject of the hearing may do so at the hearing and will be given a reasonable opportunity to submit relevant evidence, data, views, and arguments, orally or in writing, to

introduce exhibits and to examine witnesses in accordance with the Joint Air Quality Control Board Ordinances, Section 9-5-1-6 ROA 1994 and Bernalillo County Ordinance 94-5, Section 6, and 20.11.82 NMAC, *Rulemaking Procedures -- Air Quality Control Board.*

Anyone intending to present technical testimony at this hearing is required by 20.11.82.20 NMAC, *Technical Testimony; Notice Of Intent (NOI),* to submit a written Notice Of Intent to testify (NOI) before 5:00pm on January 28, 2014, to: Attn: Neal Butt, Air Quality Division, Albuquerque Environmental Health Department, P.O. Box 1293, Albuquerque, NM 87103, or, you may deliver your NOI to the Environmental Health Department, Suite 3023, Albuquerque-Bernalillo County Government Center, One Civic Plaza NW, Albuquerque, NM, 87102. The NOI shall: 1. identify the person for whom the witness or witnesses will testify; 2. identify each technical witness the person intends to present and state the qualifications of that witness, including a description of their educational and work background; 3. summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness; 4. include the text of any recommended modifications to the proposed regulatory change; and 5. list and describe, or attach, all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of rules.

In addition, written comments to be incorporated into the public record for this hearing should be received at the above P.O. Box, or Environmental Health Department office, before 5:00 pm on February 5, 2014. Comments shall include the name and address of the individual or organization submitting the statement. Written comments may also be submitted electronically to nbutt@cabq.gov and shall include the required name and address information. Interested persons may obtain a copy of the proposed regulation at the Environmental Health Department Office, or by contacting Mr. Neal Butt electronically at nbutt@cabq.gov or by phone (505) 768-2660.

NOTICE FOR PERSON WITH DISABILITIES: If you have a disability and require special assistance to participate in this process, please call 311 (Voice) and special assistance will be made available to you to receive any public meeting documents, including agendas and minutes. TTY users may request special assistance by calling the New Mexico Relay at 1-800-659-8331.

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF RULEMAKING HEARING

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing on March 21, 2014 at 10:00 AM in Room 307 at the State Capitol located at 490 Old Santa Fe Trail in Santa Fe, New Mexico. The purpose of the hearing is to consider the matter of EIB 13-09 (R), proposed repeal of Air Quality Control Regulation 20.2.85 NMAC Mercury Emission Standards and Compliance Schedules for Electric Generating Units ("20.2.85 NMAC").

The proponent of this regulatory repeal is the New Mexico Environment Department ("NMED") Air Quality Bureau.

The purpose of the public hearing is to consider and take possible action on a petition from NMED Air Quality Bureau to repeal 20.2.85 NMAC Mercury Emission Standards and Compliance Schedules for Electric Generating Units. This regulation was first adopted in 2007 to comply with a new federal regulation known as the Clean Air Mercury Rule, or CAMR. The proposed repeal of 20.2.85 NMAC is based on the vacatur of the Clean Air Mercury Rule, leaving 20.2.85 NMAC without any federal enforceability, and the implementation of the new Mercury Air Toxics Rule (MATS). The proposed repeal will eliminate any excess or redundant regulatory burdens placed on the State and facilities located within the jurisdiction of the New Mexico Environment Department relevant to 20.2.85 NMAC and the Mercury Air Toxics Rule, and any issues associated with enforcement of 20.2.85 NMAC.

The NMED will host an informal open house on the proposed repeal of 20.2.85 NMAC at the NMED Air Quality Bureau Office at 525 Camino de los Marquez, Suite 1, Santa Fe, New Mexico from 12:00pm to 2:00pm on February 3, 2014. To attend the informational open house, please contact Robert Spillers at 505-476-4324 or robert.spillers@state.nm.us.

The full text of the regulation proposed to be repealed may be reviewed during regular business hours at the NMED Air Quality Bureau office, 525 Camino de los Marquez, Suite 1, Santa Fe, New Mexico, and is also available on NMED's web site at www.nmenv.state.nm.us, or by contacting Robert Spillers at (505) 476-4324 or robert.spillers@state.nm.us.

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures – Environmental Improvement Board), the Environmental Improvement Act, NMSA 1978,Section 74-1-9, the Air Quality Control Act Section, NMSA 1978,74-2-6, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The notice of intent shall:

(1) identify the person for whom the witness(es) will testify;
(2) identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of their education and work background;
(3) summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness;
(4) list and describe, or attach, each exhibit anticipated to be offered by that person at the hearing; and
(5) attach the text of any recommended modifications to the proposed new and revised regulations.

Notices of intent for the hearing must be received in the Office of the Board not later than 5:00 pm on February 28, 2014 and should reference the docket number, EIB 13-09 (R), and the date of the hearing. Notices of intent to present technical testimony should be submitted to:

Pam Castaneda, Board Administrator
Office of the Environmental Improvement Board
Harold Runnels Building
1190 St. Francis Dr., Room 2150-N
Santa Fe, NM 87502
Phone: (505) 827-2425, Fax (505) 827-0310

Any member of the general public may testify at the hearing. No prior notification is required to present non-technical testimony at the hearing. Any such member may also offer exhibits in connection with his testimony, so long as the exhibit is not unduly repetitious of the testimony.

A member of the general public who wishes to submit a written statement for the record, in lieu of providing oral testimony at the hearing, shall file the written statement prior to the hearing, or submit it at the hearing.

Persons having a disability and needing help in being a part of this hearing process should contact the Juan Carlos Borrego of the NMED Human Resources Bureau by March 7, 2014 at P.O. Box 26110, 1190 St. Francis Drive, Santa Fe, New Mexico, 87502, telephone 505-827-0424, or email juancarlos.borrego@state.nm.us. TDY users please access his number via the New Mexico Relay Network at 1-800-659-8331.

The Board may make a decision on the proposed revised regulations at the conclusion of the hearing, or the Board may convene a meeting at a later date to consider action on the proposal.

NEW MEXICO GAME COMMISSION

STATE GAME COMMISSION PUBLIC MEETING AND RULE MAKING NOTICE

On **Thursday, January 9, 2014**, beginning at 8:00 a.m., in the **UNM-Valencia, Learning Resource Center, Room 101, 280 La Entrada, Los Lunas, NM 87031,** the State Game Commission will meet in public session to hear and consider action as appropriate on the following: Election of Chair and Vice Chair of State Game Commission, Annual Renewal of Open Meeting Procedures, Revocations, Citizen Advisory Committee Appointments for Habitat Stamp Program, Initiation of Javelina Rule Development 19.31.21 NMAC for the 2015-2019 Seasons, Initiation of Barbary Sheep, Oryx and Persian Ibex Rule Development – 19.31.12 NMAC for the 2015-2019 Seasons, Director's Initiation of Biennial Review of State Listed and Threatened or Endangered Species (17-2-40 NMSA 1978), and New Mexico Crucial Habitat Assessment Tool. Additionally they will hear and consider action as appropriate on proposed and final amendments to the following rules: Final Proposed Amendments to portions of 19.31.3 NMAC for Donation of Licenses and Permits, Final Proposed Amendments to portions of 19.31.12 NMAC for Oryx Licenses Issues to Service Men and Women, and Final Proposed Amendments to portions of 19.35.7 and 19.35.9 NMAC for Chronic Wasting Disease Testing Requirements for Importation and Herd Certification Program. They will hear general public comments (comments are limited to three minutes). A closed executive session is planned to discuss matters related to litigation.

Obtain a copy of the agenda from the Office of the Director, New Mexico Department of Game and Fish, P.O. Box 25112, Santa Fe, New Mexico 87504, or from the Department's website. This agenda is subject to change up to 72 hours prior to the meeting. Please contact the Director's Office at (505) 476-8000, or the Department's website at www.wildlife.state.nm.us for updated information.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing or meeting, please contact the Department at (505) 476-8000 at least one week prior to the meeting or as soon as possible. Public documents, including the agenda and minutes, can be provided in various accessible formats. Please contact the Department at 505-476-8000 if a summary or other type of accessible format is needed.

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

MOTOR TRANSPORTATION DIVISION

Notice

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY MOTOR TRANSPORTATION PUBLIC HEARING

On Monday February 3, 2014 at 9:00 a.m., the Motor Transportation Division will hold Public Hearing on rule change 18.19.8.102 Police Escorts.

The Public Hearing will be held at the New Mexico Law Enforcement Academy, 4491 Cerrillos Rd. Santa Fe, NM 87507

For copies of the proposed rule change may be obtained by accessing our website at www.dps.nm.org or by calling Captain Chris Mayrant at (505) 476-2467.

End of Notices and Proposed Rules Section

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Adopted Rules

NEW MEXICO BOARD OF DENTAL HEALTH CARE

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 5 DENTISTRY (DENTISTS, DENTAL HYGIENISTS, ETC.)
PART 58 DENTAL AMALGAM WASTE

16.5.58.1 ISSUING AGENCY: New Mexico Board of Dental Health Care.
[16.5.58.1 NMAC - N, 01-04-14]

16.5.58.2 SCOPE: The provisions of Part 58 of Chapter 5 apply to all New Mexico dental offices.
[16.5.58.2 NMAC - N, 01-04-14]

16.5.58.3 STATUTORY AUTHORITY: Part 58 of Chapter 5 is promulgated pursuant to the Dental Health Care Act, NMSA 1978, 61-5A-10 (2013) and the Dental Amalgam Waste Reduction Act, NMSA 1978, Sections 61-5C-1 to 6 (2013).
[16.5.58.3 NMAC - N, 01-04-14]

16.5.58.4 DURATION: Permanent.
[16.5.58.4 NMAC - N, 01-04-14]

16.5.58.5 EFFECTIVE DATE: January 4, 2014, unless a later date is cited at the end of a section.
[16.5.58.5 NMAC - N, 01-04-14]

16.5.58.6 OBJECTIVE: To promote the safe disposal of dental amalgam waste generated in dental offices.
[16.5.58.6 NMAC - N, 01-04-14]

16.5.58.7 DEFINITIONS:

A. "Amalgam" means a dental restorative material that is typically composed of mercury, silver, tin, and copper, along with other metallic elements, and that is used by a dentist to restore a cavity in a tooth.

B. "Amalgam separator" means a device that removes dental amalgam from the waste stream prior to discharge into either the local public wastewater system or a private septic system and that meets minimum removal efficiency in accordance with international standards contained in *ISO 11143, dental equipment-amalgam separators*, published by the international organization for standardization.

C. "Dental office" means a fixed physical structure in which dental services are provided to patients by dentists and dental professionals licensed or certified by the New Mexico board of dental health care under the management of a licensed owner, operator, or designee.
[16.5.58.7 NMAC - N, 01-04-14]

16.5.58.8 AMALGAM SEPARATOR; INSTALLATION REQUIREMENTS:

A. On or before December 31, 2014, the licensed owner(s), operator(s) or designee(s) of a dental office shall:

(1) install an appropriately sized amalgam separator system on each wastewater drain at the licensee or certificate holder's dental office; the amalgam separator system must, at a minimum, comply with international standard contained in *ISO 11143*; and

(2) within 90 days of installation, report the type, model, and size of the amalgam separator system, and the date the amalgam separator system became operational, to the board office and where applicable, to the local water treatment facility.

B. Exemption: An amalgam separator shall not be required for the offices or clinical sites of:

(1) a dental office that is not engaged in amalgam placement, removal or modification;

(2) an orthodontists;

(3) a periodontist;

(4) an oral and maxillofacial surgeons;

(5) an oral and maxillofacial radiologists;

(6) an oral pathologists; or

(7) a portable dental office without a fixed connection for wastewater discharge.

C. Licensed owner(s), operator(s) or designee(s) of a dental office with an existing amalgam separator must be in compliance with *ISO 11143* and shall report the type, model and size of the amalgam separator system to the board no later than December 31, 2014.
[16.5.58.8 NMAC - N, 01-04-14]

16.5.58.9 RECORD KEEPING AND REPORTING:

A. The board shall require all licensed owner(s), operator(s) or designee(s) of a dental office to verify, on each initial application and each triennial renewal that they are in compliance with Part 58 of Chapter 5.

B. Licensed owner(s), operator(s) or designee(s) of a dental office shall maintain records of operation, maintenance, and recycling or disposal of amalgam waste for the three years prior to their triennial license renewal; records shall include the following information:

(1) dates of maintenance;

(2) dates separator contents were recycled; and

(3) name of the staff or contractor performing the service.

C. Upon the board's inspection for cause, the licensed owner(s), operator(s) or designee(s) shall demonstrate proper installation, operation, maintenance, and recycling or disposal of amalgam waste in accordance with the amalgam separator manufacture's recommendations.
[16.5.58.9 NMAC - N, 01-04-14]

16.5.58.10 COMPLIANCE AND ENFORCEMENT: Failure to comply with Part 58 of Chapter 5 will constitute "unprofessional conduct" and may subject the licensed owner(s), operator(s) or designee(s) of a dental office to disciplinary action; willful and persistent noncompliance with the provisions of Part 58 of Chapter 5 and the Dental Amalgam Waste Reduction Act shall result in disciplinary action.
[16.5.58.10 NMAC - N, 01-04-14]

HISTORY OF 16.5.58 NMAC: [RESERVED]

NEW MEXICO BOARD OF DENTAL HEALTH CARE

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 5 DENTISTRY (DENTISTS, DENTAL HYGIENISTS, ETC.)
PART 59 LICENSURE FOR MILITARY SERVICE MEMBERS, SPOUSES AND VETERANS

16.5.59.1 ISSUING AGENCY: New Mexico Board of Dental Health Care.
[16.5.59.1 NMAC - N, 01-04-14]

16.5.59.2 SCOPE: This part sets forth application procedures to expedite licensure for military service members, spouses and veterans.
[16.5.59.2 NMAC - N, 01-04-14]

16.5.59.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to Section 61-1-34 of the Uniform Licensing Act, NMSA 1978, Section 61-1-1 to -34 (1957, as amended through 2013) and the Dental Health Care Act, NMSA 1978, Sections 61-5A-1 to -30.
[16.5.59.3 NMAC - N, 01-04-14]

16.5.59.4 DURATION: Permanent.
[16.5.59.4 NMAC - N, 01-04-14]

16.5.59.5 EFFECTIVE DATE: January 4, 2014, unless a later date is cited at the end of a section.
[16.5.59.5 NMAC - N, 01-04-14]

16.5.59.6 OBJECTIVE: The purpose of this part is to expedite licensure for military service members, spouses and veterans pursuant to NMSA 1978, Section 61-1-34.
[16.5.59.6 NMAC - N, 01-04-14]

16.5.59.7 DEFINITIONS:

A. "Military service member" means a person who is serving in the armed forces of the United States or in an active reserve component of the armed forces of the United States, including the national guard.

B. "Recent veteran" means a person who has received an honorable discharge or separation from military service within the two years immediately preceding the date the person applied for an occupational or professional license pursuant to this section.
[16.5.59.7 NMAC - N, 01-04-14]

16.5.59.8 APPLICATION REQUIREMENTS:

A. Applications for registration shall be completed on a form provided by the department.

B. Completed application shall include:

(1) application fee; and

(2) satisfactory evidence that the applicant holds a license that is current and in good standing, issued by another jurisdiction, including a branch of armed forces of the United States, that has met the minimal licensing requirements that are substantially equivalent to the licensing requirements for the occupational or professional license the applicant applies for pursuant to Chapter 61, Articles 5A NMSA 1978.

C. Electronic signatures will be acceptable for applications submitted pursuant to section 14-16-1 through section 14-16-19 NMSA 1978.
[16.5.59.8 NMAC - N, 01-04-14]

16.5.59.9 FEES: An applicant seeking licensure under Part 59 of Chapter 5 NMAC shall refer to the following parts for applicable fees:

A. for a dentist applicant, refer to 16.5.5 NMAC;

B. for a dental hygiene applicant, refer to 16.5.18 NMAC;

C. for a dental assistant applicant, refer to 16.5.32 NMAC;

D. for an expanded function dental auxiliary applicant, refer to 16.5.41 NMAC; and

E. for a community dental health coordinator applicant, refer to 16.5.49 NMAC.
[16.5.59.9 NMAC - N, 01-04-14]

16.5.59.10 RENEWAL REQUIREMENTS:

A. A license or certificate issued pursuant to this section shall not be renewed unless the license or certificate holder satisfies the requirements for the issuance and for the renewal of a license or certificate pursuant to Chapter 61, Articles 5A NMSA 1978.

B. The licensee or certificate holder issued under Part 59 of Chapter 5 shall submit the documentation required under the following parts:

(1) for a dentist, refer to 16.5.8 NMAC for required documentation;

(2) for a dental hygienist, refer to 16.5.20 NMAC for required documentation;

(3) for a dental assistants, refer to 16.5.33 NMAC for required documentation;

(4) for an expanded function dental auxiliary, refer to 16.5.42 NMAC for required documentation; and

(5) for a community dental health coordinator, refer to 16.5.50 NMAC for required documentation.

C. All licenses and certificates issued under Part 59 of Chapter 5 shall be valid for a period not to exceed three years.

D. Prior to the expiration of the license, all licensees or certificate holders shall apply for registration renewal and shall pay the renewal fee as set forth in 16.5.59.9 NMAC.
[16.5.59.10 NMAC - N, 01-04-14]

HISTORY OF 16.5.59 NMAC: [RESERVED]

NEW MEXICO BOARD OF DENTAL HEALTH CARE

This is an amendment to 16.5.1 NMAC, Section 3, 7 & 26, effective 01/04/14.

16.5.1.3 STATUTORY AUTHORITY: NMSA 1978 Section 61-5A-1 through Section 61-5A-29 (1996 Repl. Pamp.). Section 16.5.1.10 NMAC is authorized by NMSA 1978 Section 10-15-1 (C) (1993 Repl. Pamp.) Section 16.5.1.11 NMAC and 16.5.1.12 NMAC are authorized by NMSA 1978 Section 14-2-1 through 14-2-16 (1993 Repl. Pamp.). Section 16.5.1.26 is authorized by NMSA 1978, Section 14-16-18.
[9-30-96; 16.5.1.3 NMAC - Rn, 16 NMAC 5.1.3, 12-14-00; A, 01-04-14]

16.5.1.7 DEFINITIONS:

A. "Act" means the Dental Health Care Act, Sections 61-5A-1 through 61-5A-29, NMSA 1978.

B. "Assessment" means the review and documentation of the oral condition, and the recognition and documentation of deviations from the healthy condition, without a diagnosis to determine the cause or nature of disease or its treatment.

C. "Authorization" means written or verbal permission from a dentist to a dental hygienist, dental assistant, or dental student to provide specific tests, treatments or regimes of care.

D. "CITA" means the council of interstate testing agencies, a separate and independent entity not including any successor, which acts as a representative agent for the board and committee in providing written and clinical examinations to test the applicant's competence to practice in New Mexico.

[~~D.~~] E. "Close personal supervision" means a New Mexico licensed dentist directly observes, instructs and certifies in writing the training and expertise of New Mexico licensed or certified employees or staff.

[~~E.~~] F. "Consulting dentists" means a dentist who has entered into an approved agreement to provide consultation and create protocols with a collaborating dental hygienist and, when required, to provide diagnosis and authorization for services, in accordance with the rules of the board and the committee.

[~~F.~~] G. "CRDTS" means the central regional dental testing service, a separate and independent entity not including any successor, which acts as a representative agent for the board and committee in providing written and clinical examinations to test the applicant's competence to practice in New Mexico.

[~~G.~~] H. "Current patients of record" means the New Mexico licensed dentist has seen the patient in the practice in the last 12 months.

[~~H.~~] I. "Dental hygiene-focused assessment" means the documentation of existing oral and relevant systemic conditions and the identification of potential oral disease to develop, communicate, implement and evaluate a plan of oral hygiene care and treatment.

[~~I.~~] J. "Dental record" means electronic, photographic, radiographic or manually written records.

[~~J.~~] K. "Diagnosis" means the identification or determination of the nature or cause of disease or condition.

[~~K.~~] L. "Direct supervision" means the process under which an act is performed when a dentist licensed pursuant to the Dental Health Care Act:

(1) is physically present throughout the performance of the act;

(2) orders, controls and accepts

full professional responsibility for the act performed;

(3) evaluates and approves the procedure performed before the patient departs the care setting; and

(4) is capable of responding immediately if any emergency should arise.

M. "Electronic signature" means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

[~~L.~~] N. "Extenuating circumstances" are defined as a serious, physician-verified illness or death in immediate family, or military service. The extenuating circumstances must be presented for the board's consideration on a case-by-case basis.

[~~M.~~] O. "General supervision" means the authorization by a dentist of the procedures to be used by a dental hygienist, dental assistant, expanded function dental auxiliary, dental student, or community dental health coordinator and the execution of the procedures in accordance with a dentist's diagnosis and treatment plan at a time the dentist is not physically present and in facilities as designated by the rules of the board.

[~~N.~~] P. "Impaired Act" means the Impaired Dentists and Dental Hygienists Act, Sections 61-5B-1 through 61-5B-11, NMSA 1978.

[~~O.~~] Q. "Indirect supervision" means that a dentist, or in certain settings a dental hygienist or dental assistant certified in expanded functions, is present in the treatment facility while authorized treatments are being performed by a dental hygienist, dental assistant or dental student as defined in 61-5A-3 NMSA 1978.

[~~P.~~] R. "Jurisprudence exam" means the examination given regarding the laws, rules and regulations, which relate to the practice of dentistry, dental hygiene and dental assisting in the state of New Mexico.

[~~Q.~~] S. "Licensee" means an individual who holds a valid license to practice dentistry or dental hygiene in New Mexico.

[~~R.~~] T. "NERB/ADEX" means the north east regional board of dental examiners, a separate and independent entity not including any successor, which acts as a representative agent for the board and committee in providing written and clinical examinations to test the applicant's competence to practice in New Mexico.

[~~S.~~] U. "Non-dentist owner" means an individual not licensed as a dentist in New Mexico or a corporate entity not owned by a majority interest of a New Mexico licensed dentist that employs or contracts with a dentist or dental hygienist to provide dental or dental hygiene services and that does not meet an exemption status as detailed in 61-5A-5 G, NMSA 1978.

[~~T.~~] V. "Palliative procedures" means nonsurgical, reversible procedures that are meant to alleviate pain and stabilize acute or emergent problems.

[~~U.~~] W. "Professional background service" means a board designated professional background service, which compiles background information regarding an applicant from multiple sources.

[~~V.~~] X. "Provider" means a provider of dental health care services, including but not limited to dentists, dental hygienists, and dental assistants.

[~~W.~~] Y. "Specialist" means a specialty is an area of dentistry that has been formally recognized by the board and the American dental association as meeting the specified requirements for recognition of dental specialists.

[~~X.~~] Z. "SRTA" means the southern regional testing agency, a separate and independent entity not including any successor, which acts as a representative agent for the board and committee in providing written and clinical examinations to test the applicant's competence to practice in New Mexico.

[~~Y.~~] AA. "Supervising dentist" means a dentist that maintains the records of a patient, is responsible for their care, has reviewed their current medical history and for purposes of authorization, has examined that patient within the previous 11 months or will examine that patient within 30 days of giving authorization.

[~~Z.~~] BB. "Supervision" means the dentist shall adequately monitor the performance of all personnel, licensed or unlicensed, that he or she supervises. The dentist is ultimately responsible for quality patient care and may be held accountable for all services provided by administrative and clinical individuals that the dentist supervises.

[~~AA.~~] CC. "Teledentistry" means a dentist's use of health information technology in real time to provide limited diagnostic treatment planning services in cooperation with another dentist, a dental hygienist, a community health coordinator or a student enrolled in a program of study to become a dental assistant, dental hygienist or dentist.

[~~BB.~~] DD. "WREB" means the western regional examining board, which acts as the representative agent for the board and committee in providing written and clinical examinations to test the applicant's competence to practice in New Mexico.

[~~CC.~~] EE. "Written authorization" means a signed and dated prescription from a supervising dentist to a dental hygienist to provide specific tests, treatments or regimes of care in a specified location for 30 days following the date of signature.

[3-11-89, 5-31-95, 9-30-96, 12-15-97; 16.5.1.7 NMAC - Rn, 16 NMAC 5.1.7, 12-14-00; A, 06-14-01; A, 03-29-02; A, 03-06-05; A, 07-16-07; A, 07-17-08; A, 07-19-10; A, 01-09-12; A, 06-14-12; A, 07-17-13; A, 01-04-14]

16.5.1.26 ELECTRONIC SIGNATURES: The board will accept electronic signatures on all applications and renewals submitted for professional licensure under the Dental Health Care Act, NMSA 1978, Sections 61-5A-1 to-30.

[16.5.1.26 NMAC - N, 01-04-14]

NEW MEXICO BOARD OF DENTAL HEALTH CARE

This is an amendment to 16.5.16 NMAC, Section 10, effective 01/04/14.

16.5.16.10 GUIDELINES: The board shall use the following as guidelines for disciplinary action.

A. "Gross incompetence" or "gross negligence" means, but shall not be limited to, a significant departure from the prevailing standard of care in treating patients.

B. "Unprofessional conduct" means, but is not limited to because of enumeration:

(1) performing, or holding oneself out as able to perform, professional services beyond the scope of one's license and field or fields of competence as established by education, experience, training, or any combination thereof; this includes, but is not limited to, the use of any instrument or device in a manner that is not in accordance with the customary standards and practices of the dental profession;

(2) failure to refer a patient, after emergency treatment, to his/her regular dentist and inform the latter of the conditions found and treated;

(3) failure to release to a patient copy of that patient's records and x-rays regardless whether patient has an outstanding balance;

(4) failure to seek consultation whenever the welfare of the patient would be safeguarded or advanced by referral to individuals with special skills, knowledge, and experience;

(5) failure to advise the patient in simple understandable terms of the proposed treatment, the anticipated fee, the expectations of success, and any reasonable alternatives;

(6) failure of a dentist to comply with the following advertising guidelines, no person shall:

(a) practice dentistry under the name of a corporation, company, association,

limited liability company, or trade name without full and outward disclosure of his/her full name, which shall be the name used in his/her license or renewal certificate as issued by the board, or his/her commonly used name;

(b) practice dentistry without displaying his/her full name as it appears on the license issued by the board on the entrance of each dental office;

(c) fail to include in all advertising media for the practice (excluding building signage and promotional items), in a reasonably visible and legible manner, the dentist's names(s), address and telephone number or direct reference where the name of the dentist(s) can be found as defined in 16.5.16.7 NMAC;

(d) advertise a practice in a false, fraudulent or misleading manner; if the name of the practice or office contains one of the American dental association recognized specialties and only a general dentists performs that service, the advertisement, signage, or broadcast media must say "services provided by a general dentist", so as not to imply that a specialist is performing such procedures; and

(e) advertise as a specialist unless the dentist is licensed by the board to practice the specialty or unless the dentist has earned a post-graduate degree or certificate from an accredited dental college, school of dentistry of a university or other residency program that is accredited by commission on dental accreditation (CODA) in one of the specialty areas of dentistry recognized by the American dental association;

(7) failure to use appropriate infection control techniques and sterilization procedures;

(8) deliberate and willful failure to reveal, at the request of the board, the incompetent, dishonest, or corrupt practices of another dentist licensed or applying for licensure by the board;

(9) accept rebates, or split fees or commissions from any source associated with the service rendered to a patient; provided, however, the sharing of profits in a dental partnership, association, HMO or DMO, or similar association shall not be construed as fee-splitting, nor shall compensating dental hygienists or dental assistants on a basis of percentage of the fee received for the overall service rendered be deemed accepting a commission;

(10) prescribe, dispense or administer drugs outside the scope of dental practice;

(11) charge a patient a fee which is not commensurate with the skill and nature of services rendered, such as to be unconscionable;

(12) sexual misconduct;

(13) breach of ethical standards, an inquiry into which the board will begin by reference to the code of ethics of the American dental association;

(14) the use of a false, fraudulent or deceptive statement in any document connected with the practice of dentistry;

(15) employing abusive billing practices;

(16) fraud, deceit or misrepresentation in any application;

(17) violation of any order of the board, including any probation order;

(18) injudicious prescribing, administration, or dispensing of any drug or medicine;

(19) failure to report to the board any adverse action taken by any licensing board, peer review body, malpractice insurance carrier or any other entity as defined by the board or committee; the surrender of a license to practice in another state, surrender of membership on any medical staff or in any dental or professional association or society, in lieu of, and while under disciplinary investigation by any authority;

(20) negligent supervision of a dental hygienist or dental assistant;

(21) cheating on an examination for licensure; or

(22) failure to comply with the terms of a signed collaborative practice agreement;

(23) failure of a dentist of record, or consulting dentist, to communicate with a collaborative practice dental hygienist in an effective professional manner in regard to a shared patient's care under part 17 of these rules;

(24) assisting a health professional, or being assisted by a health professional that is not licensed to practice by a New Mexico board, agency or commission;

(25) failure to make available to current patients of record a reasonable method of contacting the treating dentist or on-call service for dental emergencies; dental practices may refer patients to an alternate urgent care or emergency facility if no other option is available at the time, or if the contacted dentist deems it necessary for the patient's well-being;

(26) conviction of either a misdemeanor or a felony punishable by incarceration;

(27) aiding and abetting a dental assistant, expanded function dental auxiliary or community dental health coordinator who is not properly certified;

(28) patient abandonment;

(29) habitually addicted as defined in NMSA 1978, Sections 61.5A-21 4 & 6 or 61.5B-3 (C) and (D) habitual or excessive use or abuse of drugs, as defined in the Controlled Substances Act [30-31-1 NMSA 1978] or habitual or excessive use or abuse of alcohol;

(30) failure of the licensee to furnish the board within 10 business days of request, its investigators or representatives with information requested by the board;

(31) failure to appear before the board when requested by the board in any disciplinary proceeding; [~~and~~]

(32) failure to be in compliance with the Parental Responsibility Act NMSA1978, Section 40-5A-3 seq.;

(33) fraudulent record keeping;

(34) failure to properly install amalgam separator as defined in 16.5.58 NMAC;

(35) failure to properly operate and maintain amalgam separator as defined in 16.5.58 NMAC; and

(36) failure to properly dispose of amalgam waste as defined in 16.5.58 NMAC.

[9-13-69, 10-21-70, 4-11-81, 3-9-89, 3-11-89,10-16-92, 5-31-95, 6-4-96, 2-14-00; 16.5.16.10 NMAC - Rn & A, 16 NMAC 5.16.10, 12-14-00; A, 07-16-07; A, 07-19-10; A, 01-09-12; A, 06-14-12; A, 07-17-13; A, 01-04-14]

NEW MEXICO BOARD OF DENTAL HEALTH CARE

This is an amendment to 16.5.29 NMAC, Section 7, 8 & 11, added a new Section 12, effective 01/04/14.

16.5.29.7 DEFINITIONS:

A. "Cavitation" means a break in the continuous, solid surface of the enamel of a tooth, created either by genetic formation or demineralization.

B. "Dental hygiene-focused assessment" means the documentation of existing oral and relevant systemic conditions and the identification of potential oral disease to develop, communicate, implement and evaluate a plan of oral hygiene care and treatment.

C. "Laser" means light amplification by stimulated emission of radiation used for the therapeutic treatment of the head and neck or oral cavity.

[~~C.~~] D. "Topical **[**~~theraputic~~] therapeutic agents" means agents applied to the teeth or gingiva that have a therapeutic effect locally with limited or no systemic effect.

[9/30/96; 16.5.29.7 NMAC - Rn, 16 NMAC 5.29.7, 04/17/06; A, 01/09/12; A, 01/04/14]

16.5.29.8 SCOPE OF PRACTICE: A dental hygienist may perform dental hygiene services as defined in Section 61-5A-4 B thru F of the act with the supervision defined. In addition, a licensed [~~hygienst~~] hygienist may:

A. prescribe, administer or dispense therapeutic [~~agenst~~] agents as per the formulary as defined in Subsection C of

16.5.29.11 NMAC;

B. function as an expanded function dental auxiliary after passing the certifying exam and completing the apprenticeship accepted by the board;

C. function as a community dental health coordinator after completing a program certified by the board;

D. except in cases where a tooth exhibits cavitation of the enamel surface, assessing without a dentist's evaluation whether the application of pit and fissure sealants is indicated;

E. except in cases where a tooth exhibits cavitation of the enamel surface, applying pit and fissure sealants without mechanical alteration of the tooth;

F. administration of local anesthesia as defined in 16.5.28 NMAC; and

G. such other closely related services as permitted by the rules of the committee and the board.

[10/21/70, 5/31/95; 16.5.29.8 NMAC - Rn, 16 NMAC 5.29.8, 04/17/06; A, 01/09/12; A, 12/15/12; A, 01/04/14]

16.5.29.11 DENTAL HYGIENISTS PRESCRIPTIVE AUTHORITY: A dental hygienist may prescribe, administer and dispense a [~~flouride~~] fluoride supplement, topically applied [~~flouride~~] fluoride, and topically applied antimicrobials from the following formulary under the following stipulations.

A. A New Mexico licensed dentist shall supervise, at least by general supervision the prescribing, administration or dispensing by the hygienist. In a collaborative hygiene practice the formulary used by the dental hygienist and situations for each therapeutic agent must be set forth in the collaborative practice agreement. Dental hygienists shall keep as part of the patient record a clear documentation of the therapeutic agent prescribed, administered or dispensed, the date and reason.

B. Under no circumstances shall a dental hygienist be allowed to prescribe, dispense or administer:

(1) drugs whose primary effect is systemic; and

(2) dangerous drugs or controlled substances as defined in the pharmacy act (NMSA 1978, Section 61-11-1 et deq.) controlled substances act (NMSA 1978, Sections 31-30-1 et seq.) or Drug Device and Cosmetic Act (NMSA 1978, Sections 26-1-1 et seq.).

C. Dental hygienists may prescribe from the following list:

(1) fluoride supplements (all using sodium fluoride);

(a) tablets – 0.5 mg, 1.1 mg, 2.2 mg;

(b) lozenges – 2.21 mg;

(c) drops – 1.1 mg/mL;

(2) topical anti-caries treatments (all using sodium fluoride unless otherwise stated);

(a) toothpastes – 1.1% or less (or stannous fluoride 0.4%);

(b) topical gels – 1.1% or less (or stannous fluoride 0.4%);

(c) oral rinses – 0.05%, 0.2%, 0.44%, 0.5%;

(d) oral rinse concentrate (used in periodontal disease) – 0.63% stannous fluoride;

(e) fluoride varnish – 5 %;

(f) prophy pastes (containing approximately 1.23% sodium fluoride and used for cleaning and polishing procedures as part of professional dental prophylaxis treatment);

(3) topical anti-infectives:

(a) chlorhexidine gluconate ;

(i) rinses – 0.12%;

(ii) periodontal chips (for insertion into the periodontal pocket);

(b) tetracycline impregnated fibers (inserted subgingivally into the periodontal sulcus);

(c) doxycycline hyclate periodontal gel (inserted subgingivally into the periodontal sulcus); and

(d) minocycline hydrochloride periodontal paste (inserted subgingivally into the periodontal sulcus).

[16.5.29.11 NMAC - N, 01/09/12; A, 01/04/14]

16.5.29.12 THERAPEUTIC USE OF LASERS: The board does not issue permits for the use of lasers by hygienists in soft tissue curettage, sulcular debridement and tissue disinfection in periodontal therapy. Due to the rising utilization of lasers by dental hygienists, the committee and board sets forth the following requirements:

A. a New Mexico licensed dental hygienist may use laser devices that are approved by the U.S. food and drug administration under the indirect supervision of a New Mexico licensed dentist;

B. the hygienist must successfully complete an educational progaram on laser use that is a minimum of 6 hours and includes hand-on clinical simulation training; the course shall comply with current gudelines as outlined in 16.5.1.15 NMAC for continuing education;

C. a certificate of sucessful course completion from the dental laser training entity shall be posted in a conspicious location within the dental facility;

D. all promotion or advertising of dental laser treatment shall comply with current requirements as outlined in Subsection B of 16.5.30.10. NMAC, identifying the "supervising dentist" as responsible for the provision of or the supervision of the laser procedure;

E. dental laser treatment shall not be designated to a dental assistant.

[16.5.29.12 NMAC - N, 01/04/14]

NEW MEXICO BOARD OF DENTAL HEALTH CARE

This is an amendment to 16.5.39 NMAC, Section 10, effective 01/04/14.

16.5.39.10 NON-ALLOWABLE PROCEDURES: Licensees may not delegate the performance of the following procedures to auxiliary personnel:

A. removal of, or addition to, the hard or soft tissue of the oral cavity;

B. diagnosis and treatment planning;

C. final impressions, to include physical and digital impressions, for restorations or prosthetic appliances;

D. initial fitting and adaptation of prostheses;

E. final fitting, adaptation, seating and cementation of any fixed or removable dental appliance or restoration, including but not limited to inlays, crowns, space maintainers, habit devices, anti-snoring or sleep apnea appliances or splints;

F. irrigation and medication of canals, cone try-in, reaming, filing or filling of root canals;

G. other services defined as the practice of dentistry or dental hygiene in Section 61-5A-4, A, B, and C; [~~and~~]

H. bleaching or whitening teeth without direct or indirect supervision of a dentist; and

I. laser-assisted non-surgical periodontal treatment.

[10-21-70...5-31-95; 9-30-96; 16.5.39.10 NMAC - Rn & A, 16 NMAC 5.39.10, 9-30-02; A, 07-17-13; A, 01-04-14]

NEW MEXICO BOARD OF DENTAL HEALTH CARE

This is an amendment to 16.5.46 NMAC, Section 9, effective 01/04/14.

16.5.46.9 ALLOWABLE DUTIES UNDER DIRECT SUPERVISON: The following EFDA procedures are allowable under direct supervision as set forth in 16.5.46.8 NMAC.

A. Placing and shaping of direct restorative materials into cavity preparations completed by a dentist; EFDA may use instrumentation as necessary and proper for this purpose.

B. Taking of impressions for permanent fixed or removable prosthetics involving single teeth, to include digital impressions. These include single crowns or single tooth replacement prosthetics. EFDA shall NOT take final impressions for multiple units of single crowns, bridges, cast

framework partial dentures or full dentures final impressions.

C. Cement permanent or provisional restorations with temporary or provisional cement, provided the permanent cementation will be completed or monitored by the dentist within six months.

D. Place pit and fissure sealants under supervision as certification or licensure allows.

E. Place temporary or sedative restorations in open carious lesions after hand excavation of gross decay and debris. If pain is perceived by the patient dentist shall evaluate lesion before completion by EFDA. The EFDA shall NOT use any automated method to clean out the lesion or prepare the tooth, including but not limited to high speed, slow speed, air abrasion, ultrasonic, laser etc.

F. The EFDA may place temporary or sedative restorative material into unprepared tooth fractures as a palliative measure. The EFDA shall NOT use any automated method to clean out the fracture or prepare the tooth, including but not limited to high speed, slow speed, air abrasion, ultrasonic, laser etc.

G. Remove residual orthodontic bracket or band cement or resin from teeth after the brackets or bands have been removed by the dentist performing the orthodontic treatment, or to prepare the tooth or teeth for re-cementation of a debonded bracket or band. This removal of cement/ resin may include the use of instrumentation, as necessary and proper for this purpose.

H. Perform preliminary fitting and shaping of stainless steel crowns which shall undergo final evaluation and cementation by a dentist.

I. In emergency situation recement temporary or permanent crowns or bridges using provisional cement under the general supervision of a dentist and when instructed to do so by the dentist provided the permanent cementation will be completed or monitored by the dentist within six months.

[16.5.46.9 NMAC - N, 01/09/12; A, 06/14/12; A. 01/04/14]

NEW MEXICO EDUCATIONAL RETIREMENT BOARD

This is an amendment to 2.82.1 NMAC, Section 14, effective 12-30-13.

2.82.1.14 INVESTMENT COMMITTEE: The investments of the retirement fund shall be under the immediate direction of an investment committee composed of the [~~director, the~~] chairman of the board, and [~~two~~] three members of the board appointed by the chairman and approved by the board, for terms of one (1) year. The appointments by the chairman shall take place at the board's regular October meeting each year. In the event of a vacancy on the committee, the chairman may appoint a member of the board to serve for the remaining portion of the one (1) year term. The appointment shall become effective immediately; provided, however, that it shall be subject to approval by the board at its first meeting occurring after said appointment. The actions of [~~this~~] the committee shall be [~~governed by~~] subject to the applicable statutes governing investment of the educational retirement fund, and [~~by~~] the administrative rules and [~~regulations~~] policies adopted by the board relating to investments [~~adopted by the board~~] of the fund.

[2.82.1.14 NMAC - Rp, 2.82.1.13 NMAC, 11-15-12; A, 12-30-13]

NEW MEXICO EDUCATIONAL RETIREMENT BOARD

This is an amendment to 2.82.8 NMAC, Section 8, effective 12-30-13.

2.82.8.8 INVESTMENT COMMITTEE:

A. The investment committee shall be composed [~~of the chairman who shall be an ex-officio member, two members of the board who shall be appointed by the chairman and approved by the board for a term of one year, and the director~~] as set forth in 2.82.1.14 NMAC.

B. The investment committee shall meet regularly each calendar quarter with additional meetings as required. The committee shall elect a chairman annually who shall call special meetings and preside at all meetings. Three members of the committee shall constitute a quorum.

C. The investment committee shall have the following responsibilities:

(1) to review all actions taken by the investment division in the management of the fund and recommend to the board specific action with regard to the continuation or change in the investment practices of the investment vision;

(2) to review on a continuing basis the investment philosophy and investment guidelines of the fund, make policy recommendations to the board and generally oversee the investment activities of the fund;

(3) to recommend the employment of the services of an investment advisory firm to assist and advise the board in the management of the fund;

(4) to recommend the employment of the services of investment management firm(s) to manage a portion of the assets of the fund, either through separately managed accounts or through individual, common or collective trust funds;

(5) to establish asset allocation guidelines, which shall define asset allocation targets and ranges, and to annually review/ modify these guidelines; as set forth in the ERB investment objectives and guidelines which shall be approved by the investment committee and recommended for board approval.

D. The investment committee may at any time withdraw the authority of the investment division to execute orders on behalf of the fund. Authority cannot be denied retroactively.

E. Investment committee members may attend and participate in any regular or special investment committee meeting by telephone or other electronic device only if:

(1) the member cannot attend the meeting due to an emergency or unforeseen circumstance;

(2) the member's voice can clearly be heard by everyone in attendance of the meetings and the member clearly identifies himself before speaking or participating in a vote;

(3) the member has not attended regular meetings electronically more than four times in a rolling twelve month period;

(4) no more than two members who otherwise qualify for participation under this section may do so at the same meeting; and

(5) the member otherwise complies with the Open Meetings Act.

[6-30-99; 2.82.8.8 NMAC - Rn, 2 NMAC 82.8.8, 1-30-2004; A, 12-30-2013]

NEW MEXICO ENERGY, MINERALS, AND NATURAL RESOURCES DEPARTMENT

ENERGY CONSERVATION AND MANAGEMENT DIVISION

Repeal Language

The Energy Conservation and Management Division repeals its rule entitled Sustainable Building Tax Credit for Commercial Buildings, 3.3.30 NMAC (filed 10-10-2007) and replaces it with 3.3.30 NMAC entitled Sustainable Building Tax Credit for Commercial Buildings, effective 1-1-2014.

The Energy Conservation and Management Division repeals its rule entitled Sustainable Building Tax Credit for Commercial Buildings, 3.4.17 NMAC (filed 10-10-2007) and replaces it with 3.4.17 NMAC entitled Sustainable Building Tax Credit for Commercial Buildings, effective 1-1-2014.

NEW MEXICO ENERGY, MINERALS, AND NATURAL RESOURCES DEPARTMENT

ENERGY CONSERVATION AND MANAGEMENT DIVISION

TITLE 3 TAXATION
CHAPTER 3 PERSONAL INCOME TAXES
PART 30 SUSTAINABLE BUILDING TAX CREDIT FOR COMMERCIAL BUILDINGS

3.3.30.1 ISSUING AGENCY: Energy, Minerals and Natural Resources Department.
[3.3.30.1 NMAC - Rp, 3.3.30.1 NMAC, 1-1-14]

3.3.30.2 SCOPE: 3.3.30 NMAC applies to the application and certification procedures for administration of the sustainable building tax credit for sustainable commercial buildings.
[3.3.30.2 NMAC - Rp, 3.3.30.2 NMAC, 1-1-14]

3.3.30.3 STATUTORY AUTHORITY: 3.3.30 NMAC is established under the authority of NMSA 1978, Section 7-2-18.19 and NMSA 1978, Section 9-1-5.
[3.3.30.3 NMAC - Rp, 3.3.30.3 NMAC, 1-1-14]

3.3.30.4 DURATION: Permanent.
[3.3.30.4 NMAC - Rp, 3.3.30.4 NMAC, 1-1-14]

3.3.30.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[3.3.30.5 NMAC - Rp, 3.3.30.5 NMAC, 1-1-14]

3.3.30.6 OBJECTIVE: 3.3.30 NMAC's objective is to establish procedures for administering the program to issue a certificate of eligibility for the sustainable building tax credit for sustainable commercial buildings.
[3.3.30.6 NMAC - Rp, 3.3.30.6 NMAC, 1-1-14]

3.3.30.7 DEFINITIONS:

A. "Annual cap" means the annual aggregate amount of the sustainable building tax credit available to taxpayers owning sustainable commercial buildings.

B. "Applicant" means a taxpayer who owns a sustainable commercial building in New Mexico and who desires to have the department issue a certificate of eligibility for a sustainable building tax credit.

C. "Application package" means the application documents an applicant submits to the division to receive a certificate of eligibility for a sustainable building tax credit.

D. "Build green New Mexico certification" means the verification by a department-approved verifier, that a building project has met certain prerequisites and performance benchmarks or credits within each category of the build green New Mexico rating system resulting in the issuance of a certification document.

E. "Build green New Mexico rating system" means the certification standards adopted by the homebuilders association of central New Mexico.

F. "Building project" means a new construction or renovation project that will result in one or more sustainable commercial buildings.

G. "Building type" means the primary use of a building or section of a building as defined in target finder.

H. "Certificate of eligibility" means the document, with a unique identifying number that specifies the amount and taxable year for the approved sustainable building tax credit.

I. "Certification level" means one of the following:

(1) LEED-H silver or build green New Mexico silver;

(2) LEED-H gold or build green New Mexico gold; or

(3) LEED-H platinum or build green New Mexico emerald.

J. "Department" means the energy, minerals and natural resources department.

K. "Division" means the department's energy conservation and management division.

L. "Energy reduction requirements":

(1) for a non-multi-family commercial building means beginning January 1, 2012, a 60 percent energy reduction based on the national average for that building type as published by the United States department of energy;

(2) for a multi-family dwelling unit means that it has achieved a home energy rating system index of sixty or lower as developed by the residential energy services network.

M. "HERS" means home energy rating system as developed by RESNET.

N. "HERS index" means a relative energy use index, where 100 represents the energy use of a home built to a HERS reference house and zero indicates that the proposed home uses no net purchased energy.

O. "LEED" means the most current leadership in energy and environmental design green building rating system guidelines developed and adopted by the U. S. green building council.

P. "LEED certification" means the U. S. green building council's verification that a building project has met certain prerequisites and performance benchmarks or credits within each category of a LEED rating system resulting in the issuance of a certification document.

Q. "LEED-CI" means the LEED rating system for commercial interiors.

R. "LEED-CS" means the LEED rating system for the core and shell of buildings.

S. "LEED-EB" means the LEED rating system for existing buildings.

T. "LEED-NC" means the LEED rating system for new buildings and major renovations.

U. "LEED rating system" means one of the following:

(1) LEED-CI;

(2) LEED-CS;

(3) LEED-EB; or

(4) LEED-NC.

V. "LEED registration" means the notification to the U. S. green building council that a project is pursuing LEED certification.

W. "Most current" means the LEED rating system available and selected at the time of LEED registration.

X. "Person" does not include state, local government, public school district or tribal agencies.

Y. "Qualified occupied square footage" means the building's occupied spaces as determined by the U. S. green building council for those buildings obtaining LEED certification or the administrators of the build green New Mexico rating system for those homes obtaining build green New Mexico certification.

Z. "RESNET" means the residential energy services network, an industry not-for-profit membership corporation and national standards making body for building energy efficiency rating systems.

AA. "Solar market development tax credit" means the personal income tax credit the state of New Mexico issues to a taxpayer for a solar energy system the department has certified.

BB. "Sustainable building tax credit" means the personal income tax credit the state of New Mexico issues to an applicant for a sustainable commercial building.

CC. "Sustainable commercial building" means one of the

following:

(1) a building that is registered with and certified by the U.S. green building council under the LEED-NC, LEED-EB, LEED-CS or LEED-CI rating system at the certification level of silver, gold or platinum and that:

(a) achieves any prerequisite for and at least one point related to commissioning under the "energy and atmosphere" credits of LEED, if included in the applicable rating system; and

(b) has met the energy reduction requirements as substantiated by the United States environmental protection agency target finder energy performance results form, dated no sooner than the schematic design phase of development, or an alternative method the division approved pursuant to 3.3.30.12 NMAC;

(2) a building used as multi-family residences where all dwelling units have met the energy reduction requirements and the building has been awarded:

(a) LEED-H certification at the certification level of silver, gold or platinum; or

(b) build green New Mexico certification at the certification level of silver, gold or emerald.

DD. "Target finder" means the web-based program developed by the United States environmental protection agency to establish an energy goal in kilo British thermal units per square foot per year for predetermined building types.

EE. "Taxpayer" means an individual subject to the tax imposed by the Income Tax Act, NMSA 1978, Section 7-2-1 *et seq*.

FF. "Taxpayer identification number" means the taxpayer's nine digit social security number.

GG. "Tribal" means of, belonging to or created by a federally recognized Indian nation, tribe or pueblo.

HH. "Verifier" means an entity the department approves to provide certification for homes under the build green New Mexico or LEED-H rating systems.

[3.3.30.7 NMAC - Rp, 3.3.30.7 NMAC, 1-1-14]

3.3.30.8 GENERAL PROVISIONS:

A. A person who is the owner of a building in New Mexico that has been constructed or renovated to be a sustainable commercial building and that receives certification on or after January 1, 2007 may receive a certificate of eligibility for a sustainable building tax credit.

B. The annual total amount of the sustainable building tax credit available to taxpayers owning sustainable commercial buildings is limited to $1,000,000. When the $1,000,000 limit for sustainable commercial buildings is reached, based on all certificates of eligibility the department has issued, the department shall:

(1) if part of the eligible sustainable building tax credit is within the annual cap and part is over the annual cap, issue a certificate of eligibility for the amount under the annual cap for the applicable tax year and issue a certificate of eligibility for the balance for the subsequent tax year; or

(2) if no sustainable building tax credit funds are available, issue a certificate of eligibility for the next subsequent tax year in which funds are available, except for the last taxable year when the sustainable building tax credit is in effect.

C. The department may issue certificates of eligibility to applicants who meet the requirements for the sustainable residential buildings tax credit in a taxable year when applications for the sustainable residential buildings tax credit exceed the annual cap and applications for the sustainable commercial buildings tax credit are under the annual cap for commercial buildings by April 30 of any year in which the tax credit is in effect.

D. In the event of a discrepancy between a requirement of 3.3.30 NMAC and an existing New Mexico taxation and revenue department rule promulgated before 3.3.30 NMAC's adoption, the existing rule governs.

[3.3.30.8 NMAC - Rp, 3.3.30.8 NMAC, 1-1-14]

3.3.30.9 VERIFIERS' S ELIGIBILITY:

A. The division reviews the qualification for verifiers of the build green New Mexico or LEED-H certifications based on the following criteria:

(1) the verifier is independent from the homebuilders or homeowners that may apply for certification;

(2) the verifier has adequate staff and expertise to provide certification services, including;

(a) experience in green home building services;

(b) ability to enlist and serve builders and provide training, consulting and other guidance as necessary;

(c) a method of auditing the certification process to maintain adequate stringency; and

(d) ability to administer the program and report on the certifications, audits and other relevant information the department may request;

(3) the verifier can identify the geographic area being served; and

(4) the verifier provides a statement that expresses a commitment to promoting energy efficient green building with the highest standard of excellence.

B. The department approves verifiers after an entity submits a written request to the department that includes documentation on how the entity meets the required criteria. The department notifies the entity of the reasons for disapproving eligibility.

C. The verifier shall notify the division 30 calendar days prior to making changes to its certification process or rating systems.

D. The department may rescind an existing verifier's approval, if it determines that the above criteria are not being met. The department notifies the verifier of the reasons for disapproving or rescinding eligibility.

(1) The division shall notify the verifier of the proposed rescission in writing. The verifier has the right to request in writing review of the decision to rescind the verifier's approval. The verifier shall file a request for review within 20 calendar days after the division's notice is sent. The verifier shall address the request to the division director and include the reasons that the department should not rescind the verifier's approval. The director shall consider the request. The division director may hold a hearing and appoint a hearing officer to conduct the hearing. The division director shall send a final decision to the verifier within 20 calendar days after receiving the request or the date the hearing is held.

(2) The verifier may appeal in writing to the department's secretary a division director's decision. The notice of appeal shall include the reasons that the secretary should overturn the division director's decision. The secretary shall consider any appeal from a division director's decision. The verifier shall file the appeal and the reasons for the appeal with the secretary within 14 calendar days of the division director's issuance of the decision. The secretary may hold a hearing and appoint a hearing officer to conduct the hearing. The secretary shall send a final decision to the verifier within 20 calendar days after receiving the request or the date the hearing concludes.

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

3.3.30.10 APPLICATION FOR THE SUSTAINABLE BUILDING TAX CREDIT:

A. In order to receive a certificate of eligibility for the tax credit, the applicant must submit an application for the sustainable building tax credit after the building is completed, the applicant has fulfilled all other requirements and the total annual cap for the sustainable building tax credit has not been met. An applicant may obtain an application form from the division.

B. An application package shall include a completed application form and attachments as specified on the form. The

applicant shall submit the application form and required attachments at the same time. An applicant shall submit one application form for each sustainable commercial building. The applicant shall submit all material in the application package on 8½ inch by 11 inch paper. If the applicant fails to submit the application form and required attachments at the same time or on 8½ inch by 11 inch paper the division may consider the application incomplete.

C. An applicant shall submit a complete application package to the division no later than April 30 of the calendar year for which the applicant seeks the sustainable building tax credit. If an applicant does not submit a complete application package by April 30, any remaining sustainable commercial building tax credit funds under the cap may be used in that taxable year for completed sustainable residential building applications. The division may review application packages it receives after that date for the subsequent calendar year if the tax credit remains in effect.

D. The completed application form shall consist of the following information:

(1) the applicant's name, mailing address, telephone number and taxpayer identification number;

(2) the address of the sustainable commercial building, including the property's legal description;

(3) whether the applicant was the building owner at time of certification or a subsequent purchaser;

(4) the rating system under which the sustainable commercial building was certified;

(5) the certification level achieved;

(6) for non-multi-family commercial buildings, the kilo British thermal units per square foot per year anticipated as demonstrated in the energy model submitted for LEED certification, broken out by all energy sources and including the percent of use for each energy source;

(7) for non-multi-family commercial buildings, revised documentation of the energy reduction requirement, if the percent of use of any energy source for the energy model is different from the original energy target documentation by more than 10 percent;

(8) the qualified occupied square footage of the sustainable commercial building;

(9) the date of certification;

(10) for multi-family commercial buildings, the HERS index; and

(11) a statement signed and dated by the applicant or an authorized representative of the applicant, which may be a form of electronic signature if approved by the department, asserting that:

(a) all information provided in the application package is true and correct to the best of the applicant's knowledge under penalty of perjury;

(b) all inputs for the energy reduction requirements are the same as the inputs for the energy model;

(c) if an onsite solar system is used to meet the requirements of either the certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the applicant has not applied for and will not apply for a solar market development tax credit;

(d) applicant understands that there are annual caps in place for the sustainable building tax credit;

(e) applicant understands that the division must verify the documentation submitted in the application package before the department issues a certificate of eligibility for a sustainable building tax credit; and

(f) applicant understands that the department issues a certificate of eligibility for the tax year in which the sustainable commercial building was certified or if the applicant submitted the application after April 30 or the sustainable building tax credit's annual cap has been reached for the next tax year in which funds are available.

E. In addition to the application form, the application package shall consist of the following information provided as attachments:

(1) a copy of a current warranty deed, property tax bill or ground lease in the applicant's name as of or after the date of certification for the address or legal description of the sustainable commercial building;

(2) a copy of the rating system certification form;

(3) a copy of the final LEED project info or project summary that shows the building's square footage;

(4) a copy of the final certification review LEED checklist that shows the LEED credits achieved;

(5) for non-multi-family commercial buildings, a copy of the final LEED optimize energy performance template or templates, signed by a New Mexico licensed design professional, that the applicant submitted for LEED certification including the results of the energy model that shows the kilo British thermal units per square foot per year for the sustainable commercial building;

(6) for non-multi-family commercial buildings, revised documentation of the energy reduction requirement, if the percent of use of any energy source for the energy model is different from the original energy target documentation by more than 10 percent; and

(7) a copy of the final LEED enhanced commissioning template, if available under the applicable LEED rating system;

(8) for multi-family commercial buildings, a copy of a HERS certificate from a RESNET (or a rating network that has the same standards as RESNET accredited HERS provider, using software the internal revenue service lists as eligible for certification of the federal tax credit, showing the HERS index achieved, if applicable; and

(9) other information the department needs to review the building project for the sustainable building tax credit.

[3.3.30.10 NMAC - Rp, 3.3.30.11 NMAC, 1-1-14]

3.3.30.11 APPLICATION REVIEW PROCESS:

A. The department considers applications in the order received, according to the day they are received, but not the time of day.

B. The department approves or disapproves an application package following the receipt of the complete application package.

C. The division reviews the application package to calculate the maximum sustainable building tax credit, check accuracy of the applicant's documentation and determine whether the department issues a certificate of eligibility for the sustainable building tax credit.

D. If an onsite solar system is used to meet the requirements of either the certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the division verifies that no person has applied for a solar market development tax credit for that solar system. If the division finds that a solar market development tax credit has been approved for that solar system, the division shall disapprove the application for the sustainable building tax credit. The applicant may submit a revised application package to the division. The division places the resubmitted application in the review schedule as if it were a new application.

E. If the division finds that the application package meets the requirements and funds for a sustainable building tax credit are available, the department issues the certificate of eligibility for a sustainable building tax credit. If funds for a sustainable building tax credit are partially available or not available, the department issues a certificate of eligibility for any amount that is available and a certificate of eligibility for the balance for the next taxable year in which funds are available, until the last taxable year when the sustainable building tax credit is in effect.

The department provides approval through written notification to the applicant upon the application's completed review. The notification shall include the taxpayer's contact information, taxpayer identification number, certificate of eligibility number or numbers, the sustainable building tax credit amount or amounts and the sustainable building tax credit's taxable year or years.

F. The department shall disapprove an application that is not complete or correct. The department's disapproval letter shall state the reasons why the department disapproved the application. The applicant may resubmit the application package for the disapproved project. The division places the resubmitted application in the review schedule as if it were a new application.

[3.3.30.11 NMAC - Rp, 3.3.30.12 NMAC, 1-1-14]

3.3.30.12 VERIFICATION OF THE ALTERNATIVE METHOD USED FOR THE ENERGY REDUCTION REQUIREMENT:

A. In the event the sustainable commercial building is a building type that is not available in target finder and the applicant uses an alternative method for the energy reduction requirement, the division reviews the submitted documentation. The following information shall be included:

(1) a narrative describing the methodology used;

(2) the kilo British thermal units per square foot per year for all buildings, real or modeled, used as a basis of comparison, broken out by all energy sources and including the percent of use for each energy source; and

(3) all formulas, assumptions and other explanation necessary to clarify how the kilo British thermal units per square foot per year for this project was derived.

B. The division uses the following criteria to evaluate the alternative method:

(1) clarity and completeness of the description of the alternative method;

(2) reasonableness of assumptions and comparisons; and

(3) thoroughness of justification of the method.

C. If the division rejects an alternative method it notifies the applicant of the reasons for the rejection.

D. The applicant may request that the division obtain the advice of a volunteer review committee of three or more New Mexico registered architects and New Mexico licensed professional mechanical and electrical engineers, chosen by the division, on their assessment of the alternative method, at which time the division may:

(1) reconsider the decision and accept the alternative method;

(2) recommend a revised alternative method; or

(3) reaffirm the rejection of the alternative method.

[3.3.30.12 NMAC - Rp, 3.3.30.13 NMAC, 1-1-14]

3.3.30.13 CALCULATING THE TAX CREDIT:

A. The division calculates the maximum sustainable building tax credit for non-multi-family commercial buildings based on the qualified occupied square footage of the sustainable commercial building, the LEED rating system under which the applicant achieved LEED certification and the certification level the applicant achieved. The tax credit for various square footages is specified in the chart below:

LEED-NC silver:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $3.50; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.75; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.70
LEED-NC gold:	
first 10,000 square	equals the qualified square footage less than or equal to 10,000 multiplied by $4.75; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $2.00; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $1.00
LEED-NC platinum:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $6.25; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $3.25; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $2.00
LEED-EB OR LEED-CS silver:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $2.50; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.25; plus

next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.50
LEED-EB OR LEED-CS gold:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $3.35; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.40; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.70
LEED-EB OR LEED-CS platinum:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $4.40; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $2.30; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $1.40
LEED-CI silver:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $1.40; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $.70; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.30
LEED-CI gold:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $1.90; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $.80; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.40
LEED-CI platinum:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $2.50; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.30; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.80

B. The division calculates the maximum sustainable building tax credit for multi-family residences based on the qualified occupied square footage of the sustainable building, the rating system under which the applicant achieved certification and the certification level the applicant achieved. The tax credit for various square footages is specified in the chart below:

LEED-H silver or build green New Mexico silver:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $5.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $2.50.
LEED-H gold or build green New Mexico gold:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $6.85; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $3.40.
LEED-H platinum or build green New Mexico emerald:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $9.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $4.45.

C. An applicant may receive both a sustainable building tax credit and a federal tax credit if the applicant is eligible for each tax credit.

D. The taxation and revenue department makes the final determination of the amount of the sustainable building tax credit.

[3.3.30.13 NMAC - Rp, 3.3.30.14 NMAC, 1-1-14]

3.3.30.14 CLAIMING THE STATE TAX CREDIT:

A. To claim the sustainable building tax credit for a given year, an applicant shall submit all certificates of eligibility to the taxation and revenue department prior to the end of that calendar year, along with a completed form provided by the taxation and revenue department, and any other information the taxation and revenue department requires.

B. If the amount of the sustainable building tax credit the applicant claims exceeds the applicant's income tax liability, the applicant may carry the excess forward for up to seven consecutive taxable years.

C. A taxpayer claiming a sustainable building tax credit shall not claim a tax credit pursuant to another law for the same sustainable commercial building unless the other tax credit is applicable to systems that are unrelated to the sustainable building tax credit. In addition, a taxpayer claiming the sustainable building tax credit shall not claim the credit for the same sustainable building under both the Income Tax Act and the Corporate Income and Franchise Tax Act.

[3.3.30.14 NMAC - Rp, 3.3.30.15 NMAC, 1-1-14]

HISTORY OF 3.3.30 NMAC:

History of Repealed Material:

3.3.30 NMAC, Sustainable Building Tax Credit for Commercial Buildings, filed 10-10-2007 - Repealed effective 1-1-2014.

NEW MEXICO ENERGY, MINERALS, AND NATURAL RESOURCES DEPARTMENT

ENERGY CONSERVATION AND MANAGEMENT DIVISION

TITLE 3 TAXATION

CHAPTER 4 CORPORATE INCOME TAXES

PART 17 SUSTAINABLE BUILDING TAX CREDIT FOR COMMERCIAL BUILDINGS

3.4.17.1 ISSUING AGENCY: Energy, Minerals and Natural Resources Department.

[3.4.17.1 NMAC - Rp, 3.4.17.1 NMAC, 1-1-14]

3.4.17.2 SCOPE: 3.4.17 NMAC applies to the application and certification procedures for administration of the sustainable building tax credit for sustainable commercial buildings.

[3.4.17.2 NMAC - Rp, 3.4.17.2 NMAC, 1-1-14]

3.4.17.3 STATUTORY AUTHORITY: 3.4.17 NMAC is established under the authority of NMSA 1978, Section 7-2A-21 and NMSA 1978, Section 9-1-5.

[3.4.17.3 NMAC - Rp, 3.4.17.3 NMAC, 1-1-14]

3.4.17.4 DURATION: Permanent.

[3.4.17.4 NMAC - Rp, 3.4.17.4 NMAC, 1-1-14]

3.4.17.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

[3.4.17.5 NMAC - Rp, 3.4.17.5 NMAC, 1-1-14]

3.4.17.6 OBJECTIVE: 3.4.17 NMAC's objective is to establish procedures for administering the program to issue a certificate of eligibility for the sustainable building tax credit for sustainable commercial buildings.

[3.4.17.6 NMAC - Rp, 3.4.17.6 NMAC, 1-1-14]

3.4.17.7 DEFINITIONS:

A. "Annual cap" means the annual aggregate amount of the sustainable building tax credit available to taxpayers owning sustainable commercial buildings.

B. "Applicant" means a taxpayer that owns a sustainable commercial building in New Mexico and who desires to have the department issue a certificate of eligibility for a sustainable building tax credit.

C. "Application package" means the application documents an applicant submits to the division to receive a certificate of eligibility for a sustainable building tax credit.

D. "Build green New Mexico certification" means the verification by a department-approved verifier, that a building project has met certain prerequisites and performance benchmarks or credits within each category of the build green New Mexico rating system resulting in the issuance of a certification document.

E. "Build green New Mexico rating system" means the certification standards adopted by the homebuilders association of central New Mexico.

F. "Building project" means a new construction or renovation project that will result in one or more sustainable commercial buildings.

G. "Building type" means the primary use of a building or section of a building as defined in target finder.

H. "Certificate of eligibility" means the document, with a unique identifying number that specifies the amount and taxable year for the approved sustainable building tax credit.

I. "Certification level" means one of the following:

(1) LEED-H silver or build green New Mexico silver;

(2) LEED-H gold or build green New Mexico gold; or

(3) LEED-H platinum or build green New Mexico emerald.

J. "Department" means the energy, minerals and natural resources department.

K. "Division" means the department's energy conservation and management division.

L. "Energy reduction requirements":

(1) for a non-multi-family commercial building means beginning January 1, 2012, a 60 percent energy reduction based on the national average for that building type as published by the United States department of energy;

(2) for a multi-family dwelling unit means that it has achieved a home energy rating system index of sixty or lower as developed by the residential energy services network.

M. "HERS" means home energy rating system as developed by RESNET.

N. "HERS index" means a relative energy use index, where 100 represents the energy use of a home built to a HERS reference house and zero indicates that the proposed home uses no net purchased energy.

O. "LEED" means the most current leadership in energy and environmental design green building rating system guidelines developed and adopted by the U. S. green building council.

P. "LEED certification" means the U. S. green building council's verification that a building project has met certain prerequisites and performance benchmarks or credits within each category of a LEED rating system resulting in the issuance of a certification document.

Q. "LEED-CI" means the LEED rating system for commercial interiors.

R. "LEED-CS" means the LEED rating system for the core and shell of buildings.

S. "LEED-EB" means the LEED rating system for existing buildings.

T. "LEED-NC" means the LEED rating system for new buildings and major renovations.

U. "LEED rating system" means one of the following:

(1) LEED-CI;

(2) LEED-CS;

(3) LEED-EB; or

(4) LEED-NC.

V. "LEED registration" means the notification to the U. S. green building council that a project is pursuing LEED certification.

W. "Most current" means the LEED rating system available and selected at the time of LEED registration.

X. "Person" does not include state, local government, public school district or tribal agencies.

Y. "Qualified occupied square footage" means the building's occupied spaces as determined by the U. S. green building council for those buildings obtaining LEED certification or the administrators of the build green New Mexico rating system for those homes obtaining build green New Mexico certification.

Z. "RESNET" means the residential energy services network, an industry not-for-profit membership corporation and national standards making body for building energy efficiency rating systems.

AA. "Solar market development tax credit" means the personal income tax credit the state of New Mexico issues to a taxpayer for a solar energy system the department has certified.

BB. "Sustainable building tax credit" means the income tax credit the state of New Mexico issues to an applicant for a sustainable building.

CC. "Sustainable commercial building" means one of the following:

(1) a building that is registered with and certified by the U.S. green building council under the LEED-NC, LEED-EB, LEED-CS or LEED-CI rating system at the certification level of silver, gold or platinum and that:

(a) achieves any prerequisite for and at least one point related to commissioning under the "energy and atmosphere" credits of LEED, if included in the applicable rating system; and

(b) has met the energy reduction requirements as substantiated by the United States environmental protection agency target finder energy performance results form, dated no sooner than the schematic design phase of development, or an alternative method the division approved pursuant to 3.4.17.12 NMAC;

(2) a building used as multi-family residences where all dwelling units have met the energy reduction requirements and the building has been awarded:

(a) LEED-H certification at the certification level of silver, gold or platinum; or

(b) build green New Mexico certification at the certification level of silver, gold or emerald.

DD. "Target finder" means the web-based program developed by the United States environmental protection agency to establish an energy goal in kilo British thermal units per square foot per year for predetermined building types.

EE. "Taxable year" means the calendar year or fiscal year upon the basis of which the net income is computed under the Corporate Income and Franchise Tax Act, NMSA 1978, 7-2A-1 *et seq*.

FF. "Taxpayer" means an individual subject to the tax imposed by the Income Tax Act, NMSA 1978, Section 7-2-1 *et seq*.

GG. "Tribal" means of, belonging to or created by a federally recognized Indian nation, tribe or pueblo.

HH. "Verifier" means an entity the department approves to provide certification for homes under the build green New Mexico or LEED-H rating systems.

[3.4.17.7 NMAC - Rp, 3.4.17.7 NMAC, 1-1-14]

3.4.17.8 GENERAL PROVISIONS:

A. A person who is the owner of a building in New Mexico that has been constructed or renovated to be a sustainable commercial building and that receives certification on or after January 1, 2007 may receive a certificate of eligibility for a sustainable building tax credit.

B. The annual total amount of the sustainable building tax credit available to taxpayers owning sustainable commercial buildings is limited to $1,000,000. When the $1,000,000 limit for sustainable commercial buildings is reached, based on all certificates of eligibility the department has issued, the department shall:

(1) if part of the eligible sustainable building tax credit is within the annual cap and part is over the annual cap, issue a certificate of eligibility for the amount under the annual cap for the applicable tax year and issue a certificate of eligibility for the balance for the subsequent tax year; or

(2) if no sustainable building tax credit funds are available, issue a certificate of eligibility for the next subsequent tax year in which funds are available, except for the last taxable year when the sustainable building tax credit is in effect.

C. The department may issue certificates of eligibility to applicants who meet the requirements for the sustainable residential buildings tax credit in a taxable year when applications for the sustainable residential buildings tax credit exceed the annual cap and applications for the sustainable commercial buildings tax credit are under the annual cap for commercial buildings by April 30 of any year in which the tax credit is in effect.

D. In the event of a discrepancy between a requirement of 3.4.17 NMAC and an existing New Mexico taxation and revenue department rule promulgated before 3.4.17 NMAC's adoption, the existing rule governs.

[3.4.17.8 NMAC - Rp, 3.4.17.8 NMAC, 1-1-14]

3.4.17.9 VERIFIER ELIGIBILITY:

A. The division reviews the qualification for verifiers of the build green New Mexico or LEED-H certifications based on the following criteria:

(1) the verifier is independent from the homebuilders or homeowners that may apply for certification;

(2) the verifier has adequate staff and expertise to provide certification services, including;

(a) experience in green home building services;

(b) ability to enlist and serve builders and provide training, consulting and other guidance as necessary;

(c) a method of auditing the certification process to maintain adequate stringency; and

(d) ability to administer the program and report on the certifications, audits and other relevant information the department may request;

(3) the verifier can identify the geographic area being served; and

(4) the verifier provides a statement that expresses a commitment to promoting energy efficient green building with the highest standard of excellence.

B. The department approves verifiers after an entity submits a written request to the department that includes documentation on how the entity meets the required criteria. The department notifies the entity of the reasons for disapproving eligibility.

C. The verifier shall notify the division 30 calendar days prior to making changes to its certification process or rating systems.

D. The department may rescind an existing verifier's approval, if it determines that the above criteria are not being met. The department notifies the verifier of the reasons for disapproving or rescinding eligibility.

(1) The division shall notify the verifier of the proposed rescission in writing. The verifier has the right to request in writing review of the decision to rescind the verifier's approval. The verifier shall file a request for review within 20 calendar days after the division's notice is sent. The verifier shall

address the request to the division director and include the reasons that the department should not rescind the verifier's approval. The director shall consider the request. The division director may hold a hearing and appoint a hearing officer to conduct the hearing. The division director shall send a final decision to the verifier within 20 calendar days after receiving the request or the date the hearing is held.

(2) The verifier may appeal in writing to the department's secretary a division director's decision. The notice of appeal shall include the reasons that the secretary should overturn the division director's decision. The secretary shall consider any appeal from a division director's decision. The verifier shall file the appeal and the reasons for the appeal with the secretary within 14 calendar days of the division director's issuance of the decision. The secretary may hold a hearing and appoint a hearing officer to conduct the hearing. The secretary shall send a final decision to the verifier within 20 calendar days after receiving the request or the date the hearing concludes.

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

3.4.17.10 APPLICATION FOR THE SUSTAINABLE BUILDING TAX CREDIT:

A. In order to receive a certificate of eligibility for the tax credit, the applicant must submit an application for the sustainable building tax credit after the building is completed, the applicant has fulfilled all other requirements and the total annual cap for the sustainable building tax credit has not been met. An applicant may obtain an application form from the division.

B. An application package shall include a completed application form and attachments as specified on the form. The applicant shall submit the application form and required attachments at the same time. An applicant shall submit one application form for each sustainable commercial building. The applicant shall submit all material in the application package on 8½ inch by 11 inch paper. If the applicant fails to submit the application form and required attachments at the same time or on 8½ inch by 11 inch paper the division may consider the application incomplete.

C. An applicant shall submit a complete application package to the division no later than April 30 of the taxable year for which the applicant seeks the sustainable building tax credit. If an applicant does not submit a complete application package by April 30, any remaining sustainable commercial building tax credit funds under the cap may be used in that taxable year for completed sustainable residential building applications. The division may review application packages it receives after that date for the subsequent calendar year if the tax credit remains in effect.

D. The completed application form shall consist of the following information:

(1) the applicant's name, mailing address, telephone number and taxpayer identification number;

(2) the name of the authorized representative of the applicant, if different from the tax credit request form;

(3) the ending date of the applicant's taxable year;

(4) the address of the sustainable commercial building, including the property's legal description;

(5) whether the applicant was the building owner at time of certification or a subsequent purchaser;

(6) the rating system under which the sustainable commercial building was certified;

(7) the certification level achieved;

(8) for non-multi-family commercial buildings, the kilo British thermal units per square foot per year anticipated as demonstrated in the energy model submitted for LEED certification, broken out by all energy sources and including the percent of use for each energy source;

(9) for non-multi-family commercial buildings, revised documentation of the energy reduction requirement, if the percent of use of any energy source for the energy model is different from the original energy target documentation by more than 10 percent;

(10) the qualified occupied square footage of the sustainable commercial building;

(11) the date of certification;

(12) for multi-family commercial buildings, the HERS index; and

(13) a statement signed and dated by the applicant or an authorized representative of the applicant, which may be a form of electronic signature if approved by the department, asserting that:

(a) all information provided in the application package is true and correct to the best of the applicant's knowledge under penalty of perjury;

(b) all inputs for the energy reduction requirements are the same as the inputs for the energy model;

(c) if an onsite solar system is used to meet the requirements of either the certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the applicant has not applied for and will not apply for a solar market development tax credit;

(d) applicant understands that there are annual caps in place for the sustainable building tax credit;

(e) applicant understands that the division must verify the documentation submitted in the application package before the department issues a certificate of eligibility for a sustainable building tax credit; and

(f) applicant understands that the department issues a certificate of eligibility for the tax year in which the sustainable commercial building was certified or if the applicant submitted the application after April 30 or the sustainable building tax credit's annual cap has been reached for the next tax year in which funds are available.

E. In addition to the application form, the application package shall consist of the following information provided as attachments:

(1) a copy of a current warranty deed, property tax bill or ground lease in the applicant's name as of or after the date of certification for the address or legal description of the sustainable commercial building;

(2) a copy of the rating system certification form;

(3) a copy of the final LEED project info or project summary that shows the building's square footage;

(4) a copy of the final certification review LEED checklist that shows the LEED credits achieved;

(5) for non-multi-family commercial buildings, a copy of the final LEED optimize energy performance template or templates, signed by a New Mexico licensed design professional, that the applicant submitted for LEED certification including the results of the energy model that shows the kilo British thermal units per square foot per year for the sustainable commercial building;

(6) for non-multi-family commercial buildings, revised documentation of the energy reduction requirement, if the percent of use of any energy source for the energy model is different from the original energy target documentation by more than 10 percent; and

(7) a copy of the final LEED enhanced commissioning template, if available under the applicable LEED rating system;

(8) for multi-family commercial buildings, a copy of a HERS certificate from a RESNET (or a rating network that has the same standards as RESNET accredited HERS provider, using software the internal revenue service lists as eligible for certification of the federal tax credit, showing the building has achieved a HERS index of sixty or lower; and

(9) other information the department needs to review the building project for the sustainable building tax credit.

[3.4.17.10 NMAC - Rp, 3.4.17.11 NMAC, 1-1-14]

3.4.17.11 APPLICATION REVIEW PROCESS:

A. The department considers applications in the order received, according to the day they are received, but not the time of day.

B. The department approves or disapproves an application package following the receipt of the complete application package.

C. The division reviews the application package to calculate the maximum sustainable building tax credit, check accuracy of the applicant's documentation and determine whether the department issues a certificate of eligibility for the sustainable building tax credit.

D. If an onsite solar system is used to meet the requirements of either the certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the division verifies that no person has applied for a solar market development tax credit for that solar system. If the division finds that a solar market development tax credit has been approved for that solar system, the division disapproves the application for the sustainable building tax credit. The applicant may submit a revised application package to the division. The division places the resubmitted application in the review schedule as if it were a new application.

E. If the division finds that the application package meets the requirements and funds for a sustainable building tax credit are available, the department issues the certificate of eligibility for a sustainable building tax credit. If funds for a sustainable building tax credit are partially available or not available, the department issues a certificate of eligibility for any amount that is available and a certificate of eligibility for the balance for the next taxable year in which funds are available, until the last taxable year when the sustainable building tax credit is in effect. The department provides approval through written notification to the applicant upon the application's completed review. The notification shall include the taxpayer's contact information, taxpayer identification number, certificate of eligibility number or numbers, the sustainable building tax credit maximum amount or amounts and the sustainable building tax credit's taxable year or years.

F. The department disapproves an application that is not complete or correct. The department's disapproval letter shall state the reasons why the department disapproved the application. The applicant may resubmit the application package for the disapproved project. The division places the resubmitted application in the review schedule as if it were a new application.

[3.4.17.11 NMAC - Rp, 3.4.17.12 NMAC, 1-1-14]

3.4.17.12 VERIFICATION OF THE ALTERNATIVE METHOD USED FOR THE ENERGY REDUCTION REQUIREMENT:

A. In the event the sustainable commercial building is a building type that is not available in target finder and the applicant uses an alternative method for the energy reduction requirement, the division reviews the submitted documentation. The following information shall be included:

(1) a narrative describing the methodology used;

(2) the kilo British thermal units per square foot per year for all buildings, real or modeled, used as a basis of comparison, broken out by all energy sources and including the percent of use for each energy source; and

(3) all formulas, assumptions, and other explanation necessary to clarify how the kilo British thermal units per square foot per year for this project was derived.

B. The division uses the following criteria to evaluate the alternative method:

(1) clarity and completeness of the description of the alternative method;

(2) reasonableness of assumptions and comparisons; and

(3) thoroughness of justification of the method.

C. If the division rejects an alternative method it notifies the applicant of the reasons for the rejection.

D. The applicant may request that the division obtain the advice of a volunteer review committee of three or more New Mexico registered architects and New Mexico licensed professional mechanical and electrical engineers, chosen by the division, on their assessment of the alternative method, at which time the division may:

(1) reconsider the decision and accept the alternative method;

(2) recommend a revised alternative method; or

(3) reaffirm the rejection of the alternative method.

[3.4.17.12 NMAC - Rp, 3.4.17.13 NMAC, 1-1-14]

3.4.17.13 CALCULATING THE TAX CREDIT:

A. The division calculates the maximum sustainable building tax credit for the non-multi-family commercial buildings based on the qualified occupied square footage of the sustainable commercial building, the LEED rating system under which the applicant achieved LEED certification and the certification level the applicant achieved. The tax credit for various square footages is specified in the chart below:

LEED-NC silver:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $3.50; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.75; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.70
LEED-NC gold:	
first 10,000 square	equals the qualified square footage less than or equal to 10,000 multiplied by $4.75; plus

next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $2.00; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $1.00
LEED-NC platinum:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $6.25; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $3.25; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $2.00
LEED-EB OR LEED-CS silver:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $2.50; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.25; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.50
LEED-EB OR LEED-CS gold:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $3.35; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.40; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.70
LEED-EB OR LEED-CS platinum:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $4.40; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $2.30; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $1.40
LEED-CI silver:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $1.40; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $.70; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.30
LEED-CI gold:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $1.90; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $.80; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.40
LEED-CI platinum:	
first 10,000 square feet	equals the qualified square footage less than or equal to 10,000 multiplied by $2.50; plus
next 40,000 square feet	the qualified square footage greater than 10,000 and less than or equal to 50,000 multiplied by $1.30; plus
next 450,000 square feet	the qualified square footage greater than 50,000 and less than or equal to 500,000 multiplied by $.80

B. The division calculates the maximum sustainable building tax credit for multi-family residences based on the qualified occupied square footage of the sustainable building, the rating system under which the applicant achieved certification and the certification level the applicant achieved. The tax credit for various square footages is specified in the chart below:

LEED-H silver or build green New Mexico silver:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $5.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $2.50.
LEED-H gold or build green New Mexico gold:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $6.85; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $3.40.
LEED-H platinum or build green New Mexico emerald:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $9.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $4.45.

C. An applicant may receive both a sustainable building tax credit and a federal tax credit if the applicant is eligible for each tax credit.

D. The taxation and revenue department makes the final determination of the amount of the sustainable building tax credit.
[3.4.17.13 NMAC - Rp, 3.4.17.14 NMAC, 1-1-14]

3.4.17.14 CLAIMING THE STATE TAX CREDIT:

A. To claim the sustainable building tax credit for a given year, an applicant shall submit all certificates of eligibility to the taxation and revenue department prior to the end of that taxable year, along with a completed form provided by the taxation and revenue department, and any other information the taxation and revenue department requires.

B. If the amount of the sustainable building tax credit the applicant claims exceeds the applicant's income tax liability, the applicant may carry the excess forward for up to seven consecutive taxable years.

C. A taxpayer claiming a sustainable building tax credit shall not claim a tax credit pursuant to another law for the same sustainable commercial building unless the other tax credit is applicable to systems that are unrelated to the sustainable building tax credit. In addition, a taxpayer claiming the sustainable building tax credit shall not claim the credit for the same sustainable building under both the Income Tax Act and the Corporate Income and Franchise Tax Act.
[3.4.17.14 NMAC - Rp, 3.4.17.15 NMAC, 1-1-14]

HISTORY OF 3.4.17 NMAC:
History of Repealed Material:
3.4.17 NMAC, Sustainable Building Tax Credit for Commercial Buildings, filed 10-10-2007 - Repealed effective 1-1-2014.

NEW MEXICO ENERGY, MINERALS, AND NATURAL RESOURCES DEPARTMENT

ENERGY CONSERVATION AND MANAGEMENT DIVISION

This is an amendment to 3.3.29 NMAC, Sections 7, 8, 10, 11, 12 and 13, effective January 1, 2014.

3.3.29.7 DEFINITIONS:

A. "Annual cap" means the annual total amount of the sustainable building tax credit available to taxpayers owning sustainable residential buildings.

B. "Applicant" means a taxpayer who owns a sustainable residential building in New Mexico and [~~that~~] who desires to have the department issue a certificate of eligibility for a sustainable building tax credit.

C. "Application package" means the application documents an applicant submits to the division to receive a certificate of eligibility for a sustainable building tax credit.

D. "Build green New Mexico certification" means the verification by a department-approved verifier, that a building project has met certain prerequisites and performance benchmarks or credits within each category of the build green New Mexico rating system resulting in the issuance of a certification document.

E. "Build green New Mexico rating system" means the certification standards adopted by the homebuilders association of central New Mexico.

F. "Certification" means build green New Mexico certification, LEED certification or energy star qualified.

G. "Certificate of eligibility" means the document, with a unique identifying number that specifies the amount and taxable year for the approved sustainable building tax credit.

H. "Certification level" means one of the following:

(1) LEED-H silver or build green New Mexico silver;

(2) LEED-H gold or build green New Mexico gold; or

(3) LEED-H platinum or build green New Mexico emerald.

I. "Department" means the energy, minerals and natural resources department.

J. "Division" means the department's energy conservation and management division.

K. "Energy reduction requirements" means has achieved a HERS index of 60 or lower.

L. "Energy star" means a joint program of the United States environmental protection agency and the United States department of energy that qualifies homes based on a predetermined threshold of energy efficiency.

M. "Energy star qualified manufactured home" means a home that an in state or out of state energy star certified plant has certified as being designed, produced and installed in accordance with energy star's guidelines.

N. "HERS" means home energy rating system as developed by RESNET.

O. "HERS index" means a relative energy use index, where 100

represents the energy use of a home built to a HERS reference house and zero indicates that the proposed home uses no net purchased energy.

P. "LEED" means the most current leadership in energy and environmental design green building rating system guidelines the U. S. green building council developed and adopted.

Q. "LEED certification" means the verification by the U.S. green building council, or a department-approved verifier, that a building project has met certain prerequisites and performance benchmarks or credits within each category of the LEED-H rating system resulting in the issuance of a certification document.

R. "LEED-H" means the LEED rating system for homes.

S. "Manufactured housing" means [~~homes built in a factory meeting the federal manufactured home construction and safety standards, commonly referred to as the HUD Code.~~] a multisectioned home that is:

(1) a manufactured home or modular home;

(2) a single-family dwelling with a heated area of at least thirty-six feet by twenty feet and a total area of at least eight-hundred sixty-four square feet;

(3) constructed in a factory to the standards of the United States department of housing and urban development, the National Manufactured Housing Construction and Safety Standards Act of 1974 and the housing and urban development zone code 2 or New Mexico construction codes up to the date of the unit's construction; and

(4) installed consistent with the Manufactured Housing Act and rules adopted pursuant to that act relating to permanent foundations.

T. "Person" does not include state, local government, public school district or tribal agencies.

[~~T.~~] U. "Qualified occupied square footage" means the [~~building's conditioned spaces as determined per the American national standards institute standard Z765-2003 or as specified by the manufactured housing manufacturer~~] occupied spaces of the building as determined by:

(1) the United States green building council for those buildings obtaining LEED certification;

(2) the administrators of the build green New Mexico rating system for those homes obtaining build green New Mexico certification; or

(3) the United States environmental protection agency for energy star certified manufactured homes.

[~~U.~~] V. "Rating system" means the LEED-H rating system, the build green New Mexico rating system or the energy star program for manufactured housing.

[~~V.~~] W. "RESNET" means the residential energy services network, an industry not-for-profit membership corporation and national standards making body for building energy efficiency rating systems.

[~~W.~~] X. "Solar market development tax credit" means the personal income tax credit the state of New Mexico issues to a taxpayer for a solar energy system the department has certified.

[~~X.~~] Y. "Sustainable building tax credit" means the personal income tax credit the state of New Mexico issues to an applicant for a sustainable residential building.

[~~Y.~~] Z. "Sustainable residential building" means:

(1) a building used as a single-family residence that meets the energy reduction requirements and has been awarded:

(a) LEED-H certification at the certification level of silver, gold or platinum; or

(b) build green New Mexico certification at the silver, gold or emerald certification level; or

[~~(2) a building used as multi-family residences where all dwelling units have met the energy reduction requirements and the building has been awarded:~~

~~(a) LEED-H certification at the certification level of silver, gold or platinum; or~~

~~(b) build green New Mexico certification at the gold certification level; or~~]

[~~(3)~~] (2) an energy star qualified manufactured home.

[~~Z.~~] AA. "Taxpayer" means any individual subject to the tax imposed by the Income Tax Act, NMSA 1978, Section 7-2-1 et seq.

[~~AA.~~] BB. "Taxpayer identification number" means the taxpayer's nine digit social security number.

CC. "Tribal" means of, belonging to or created by a federally recognized Indian nation, tribe or pueblo.

[~~BB.~~] DD. "Verifier" means an entity the department approves to provide certifications for homes under the build green New Mexico or LEED-H rating systems.

[3.3.29.7 NMAC - N, 10-31-07; A, 1-1-14]

3.3.29.8 GENERAL PROVISIONS:

A. [~~Only a taxpayer~~] A person who is the owner of a building in New Mexico that has been constructed, [~~or~~] renovated or manufactured to be a sustainable residential building and that receives certification on or after January 1, 2007 may receive a certificate of eligibility for a sustainable building tax credit. A subsequent purchaser of a sustainable residential building may receive a certificate if no tax credit has previously been claimed for the building.

B. The annual total amount of the sustainable building tax credit available to taxpayers owning sustainable residential buildings is limited to [~~$5,000,000~~] $4,000,000. When the [~~$5,000,000 limit~~] $4,000,000 cap for sustainable residential buildings is reached, based on all certificates of eligibility the department has issued, the department shall:

(1) if part of the eligible sustainable building tax credit is within the annual cap and part is over the annual cap, issue a certificate of eligibility for the amount under the annual cap for the applicable tax year and issue a certificate of eligibility for the balance for the subsequent tax year; or

(2) the department may issue certificates of eligibility to applicants who meet the requirements for the sustainable residential buildings tax credit in a taxable year when applications for the sustainable residential buildings tax credit exceed the annual cap and applications for the sustainable commercial buildings tax credit are under the annual cap for commercial buildings by April 30 of any year in which the tax credit is in effect; or

[~~(2)~~] (3) if no sustainable building tax credit funds are available, issue a certificate of eligibility for the next subsequent tax year in which funds are available, except for the last taxable year when the sustainable building tax credit is in effect.

C. No more than $1,250,000 of the [~~$5,000,000~~] $4,000,000 annual cap is for manufactured housing.

D. In the event of a discrepancy between a requirement of 3.3.29 NMAC and an existing New Mexico taxation and revenue department rule promulgated before 3.3.29 NMAC's adoption, the existing rule governs.

[3.3.29.8 NMAC - N, 10-31-07; A, 1-1-14]

3.3.29.10 APPLICATION FOR THE SUSTAINABLE BUILDING TAX CREDIT:

A. In order to obtain the sustainable building tax credit, a taxpayer shall apply for a certificate of eligibility with the division on a division-developed form. An applicant may obtain an application form from the division.

B. An application package shall include a completed application form and attachments as specified on the application form. The applicant shall submit the application form and required attachments at the same time. An applicant shall submit one application form for each sustainable residential building.

The applicant shall submit all material [~~submitted~~] in the application package on 8½ inch by 11 inch paper. If the applicant fails to submit the application form and required attachments at the same time or on 8½ inch by 11 inch paper the division may consider the application incomplete.

[~~C.~~ ~~An applicant shall submit a complete application package to the division no later than November 15 of the calendar year for which the applicant seeks the sustainable building tax credit to allow time for approval and issuance of a certificate of eligibility. The division will review application packages it receives after that date for the subsequent taxable year.~~]

[~~D.~~] C. The completed application form shall consist of the following information:

(1) the applicant's name, mailing address, telephone number and taxpayer identification number;

(2) the name of the applicant's authorized representative;

(3) the ending date of the applicant's taxable year;

(4) the address of the sustainable residential building, including the property's legal description;

(5) whether the applicant was the building owner at time of certification or a subsequent purchaser;

(6) the qualified occupied square footage of the sustainable residential building;

(7) the rating system under which the sustainable residential building was certified;

(8) the certification level achieved, if applicable;

(9) the HERS index[~~, if applicable~~];

(10) the date of rating system certification;

(11) a statement signed and dated by the applicant, which may be a form of electronic signature if approved by the department, agreeing that:

(a) all information provided in the application package is true and correct to the best of the applicant's knowledge under penalty of perjury[?];

(b) applicant has read the requirements contained in 3.3.29 NMAC[?];

(c) if an onsite solar system is used to meet the requirements of either the rating system certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the applicant has not applied for and will not apply for a solar market development tax credit;

(d) applicant understands that there are annual [~~limits~~] caps for the sustainable building tax credit[?];

(e) applicant understands that the division must verify the documentation submitted in the application package before the department issues a certificate of eligibility for a sustainable building tax credit[?]; and

(f) applicant understands that the department issues a certificate of eligibility for the taxable year in which the sustainable residential building was certified or, if the sustainable building tax credit's annual cap has been reached, for the next taxable year in which funds are available; and

(12) a project number the division assigns to the tax credit application.

[~~E.~~] D. In addition to the application form, the application package shall consist of the following information provided as attachments:

(1) a copy of a deed, property tax bill or ground lease in the applicant's name as of or after the date of certification for the address or legal description of the sustainable residential building[?];

(2) a copy of the rating system certification form[?];

(3) a copy of the final certification review checklist that shows the points achieved, if applicable[?];

(4) a copy of a HERS certificate, from a RESNET (or a rating network that has the same standards as RESNET) accredited HERS provider, using software the internal revenue service lists as eligible for certification of the federal tax credit, showing the building has achieved a HERS index [~~achieved, if applicable,~~] of sixty or lower; and

(5) other information the department needs to review the building project for the sustainable building tax credit.

[3.3.29.10 NMAC - N, 10-31-07; A, 1-1-14]

3.3.29.11 APPLICATION REVIEW PROCESS:

A. The department considers applications in the order received, according to the day they are received, but not the time of day.

B. The department approves or disapproves an application package following the receipt of the complete application package. The department disapproves an application that is not complete or correct. The department's disapproval letter shall state the reasons why the department disapproved the application. The applicant may resubmit the application package for the disapproved project. The division places the resubmitted application in the review schedule as if it were a new application.

C. The division reviews the application package to calculate the maximum sustainable building tax credit, check accuracy of the applicant's documentation and determine whether the department issues a certificate of eligibility for the sustainable building tax credit.

D. If an onsite solar system is used to meet the requirements of either the certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the division verifies that no person has applied for a solar market development tax credit for that solar system. If the division finds that a solar market development tax credit has been approved for that solar system, the division shall disapprove the application for the sustainable building tax credit. The applicant may submit a revised application package to the division. The division places the resubmitted application in the review schedule as if it were a new application.

E. If the division finds that the application package meets the requirements and a sustainable building tax credit is available, the department issues the certificate of eligibility for a sustainable building tax credit. If a sustainable building tax credit is partially available or not available, the department issues a certificate of eligibility for any amount that is available and a certificate of eligibility for the balance for the next taxable year, until the last taxable year when the sustainable building tax credit is in effect. The notification shall include the taxpayer's contact information, taxpayer identification number, certificate of eligibility number or numbers, the rating system certification level awarded to the building, the amount of qualified occupied square footage in the building, the sustainable building tax credit amount or amounts and the sustainable building tax credit's taxable year or years.

[3.3.29.11 NMAC - N, 10-31-07; A, 1-1-14]

[*Continued on page 972*]

3.3.29.12 CALCULATING THE TAX CREDIT:

A. The division calculates the maximum sustainable building tax credit based on the qualified occupied square footage of the sustainable residential building, the rating system under which the applicant achieved certification and the certification level the applicant achieved. The tax credit for various square footages is specified in the chart below:

[~~build green New Mexico gold:~~	
~~first 2,000 square feet~~	~~equals the qualified square footage less than or equal to 2,000 multiplied by $4.50; plus~~
~~next 1,000 square feet~~	~~the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $2.00]~~
LEED-H [~~Silver~~] silver or build green New Mexico silver:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $5.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $2.50
LEED-H [~~Gold~~] gold or build green New Mexico gold:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $6.85; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $3.40
LEED-H [~~Platinum~~] platinum or build green New Mexico emerald:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $9.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $4.45
energy star manufactured housing:	
up to 3,000 square feet	equals the qualified square footage less than or equal to 3,000 multiplied by $3.00.

B. An applicant may receive both a sustainable building tax credit and a federal tax credit if the applicant is eligible for each tax credit.

C. The taxation and revenue department makes the final determination of the amount of the sustainable building tax credit.
[3.3.29.12 NMAC - N, 10-31-07; A, 1-1-14]

3.3.29.13 CLAIMING THE STATE TAX CREDIT:

A. To claim the sustainable building tax credit, an applicant shall submit all certificates of eligibility to the taxation and revenue department within 30 days of the department's issuance, along with a completed form provided by the taxation and revenue department, and any other information the taxation and revenue department requires.

[~~**B.** Beginning with the taxable year on each certificate of eligibility, the taxation and revenue department will apply 25 percent of the amount on the certificate against the applicant's income tax liability for four years, unless the amount is less than or equal to $25,000, in which case the taxation and revenue department applies the entire sustainable building tax credit in the taxable year on the certificate.~~]

[~~**C.**~~] **B.** If the amount of the sustainable building tax credit the applicant claims exceeds the applicant's income tax liability, the applicant may carry the excess forward for up to seven consecutive taxable years.

~~**[D.]**~~ **C.** A taxpayer claiming a sustainable building tax credit shall not claim a tax credit pursuant to another law for the same sustainable residential building unless the other tax credit is applicable to systems that are unrelated to the sustainable building tax credit. In addition, a taxpayer claiming the sustainable building tax credit shall not claim the credit for the same sustainable building under both the Income Tax Act and the Corporate Income and Franchise Tax Act.
[3.3.29.13 NMAC - N, 10-31-07; A, 1-1-14]

NEW MEXICO ENERGY, MINERALS, AND NATURAL RESOURCES DEPARTMENT

ENERGY CONSERVATION AND MANAGEMENT DIVISION

This is an amendment to 3.4.16 NMAC, Sections 7, 8, 10, 11, 12 & 13, effective January 1, 2014.

3.4.16.7 DEFINITIONS:

A. "Annual cap" means the annual total amount of the sustainable building tax credit available to taxpayers owning sustainable residential buildings.

B. "Applicant" means a taxpayer that owns a sustainable residential building in New Mexico and [~~that~~] who desires to have the department issue a certificate of eligibility for a sustainable building tax credit.

C. "Application package" means the application documents an applicant submits to the division to receive a certificate of eligibility for a sustainable building tax credit.

D. "Build green New Mexico certification" means the verification by a department-approved verifier, that a building project has met certain prerequisites and performance benchmarks or credits within each category of the build green New Mexico rating system resulting in the issuance of a certification document.

E. "Build green New Mexico rating system" means the certification standards adopted by the homebuilders association of central New Mexico.

F. "Certification" means build green New Mexico certification, LEED certification or energy star qualified.

G. "Certificate of eligibility" means the document, with a unique identifying number that specifies the amount and taxable year for the approved sustainable building tax credit.

H. "Certification level" means one of the following:

(1) LEED-H silver or build green New Mexico silver;

(2) LEED-H gold or build green New Mexico gold; or

(3) LEED-H platinum or build green New Mexico emerald.

I. "Department" means the energy, minerals and natural resources department.

J. "Division" means the department's energy conservation and management division.

K. "Energy reduction requirements" means the sustainable residential building has achieved a HERS index of 60 or lower.

L. "Energy star" means a joint program of the United States environmental protection agency and the United States department of energy that qualifies homes based on a predetermined threshold of energy efficiency.

M. "Energy star qualified manufactured home" means a home that an in state or out of state energy star certified plant has certified as being designed, produced and installed in accordance with energy star's guidelines.

N. "HERS" means home energy rating system as developed by RESNET.

O. "HERS index" means a relative energy use index, where 100 represents the energy use of a home built to a HERS reference house and zero indicates that the proposed home uses no net purchased energy.

P. "LEED" means the most current leadership in energy and environmental design green building rating system guidelines the U. S. green building council developed and adopted.

Q. "LEED certification" means the verification by the U. S. green building council, or a department-approved verifier, that a building project has met certain prerequisites and performance benchmarks or credits within each category of the LEED-H rating system resulting in the issuance of a certification document.

R. "LEED-H" means the LEED rating system for homes.

S. "Manufactured housing" means [~~homes built in a factory meeting the federal manufactured home construction and safety standards, commonly referred to as the HUD Code.~~] a multisectioned home that is:

(1) a manufactured home or modular home;

(2) a single-family dwelling with a heated area of at least thirty-six feet by twenty feet and a total area of at least eight-hundred sixty-four square feet;

(3) constructed in a factory to the standards of the United States department of housing and urban development, the National Manufactured Housing Construction and Safety Standards Act of 1974 and the housing and urban development zone code 2 or New Mexico construction codes up to the date of the unit's construction; and

(4) installed consistent with the Manufactured Housing Act and rules adopted pursuant to that act relating to permanent foundations.

T. "Person" does not include state, local government, public school district or tribal agencies.

[~~T.~~] U. "Qualified occupied square footage" means the [~~building's conditioned spaces as determined per the American national standards institute standard Z765-2003 or as specified by the manufactured housing manufacturer~~] occupied spaces of the building as determined by:

(1) the United States green building council for those buildings obtaining LEED certification;

(2) the administrators of the build green New Mexico rating system for those homes obtaining build green New Mexico certification; or

(3) the United States environmental protection agency for energy star certified manufactured homes.

[~~**U.**~~] **V.** "Rating system" means the LEED-H rating system, the build green New Mexico rating system or the energy star program for manufactured housing.

[~~**V.**~~] **W.** "RESNET" means the residential energy services network, an industry not-for-profit membership corporation and national standards making body for building energy efficiency rating systems.

[~~**W.**~~] **X.** "Solar market development tax credit" means the personal income tax credit the state of New Mexico issues to a taxpayer for a solar energy system the department has certified.

[~~**X.**~~] **Y.** "Sustainable building tax credit" means the corporate income tax credit the state of New Mexico issues to an applicant for a sustainable residential building.

[~~**Y.**~~] **Z.** "Sustainable residential building" means:

(1) a building used as a single-family residence that meets the energy reduction requirements and has been awarded:

(a) LEED-H certification at the certification level of silver, gold or platinum; or

(b) build green New Mexico certification at the gold certification level; or

[~~**(2)** a building used as multi-family residences where all dwelling units have met the energy reduction requirements and the building has been awarded:~~

~~**(a)** LEED-H certification at the certification level of silver, gold or platinum; or~~

~~**(b)** build green New Mexico certification at the gold certification level; or~~]

[~~**(3)**~~] **(2)** an energy star qualified manufactured home.

[~~**Z.**~~] **AA.** "Taxable year" means the calendar year or fiscal year upon the basis of which the net income is computed under the Corporate Income and Franchise Tax Act, NMSA 1978, 7-2A-1 *et seq*.

[~~**AA.**~~] **BB.** "Taxpayer" means a corporation subject to the taxes imposed by the Corporate Income and Franchise Tax Act, NMSA 1978, Section 7-2A-1 *et seq*.

[~~**BB.** "Taxpayer identification number" means an 11-digit number the New Mexico taxation and revenue department issues that indicates that the taxpayer is registered with the taxation and revenue department to pay gross receipts and compensating taxes.~~]

CC. "Tribal" means of, belonging to or created by a federally recognized Indian nation, tribe or pueblo.

[~~**CC.**~~] **DD.** "Verifier" means an entity the department approves to provide certifications for homes under the build green New Mexico or LEED-H rating systems.

[3.4.16.7 NMAC - N, 10-31-07; A, 1-1-14]

3.4.16.8 GENERAL PROVISIONS:

A. [~~Only a taxpayer that~~] A person is the owner of a building in New Mexico that has been constructed, [~~or~~] renovated or manufactured to be a sustainable residential building and that receives certification on or after January 1, 2007 may receive a certificate of eligibility for a sustainable building tax credit. A subsequent purchaser of a sustainable residential building may receive a certificate if no tax credit has previously been claimed for the building.

B. The annual total amount of the sustainable building tax credit available to taxpayers owning sustainable residential buildings is limited to [~~$5,000,000~~] $4,000,000. When the [~~$5,000,000 limit~~] $4,000,000 cap for sustainable residential buildings is reached, based on all certificates of eligibility the department has issued, the department shall:

(1) if part of the eligible sustainable

building tax credit is within the annual cap and part is over the annual cap, issue a certificate of eligibility for the amount under the annual cap for the applicable tax year and issue a certificate of eligibility for the balance for the subsequent tax year; or

(2) the department may issue certificates of eligibility to applicants who meet the requirements for the sustainable residential buildings tax credit in a taxable year when applications for the sustainable residential buildings tax credit exceed the annual cap and applications for the sustainable commercial buildings tax credit are under the annual cap for commercial buildings by April 30 of any year in which the tax credit is in effect; or

[~~**(2)**~~] **(3)** if no sustainable building tax credit funds are available, issue a certificate of eligibility for the next subsequent tax year in which funds are available, except for the last taxable year when the sustainable building tax credit is in effect.

C. No more than $1,250,000 of the [~~$5,000,000~~] $4,000,000 annual cap is for manufactured housing.

D. In the event of a discrepancy between a requirement of 3.4.16 NMAC and an existing New Mexico taxation and revenue department rule promulgated before 3.4.16 NMAC's adoption, the existing rule governs.

[3.4.16.8 NMAC - N, 10-31-07; A, 1-1-14]

3.4.16.10 APPLICATION FOR THE SUSTAINABLE BUILDING TAX CREDIT:

A. In order to obtain the sustainable building tax credit, a taxpayer shall apply for a certificate of eligibility with the division on a division-developed form. An applicant may obtain an application form from the division.

B. An application package shall include a completed application form and attachments as specified on the application form. The applicant shall submit the application form and required attachments at the same time. An applicant shall submit one application form for each sustainable residential building. The applicant shall submit all material submitted in the application package on 8½ inch by 11 inch paper. If the applicant fails to submit the application form and required attachments at the same time or on 8½ inch by 11 inch paper the division may consider the application incomplete.

[~~**C.** An applicant shall submit a complete application package to the division no later than 30 days before the end of taxable year for which the applicant seeks the sustainable building tax credit to allow time for approval and issuance of a certificate of eligibility. The division will review application packages it receives after that date for the subsequent taxable year.~~]

[~~**D.**~~] **C.** The completed application form shall consist of the following information:

(1) the applicant's name, mailing address, telephone number and taxpayer identification number;

(2) the name of the applicant's authorized representative;

(3) the ending date of the applicant's taxable year;

(4) the address of the sustainable residential building, including the property's legal description;

(5) whether the applicant was the building owner at time of certification or a subsequent purchaser;

(6) the qualified occupied square footage of the sustainable residential building;

(7) the rating system under which the sustainable residential building was certified;

(8) the certification level achieved, if applicable;

(9) the HERS index[~~, if applicable~~];

(10) the date of rating system certification;

(11) a statement signed and dated by the applicant, which may be a form of electronic signature if approved by the department, agreeing that:

(a) all information provided in the application package is true and correct to the best of the applicant's knowledge under penalty of perjury;

(b) applicant has read the requirements contained in 3.4.16 NMAC;

(c) if an onsite solar system is used to meet the requirements of either the rating system certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the applicant has not applied for and will not apply for a solar market development tax credit;

(d) applicant understands that there are annual [~~limits~~] caps for the sustainable building tax credit;

(e) applicant understands that the division must verify the documentation submitted in the application package before the department issues a certificate of eligibility for a sustainable building tax credit; and

(f) applicant understands that the department issues a certificate of eligibility for the taxable year in which the sustainable residential building was certified or, if the sustainable building tax credit's annual cap has been reached, for the next taxable year in which funds are available; and

(12) a project number the division assigns to the tax credit application.

[~~**E.**~~] **D.** In addition to the application form, the application package shall consist of the following information

[Continued on page 975]

provided as attachments:

(1) a copy of a deed, property tax bill or ground lease in the applicant's name as of or after the date of certification for the address or legal description of the sustainable residential building;

(2) a copy of the rating system certification form;

(3) a copy of the final certification review checklist that shows the points achieved, if applicable;

(4) a copy of a HERS certificate, from a RESNET (or a rating network that has the same standards as RESNET) accredited HERS provider, using software the internal revenue service lists as eligible for certification of the federal tax credit, showing the building has achieved a HERS index [~~achieved, if applicable~~] of sixty or lower; and

(5) other information the department needs to review the building project for the sustainable building tax credit.

[3.4.16.10 NMAC - N, 10-31-07; A, 1-1-14]

3.4.16.11 APPLICATION REVIEW PROCESS:

A. The department considers applications in the order received, according to the day they are received, but not the time of day.

B. The department approves or disapproves an application package following the receipt of the complete application package. The department disapproves an application that is not complete or correct. The department's disapproval letter shall state the reasons why the department disapproved the application. The applicant may resubmit the application package for the disapproved project. The division places the resubmitted application in the review schedule as if it were a new application.

C. The division reviews the application package to calculate the maximum sustainable building tax credit, check accuracy of the applicant's documentation and determine whether the department issues a certificate of eligibility for the sustainable building tax credit.

D. If an onsite solar system is used to meet the requirements of either the certification level applied for in the sustainable building tax credit or the energy reduction requirement achieved, the division verifies that no person has applied for a solar market development tax credit for that solar system. If the division finds that a solar market development tax credit has been approved for that solar system, the division shall disapprove the application for the sustainable building tax credit. The applicant may submit a revised application package to the division. The division places the resubmitted application in the review schedule as if it were a new application.

E. If the division finds that the application package meets the requirements and a sustainable building tax credit is available, the department issues the certificate of eligibility for a sustainable building tax credit. If a sustainable building tax credit is partially available or not available, the department issues a certificate of eligibility for any amount that is available and a certificate of eligibility for the balance for the next taxable year, until the last taxable year when the sustainable building tax credit is in effect. The notification shall include the taxpayer's contact information, taxpayer identification number, certificate of eligibility number or numbers, the rating system certification level awarded to the building, the amount of qualified occupied square footage in the building, the sustainable building tax credit amount or amounts and the sustainable building tax credit's taxable year or years.

[3.4.16.11 NMAC - N, 10-31-07; A, 1-1-14]

3.4.16.12 CALCULATING THE TAX CREDIT:

A. The division calculates the sustainable building tax credit based on the qualified occupied square footage of the sustainable residential building, the rating system under which the applicant achieved certification and the certification level the applicant achieved. The tax credit for various square footages is specified in the chart below:

[~~build green New Mexico gold:~~	
~~first 2,000 square feet~~	~~equals the qualified square footage less than or equal to 2,000 multiplied by $4.50; plus~~
~~next 1,000 square feet~~	~~the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $2.00]~~
LEED-H [~~Silver~~] silver or build green New Mexico silver:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $5.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $2.50
LEED-H [~~Gold~~] gold or build green New Mexico gold:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $6.85; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $3.40
LEED-H [~~Platinum~~] platinum or build green New Mexico emerald:	
first 2,000 square feet	equals the qualified square footage less than or equal to 2,000 multiplied by $9.00; plus
next 1,000 square feet	the qualified square footage greater than 2,000 and less than or equal to 3,000 multiplied by $4.45
energy star manufactured housing:	
up to 3,000 square feet	equals the qualified square footage less than or equal to 3,000 multiplied by $3.00.

B. An applicant may receive both a sustainable building tax credit and a federal tax credit if the applicant is eligible for each

tax credit.

C. The taxation and revenue department makes the final determination of the amount of the sustainable building tax credit.

[3.4.16.12 NMAC - N, 10-31-07; A, 1-1-14]

3.4.16.13 CLAIMING THE STATE TAX CREDIT:

A. To claim the sustainable building tax credit, an applicant shall submit all certificates of eligibility to the taxation and revenue department within 30 days of the department's issuance, along with a completed form provided by the taxation and revenue department, and any other information the taxation and revenue department requires.

[~~**B.** Beginning with the taxable year on each certificate of eligibility, the taxation and revenue department will apply 25 percent of the amount on the certificate against the applicant's income tax liability for four years, unless the amount is less than or equal to $25,000, in which case the taxation and revenue department applies the entire sustainable building tax credit in the taxable year on the certificate.~~]

[~~**C.**~~] **B.** If the amount of the sustainable building tax credit the applicant claims exceeds the applicant's income tax liability, the applicant may carry the excess forward for up to seven consecutive taxable years.

[~~**D.**~~] **C.** A taxpayer claiming a sustainable building tax credit shall not claim a tax credit pursuant to another law for the same sustainable residential building unless the other tax credit is applicable to systems that are unrelated to the sustainable building tax credit. In addition, a taxpayer claiming the sustainable building tax credit shall not claim the credit for the same sustainable building under both the Income Tax Act and the Corporate Income and Franchise Tax Act.

[3.4.16.13 NMAC - N, 10-31-07; A, 1-1-14]

NEW MEXICO DEPARTMENT OF GAME AND FISH

The Department of Game and Fish repeals its rules 19.35.6 NMAC entitled "Educational Use of Wildlife" and its rule 19.36.2 NMAC entitled "Taking and Possession of Protected Wildlife for Scientific and Educational Purposes" and replaces them both with 19.35.6 NMAC entitled "Authorized Uses of Wildlife For Education, Law Enforcement, Research and Scientific Purposes", effective 12/30/2013.

NEW MEXICO DEPARTMENT OF GAME AND FISH

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 35 CAPTIVE WILDLIFE USES
PART 6 AUTHORIZED USES OF WILDLIFE FOR EDUCATION, LAW ENFORCEMENT, RESEARCH AND SCIENTIFIC PURPOSES

19.35.6.1 ISSUING AGENCY: New Mexico Department of Game and Fish.
[19.35.6.1 NMAC - Rp, 19 NMAC 35.6.1 & 19 NMAC 36.2.1, 12/30/2013]

19.35.6.2 SCOPE: The department of game and fish and persons seeking authorization for the taking of protected wildlife for educational, law enforcement, scientific or research purposes.
[19.35.6.2 NMAC - Rp, 19 NMAC 35.6.2 & 19 NMAC 36.2.2, 12/30/2013]

19.35.6.3 STATUTORY AUTHORITY: Sections 17-1-14, 17-1-26, NMSA 1978 and 17-2-37 through 17-2-46, and 17-3-1, NMSA 1978 provide that the New Mexico state game commission has the authority to establish rules and regulations that it may deem necessary to carry out the purpose of Chapter 17, NMSA 1978 and all other acts pertaining to protected species.
[19.35.6.3 NMAC - Rp, 19 NMAC 35.6.3 & 19 NMAC 36.2.3, 12/30/2013]

19.35.6.4 DURATION: Permanent.
[19.35.6.4 NMAC - Rp, 19 NMAC 35.6.4 & 19 NMAC 36.2.4, 12/30/2013]

19.35.6.5 EFFECTIVE DATE: December 30, 2013, unless a later date is cited at the end of a section.
[19.35.6.5 NMAC - Rp, 19 NMAC 35.6.5 & 19 NMAC 36.2.5, 12/30/2013]

19.35.6.6 OBJECTIVE: To provide consistent criteria for application and permit issuance for the take, possession and use of protected wildlife for educational, law enforcement, research or scientific purposes.
[19.35.6.6 NMAC - Rp, 19 NMAC 35.6.6 & 19 NMAC 36.2.6, 12/30/2013]

19.35.6.7 DEFINITIONS:

A. "Applicant": A person who has submitted an application for a permit pursuant to this rule.

B. "Apprentice": A person who is over the age of 14 and is in training under the direct supervision of a permittee or sub-permittee, who assists in the use of wildlife for scientific and educational purposes.

C. "Department": The New Mexico department of game and fish.

D. "Director": Shall mean the director of the department of game and fish.

E. "Designated cooperator": Shall mean a person designated in writing by the director of the department of game and fish, as an official cooperator of the agency.

F. "Educational purposes": Shall mean the possession or take of protected wildlife as specimens for educational programs and instructional display as approved by the department.

G. "Permit": A document issued pursuant to this rule that authorizes a person to conduct specific activities involving protected wildlife.

H. "Protected wildlife": Shall mean those taxonomic groups listed in Chapter 17, NMSA 1978, including any species that are listed as either state or federally threatened or endangered.

I. "Scientific purposes": Shall mean the possession or take of protected wildlife for conducting research or monitoring for management purposes, as approved by the department.

J. "Sub-permittee": Shall mean a person authorized by a permit to conduct specified activities in the absence of a permit holder.

K. "Take": Shall mean the act of killing, capturing, pursuing, harassing, salvaging, retaining, or sacrificing protected wildlife by any means or device including attempting to take by the use of any method.
[19.35.6.7 NMAC - Rp, 19 NMAC 35.6.7 & 19 NMAC 36.2.7, 12/30/2013]

19.35.6.8 APPLICATION REQUIREMENTS:

A. The following requirements must be met for an application to be considered:

(1) A completed application form and the non-refundable application fee must be submitted to the department.

(2) Applicant must be 18 years of age or older and provide their full name, date of birth, home address and facility address; unless they are an apprentice who must be at least 14 years of age.

(**3)** Applicant must provide two references able to verify the applicant's ability to conduct activities relevant to the species and purpose requested.

(4) Application must include a containment or confinement plan describing where and how permitted species will be maintained, if applicable.

(5) Application must include copies of all applicable municipal, state or federal permits.

(6) Supplemental information must be supplied as requested by the department.

(7) Each application must include the applicant's signature as well as signatures of all sub-permittees being requested on the permit.

B. Additional requirements for educational use applications:

(1) Applicant must provide verifiable experience of at least 240 hours in handling, caring for and training live non-releasable wildlife of the same or similar species as those identified in the application. If this requirement cannot be met, an apprenticeship with a permitted individual or approved organization is required.

(2) Letters must be supplied from at least five separate and legitimate organizations or entities requesting wildlife related educational programs.

(3) Wildlife proposed for educational use must be obtained from a department approved source.

(4) Applicant must provide a detailed educational class or program curriculum or lesson plan which is subject to department approval prior to permit issuance.

C. Additional requirements for scientific use applications:

(1) Applicant must identify the specific wildlife being requested and provide details for disposition.

(2) Applicant must provide detailed justification for all activities, methods and locations.

(3) Applicant must provide requested take amounts, locations and specific take time frame.

(4) Applicant must provide detailed explanation of the scientific benefits to the species and the state of New Mexico. Scientific benefits will be subject to department review and approval.

(5) Applicant must provide evidence of education or experience supporting qualifications to conduct wildlife related research or monitoring activities.

[19.35.6.8 NMAC - Rp, 19 NMAC 35.6.8 & 19 NMAC 36.2.8, 12/30/2013]

19.35.6.9 PERMIT ISSUANCE:

A. Permits may be issued or denied under the authority of the director or his/her designee.

B. Authorizations and permits shall only be issued to individuals and not to parties or organizations.

C. Only those individuals that the applicant intends to utilize to take or possess protected wildlife when outside the immediate oversight and supervision of the permittee will be listed as sub-permittees.

D. A permit shall not be issued to applicants who cannot demonstrate sufficient wildlife handling qualifications and containment and confinement facilities to ensure the humane care of captive wildlife.

E. Applicant must obtain a permit prior to conducting requested activities.

F. Upon issuance of a permit, containment and confinement facilities shall be subject to random inspection by department employees.

G. Initial permits shall be issued for one year. Permit renewals may be approved for up to three years subject to director approval.

H. Each permit shall specify the number and species of protected wildlife the permittee shall be authorized to collect, possess, or handle for scientific or educational purposes.

I. Applications for permits or permit renewals shall not be considered if the applicant is subject to pending criminal charges or violations of any municipal, state or federal law relating to wildlife or other animal violations.

[19.35.6.9 NMAC - Rp, 19.35.6.8 NMAC, 12/30/2013]

19.35.6.10 PERMIT PROVISIONS:

A. General permit provisions:

(1) All protected wildlife, their offspring, and any parts held under the authority of a p ermit shall remain property of the state of New Mexico. The director shall have the authority to require that any permitted wildlife be returned to the department or to direct the disposition of such wildlife.

(2) A permit issued pursuant to this rule does not authorize propagation of wildlife unless specifically allowed in writing by the director.

(3) Protected wildlife held under the authority of a permit may not be sold, bartered, or exchanged unless specially allowed in writing by the director.

(4) Protected wildlife may not be disposed of, released as prescribed by permit provisions, or transferred to another permittee, unless specially allowed in writing by the director.

(5) Protected wildlife may not be imported from another state or another country without first obtaining an importation permit from the department.

(6) The director may apply specific provisions on individual permits to carry out the intent of this rule and applicable statutes.

(7) A copy of a valid permit must be in the possession of permittees and sub-permittees at all times when conducting permitted activities and must be available upon request by department officials.

(8) A permit holder shall carry out all educational activities in a humane manner.

B. Amendment and renewal requirements:

(1) Amendments to permits must be requested in writing, include justification, and be signed by permittee and any proposed additional sub-permittees;

(2) Payment of a fee approved by the director shall be required for each permit amendment.

(3) Annual reports must be filed and received by the department prior to renewal or reissuance of any permit.

(4) Permits must be amended prior to any changes in activities, including the addition of sub-permittees, type and numbers of wildlife to be collected, and collection locations and time frames.

C. Education permit requirements:

(1) Only a permit holder shall be permitted to possess wildlife specimens and no sharing of permitted wildlife shall be allowed between other permit holders.

(2) A permit holder must conduct a minimum of 12 educational programs per year or have the permitted animals available on static display to the public a minimum of 100 days per year.

(3) A permit holder shall carry out all educational activities in a manner which will benefit the species represented and wildlife in general.

(4) A permit holder shall not allow public contact with permitted wildlife. Applicants may request a waiver to this restriction. Waiver requests must be submitted to the department in writing and include justification for the request, and a signed waiver of liability and indemnification shall be required from the permit holder.

(5) All protected wildlife displayed must be controlled at all times and be presented in a professional manner.

(6) The loss or escape of any permitted wildlife shall be reported to the department within five business days.

(7) Health records shall be maintained at the housing facility approved for the permitted wildlife.

D. Scientific permit provisions:

(1) Specimens may not be donated, sold, exchanged, or otherwise processed except as allowed by permit provisions and in accordance with municipal, state or federal law.

(2) The disposition of progeny of wildlife taken or possessed shall be defined by permit provisions.

[19.35.6.10 NMAC - Rp, 19 NMAC 35.6.12 & 19 NMAC 36.2.8 & 10, 12/30/2013]

19.35.6.11 ANNUAL REPORTS:

A. A permit holder must submit an annual report by the deadline specified by the director.

B. Annual reports must be

submitted, received, and approved by the department prior to renewal or reissuance of any permit.

C. The annual report shall include the disposition of all wildlife taken pursuant to the permit and any additional information required by the permit.

D. Annual reports shall be completed in a format as determined by the department. All data submitted shall become property of the department.

E. Educational permit annual reports shall include:

(1) dates of all presentations;

(2) names of organizations and schools at which presentations were given;

(3) number and age group of attendees;

(4) subject matter covered;

(5) specific wildlife or wildlife parts used in each program; and

(6) number of persons viewing wildlife on permanent display.

[19.35.6.11 NMAC - Rp, 19 NMAC 35.6.13 & 19 NMAC 36.2.11, 12/30/2013]

19.35.6.12 FACILITY STANDARDS:

A. Permit holders shall adhere to department guidelines for reasonable and humane care of captive wildlife. Requests for variations on facility guidelines must be submitted to the department in writing and include justification. All facility variation requests are subject to department review and approval prior to making any facility changes.

B. Permit holders must comply with all provisions, guidelines and specific requirements listed on their permit.

C. Permitted wildlife must be housed separately from human living areas and domestic pets.

D. Permit holders shall utilize travel containers that are appropriately sized, constructed, and maintained to ensure a humane and safe environment for wildlife in transit.

E. All permittee and sub-permittee facilities shall be subject to random inspections by department personnel.

[19.35.6.12 NMAC - Rp, 19.35.6.14 NMAC, 12/30/2013]

19.35.6.13 DIRECTOR'S AUTHORITY:

A. The director shall have the authority to:

(1) establish and approve any forms, applications and documents necessary to carry out the provisions of this rule;

(2) establish and approve all notice and posting provisions for public displays of wildlife;

(3) impose corrective measures to ensure the safety and welfare of humans and wildlife;

(4) require an applicant to purchase the appropriate hunting, fishing or trapping license when applicable;

(5) establish collection limits for protected wildlife;

(6) deny any application if it is determined that the applicant has provided false or incomplete information;

(7) deny any application that conflicts with current conservation measures, negatively affects local or regional species numbers, or is contrary to angling, hunting or trapping objectives;

(8) deny any application that does not represent a valid scientific or educational benefit; and

(9) declare any applicant or permittee who fails to comply with all of the application requirements, director's conditions, permit provisions, or rule requirements as non-compliant; upon a declaration of non-compliance, the director may deny any subsequent application and requests for amendments until all permit violations are corrected and the appropriate certificate of compliance is issued and fees are paid in full.

B. Certificate of compliance fee: The director shall determine the appropriate certificate of compliance fee per violation, not to exceed $500.00 based on the following criteria:

(1) department expenses including staff time and travel costs associated with inspection and compliance monitoring;

(2) department office expenses including mailing, shipping, and certificate issuance;

(3) animal care, treatment, housing and feeding; and

(4) other miscellaneous expenses.

[19.35.6.13 NMAC - N, 12/30/2013]

19.35.6.14 VIOLATIONS AND ENFORCEMENT:

A. Any violation of state statutes, rules, or permit provisions, including amendments, may result in cooperative compliance or denial or of a permit in addition to any applicable civil, criminal or administrative remedies and penalties.

B. The signature of an applicant, permittee, or sub-permittee on any application, annual report, permit, or any other department document, shall obligate the signatory to adhere to all applicable statutes, rules, and permit provisions. Violations of this rule shall include but not be limited to:

(1) providing false or fraudulent information on any application or annual report;

(2) late submission of an annual report;

(3) exceeding authorized take limits of wildlife;

(4) take of protected wildlife in an unauthorized locality or manner;

(5) take of protected wildlife during an unauthorized time frame; or

(6) take or possession of any wildlife not authorized by the permit.

C. The director may declare any permittee who fails to comply with all requirements or provisions as ineligible for future permits until all violations are corrected and the appropriate certificate of compliance fees are paid in full.

(1) The director may impose additional corrective measures in those instances where violations of this provision have been identified.

(2) The director may deny any subsequent applications or amendments submitted by a permittee or sub-permittee that has failed to implement corrective measures or has committed repeated violations.

[19.35.6.14 NMAC - Rp, 19 NMAC 35.6.10 & 19 NMAC 36.2.12, 12/30/2013]

19.35.6.15 APPEAL PROCESS: A permit applicant may appeal a denial by the director in accordance with the following procedures:

A. Commission appeal:

(1) The applicant must submit, by certified mail, a written appeal to the chairman of the state game commission within 20 days of denial by the director.

(2) The written appeal must include the reason for the objection.

B. Commission decision: The commission may reverse the director's decision if:

(1) the commission determines that the decision of the director was arbitrary or capricious;

(2) the decision of the director was not based on law or regulation; or

(3) the appellant provides additional data or evidence that contradicts the data or evidence used by the department to deny the permit.

(4) The decision of the commission shall be final.

C. Schedule of appeal: Appeals filed with the commission will be heard at the next scheduled commission meeting subject to agenda item availability and related time constraints.

[19.35.6.15 NMAC - Rp, 19 NMAC 35.6.11, 12/30/2013]

19.35.6.16 EXEMPTIONS: The following are exempt from applying for or holding permits for conducting activities under this rule:

A. employees of the New Mexico department of game and fish and other government agencies acting in the course of their official duties as determined

by the director;

B. persons that salvage or aid in salvaging dead, injured or otherwise incapacitated wildlife at the direction of the department or others authorized for such possession; and

C. designated cooperators and department contractors provided the activities are consistent with their contractual or cooperative duties.

[19.35.6.16 NMAC - Rp, 19 NMAC 36.2.9, 12/30/2013]

19.35.6.17 COMPLIANCE AND ENFORCEMENT ALLOWANCE: A law enforcement officer operating in a director approved covert operation may take protected wildlife pursuant to a license issued to a covert identity or pursuant to a permit or written authorization issued by the director or his designee.

[19.35.6.17 NMAC - N, 12/30/2013]

HISTORY OF 19.35.6 NMAC:

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

Regulation No. 705, Regulation for the Taking and Possession of Protected Wildlife for Scientific and Educational Purposes, filed 3/11/93.

History of Repealed Material:

19 NMAC 35.6, Educational Use of Wildlife, filed 10/19/94.

19 NMAC 36.2, Taking and Possession of Protected Wildlife for Scientific and Educational Purposes, filed 1/18/96.

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an amendment to 19.31.12 NMAC, Sections 10, 11 and 13, effective 12-30-2013.

19.31.12.10 BARBARY SHEEP, ORYX, AND PERSIAN IBEX MANNER AND METHOD REQUIREMENTS AND RESTRICTIONS:

A. Season and hours: Barbary sheep, oryx or Persian ibex may be hunted or taken only during open seasons and only during the period from one-half hour before sunrise to one-half hour after sunset.

B. Bag limit: It is unlawful for any person to hunt for or take more than one Barbary sheep, oryx or Persian ibex during a current license year unless otherwise provided by regulation.

C. [RESERVED]

D. Seizure: Any conservation officer or other officer authorized to enforce game laws and regulations shall seize the carcasses of Barbary sheep, oryx or Persian ibex that are improperly notched.

E. Proof of sex: It shall be unlawful for anyone to transport or possess the carcass of any Persian ibex without proof of sex. The horns of any Persian ibex shall remain attached to the skull until arriving at a residence, taxidermist, meat processing facility, or place of final storage. The head of females or immature males of Persian ibex shall accompany the carcass in the same manner.

F. Proof of bag limit: It shall be unlawful for anyone to transport or possess the carcass of any oryx without proof of bag limit. The horns of any oryx taken shall remain attached to the skull until arriving at a residence, taxidermist, meat processing facility, or place of final storage.

G. Use of dogs in hunting: It shall be unlawful to use dogs to hunt any Barbary sheep, oryx or Persian ibex.

H. Use of baits or scents: It shall be unlawful for anyone to take or attempt to take any Barbary sheep, oryx or Persian ibex by use of baits or scents as defined in 19.31.10.7 NMAC. Scent masking agents on one's person are allowed.

I. Live animals: It shall be unlawful to use live animals as a blind or decoy in taking or attempting to take any Barbary sheep, oryx or Persian ibex.

J. Use of calling devices: It shall be unlawful to use any electrically or mechanically recorded calling device in taking or attempting to take any Barbary sheep, oryx or Persian ibex.

K. Killing out-of-season: It shall be unlawful to kill any Barbary sheep, oryx or Persian ibex out of their respective hunting seasons.

L. Legal weapon types for oryx are as follows: any center-fire rifle of .24 caliber or larger; any center-fire handgun of .24 caliber or larger; shotguns not smaller than 28 gauge, firing a single slug; muzzle-loading rifles not smaller than .45 caliber; bows and arrows; and crossbows and bolts.

M. Legal weapon types for Barbary sheep and Persian ibex are as follows: any center-fire rifle; any center-fire handgun; shotguns not smaller than 28 gauge, firing a single slug; muzzle-loading rifles; bows and arrows; and crossbows and bolts.

N. Areas closed to hunting: The following areas shall remain closed to hunting Barbary sheep, oryx, and Persian ibex, except as permitted by regulation: Sugarite canyon state park; Orilla Verde and Wild Rivers recreation areas, including the Taos valley overlook; all wildlife management areas; the Valle Vidal area; and sub-unit 6B (Valles Caldera national preserve).

O. Restricted areas on White Sands missile range: It shall be unlawful:

(1) to drive or ride in a motor vehicle into an area signed *no hunting* or otherwise restricting hunting or as documented on a map or as presented during the hunt's briefing, except if the hunter or driver is escorted by official personnel;

(2) for a licensed hunter to enter an area signed *no hunting* or otherwise restricting hunting except if the hunter is escorted by official personnel; and

(3) for a licensed security badged hunter to hunt or take any oryx in an area other than their TBA area.

~~**[P. Mandatory check-in and harvest limit for IBX-1-521:** Every hunter or hunter's designee must call the toll free number designated by the department or access the department's web site to determine if the hunt is open within 24 hours prior to hunting each day after opening day. The season will remain open until the harvest limit, as designated in 19.31.12.13 NMAC, is reached or the ending hunt date. It shall be unlawful for a person holding an IBX-1-521 license to hunt after the department designates the hunt as closed. Successful hunters of the over-the-counter (OTC) female-immature Persian ibex hunt (IBX-1-521) must present their ibex head to a department office or department official within five days of take.~~]

[19.31.12.10 NMAC - Rp, 19.31.12.10 NMAC, 4-1-11; A, 1-31-13; A, 12-30-13]

19.31.12.11 BARBARY SHEEP HUNTING SEASONS: Barbary sheep hunts shall be as indicated below, listing the open GMUs or areas, eligibility requirements or restrictions, hunt dates, hunt codes, number of licenses, and bag limit. Public land Barbary sheep licenses for GMUs 29, 30, 31, 32, 34, 36 and 37 are available only through application in the special entry draw. Private land only licenses for GMUs 29, 30, 31, 32, 34, 36 and 37 shall not be issued through the public draw and will only be available from department offices or through the department's web site and shall only be valid on deeded private lands. BBY-1-100 and BBY-1-101 licenses shall also be valid for over-the-counter hunt areas. The department shall issue military only Barbary sheep hunting licenses for McGregor range to full time military personnel providing a valid access authorization issued by Fort Bliss (BBY-1-102).

[*Continued on page 980*]

A. Southeast area public lands entry hunts:

open GMUs or areas	2011-2012 hunt dates	2012-2013 hunt dates	2013-2014 hunt dates	2014-2015 hunt dates	hunt code	lic.	bag limit
31, 32, 34, 36, 37	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	BBY-1-100	600	ES
29, 30	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	BBY-1-101	600	ES
28 McGregor range, **MO**	12/31-1/1	12/29-12/30	12/28-12/29	12/27-12/28	BBY-1-102	5	ES
28 McGregor range	12/31-1/1	12/29-12/30	12/28-12/29	12/27-12/28	BBY-1-103	5	ES

B. Southeast area private land-only hunts: Private land-only licenses shall only be available through department offices or the department's web site.

open GMUs	2011-2012 hunt dates	2012-2013 hunt dates	2013-2014 hunt dates	2014-2015 hunt dates	hunt code	licenses	bag limit
31, 32, 34, 36, 37	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	BBY-1-200	unlimited	ES
30, 29	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	BBY-1-201	unlimited	ES

C. Over-the-counter hunts: The hunt area shall be statewide (including Water canyon WMA in GMU 9) except those GMUs with bighorn sheep (8, 13, 14, 16, 20, 22, 23, 24, 26 and 27), WSMR and Fort Bliss portions of GMU 19, and those GMUs in the southeast area (28, 29, 30 31, 32, portions of 34, 36 and 37). The western portion of GMU 34 shall be open to over-the-counter licenses. Eastern portion of GMU 34 shall be closed to any license holder of a BBY-1-300 license. The boundary line dividing GMU 34 for the eastern and western portion is described as a line beginning at the southwest corner of the Mescalero Apache Indian Reservation and traveling due south to High Rolls then south on Forest Service Road (FR) 90 to it junction with FR570, then south on FR 570 to its junction with the southern boundary of GMU 34.

open GMUs or areas	2011-2012 hunt dates	2012-2013 hunt dates	2013-2014 hunt dates	2014-2015 hunt dates	hunt code	licenses	bag limit
statewide, with restrictions listed above	4/1-3/31	4/1-3/31	4/1-3/31	4/1-3/31	BBY-1-300	unlimited	ES

D. Barbary sheep population management hunts:

(1) The director or his designee may authorize population management hunts for Barbary sheep when justified in writing by department personnel.

(2) The director or his designee shall designate the sporting arms, season dates, season lengths, bag limits, hunt boundaries, and number of licenses. No qualifying license holder shall take more than one Barbary sheep per license year.

(3) The specific hunt dates, hunt area, the name of the department representative providing the information and the date and time of notification shall be written on the license after notification by telephone.

(4) Applications must be submitted by the deadline date set by the department.

(5) Applications for licenses may be rejected, and fees returned to an applicant, if such applications are not on the proper form or do not supply adequate information.

(6) In the event that an applicant is not able to hunt on the dates specified, the applicant's name shall be moved to the bottom of the list and another applicant may be contacted for the hunt.

(7) No more than one person may apply under each application.

(8) Population management hunts for Barbary sheep may be anywhere in the state with dates, number of licenses, bag limit, and specific hunt areas to be determined by the department. The hunt code to apply for Barbary sheep population management hunts shall be BBY-5-100.

(9) In those instances where a population management hunt is warranted on deeded private lands, the landowner may suggest eligible hunters of their choice by submitting a list of prospective hunter's names to the department for licensing consideration. No more than one-half of the total number of licenses authorized shall be available to landowner identified hunters. The balance of prospective hunters shall be identified by the department.

E. Special management properties: For private lands within GMUs 29, 30, 31, 32, 34, 36 and 37, the department may work with interested landowners to develop appropriate bag limits, weapon types, season dates and authorization numbers for private land hunting needed to achieve the proper harvest within the exterior boundaries of participating ranches.

[19.31.12.11 NMAC - Rp, 19.31.12.11 NMAC, 4-1-11; A, 1-31-13; A, 12-30-13]

19.31.12.13 PERSIAN IBEX HUNTING SEASONS:

A. Persian ibex hunts shall be as indicated below, listing the open GMUs or areas, eligibility requirements or restrictions, hunt dates, hunt code, number of available licenses and bag limit. The IBX-1-525 hunt is restricted to only those who have never held an ibex once-in-lifetime license. Youth, muzzle-loading rifle, bow, year-long off-mountain, and female or immature (F-IM) ibex hunts are not restricted; anyone may apply, regardless if they have ever held an ibex once-in-a-lifetime license. [~~The bag limit for IBX-1-521 hunt is two F-IM ibex.~~] The IBX-1-526 hunt is restricted to applicants who were successful harvesting two F-IM ibex during [~~the IBX-1-521~~] a population management hunt from the previous year and have presented their ibex heads within five days of harvest to a department office or department official for confirmation that they are eligible to enter a drawing for this hunt. Holders of the off-mountain license (IBX-1-528) may apply for any Florida mountain ibex hunt (IBX-1-500, IBX-1-520, IBX-1-525, IBX-2-535, IBX-2-536 or IBX-3-540) unless otherwise restricted by rule. The off-mountain (IBX-1-528) license holders need only submit the application fee and their license number along with their application. Any valid Persian ibex license shall be valid during the off-mountain (IBX-1-528) hunts. Holders of a valid ibex license may take an unlimited number of ibex for the year-long off mountain hunt. Any person that kills an off mountain ibex must notch the license according to instructions on the license. Hunt codes for Persian ibex hunts allowing "any legal weapon type" shall be designated IBX-1.

Hunt codes for Persian ibex hunts allowing the "bow only" weapon type shall be designated as IBX-2. Hunt codes for Persian ibex hunts allowing the "muzzle loading rifles or bow" weapon type shall be designated as IBX-3. The Florida mountain hunt is that portion of GMU 25 bounded by interstate 10 on the north, U.S.-Mexico border on the south, NM 11 on the west and the Dona Ana-Luna county line on the east. The year-long off-mountain hunt area is any public land open for hunting and private lands with written permission outside the Florida mountain hunt area, including Big Hatchet WMA. Youth hunters must provide hunter education certificate number on application.

open GMUs or areas	**2011-2012 hunt dates**	**2012-2013 hunt dates**	**2013-2014 hunt dates**	**2014-2015 hunt dates**	**hunt code**	**licenses/ bag limit**
Florida mountains, **YO**	9/24-10/2	9/22-9/30	12/27-1/9	12/27-1/9	IBX-1-500	15/ES
Florida mountains	11/26-12/12	11/24-12/10	11/15-11/28	11/15-11/28	IBX-1-525	25/ES
Florida mountains: only qualified IBX-1-521 hunters are eligible			2/7-2/20	2/7-2/20	IBX-1-526	10/ES
[~~Florida mountains: OTC, unlimited licenses available, harvest limit of 125 F-IM~~		~~2/21-3/31~~	~~2/21-3/31~~	~~2/21-3/31~~	~~IBX-1-521~~	~~unlimited, OTC/2 F-IM~~]
Florida mountains	1/1-1/15	1/1-1/15	10/1-10/14	10/1-10/14	IBX-2-535	100/ES
Florida mountains	1/16-1/31	1/16-1/31	1/17-1/30	1/17-1/30	IBX-2-536	100/ES
Florida mountains	2/11-2/19	2/9-2/17	12/6-12/19	12/6-12/19	IBX-3-540	25/ES
off-mountain hunt area, OTC, unlimited licenses available	4/1-3/31	4/1-3/31	4/1-3/31	4/1-3/31	IBX-1-528	unlimited/ES

B. Population Management Hunts:

(1) The director or their designee may authorize population management hunts for ibex when justified in writing by department personnel.

(2) The director or their designee shall designate the sporting arms, season dates, season lengths, bag limits, hunt boundaries, specific requirements or restrictions, and number of licenses or permits.

(3) Applications must be made on-line through the special hunt application form provided by the department. Applications must be submitted by the deadline date set by the department.

(4) Applications for licenses may be rejected, and fees returned to an applicant, if such applications are not on the proper form or do not supply adequate information.

(5) In the event that an applicant is not able to hunt on the dates specified, the applicant's name shall be moved to the bottom of the list and another applicant may be contacted for the hunt.

(6) In those instances where a population management hunt is warranted on deeded private lands, the landowner may suggest eligible hunters of their choice by submitting a list of prospective hunter's names to the department for licensing consideration. No more than one-half of the total number of licenses authorized shall be available to landowner identified hunters. The balance of prospective hunters shall be identified by the department.

[19.31.12.13 NMAC - Rp, 19.31.12.13 NMAC, 4-1-11; A, 1-31-13: A, 12-30-13]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

The Human Services Department, Medical Assistance Division, is repealing the following rules in Title 8, effective January 1, 2014.

8 NMAC 4.MAD.718, Midwife Services, filed 1-18-1995
8 NMAC 4.MAD.722, Outpatient Psychiatric Services and Partial Hospitalization, filed 1-18-1995
8 NMAC 4.MAD.762, Reproductive Health Services, filed 1-18-1995
8.262.400 NMAC, Recipient Policies, filed 6-14-05
8.262.500 NMAC, Income and Resource Standards, filed 6-14-05
8.262.600 NMAC, Benefit Description, filed 6-14-05
8.301.2 NMAC, General Benefit Description, filed 1-12-2006
8.301.3 NMAC, General Noncovered Services, filed 2-13-2006
8.302.5 NMAC, Prior Authorization and Utilization Review, filed 12-11-2003
8.310.5 NMAC, Anesthesia Services, filed 5-12-2003
8.310.6 NMAC, Vision Care Services, filed 11-12-2003
8.310.7 NMAC, Dental Services, filed 9-16-2002
8.310.8 NMAC, Behavioral Health Professional Services, filed 10-12-2004
8.310.11 NMAC, Podiatry Services, filed 6-16-2004
8.310.13 NMAC, Telehealth Services, filed 7-17-2007
8.315.3 NMAC, Psychosocial Rehabilitation Services, filed 1-17-2012
8.315.5 NMAC, Assertive Community Treatment Services, filed 9-14-2005
8.315.6 NMAC, Comprehensive Community Support Services, filed 12-10-2007
8.320.3 NMAC, Tot to Teen Healthcheck, filed 2-17-2012
8.320.4 NMAC, Special Rehabilitation Services, filed 11-12-2003
8.320.5 NMAC, EPSDT Case Management, filed 2-17-2012
8.321.3 NMAC, Accredited Residential Treatment Center Services, filed 2-17-2012
8.321.4 NMAC, Non-Accredited Residential Treatment Centers and Group Homes, filed 2-17-2012
8.321.5 NMAC, Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals, filed 1-5-2012
8.322.2 NMAC, Treatment Foster Care, filed 2-17-2012
8.322.3 NMAC, Behavioral Management Skills Development Services, filed 10-12-2005
8.322.4 NMAC, Day Treatment, filed 10-12-2005
8.322.5 NMAC, Treatment Foster Care II, filed 2-17-2012
8.322.6 NMAC, Multi-Systemic Therapy, filed 11-16-2007
8.323.2 NMAC, EPSDT Personal Care

Services, filed 9-16-2002
8.323.4 NMAC, EPSDT Private Duty Nursing Services, filed 2-17-2012
8.323.5 NMAC, EPSDT Rehabilitation Services, filed 6-6-2002
8.324.2 NMAC, Laboratory Services, filed 2-17-2012
8.324.3 NMAC, Diagnostic Imaging and Therapeutic Radiology Services, filed 2-17-2012
8.324.6 NMAC, Hearing Aids and Related Evaluations, filed 6-16-2004
8.324.8 NMAC, Prosthetics and Orthotics, filed 6-16-2004
8.324.9 NMAC, Nutrition Services, filed 2-17-2012
8.325.5 NMAC, Transplant Services, filed 2-17-2012
8.325.6 NMAC, Experimental or Investigational Procedures, Technologies or Non-Drug Therapies, filed 5-12-2003
8.325.7 NMAC, Pregnancy Termination Services, filed 10-16-2003
8.325.11 NMAC, Medical Assisted Treatment for Opioid Addiction, filed 8-16-2012

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

The Human Services Department, Medical Assistance Division, is repealing all the rules in Title 8, Chapters 305, 306 and 307, effective January 1, 2014.

8.305.1 NMAC, General Provisions, filed 6-16-2004
8.305.2 NMAC, Member Education, filed 6-16-2004
8.305.3 NMAC, Contract Management, filed 6-16-2004
8.305.4 NMAC, Managed Care Eligibility, filed 6-18-2001
8.305.5 NMAC, Enrollment in Managed Care, filed 6-16-2004
8.305.6 NMAC, Provider Networks, filed 6-18-2001
8.305.7 NMAC, Benefit Package, filed 6-16-2004
8.305.8 NMAC, Quality Management, filed 6-18-2001
8.305.9 NMAC, Coordination of Services, filed 6-16-2004
8.305.10 NMAC, Encounters, filed 6-18-2001
8.305.11 NMAC, Reimbursement for Managed Care, filed 6-18-2001
8.305.12 NMAC, MCO Member Grievance System, filed 6-16-2004
8.305.13 NMAC, Fraud and Abuse, filed 6-18-2001
8.305.14 NMAC, Reporting Requirements, filed 6-18-2001
8.305.15 NMAC, Services for Individuals with Special Health Care Needs, filed 6-16-2004
8.305.16 NMAC, Client Transition of Care, filed 6-18-2001
8.305.17 NMAC, Value Added Services, filed 6-12-2007

8.306.1 NMAC, General Provisions, filed 6-14-2005
8.306.2 NMAC, Member Education, filed 6-14-2005
8.306.3 NMAC, Contract Management, filed 6-14-2005
8.306.4 NMAC, Eligibility, filed 6-14-2005
8.306.5 NMAC, Enrollment, filed 6-14-2005
8.306.6 NMAC, Provider Networks, filed 6-14-2005
8.306.7 NMAC, Benefit Package, filed 6-14-2005
8.306.8 NMAC, Quality Management, filed 6-14-2005
8.306.9 NMAC, Coordination of Benefits, filed 6-15-2005
8.306.10 NMAC, Encounters, filed 6-15-2005
8.306.11 NMAC, Reimbursement, filed 6-15-2005
8.306.12 NMAC, Member Grievance Resolution, filed 6-15-2005
8.306.13 NMAC, Fraud and Abuse, filed 6-15-2005
8.306.14 NMAC, Reporting Requirements, filed 6-15-2005
8.306.15 NMAC, Services for SCI Members with Special Health Care Needs, filed 6-15-2005
8.306.16 NMAC, Member Transition of Care, filed 6-15-2005

8.307.1 NMAC, General Provisions, filed 7-9-2008
8.307.2 NMAC, Member Education, filed 7-9-2008
8.307.3 NMAC, Contract Management, filed 7-9-2008
8.307.4 NMAC, Eligibility, filed 7-9-2008
8.307.5 NMAC, Enrollment, filed 7-9-2008
8.307.6 NMAC, Provider Networks, filed 7-9-2008
8.307.7 NMAC, Benefit Package, filed 10-2-2012
8.307.8 NMAC, Quality Management, filed 7-9-2008
8.307.9 NMAC, Coordination of Services, filed 7-9-2008
8.307.10 NMAC, Encounters, filed 7-9-2008
8.307.11 NMAC, Reimbursement, filed 7-9-2008
8.307.12 NMAC, Member Grievance Resolution, filed 7-9-2008
8.307.13 NMAC, Fraud and Abuse, filed 7-9-2008
8.307.14 NMAC, Reporting Requirements, filed 7-9-2008
8.307.15 NMAC, Services for Members with Special Health Care Needs, filed 7-9-2008
8.307.16 NMAC, Client Transition of Care, filed 7-9-2008
8.307.17 NMAC, Value Added Services, filed 7-9-2008
8.307.18 NMAC, COLTS 1915 (C) Home and Community-Based Services Waiver, filed 10-2-2012

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

The Human Services Department, Medical Assistance Division, is repealing and replacing the following rules in Title 8, effective January 1, 2014.

8.302.2 NMAC, Billing for Medicaid Services, filed 4-16-04. Replaced with 8.302.2 NMAC, Billing for Medicaid Services.
8.310.2 NMAC, Medical Services Providers, filed 2-16-04. Replaced with 8.310.2 NMAC, General Benefit Description.
8.310.3 NMAC, Rural Health Clinic Services filed 2-16-04. Replaced with 8.310.9 NMAC, Rural Health Clinic Services.
8.320.2 NMAC, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, filed 2-17-12. Replaced with 8.320.2 NMAC, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.
8.320.6 NMAC, School Based Services for Recipients under Twenty-One Years of Age, filed 2-17-12. Replaced with 8.320.6 NMAC, School Based Services for MAP Recipients under Twenty-One Years of Age.
8.321.2 NMAC, Inpatient Psychiatric Care in a Freestanding Psychiatric Hospital, filed 10-8-10. Replaced with 8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement.
8.324.4 NMAC, Pharmacy Services, filed 8-2-04. Replaced with 8.324.4 NMAC, Pharmacy Services, Prescribing, and Practitioner Administered Drug Items.
8.324.5 NMAC, Durable Medical Equipment and Medical Supplies, filed 6-16-04. Replaced with 8.324.5 NMAC, Vision Appliances, Hearing Appliances, Durable Medical Equipment, Oxygen, Medical Supplies, Prosthetics and Orthotics.
8.324.7 NMAC, Transportation Services, filed 6-16-04. Replaced with 8.324.7 NMAC, Transportation and Lodging Services.
8.351.2 NMAC, Sanctions and Remedies, filed 6-16-03. Replaced with 8.351.2 NMAC, Sanctions and Remedies.
8.352.2 NMAC, Recipient Hearings, filed 6-15-01. Replaced with 8.352.2 NMAC, Claimant Hearings.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 400 ELIGIBILITY REQUIREMENTS

8.291.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.291.400.1 NMAC - Rp, 8.291.400.1 NMAC, 1-1-14]

8.291.400.2 SCOPE: The rule applies to the general public.
[8.291.400.2 NMAC - Rp, 8.291.400.2 NMAC, 1-1-14]

8.291.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.291.400.3 NMAC - Rp, 8.291.400.3 NMAC, 1-1-14]

8.291.400.4 DURATION: Permanent.
[8.291.400.4 NMAC - Rp, 8.291.400.4 NMAC, 1-1-14]

8.291.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.291.400.5 NMAC - Rp, 8.291.400.5 NMAC, 1-1-14]

8.291.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.400.6 NMAC - Rp, 8.291.400.6 NMAC, 1-1-14]

8.291.400.7 DEFINITIONS:

A. Action: an approval, termination, suspension, or reduction of medicaid eligibility or a reduction in the level of benefits and services, including a determination of income for the purposes of imposing any premiums, enrollment fees, or cost-sharing. It also means determinations made by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determination made by a state with regard to the preadmission screening and resident review requirements.

B. Advance payments of the premium tax credit (APTC): payment of the tax credits specified in Section 36B of the Internal Revenue Code which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through an exchange.

C. Affordable Care Act (ACA): the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and the Three Percent Withholding Repeal and Job Creation Act (Public Law 112-56.)

D. Affordable insurance exchanges (exchanges): a governmental agency or non-profit entity that meets the applicable requirements and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to state exchanges, regional exchanges, subsidiary exchanges, and a federally-facilitated exchange.

E. Agency: the single state agency designated or established by a state to administer or supervise the administration of the medicaid state plan. This designation includes a certification by the state attorney general, citing the legal authority for the single state agency to make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

F. Appeal record: the appeal decision, all papers and requests filed in the proceeding, and if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

G. Appeal request: a clear expression, either verbally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued reviewed by an appeals entity.

H. Appeals entity: a body designated to hear appeals of eligibility determinations or redeterminations contained in notices, or notices issued in accordance with future guidance on exemptions.

I. Appeals decision: a decision made by a hearing officer adjudicating a fair hearing, including by a hearing officer employed by an exchange appeals entity to which the agency has delegated authority to conduct such hearings.

J. Applicable modified adjusted gross income (MAGI) standard: the income standard for each category of ACA eligibility.

K. Application: the single streamlined application required by ACA and other medicaid applications used by the agency.

L. Authorized representative: the agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency.

(1) Such a designation must be in writing including the applicant's signature, and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary.

(2) Representatives may be authorized to:

(a) sign an application on the applicant's behalf;

(b) complete and submit a renewal form;

(c) receive copies of the applicant or beneficiary's notices and other communications from the agency; and

(d) act on behalf of the applicant or beneficiary in all other matters with the agency.

(3) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate.

(4) The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual he or she represents, and must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(5) As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that he or she will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf),

as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

M. Beneficiary: an individual who has been determined eligible and is currently receiving medicaid.

N. Citizenship: a national of the United States means a citizen of the United States or a person who, though not a citizen of the United States, owes permanent allegiance to the United States.

O. Code: the internal revenue code.

P. Coordinated content: information included in an eligibility notice regarding the transfer of the individual's or households electronic account to another insurance affordability program for a determination of eligibility.

Q. Current beneficiaries: individuals who have been determined financially eligible for medicaid using MAGI-based methods.

R. Dependent child: an un-emancipated child who is under the age of 19.

S. Documentary evidence: a photocopy facsimile, scanned or other copy of a document must be accepted to the same extent as an original document.

T. Electronic account: an electronic file that includes all information collected and generated by the state regarding each individual's medicaid eligibility and enrollment, including all documentation required to support the agency's decision on the case.

U. Expedited appeals: the agency must establish and maintain an expedited review process for hearings when an individual requests or a provider requests, or supports the individual's request, that the time otherwise permitted for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. If the agency denies a request for an expedited appeal, it must use the standard appeal timeframe.

V. Family size: the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

W. Insurance affordability program: a state medicaid program under Title XIX of the act, state children's health insurance program (CHIP) under Title XXI of the act, a state basic health program established under ACA and coverage in a qualified health plan through the exchange with cost-sharing reductions established under Section 1402 of ACA.

X. MAGI-based income: For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine a modified adjusted gross income as defined in Section 36B(d)(2)(B) of the Internal Revenue Code, with the certain exceptions.

Y. Managed care organization (MCO): an organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to medicaid eligible members.

Z. Modified adjusted gross income (MAGI): has the meaning of 26 CFR 1.36B-1 Section (2).

AA. Non-applicant: an individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or beneficiary's household to determine eligibility for such applicant or beneficiary.

BB. Non-citizen: has the same meaning as the term "alien" and includes any individual who is not a citizen or national of the United States (8 USC 1101(a)(22).

CC. Parent caretaker: a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes) and who is one of the following:

(1) the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(2) the spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

(3) other relatives within the fifth degree of relationship. (42 CFR 435.4)

DD. Patient Protection and Affordable Care Act (PPACA): also known as the Affordable Care Act (ACA) and is the health reform legislation passed by the 111th congress and signed into law in March of 2010.

EE. Tax dependent: has the same meaning as the term "dependent" under Section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under Section 151 of the Internal Revenue Code for a taxable year.

[8.291.400.7 NMAC - Rp, 8.291.400.7 NMAC, 1-1-14]

8.291.400.8 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.

[8.291.400.8 NMAC - Rp, 8.291.400.8 NMAC, 1-1-14]

8.291.400.9 LEGAL BASIS: HSD is the single state agency designated to administer the New Mexico Title XIX medicaid program in accordance with 42 CFR 431.10, single state agency. State authority is provided by Section 27-2-12 NMSA 1978 (Repl. 1984). Title XIX of the Social Security Act and United States department of health and human services rules establish the requirements for state plans for medical assistance.

[8.291.400.9 NMAC - Rp, 8.291.400.9 NMAC, 1-1-14]

8.291.400.10 BASIS FOR DEFINING GROUP: Medicaid is a federally matched program that makes certain essential health care services available to eligible New Mexico residents who otherwise would not have the financial resources to obtain them. With certain exceptions, medicaid benefits are provided through the department's medicaid managed care program.

A. Requirements outlined in 8.291.400 through 8.298.600 NMAC provides eligibility requirements for the ACA related categories listed below.

B. ACA related categories include the following:

(1) other adult;

(2) parent caretaker;

(3) pregnant women;

(4) pregnancy-related services;

(5) children under 19 years of age;

(6) adult caretaker recipients who are in transition to self-support due to the amount of spousal support; and

(7) adult caretaker recipients who are in transition to self-support due to the amount of earned income.

[8.291.400.10 NMAC - Rp, 8.291.400.10 NMAC, 1-1-14]

8.291.400.11 CONTINUOUS ELIGIBILITY FOR CHILDREN:

A. Recipients under 19 years of age will remain eligible for the 12 month certification period. The 12 months of continuous medicaid starts with the month of approval or re-determination and is separate from any months of presumptive or retroactive eligibility. This provision applies even if it is reported that income exceeds the applicable federal income poverty guidelines or there is a change in household composition. This provision does not apply when any of the following circumstances occur:

(1) death of the eligible household member;

(2) the eligible recipient or the family moves out of state;

(3) the child turns 19 years of age;

(4) failure to respond to an HSD request for information;

(5) the individual or the individual's representative requests a voluntary termination of eligibility;

(6) HSD determines that eligibility was erroneously granted at determination or renewal of eligibility because of agency error, fraud, abuse, or perjury attributed to the child or the child's representative;

(7) change in household composition; or

(8) any factor of eligibility with the exception of increased income is not met.

B. Continuous eligibility for pregnant women: Recipients who are or become pregnant, will remain eligible for medicaid up to two months port partum regardless of changes in circumstances. This provision does not apply when any of the following circumstances occur:

(1) death of the eligible household member;

(2) the eligible recipient or the family moves out of state;

(3) failure to respond to an HSD request for information;

(4) the individual or the individual's representative requests a voluntary termination of eligibility;

(5) HSD determines that eligibility was erroneously granted at determination or renewal of eligibility because of agency error, fraud, abuse, or perjury attributed to the child or the child's representative;

[8.291.400.11 NMAC - Rp, 8.291.400.11 NMAC, 1-1-14]

8.291.400.12 REPORTING REQUIREMENTS: A medicaid applicant or recipient is required to report any changes which might affect his or her eligibility. The following changes must be reported to a local income support division (ISD) office within 10 days from the date the change occurred:

A. living arrangements or change of address: any change in where an individual lives or receives 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 assistance unit or budget group;

C. enumeration: any new social security number must be reported; or

D. income: any increase or decrease in the amount of income or change in the source of income must be reported.

[8.291.400.12 NMAC - Rp, 8.291.400.12 NMAC, 1-1-14]

8.291.400.13 PRESUMPTIVE ELIGIBILITY: Presumptive eligibility (PE) provides medicaid benefits under one of the eligible groups outlined in Subsection B of 8.291.400.10 NMAC, starting with the date of the PE determination and ending with the last day of the following month.

A. Only one presumptive eligibility period is allowed per pregnancy or per 12 month period for other ACA related categories.

B. Determinations can be made only by individuals employed by eligible entities and certified as presumptive eligibility PE determiners by the medical assistance division. Determiners must notify the medical assistance division (MAD) claims processing contractor of the determination within 24 hours of the determination of presumptive eligibility.

(1) Processing PE information: MAD authorizes certain providers to make PE determinations based on the qualified entity. The provider must notify MAD through an established procedure of the determination within 24 hours of the determination of presumptive eligibility.

(2) PE: The PE provider must process both presumptive eligibility as well as an application for medical assistance.

(3) Provider eligibility: Entities who may participate must be:

(a) a qualified hospital that participates as a provider under the medicaid state plan or a medicaid 1115 demonstration, notifies the medicaid agency of its election to make presumptive eligibility determinations and agrees to make PE determinations consistent with state policies and procedures; or

(b) a qualified hospital that has as not been disqualified by the medicaid agency for failure to make PE determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the medicaid agency; or

(c) a federally qualified health center (FQHC), an Indian health service (IHS) facility, a department of health (DOH) clinic, a school, a children, youth and families department (CYFD) child care bureau staff member, a primary care provider who is contracted with at least one HSD contracted MCO, or a head start agency; or

(d) other entities HSD has determined as an eligible presumptive participant.

C. PE approval limitations:

(1) all MAD authorized PE determiners can approve PE for children and pregnant women ACA categories;

(2) hospitals opting to do PE can approve PE for all ACA related categories; and

(3) correctional facilities (state prisons and county jails) and health facilities operated by the Indian health Service, a tribe, or tribal organization, or an urban Indian organization can approve PE for the other adult, parent caretaker, pregnant women, pregnancy-related services, and children under 19 years of age ACA categories.

D. Children's health insurance program (CHIP): to be eligible for CHIP, the child cannot have other health insurance coverage.

E. A PE provider must ensure that a signed application for medicaid coverage is submitted to the ISD office within 10 days.

F. For pregnant women, PE allows medicaid payment for ambulatory prenatal services furnished to a pregnant woman while her application for medicaid is being processed. Only one presumptive eligibility period is allowed per pregnancy. A pregnant woman can receive ambulatory prenatal care from the date of the PE determination until the end of the month following the month the determination was made.

(1) For PE, an approved PE provider must accept self attestation of pregnancy.

(2) The needs and income of the unborn child(ren) are considered when determining the woman's countable family size.

[8.291.400.13 NMAC - Rp, 8.291.400.13 NMAC, 1-1-14]

HISTORY OF 8.291.400 NMAC:

History of Repealed Material:
8.291.400 NMAC, Eligibility Requirements, filed 9-17-13 - Duration expired 12-31-13.

[*Continued on page 986*]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.291.410.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.291.410.1 NMAC - Rp, 8.291.410.1 NMAC, 1-1-14]

8.291.410.2 SCOPE: The rule applies to the general public.
[8.291.410.2 NMAC - Rp, 8.291.410.2 NMAC, 1-1-14]

8.291.410.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.291.410.3 NMAC - Rp, 8.291.410.3 NMAC, 1-1-14]

8.291.410.4 DURATION: Permanent.
[8.291.410.4 NMAC - Rp, 8.291.410.4 NMAC, 1-1-14]

8.291.410.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.291.410.5 NMAC - Rp, 8.291.410.5 NMAC, 1-1-14]

8.291.410.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.410.6 NMAC - Rp, 8.291.410.6 NMAC, 1-1-14]

8.291.410.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.291.410.7 NMAC - Rp, 8.291.410.7 NMAC, 1-1-14]

8.291.410.8 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.
[8.291.410.8 NMAC - Rp, 8.291.410.8 NMAC, 1-1-14]

8.291.410.9 GENERAL RECIPIENT REQUIREMENTS: To be eligible for medical assistance programs, applicants or recipients must meet specific requirements as outlined in this part.
[8.291.410.9 NMAC - Rp, 8.291.410.9 NMAC, 1-1-14]

8.291.410.10 ENUMERATION: The social security administration (SSA) is responsible for the assigning of social security numbers (SSN), a process called enumeration. HSD uses the SSN as a unique identifier for the individual and to verify income and resources where applicable.

A. Applicant or recipients: Except as noted in Subsection B below, it is mandatory for medicaid applicants or recipients to report their SSNs if they are requesting assistance. If an applicant or recipient does not have a valid SSN, he or she must apply for one. Applications for an SSN are available at any SSA or HSD income support division (ISD) office. Proof of the SSN application must be provided to ISD.

B. Non-applicants/recipients: Reporting an SSN is voluntary for individuals who are not seeking medicaid for themselves.

C. The agency must not delay or deny services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA.

D. This requirement does not apply and the state will give a identification number to an individual who is not eligible to receive an SSN if the individual does not have an SSN and is lawfully residing for a valid non-work reason or refuses to obtain an SSN because of well-established religious objections.
[8.291.410.10 NMAC - Rp, 8.291.410.10 NMAC, 1-1-14]

8.291.410.11 AGE: The age of the applicant is verified to determine if he or she is under or over the specified age limit**.**

A. Age of child: Verification of the age, including through self-attestation, of children is mandatory for medical assistance for children programs.

B. Age of adults: Age of adult member(s) is verified if questionable.

C. Documents that can be used to verify age can be found in 8.100.130 NMAC.
[8.291.410.11 NMAC - Rp, 8.291.410.11 NMAC, 1-1-14]

8.291.410.12 RELATIONSHIP: Verification of relationship is mandatory, see 8.291.410.20 NMAC

A. Documents that can be used to verify relationship can be found at 8.100.130 NMAC.

B. The documentary evidence must contain the names of related individuals in question.

(1) If the relative is other than a parent, the relationship must be traced if questionable.

(2) In situations in which both parents are living in the home and the father's paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the child to the father by completion of the child support enforcement division (CSED) acknowledgment of paternity packet.

(3) If the child is living with a relative, it will be necessary to establish the relationship of the absent parents. A CSED acknowledgement of paternity will be an acceptable means of establishing relationship.

C. The following relatives are within the fifth degree of relationship:

(1) father (biological or adoptive);

(2) mother (biological or adoptive);

(3) grandfather, great grandfather, great great grandfather, great great great grandfather;

(4) grandmother, great grandmother, great great grandmother, great great great grandmother;

(5) spouse of child's parent (stepparent);

(6) spouse of child's grandparent, great grandparent, great great grandparent, great great great grandparent (step grandparent);

(7) brother, half-brother, brother-in-law, step-brother;

(8) sister, half-sister, sister-in-law, step-sister;

(9) uncle of the whole or half blood, uncle-in-law, great uncle, great great uncle;

(10) aunt of the whole or half blood, aunt-in-law, great aunt, great great aunt;

(11) first cousin and spouse of first cousin;

(12) son or daughter of first cousin (first cousin once removed);

(13) son or daughter of great aunt or great uncle (first cousin once removed) and spouse; or

(14) nephew or niece and spouses.

D. Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death.
[8.291.410.12 NMAC - Rp, 8.291.410.12 NMAC, 1-1-14]

8.291.410.13 IDENTITY: Verification of identity for the applicant is mandatory at application if questionable.

A. The following may be used as proof of identity, provided that such document has a photograph or identifying information including, but not limited to, name, age, gender, race, height, weight, eye color, or address:

(1) driver's license that includes a photograph and issued by a state or outlying possession of the U.S; if the driver's license does not contain a photograph, identifying information on the driver's license shall be included such as name, date of birth, sex, height, color of eyes, and address;

(2) voter's registration card;

(3) U.S. military card or draft record;

(4) identification card issued by the federal, state, or local government agencies or entities; if the identification card does not contain a photograph, identifying information on the identification card must be included such as name, date of birth, sex, height, color of eyes, and address;

(5) military dependent's identification card;

(6) native American tribal documents;

(7) US coast guard mariner card;

(8) for children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records;

(9) two documents containing consistent information that corroborates an applicant's identity; such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds or titles;

(10) finding of identity from a federal or state government agency; or

(11) a finding of identity from a federal agency or another state agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity.

B. For individuals under the age of 18 who are unable to produce a document listed above, the following are acceptable to establish identity only:

(1) school record or report card;

(2) clinic, doctor or hospital record; or

(3) day care or nursery school record.

C. If an individual under the age of 18 is unable to produce one of the identity documents listed, then the individual must provide one of the following:

(1) the minor's parent or legal guardian completes on Form I-9 Section 1-"employee information and verification" and in the space for the minor's signature, the parent or legal guardian writes the words "minor under age 18.";

(2) the minor's parent or legal guardian completes on Form I-9 the "preparer/translator certification.";

(3) the employer or the recruiter or referrer for a fee writes in Section 2-"employer review and verification" under List B, in the space after the words "document identification#," the words "minor under the age 18."; or

(4) individuals with handicaps who are unable to produce one of the identity documents listed in the standalone or secondary tier documentation, and who are being placed into employment by a nonprofit organization, association or as part of a rehabilitation program, may follow the procedures for establishing identity provided in this section for minors under the age of 18, substituting where appropriate, the term "special placement" for "minor under age 18," and permitting in addition to a parent or legal guardian, a representative of the nonprofit organization, association or rehabilitation program placing the individual into a position of employment, to fill out and sign in the appropriate section on the Form I-9; for purposes of this section, the term "individual with handicaps" means any person who:

(a) has a physical or mental impairment which substantially limits one or more of a person's major life activities;

(b) has a record of such impairment; or

(c) is regarded as having such impairment.

[8.291.410.13 NMAC - Rp, 8.291.410.13 NMAC, 1-1-14]

8.291.410.14 CITIZENSHIP/ ALIEN STATUS: To be eligible for medicaid, an individual must be a citizen of the United States or meet the alien/ immigrant eligibility criteria in 8.200.410 NMAC. Verification of citizenship and alien status is mandatory at initial determination of medicaid eligibility. The applicant or recipient is required to submit documentary evidence as verification. Documentation will be verified by using a two tiered process:

A. **Tier one:** Standalone evidence of citizenship can be verified using the following:

(1) a US passport issued by the department of state (without regard to any expiration date as long as the passport or card was issued without limitation);

(2) a certificate of naturalization;

(3) a certificate of US citizenship;

(4) a valid state-issued driver's license if the state issuing the license requires proof of US citizenship, or obtains and verifies a social security number from the applicant who is a citizen before issuing such license;

(5) documentation issued by a federally recognized Indian tribe, as published in the federal register by the bureau of Indian affairs within the U.S. department of the interior and including tribes located in the state that has an international border, which:

(a) identifies the federally recognized tribe that issued the document;

(b) identifies the individual by name; and

(c) confirms the individual's membership, enrollment, or affiliation with the tribe;

(6) documents include, but are not limited to:

(a) a tribal enrollment card;

(b) a certificate of degree of Indian blood;

(c) a tribal census document; and

(d) documents on tribal letterhead, issued under the signature of the appropriate tribal official, that meet the requirements of documentary evidence issued by a federally recognized Indian tribe, as published by the bureau of Indian affairs within the U.S. department of the interior, and including tribes located in a state that has an international border, which identifies the federally recognized Indian tribe that issued the document, identifies the individual by name, and confirms the individual's membership, enrollment, or affiliation with the tribe.

B. **Tier two:** Documents must accompany an identity document that includes a photograph or other identifying information such as name, age, sex, face, height, color of eyes, date of birth and address.

(1) A driver's license or identification card containing a photograph, issued by a state or an outlying possession of the United States. If the driver's license or identification card does not contain a photograph, identifying information shall be included such as: name, date of birth, sex, height, color of eyes, and address.

(2) School identification card with a photograph.

(3) Voter's registration card.

(4) U.S. military card or draft record.

(5) Identification card issued by federal, state, or local government agencies or entities; if the identification card does not contain a photograph, identifying information shall be included such as: name, date of birth, sex, height, color of eyes, and address.

(6) Military dependent's identification card.

(7) Native American tribal documents.

(8) United States coast guard merchant mariner card.

C. Evidence of citizenship: If an applicant does not provide documentary evidence from the list of primary documents, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by a document list in 8.291.410 NMAC.

(1) A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S. (if born on or after January 13, 1941), American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (after November 4, 1986 (CNMI local time.)) The birth record document may be issued by the state, commonwealth, territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen.

(2) A certification of report of birth, issued to U.S. citizens who were born outside the U.S.

(3) A report of birth abroad of a U.S. citizen.

(4) A certification of birth.

(5) A U.S. citizen I.D. card.

(6) A Northern Mariana's identification card, issued to a collectively naturalized citizen, who was born in the CNMI before November 4, 1986.

(7) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(8) Evidence of U.S. civil service employment before June 1, 1976.

(9) U.S. military record showing a U.S. place of birth.

(10) A data match with the systematic alien verification for entitlements (SAVE) or any other process established by the department of homeland security to verify that an individual is a citizen.

(11) Documentation that a child meets the requirements of Section 101 of the Child Citizenship Act of 2000 (8 U.S.C. 1431).

(12) Medical records, including but not limited to hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(13) Life, health, or other insurance record that indicates a U.S. place of birth.

(14) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(15) School records, including pre-school, head start, and daycare, showing the child's name and U.S. place of birth.

(16) Federal or state census record showing U.S. citizenship or a U.S. place of birth.

(17) If the applicant does not have one of the documents listed in the stand alone or second tier sections, he or she must submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

D. Exemptions: The following individuals are exempt from providing documentation of citizenship and identity:

(1) individuals receiving supplemental security income benefits under Title XVI of the Social Security Act;

(2) individuals entitled to or enrolled in any part of medicare;

(3) individuals receiving social security disability insurance benefits under Section 223 of the Social Security Act or monthly benefits under Section 202 of the act, based on the individual's disability, as defined in Section 223(d) of the act;

(4) individuals who are in foster care and who are assisted under Title IV-B of the Social Security Act; or

(5) individuals who are recipients of foster care maintenance or adoption assistance payment under Title IV-E of the act.

[8.291.410.14 NMAC - Rp, 8.291.410.14 NMAC, 1-1-14]

8.291.410.15 RESIDENCE: To be eligible for medicaid, applicants or recipients must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated an intention to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities associated with day-to-day living, such as occupying a home, enrolling child(ren) in school, getting a state driver's license, or renting a post office box. An applicant or recipient who is homeless is considered to have met the residence requirements if he or she intends to remain in the state.

B. Recipients receiving benefits out-of-state: Applicants or recipients who receive financial or medical assistance in another state which makes residence in that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or recipient of the abandonment of residence in that state.

C. Individuals court ordered into full or partial responsibility of the state children youth and families department (CYFD): When CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited coverage for services that are part of the New Mexico medicaid benefit package and not available in the new state of residence.

D. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when recipients leave New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when the applicant or recipient leaves New Mexico for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 days, without notifying HSD of his or her departure or intention of returning.

E. Dispute in residency: If there is a dispute in state residency, the individual may be considered a resident in the state in which the individual is physically located.

[8.291.410.15 NMAC - Rp, 8.291.410.15 NMAC, 1-1-14]

8.291.410.16 NON-CONCURRENT RECEIPT OF ASSISTANCE: A medicaid applicant or recipient receiving medicaid in another state is not eligible for medicaid in accordance with 8.200.410 NMAC.

[8.291.410.16 NMAC - Rp, 8.291.410.16 NMAC, 1-1-14]

8.291.410.17 APPLICATIONS FOR OTHER BENEFITS: As a condition of eligibility, a medicaid applicant or recipient must take all necessary steps to obtain any benefits they are entitled to in accordance with 8.200.410 NMAC.

[8.291.410.17 NMAC - Rp, 8.291.410.17 NMAC, 1-1-14]

8.291.410.18 PROCESSING APPLICATIONS:

A. Applicants or recipients may submit applications to a county office in person, through an authorized representative, by mail or electronically.

(1) Requesting application forms: Applicants or recipients may request an application form by mail or by telephone. In either case, the ISD staff must mail the requested form to the applicant within 24 hours.

(2) Application: An applicant has the right to file an application as long as the

application contains the applicant's name, address and the signature of a responsible adult household member or an authorized representative if one is designated.

B. Interviews: In-person interviews are not required as part of the application or re-certification process for a determination of eligibility.

(1) Applications will be processed in accordance with time standards and procedures set forth in federal regulations governing the medical assistance programs.

(2) Single interview: If a face to face or a telephonic interview is requested, a single interview will be held with an applicant who applies jointly for all benefits HSD administers.

(3) Application processing: As a result of differences in all HSD's benefit application processing procedures and timeliness standards, eligibility for medical benefits may be determined prior to eligibility determination for other benefits that HSD administers.

(4) Application is denied: If a medicaid application is denied, a new application for other assistance programs is not required if other assistance programs were requested.

(5) Responsibility in application or recertification process: The burden of proving eligibility for medicaid is on the applicant or recipient if the department is unable to verify required information. An individual has the primary responsibility for providing required information and documents and for taking the action necessary to establish eligibility.

(a) An applicant or recipient's failure to provide documentation or to take required action results in a decision that eligibility does not exist.

(b) An applicant or recipient must give the department permission to contact other individuals, agencies, or sources of information which are necessary to establish eligibility.

C. Redetermination/recertification: A complete review of all conditions of eligibility which are subject to change are conducted by ISD no later than 12 months from the month of approval or redetermination and is separate from any months of presumptive or retroactive eligibility.

(1) Administrative renewal: 90 days prior to expiration, HSD will utilize electronic verification sources to verify financial eligibility and will proceed with the re-determination or re-certification process.

(2) If an administrative renewal cannot be completed for any reason, 45 days prior to redetermination or recertification HSD will mail a pre-populated application with the recipient's previously reported information.

(3) An eligible recipient's failure to provide necessary verification may result in medicaid ineligibility. The recertifying eligible recipient is responsible for providing verification of eligibility if administrative renewal cannot be completed.

D. An applicant or a recertifying eligible recipient must give HSD permission to contact other individuals, agencies, or electronic sources for information which is necessary to establish initial and continued eligibility.

[8.291.410.18 NMAC - Rp, 8.291.410.18 NMAC, 1-1-14]

8.291.410.19 VERIFICATION METHODS: Verification will be obtained through various methods. Not all methods will necessarily be used in each case. This section details the specific types of methods to be used in establishing the applicant or recipient's eligibility.

A. Prior case data not subject to change: Verification of an eligibility factor not subject to change, which previously has been verified and accepted, will not be subject to re-verification. The caseworker shall not ask an applicant or recipient for verification of any eligibility factors which have previously been established through documents in HSD's possession and are not subject to change. Such factors include U.S. citizenship, birth date, relationship and enumeration.

B. Electronic data: Every applicant or recipient shall be informed that the information provided is subject to verification through state, federal and contracted data systems. The caseworker shall not require further verification of such information unless it is disputed by the applicant or the information is otherwise questionable as defined in 8.100.130 NMAC.

C. Self attestation is the information that a client or recipient reports on an application and is certifying as true and correct to the best of their knowledge.

D. Documentary evidence is the primary source of verification for information not established in prior case information or electronic source data. Obtaining necessary verification through documentary evidence readily available to the applicant or recipient shall always be explored before collateral contacts or sworn statements are used. Documentary evidence consists of a written confirmation of a household's circumstances. Acceptable verification is not limited to any single type of document. The types of documents which may be accepted as verification are specified under the sections pertaining to verification methods later in this chapter. The caseworker shall provide applicants or recipients with receipts for verification documents provided subsequent to the interview.

E. Collateral contact is defined at 8.100.130 NMAC.

F. Sworn statement is defined at 8.100.130 NMAC.

[8.291.410.19 NMAC - Rp, 8.291.410.19 NMAC, 1-1-14]

8.291.410.20 VERIFICATION STANDARDS: Below is a list of standards HSD will utilize to determine eligibility for medicaid categories defined at 8.291.400.10 NMAC. If verification cannot be confirmed utilizing the various methods described in each section, HSD may request additional information. If information is provided and becomes questionable as defined at 8.100.130 NMAC, then additional documentation must be provided as described by 8.100.130 NMAC.

A. Income: Verification of income is mandatory for ACA related medicaid programs and HSD will utilize electronic sources and documents provided by the applicant or recipient to verify an applicant or recipient's income. Examples of acceptable documentation can be found at 8.100.130 NMAC.

B. Residency: Self attestation is an acceptable form of verification of residency.

C. Age: Self attestation is an acceptable form of verification of age.

D. Enumeration: HSD will utilize electronic sources to verify an applicant or recipient's enumeration.

E. Citizenship: HSD will utilize electronic sources to verify an applicant or recipient's citizenship.

F. Immigration status: HSD will utilize electronic sources to verify an applicant or recipient's immigration status.

G. Relationship: Self attestation is an acceptable form of verification of relationship.

H. Receipt of other benefits: HSD will utilize electronic sources to verify an applicant or recipient's receipt of other benefits.

[8.291.410.20 NMAC - Rp, 8.291.410.20 NMAC, 1-1-14]

8.291.410.21 TIMEFRAME FOR DISPOSITION: An applicant or recipient is given a timeframe to provide necessary verification in order for ISD to process an application within the time frame set forth in this section. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. ISD shall make an eligibility decision within three work days of the receipt of all necessary verification.

A. The application disposition deadline for medical assistance programs is 45 days from the date of application.

(1) Day one: the date of application is the first day.

(2) No later than day 44, or by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 - 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant or recipient requests one or more 10-day extensions of time to provide needed verification. An applicant or recipient is entitled to receive up to three 10-day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three work days of receipt of all necessary verification.

B. Tracking the application processing time limit: The application processing time limit begins on the day the signed application is received in the ISD county office.

C. Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant or recipient shall be notified in writing of the reason for the delay and that the applicant or recipient has the right to request a fair hearing regarding ISD's failure to act within the time limit.

D. Extensions of time: Up to three ten-calendar day extensions for providing verification shall be granted at the applicant or recipient's request. The extension begins at the end of the application processing time period or at the end of the previous extension.

E. Lack of verification: If verification needed to determine eligibility is not provided and no extension of time is requested, the application will be denied on the 45th day after the application date or by the next work day if 45th day falls on weekend or holiday.

[8.291.410.21 NMAC - Rp, 8.291.410.21 NMAC, 1-1-14]

HISTORY OF 8.291.410 NMAC:

History of Repealed Material:
8.291.410 NMAC, General Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 420 RECIPIENT RIGHTS AND RESPONSIBILITIES

8.291.420.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.291.420.1 NMAC - Rp, 8.291.420.1 NMAC, 1-1-14]

8.291.420.2 SCOPE: The rule applies to the general public.
[8.291.420.2 NMAC - Rp, 8.291.420.2 NMAC, 1-1-14]

8.291.420.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.291.420.3 NMAC - Rp, 8.291.420.3 NMAC, 1-1-14]

8.291.420.4 DURATION: Permanent.
[8.291.420.4 NMAC - Rp, 8.291.420.4 NMAC, 1-1-14]

8.291.420.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.291.420.5 NMAC - Rp, 8.291.420.5 NMAC, 1-1-14]

8.291.420.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.420.6 NMAC - Rp, 8.291.420.6 NMAC, 1-1-14]

8.291.420.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.291.420.7 NMAC - Rp, 8.291.420.7 NMAC, 1-1-14]

8.291.420.8 RIGHT TO APPLY:

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

(1) The income support division (ISD) determines eligibility for medicaid, unless otherwise determined by another entity as stated in another NMAC rule. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.291.410 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 signed electronic or paper application, as defined in 8.291.410 NMAC, is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may complete a joint application for all benefits that HSD administers. A recipient will not be required to submit an application if there is a need to switch from one medicaid benefit to another unless a redetermination is due in that month or the following month. Additional information may be requested if the new benefit requires additional information and verification of eligibility.
[8.291.420.8 NMAC - Rp, 8.291.420.8 NMAC, 1-1-14]

8.291.420.9 FREEDOM OF CHOICE OF PROVIDER: Refer to 8.200.430.10 NMAC.
[8.291.420.9 NMAC - Rp, 8.291.420.9 NMAC, 1-1-14]

8.291.420.10 RELEASE OF INFORMATION/CONFIDENTIALITY: Refer to 8.200.430.11 NMAC.
[8.291.420.10 NMAC - Rp, 8.291.420.10 NMAC, 1-1-14]

8.291.420.11 RIGHT TO ADEQUATE NOTICE AND ADMINISTRATIVE HEARING: Refer to 8.200.430.12 NMAC.
[8.291.420.11 NMAC - Rp, 8.291.420.11 NMAC, 1-1-14]

8.291.420.12 ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: Refer to 8.200.430.13 NMAC.
[8.291.420.12 NMAC - Rp, 8.291.420.12 NMAC, 1-1-14]

8.291.420.13 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS: Refer to 8.200.430.14 NMAC.
[8.291.420.13 NMAC - Rp, 8.291.420.13 NMAC, 1-1-14]

8.291.420.14 ELIGIBLE RECIPIENT RESPONSIBILITY

TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES: Refer to 8.200.430.15 NMAC.
[8.291.420.14 NMAC - Rp, 8.291.420.14 NMAC, 1-1-14]

8.291.420.15 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES: Refer to 8.200.430.16 NMAC.
[8.291.420.15 NMAC - Rp, 8.291.420.15 NMAC, 1-1-14]

8.291.420.16 RESTITUTION: Refer to 8.200.430.17 NMAC.
[8.291.420.16 NMAC - Rp, 8.291.420.16 NMAC, 1-1-14]

8.291.420.17 THIRD PARTY LIABILITY: Refer to 8.200.420.12 NMAC.
[8.291.420.17 NMAC - Rp, 8.291.420.17 NMAC, 1-1-14]

8.291.420.18 MAD ESTATE RECOVERY: Refer to 8.200.420.13 NMAC.
[8.291.420.18 NMAC - Rp, 8.291.420.18 NMAC, 1-1-14]

HISTORY OF 8.291.420 NMAC:

History of Repealed Material:
8.291.420 NMAC, Recipient Rights and Responsibilities, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 430 FINANCIAL RESPONSIBILITY REQUIREMENTS

8.291.430.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.291.430.1 NMAC - Rp, 8.291.430.1 NMAC, 1-1-14]

8.291.430.2 SCOPE: The rule applies to the general public.
[8.291.430.2 NMAC - Rp, 8.291.430.2 NMAC, 1-1-14]

8.291.430.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.291.430.3 NMAC - Rp, 8.291.430.3 NMAC, 1-1-14]

8.291.430.4 DURATION: Permanent.
[8.291.430.4 NMAC - Rp, 8.291.430.4 NMAC, 1-1-14]

8.291.430.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.291.430.5 NMAC - Rp, 8.291.430.5 NMAC, 1-1-14]

8.291.430.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for medicaid programs and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.430.6 NMAC - Rp, 8.291.430.6 NMAC, 1-1-14]

8.291.430.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.291.430.7 NMAC - Rp, 8.291.430.7 NMAC, 1-1-14]

8.291.430.8 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.
[8.291.430.8 NMAC - Rp, 8.291.430.8 NMAC, 1-1-14]

8.291.430.9 GENERAL NEED DETERMINATION: To be eligible for medicaid, an applicant/recipient must meet specific income standards.
[8.291.430.9 NMAC - Rp, 8.291.430.9 NMAC, 1-1-14]

8.291.430.10 FEDERAL POVERTY LEVEL (FPL): This part contains the monthly federal poverty level table for use in determining monthly income standards for categories of eligibility outlined in 8.291.400.10 NMAC:

[*Continued on page 992*]

HOUSEHOLD SIZE	100%	133%	138%	190%	240%	250%	300%
1	$958	$1,274	$1,322	$1,820	$2,298	$2,394	$2,873
2	$1,293	$1,720	$1,784	$2,456	$3,102	$3,232	$3,878
3	$1,628	$2,165	$2,246	$3,093	$3,906	$4,069	$4,883
4	$1,969	$2,611	$2,709	$3,729	$4,710	$4,907	$5,888
5	$2,298	$3,056	$3,171	$4,366	$5,514	$5,744	$6,893
6	$2,633	$3,502	$3,633	$5,002	$6,318	$6,582	$7,898
7	$2,968	$3,947	$4,096	$5,639	$7,122	$7,419	$8,903
8	$3,303	$4,393	$4558	$6,275	$7,926	$8,257	$9,908
+1	$335	$446	$462	$636	$804	$838	$1,005

[8.291.430.10 NMAC - Rp, 8.291.430.10 NMAC, 1-1-14]

8.291.430.11 INCOME STANDARD FOR PARENT CARETAKER ELIGIBILITY: This part contains the fixed monthly standard for individuals eligible for parent caretaker medicaid:

HOUSEHOLD SIZE	MONTHLY INCOME LIMIT
1	$451
2	$608
3	$765
4	$923
5	$1,080
6	$1,238
7	$1,395
8	$1,553
+1	$158

[8.291.430.11 NMAC - Rp, 8.291.430.11 NMAC, 1-1-14]

8.291.430.12 INCOME DISREGARD: A disregard of five percent of 100 percent of the current FPL, according to the individual's budget group size, will be given according to the ACA related category of eligibility. This income disregard will be subtracted from the countable income.

[8.291.430.12 NMAC - Rp, 8.291.430.12 NMAC, 1-1-14]

8.291.430.13 LIVING ARRANGEMENT: All individuals listed on the application are evaluated according to their living arrangement to determine if they can be included in an assistance group or budget group.

A. Extended living in the home: An individual physically absent from the home is a member of the assistance unit or budget group. Extended living in the home includes:

(1) attending college or boarding school;

(2) receiving treatment in a title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for the mentally retarded (ICF-MRs);

(3) emergency absences: an individual absent from the home due to an emergency, who is expected to return to the household, continues to be a member of the household;

(4) foster care placements: a child removed from the home by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department) will be considered to be living in the home until the adjudicatory hearing; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit and budget group;

(5) a stay in a detention center:

(a) regardless of adjudication status the individual continues to be a member of the household but will not be medicaid eligible;

(b) once an adjudicated individual leaves the detention center to receive inpatient services in a medical institution, the individual may be eligible during treatment if all other criteria are met; eligibility ceases to exist when the individual returns to the detention center.

B. Extended living in the home also includes:

(1) residential treatment centers;

(2) group homes; and

(3) free-standing psychiatric hospitals.

C. Living in the home with a parent caretaker: To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a biological or adoptive or step parent (there is a presumption that a child born to a married woman is the child of the

husband); or

(2) a specified relative who:

(a) is related within the fifth degree of relationship by blood, marriage or adoption, as determined by New Mexico statute Chapter 45 - Uniform Probate Code; a relationship based upon marriage, such as "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death; and

(b) assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise;

(3) a child considered to be living in the home: a child is considered to be part of the assistance unit and budget group as evidenced by the child's customary physical presence in the home; if a child is living in more than one household, the following applies:

(a) the custodial parent is the parent with whom the child lives the greater number of nights; or

(b) if the child spends equal amounts of time with each household, the child shall be considered to be living in the household of the parent with the higher MAGI.

[8.291.430.13 NMAC - Rp, 8.291.430.13 NMAC, 1-1-14]

8.291.430.14 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUPS: At the time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in an assistance unit and budget group. The composition of the assistance unit and budget group is based on the following factors:

A. Assistance group: the assistance unit includes an individual who applies and who is determined eligible under one of the categories of eligibility outlined in 8.291.400.10 NMAC.

B. Budget group: the budget group consists of the following types and will be established on an individual basis:

(1) Tax filer(s): households that submit an application where an individual intends to file for federal taxes or will be claimed as a dependent on federal income taxes for the current year.

(a) The budget group will consist of individuals who are listed on the application as the taxpayer and tax dependents.

(b) If there are multiple taxpayers listed on a single application, the budget group(s) will be established based on who the taxpayer intends to claim as a dependent (including the taxpayer). Only the taxpayer and dependents listed on the application will be considered as part of the budget group.

(c) In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return, a separate tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(d) Exceptions to tax filer rules: the following individuals will be treated as non-filers:

(i) individuals other than a spouse or a biological, adopted, or step child who expect to be claimed as a tax dependent by another taxpayer outside of the household;

(ii) individuals under 19 who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(iii) individuals under 19 who expect to be claimed as a tax dependent by a non-custodial parent.

(2) Non-filer(s) are individuals applying for medicaid who have not filed for taxes, do not intend to file for federal taxes, have not been claimed as a dependent on taxes in the current year or who meet an exception to tax filer rules in Paragraph (1) above. The following individuals may be included in a budget group when evaluating eligibility for an ACA related medicaid eligibility category, provided that they live together:

(a) the individual;

(b) the individual's spouse;

(c) parents/step-parents; or

(d) the individual's biological, adopted and step children under the age of 19.

(3) Households may submit an application that includes both filer and non-filers as defined in Subsections A and B above. The budget group(s) will be organized using the filer and non-filer concepts, and eligibility will be established on an individual basis.

[8.291.430.14 NMAC - Rp, 8.291.430.14 NMAC, 1-1-14]

8.291.430.15 INCOME STANDARDS: Verification of income, both earned and unearned, is mandatory for all ACA-related medicaid programs**.** Verification methods can be found at 8.291.410 NMAC.

A. All income will be calculated as defined by Section 36B of the code to produce a modified adjusted gross income (MAGI). This amount is compared to the FPL for the appropriate medicaid category of eligibility and household size.

B. MAGI is calculated using the methodologies defined in Section 36B(d)(2)(B) of the federal tax code, with the following exceptions:

(1) an amount received as a lump sum is counted as income only in the month received.

(2) scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) American Indian/Alaska native exceptions; the following are excluded from income:

(a) distributions from Alaska native corporations and settlement trusts;

(b) distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the secretary of the interior;

(c) distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from;

(i) rights of ownership or possession in any lands described in Subparagraph (b) above; or

(ii) federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(d) distributions resulting from real property ownership interests related to natural resources and improvements;

(i) located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(ii) resulting from the exercise of federally-protected rights relating to such real property ownership interests.

(e) payments resulting from ownership interests in or usage rights to items 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; and

(f) student financial assistance provided under the bureau of Indian affairs education programs.

(g) all social security benefits under Title II will be counted in determining MAGI.

[8.291.430.15 NMAC - Rp, 8.291.430.15 NMAC, 1-1-14]

8.291.430.16 RESOURCE STANDARDS: Resources as defined in 8.100.130 NMAC are not a factor of eligibility for ACA related medicaid categories.

[8.291.430.16 NMAC - Rp, 8.291.430.16 NMAC, 1-1-14]

HISTORY OF 8.291.430 NMAC:

History of Repealed Material:

8.291.430 NMAC, Financial Responsibility Requirements, filed 9-17-13 - Duration

expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 292 MEDICAID ELIGIBILITY - PARENT CARETAKER
PART 400 RECIPIENT REQUIREMENTS

8.292.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.292.400.1 NMAC - Rp, 8.292.400.1 NMAC, 1-1-14]

8.292.400.2 SCOPE: The rule applies to the general public.
[8.292.400.2 NMAC - Rp, 8.292.400.2 NMAC, 1-1-14]

8.292.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.292.400.3 NMAC - Rp, 8.292.400.3 NMAC, 1-1-14]

8.292.400.4 DURATION: Permanent.
[8.292.400.4 NMAC - Rp, 8.292.400.4 NMAC, 1-1-14]

8.292.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.292.400.5 NMAC - Rp, 8.292.400.5 NMAC, 1-1-14]

8.292.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.292.400.6 NMAC - Rp, 8.292.400.6 NMAC, 1-1-14]

8.292.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.292.400.7 NMAC - Rp, 8.292.400.7 NMAC, 1-1-14]

8.292.400.8 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.
[8.292.400.8 NMAC - Rp, 8.292.400.8 NMAC, 1-1-14]

8.292.400.9 WHO CAN BE A RECIPIENT: To be eligible, an individual must meet specific eligibility requirements:

A. The individual must be a biological, step or adoptive parent of a child, provided they live with the child. There is a presumption that a child born to a married woman is the child of the husband.

B. When the parent does not live with the child, specified relative(s) within the fifth degree of relationship by blood, marriage or adoption, as determined by New Mexico statute Chapter 45 - Uniform Probate Code, who live with the child are evaluated as a specified relative caretaker(s). Refer to the relationship section in 8.291.410 NMAC.

C. A parent caretaker(s) whose only dependent child is an SSI recipient under age 18 may be an eligible recipient. If the parent does not live in the household, then the specified relative may be an eligible recipient.

D. An individual who meets the eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

E. Prior to the parent caretaker individual becoming an eligible recipient, all children listed on an application must meet the following:

(1) be evaluated for eligibility for a medicaid program if not already eligible; or

(2) if not medicaid eligible, have current health insurance coverage that meets criteria as a qualified health plan.
[8.292.400.9 NMAC - Rp, 8.292.400.9 NMAC, 1-1-14]

8.292.400.10 PARENT CARETAKER ASSISTANCE UNIT AND BUDGET GROUP: To be considered in a parent caretaker assistance unit, an individual must apply and be determined eligible. Individuals living with the parent caretaker who meet criteria in 8.291.430 NMAC are included in the budget group.
[8.292.400.10 NMAC - Rp, 8.292.400.10 NMAC, 1-1-14]

HISTORY OF 8.292.400 NMAC:

History of Repealed Material:
8.292.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 292 MEDICAID ELIGIBILITY - PARENT CARETAKER
PART 500 INCOME AND RESOURCE STANDARDS

8.292.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.292.500.1 NMAC - Rp, 8.292.500.1 NMAC, 1-1-14]

8.292.500.2 SCOPE: The rule applies to the general public.
[8.292.500.2 NMAC - Rp, 8.292.500.2 NMAC, 1-1-14]

8.292.500.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.292.500.3 NMAC - Rp, 8.292.500.3 NMAC, 1-1-14]

8.292.500.4 DURATION: Permanent.
[8.292.500.4 NMAC - Rp, 8.292.500.4 NMAC, 1-1-14]

8.292.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.292.500.5 NMAC - Rp, 8.292.500.5 NMAC, 1-1-14]

8.292.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.292.500.6 NMAC - Rp, 8.292.500.6 NMAC, 1-1-14]

8.292.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.292.500.7 NMAC - Rp, 8.292.500.7 NMAC, 1-1-14]

8.292.500.8 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.

[8.292.500.8 NMAC - Rp, 8.292.500.8 NMAC, 1-1-14]

8.292.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.292.500.9 NMAC - Rp, 8.292.500.9 NMAC, 1-1-14]

8.292.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430.11 NMAC.

B. Income test: In order to become eligible for parent caretaker medicaid, the total countable income of the budget group must be less than the income standard for parent caretaker eligibility at 8.291.430 NMAC.
[8.292.500.10 NMAC - Rp, 8.292.500.10 NMAC, 1-1-14]

8.292.500.11 AVAILABLE INCOME: Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.
[8.292.500.11 NMAC - Rp, 8.292.500.11 NMAC, 1-1-14]

8.292.500.12 INCOME ELIGIBILITY: Income from a 30 day-period is used to determine eligibility. Income from a terminated source is not counted. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover. Income received more frequently than monthly will be converted using the following multipliers:

A. four (paid weekly);

B. two (paid biweekly/ semi-monthly).
[8.292.500.12 NMAC - Rp, 8.292.500.12 NMAC, 1-1-14]

8.292.500.13 DISREGARDS: Once a MAGI is calculated, no disregard will be given unless the individual is in receipt of medicare or has reached the age of 65, in which case the household will receive an income disregard in accordance with 8.291.430 NMAC.
[8.292.500.13 NMAC - Rp, 8.292.500.13 NMAC, 1-1-14]

HISTORY OF 8.292.500 NMAC:

History of Repealed Material:
8.292.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 292 MEDICAID ELIGIBILITY - PARENT CARETAKER
PART 600 BENEFIT DESCRIPTION

8.292.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.292.600.1 NMAC - Rp, 8.292.600.1 NMAC, 1-1-14]

8.292.600.2 SCOPE: The rule applies to the general public.
[8.292.600.2 NMAC - Rp, 8.292.600.2 NMAC, 1-1-14]

8.292.600.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.292.600.3 NMAC - Rp, 8.292.600.3 NMAC, 1-1-14]

8.292.600.4 DURATION: Permanent.
[8.292.600.4 NMAC - Rp, 8.292.600.4 NMAC, 1-1-14]

8.292.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.292.600.5 NMAC - Rp, 8.292.600.5 NMAC, 1-1-14]

8.292.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.292.600.6 NMAC - Rp, 8.292.600.6 NMAC, 1-1-14]

8.292.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.292.600.7 NMAC - Rp, 8.292.600.7 NMAC, 1-1-14]

8.292.600.8 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.
[8.292.600.8 NMAC - Rp, 8.292.600.8 NMAC, 1-1-14]

8.292.600.9 BENEFIT DESCRIPTION: This medicaid category provides the full range of medicaid-covered services for individuals considered a parent caretaker.
[8.292.600.9 NMAC - Rp, 8.292.600.9 NMAC, 1-1-14]

8.292.600.10 BENEFIT DETERMINATION: The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Up to three months of retroactive medicaid coverage is provided to applicants who have received medicaid-covered services during the retroactive period and who would have met applicable eligibility criteria had they applied. Eligibility for each retroactive month is determined separately. Application for retroactive medicaid must be made within 180 days of the date of the medicaid application. Retroactive coverage is not available prior to January 1, 2014 for this category.
[8.292.600.10 NMAC - Rp, 8.292.600.10 NMAC, 1-1-14]

8.292.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.292.600.11 NMAC - Rp, 8.292.600.11 NMAC, 1-1-14]

HISTORY OF 8.292.600 NMAC:

History of Repealed Material:
8.292.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 293 MEDICAID ELIGIBILITY - PREGNANT WOMEN
PART 400 RECIPIENT REQUIREMENTS

8.293.400.1 ISSUING AGENCY: New Mexico Human Services Department

(HSD).
[8.293.400.1 NMAC - Rp, 8.293.400.1 NMAC, 1-1-14]

8.293.400.2 SCOPE: The rule applies to the general public.
[8.293.400.2 NMAC - Rp, 8.293.400.2 NMAC, 1-1-14]

8.293.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.293.400.3 NMAC - Rp, 8.293.400.3 NMAC, 1-1-14]

8.293.400.4 DURATION: Permanent.
[8.293.400.4 NMAC - Rp, 8.293.400.4 NMAC, 1-1-14]

8.293.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.293.400.5 NMAC - Rp, 8.293.400.5 NMAC, 1-1-14]

8.293.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.293.400.6 NMAC - Rp, 8.293.400.6 NMAC, 1-1-14]

8.293.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.293.400.7 NMAC - Rp, 8.293.400.7 NMAC, 1-1-14]

8.293.400.8 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.
[8.293.400.8 NMAC - Rp, 8.293.400.8 NMAC, 1-1-14]

8.293.400.9 WHO CAN BE A RECIPIENT: To be eligible, a woman must meet the following eligibility requirements:

A. a woman who self attests to pregnancy;

B. a woman who meets all ACA eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

C. the existence of creditable health insurance is not a disqualifying factor.
[8.293.400.9 NMAC - Rp, 8.293.400.9 NMAC, 1-1-14]

8.293.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: At the time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC. Each member of the assistance unit and budget group, including any unborn child(ren), is counted as one in the household size.
[8.293.400.10 NMAC - Rp, 8.293.400.10 NMAC, 1-1-14]

8.293.400.11 PREGNANCY ASSISTANCE UNIT: The assistance unit is the pregnant woman who applies for medicaid and for whom an eligibility determination is made.
[8.293.400.11 NMAC - Rp, 8.293.400.11 NMAC, 1-1-14]

8.293.400.12 BUDGET GROUP: The budget group is established in accordance with 8.291.430 NMAC.
[8.293.400.12 NMAC - Rp, 8.293.400.12 NMAC, 1-1-14]

HISTORY OF 8.293.400 NMAC:

History of Repealed Material:
8.293.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 293 MEDICAID ELIGIBILITY - PREGNANT WOMEN
PART 500 INCOME AND RESOURCE STANDARDS

8.293.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.293.500.1 NMAC - Rp, 8.293.500.1 NMAC, 1-1-14]

8.293.500.2 SCOPE: The rule applies to the general public.
[8.293.500.2 NMAC - Rp, 8.293.500.2 NMAC, 1-1-14]

8.293.500.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.293.500.3 NMAC - Rp, 8.293.500.3 NMAC, 1-1-14]

8.293.500.4 DURATION: Permanent.
[8.293.500.4 NMAC - Rp, 8.293.500.4 NMAC, 1-1-14]

8.293.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.293.500.5 NMAC - Rp, 8.293.500.5 NMAC, 1-1-14]

8.293.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.293.500.6 NMAC - Rp, 8.293.500.6 NMAC, 1-1-14]

8.293.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.293.500.7 NMAC - Rp, 8.293.500.7 NMAC, 1-1-14]

8.293.500.8 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.
[8.293.500.8 NMAC - Rp, 8.293.500.8 NMAC, 1-1-14]

8.293.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.293.500.9 NMAC - Rp, 8.293.500.9 NMAC, 1-1-14]

8.293.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for pregnant women medicaid, the total countable income of the budget group must be less than 138 percent of the FPL found at 8.291.430 NMAC.
[8.293.500.10 NMAC - Rp, 8.293.500.10 NMAC, 1-1-14]

8.293.500.11 AVAILABLE INCOME: Determination of eligibility for the assistance unit is made by considering

income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.
[8.293.500.11 NMAC - Rp, 8.293.500.11 NMAC, 1-1-14]

8.293.500.12 INCOME ELIGIBILITY: Income from a 30 day-period is used to determine eligibility. Income from a terminated source is not counted. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover to determine a modified adjusted gross income for financial eligibility. For the purposes of this calculation, a partial month is considered to be one full month. Income received more frequently than monthly will be converted using the following multipliers:

A. four (paid weekly);

B. two (paid biweekly/ semi-monthly).

[8.293.500.12 NMAC - Rp, 8.293.500.12 NMAC, 1-1-14]

8.293.500.13 DISREGARDS: Disregards are not applicable for this eligibility group.
[8.293.500.13 NMAC - Rp, 8.293.500.13 NMAC, 1-1-14]

HISTORY OF 8.293.500 NMAC:

History of Repealed Material:
8.293.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 293 MEDICAID ELIGIBILITY - PREGNANT WOMEN
PART 600 BENEFIT DESCRIPTION

8.293.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.293.600.1 NMAC - Rp, 8.293.600.1 NMAC, 1-1-14]

8.293.600.2 SCOPE: The rule applies to the general public.
[8.293.600.2 NMAC - Rp, 8.293.600.2 NMAC, 1-1-14]

8.293.600.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.293.600.3 NMAC - Rp, 8.293.600.3 NMAC, 1-1-14]

8.293.600.4 DURATION: Permanent.
[8.293.600.4 NMAC - Rp, 8.293.600.4 NMAC, 1-1-14]

8.293.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.293.600.5 NMAC - Rp, 8.293.600.5 NMAC, 1-1-14]

8.293.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.293.600.6 NMAC - Rp, 8.293.600.6 NMAC, 1-1-14]

8.293.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.293.600.7 NMAC - Rp, 8.293.600.7 NMAC, 1-1-14]

8.293.600.8 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.
[8.293.600.8 NMAC - Rp, 8.293.600.8 NMAC, 1-1-14]

8.293.600.9 BENEFIT DESCRIPTION: This category provides the full range of medicaid coverage for pregnant women.
[8.293.600.9 NMAC - Rp, 8.293.600.9 NMAC, 1-1-14]

8.293.600.10 BENEFIT DETERMINATION: The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. A woman eligible for pregnancy medicaid remains eligible throughout her pregnancy and for two months after the month of delivery or after the month in which the pregnancy terminates. Up to three months of retroactive medicaid coverage is provided to applicants who have received medicaid-covered services during the retroactive period and who would have met applicable eligibility criteria had they applied. Eligibility for each retroactive month is determined separately. Application for retroactive medicaid must be made within 180 days of the date of the medicaid application. Retroactive coverage is not available prior to January 1, 2014.
[8.293.600.10 NMAC - Rp, 8.293.600.10 NMAC, 1-1-14]

8.293.600.11 REPORTING REQUIREMENTS: All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.293.600.11 NMAC - Rp, 8.293.600.11 NMAC, 1-1-14]

HISTORY OF 8.293.600 NMAC:

History of Repealed Material:
8.293.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 294 MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES
PART 400 RECIPIENT REQUIREMENTS

8.294.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.294.400.1 NMAC - Rp, 8.294.400.1 NMAC, 1-1-14]

8.294.400.2 SCOPE: The rule applies to the general public.
[8.294.400.2 NMAC - Rp, 8.294.400.2 NMAC, 1-1-14]

8.294.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.294.400.3 NMAC - Rp, 8.294.400.3 NMAC, 1-1-14]

8.294.400.4 DURATION: Permanent.
[8.294.400.4 NMAC - Rp, 8.294.400.4 NMAC, 1-1-14]

8.294.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.294.400.5 NMAC - Rp, 8.294.400.5

NMAC, 1-1-14]

8.294.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.294.400.6 NMAC - Rp, 8.294.400.6 NMAC, 1-1-14]

8.294.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.294.400.7 NMAC - Rp, 8.294.400.7 NMAC, 1-1-14]

8.294.400.8 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.
[8.294.400.8 NMAC - Rp, 8.294.400.8 NMAC, 1-1-14]

8.294.400.9 WHO CAN BE A RECIPIENT: To be eligible, a woman must meet the following eligibility requirements:

A. a woman who self attests to pregnancy;

B. a woman who meets all ACA eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

C. the existence of creditable health insurance is not a disqualifying factor.

[8.294.400.9 NMAC - Rp, 8.294.400.9 NMAC, 1-1-14]

8.294.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: At time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC. Each member of the assistance unit and budget group, including any unborn child(ren), is counted as one in the household size.
[8.294.400.10 NMAC - Rp, 8.294.400.10 NMAC, 1-1-14]

8.294.400.11 PREGNANCY ASSISTANCE UNIT: The assistance unit is the pregnant woman who applies for medicaid and for whom an eligibility determination is made.
[8.294.400.11 NMAC - Rp, 8.294.400.11 NMAC, 1-1-14]

8.294.400.12 BUDGET GROUP: The budget group is established in accordance with 8.291.430 NMAC.
[8.294.400.12 NMAC - Rp, 8.294.400.12 NMAC, 1-1-14]

HISTORY OF 8.294.400 NMAC:

History of Repealed Material:
8.294.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 294 MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES
PART 500 INCOME AND RESOURCE STANDARDS

8.294.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.294.500.1 NMAC - Rp, 8.294.500.1 NMAC, 1-1-14]

8.294.500.2 SCOPE: The rule applies to the general public.
[8.294.500.2 NMAC - Rp, 8.294.500.2 NMAC, 1-1-14]

8.294.500.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.294.500.3 NMAC - Rp, 8.294.500.3 NMAC, 1-1-14]

8.294.500.4 DURATION: Permanent.
[8.294.500.4 NMAC - Rp, 8.294.500.4 NMAC, 1-1-14]

8.294.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.294.500.5 NMAC - Rp, 8.294.500.5 NMAC, 1-1-14]

8.294.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.294.500.6 NMAC - Rp, 8.294.500.6 NMAC, 1-1-14]

8.294.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.294.500.7 NMAC - Rp, 8.294.500.7 NMAC, 1-1-14]

8.294.500.8 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.
[8.294.500.8 NMAC - Rp, 8.294.500.8 NMAC, 1-1-14]

8.294.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.294.500.9 NMAC - Rp, 8.294.500.9 NMAC, 1-1-14]

8.294.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for pregnancy medicaid, the total countable income of the budget group must be less than 250 percent of the federal poverty guidelines found at 8.291.430 NMAC.

[8.294.500.10 NMAC - Rp, 8.294.500.10 NMAC, 1-1-14]

8.294.500.11 AVAILABLE INCOME: Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.
[8.294.500.11 NMAC - Rp, 8.294.500.11 NMAC, 1-1-14]

8.294.500.12 INCOME ELIGIBILITY: Income from a 30 day-period is used to determine eligibility. Income from a terminated source is not counted. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover. Income received more frequently than monthly will be converted using the following multipliers:

A. four (paid weekly);

B. two (paid biweekly/ semi-monthly).

[8.294.500.12 NMAC - Rp, 8.294.500.12 NMAC, 1-1-14]

8.294.500.13 DISREGARDS: An income disregard according to 8.291.430

NMAC will be given only to individuals whose countable MAGI income is at or above 250 percent of the federal poverty level for the size of the budget group.
[8.294.500.13 NMAC - Rp, 8.294.500.13 NMAC, 1-1-14]

HISTORY OF 8.294.500 NMAC:

History of Repealed Material:
8.294.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 294 MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES
PART 600 BENEFIT DESCRIPTION

8.294.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.294.600.1 NMAC - Rp, 8.294.600.1 NMAC, 1-1-14]

8.294.600.2 SCOPE: The rule applies to the general public.
[8.294.600.2 NMAC - Rp, 8.294.600.2 NMAC, 1-1-14]

8.294.600.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.294.600.3 NMAC - Rp, 8.294.600.3 NMAC, 1-1-14]

8.294.600.4 DURATION: Permanent.
[8.294.600.4 NMAC - Rp, 8.294.600.4 NMAC, 1-1-14]

8.294.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.294.600.5 NMAC - Rp, 8.294.600.5 NMAC, 1-1-14]

8.294.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.294.600.6 NMAC - Rp, 8.294.600.6 NMAC, 1-1-14]

8.294.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.294.600.7 NMAC - Rp, 8.294.600.7 NMAC, 1-1-14]

8.294.600.8 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.
[8.294.600.8 NMAC - Rp, 8.294.600.8 NMAC, 1-1-14]

8.294.600.9 BENEFIT DESCRIPTION: This category provides medicaid services restricted to and related to pregnancy only. These services do not cover procedures, services, pharmaceuticals, or miscellaneous items which are not related to pregnancy.
[8.294.600.9 NMAC - Rp, 8.294.600.9 NMAC, 1-1-14]

8.294.600.10 BENEFIT DETERMINATION: The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. A woman eligible for pregnancy-related services remains eligible throughout her pregnancy and for two months after the month of delivery or after the month in which the pregnancy terminates. Up to three months of retroactive medicaid coverage is provided to applicants who have received medicaid-covered services during the retroactive period and who would have met applicable eligibility criteria had they applied. Eligibility for each retroactive month is determined separately. Application for retroactive medicaid must be made within 180 days of the date of the medicaid application. Retroactive coverage is not available prior to January 1, 2014.
[8.294.600.10 NMAC - Rp, 8.294.600.10 NMAC, 1-1-14]

8.294.600.11 REPORTING REQUIREMENTS: All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.292.600.11 NMAC - Rp, 8.294.600.11 NMAC, 1-1-14]

HISTORY OF 8.294.600 NMAC:

History of Repealed Material:
8.294.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 295 MEDICAID ELIGIBILITY - CHILDREN UNDER 19
PART 400 RECIPIENT REQUIREMENTS

8.295.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.295.400.1 NMAC - Rp, 8.295.400.1 NMAC, 1-1-14]

8.295.400.2 SCOPE: The rule applies to the general public.
[8.295.400.2 NMAC - Rp, 8.295.400.2 NMAC, 1-1-14]

8.295.400.3 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 and XXI of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.295.400.3 NMAC - Rp, 8.295.400.3 NMAC, 1-1-14]

8.295.400.4 DURATION: Permanent.
[8.295.400.4 NMAC - Rp, 8.295.400.4 NMAC, 1-1-14]

8.295.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.295.400.5 NMAC - Rp, 8.295.400.5 NMAC, 1-1-14]

8.295.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.295.400.6 NMAC - Rp, 8.295.400.6 NMAC, 1-1-14]

8.295.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.295.400.7 NMAC - Rp, 8.295.400.7 NMAC, 1-1-14]

8.295.400.8 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.
[8.295.400.8 NMAC - Rp, 8.295.400.8 NMAC, 1-1-14]

8.295.400.9 WHO CAN BE A RECIPIENT: To be eligible, a child must meet specific eligibility requirements:

A. an individual under 19 years of age; and

B. an individual who meets ACA eligibility requirements pursuant to 8.291.400 through 2.291.430 NMAC.
[8.295.400.9 NMAC - Rp, 8.295.400.9 NMAC, 1-1-14]

8.295.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: To be considered in a child assistance unit, an individual must apply and be determined eligible. Individuals living with the child who meet criteria in 8.291.430 NMAC are included in the budget group.
[8.295.400.10 NMAC - Rp, 8.295.400.10 NMAC, 1-1-14]

8.295.400.11 CHILDRENS HEALTH INSURANCE PROGRAM (CHIP):

A. A budget group that includes a child and has countable income between the following federal income poverty limits (FPL) is considered to be eligible for the CHIP:

(1) if the child in the assistance unit is under the age of six and the assistance unit and budget group's countable income is between 240 and 300 percent of FPL for the countable household size; or

(2) if the assistance unit consists of a child age six or over and the assistance unit's and budget group's countable income is between 190 and 240 percent of FPL for the countable household size.

B. In order to be eligible for CHIP, the child in the assistance unit cannot have other qualified health plan (QHP) coverage. Individuals who have voluntarily dropped a QHP will be eligible for inclusion in the assistance unit in the month the individual no longer has a QHP.
[8.295.400.11 NMAC - Rp, 8.295.400.11 NMAC, 1-1-14]

HISTORY OF 8.295.400 NMAC:

History of Repealed Material:
8.295.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 295 MEDICAID ELIGIBILITY - CHILDREN UNDER 19
PART 500 INCOME AND RESOURCE STANDARDS

8.295.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.295.500.1 NMAC - Rp, 8.295.500.1 NMAC, 1-1-14]

8.295.500.2 SCOPE: The rule applies to the general public.
[8.295.500.2 NMAC - Rp, 8.295.500.2 NMAC, 1-1-14]

8.295.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Titles XIX and XXI of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.295.500.3 NMAC - Rp, 8.295.500.3 NMAC, 1-1-14]

8.295.500.4 DURATION: Permanent.
[8.295.500.4 NMAC - Rp, 8.295.500.4 NMAC, 1-1-14]

8.295.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.295.500.5 NMAC - Rp, 8.295.500.5 NMAC, 1-1-14]

8.295.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.295.500.6 NMAC - Rp, 8.295.500.6 NMAC, 1-1-14]

8.295.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.295.500.7 NMAC - Rp, 8.295.500.7 NMAC, 1-1-14]

8.295.500.8 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.
[8.295.500.8 NMAC - Rp, 8.295.500.8 NMAC, 1-1-14]

8.295.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.295.500.9 NMAC - Rp, 8.295.500.9 NMAC, 1-1-14]

8.295.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for children's medicaid, the total countable income of the budget group must be less than the income standard for eligibility found at 8.291.430 NMAC.

(1) If the assistance unit consists of a child under the age of six, the assistance unit and budget group's countable income must be less than 300 percent of FPL for the countable household size.

(2) If the assistance unit consists of a child age six to age 19, the assistance unit and budget group's countable income must be less than 240 percent of FPL for the countable household size.
[8.295.500.10 NMAC - Rp, 8.295.500.10 NMAC, 1-1-14]

8.295.500.11 INCOME ELIGIBILITY: Income from a 30 day-period is used to determine eligibility. Income from a terminated source is not counted. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover. Income received more frequently than monthly will be converted using the following multipliers:

A. four (paid weekly);

B. two (paid biweekly/ semi-monthly).
[8.295.500.11 NMAC - Rp, 8.295.500.11 NMAC, 1-1-14]

8.295.500.12 DISREGARDS: An income disregard according to 8.291.430 NMAC, will be given only to the following:

A. individuals whose budget group's countable MAGI income is at or above 190 percent of the FPL if the assistance unit consists of a child age six to age 19, or 240 percent of the FPL if the assistance unit consists of a child under the age of six; when a child has a QHP, an income disregard will be given when the existence of the QHP makes the individual ineligible due to CHIP requirements found at 8.295.400 NMAC; or

B. individuals whose budget group's countable MAGI income is at or above 240 percent of the FPL if the assistance unit consists of a child age six to age 19, or 300 percent of the FPL if the assistance unit consists of a child under the age of six.
[8.295.500.12 NMAC - Rp, 8.295.500.12 NMAC, 1-1-14]

HISTORY OF 8.295.500 NMAC:

History of Repealed Material:
8.295.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 295 MEDICAID ELIGIBILITY - CHILDREN UNDER 19
PART 600 BENEFIT DESCRIPTION

8.295.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.295.600.1 NMAC - Rp, 8.295.600.1 NMAC, 1-1-14]

8.295.600.2 SCOPE: The rule applies to the general public.
[8.295.600.2 NMAC - Rp, 8.295.600.2 NMAC, 1-1-14]

8.295.600.3 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 and XXI of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.295.600.3 NMAC - Rp, 8.295.600.3 NMAC, 1-1-14]

8.295.600.4 DURATION: Permanent.
[8.295.600.4 NMAC - Rp, 8.295.600.4 NMAC, 1-1-14

8.295.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.295.600.5 NMAC - Rp, 8.295.600.5 NMAC, 1-1-14]

8.295.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.295.600.6 NMAC - Rp, 8.295.600.6 NMAC, 1-1-14]

8.295.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.295.600.7 NMAC - Rp, 8.295.600.7 NMAC, 1-1-14]

8.295.600.8 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.
[8.295.600.8 NMAC - Rp, 8.295.600.8 NMAC, 1-1-14]

8.295.600.9 BENEFIT DESCRIPTION: This category provides full range of medicaid-covered services for eligible children.

A. An eligible child age five and under, whose budget group's countable income is less than 240 percent of the federal poverty level (FPL) guidelines, receives the full range of medicaid services. No copayments are required under this category of eligibility.

B. An eligible child age six to 18, whose budget group's countable income is less than 190 percent of the FPL guidelines, receives the full range of medicaid services. No copayments are required under this category of eligibility.

C. An eligible child age five and under, whose budget group's countable income is greater than 240 percent but less than 300 percent of the FPL guidelines receives the full range of medicaid services. Copayments are required for this category of eligibility pursuant to 8.200.430 NMAC.

D. An eligible recipient child age six to 18, whose budget group's countable income is greater than 190 percent but less than 240 percent of the FPL guidelines, receives the full range of medicaid services. Copayments are required for this category of eligibility pursuant to 8.200.430 NMAC.

E. During the initial eligibility determination and at each annual redetermination, the co-payment maximum amount is calculated. Maximum copayment amounts are calculated for every calendar quarter in a calendar year. The amount is prorated for the remainder of the calendar quarter if the first month of eligibility is not in the first month of a calendar quarter.
[8.295.600.9 NMAC - Rp, 8.295.600.9 NMAC, 1-1-14]

8.295.600.10 BENEFIT DETERMINATION: The HSD income support division determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Up to three months of retroactive medicaid coverage is provided to applicants who have received medicaid-covered services during the retroactive period and who would have met applicable eligibility criteria had they applied. Eligibility for each retroactive month is determined separately. Application for retroactive medicaid must be made within 180 days of the date of the medicaid application. Retroactive coverage is not available prior to January 1, 2014.
[8.295.600.10 NMAC - Rp, 8.295.600.10 NMAC, 1-1-14]

8.295.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is made in accordance with 8.291.410 NMAC.

B. Continuous eligibility is applicable for medicaid eligible children. Refer to 8.291.400 NMAC.

C. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.295.600.11 NMAC - Rp, 8.295.600.11 NMAC, 1-1-14]

HISTORY OF 8.295.600 NMAC:

History of Repealed Material:
8.295.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 296 MEDICAID ELIGIBILITY - OTHER ADULTS
PART 400 RECIPIENT REQUIREMENTS

8.296.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.296.400.1 NMAC - Rp, 8.296.400.1 NMAC, 1-1-14]

8.296.400.2 SCOPE: The rule applies to the general public.
[8.296.400.2 NMAC - Rp, 8.296.400.2 NMAC, 1-1-14]

8.296.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.296.400.3 NMAC - Rp, 8.296.400.3 NMAC, 1-1-14]

8.296.400.4 DURATION: Permanent.
[8.296.400.4 NMAC - Rp, 8.296.400.4 NMAC, 1-1-14]

8.296.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.296.400.5 NMAC - Rp, 8.296.400.5 NMAC, 1-1-14]

8.296.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.296.400.6 NMAC - Rp, 8.296.400.6 NMAC, 1-1-14]

8.296.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.296.400.7 NMAC - Rp, 8.296.400.7 NMAC, 1-1-14]

8.296.400.8 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.
[8.296.400.8 NMAC - Rp, 8.296.400.8 NMAC, 1-1-14]

8.296.400.9 WHO CAN BE A RECIPIENT: To be eligible, an individual must meet specific eligibility requirements:

A. an individual age 19 or older and under the age of 65 who is not entitled to or eligible for medicare Part A;

B. an individual who meets ACA eligibility requirements pursuant to 8.291.400 through 2.291.430 NMAC; and

C. individuals may have a qualified health plan.

[8.296.400.9 NMAC - Rp, 8.296.400.9 NMAC, 1-1-14]

8.296.400.10 OTHER ADULT ASSISTANCE UNIT AND BUDGET GROUP: To be considered in the other adult assistance unit, an individual must apply and be determined eligible. Individuals living with the other adult who meet criteria in 8.291.430 NMAC are included in the budget group.
[8.296.400.10 NMAC - Rp, 8.296.400.10 NMAC, 1-1-14]

HISTORY OF 8.296.400 NMAC:

History of Repealed Material:
8.296.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 296 MEDICAID ELIGIBILITY - OTHER ADULTS
PART 500 INCOME AND RESOURCE STANDARDS

8.296.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.296.500.1 NMAC - Rp, 8.296.500.1 NMAC, 1-1-14]

8.296.500.2 SCOPE: The rule applies to the general public.
[8.296.500.2 NMAC - Rp, 8.296.500.2 NMAC, 1-1-14]

8.296.500.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.296.500.3 NMAC - Rp, 8.296.500.3 NMAC, 1-1-14]

8.296.500.4 DURATION: Permanent.
[8.296.500.4 NMAC - Rp, 8.296.500.4 NMAC, 1-1-14]

8.296.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.296.500.5 NMAC - Rp, 8.296.500.5 NMAC, 1-1-14]

8.296.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.296.500.6 NMAC - Rp, 8.296.500.6 NMAC, 1-1-14]

8.296.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.296.500.7 NMAC - Rp, 8.296.500.7 NMAC, 1-1-14]

8.296.500.8 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.
[8.296.500.8 NMAC - Rp, 8.296.500.8 NMAC, 1-1-14]

8.296.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.296.500.9 NMAC - Rp, 8.296.500.9 NMAC, 1-1-14]

8.296.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for other adult medicaid, the total countable income of the budget group must be less than 133 percent of the federal poverty guidelines found at 8.291.430 NMAC.

[8.296.500.10 NMAC - Rp, 8.296.500.10 NMAC, 1-1-14]

8.296.500.11 INCOME ELIGIBILITY: Income from a 30 day-period is used to determine eligibility. Income from a terminated source is not counted even in the month of application. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover to determine a modified adjusted gross income for financial eligibility. For the purposes of this calculation, a partial month is considered to be one full month. Income received more frequently than monthly will be converted using the following multipliers:

A. four (paid weekly);

B. two (paid biweekly/ semi-monthly).

[8.296.500.11 NMAC - Rp, 8.296.500.11 NMAC, 1-1-14]

8.296.500.12 DISREGARD: An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable MAGI income is at or above 133 percent of federal poverty level for the size of the budget group.
[8.296.500.12 NMAC - Rp, 8.296.500.12 NMAC, 1-1-14]

HISTORY OF 8.296.500 NMAC:

History of Repealed Material:
8.296.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 296 MEDICAID ELIGIBILITY - OTHER ADULTS
PART 600 BENEFIT DESCRIPTION

8.296.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.296.600.1 NMAC - Rp, 8.296.600.1 NMAC, 1-1-14]

8.296.600.2 SCOPE: The rule applies to the general public.
[8.296.600.2 NMAC - Rp, 8.296.600.2 NMAC, 1-1-14]

8.296.600.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.296.600.3 NMAC - Rp, 8.296.600.3 NMAC, 1-1-14]

8.296.600.4 DURATION: Permanent.
[8.296.600.4 NMAC - Rp, 8.296.600.4 NMAC, 1-1-14]

8.296.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.296.600.5 NMAC - Rp, 8.296.600.5 NMAC, 1-1-14]

8.296.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.296.600.6 NMAC - Rp, 8.296.600.6 NMAC, 1-1-14]

8.296.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.296.600.7 NMAC - Rp, 8.296.600.7 NMAC, 1-1-14]

8.296.600.8 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.
[8.296.600.8 NMAC - Rp, 8.296.600.8 NMAC, 1-1-14]

8.296.600.9 BENEFIT DESCRIPTION: This medicaid category provides alternative benefit plan services for individuals who meet other adult eligibility requirements. Refer to 8.309 NMAC.
[8.296.600.9 NMAC - Rp, 8.296.600.9 NMAC, 1-1-14]

8.296.600.10 BENEFIT DETERMINATION: The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Up to three months of retroactive medicaid coverage is provided to applicants who have received medicaid-covered services during the retroactive period and who would have met applicable eligibility criteria had they applied. Eligibility for each retroactive month is determined separately. Application for retroactive medicaid must be made within 180 days of the date of the medicaid application. Retroactive coverage is not available prior to January 1, 2014.
[8.296.600.10 NMAC - Rp, 8.296.600.10 NMAC, 1-1-14]

8.296.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.292.600.11 NMAC - Rp, 8.296.600.11 NMAC, 1-1-14]

HISTORY OF 8.296.600 NMAC:

History of Repealed Material:
8.296.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 297 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT
PART 400 RECIPIENT REQUIREMENTS

8.297.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.297.400.1 NMAC - Rp, 8.297.400.1 NMAC, 1-1-14]

8.297.400.2 SCOPE: The rule applies to the general public.
[8.297.400.2 NMAC - Rp, 8.297.400.2 NMAC, 1-1-14]

8.297.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.297.400.3 NMAC - Rp, 8.297.400.3 NMAC, 1-1-14]

8.297.400.4 DURATION: Permanent.
[8.297.400.4 NMAC - Rp, 8.297.400.4 NMAC, 1-1-14]

8.297.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.297.400.5 NMAC - Rp, 8.297.400.5 NMAC, 1-1-14]

8.297.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.297.400.6 NMAC - Rp, 8.297.400.6 NMAC, 1-1-14]

8.297.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.297.400.7 NMAC - Rp, 8.297.400.7 NMAC, 1-1-14]

8.297.400.8 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.
[8.297.400.8 NMAC - Rp, 8.297.400.8 NMAC, 1-1-14]

8.297.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT: Eligibility begins the first month immediately following

parent caretaker medicaid ineligibility.

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received parent caretaker medicaid in at least one month of the six months prior to ineligibility for parent caretaker medicaid;

(2) lost parent caretaker medicaid wholly or in part due to new or increased spousal support;

(3) at least one medicaid eligible dependent child living in the home; and

(4) an individual who meets the medicaid eligibility requirements pursuant to 8.291.400 through 2.291.430 NMAC.

B. An applicant or an eligible recipient may have a qualified health plan.

[8.297.400.9 NMAC - Rp, 8.297.400.9 NMAC, 1-1-14]

HISTORY OF 8.297.400 NMAC:

History of Repealed Material:
8.297.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 297 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT
PART 500 INCOME AND RESOURCE STANDARDS

8.297.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.297.500.1 NMAC - Rp, 8.297.500.1 NMAC, 1-1-14]

8.297.500.2 SCOPE: The rule applies to the general public.
[8.297.500.2 NMAC - Rp, 8.297.500.2 NMAC, 1-1-14]

8.297.500.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.297.500.3 NMAC - Rp, 8.297.500.3 NMAC, 1-1-14]

8.297.500.4 DURATION: Permanent.
[8.297.500.4 NMAC - Rp, 8.297.500.4 NMAC, 1-1-14]

8.297.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.297.500.5 NMAC - Rp, 8.297.500.5 NMAC, 1-1-14]

8.297.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.297.500.6 NMAC - Rp, 8.297.500.6 NMAC, 1-1-14]

8.297.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.297.500.7 NMAC - Rp, 8.297.500.7 NMAC, 1-1-14]

8.297.500.8 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.
[8.297.500.8 NMAC - Rp, 8.297.500.8 NMAC, 1-1-14]

8.297.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.297.500.9 NMAC - Rp, 8.297.500.9 NMAC, 1-1-14]

8.297.500.10 INCOME STANDARDS: There are no income standards for this category of eligibility.
[8.297.500.10 NMAC - Rp, 8.297.500.10 NMAC, 1-1-14]

HISTORY OF 8.297.500 NMAC:
[RESERVED]

History of Repealed Material:
8.297.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 297 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT
PART 600 BENEFIT DESCRIPTION

8.297.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.297.600.1 NMAC - Rp, 8.297.600.1 NMAC, 1-1-14]

8.297.600.2 SCOPE: The rule applies to the general public.
[8.297.600.2 NMAC - Rp, 8.297.600.2 NMAC, 1-1-14]

8.297.600.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.297.600.3 NMAC - Rp, 8.297.600.3 NMAC, 1-1-14]

8.297.600.4 DURATION: Permanent.
[8.297.600.4 NMAC - Rp, 8.297.600.4 NMAC, 1-1-14]

8.297.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.297.600.5 NMAC - Rp, 8.297.600.5 NMAC, 1-1-14]

8.297.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.297.600.6 NMAC - Rp, 8.297.600.6 NMAC, 1-1-14]

8.297.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.297.600.7 NMAC - Rp, 8.297.600.7 NMAC, 1-1-14]

8.297.600.8 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.
[8.297.600.8 NMAC - Rp, 8.297.600.8 NMAC, 1-1-14]

8.297.600.9 BENEFIT DESCRIPTION: A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services.
[8.297.600.9 NMAC - Rp, 8.297.600.9 NMAC, 1-1-14]

8.297.600.10 BENEFIT DETERMINATION: The HSD income support division (ISD) determines initial and ongoing eligibility.
[8.297.600.10 NMAC - Rp, 8.297.600.10 NMAC, 1-1-14]

8.297.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. Redetermination of eligibility is not applicable. A four month period of eligibility following parent caretaker medicaid is established without a new application. To be considered for eligibility after the four months of transitional spousal medicaid, a new application must be submitted.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.297.600.11 NMAC - Rp, 8.297.600.11 NMAC, 1-1-14]

HISTORY OF 8.297.600 NMAC:

History of Repealed Material:
8.297.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 298 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT
PART 400 RECIPIENT REQUIREMENTS

8.298.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.298.400.1 NMAC - Rp, 8.298.400.1 NMAC, 1-1-14]

8.298.400.2 SCOPE: The rule applies to the general public.
[8.298.400.2 NMAC - Rp, 8.298.400.2 NMAC, 1-1-14]

8.298.400.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.298.400.3 NMAC - Rp, 8.298.400.3 NMAC, 1-1-14]

8.298.400.4 DURATION: Permanent.
[8.298.400.4 NMAC - Rp, 8.298.400.4 NMAC, 1-1-14]

8.298.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.298.400.5 NMAC - Rp, 8.298.400.5 NMAC, 1-1-14]

8.298.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.298.400.6 NMAC - Rp, 8.298.400.6 NMAC, 1-1-14]

8.298.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.298.400.7 NMAC - Rp, 8.298.400.7 NMAC, 1-1-14]

8.298.400.8 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.
[8.298.400.8 NMAC - Rp, 8.298.400.8 NMAC, 1-1-14]

8.298.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT: Eligibility begins the first month immediately following parent caretaker medicaid ineligibility.

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received parent caretaker medicaid in at least one month of the six months prior to ineligibility for parent caretaker medicaid;

(2) lost parent caretaker medicaid wholly or in part due to new or increased earnings;

(3) at least one medicaid eligible dependent child living in the home; and

(4) an individual who meets the medicaid eligibility requirements pursuant to 8.291.400 through 2.291.430 NMAC.

B. An applicant or an eligible recipient may have a qualified health plan.
[8.298.400.9 NMAC - Rp, 8.298.400.9 NMAC, 1-1-14]

HISTORY OF 8.298.400 NMAC:

History of Repealed Material:
8.298.400 NMAC, Recipient Requirements, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 298 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT
PART 500 INCOME AND RESOURCE STANDARDS

8.298.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.298.500.1 NMAC - Rp, 8.298.500.1 NMAC, 1-1-14]

8.298.500.2 SCOPE: The rule applies to the general public.
[8.298.500.2 NMAC - Rp, 8.298.500.2 NMAC, 1-1-14]

8.298.500.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.298.500.3 NMAC - Rp, 8.298.500.3 NMAC, 1-1-14]

8.298.500.4 DURATION: Permanent.
[8.298.500.4 NMAC - Rp, 8.298.500.4 NMAC, 1-1-14]

8.298.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.298.500.5 NMAC - Rp, 8.298.500.5 NMAC, 1-1-14]

8.298.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.298.500.6 NMAC - Rp, 8.298.500.6 NMAC, 1-1-14]

8.298.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.298.500.7 NMAC - Rp, 8.298.500.7 NMAC, 1-1-14]

8.298.500.8 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.
[8.298.500.8 NMAC - Rp, 8.298.500.8 NMAC, 1-1-14]

8.298.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.298.500.9 NMAC - Rp, 8.298.500.9 NMAC, 1-1-14]

8.298.500.10 INCOME STANDARDS: There are no income standards for this category of eligibility.
[8.298.500.10 NMAC - Rp, 8.298.500.10 NMAC, 1-1-14]

HISTORY OF 8.298.500 NMAC:

History of Repealed Material:
8.298.500 NMAC, Income and Resource Standards, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 298 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT
PART 600 BENEFIT DESCRIPTION

8.298.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.298.600.1 NMAC - Rp, 8.298.600.1 NMAC, 1-1-14]

8.298.600.2 SCOPE: The rule applies to the general public.
[8.298.600.2 NMAC - Rp, 8.298.600.2 NMAC, 1-1-14]

8.298.600.3 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.298.600.3 NMAC - Rp, 8.298.600.3 NMAC, 1-1-14]

8.298.600.4 DURATION: Permanent.
[8.298.600.4 NMAC - Rp, 8.298.600.4 NMAC, 1-1-14]

8.298.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.298.600.5 NMAC - Rp, 8.298.600.5 NMAC, 1-1-14]

8.298.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.298.600.6 NMAC - Rp, 8.298.600.6 NMAC, 1-1-14]

8.298.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.298.600.7 NMAC - Rp, 8.298.600.7 NMAC, 1-1-14]

8.298.600.8 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.
[8.298.600.8 NMAC - Rp, 8.298.600.8 NMAC, 1-1-14]

8.298.600.9 BENEFIT DESCRIPTION: A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services.
[8.298.600.9 NMAC - Rp, 8.298.600.9 NMAC, 1-1-14]

8.298.600.10 BENEFIT DETERMINATION: The HSD income support division (ISD) determines initial and ongoing eligibility.
[8.298.600.10 NMAC - Rp, 8.298.600.10 NMAC, 1-1-14]

8.298.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. Redetermination of eligibility is not applicable. A 12-month period of eligibility following parent caretaker medicaid is established without a new application. To be considered for eligibility after the 12 months of transitional employment medicaid, a new application must be submitted.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.291.400 NMAC.
[8.298.600.11 NMAC - Rp, 8.298.600.11 NMAC, 1-1-14]

HISTORY OF 8.298.600 NMAC:

History of Repealed Material:
8.298.600 NMAC, Benefit Description, filed 9-17-13 - Duration expired 12-31-13.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

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 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]

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: [RESERVED]

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) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (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, 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.
[8.302.9 NMAC - Rp, 8.302.9 NMAC, 1-1-14]

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 or the medicaid fee for service 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 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, 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 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.

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 CMS's 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 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, 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 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 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 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 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 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 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 because of the eligible recipient's inability to pay the co-payment amount at the time of service. The eligible recipient remains liable for the co-payment. The provider may attempt to collect the co-payment amount at a later appointment or by billing the recipient.

(e) After an eligible recipient's assistance unit has reached the maximum out-of-pocket cost sharing limit (five percent of the eligible recipient's family's income, calculated on a quarterly basis), a provider shall reimburse any co-payments that it has collected from the recipient 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.

(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 recipient.

(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 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 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 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 recipient 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 recipient 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 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 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 whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients:

(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 is admitted as an inpatient in which case the inpatient hospital co-payment applies;

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

(f) $5 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) $50 for non-emergent use of the ED.

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

(a) $5 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) $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 recipient as a transfer from another hospital;

(f) $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; and

(g) $28 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.

(8) **All other MAD eligible recipients:** Providers shall charge the following co-payment amounts on other MAP eligible recipients 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 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 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 is native American;

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

(iii) the eligible 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

(iv) the eligible recipient 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 the poverty guidelines updated periodically in the federal register by the U.S. department of health and human services 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]

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 discharge, transfer, or otherwise leaving the facility.

(3) When the provider can document that a claim was filed with another primary payer including medicare, medicaid managed care organizations, medicare replacement plans, or another insurer, the claim must be received within 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 only considers payment for a claim denied by the other primary payer when under the primary payer's plan the MAD recipient is not eligible, the diagnosis, service or item is not within the scope of the benefits, benefits are exhausted, pre-existing conditions are not covered, or out-of-pocket expenses or the deductibles have not been met. MAD will evaluate a claim for further payment including payment toward a deductible, co-insurance, co-payment or other patient responsibility. Claims for payment towards a deductible, co-insurance, co-payment or other patient responsibility 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 for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within 120 calendar days of the date the eligibility was added to the eligibility record of MAD or its selected claims processing contractor.

(5) For a provider of services not enrolled as a MAD provider at the time the services were rendered, including a provider that is in the process of purchasing an enrolled MAD provider entity such as a practice or facility, claims must be received within 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 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 or their authorized representative is responsible for notifying the provider of MAD eligibility or pending eligibility and when retroactive MAD 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 eligibility, the circumstances under which an eligible recipient or their 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) or MCO eligible recipient, the provider must provide the eligible recipient or their authorized representative written notification that they have the right to seek treatment with another provider that does accept MAD FFS or MCO eligible recipients. It is the provider's responsibility to have the eligible recipient or their 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 or their authorized representative if all the following requirements are satisfied:

(a) The eligible recipient or their 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 or their 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 is financially responsible for payment if a

provider's claims are denied because of the eligible recipient's or their 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 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.

(4) The provider must accept medicaid payment as payment in full and cannot bill a remaining balance to the eligible recipient or their 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 or their 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 or their 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 or their 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 eligibility or pending MAD eligibility of a recipient, the provider cannot turn an account over to collections or to any other entity intending to collect from the eligible recipient or their 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.

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

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

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

(7) The claim is from a federal IHS facility operating within the federal department of health and human services 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 school-based service program when providing services to a MAD eligible recipient through an individualized education plan or an individualized family service plan to which an initial filing limit of 120 calendar days is applied.

F. The medicaid program 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 or their 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 in which an eligible recipient is enrolled, the covered or non-covered status of a service or item, the need for prior authorization for a service or item, and to bill the claim correctly and supply required documentation. The eligible recipient or their 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 or their 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; or if the service is not a benefit of the MAD program, prior to rendering the service the provider informed the eligible recipient or their authorized

representative that the specific service is not covered by the MAD program and obtained a signed statement from the eligible recipient or their authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient or their 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 or their 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 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]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS: To receive payment for services furnished to a MAD eligible recipient 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 reimbursement limitations. If a medically necessary service is excluded from medicare and it is a medicaid covered services, 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 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. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient or their 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 or their authorized representative of the estimated amount for which the eligible recipient 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 may seek services. The provider cannot bill a dually eligible MAD recipient for a service that medicare cannot pay because the provider chooses not to participate in medicare, or which MAD cannot pay because the provider chooses not to accept assignment on a claim, without the expressed consent of the MAD eligible recipient or their 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, 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 belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for copayments, coinsurance or deductible, subject to medicaid reimbursement limitations. When the payer payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the copayment, coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer copayment, coinsurance or deductible from the eligible recipient or their 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 coinsurance rate, medicare coinsurance and deductible amounts are paid at the amount that allows the provider to receive up to 80 percent of the payer amount allowed even if the amount exceeds the MAD allowed amount for the services.

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

[8.302.12 NMAC - Rp, 8.302.12 NMAC, 1-1-14]

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, 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 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)].

[8.302.13 NMAC - Rp, 8.302.13 NMAC, 1-1-14]

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 on the day of admission but are not reimbursed for services furnished on day of discharge.

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

(1) services provided to the wrong patient;

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

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

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

[8.302.14 NMAC - Rp, 8.302.14 NMAC, 1-1-14]

8.302.2.15 INTEREST 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.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 2 PROVIDER NETWORK

8.308.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.2.2 SCOPE: This rule applies to the general public.

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

8.308.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.

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

8.308.2.4 DURATION: Permanent.

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

8.308.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

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

8.308.2.7 DEFINITIONS: [RESERVED]

8.308.2.8 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.

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

8.308.2.9 GENERAL REQUIREMENTS: The HSD medicaid managed care organization (MCO) shall establish and maintain a comprehensive network of providers and required specialists in sufficient numbers to make all services included in the benefit package available in accordance with access standards. The MCO shall require any contracted provider to be enrolled with HSD's medical assistance division (MAD) as a managed care provider; and refer any provider who notifies the MCO of a change in his or her location, licensure, certification, or status to the MAD provider web portal to update his or her provider information.

A. Required MCO policies and procedures:

(1) Pursuant to section 1932(b)(7) of the Social Security Act, the MCO shall not discriminate against a provider that serves high-risk populations or specializes in conditions that require costly treatment.

(2) The MCO shall not discriminate with respect to participation, reimbursement, or indemnification of any provider acting within the scope of his or her provider's license or certification under applicable state statute or rule solely on the basis of the provider's license or certification.

(3) The MCO shall upon declining to include an individual or a group of providers in its network, give the affected provider written notice of the reason for the MCO decision.

(4) The MCO shall conduct screenings of all subcontractors and contract providers in accordance with the Employee Abuse Registry Act, NMSA 1978 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 2-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, NMSA 1978 32A-15-1 to 32A-15-4, Patient Protection and Affordable Care Act (PPACA), and ensure that all subcontracted and contracted providers are screened against the New Mexico "list of excluded individuals or entities" and the medicare exclusion databases.

(5) The MCO shall require that any provider, including a provider making a referral or ordering a covered service, have a national provider identifier (NPI) unless the provider is an atypical provider as defined

by the centers for medicare and medicaid services (CMS).

(6) The MCO shall require that each provider billing for or rendering services to a MCO member has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act.

(7) The MCO shall consider in establishing and maintaining the network of appropriate providers its:

(a) anticipated enrollment;

(b) numbers of contracted providers who are not accepting new patients; and

(c) geographic locations of contracted providers and members, considering distance, travel time, the means of transportation ordinarily used by members; and whether the location provides physical access for members with disabilities.

(8) The MCO shall ensure that a contracted provider offers hours of operation that are no less than the hours of operation offered to its commercial enrollees.

(9) The MCO shall establish mechanisms such as notices or training materials to ensure that a contracted provider comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a failure to comply.

(10) The MCO shall provide to its members and contracted providers clear instructions on how to access covered services, including those that require prior approval and referral.

(11) The MCO shall ensure that all contracted providers meet all availability; time and distance standards set by HSD, and have a system to track and report this data.

(12) The MCO shall provide access to a non-contracted provider if the MCO is unable to provide covered benefits covered under its agreement with HSD in an adequate and timely manner to a member and continue to authorize the use of a non-contracted provider for as long as the MCO is unable to provide these services through its contracted providers. The MCO must ensure that the cost to its members utilizing a non-contracted provider is not greater than it would be if the service was provided within the MCO's network.

B. Health services contracting: Contracts with an individual and an institutional provider shall mandate compliance with the MCOs quality management (QM) and quality improvement (QI) programs.

C. Provider qualifications and credentialing: The MCO shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal and state statutes, regulations, and rules.

D. Utilization of out-of-state providers: To the extent possible, the MCO is encouraged to utilize in-state and border providers, which are defined as those providers located within 100 miles of the New Mexico border, Mexico excluded. The MCO may include out-of-state providers in its network.

E. Provider lock-in: HSD shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or the member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on a provider lock-in, the MCO shall inform the member of its intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HSD shall be notified of provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

F. Pharmacy lock-in: HSD shall allow the MCO to require that its member see a certain pharmacy provider when the member's compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member of the intent to lock-in. The MCO's grievance procedure shall be made available to a member being designated for pharmacy lock-in. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

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

8.308.2.10 PRIMARY CARE PROVIDER (PCP): The MCO shall ensure that each member is assigned a primary care provider (PCP), except a member that is dually eligible for medicare and medicaid (dual eligible). The PCP shall be a provider identified in Subsection A below, participating in the MCO's network who will assume the responsibility for supervising, coordinating, and providing primary health care to its member, initiating referrals for specialist care, and maintaining the continuity of the member's care. For a dual-eligible member, the MCO will be responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's medicare PCP.

A. Types of PCPs: The MCO shall designate the following types of providers as a PCP as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, gynecology and pediatrics;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individual basis, for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness, complex behavioral health conditions, or disabilities;

(4) a primary care team consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include mid-level practitioners who, at the member's request, may serve as the point of first contact; in both instances the MCO shall organize its team to ensure continuity of care to the member and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician; medical students, interns and residents may not serve as "lead physicians";

(5) federally qualified health centers (FQHC), rural health clinics (RHC), or Indian health service (IHS), tribal health providers, and urban Indian providers (I/T/U); or

(6) other providers that meet the credentialing requirements for PCPs.

B. Selection of or assignment to a PCP: The MCO shall maintain and implement written policies and procedures governing the process of member selection of a PCP and requests for change.

(1) Initial enrollment: At the time of enrollment, the MCO shall ensure that each member has the freedom to choose a PCP within a reasonable distance from his or her place of residence.

(2) Subsequent change in PCP initiated by a member: the MCO shall allow its member to change his or her PCP at any time for any reason. The request can be made in writing or verbally via telephone:

(a) if a request is made on or before the 20th calendar day of the month, the change shall be effective as the first of the following month;

(b) if a request is made after the 20th calendar day of the month, the change

shall be effective the first calendar day of the second month following the request.

(3) A subsequent change in PCP initiated by the MCO: The MCO may initiate a PCP change for its member under the following circumstances:

(a) the member and the MCO agree that assignment to a difference PCP in the MCO's provider network is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to be a contracted provider;

(c) a member's behavior toward his or her PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made reasonable efforts to accommodate the member;

(d) a member has initiated legal actions against the PCP; or

(e) the PCP is suspended for any reason.

(4) The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. In such instances, the MCO shall allow affected members to select a PCP or the MCO shall make an assignment within 15 calendar days of the termination effective date.

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

8.308.2.11 STANDARDS FOR ACCESS: The MCO shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service to its members. The MCO shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.

A. Access to urgent and emergency services: Services for emergency conditions provided by physical and behavioral health providers, including emergency transportation, urgent conditions, and post-stabilization care shall be covered by the MCO (only within the United States for both physical and behavioral health). An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for child and adolescent members or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health treatment, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. Post-stabilization care means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The MCO shall ensure that there is no clinically significant delay caused by the MCO's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO's network, and all emergency services shall be reimbursed at the HSD approved rate. The MCO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergent in nature.

(2) The MCO shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO.

(3) The MCO shall ensure that the member has access to the nearest appropriately designated trauma center according to established emergency medical standards (EMS) triage and transportation protocols.

B. PCP availability: the MCO shall follow a process that ensures a sufficient number of PCPs are available to allow members a reasonable choice among providers.

(1) The MCO shall have at least one PCP available per 2,000 members and not more than 2,000 members are assigned to a single provider unless approved by HSD.

(2) The MCO must ensure that members have adequate access to specialty providers.

(3) The minimum number of PCPs from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90 percent of urban member residents shall travel no farther than 30 miles;

(b) 90 percent of rural member residents shall travel no farther than 45 miles; and

(c) 90 percent of frontier member residents shall travel no farther than 60 miles.

C. Pharmacy provider availability: The MCO shall ensure that a sufficient number of pharmacy providers are available to its members. The MCO shall ensure that pharmacy services meet geographic access standards based on its member's county of residence. The access standards are as follows:

(1) 90 percent of urban residents shall travel no farther than 30 miles;

(2) 90 percent of rural residents shall travel no farther than 45 miles; and

(3) 90 percent of frontier residents shall travel no farther than 60 miles.

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

8.308.2.12 ACCESS TO HEALTH CARE SERVICES: The MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice, and ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

A. The MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in its network that are not accepting new MCO members.

B. For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 calendar days, unless the member requests a later time.

C. For routine asymptomatic member-initiated dental appointments the request-to-appointment time shall be consistent with community norms for dental appointments.

D. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

E. For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

F. Primary medical, dental and behavioral health care outpatient

appointments for urgent conditions shall be available within 24 hours.

G. For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in Subsection E of this section, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time.

H. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 calendar days, unless the member requests a later time.

I. For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

J. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

K. The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

L. The MCO shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

M. The MCO's preferred drug list (PDL) shall follow HSD guidelines for services and items included in the managed care benefit package, pharmacy services.

N. Access to durable medical equipment: The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(1) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 calendar days of the request date.

(2) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(3) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(4) All DME repairs or non-customized modifications shall be delivered within 60 calendar days of the request date.

(5) The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(6) The MCO shall ensure that its member and his or her family or caretaker receive proper instruction on the use of DME provided by the MCO or its subcontractor.

O. Access to prescribed medical supplies: The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(1) a member can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(2) a member can access routine medical supplies within a time frame consistent with the clinical need;

(3) subject to any requirements to procure a PCP order to provide supplies to its members, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need;

(4) the MCO shall ensure that its member and his or her family receive proper instruction on the use of medical supplies provided by the MCO or its subcontractors.

P. Access to transportation services: The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall have sufficient transportation providers available to meet the needs of its members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependent or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minor aged members are accompanied by a parent or legal guardian as indicated to provide safe transportation.

Q. Use of technology: The MCO is encouraged to use technology, such as telemedicine, to ensure access and availability of services statewide.

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

8.308.2.13 SPECIALTY PROVIDERS: The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the members are met within the MCO's provider network. The MCO shall also have a system to refer members to non-contracted providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the MCO with respect to payment. The MCO must ensure that cost to its member is no greater than it would be if the services were furnished within the network.

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

8.308.2.14 FAMILY PLANNING PROVIDERS:

A. The MCO shall give each adolescent and adult member the opportunity to use his or her own PCP or to use any family planning provider for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a contracted women's health specialist for covered services necessary to provide women's routine and preventive health services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist. Family planning providers, including those funded by Title X of the public health service, shall be reimbursed by the MCO for all covered family planning services, regardless of whether they are contracted providers of the member's MCO. Unless otherwise negotiated, the MCO shall reimburse providers of family planning services pursuant to the medicaid fee schedule.

B. Pursuant to state statute and rule, a non-contracted provider is responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. The MCO is not responsible for the confidentiality of medical records maintained by a non-contracted provider, but shall notify the non-contracted provider of the confidentiality provisions contained herein.

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

8.308.2.15 STANDARDS FOR CREDENTIALING AND RE-CREDENTIALING: The MCO shall verify that each contracted or subcontracted provider participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal medicaid statues and state law. The MCO shall document the mechanism for credentialing and re-credentialing of a provider with whom it contracts or employs to treat its members outside the inpatient setting and

who fall under its scope of authority. The documentation shall include, but not be limited to, defining the provider's scope of practice, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions, and the extent of delegated credentialing or re-credentialing arrangements. The credentialing process shall be completed within 45 calendar days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCO shall use the HSD approved primary source verification entity or one entity for the collection and storage of provider credentialing application information unless there are more cost effective alternatives approved by HSD.

A. Practitioner participation: The MCO shall have a process for receiving input from participating providers regarding credentialing and re-credentialing of its providers.

B. Primary source verification: The MCO shall verify the following information from primary sources during its credentialing process:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of practitioner including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that he or she is board certified in a specialty;

(6) current, adequate malpractice insurance, according to the MCOs policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. Credentialing application: The MCO shall use the HSD approved credentialing form. The provider shall complete a credentialing application that includes a statement by him or her regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. External source verification: Before a practitioner is credentialed, the MCO shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other practitioner types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline;

(3) a health and human services (HHS)/office of inspector general (OIG) exclusion from participation on medicare, medicaid, the state children's health insurance plan (SCHIP), and all federal health care programs (as defined in Section 1128B(f) of the Social Security Act), and sanctions by medicare, medicaid, SCHIP or any federal health care program.

E. Evaluation of practitioner site and medical records: The MCO shall perform an initial visit to the offices of a potential PCP, obstetrician, and gynecologist, and shall perform an initial visit to the offices of a potential high volume behavioral health care practitioner prior to acceptance and inclusion as a contracted provider. The MCO shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the HSD managed care contract.

(2) The MCO shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO's organizational standards.

F. Re-credentialing: The MCO shall have formalized re-credentialing procedures.

(1) The MCO shall re-credential its providers at least every three years. The MCO shall verify the following information from primary sources during re-credentialing:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or re-credentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(f) a current signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a re-credentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other provider types;

(i) other recognized monitoring organizations appropriate to the provider's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, SCHIP and all federal health care programs.

(3) The MCO shall incorporate data from the following sources in its re-credentialing decision making process for its providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E this section.

G. Imposition of remedies: The MCO shall have policies and procedures for altering the conditions of the provider's participation with the MCO based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO may take to improve the provider's performance prior to termination:

(1) The MCO shall have procedures for reporting to appropriate authorities, including HSD, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The MCO shall have an appeal process by which the MCO may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO shall inform providers of the appeal process in writing.

H. Assessment of organizational providers: The MCO shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. At least every three years, the MCO shall:

(1) confirm that the provider has been certified by the appropriate state certification agency, when applicable; behavioral health organizational providers and services are certified by the following;

(a) the department of health (DOH) is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) the children, youth and families department (CYFD) is the certification agency for child and adolescent behavioral health organizational services and providers that require certification; and

(2) confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission (JC); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

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

8.308.2.16 PROVIDER TRANSITION: The MCO shall notify HSD within five working days of unexpected changes to the composition of its provider network that would have a negative effect on member access to services or on the MCOs ability to deliver services included in the benefit package. Anticipated material changes in the MCO provider network shall be reported in writing within 30 calendar days prior to the change or as soon as the MCO becomes aware of the anticipated change. In the event that provider network changes are unexpected or when it is determined that its provider is unable to meet its contractual obligation, the MCO shall be required to submit a transition plan to HSD for all affected members. For all provider transitions, the MCO shall require the provider to submit a member specific transition plan. For both expected and unexpected changes in the network, the MCO shall be required to assess the significance of the change or closure to the network and shall submit a narrative as part of the notification of the closure within timeframes designated, and in a template approved by, the state as detailed in the HSD policy manual.

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

8.308.2.17 DELEGATION: Delegation is a process whereby a MCO gives another entity the authority to perform certain functions on its behalf. The MCO is fully accountable for all pre-delegation and delegation activities and decisions made. The MCO shall document its oversight of the delegated activity. The MCO may assign, transfer, or delegate to a subcontractor key management functions with the explicit written approval of HSD.

A. A mutually agreed upon document between MCO and the delegated entity shall describe:

(1) the responsibilities of the MCO and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

B. The MCO shall document evidence that it:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports and proactively indentifies opportunities for improvement; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the MCO expectations and HSD's standards.

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

HISTORY OF 8.308.2 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 6 ELIGIBILITY AND ENROLLMENT

8.308.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.6.2 SCOPE: This rule applies to the general public.

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

8.308.6.3 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.

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

8.308.6.4 DURATION: Permanent.

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

8.308.6.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.6.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

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

8.308.6.7 DEFINITIONS: [RESERVED]

8.308.6.8 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.

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

8.308.6.9 MANAGED CARE ELIGIBILITY:

A. General requirements:

HSD determines eligibility for enrollment in the medical assistance division (MAD) managed care program. An eligible recipient is required to participate in a HSD managed care program unless specifically excluded as listed below. Enrollment in a particular MCO will be according to the eligible recipient's selection of a MCO at the time of application for eligibility, or during other permitted selection periods, or as assigned by HSD, if the recipient makes no selection.

B. The following eligible recipients, as established by their eligibility category, are excluded from managed care enrollment:

(1) qualified medicare beneficiaries (QMB)-only recipients;

(2) specified low income medicare beneficiaries;

(3) qualified individuals;

(4) qualified disabled working individuals;

(5) refugees;

(6) participants in the program of all inclusive care for the elderly (PACE); and

(7) children and adolescents in out-of-state foster care or adoption placements.

C. A native American who does not meet a nursing facility (NF) level of care or intermediate care facility for individuals with intellectual disabilities (ICF/IID) levels of care (LOC) or is not dually-eligible for both medicaid and medicare will not be enrolled in a HSD managed care program unless the eligible recipient elects to enroll.

D. For those individuals who are not otherwise eligible for medicaid and who meet the financial and medical criteria established by HSD, HSD or its authorized agent may further determine eligibility for managed care enrollment through a waiver allocation process contingent upon available funding and enrollment capacity.

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

8.308.6.10 SPECIAL SITUATIONS:

A. HSD has established newborn eligibility criteria.

(1) When a child is born to a member enrolled in a MCO, the hospital or other providers will complete a MAD Form 313 (*notification of birth*) or its successor, prior to or at the time of discharge. HSD shall ensure that upon receipt of the MAD Form 313 and upon completion of the eligibility process, the newborn is enrolled into his or her mother's MCO. The newborn is eligible for a period of 12 months, starting with the month of his or her birth.

(2) When the newborn's mother is covered by health insurance through the New Mexico health insurance exchange and the mother's qualified health plan is also an HSD-contracted MCO, HSD will enroll the newborn into the mother's MCO as of the month of his or her birth.

(3) When the newborn member's mother is covered by health insurance through New Mexico health insurance exchange and the mother's qualified health plan is not an HSD-contracted MCO, HSD shall auto-assign and enroll the newborn in a medicaid MCO as of the month of his or her birth. The newborn member's parent or legal guardian will have one opportunity during the 90 calendar day period from the effective date of enrollment to change the newborn's MCO assignment.

B. Community benefit eligibility:

(1) A member who meets a NF LOC and is eligible for the community benefit will be eligible to receive home and community-based services and may choose to receive such services either through an agency-based or self-directed model according to the self-direction criteria as outlined in 8.308.9 NMAC.

(2) An individual who is not otherwise eligible for medicaid services but meets certain financial requirements and has a NF LOC determination may be eligible for enrollment through a waiver allocation process, contingent upon funding and enrollment capacity.

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

HISTORY OF 8.308.6 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 7 ENROLLMENT AND DISENROLLMENT

8.308.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.7.2 SCOPE: This rule applies to the general public.

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

8.308.7.3 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.

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

8.308.7.4 DURATION: Permanent.

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

8.308.7.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

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

8.308.7.7 DEFINITIONS: [RESERVED].

8.308.7.8 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.

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

8.308.7.9 MANAGED CARE ENROLLMENT

A. **General:** A medical assistance division (MAD) eligible recipient is required to enroll in a HSD managed care organization (MCO) unless he or she is: (1) a native American and elects enrollment in MAD's fee-for-service (FFS); or (2) is in an excluded population. See 8.200.400 NMAC. Enrollment in a MCO may be the result of the eligible recipient's selection of a particular MCO or assigned by HSD. The MCO shall accept as a member an eligible recipient in accordance with 42 C.F.R. 434.25 and shall not discriminate against, or use any policy or practice that has the effect of discrimination against the potential or enrolled member on the basis of health status, the need for health care services, or the race, color, national origin, ancestry, spousal affiliation, sexual orientation or gender identity. HSD reserves the right to limit enrollment in a specific MCO.

B. **Newly eligible recipients:** An individual who applies for a MAD category of eligibility and has an approved eligibility effective date of January 1, 2014, or later, and who is required to enroll in a MCO, must select a MCO at the time of his or her application for a MAD category of eligibility. An eligible recipient who fails to select a MCO at such time will be assigned to a MCO. See Subsection C of this section. Members may choose a different MCO during the first 90 days of their enrollment.

C. **Auto assignment:** HSD will auto assign an eligible recipient to a MCO in specific circumstances, including but not limited to: a) the eligible recipient is not exempt from managed care and does not select a MCO at the time of his or her

application for MAD eligibility; b) the eligible recipient cannot be enrolled in the requested MCO pursuant to the terms of this rule (e.g., the MCO is subject to and has reached its enrollment limit). HSD may modify the auto assignment algorithm, at its discretion, when it determines it is in the best interest of the program, including but not limited to, sanctions imposed on the MCO, consideration of quality measures, cost or utilization management performance criteria.

(1) The HSD auto assignment process will consider the following:

(a) if the eligible recipient was previously enrolled with a MCO and lost his or her eligibility for a period of two months or less, he or she will be re-enrolled with that MCO;

(b) if the eligible recipient has a family member enrolled in a specific MCO, he or she will be enrolled with that MCO;

(c) if the eligible recipient is a newborn, he or she will be assigned to the mother's MCO; see Subsection A of 8.308.6.10 NMAC; or

(d) if none of the above applies, the eligible recipient will be assigned using the default logic that randomly assigns an eligible recipient to a MCO.

D. **Effective date for a newly eligible recipient's enrollment in managed care:** In most instances, the effective date of enrollment with a MCO will be the same as the effective date of eligibility approval. In instances of an award of retroactive MAD eligibility, the effective date of managed care enrollment of the eligible recipient may not include time periods prior to January 1, 2014. In those instances of retroactive eligibility prior to January 1, 2014, retroactive enrollment may be through fee-for-service medicaid rather than managed care.

E. **Eligible recipient member lock-in:** A member's enrollment with a MCO is for a 12-month lock-in period. During the first 90 calendar days after his or her initial MCO enrollment, either by the member's choice or by auto assignment, he or she shall have one option to change MCOs for any reason, except as described below.

(1) If the member does not choose a different MCO during his or her first 90 calendar days, the member will remain with this MCO for the full 12-month lock-in period before being able to switch MCOs.

(2) If during the member's first 90 calendar days of enrollment in the initially-selected or a HSD assigned MCO, and chooses a different MCO, he or she is subject to a new 12-month lock-in period and will remain with the newly selected MCO until the lock-in period ends. After that time, the member may switch to another MCO.

(3) At the conclusion of the 12-month lock-in period, the member shall have the option to select a new MCO, if desired. The member shall be notified of the option to switch MCOs 60 days prior to the expiration date of the member's lock-in period, the deadline by when to choose a new MCO.

(4) If a member loses his or her MAD eligibility for a period of two months or less, he or she will be automatically reenrolled with the former MCO. If the member misses what would have been his or her annual switch MCO enrollment period during this two-month period, he or she may select another MCO.

F. **Open MCO enrollment period:** Open enrollment periods are when a member can change his or her MCO without having to wait until the end of the 12 month lock-in period, and may be initiated at HSD's discretion in order to support program needs.

G. **Mass transfers from another MCO:** A MCO shall accept any member transferring from another MCO as authorized by HSD. The transfer of membership may occur at any time during the year.

H. **Change of enrollment initiated by a member:**

(1) A member may select another MCO during his or her annual renewal of eligibility, or re-certification period.

(2) A member may request to be switched to another MCO for cause, even during a lock-in period. The member must submit a written request to HSD. Examples of "cause" include, but are not limited to:

(a) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(b) the member requires related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all of the related services are available within the network, and his or her PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(c) poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs.

(3) No later than the first calendar day of the second month following the month in which the request is filed by the member, HSD must respond. If HSD does not respond, the request of the member is deemed approved. If the member is dissatisfied with HSD's determination, he or she may request a HSD administrative hearing.

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

8.308.7.10 DISENROLLMENT

A. **Member disenrollment initiated by a MCO:** The MCO shall not, under any circumstances, disenroll a member. The MCO shall not request disenrollment because of a change in the member's health status, because of the his or her utilization of medical or behavioral health services, his or her diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either a particular member or other members).

B. **Other HSD member disenrollment:** A member may be disenrolled from a MCO or may lose his or her MAD eligibility if:

(1) he or she moves out of the state of New Mexico;

(2) he or she no longer qualifies for a MAD category of eligibility;

(3) he or she requests disenrollment for cause, including but not limited to the unavailability of a specific care requirement that none of the contracted MCOs are able to deliver and disenrollment is approved by HSD;

(4) a member makes a request for disenrollment which is denied by HSD, but the denial is overturned in the member's HSD administrative hearing final decision; or

(5) HSD imposes a sanction on the MCO that warranted disenrollment.

C. Effective date of disenrollment: All HSD-approved disenrollment requests are effective on the first calendar day of the month following the month of the request for disenrollment, unless otherwise indicated by HSD. In all instances, the effective date shall be indicated on the termination record sent by HSD to the MCO.

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

8.308.7.11 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is in the best interests of the program.

A. **Triggering a mass transfer:** The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in the MCO identification number or the MCO changes its name or other changes that is not relevant to the member and services will continue with that MCO; and

(2) a significant change in a MCO's contracting status, including but not limited to, the loss of licensure, substandard care, fiscal insolvency or significant loss in network providers; in such instances, a notice is sent to the member informing him or her of the transfer and the opportunity to select a different MCO.

B. **Effective date of mass**

transfer: The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer MCO members.
[8.308.7.11 NMAC - N, 1-1-14]

8.308.7.12 MEMBER IDENTIFICATION CARD

A. Each member shall receive an identification card (ID) that provides his or her MCO membership information within 30 calendar days of notification of enrollment with the MCO.

B. The MCO shall re-issue a member ID card within 10 calendar days of notice if the member reports a lost card or if information on the card needs to be changed.

C. The MCO shall ensure a member understands that the ID card: (1) is intended to be used only by the member; (2) the sharing the member's ID card constitutes fraud; and (3) the process of how to report sharing of a member's ID card.
[8.308.7.12 NMAC - N, 1-1-14]

8.308.7.13 MEDICAID MARKETING GUIDELINES: HSD shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at a member before use by a MCO. The MCO shall comply with all federal regulations regarding medicare-advantage and medicaid marketing. See 42 C.F.R. Parts 422, 438.
[8.308.7.13 NMAC - N, 1-1-14]

HISTORY OF 8.308.7 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 8 MEMBER EDUCATION

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

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

8.308.8.3 STATUTORY AGENCY: 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.
[8.308.8.3 NMAC - N, 1-1-14]

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

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

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

8.308.8.7 DEFINITIONS: [RESERVED]

8.308.8.8 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.
[8.308.8.8 NMAC - N, 1-1-14]

8.308.8.9 MEMBER EDUCATION: The managed care organization (MCO) shall educate its members about their rights and responsibilities, covered services and service availability. Member education is initiated when an eligible recipient becomes a MCO member and includes information provided by HSD and the MCO.
[8.308.8.9 NMAC - N, 1-1-14]

8.308.8.10 WRITTEN MEMBER MATERIALS:

A. All written materials will be available in English and all languages spoken by approximately five percent or more of the MCO's membership, as determined by the MCO or HSD. Upon consent from the appropriate native American tribal leadership, the MCO shall make every effort when a written form is not in the member's native language to translate the form in the member's native language.

B. The MCO is responsible for providing a member or potential member with its member handbook and provider directory, as requested by a member.

(1) The MCO shall send such information to the member within 30 calendar days of receipt of notification of enrollment in the MCO.

(2) Thereafter, upon the request from a member, the MCO shall send such information within 10 calendar days. The MCO shall provide the requestor the option to receive the material in a written or electronic form or by citation to be found on the member's MCO's website.

(3) On an annual basis, the MCO shall notify the member of the availability of updated materials and how to obtain such materials.
[8.308.8.10 NMAC - N, 1-1-14]

8.308.8.11 MEMBER RIGHTS AND RESPONSIBILITIES:

A. Included in its membership information, the MCO shall provide each member written information on his, her or the authorized representative rights and responsibilities.

B. These include the right:

(1) to be treated with respect and with due consideration for his or her dignity and privacy;

(2) to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand such information;

(3) to make and have honored his or her advance directive that is consistent with state and federal laws;

(4) to receive MCO covered services in a nondiscriminatory manner;

(5) to participate in decisions regarding his or her health care, including the right to refuse treatment;

(6) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

(7) to request and receive a free copy of his or her medical records and to request that those records be amended or corrected; see [45 CFR164];

(8) to choose an authorized representative to be involved, as appropriate, in making his or her care decisions;

(9) to provide informed consent;

(10) to voice a grievance concerning the care provided by his or her MCO, and to make use of his or her grievance and appeal process, and his or her HSD administrative hearing process without fear of retaliation;

(11) to choose from among contracted providers in accordance with his or her MCO's prior authorization requirements;

(12) to receive information about covered services and how to access these covered services, and contracted providers;

(13) to be free from harassment by the MCO or its contracted providers in regard to contractual disputes between the MCO and the provider; and

(14) participate in understanding physical an behavioral health problems and developing mutually agreed-upon treatment goals.

C. The MCO shall ensure that each member or his or her authorized representative is free to exercise his or her

rights, and the exercise of those rights does not adversely affect the way that the MCO or its contracted provider treat the member or his or her authorized representative.

D. The member or his or her authorized representative, to the extent possible, has a responsibility:

(1) to provide information that the MCO and its contracted providers need in order to care for the member, such information includes, but is not limited to the member's:

(a) most current mailing address;

(b) most current email address, if one is available;

(c) most current phone number, including any land line and cell phone, if available; and

(d) most current emergency contact information;

(2) to follow the care plans and instructions from his or her provider that have been agreed upon;

(3) to keep a scheduled appointment; and

(4) to reschedule or cancel a scheduled appointment rather than simply fail to keep it.

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

8.308.8.12 MEMBER HEALTH RECORDS: The MCO shall provide a member with access to electronic versions of his or her personal health records.

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

8.308.8.13 MEMBER HEALTH EDUCATION:

A. The MCO shall develop a member health education plan that includes classes, individual or group sessions, videotapes, written materials, media campaigns and modern technologies (e.g. mobile applications and tools).

(1) All instructional materials shall be provided in a manner and format that is easily understood by a member.

(2) The MCO shall notify a member of the schedule of educational events and shall post such information on its website.

B. The MCO shall distribute a quarterly newsletter that is intended to educate members about the managed care system, the proper utilization of services, and to encourage utilization of preventative care services.

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

8.308.8.14 MEMBER WEBSITE: The MCO should have a member portal on its website that is available to all members and potential members, and contains accurate, up-to-date information about the MCO, services provided, the preferred drug list, the provider directory, frequently asked questions (FAQs), and contact phone numbers and its email addresses. A member or potential member shall have access to the member handbook and provider directory via the website without having to log-in.

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

8.308.8.15 MEMBER TOLL-FREE LINE: The MCO shall operate a call center with a toll-free phone line to respond to member questions, concerns, inquiries and complaints from a member and his or her provider. The line shall be equipped to handle calls from an individual with limited English proficiency, as well as calls from a member who is hearing impaired. It should be staffed 24 hours a day, seven days a week, with qualified nurses to triage urgent care and emergency calls from a member, and when necessary, to facilitate the transfer of such calls to a care coordinator.

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

8.308.8.16 MEMBER ADVISORY BOARD: The MCO shall convene an advisory board of that meets quarterly and reflects appropriate representation of its membership. The advisory board shall advise the MCO on issues concerning service delivery, quality of its covered services, and other member issues as needed or as directed by HSD.

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

HISTORY OF 8.308.8 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 9 BENEFIT PACKAGE

8.308.9.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.9.2 SCOPE: This rule applies to the general public.

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

8.308.9.3 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.

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

8.308.9.4 DURATION: Permanent.

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

8.308.9.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.9.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

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

8.308.9.7 DEFINITIONS:

A. **Alternative benefits plan services with limitations (ABP):** The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). The HSD contracted managed care organization (MCO) covers ABP specific services for an ABP member. 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 member has limitations on specific benefits; and does not have all MCO medicaid benefits available. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP member under 21 years. ABP services for an ABP member 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 MCO ABP contracted provider and an ABP member have rights and responsibilities as described in chapter 308 of Title 8 NMAC, Social Services.

B. **Alternative benefits plan general benefits for ABP exempt member (ABP exempt):** An ABP member who self-declares he or she has a qualifying condition is evaluated by the MCO's utilization management for determination if he or she meets the qualifying condition. An ABP exempt member utilizes his or her benefits described in this rule and in 8.308.12 NMAC.

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

8.308.9.8 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.

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

8.308.9.9 BENEFIT PACKAGE: This part defines the benefit package for which an MCO shall be paid a fixed per-member-per-month capitated payment rate. The MCO shall cover the services specified in this rule. The MCO shall not delete a

benefit from the MCO benefit package. A MCO is encouraged to provide a value added benefit package which could include health-related educational, preventive, outreach and other physical and behavioral health benefits. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services. The MCO shall provide and coordinate comprehensive and integrated health care benefits to each enrolled member in either a MCO medicaid or MCO ABP member and shall cover the physical health, behavioral health and long-term care services per this section, its contract, and as directed. If the MCO is unable to provide covered services to a particular member using one of its contracted providers, the MCO shall adequately and timely cover these services for that member using a non-contract provider for as long as the member's MCO provider network is unable to provide the service. At such time that the required services become available within the MCO's network and the member can be safely transferred, the MCO may transfer the member to an appropriate contract provider according to a transition of care plan developed specifically for the member; see 8.308.11 NMAC.
[8.308.9.9 NMAC - N, 1-1-14]

8.308.9.10 MEDICAL ASSISTANCE DIVISION PROGRAM RULES: New Mexico administrative code (NMAC) rules and related documents contain a detailed description of the services covered by MAD, the limitations and exclusions to covered services, and noncovered services. The NMAC rules are the official source of information on covered and noncovered services. Unless otherwise directed, the MCO shall determine its own utilization management (UM) protocols, which are based on reasonable medical evidence and are not bound by those found in NMAC rules, billing instructions or utilization review instructions. MAD may review and approve the MCO's UM protocols. Unless otherwise directed by MAD, a HSD contracted MCO is not required to follow MAD's reimbursement methodologies or MAD's fee schedules unless otherwise required in an NMAC rule.
[8.308.9.10 NMAC - N, 1-1-14]

8.308.9.11 GENERAL PROGRAM DESCRIPTION:

A. The MCO shall provide medically necessary services consistent with the following:

(1) a determination that a health care service is medically necessary does not mean that the health care service is a covered service; benefits are to be determined by HSD;

(2) in making the determination of medical necessity of a covered service the MCO shall do so by:

(a) evaluating the member's physical and behavioral health information provided by the a qualified professional who has personally evaluated the member within his or her scope of practice; who have taken into consideration the member's clinical history, including the impact of previous treatment and service interventions and who has consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the member or his or her authorized agent regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

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

(3) not denying physical, behavioral health and long-term care services solely because the member has a poor prognosis; medically necessary services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of his or her diagnosis, type of illness or condition;

(4) governing decisions regarding benefit coverage for a member under 21 years of age by the EPSDT program coverage rule to the extent they are applicable; and

(5) making services available 24 hours, seven days a week, when medically necessary and are a MAD covered service.

B. The MCO shall meet all HSD requirements related to the anti-gag requirement. The MCO shall meet all HSD requirements related to advance directives. This includes but is not limited to:

(1) providing a member or his or her authorized agent with written information on advance directives that include a description of applicable state and federal law and regulation, the MCO's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;

(2) honoring advance directives within its UM protocols; and

(3) ensuring that a member is offered the opportunity to prepare an advance directive and that, upon request, the MCO provides assistance in the process.

C. The MCO shall allow second opinions: A member or his or her authorized representative shall have the right to seek a second opinion from a qualified health care professional within his or her MCO's network, or the MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested when the member or his or her authorized agent needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

D. The MCO shall meet all care coordination requirement set forth in Section 10 of this rule.
[8.308.9.11 NMAC - N, 1-1-14]

8.308.9.12 GENERAL 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 member 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.

D. **Client transportation:** The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MCO member in or out of his or her home community as detailed in 8.310.2 NMAC.

E. **Community intervener:** The benefit package includes community intervener services. The community intervener works one-on-one with a deaf-blind member who is five-years of age or older to provide critical connections to other people and his or her environment. The community intervener opens channels of communication between the member and others, provides access to information, and facilitates the development and maintenance of self-directed independent living.

(1) Member eligibility: To be eligible for community intervener services, a member must be five-years of age or older and meet the clinical definition of deaf-blindness, defined as:

(a) the member has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(b) the member has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or the progressive hearing loss having a prognosis leading to this condition; and

(c) the member for whom the combination of impairments described above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(2) Provider qualifications: The minimum provider qualifications for a community intervener are as follows:

(a) is at least 18 years of age;

(b) is not the spouse of the member to whom the intervener is assigned;

(c) holds a high school diploma or a high school equivalency certificate;

(d) has a minimum of two years of experience working with individuals with developmental disabilities;

(e) has the ability to proficiently communicate in the functional language of the deaf-blind member to whom the intervener is assigned; and

(f) completes an orientation or training course by any person or agency who provides direct care services to deaf-blind individuals.

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

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

H. **Dialysis services:** The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. A dialysis provider shall assist a member in applying for and pursuing final medicare eligibility determination.

I. **Durable medical equipment and medical supplies:** The benefit package includes covered vision appliances, hearing aids and related services and durable medical equipment and medical supplies and covered prosthetic and orthotic services as detailed in 8.324.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

J. **Emergency and non-emergency transportation services:**

(1) The benefit package includes transportation service such as ground ambulance and air ambulance in an emergency and when medically necessary, and 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 a member does not have a source of transportation available and the member does not have access to alternative free sources. The MCO shall coordinate efforts when providing transportation services for a member requiring physical or behavioral health services.

(2) The benefit package also includes non-medical transportation as detailed in 8.314.5 NMAC.

K. **Experimental or investigational services:** The benefit package includes medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD as detailed in 8.310.2 NMAC.

L. **Home health services:** The benefit package includes home health services as detailed in 8.325.9 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

M. **Hospice services:** The benefit package includes hospice services as detailed in 8.325.4 NMAC.

N. **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 NMAC.

O. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services for the member as detailed in 8.311.2 NMAC. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the member and her newborn child. Health coverage for a hospital stay in connection with childbirth following a casarean section may not be limited to less than 96 hours for the member and her newborn child.

P. **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.

Q. **Nursing facility services:** The benefit package includes nursing facility services as detailed in 8.312.2 NMAC. Nursing facility services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

R. **Physical health services:** The benefit package includes primary, primary care in a school-based setting, 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 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 the MCO or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC.

(1) The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology.

(2) The MCO shall participate in MAD's birthing options program.

S. **Prosthetics and orthotics:** The benefit package includes prosthetic and orthotic services as detailed in 8.324.5 NMAC.

T. **Rehabilitation services:** The benefit package includes inpatient and outpatient hospital, and outpatient physical, occupational and speech therapy services as detailed in 8.323.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations

U. **Private duty nursing:** The benefit package includes private duty nursing services for a member under 21 years of age. The benefit package only includes private duty nursing for the adult population through home health agencies as detailed in 8.325.9 NMAC.

V. **Swing bed hospital services:** This benefit package includes services provided in hospital swing beds to a member expected to reside in such a facility on a long-term or permanent basis as defined in 8.311.5 NMAC. Swing bed hospital services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

W. **Tobacco cessation services:** The benefit package includes cessation sessions as described in 8.310.2 NMAC and education.

X. **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 as detailed in 8.310.2 NMAC. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

Y. **Nutrition services:** The benefit package includes nutritional services based on scientifically validated

nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the member as detailed in 8.310.2 NMAC.

Z. **Podiatry:** The benefit package includes podiatric services furnished by a provider, as required by the condition of the member as detailed in 8.310.2 NMAC.

AA. **Vision and eye care services:** The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a member 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 and older, the service limitations are listed below:

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

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

BB. **Other services:** When an additional benefit service is approved by MAD, the MCO shall cover that service as well**.**

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

8.308.9.13 SPECIFIC CASE MANAGEMENT PROGRAMS: The benefit package includes case management services necessary to meet an identified service need of a member. The following are specific case management programs available when a member meets the requirements of a specific service.

A. **Case management services for adults with developmental disabilities:** Case management services are provided to a member 21 years of age and older who is developmentally disabled as detailed in 8.326.2 NMAC.

B. **Case management services for pregnant women and their infants:** Case management services are provided to a member who is pregnant up to 60 calendar days following the end of the month of the delivery as detailed in 8.326.3 NMAC.

C. **Case management services for traumatically brain injured adults:** Case management services are provided to a member 21 years of age and older who is traumatically brain injured as detailed in 8.326.5 NMAC.

D. **Case management services for children up to the age of three:** Case management services for a member up to the age of three years who is medically at-risk due to family conditions and who does not have a developmental delay as detailed in 8.326.6 NMAC.

E. **Case management services for the medically at risk (EPSDT):** Case management services for a member under 21 years of age who is medically at-risk for a physical or behavioral health condition as detailed in 8.320.2 NMAC.

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

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

A. The MCO may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement. The MCO must comply with the provisions of NMSA 1978, 27-2-16(B). Specifically, the MCO must base its formula for estimation of acquisition cost and reimbursement on regulations promulgated and published by HSD regarding the wholesale cost for the ingredient component of pharmacy reimbursement.

B. The MCO shall include on the MCO's formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one therapeutic ingredient, anti-obesity items, items that are not medically necessary and as otherwise approved by MAD. Cough, cold and allergy medications must be covered but all multi-source generic products do not need to be covered. This requirement does not preclude a MCO from requiring authorization prior to dispensing a multi-source generic item.

C. The MCO is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted to instances for which a practitioner has written a prescription, and for which the item is an economical or preferred therapeutic alternative to the prescribed item.

D. The MCO shall cover brand name drugs and drug items not generally on the MCO formulary or PDL when determined to be medically necessary by the MCO or through a fair hearing process.

E. Unless otherwise approved by MAD, the MCO shall have an open formulary for all psychotropic medications. Minor tranquilizers, sedatives, and hypnotics are not considered psychotropic medications for the purpose of this rule.

F. MCO shall ensure that a native American member accessing the pharmacy benefit at an Indian health service (IHS), tribal, and urban Indian (I/T/U) facility is exempt from the MCO's PDL when these pharmacies have their own PDL.

G. The MCO shall reimburse family planning clinics, school-based health clinics (SBHCs) and the department of health (DOH) public health clinics for oral contraceptive agents and plan B when dispensed to a member and billed using healthcare common procedure coding (HCPC) codes and CMS 1500 forms.

H. The MCO shall meet all federal and state requirements related to pharmacy rebates and submit all necessary information as directed by HSD.

I. When directed and approved by MAD, the MCO shall follow all contractual and NMAC rules as they relate to the co-payment for legend drugs when a generic is available.

(1) The MCO shall impose the maximum nominal co-payment established by HSD in accordance with federal regulations on any prescription filled for its member with a brand name drug when a therapeutically equivalent generic drug is available unless the brand name drug will provide better therapeutic response or will have fewer adverse effects for the member. This co-payment shall not apply to brand name drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions.

(2) The MCO shall not impose any co-payments on native Americans.

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

8.308.9.15 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES (EPSDT): The benefit package includes the delivery of the federally mandated EPSDT services [42 CFR Section 441.57] provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. The MCO shall provide access to early intervention programs and services for a member 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, EPSDT services are for a member under 21 years of age. For detailed description of each service, see 8.320.2 NMAC. EPSDT behavioral health services are included in Section 19 of this rule.

A. **EPSDT nutritional counseling and services:** The benefit package includes nutritional services furnished to a pregnant member and a member under 21 years of age as detailed in 8.310.2 NMAC.

B. **EPSDT personal care:** The benefit package includes personal care services for a member.

C. **EPSDT private duty nursing:** The benefit package includes private duty nursing for a member and the services shall be delivered in either his or her home or school setting.

D. **EPSDT rehabilitation services:** A member under 21 years of age who is eligible for home and community based waiver services receives medically

necessary rehabilitation services through the EPSDT program; see 8.320.2 NMAC for a detailed description. The home and community-based waiver program provides rehabilitation services only for the purpose of community integration.

E. **Services provided in schools:** The benefit package includes services to a member provided in a school, excluding those specified in his or her individual education plan (IEP) or the individualized family service plan (IFSP); see 8.320.6 NMAC.

F. **Tot-to-teen health checks:**

(1) The MCO shall adhere to the periodicity schedule and ensure that the member receives EPSDT screens (tot-to-teen health checks). The services include the following with respect to treatment follow-up:

(a) education of and outreach to a member regarding the importance of the health checks;

(b) development of a proactive approach to ensure that the member receives the services;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(e) processes to document, measure and assure compliance with the periodicity schedule; and

(f) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for vision and hearing screening, dental examinations and current immunizations.

(2) The MCO will facilitate appropriate referral for possible or identified behavioral health conditions. See 8.321.2 NMAC for EPSDT behavioral health services descriptions.

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

8.308.9.16 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC. The MCO shall implement written policies and procedures approved by HSD which define how a member is educated about his or her rights to family planning services, freedom of choice, to include access to non-contract providers, and methods for accessing family planning services.

A. The family planning policy shall ensure that a member of the appropriate age of both sexes who seeks family planning services shall be provided with counseling pertaining to the following:

(1) human immunodeficiency virus (HIV) and other sexually transmitted diseases and risk reduction practices; and

(2) birth control pills and devices (including plan B).

B. The MCO shall provide a member with sufficient information to allow him or her to make informed choices including the following:

(1) types of family planning services available;

(2) the member's right to access these services in a timely and confidential manner;

(3) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the member's MCO network; and

(4) if a member chooses to receive family planning services from a non-contracted provider, the member shall be encouraged to exchange medical information between the PCP and the non-contracted provider for better coordination of care.

C. **Pregnancy termination procedures:** The benefit package includes services for the termination of a pregnancy as detailed in 8.310.2 NMAC. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.310.2 NMAC.

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

8.308.9.17 PREVENTIVE PHYSICAL HEALTH SERVICES: The MCO shall follow current national standards for preventive health services, including behavioral health preventive services. Standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the MCO under these standards shall be adopted and reviewed at least every two years, updated when appropriate and disseminated to its practitioners and members. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** The MCO shall conduct a health risk assessment (HRA), per HSD guidelines and processes, for the purpose of introducing the MCO to the member, obtaining basic health and demographic information about the member, assisting the MCO in determining the LOC coordination needed by the member, and determining the need for a NF LOC assessment.

B. **Family planning:** The MCO must have a family planning policy. This policy must ensure that a member of the appropriate age of both sexes who seeks family planning services is provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

C. **Guidance:** The MCO shall adopt policies that shall ensure that an applicable asymptomatic member is provided guidance on the following topics unless the member's refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in a menopausal member citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

(8) prevention of HIV infection and other sexually transmitted diseases;

(9) prevention of an unintended pregnancy; and

(10) prevention or intervention for obesity or weight issues.

D. **Immunizations:** The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, a member is immunized according to the type and schedule provided by current recommendations of the state department of health (DOH). The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

E. **Nurse advice line:** The MCO shall provide a toll-free clinical telephone nurse advice line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(2) pre-diagnostic and post-treatment health care decision assistance based on the member's symptoms.

F. **Prenatal care:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The

program shall include at least the following:

(1) educational outreach to a member of childbearing age;

(2) prompt and easy access to obstetrical care, including an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(3) risk assessment of a pregnant member to identify high-risk cases for special management;

(4) counseling which strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of a member who has a high risk pregnancy, especially if risk is due to psychosocial factors, such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit; and

(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

G. **Screens:** The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, each asymptomatic member receives at least the following preventive screening services listed below.

(1) *Screening for breast cancer*: A female member between the ages of 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Blood pressure measurement*: A member 18 years of age or older shall receive a blood pressure measurement at least every two years.

(3) *Screening for cervical cancer*: A female member with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age when prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(4) *Screening for chlamydia*: All sexually active female members 25 years of age and younger shall be screened for chlamydia. All female members over 25 years of age shall be screened for chlamydia if they inconsistently use barrier contraception, have more than one sex partner, or have had a sexually transmitted disease in the past.

(5) *Screening for colorectal cancer*: A member 50 years of age and older, who is at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium at a periodicity determined by the MCO.

(6) *Screening for elevated lead levels*: A member between 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once. A member at one (1) and at two (2) years of age shall receive a blood lead measurement. A member between the ages of 3 to 6 years, for whom no previous test exists, should also be tested.

(7) *Newborn screening*: A newborn member shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(8) *Screening for obesity*: A member shall receive body weight, height and length measurements with each physical exam. A member under 21 years of age shall receive a BMI percentile designation.

(9) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(10) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(11) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk members shall be screened or previous screenings noted:

(a) a member who has immigrated from countries in Asia, Africa, latin America or the middle east in the preceding five years;

(b) a member who has substantial contact with immigrants from those areas; a member who is a migrant farm worker;

(c) a member who is an alcoholic, homeless or is an injecting drug user. HIV-infected persons shall be screened annually; and

(d) a member whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local DOH public health office in his or her community of residence for contact investigation.

(12) *Serum cholesterol measurement*: A male member 35 years and older and a female member 45 years and older who is at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. A member 20 years and older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements annually.

(13) *Tot-to-teen health checks*: The MCO shall operate the tot-to-teen mandated EPSDT program as outlined in 8.320.2 NMAC. Within three months of enrollment lock-in, the MCO shall ensure that the member is current according to the screening schedule, unless more stringent requirements are specified in these standards. The MCO shall encourage its PCPs to assess and document for age, height and gender appropriate weight and for body mass index (BMI) percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in members under 21 years of age.

(14) *Screening for type 2 diabetes*: A member with one or more of the following risk factors for diabetes shall be screened. Risk factors include:

(a) a family history of diabetes (parent or sibling with diabetes); obesity (>20% over desired body weight or BMI >27kg/m2);

(b) race or ethnicity (e.g. hispanic, native American, African American, Asian-Pacific islander);

(c) previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM); and

(d) a delivery of newborn over nine pounds.

(15) A member 21 years of age and older must be screened to detect high risk for behavioral health conditions at his or her first encounter with a PCP after enrollment.

(16) The MCO shall require its PCPs to refer a member, whenever clinically appropriate, to behavioral health provider, see 8.321.2 NMAC. The MCO shall assist the member with an appropriate behavioral health referral.

(17) Screens and preventative screens shall be updated as recommended by the United States preventative services task force.

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

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

A. The MCO must:

(1) promote and employ broad-based utilization of statewide access to Health Insurance Portability and Accountability Act (HIPAA)-compliant telemedicine service systems including, but not limited to, access to text telephones or teletype (TTYs) and 711 telecommunication relay services;

(2) follow state guidelines for telemedicine equipment or connectivity;

(3) follow accepted HIPAA and 42 C.F.R. part two regulations that affect telemedicine transmission, including but not limited to staff and contract provider training, room setup, security of transmission lines, etc; the MCO shall have and implement policies and procedures that follow all

federal and state security and procedure guidelines;

(4) identify, develop, and implement training for accepted telemedicine practices;

(5) participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs;

(6) report to HSD on the telemedicine outcomes of telemedicine projects and submit the telemedicine report; and

(7) ensure that telemedicine services meet the following shared values, which are ensuring: competent care with regard to culture and language needs; work sites are distributed across the state, including native American sites for both clinical and educational purposes; and coordination of telemedicine and technical functions at either end of network connection.

B. The MCO shall participate in project extension for community healthcare outcomes (ECHO), in accordance with state prescribed requirements and standards, and shall:

(1) work collaboratively with HSD, the university of New Mexico, and providers on project ECHO;

(2) identify high needs, high cost members who may benefit from project ECHO participation;

(3) identify its PCPs who serve high needs, high cost members to participate in project ECHO;

(4) assist project ECHO with engaging its MCO PCPs in project ECHO's center for medicare and medicaid innovation (CMMI) grant project;

(5) reimburse primary care clinics for participating in the project ECHO model;

(6) reimburse "intensivist" teams;

(7) provide claims data to HSD to support the evaluation of project ECHO;

(8) appoint a centralized liaison to obtain prior authorization approvals related to project ECHO; and

(9) track quality of care and outcome measures related to project ECHO. [8.308.9.18 NMAC - N, 1-1-14]

8.308.9.19 BEHAVIORAL HEALTH SERVICES:

A. The MCO shall cover the following behavioral health services listed below. When an additional behavioral health service is approved by MAD, the MCO shall cover that service as well. See 8.321.2 NMAC for detailed descriptions of each service. MAD makes available on its website its behavioral health service definitions and crosswalk, along with other information.

(1) **Applied behavior analysis:** The benefit package includes applied behavior analysis (ABA) services for a member three years of age up to 21 years of age who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for a member under three years of age who has a well-documented risk for the development of ASD. The need for ABA services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(2) **Assertive community treatment services (ACT):** The benefit package includes assertive community treatment services for a member 18 years of age and older.

(3) **Behavioral health respite:** Behavioral health respite care is provided to a member under 21 years of age to support the member's family and strengthen their resiliency during the respite while the member is in a supportive environment. Respite care is provided to a member with a severe emotional disturbance who resides with his or her family and displays challenging behaviors that may periodically overwhelm the member's family's ability to provide ongoing supportive care. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines–respite services-for a detailed description. Behavioral health respite is not a benefit for ABP eligible recipients.

(4) **Comprehensive community support services:** The benefit package includes comprehensive community support services for a member.

(5) **Family support services:** The benefit package includes family support services to a member whose focus is on the member and his or her family and the interactive effect through a variety of informational and supportive activities that assists the member and his or her family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and his or her family strengthens the effectiveness of other treatment and recovery initiatives. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines –family support services-for a detailed description. Family support services are not a benefit for ABP eligible recipients.

(6) **Hospital outpatient services:** The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt unit of a general hospital for a member.

(7) **Inpatient hospital services:** The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC.

(8) **Intensive outpatient (IOP) services:** The benefit package includes intensive outpatient services for a member 13 years of age.

(9) **Medication assisted treatment for opioid addiction:** The benefit package includes medication assisted treatment services for opioid addiction to a member through an opioid treatment center as defined in 42 CFR Part 8, *Certification of Opioid Treatment*.

(10) **Outpatient therapy services:** The benefit package includes outpatient therapy services (individual, family, and group) for a member.

(11) **Psychological rehabilitation services:** The benefit package includes adult psychosocial rehabilitation services for a member 18 years and older.

(12) **Recovery services:** The benefit package includes recovery services for a member. Recovery services are peer-to-peer support within a group setting to develop and enhance wellness and healthcare practices. The service enables a member to identify additional needs and goals and link him or herself to additional support as a result. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines –recovery services-for a detailed description. Recovery services are not a benefit for ABP eligible recipients.

B. **Behavioral health EPSDT services:** The benefit package includes the delivery of the federally mandated EPSDT services [42 CFR Section 441.57] provided by a behavioral health practitioner for a member under 21 years of age. See 8.321.2 NMAC for a detailed description of each service. The MCO shall provide access to EPSDT for a member identified in his or her EPSDT tot to teen health check screen or another diagnostic evaluation as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

(1) **Accredited residential treatment center (ARTC):** The benefit package includes services furnished in an ARTC furnished as part of the EPSDT program. ARTC services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for ARTC services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(2) **Behavior management skills development services (BMS):** The benefit package includes BMS services furnished as part of the EPSDT program. BMS services are provided to a member who has an identified need for such services and meets the required LOC. The need for BMS services must be identified in the member's

tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(3) **Day treatment services:** The benefit package includes day treatment services furnished as part of the EPSDT program. Day treatment services are provided to a member who has an identified need for such services and meets the required LOC. The need for day treatment services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(4) **Inpatient hospitalization services provided in freestanding psychiatric hospitals:** The benefit package includes inpatient psychiatric care furnished in a freestanding psychiatric hospital furnished as part of the EPSDT program. Inpatient hospitalization services are provided in a freestanding psychiatric hospital are provided to a member who has an identified need for such services and meet the required LOC. The need for such services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(5) **Multi-systemic therapy (MST):** The benefit package includes MST services furnished as part of the EPSDT program. MST services are provided to a member who has an identified need for such services and meets the required LOC. The need for MST services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(6) **Psychosocial rehabilitation services (PSR):** The benefit package includes PSR services furnished as part of the EPSDT program. PSR is provided to a member who has an identified need for such services and meets the required LOC. The need for PSR services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(7) **Treatment foster care I (TFC I):** The benefit package includes TFC I furnished as part of the EPSDT program. TFC I services are provided to a member who has an identified need for such services and meets the required LOC. The need for TFC I services must be identified in the member's tot to teen healthcheck or another diagnostic evaluation furnished through a healthcheck referral.

(8) **Treatment foster care II (TFC II):** The benefit package includes TFC II services furnished as part of the EPSDT program. TFC II is provided to a member who has an identified need for such services and meets the required LOC. The need for TFC II services must be identified in the member's tot to teen healthcheck or another diagnostic evaluation furnished through a healthcheck referral.

(9) **Residential non-accredited treatment center (RTC) and group home:** The benefit package includes services furnished in a RTC center or group home as part of the EPSDT program. RTC or group home services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for RTC and group home services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.
[8.308.9.19 NMAC - N, 1-1-14]

8.308.9.20 COMMUNITY BENEFIT SERVICES: The MCO shall cover community benefit services for a member who meets the specific eligibility requirements for each MCO community benefit service as detailed in 8.308.12 NMAC. When an additional community benefit service is approved by MAD, the MCO shall cover that service as well.
[8.308.9.20 NMAC - N, 1-1-14]

8.308.9.21 ALTERNATIVE BENEFITS PLAN (ABP) BENEFITS FOR ABP MCO MEMBERS: The MAD category of eligibility "other adults" has an alternative benefit plan (ABP). The MCO shall cover the ABP specific services for an ABP member. Services are made available through a MCO under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member: (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 member. The ABP benefits and services are detailed in Sections 12 through 18 of 8.309.4 NMAC. All EPSDT services are available to an ABP member under 21 years. Services for an ABP member 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. The MCO shall comply with all HSD MAD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;

B. managed care eligibility found in 8.308.6 NMAC;

C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;

D. managed care member education – rights and responsibilities found in 8.308.8 NMAC;

E. care coordination found in 8.308.10 NMAC;

F. transition of care found in 8.308.11 NMAC;

G. managed care cost sharing found in 8.308.14 NMAC;

H. managed care grievance and appeals found in 8.308.15 NMAC;

I. managed care reimbursement found in 8.308.20 NMAC;

J. quality management found in 8.308.21 NMAC; and

K. managed care fraud, waste and abuse found in 8.308.22.
[8.308.9.21 NMAC - N, 1-1-14]

8.308.9.22 MAD ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP EXEMPT MEMBERS (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by his or her MCO for determination if he or she meets the ABP qualifying condition. An ABP exempt member may select to no longer utilize his or her ABP benefits package. Instead, the ABP exempt member will utilize his or her MCO's medicaid benefits package. See Sections 11 through 20 of this rule for detailed description of the MCO medicaid benefit services. All services, services limitations and co-payments that apply to full benefit medicaid recipients are 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 MCO shall comply with all HSD MAD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;

B. managed care eligibility found in 8.308.6 NMAC;

C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;

D. managed care member education – rights and responsibilities found in 8.308.8 NMAC;

E. care coordination found in 8.308.10 NMAC;

F. transition of care found in 8.308.11 NMAC;

G. community benefits found in 8.308.12 NMAC;

H. managed care member rewards found in 8.308.13 NMAC

I. managed care cost sharing found in 8.308.14 NMAC;

J. managed care grievance and appeals found in 8.308.15 NMAC;

K. managed care reimbursement found in 8.308.20 NMAC;

L. quality management found in 8.308.21 NMAC; and

M. managed care fraud, waste and abuse found in 8.308.22.

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

8.308.9.23 SERVICES EXCLUDED FROM THE MCO BENEFIT PACKAGE: MAD does not cover some services. The services which are not included in the MCO benefit package are detailed in the specific NMAC rules cited in the Sections 12 through 21 of this rule. The following services that are covered in other medical assistance program (MAP), reimbursement shall be made by MAD or its contractor. However, the MCO is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination.

A. **Medicaid in the schools:** Services are covered under 8.320.6 NMAC. Reimbursement for services is made by MAD or its contractor.

B. **Special rehabilitation services-family infant toddler (FIT):** Early intervention services provided for a member birth to three years of age who has or is at risk for a developmental delay. Reimbursement for services is made by MAD or its contractor.

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

HISTORY OF 8.308.9 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 10 CARE COORDINATION

8.308.10.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.10.2 SCOPE: This rule applies to the general public.

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

8.308.10.3 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.

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

8.308.10.4 DURATION: Permanent.

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

8.308.10.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.10.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

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

8.308.10.7 DEFINITIONS: [RESERVED]

8.308.10.8 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.

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

8.308.10.9 CARE COORDINATION:

A. **General requirements:**

(1) Care coordination services are provided and coordinated with the eligible recipient member and his or her family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning.

(2) Every member has the right to refuse to participate in care coordination. In the event the member refuses this service, managed care organization (MCO) will document the refusal in the member's file and report it to HSD.

(3) If a native American member requests assignment to a native American care coordinator and the MCO is unable to provide a native American care coordinator to such member, the MCO must ensure that a mutually-agreed upon community health worker is present for all in–person meetings between the care coordinator and the member.

(4) Individuals with special health care needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other members. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO shall facilitate access to appropriate services through its care coordination process and comply with provisions of 42 CFR Section 438.208.

B. **Health risk assessment (HRA):**

(1) Within 30 calendar days of the member's enrollment with a MCO, the MCO shall conduct a health risk assessment (HRA) either by telephone, in person or as otherwise approved by HSD. The HRA is conducted for the purpose of: (a) introducing the MCO to the member; (b) obtaining basic health and demographic information about (c) assisting the MCO in determining the level of care coordination services needed by him or her; and (d) determining the need for a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC) assessment, as applicable.

(2) The MCO shall provide the following to every member during the HRA:

(a) information about the services are available through care coordination;

(b) notification of the care coordination level;

(c) notification of the member's right to request a higher level of care coordination;

(d) requirement for an in-person comprehensive needs assessment for the purpose of providing services associated with care coordination Levels 2 or 3; and

(e) information detailing specific next steps for the member.

C. **Assignment to care coordination levels**

(1) Within seven calendar days of completion of the HRA, a member shall be informed of either a Level 1 care coordination assignment or the need for a comprehensive needs assessment to determine the need for Level 2 or Level 3 care coordination.

(2) Within 10 calendar days of completion of the HRA, the member shall receive:

(a) contact information for the contractor's care coordination unit;

(b) the name of the assigned care coordinator if applicable; and

(c) a timeframe during which he or she can expect to be contacted by the care coordination unit or individual care coordinator.

D. **Level 1 care coordination:** a member who is assigned this level will not receive a comprehensive needs assessment and is not assigned to an individual care coordinator.

E. **Level 2 and Level 3 care coordination:** a member meeting one of the indicators below shall have a comprehensive needs assessment conducted by the MCO to determine whether the member shall be in Level 2 or Level 3 care coordination. The member:

(1) is a high-cost user as defined by the MCO;

(2) is in out-of-state medical placement;

(3) is a dependent child in out-of-home placement;

(4) is a transplant patient;

(5) is identified as having a high risk pregnancy;

(6) has a behavioral health diagnosis including substance abuse that adversely affects his or her life;

(7) is medically fragile or is an ISHCN;

(8) is designated as an ICF/IID or has a HSD-recognized developmental delay (DD);

(9) has high emergency room use as defined by the MCO;

(10) has an acute or terminal disease;

(11) is readmitted to the hospital within 30 calendar days of discharge; or

(12) has other indicators as prior approved by HSD.

F. **Care coordination requirements for Level 1:** Each member will receive, at a minimum, the following care coordination:

(1) a HRA annual review to determine appropriate care coordination level; and

(2) a review of claims and utilization data at least quarterly to determine if the member is in need of a comprehensive needs assessment and potentially higher care coordination level.

G. **Comprehensive needs assessment for Level 2 and Level 3 care coordination:**

(1) The MCO shall schedule an in-person comprehensive needs assessment within 14 calendar days of the member receiving notification of the need for a comprehensive needs assessment for a Level 2 or Level 3 care coordination assignment.

(2) Within 30 calendar days of the HRA, the MCO shall complete the comprehensive needs assessment.

(3) For all members who become newly eligible on January 1, 2014 or later, the MCO will conduct the HRA within 30 calendar days of the member's enrollment. For members transitioning from legacy medicaid programs on January 1, 2014, the MCO shall conduct the HRA and, if required, a comprehensive needs assessment and a CCP within 180 calendar days.

(4) The comprehensive needs assessment shall be conducted at least annually or as the care coordinator deems necessary as a result of a request from the member, provider or family member, or as a result of change in the member's health status.

(5) At a minimum, the comprehensive needs assessment shall:

(a) assess the member's physical, behavioral health, and long-term care and social needs; and

(b) identify targeted needs, such as improving health, functional outcomes, or quality of life outcomes.

H. **Care coordination services requirements for Level 2:** The MCO shall assign a specific care coordinator to each member in Level 2. The care coordinator for a member in Level 2 shall, at the minimum, arrange for or provide the following care coordination:

(1) the development and implementation of a care plan;

(2) the monitoring of the care plan to determine if the plan is meeting the members identified needs;

(3) the assessment of need for assignment to a health home;

(4) targeted health education, including disease management;

(5) the annual in-person comprehensive needs assessment;

(6) the semi-annual in-person visits with the member; and

(7) the quarterly telephone contact with the member.

I. **Care coordination requirement for Level 3:** The MCO shall assign a specific care coordinator to each member in Level 3. The care coordinator for a member in Level 3 shall arrange for or provide the following care coordination services:

(1) the development and implementation of a care plan;

(2) the monitoring of the care plan to determine if the plan is meeting the member's identified needs;

(3) the assessment of need for assignment to a health home;

(4) targeted health education, including disease management;

(5) the semi-annual in-person comprehensive needs assessment;

(6) the quarterly in-person visits with the member; and

(7) monthly telephone contact with the member.

J. **Increase in the level of care coordination services:**

(1) The following triggers, at a minimum, shall identify a member's need for a comprehensive needs assessment for a higher level of care coordination:

(a) a referral from his or her primary care provider (PCP), specialist, another provider, or from another referral source;

(b) member's self-referral or a referral by his or her authorized representative;

(c) a referral from the member's MCO staff or at the request of HSD staff;

(d) the notification of a hospital admission or emergency room visit; and

(e) claims or encounter data, hospital admission, discharge data, pharmacy data and data collected through the MCO's utilization management (UM) or the quality management (QM) processes.

(2) The MCO shall contact the member within 10 calendar days of receiving the referral, or request, or while conducting a data review or becoming aware of a change in the member's condition, to conduct the comprehensive needs assessment for a higher level of care coordination.

K. **Comprehensive care plan requirements:**

(1) The MCO shall develop and implement a comprehensive care plan (CCP) for a member in Level 2 or 3 care coordination within 14 business days of the completion of the comprehensive needs assessment.

(2) The MCO is not required to develop and implement a CCP for a member in Level 1 care coordination.

(3) The MCO shall ensure that the member and his or her authorized representative participate in the development of the CCP.

(4) The MCO shall ensure that the care coordinator consults with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed in the development of the CCP.

L. **On-going reporting:** The MCO shall require that the following information about the member's care is shared amongst medical, behavioral health, and long-term care providers:

(1) drug therapy;

(2) laboratory and radiology results;

(3) sentinel events, such as hospitalization, emergencies, or incarceration;

(4) discharge from a psychiatric hospital, a residential treatment service, treatment foster care or from other behavioral health services; and

(5) all LOC transitions.

M. **Electronic visit verification system:**

(1) The MCO, together with the other MCOs, shall contract with a vendor to implement an electronic visit verification system to monitor the member's receipt of and utilization of a covered community benefit.

(2) The MCO shall monitor and use information from the electronic verification system to verify that services are provided

as specified in the member's CCP, and in accordance with the established schedule, including verification of the amount, frequency, duration, and the scope of each service and that service gaps are identified and addressed immediately, including late and missed visits. The MCO shall monitor all approved services that a member is receiving, including after the MCO's regular business hours.
[8.308.10.9 NMAC - N, 1-1-14]

HISTORY OF 8.308.10 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 11 TRANSITION OF CARE

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

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

8.308.11.3 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.
[8.308.11.3 NMAC - N, 1-1-14]

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

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

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

8.308.11.7 DEFINITIONS: [RESERVED]

8.308.11.8 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.
[8.308.11.8 NMAC - N, 1-1-14]

8.308.11.9 TRANSITION OF CARE: Transition of care refers to movement of an eligible recipient or a manage care organization (MCO) member from one health care practitioner or setting to another as his or her condition and health care needs change. The MCO shall have the resources, the policies and the procedures in place to actively assist the member with his or her transition of care. Care coordination will be provided to a member transitioning from an institutional facility, such as a hospital, a nursing home, a residential treatment facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) back into his or her community. A member changing from MCO to MCO, or from fee-for-service (FFS) to a MCO, or vice versa shall continue to receive medically necessary services in an uninterrupted manner.

A. The following is a list of HSD's general MCO requirements for transition of care.

(1) The MCO shall establish policies and procedures to ensure that each member is contacted in a timely manner and is appropriately assessed by its MCO, using the HSD prescribed timeframes, processes and tools to identify his or her needs.

(2) The MCO shall have policies and procedures covering the transition of an eligible recipient into a MCO, which shall include:

(a) member and provider educational information about the MCO;

(b) self-care and the optimization of treatment; and

(c) the review and update of existing courses of the member's treatment.

(3) The MCO shall not transition a member to another provider for continuing services, unless the current provider is not a contracted provider.

(4) The MCO shall facilitate a seamless transition into a new service, a new provider, or both, in a care plan developed by the MCO without disruption in the member's services.

(5) When a member of a MCO is transitioning to another MCO, the receiving MCO shall immediately contact the member's relinquishing MCO and request the transfer of "transition of care data" as specified by HSD. If a MCO is contacted by another MCO requesting the transfer of "transition of care data" for a transitioning member, then upon verification of such a transition, the relinquishing MCO shall provide such data in the timeframe and format specified by HSD to the receiving MCO, and both MCOs shall facilitate a seamless transition for the member.

(6) The receiving MCO will ensure that its newly transitioning member is held harmless by his or her provider for the costs of medically necessary covered services, except for applicable cost sharing.

(7) For a medical assistance division (MAD) medically necessary covered service provided by a contracted provider, the MCO shall provide continuation of such services from that provider, but may require prior authorization for the continuation of such services from that provider beyond 30 calendar days. The receiving MCO may initiate a provider change only as specified in the MCO agreement with HSD.

(8) The receiving MCO shall continue providing services previously authorized by HSD, its contractor or designee, in the member's approved community benefit care plan, behavioral health treatment plan or service plan without regard to whether such a service is provided by contracted or non-contracted provider. The receiving MCO shall not reduce approved services until the member's care coordinator conducts a comprehensive needs assessment.

B. Transplant services, durable medical equipment and prescription drugs:

(1) If an eligible recipient has received HSD approval, either through FFS or any other HSD contractor, the receiving MCO shall reimburse the HSD approved providers if a donor organ becomes available during the first 30 calendar days of the member's MCO enrollment.

(2) If a member was approved by an MCO for transplant services, HSD shall reimburse the MCO approved providers if a donor organ becomes available during the first 30 calendar days of the eligible recipient's FFS enrollment. The MCO provider who delivers these services will be eligible for FFS enrollment if the provider is willing.

(3) If a member received approval from his or her MCO for durable medical equipment (DME) costing $2,000 or more, and prior to the delivery of the DME item, was disenrolled from the MCO, the relinquishing MCO shall pay for the item.

(4) If an eligible recipient received FFS approval for a DME costing $2,000 or more, and prior to the delivery of the DME item, he or she is enrolled in a MCO, HSD shall pay for the item. The DME provider will be eligible for FFS provider enrollment if the provider is willing.

(5) If a FFS eligible recipient enrolls in an MCO, the receiving MCO shall pay for prescribed drug refills for the first 30 calendar days or until the MCO makes other arrangements.

(6) If a MCO member is later determined to be exempt from MCO

enrollment, HSD will pay for prescription drug refills for the first 30 calendar days of his or her FFS enrollment. The pharmacy provider will be eligible for FFS enrollment if the provider is willing;

(7) If a FFS eligible recipient is later enrolled in a MCO, the receiving MCO will honor all prior authorizations granted by HSD or its contractors for the first 30 calendar days or until it makes other arrangements for the transition of services. A provider who delivered services approved by HSD or through its contractors shall be reimbursed by the receiving MCO.

(8) If a MCO member is later determined to be exempt from MCO enrollment, HSD will honor the relinquishing MCO's prior authorizations for the first 30 calendar days or until other arrangements for the transition of services have been made. The provider will be eligible for FFS enrollment if the provider is willing.

C. Transition of care requirements for pregnant women:

(1) When a member is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prenatal care provider (whether a contracted or non-contracted provider) through the two month postpartum period without any form of prior approval.

(2) When a newly enrolled member is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment, the receiving MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery, without any form of prior approval from the receiving MCO and without regard to whether such services are being provided by a contracted or non-contracted provider for up to 60 calendar days from her MCO enrollment or until she may be reasonably transferred to a MCO contracted provider without disruption in care, whichever is less.

(3) When a member is receiving services from a contracted provider, her MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the two month postpartum period.

(4) When a member is receiving services from a non-contracted provider, her MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, delivery, through the two month postpartum period, without any form of prior approval, until such time when her MCO determines it can reasonably transfer her to a contracted provider without impeding service delivery that might be harmful to her health.

D. Transition from institutional facility to community:

(1) The MCO shall develop and implement methods for identifying members who may have the ability, the desire, or both, to transition from institutional care to his or her community, such methods include, at a minimum:

(a) the utilization of a comprehensive needs assessment;

(b) the utilization of the preadmission screening and annual resident review (PASRR);

(c) minimum data set (MDS);

(d) the identification of wrap-around services available in the community where the member will reside;

(e) a provider referral;

(f) an ombudsman referral;

(g) a family member referral;

(h) a change in medical status; and

(i) the member's self-referral.

(2) When a member's transition assessment indicates that he or she is a candidate for transition to the community, his or her MCO care coordinator shall facilitate the development and completion of a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The transition plan shall address the member's transition needs including but not limited to:

(a) his or her physical and behavioral health needs;

(b) the selection of providers in his or her community;

(c) continuation of MAD eligibility;

(d) his or her housing needs;

(e) his or her financial needs;

(f) his or her interpersonal skills; and

(g) his or her safety.

(3) The MCO shall conduct an additional assessment within 75 calendar days of the member's transition to his or her community to determine if the transition was successful and identify any remaining needs of the member.

E. Transition from the New Mexico health insurance exchange:

(1) The receiving MCO must minimize the disruption of the newly enrolled member's care and ensure he or she has uninterrupted access to medically necessary services when transitioning between a medicaid MCO and his or her New Mexico health insurance exchange qualified health plan coverage.

(2) At a minimum, the receiving MCO shall establish transition guidelines for the following populations:

(a) pregnant members, including the two month postpartum period;

(b) members with complex medical conditions;

(c) members receiving ongoing services or who are hospitalized at the time of transition; and

(d) members who received prior authorization for services from their qualified health plan.

(3) The receiving MCO is expected to coordinate services and provide phase-in and phase-out time periods for each of these populations, and to maintain written policies and procedures to address these coverage transitions.

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

HISTORY OF 8.308.11 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 12 COMMUNITY BENEFIT

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

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

8.308.12.3 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.
[8.308.12.3 NMAC - N, 1-1-14]

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

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

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

8.308.12.7 DEFINITIONS:

A. Agency based community benefit (ABCB): The community benefit (CB) services offered to a member who does not wish to self-direct his or her CB services.

B. ABCB care plan: For a member who is participating in the ABCB approach, the care plan outlines the specific community benefit services that the member and the care coordinator have identified as needed services through the comprehensive needs assessment (CNA).

C. Authorized agent: The individual that has been legally appointed by the appropriate court to act on behalf of the eligible recipient as stated in the court's order. The member's authorized agent may be a service provider (depending on the scope of the court's order) for the member.

D. Authorized representative: The member may choose to appoint an authorized representative designated to have access to medical, behavioral health and financial information for the purpose of offering support and assisting the eligible recipient in understanding his or her community benefit services. The eligible recipient may designate a person to act as an authorized representative by signing a release of information form indicating his or her consent to the release of confidential information. The authorized representative will not have the authority to direct the member's community benefit services, which remains the sole responsibility of the member or his or her authorized agent. The member's authorized representative does not need a legal relationship with the member. The authorized representative cannot serve as the member's support broker

E. Budget: The maximum budget allotment available to a self-directed community benefit (SDCB) member, determined by his or her CNA. Based on this maximum amount, the eligible member will develop a care plan in collaboration with their support broker to meet his or her assessed functional, medical and habilitative needs to enable that member to remain in the community.

F. Care coordinator: The care coordinator provides care coordination activities that comply with all state and federal requirements. This includes, but is not limited to: assigning an appropriate care coordination level; performing a CNA a minimum of annually to determine physical, behavioral and long-term care needs; developing a budget based on those needs; and delivering on-going care coordination services based on the member's assessed need and in accordance with the care plan and contractual obligations.

G. Comprehensive care plan: A comprehensive plan that includes community benefit services that meet the member's long-term, physical and behavioral health care needs which must include, but is not limited to: the amount, frequency and duration of the community benefit services, the cost of goods and services; the type of provider who will furnish each service; other services the member will access; and the member's available supports that will complement community benefit services in meeting the individual's needs. The member works with his or her care coordinator, support broker or both to develop a care plan which is submitted to the managed care organization (MCO) for review and approval.

H. Comprehensive needs assessment (CNA): The comprehensive needs assessment will be conducted in person, in the member's primary place of residence, by the MCO care coordinator for a member who is assigned a care coordination level of two or three. The CNA will assess the physical, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member's assessed needs.

I. Eligible member: An individual who has been deemed medically and financially eligible, and through the EOR self-assessment instrument has either been deemed able to be their own EOR or must assign EOR duties to another eligible individual. A member must continue to meet medical and financial eligibility to continue accessing community benefits.

J. Employer of record (EOR): The employer of record is the individual responsible for directing the work of SDCB employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets by the financial management agency (FMA). A member may be his or her own EOR unless the member is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. A member may also designate an individual of his or her choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule.

K. Financial management agency (FMA): An entity that contracts with a HSD MCO to provide the fiscal administration functions for members participating in the SDCB approach.

L. Legally responsible individual (LRI): A legally responsible individual is any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse.

M. The level of care (LOC): A member must meet a specific LOC to be eligible for a specific community benefit service.

N. Self-directed community benefit (SDCB): The community benefit services offered to a member who is able to and who chooses to self-direct his or her CB services.

O. SDCB care plan: For a member who selected the SDCB approach, the care plan is the services that the member and the support broker have identified through the CNA that will be purchased with the member's budget.

P. Support broker: The function of the support broker is to directly assist the member in implementing the care plan and budget to ensure access to SDCB services and supports and to enhance success with self-direction. The support broker's primary function is to assist the member with employer or vendor related functions and other aspects of implementing his or her care plan and budget.

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

8.308.12.8 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.

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

8.308.12.9 MANAGED CARE COMMUNITY BENEFIT OPTIONS: A MCO member, meeting specific LOC, can select the approach to receiving his or her community benefit services. The MCO offers two approaches to the delivery of these services: agency based or self-directed. The MCO shall use the nursing facility (NF) LOC criteria for determining medical eligibility for community benefits.

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

8.308.12.10 AGENCY BASED COMMUNITY BENEFIT (ABCB): The MCOs shall offer the ABCB approach to its member who meets the nursing facility (NF) LOC and is determined through a CNA or reassessment to need MCO community benefit services. Although a member's assessment for the amount and types of services may vary, ABCB services are not provided 24 hours per day. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.

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

8.308.12.11 ELIGIBLE ABCB PROVIDERS: All ABCB agencies must apply and be approved to be a MAD provider and must then contract with any or all approved MCOs. A complete listing

of all CB provider qualifications and responsibilities are detailed in the MAD MCO manual.
[8.308.12.11 NMAC - N, 1-1-14]

8.308.12.12 ELIGIBLE ABCB MEMBERS: Enrollment in ABCB is contingent upon the member meeting the eligibility requirements as described in the New Mexico Administrative Code (NMAC) eligibility rules.
[8.308.12.12 NMAC - N, 1-1-14]

8.308.12.13 COVERED SERVICES IN AGENCY BASED COMMUNITY BENEFIT (ABCB):

A. Adult day health: adult day health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of a member that are incorporated into the member's care plan.

(1) Adult day health services are provided by a licensed community-based adult day-care facility that offers health and social services to assist a member to achieve his or her optimal functioning.

(2) Private duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the adult day health setting and in conjunction with adult day health services but would be reimbursed separately from his or her adult day health services.

B. Assisted living is a residential service that provides a homelike environment, which may be in a group setting, with individualized services designed to respond to the member's needs as identified and incorporated in the care plan.

(1) Core services are a broad range of activities of daily (ADL) living including: personal support services (homemaker, chore, attendant services, meal preparation); companion services; medication oversight (to the extent permitted under state law); 24-hour on-site response capability: (a) to meet scheduled or unpredictable member's needs, and (b) to provide supervision, safety, and security.

(2) Services include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

C. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment.

(1) Behavior support consultation:

(a) informs and guides the member's paid and unpaid caregivers about the services and supports that relate to the member's medical and behavioral health condition;

(b) identifies support strategies for a member that ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior;

(c) supports effective implementation based on a functional assessment;

(d) collaborates with medical and ancillary therapists to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and

(e) monitors and adapts support strategies based on the response of the member and his or her service and support providers.

(2) Based on the member's care plan, services are delivered in an integrated, natural setting or in a clinical setting.

D. Community transition services are non-recurring set-up expenses for a member who is transitioning from an institutional or another provider-operated living arrangement (excluding assisted living) to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses.

(1) Allowable expenses are those necessary to enable the member to establish a basic household that does not constitute room and board and may include:

(a) security deposits that are required to obtain a lease on an apartment or home;

(b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens;

(c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

(d) services necessary for the member's health and safety, such as, but not limited to, pest eradication and one-time cleaning prior to occupancy; and

(e) moving expenses.

(2) Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, household appliances, or items that are intended for purely diversional or recreational purposes.

(3) Community transition services are limited to $3,500 per member every five years. In order to be eligible for this service, the member must have a NF stay of at least 90-consecutive days prior to transition to the community.

E. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: testing and maintaining equipment; training the member, his or her caregivers and first responders on use of the equipment; 24-hour monitoring for alarms; checking systems monthly or more frequently (if warranted by electrical outages, severe weather, etc.); and reporting member emergencies and changes in the member's condition that may affect service delivery.

F. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted.

(1) The job coach provides: (a) training, skill development; (b) employer consultation that a member may require while learning to perform specific work tasks on the job; (c) co-worker training; (d) job site analysis; (e) situational and vocational assessments and profiles; (e) education of the member and co-workers on rights and responsibilities; and (f) benefits counseling. The service must be tied to a specific goal in the member's care plan.

(2) Job development is a service provided to a member by skilled staff. The service has five components:

(a) job identification and development activities;

(b) employer negotiations;

(c) job restructuring;

(d) job sampling; and

(e) job placement.

(3) Employment supports are provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by the member receiving services as a result of his or her disabilities, and does not include payment for the supervisory activities rendered as a normal part of the business setting.

(4) Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(a) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(b) payments that

are passed through to users of supported employment programs; or

(c) payments for training that is not directly related to an member's supported employment program.

(5) Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.

G. Environmental modification services include: the purchase of, the installation of equipment for the physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence.

(1) Adaptations include the installation of:

(a) ramps and grab-bars;

(b) widening of doorways and hallways;

(c) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(d) lifts and elevators;

(e) modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);

(f) turnaround space adaptations;

(g) specialized accessibility/safety adaptations/additions;

(h) trapeze and mobility tracks for home ceilings;

(i) automatic door openers/ doorbells;

(j) voice-activated, light-activated, motion-activated and electronic devices;

(k) fire safety adaptations; air filtering devices;

(l) heating and cooling adaptations;

(m) glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and

(n) alarm and alert systems, including signaling devices.

(2) All services shall be provided in accordance with applicable federal and state statutes, regulations and roles and local building codes.

(3) Non-covered adaptations or improvements to the member's home:

(a) general utility which are not for direct medical or remedial benefit to the member; and

(b) adaptations that add to the total square footage of the member's resident except when necessary to complete an approved adaptation.

(4) The environmental modification provider must:

(a) ensure proper design criteria is addressed in planning and design of the adaptation;

(b) provide or secure the appropriate licensed contractor or approved vendor to provide construction and remodeling services;

(c) provide administrative and technical oversight of construction projects;

(d) provide consultation to family enrollees, providers and contractors concerning environmental modification projects to the member's residence; and

(e) inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(5) Environmental modification services to a member are limited to $5,000 every five years. Additional services may be requested if the member's health and safety needs exceed the specified limit.

H. Home health aide services provide total care or assist the member in all ADLs.

(1) Total care includes: the provision of bathing (bed, sponge, tub, or shower); shampoo (sink, tub, or bed); care of nails and skin; oral hygiene; toileting and elimination; safe transfer techniques and ambulation; normal range of motion and positioning; and adequate oral nutrition and fluid intake.

(2) The home health aide services assist the member in a manner that promotes an improved quality of life and a safe environment for him or her. Home health aide services are intermittent and provided primarily on a short-term basis; whereas, community benefit home health aide services are provided hourly, for eligible beneficiaries who need this service on a more long term basis. Home health aide services can be provided outside the member's home.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home health aides perform an extension of therapy services:

(a) bowel and bladder care;

(b) ostomy site care;

(c) personal care;

(d) ambulation and exercise;

(e) household services essential to health care at home;

(f) assisting with medications that are normally self-administered;

(g) reporting changes in patient conditions and needs; and

(h) completing appropriate records.

(4) Home health aide services must be provided under the supervision of a registered nurse (RN) licensed by the New Mexico board of nursing, or other appropriate professional staff. Such staff must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether the member's goals are being met.

I. Personal care services (PCS) are provided to a member unable to perform a range of ADLs and instrumental activities of daily living (IADL). PCS shall not replace natural supports such as the member's family, friends, individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the member.

(1) PCS is a benefit for a member 21 years of age or older who does not receive other MAD waiver services and who meets the eligibility for CB services. A member must have a current CNA that specifically states PCS is an appropriate CB service: A member under 21years of age can access his or her PCS through the EPSDT program.

(2) PCS delivery models: A member who has selected consumer-delegated as his or her delivery model may select either the consumer-delegated or the consumer-directed delivery of his or her PCS. The PCS consumer-delegated or consumer directed agency must be certified as such by MAD or it designee to perform such duties and to be reimbursed for the delivery of those services. The MCO's care coordinator is responsible for explaining both models to each member, initially, and annually thereafter.

(a) The consumer delegated model allows the member to select his or her PCS agency to perform all PCS employer-related tasks. This agency is responsible for ensuring all PCS are delivered to the member.

(b) The consumer-directed model allows the member to oversee his or her own PCS delivery, and requires that the member to work with his or her PCS agency who then acts as a fiscal intermediary agency to processing all financial paperwork to be submitted to the MCO.

(c) A member who is unable to select or who is unable to communicate which PCS delivery model he or she selects, his or her authorized agent will then select and participate on behalf of the member. The member's authorized agent status must be properly documented with the member's PCS agency.

(d) For both models, the member may select his or her family member, with the exception of the member's spouse; a friend; neighbor; or other person as his or her PCS attendant. However, his or her family member shall not be reimbursed for a service he or she would have otherwise provided. A PCS attendant, regardless of family relationship, who resides with the member shall not be paid to deliver household services, or supports such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the member. Services include, but are not limited to, cleaning consumer's

room, linens, clothing, and special diets.

(e) A member may have an authorized representative assist him or her to give instruction to the attendant or to provide information to the MCO during assessments of the member's natural services, or supports needs. An authorized representative does not have the same level of responsibility or access as an authorized agent, yet the same person may fill both responsibilities.

(i) An authorized representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the member and understand the member's natural services, or supports needed, and know the member's daily schedule and routine including medications, medical and functional status, likes and dislikes, strengths and weaknesses.

(ii) An authorized representative does not make decisions for the member unless he or she is also the member's authorized agent. He or she may assist the member in communicating, as appropriate. An authorized representative may not be the member's attendant, unless he or she is also the authorized agent and has obtained written approval from the member's MCO. The authorized representative status must be properly documented with the member's PCS agency.

(3) Eligible PCS agencies: PCS agencies electing to provide PCS must obtain agency certification. A PCS agency provider, must comply with the requirements as listed in the MAD managed care policy manual as of the date of application for certification. PCS agencies must be an enrolled MAD provider.

(4) Bladder and bowel care: PCS must be related to the member's functional level to perform ADLs and IADLs as indicated in the members CNA. PCS will not include those services, or supports the member does not need or is already receiving from other sources including tasks provided by natural supports.

(a) A member who has a signed statement by his or her primary care provider (PCP) stating he or she is medically stable and able to communicate and assess his or her bladder and bowel care needs may access this service when included in his or her individual care plan.

(i) bowel care includes the evacuation and ostomy care, changing and cleaning of such bags and ostomy site skin care;

(ii) bladder care includes the attendant cueing the member to empty his or her bladder at timed intervals to prevent incontinence; and

(iii) catheter care, including the changing and cleaning of such bag.

(b) A member who is determined by his or her PCP in a signed statement to not be medically stable and not able to communicate and assess his or her bladder and bowel care needs may access these services:

(i) perineal care including cleansing of the perineal area and changing of feminine sanitary products;

(ii) toileting including assisting with bedside commode or bedpan;

(iii) cleaning perineal area,

(iv) changing adult briefs or pads;

(v) cleaning changing of wet or soiled clothing; and

(vi) assisting with adjustment of clothing before and after toileting;

(5) Meal preparation and assistance: Meal preparation includes cutting ingredients to be cooked, cooking meals, placing and presenting the meal in front the member to eat, cutting up food into bite-sized portions for the member, or assisting the member as stated in his or her IPoC. This includes provision of snacks and fluids and may include mobility assistance and prompting or cueing the member to prepare meals.

(a) An attendant who resides in the same household as the member may not be paid for meal preparation routinely provided as part of the household division of chores, unless those services are specific to the member, such as special diets, processing of meals into edible portions, or pureeing.

(b) When two or more members are residing in the same residence, services and supports will be assessed both independently and jointly to determine the level and amount of service and support that is shared. Services and supports will be approved based on~~ly~~ common needs and not only the member's needs. If determined by the members' PCS agency that he or she needs individualized service or support the MCO will include the services or supports in the members IPoC.

(6) Eating: Feeding or assisting the member with eating a prepared meal using a utensil or specialized utensils is a covered service. Eating assistance may include mobility assistance and prompting or cueing a member to ensure appropriate nutritional intake and monitor for choking. If the member has special needs in this area, the PCS agency will include specific instruction in the members IPoC on how to meet those needs. Gastrostomy feeding and tube feeding are not covered services.

(7) Household support services: This service is for assisting and performing interior household activities and other support services that provide additional assistance to the member. Interior household activities are limited to the upkeep of the member's personal living areas to maintain a safe and clean environment for the member, particularly a member who may not have adequate support in his or her residence. Assistance may include mobility assistance and prompting and cueing a member to ensure appropriate household support services.

(a) An attendant who resides in the same household as the member may not be paid for household support services routinely provided as part of the household division of chores, unless those services are specific to the member such as, changing the member's linens, and cleaning the member's personal living areas.

(b) When two or more members are residing in the same residence, services and supports will be assessed both independently and jointly to determine the level and amount of service and support that is shared. Services and supports will be approved based on common needs and not on the member's needs. If determined by the members' PCS agency that he or she needs individualized service or support the MCO will include the services or supports in the members IPoC.

(c) Services include:

(i) sweeping, mopping, or vacuuming

(ii) dusting furniture;

(iii) changing linens;

(iv) washing laundry;

(v) cleaning bathrooms includes tubs, showers, sinks, and toilets;

(vi) cleaning the kitchen and dining area including washing dishes, putting them away; cleaning counter tops, and eating areas, etc.; household services do not include cleaning up after other household members or pets;

(vii) minor cleaning of an assistive device, wheelchair and durable medical equipment (DME) is a covered service. A member must have an assistive device requiring regular cleaning that cannot be performed by the member and is not cleaned regularly by the supplier of the assistive device to be eligible to receive services under this category;

(viii) shopping or completing errands specific to the member with or without the member;

(ix) cueing a member to feed and hydrating his or her documented personal assistance animal or feed and hydrate such an animal when the member is unable;

(x) assistance with battery replacement and minor, routine wheelchair and DME maintenance is a covered service; a member must have an assistive device that requires regular maintenance, that is not already provided by the supplier of the assistive device, and that the member cannot maintain in order

to be eligible to receive services under this category;

(xi) assisting a member self-administering: assistance with self-administering physician ordered (prescription) medications is limited to prompting and reminding only; the use of over the counter medications does not qualify for this service; a consumer must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for this task; a consumer who does not meet the definition of ability to self-administer is not eligible for this service; this assistance does not include administration of injections, which is a skilled/nursing task; splitting or crushing medications or filling medication boxes is not a covered service; assistance includes: getting a glass of water or other liquid as requested by the consumer for the purpose of taking medications; at the direction of the consumer, handing the consumer his or her daily medication box or medication bottle; and at the direction of the consumer, helping a consumer with placement of oxygen tubes for consumers who can communicate to the caregiver the dosage or route of oxygen; and

(xii) transportation of the consumer: transportation shall only be for non-medically necessary events and may include assistance with transfers in and out of vehicles; medically necessary transportation services may be a covered PCS service when the MCO has assessed and determined that other medically necessary transportation services are not available through other state plan services.

(8) Hygiene and grooming: The attendant may perform for the member or the attendant may cue and prompt the member to perform the following services:

(a) bathing to include giving a sponge bath in the member's bed, bathtub or shower; transferring in and out of the bathtub or shower, turning water on and off; selecting a comfortable water temperature; bringing in water from outside or heating water for the member;

(b) dressing to include putting on, fastening, removing, clothing including shoes;

(c) grooming to include combing or brushing hair, applying make-up, trimming beard or mustache, braiding hair, shaving under arms, legs or face;

(d) oral care for a member with intact swallowing reflex to include brushing teeth, cleaning dentures or partials including the use of floss, swabs, or mouthwash;

(e) nail care to include cleaning, filing to trim, or cuticle care for member's without a medical condition. For a documented medically at-risk member; nail care is not a covered under PCS; it is a skilled nurse service. Medically at risk conditions include, but are not limited to covenous insufficiency, diabetes, peripheral neuropathy;

(f) applying lotion or moisturizer to intact skin for routine skin care;

(g) physician ordered skin care: limited to the application of skin cream when a member has a documented chronic skin condition and is determined by his or her PCP unable to self administer the medication. The member's PCP must order a prescription or over-the-counter medication to treat the condition.

(i) When the PCP determines the member is able to self administer the prescribed or over-the-counter medication the attendant is limited to prompting and reminding the member.

(ii) PCS does not include the care of a member's wounds, open sores, debridement or dressing of open wounds.

(h) prompting or cueing to ensure appropriate bathing, dressing, grooming, oral care, nail care and application of lotion for routine skin care; and

(i) mobility assistance to ensure appropriate bathing, dressing, grooming, oral care and skin care

(9) Supportive mobility assistance: Physical or verbal prompting and cueing mobility assistance provided by the attendant that are not already included as part of other PCS includes assistance with:

(a) ambulation to include moving around inside or outside the member's residence or living area with or without an assistive device such as a walker, cane or wheelchair;

(b) transferring to include moving to and from one location or position to another with or without an assistive devices such as in and out of a vehicle;

(c) toileting to include transferring on or off a toilet; and

(d) repositioning to include turning or changing a bed-bound member's position to prevent skin breakdown.

(10) Non-covered services: The following services are not covered as PCS:

(a) services to an inpatient or resident of a hospital, NF, ICF-IID, mental health facility, correctional facility, or other institutional settings, with the exception when a member is transitioning from a NF;

(b) services that are already provided by other sources, including natural supports;

(c) household services, support services such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores;

(d) services provided by a person not meeting the requirements and qualifications of a personal care attendant; including but not limited to, training and criminal background checks;

(e) services not approved in the member's IPoC;

(f) childcare, pet care, or personal care for other household members. This does not include the member's documented assistant service animal;

(g) retroactive services;

(h) services provided to a individual who is not a MCO member or does not meet the eligibility criteria for CB services;

(i) member assistance with finances and budgeting;

(j) member appointment scheduling;

(k) member range of motion exercises;

(l) wound care of open sores and debridement or dressing of open wounds;

(m) filling of medication boxes, cutting or grinding pills, administration of injections, assistance with over-the-counter medication or medication that the member cannot self-administer;

(n) skilled nail care for a member documented as medically at-risk;

(o) medically necessary transportation when available through the member's MCO general benefit services;

(p) bowel and bladder services that include insertion or extraction of a catheter or digital stimulation; and

(q) gastrostomy feeding and tube feeding.

J. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home.

(1) Services include:

(a) medication management,

(b) administration and teaching;

(c) aspiration precautions;

(d) feeding tube management;

(e) gastrostomy and jejunostomy;

(f) skin care;

(g) weight management;

(h) urinary catheter management;

(i) bowel and bladder care;

(j) wound care;

(k) health education;

(l) health screening;

(m) infection control;

(n) environmental management for safety;

(o) nutrition management;

(p) oxygen management;

(q) seizure management and precautions;

(r) anxiety reduction;

(s) staff supervision; and

(t) behavior and self-care assistance.

(2) All services provided under a written physician's order and must be rendered by New Mexico board of nursing licensed RN or a licensed practical nurse

(LPN) who provides services within his or her scope of practice.

K. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's unpaid primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency.

(1) Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or NF, that meet the qualifications for MAD provider enrollment requirements. For purposes of ABCB eligibility, when respite services are delivered through an institutional provider, the member is not considered a resident of the institution.

(2) Respite care services include:

(a) medical and non-medical health care;

(b) personal care; bathing;

(c) showering; skin care;

(d) grooming;

(e) oral hygiene;

(f) bowel and bladder care;

(g) catheter and supra-pubic catheter care;

(h) preparing or assisting in preparation of meals and eating;

(i) administering enteral feedings;

(j) providing home management skills;

(k) changing linens;

(l) making beds;

(m) washing dishes;

(n) shopping; errands;

(o) calls for maintenance;

(p) assisting with enhancing self-help skills, such as promoting use of appropriate interpersonal communication skills and language, working independently without constant supervision or observation;

(q) providing body positioning, ambulation and transfer skills;

(r) arranging for transportation to medical or therapy services;

(s) assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and care coordinator; and

(t) ensuring the health and safety of the member at all times.

(3) Respite may be provided on either a planned or an unplanned basis and may be provided in a variety of settings. If unplanned respite is needed, the appropriate agency personnel will assess the situation, and with the caregiver, recommend the appropriate setting for respite services to the member. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the member.

(4) Respite services are limited to a maximum of 100 hours annually per care plan year provided there is an unpaid primary caretaker. Additional hours may be requested if a member's health and safety needs exceed the specified limit.

L. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general skilled therapy services are exhausted or not a covered MCO's benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships.

(1) Physical therapy services promote gross and fine motor skills, facilitate independent functioning and prevent progressive disabilities. Specific services may include but are not limited to:

(a) professional assessment, evaluation and monitoring for therapeutic purposes;

(b) physical therapy treatments and interventions;

(c) training regarding PT activities;

(d) use of equipment and technologies or any other aspect of the member's physical therapy services;

(e) designing, modifying or monitoring use of related environmental modifications;

(f) designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and

(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(2) Occupational therapy (OT) services promote fine motor skills, coordination, sensory integration, and facilitate the use of adaptive equipment or other assistive technology. Specific services may include but are not limited to:

(a) teaching of daily living skills;

(b) development of perceptual motor skills and sensory integrative functioning;

(c) design, fabrication, or modification of assistive technology or adaptive devices;

(d) provision of assistive technology services;

(e) design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;

(f) use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and

(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(3) Speech and language therapy (SLT) services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology; and prevent progressive disabilities. Specific services may include but are not limited to:

(a) identification of communicative or oropharyngeal disorders and delays in the development of communication skills;

(b) prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;

(c) development of eating or swallowing plans and monitoring their effectiveness;

(d) use of specifically designed equipment, tools, and exercises to enhance function;

(e) design, fabrication, or modification of assistive technology or adaptive devices;

(f) provision of assistive technology services;

(g) adaptation of the member's environment to meet his or her needs;

(h) training regarding SLT activities; and

(i) consulting or collaborating with other service providers or family enrollees as directed by the member.

(4) A signed therapy referral for treatment must be obtained from the member's PCP. The referral will include frequency, estimated duration of therapy and treatment, and procedures to be provided.

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

8.308.12.14 ABCB NON-COVERED SERVICES: MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. The member uses his or her MCO general benefits for non-ABCB services, and these services are not included in the ABCB care plan. See specific NMAC rules, sections of this rule, and the MAD MCO manual for additional information on service coverage and limitations.

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

8.308.12.15 SELF-DIRECTED COMMUNITY BENEFIT (SDCB): The MCO shall offer the SDCB approach to a member who meets a NF LOC and is determined through a comprehensive needs assessment or reassessment to need the community benefit (CB). Self-direction affords a member the opportunity to have choice and control over how his or her CB services are provided and who provides the services. Although a member's assessment for the amount and types of services may vary, SDCB services are not provided 24 hours per day. Services are reimbursed according to the MAD rate schedule that has a range of allowable reimbursement to a

provider of a specific service. The member's MCO approves the final reimbursement rate for each provider of a CB service. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.
[8.308.12.15 NMAC - N, 1-1-14]

8.308.12.16 ELIGIBLE PROVIDERS:

A. The FMA, member or his or her EOR shall verify that a potential provider meets all applicable qualifications prior to rendering a service. If a provider or employee is unable to pass a nationwide criminal history screening pursuant to NMSA 1978, 29-12-2 et seq. or is listed in the abuse registry as defined in NMSA 1978, 27-7a-1 et seq., that person may not be employed to render any service to the MCO's member. Following formal approval from the MCO, LRI (including parents of minors), who must provide care to the minor, may serve as a provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid his or her institutionalization. The MCO shall make decisions regarding legally responsible LRI serving as providers for members on a case by case basis. Following formal approval from the MCO, a spouse of a member may serve as a provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid institutionalization. The MCO shall provide such approval on a case by case basis.

B. An EOR shall have an employment or vendor agreement with each of the member's providers. The employee or vendor agreement template shall be prescribed by MAD. Prior to a payment being made to a provider for SDCB services, the FMA shall ensure that: the provider meets all qualifications; and an employee agreement or vendor agreement is signed between the EOR and the provider. A member's employment agreement shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Employment agreements shall be signed by the new EOR when there is a change in EORs. A copy of each employee agreement or vendor agreement shall be provided to the member and EOR. Refer to the MAD MCO manual for a complete listing of all SDCB provider qualifications and responsibilities.
[8.308.12.16 NMAC - N, 1-1-14]

8.308.12.17 ELIGIBLE MEMBERS: Enrollment in the SDCB is contingent upon the MCO member meeting the eligibility requirements as described in the NMAC managed care eligibility rules.
[8.308.12.17 NMAC - N, 1-1-14]

8.308.12.18 COVERED SERVICES IN SELF-DIRECTED COMMUNITY BENEFIT SDCB: MAD and the member's MCO cover certain procedures, services, and miscellaneous items. For those services that are the same in ABCB and SDCB, detailed descriptions are found in 8.308.12.13 NMAC, and the corresponding sections are referenced accordingly.

A. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment. See Subsection C of Section 13 of this rule for detail description of this service.

B. Customized community supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized community supports may include day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least 4 or more hours per day one or more days per week as specified in the member's care plan.

C. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. See Subsection E of Section 13 of this rule for detail description of this service.

D. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. See Subsection F of Section 13 of this rule for detail description of this service.

E. Environmental modification services include: the purchase of, the installation of equipment for the physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence. See Subsection G of Section 13 of this rule for detailed description of this service.

F. Home health aide services provide total care or assist the member in all ADL. See Subsection H of Section 13 of this rule for a detailed description of this service.

G. Homemaker services are provided on an episodic or continuing basis to assist the member with ADL, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the member to accomplish tasks he or she would normally do for him or herself if he or she did not have a disability.

(1) Homemaker services are provided in the member's home and in the community, depending on the member's needs. The member identifies the homemaker worker's training needs, and, if the member is unable to do the training him or herself, the member arranges for the needed training.

(2) Services are not intended to replace supports available from a primary caregiver. Homemaker services are not duplicative of home health aide services.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

(4) When two or more members are residing in the same residence, services and supports will be assessed both independently and jointly to determine the level and amount of service and support that is shared. Services and supports will be approved based on common needs and not on the member's needs. If determined by the members' MCO that he or she needs individualized service or support the MCO will include the services or supports in the members care plan.

H. Non-medical transportation services are offered to enable a member to gain access to services, activities, and resources, as specified by his or her care plan. Non-medical transportation services in the SDCB are offered in accordance with the member's care plan. Payment for SDCB non-medical transportation services is made to the member's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the member.

I. Nutritional counseling services include assessment of the member's nutritional needs, development and revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

J. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home. See Subsection J of Section 13 of this rule for a detailed description of this service.

K. Related goods are equipment, supplies or fees and memberships, not otherwise provided through the member's MCO general benefits.

(1) Related goods must address a need identified in the member's care plan including improving and maintaining the member's opportunities for full membership in the community, and meets the following requirements:

(a) be responsive to the member's qualifying condition or disability;

(b) accommodates the member in managing his or her household;

(c) facilitate the member's ADL;

(d) promotes the member's personal safety and health;

(e) affords the member an accommodation for greater independence;

(f) advances the desired outcomes in the member's care plan; and

(g) decreases the need for other medicaid services.

(2) Related goods will be carefully monitored by the member's MCO to avoid abuses or inappropriate use of this benefit.

L. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's unpaid primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. See Section 13 Subsection K of this rule for a detailed description of this service.

M. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general skilled therapy services are exhausted or not a covered MCO's benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships. See Subsection L of Section 13 of this rule for a detailed description of this service.

N. Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his or her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services.

(1) Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form, and function to restore and maintain physical health and increased mental clarity to a member. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits to the member.

(2) Biofeedback uses visual, auditory or other monitors to feed back physiological information of which the member is normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order for the member to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating the member's pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(3) Chiropractic care for a member is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, the adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health of the member.

(4) Cognitive rehabilitation therapy services for a member are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of ADL. The overall goal is to restore the member's function in a cognitive domain or set of domains, or to teach compensatory strategies to overcome specific cognitive problems.

(5) Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for a member with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. A member with attention deficits and behavior problems is redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production of the member.

(6) Massage therapy for a member is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

(7) Naprapathy focuses, for a member, on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function for a member.

(8) A native American healer is an individual who is recognized as a healer within his or her respective native American community. A native American member may be from one of the 22 sovereign tribes, nations and pueblos in New Mexico or may be from other tribal backgrounds. A native American healer delivers a wide variety of culturally-appropriate therapies that support the member by addressing the member's physical, emotional and spiritual health. Treatments delivered by a native

American healer may include prayer, dance, ceremony and song, plant medicines and foods; participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects. A native American healer provides opportunities for the member to remain connected with his or her tribal community. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some tribes, nations and pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties. [8.308.12.18 NMAC - N, 1-1-14]

8.308.12.19 SDCB NON-COVERED SERVICES: MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. The member uses his or her MCO general benefits for non-SBCB services, and these services are not included in the SBCB care plan. Services and goods that are not covered by the SDCB program include, but are not limited to the following:

A. services covered by third-parties; the SDCB program is the payer of last resort;

B. any service or good, the provision of which would violate federal or state statutes, rules or guidance; this includes services that are considered primarily recreational or diversional, which are not deemed eligible SDCB services by CMS;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the division of vocational rehabilitation (DVR);

D. room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;

F. any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;

G. any goods or services that are to be used for recreational or diversional purposes;

H. personal goods or items not related to the SDCB member's condition or disability;

I. purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

J. gas cards and gift cards; items that are purchased with SDCB program funds may not be returned for cash or gift cards;

K. purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies. This includes purchase of cell phone insurance;

L. purchase of a vehicle, and long-term lease or rental of a vehicle;

M. purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;

N. firearms, ammunition or any other type of weapons;

O. gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

P. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses; this also includes mileage or driver time reimbursement for vacation travel by automobile;

Q. purchase of usual and customary furniture and home furnishings, unless adapted to the SDCB member's disability or use, or of specialized benefit to the SDCB member's condition; requests for adapted or specialized furniture or furnishings must include a doctor's order from the member's health care provider and, when appropriate, a denial of payment from any other source;

R. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the SDCB member's qualifying condition or disability;

S. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member's qualifying condition or disability; requests must include documentation that the adapted vehicle is the SDCB member's primary means of transportation;

T. clothing and accessories, except specialized clothing based on the SDCB member's disability or condition;

U. training expenses for paid employees;

V. conference or class fees may be covered for SDCB members or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging or meals;

W. for consumer electronics such as computers, printers and fax machines, or other electronic equipment, no more than one of each type of item may be purchased at one time, and consumer electronics may not be replaced more frequently than once every three years; laptops or any electronic tablets are considered computers;

X. cell phone services that include fees for data (to include GPS) or more than one cell phone per SDCB member. SDCB may cover the cost of text messaging if it is documented and determined that the need for texting is related to the SDCB member's disability; and

Y. moving expenses to include, but limited to, the cost of moving truck rental, gas/mileage, labor, moving equipment, supplies, boxes, tape and moving blankets.

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

8.308.12.20 TRANSITION TO THE SELF-DIRECTED COMMUNITY BENEFIT: A member who meets a NF LOC and who qualifies for MCO CB must first access services through his or her MCO's ABCB approach. After 120 calendar days, the member may continue his or her CB services provided through the MCO's ABCB or may now select the MCO's SDCB approach. The member's MCO shall obtain a signed statement from the member regarding his or her decision to participate in the SDCB approach. The signed statement will include member attestation that he or she understands the responsibilities of self directing his or her CB services, including the management of his or her care plan. For a member transitioning from a NF: and the member continues to meet NF LOC; the member selects his or her MCO's SDCB approach; the member must access CB services through the MCO's ABCB approach for the first 120 calendar days of eligibility; and after 120 calendar days, the member may transition to the MCO's SDCB.

A. Self-assessment: The member's care coordinator shall provide him or her with the MAD self-assessment instrument. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator upon request. The care coordinator shall file the completed self-assessment in the member's file.

B. Employer of record (EOR): A member who is an unemancipated minor or has a plenary or limited guardianship or conservatorship over financial matters in place cannot serve as his or her own EOR. When the member's care coordinator, based on the results of the self-assessment, determines the member requires assistance to direct his or her SDCB services, the member must designate an EOR to assume the functions on behalf of the member. A member that serves as his or her EOR has

the option to do so or may, on his or her own, designate a person to serve as his or her EOR. A designated EOR may not also be an employee of the member. The member's file must have documentation of either the member acting as his or her EOR or of the designated EOR. The member's MCO will make the final determination on whether the member may be his or her own EOR.

C. Supports for self-direction: A member or his or her authorized agent may designate a person to provide support to the member's self-directed functions. The member or his or her authorized agent may act as his or her EOR. A member's authorized agent may function as the member's authorized representative. The member's care coordinator shall include a copy of any EOR or authorized representative forms in the member's file and provide copies to the member, the member's authorized agent, authorized representative and the FMA.

(1) Care coordination for self-direction: The MCO shall ensure that the member or the member's authorized agent fully participate in developing and administering SDCB services and that sufficient supports, such as care coordinators and support brokers, are made available to assist the member or the member's authorized agent who request or require assistance. In this capacity, the care coordinator shall fulfill, in addition to contractual requirement, the following tasks:

(a) understand member and EOR roles and responsibilities;

(b) identify resources outside the member's MCO SDCB, including natural and informal supports, that may assist in meeting the member's long term care needs;

(c) understand the array of the SDCB services;

(d) assign the annual budget for the SDCB based on the CNA to address the needs of the member;

(e) monitor utilization of SDCB services on a regular basis;

(f) conduct employer-related activities such as assisting a member in identifying a designated EOR as appropriate;

(g) identify and resolve issues related to the implementation of the member's SDCB care plan;

(h) assist the member with quality assurance activities to ensure implementation of the member's SDCB care plan and utilization of his or her authorized budget;

(i) recognize and report critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;

(j) monitor quality of services provided by the member's support broker; and

(k) work with the member to provide the necessary assistance for successful SDCB program implementation.

(2) A support broker is a qualified vendor for a SDCB member who is either employed by or contracted by the member's MCO. At a minimum, the support broker shall perform the following functions:

(a) educate the member on how to use self-directed supports and services and provide information on program changes or updates;

(b) review, monitor and document progress of the member's SDCB care plan;

(c) assist in managing budget expenditures, complete and submit SDCB care plan and budget revisions;

(d) assist with employer functions such as recruiting, hiring and supervising SDCB providers;

(e) assist with approving and processing job descriptions for SDCB direct supports;

(f) assist with completing forms related to the member's employees;

(g) assist with approving timesheets , purchase orders or invoices for goods, obtain quotes for services and goods, as well as identify and negotiate with vendors;

(h) assist with problem solving of an employee or vendor payment issue with the FMA and other appropriate parties;

(i) facilitate resolution of any disputes regarding payment to a provider for services rendered;

(j) develop the care plan for SDCB, based on the budget amount; and

(k) assist in completing all documentation required by the FMA.

(3) FMA acts as the intermediary between the member and the member's MCO payment system and assists the member or the member's EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved SDCB care plan and budget. The FMA assures member and program compliance with state and federal employment requirements, monitors, and makes available to the member and MAD reports related to utilization of services and budget expenditures. Based on the member's approved individual care plan and budget, the FMA must:

(a) verify that the member is eligible for SDCB services prior to making payment for services;

(b) receive and verify that all required employee and vendor documentation and qualifications are in compliance with the NMAC SBCB rules and the MAD MCO manual;

(c) establish an accounting for each member's budget;

(d) process and pay invoices for goods, services, and supports approved in the member's SDCB care plan and supported by required documentation; and

(e) process all payroll functions on behalf of the member and EOR including:

(i) collects and processes timesheets of employees in accordance with the MAD approved payment schedule;

(ii) processes payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance;

(iii) tracks and reports disbursements and balances of the member's budget and provides a monthly report of expenditures and budget status to the member and his or her support broker, and quarterly and annual documentation of expenditures to MAD;

(iv) receives and verifies a provider's agreement, including collecting required provider qualifications;

(v) monitors hours billed for services provided and the total amounts billed for all goods and services during the month;

(vi) answers inquiries from the SDCB member and solves problems related to the FMA's responsibilities; and

(vii) reports any concerns related to the health and safety of the member or when the member is not following his or her approved SDCB care plan to the MCO and MAD as appropriate.

D. Budget: The member's MCO will determine the maximum annual budget allotment based on the member's CNA. The member may request a revision to the SDCB care plan and budget when a change in circumstances warrants such revisions, such as a change in health condition or loss of natural supports. All changes are subject to assessment and approval by the MCO.

E. SDCB care plan: The support broker and the member shall work together to develop an annual SDCB care plan for the SDCB services the member is identified to need as a result of his or her CNA. The SDCB care plan will not exceed the MCO determined budget. The support broker and member shall refer to the rates specified by HSD in selecting payment rates for qualified providers and vendors. The care plan for SDCB services shall be based upon the member's assessed needs and approved by the member's MCO. The support broker shall closely monitor the utilization of SDCB care plan services to ensure that the member does not exceed the approved annual budget.

(1) SDCB care plan review criteria: Services and goods identified in the member's requested SDCB care plan may be considered for approval by the MCO if all of the following requirements are met:

(a) the services or goods must be responsive to the member's qualifying condition or disability;

(b) the services or goods must

address the member's clinical, functional, medical or habilitative needs;

(c) the services or goods must facilitate ADL per the CNA;

(d) the services or goods must promote the member's personal health and safety;

(e) the services or goods must afford the member an accommodation for greater independence;

(f) the services or goods must support the member to remain in the community and reduce his or her risk for institutionalization;

(g) the need for the services or goods must be approved and documented in the CNA and advance the desired outcomes in the member's care plan;

(h) the services or goods are not available through another source;

(i) the service or good is not prohibited by federal regulations, state rules and instructions;

(j) the proposed rate for each service is the MAD approved rate for that chosen service;

(k) the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and

(l) the estimated cost of the service or good is specifically documented in the member's budget.

(2) SDCB care plan revisions: The SDCB care plan may be modified based upon a change in the member's needs or circumstances, such as a change in the member's health status or condition or a change in the eligible member's support system, such as the death or disabling condition of a family or other individual who was providing services. The member is responsible for assuring that all expenditures are in compliance with the most current determination of need. SDCB care plan revisions involve requests to add new goods or services to a care plan or to reallocate funds from any line item to another approved line item. SDCB care plan revisions must be submitted to the member's MCO for review and determination. Other than for critical health and safety reasons, SDCB care plan revisions may not be submitted to the MCO for review within the last 60 calendar days of the care plan year. Prior to submitting a SDCB care plan revision request, the member is responsible for communicating any utilization of services that are not in compliance with the care plan to the support broker. At the MCO's discretion, a revision to the SDCB care plan may require another CNA. If the SDCB care plan revision includes a request for additional services, another CNA must be performed by the MCO to determine whether the change in circumstance or need warrants additional funding for additional services prior to approval.

F. SDCB back-up plan: The support broker shall assist the member and his or her EOR in developing a back-up plan for the SDCB that adequately indentifies how the member and EOR will address situations when a scheduled provider is not available or fails to show up as scheduled. The member's support broker shall assess the adequacy of the member's back-up plan at least on an annual basis and when changes in the type, amount, duration, scope of the SDCB or the schedule of needed services, or a change of providers (when such providers also serve as back-up to other providers) or change in availability of paid or unpaid back-up providers to deliver needed care.

G. Member and EOR training: The member's MCOs shall require the member electing to enroll in the SDCB approach and his or her EORs to receive relevant training. The support broker shall be responsible for arranging for initial and ongoing training of the member and his or her EORs.

(1) At a minimum, self-direction training for member and his or her EOR shall address the following issues:

(a) understanding the role of the member and EOR with SDCB;

(b) understanding the role of the care coordinator, support broker, the MCO, and the FMA;

(c) selecting providers and vendors;

(d) critical incident reporting;

(e) member abuse and neglect prevention and reporting;

(f) being an employer, evaluating provider performance and managing providers;

(g) fraud and abuse prevention and reporting;

(h) performing administrative tasks, such as, reviewing and approving electronically captured visit information and timesheets and invoices; and

(i) scheduling providers and back-up planning.

(2) The member's MCO shall arrange for ongoing training for the member and his or her EOR upon request or if a support broker, through monitoring, determines that additional training is warranted.

H. Claims submission and payment: The member or EOR shall review and approve timesheets of his or her providers and invoices from his or her vendors to determine accuracy and appropriateness. No SDCB provider shall exceed 40 hours paid work in one work week per EOR. Timesheets must be submitted and processed on a two-week pay schedule according to the FMA's prescribed payroll payment schedule. The FMA shall be responsible for processing the member's payments for approved services and goods.

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

8.308.12.21 TERMINATION FROM SDCB: The MCO may involuntarily terminate a member from the self-directed community benefit under any of the following circumstances:

A. The member or his or her EOR refuses to follow NMAC rules and his or her MCO policies after receiving focused technical assistance on multiple occasions and support from his or her care coordinator or FMA, which is supported by documentation of the efforts to assist the member. For purposes of this rule, focused technical assistance is defined as a minimum of three separate occasions where the member or his or her EOR have received training, education or technical assistance, or a combination of both, from the MCO, the FMA or MAD.

B. There is an immediate risk to the member's health or safety by continued self-direction of services, i.e., the member is in imminent risk of death or serious bodily injury. Examples include but are not limited to the following:

(1) the member refuses to include and maintain services in his or her care plan that would address health and safety issues identified in his or her comprehensive needs assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, the care coordinator or the FMA;

(2) the member is experiencing significant health or safety needs and, refuses to incorporate the care coordinator's recommendations into his or her care plan, or exhibits behaviors that endanger him or her or others;

(3) the member misuses his or her SDCB budget following repeated and focused technical assistance and support from the care coordinator and the FMA, which is supported by documentation;

(4) the member expends his or her entire SDCB budget prior to the end of the care plan year; or

(5) the member or authorized agent intentionally misuses his or her SDCB services or goods.

C. The MCOs shall submit to MAD any requests to terminate a member from the SDCB approach with sufficient documentation regarding the rationale for termination. Upon MAD approval, the MCO shall notify the member regarding termination in accordance with NMAC rules and MCO policies. The member shall have the right to appeal the determination by requesting an internal MCO appeal and, if the termination is still upheld by the MCO, an HSD administrative hearing. The MCO shall facilitate a seamless transition from the SDCB to ABCB approach to ensure there are no interruptions or gaps in services.

Involuntary termination of a member from SDCB shall not affect a member's eligibility for covered services or continued MCO membership.

D. A member who has voluntarily switched to ABCB or who has been involuntarily terminated from SDCB may request to be reinstated in the SDCB to his or her MCO. Such requests may not be made more than once in a calendar year. The member's SDCB reinstatement for members involuntarily terminated is at the discretion of his or her MCO. The care coordinator shall work with the member's FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to such reinstatement. All members shall be required to participate in SDCB training programs prior to his or her SDCB reinstatement.
[8.308.12.21 NMAC - N, 1-1-14]

HISTORY OF 8.308.12 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 13 MEMBER REWARDS

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

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

8.308.13.3 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.
[8.308.13.3 NMAC - N, 1-1-14]

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

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

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

8.308.13.7 DEFINITIONS: [RESERVED]

8.308.13.8 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.
[8.308.13.8 NMAC - N, 1-1-14]

8.308.13.9 ELIGIBLE MEMBERS: A member of an HSD contracted managed care organization (MCO) is eligible to participate in his or her MCO's member rewards program.

A. For a native American member who elects to opt out of receiving medical assistance division (MAD) services through a HSD contracted MCO, and retains medical assistance programs (MAP) eligibility, he or she no longer will earn reward credits as of the last day of enrollment in his or her MCO.

B. Upon losing eligibility for continued enrollment in a HSD contracted MCO, the individual no longer will earn member reward credits.
[8.308.13.9 NMAC - N, 1-1-14]

8.308.13.10 REWARD CREDITS: A member may earn reward credits when engaging in healthy behaviors included in the member rewards program. Reward credits are determined for specific member healthy behaviors. Details on the requirements to earn a healthy behavior reward credit are made available to a member on MAD's website and provided in writing to a member through his or her MCO.

A. **Maximum amount of a member's reward credit balance:** A member must use credits earned during the calendar year by the end of the following calendar year. Any credits that are not used by the end of the following calendar year in which they are earned are lost.

B. **Portability of reward credits:** A member may carry his or her reward credits when transitioning from one HSD contracted MCO to another HSD contracted MCO. When a member earns reward credits for a specific healthy behavior, he or she may not earn reward credits for the same healthy behavior within the same calendar year with his or her new MCO.

C. **Retention of reward credits:** A member's reward credit balance will be accessible for the member's use up to 365 days after he or she loses MAP eligibility. For a native American who was a member of a HSD contracted MCO, and later opts in to fee-for-service (FFS) administration of benefits, the previously earned MCO reward credits are accessible up to 365 days after the close of his or her HSD contracted MCO membership.

D. Reward credit disputes: If a member believes there is a discrepancy in the way his or her HSD contracted MCO has determined a reward credit or balance, the member shall contact his or her MCO for resolution.
[8.308.13.10 NMAC - N, 1-1-14]

HISTORY OF 8.308.13 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

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 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 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 is exempt from the copayments; see Subsection B of Section 10 of 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 month. 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 has reached the co-payment cap (five percent of the eligible recipient's family's income, calculated on a monthly 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 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.

(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]

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]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 20 REIMBURSEMENT

8.308.20.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.20.2 SCOPE: This rule applies to the general public.

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

8.308.20.3 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.

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

8.308.20.4 DURATION: Permanent.

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

8.308.20.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.20.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

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

8.308.20.7 DEFINITIONS: [RESERVED]

8.308.20.8 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.

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

8.308.20.9 REIMBURSEMENT FOR MANAGED CARE:

A. **Payment for services:** HSD shall make actuarially sound payments, in accordance with 42 C.F.R. 438.6(c), for the provision of the managed care medicaid benefit package, under capitated risk contracts to the designated managed care organizations (MCOs)**.** Rates whether set by HSD or negotiated between HSD and the MCO are confidential.

(1) At the sole discretion of HSD, rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. Rates may be adjusted based on factors, including but not limited to, changes in the scope of work; CMS requiring a modification of the 1115(a) waiver; new or amended federal or state statutes, regulations or rules; inflation; significant changes in the demographic characteristics of the member population; or the disproportionate enrollment selection of the MCO by members in certain rate cohorts.

(2) The MCO shall be responsible for the provision of services for members during the month of capitation. A medicaid eligible recipient shall not be liable for debts or costs incurred by an MCO under the MCO's managed care contract for providing health care to him or her. This includes but is not limited to:

(a) the MCO's debts in the event of its insolvency;

(b) services provided to the member that are not included in the medicaid benefit package and for which HSD does not pay the MCO, e.g., value added services;

(c) instances when the MCO does not pay the health care provider who furnishes the services under contractual, referral, or other arrangement;

(d) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly; and

(e) if a MCO member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO shall accept a retroactive capitation payment for that month of eligibility and assume financial responsibility for all medically-necessary covered benefit services supplied to the member.

(3) Retroactive capitation payments may not be issued for a member for the same coverage month in which fee-for-service claims have already been paid by HSD except in special situations determined by HSD.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the MCO for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO shall accept the capitation rate paid each month by HSD as payment in full for all services including all administrative costs associated therewith, including gross receipts tax payable to the provider. The MCO is at risk of incurring losses if the cost of providing the managed care medicaid benefit package exceeds its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO to reflect the actual cost of services furnished by the MCO.

C. **Capitation recoupments:** HSD shall have the discretion to recoup capitations or payments as provided for in its contract with the MCO.

(1) Instances when HSD shall recoup payments for members include, but are not limited to:

(a) member incorrectly enrolled with more than one MCO;

(b) member who dies prior to the enrollment month for which payment was made; or

(c) member who HSD later determines was not eligible for medicaid during the enrollment month, including retroactive months for which payment was made.

(2) HSD acknowledges and agrees that in the event of any recoupment pursuant to this rule, the MCO shall have the right to recoup from a provider or another person to whom the MCO has made payment during this period of time; however, may not recoup payments for any value added services provided. Recouped payments to a provider is subject to the time periods governed by the MCO provider agreement.

(3) Any duplicate payment identified by either the MCO or HSD shall be recouped upon identification.

(4) The MCO has the right to dispute any recoupment action in accordance with contractual provisions.

D. **Patient liability:** HSD monthly capitation payments will be net of patient liability. The capitation payments are developed on "gross" cost and will be reduced by the amount of average patient

member responsibility each month. The MCO shall delegate the collection of patient member liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient member liability amount. The MCO shall submit patient member liability information associated with claim payments in their encounter data submissions.

E. **Payment time frames:** A clean claim shall be paid by the MCO to contracted and non-contracted providers according to the following timeframe: a) 90 percent within 30 calendar days of the date of receipt and b) 99 percent within 90 calendar days of the date of receipt, as required by federal guidelines in the code of federal regulations Section 42 CFR 447.45. The date of receipt is the date the MCO first receives the claim either manually or electronically. The MCO is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this requirement may be made if the MCO and its providers by mutual agreement establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the MCO. The MCO shall be financially responsible for paying all claims for all covered, emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the medicaid fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

(2) No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

F. **Special payment requirements:** This section lists special payment requirements by provider type.

(1) Reimbursement to a federally qualified health center (FQHC) and a rural health clinic (RHC): a contracted and non-contracted FQHC or RHC shall be reimbursed at a minimum of the prospective payment system (PPS) as determined by HSD or its designee or an alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act, as established by HSD.

(2) Reimbursement to Indian health service (IHS), tribal health providers, and urban Indian providers authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

(a) The MCO shall reimburse IHS and tribal compact contracted and non-contracted provider as identified by HSD, at a minimum of 100 percent of the rate established for an IHS facility or federally-leased facility by the office of management and budget (OMB). For services designated by HSD to be paid at fee schedule rates rather than OMB rates, the MCO shall reimburse the IHS or tribal contract provider at not less than the MAD fee schedule rate.

(b) IHS facilities, tribal health providers and urban Indian providers shall have up to two years from a claim's first date of service to submit a claim; claims not submitted within two years of the first date of service are not eligible for reimbursement.

(c) With the exception of residential treatment center services, services provided by IHS or a tribal 638 facility is not subject to prior authorization.

(3) Reimbursement for family planning services: the MCOs shall reimburse an out-of-network family planning provider for services provided to a MCO member at a rate that is at least equal to the MAD fee-schedule rate for the provider type.

(4) Reimbursement for a woman in her second or third trimester of pregnancy: If a woman is in the second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prental care provider (whether a contracted or non-contracted provider) through the two month postpartum period without any form of prior approval.

(5) Reimbursement for a MCO member who disenrolls transitions while hospitalized: If an eligible recipient is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health (DOH). The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the receiving MCO receiving capitation payments. The relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from the MCO.
[8.308.20.9 NMAC - N, 1-1-14]

HISTORY OF 8.308.20 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 21 QUALITY MANAGEMENT

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

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

8.308.21.3 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.
[8.308.21.3 NMAC - N, 1-1-14]

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

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

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

8.308.21.7 DEFINITIONS:

[RESERVED]

8.308.21.8 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.
[8.308.21.8 NMAC - N, 1-1-14]

8.308.21.9 QUALITY MANAGEMENT: A HSD managed care organization (MCO) quality management program includes a philosophy, a method of management, and a structured system designed to improve the quality of services; includes both quality assurance and quality improvement activities; and is incorporated into the health care delivery and administrative systems.

A. Quality management (QM) program structure: The MCO shall have QM structure and processes as detailed in the HSD managed care policy manual.

B. QM program description: The MCO shall develop a written QM and a quality improvement (QI) program description that includes the requirements described in the HSD managed care policy manual.

C. QM and QI program principles: The MCO QM and QI programs are based on principles of continuous quality improvement (CQI) and total quality management (TQM). Such an approach will:

(1) recognize clinical and non-clinical opportunities are unlimited;

(2) be data driven;

(3) use real-time input from members and MCO contracted providers to develop CQI activities; and

(4) require on-going measurement of effectiveness and improvement.

D. QM program evaluation: The MCO will have a written QM and QI program evaluation as described in the MAD policy manual.
[8.308.21.9 NMAC - N, 1-1-14]

8.308.21.10 DISEASE MANAGEMENT: The MCO will have a disease management program as described in the HSD managed care policy manual.
[8.308.21.10 NMAC - N, 1-1-14]

8.308.21.11 CLINICAL PRACTICE GUIDELINES: As described in the HSD managed care policy manual, the MCO will have a process to adopt, review, update and disseminate evidence-based clinical practice guidelines, practice parameters, consensus statements, and specific criteria for the provision of acute and chronic physical and behavioral health care services.
[8.308.21.11 NMAC - N, 1-1-14]

8.308.21.12 PERFORMANCE IMPROVEMENT: The MCO will implement performance assessment and improvement activities as described in the HSD managed care policy manual.
[8.308.21.12 NMAC - N, 1-1-14]

8.308.21.13 INCIDENT MANAGEMENT: Critical incident reporting and management is considered part of ongoing quality management. Critical incident reporting and analysis of critical incident data helps to identify causes of adverse events in critical care and areas of focus for implementation of preventative strategies.

A. MCO incident management principles: The implementation of incident management practices and effective incident reporting processes are based on the following MAD MCO principles:

(1) a member is expected to receive home and community based services free of abuse, neglect, and exploitation;

(2) training addresses the response to and the report of to include the documentation of a critical incident;

(3) a member, his or her authorized representative will receive information on his or her MCO incident reporting process; and

(4) good faith incident reporting of or the allegation of abuse, neglect or exploitation is free from any form of retaliation.

B. Reportable incidents:

(1) The MCO shall ensure that any person having reasonable cause to believe an incapacitated adult member is being abused, neglected, or exploited must immediately report that information.

(2) The MCO shall develop and provide training covering the MCO's procedures for reporting a critical incident to all subcontracted individual providers, provider agencies, and its members who are receiving self-directed services, to include his or her employees.

(3) The MCO shall comply with all statewide reporting requirements for any incident involving a member receiving a MAD covered home and community based service.

(4) A community agency providing home and community based services is required to report critical incident involving a MCO member, including:

(a) the abuse of him or her;

(b) the neglect of him or her;

(c) the exploitation of him or her;

(d) any incident involving his or her utilization of emergency services;

(e) the hospitalization of him or her;

(f) his or her involvement with law enforcement;

(g) his or her exposure to or the potential of exposure to environmental hazards that compromise his or her health and safety; and

(h) the death of the member.

(5) The MCO shall provide , coordinate, or both, intervention and shall follow up upon the receipt of an incident report that demonstrates the health and safety of its member is in jeopardy.
[8.308.21.13 NMAC - N, 1-1-14]

8.308.21.14 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO): An EQRO will conduct external, independent reviews of the MCO.

A. The MCO shall fully cooperate with the following mandatory EQRO activities, such as:

(1) the validation of required performance improvement projects (PIP);

(2) the validation of plan performance measures reported by the MCO; and

(3) a review to determine the plan's compliance with state standards for access to care, structure and operations, and QM and QI requirements.

B. The MCO shall fully cooperate with the following EQRO optional activities:

(1) the validation of encounter data reported by the plan;

(2) the administration and the validation of member and provider surveys on the quality of care;

(3) the calculation of additional performance measures;

(4) conducting additional PIPs validations;

(5) conducting studies on quality focused on a particular aspect of clinical or nonclinical services at a specific point in time; and

(6) all other optional activities as deemed appropriate by the EQRO.
[8.308.21.14 NMAC - N, 1-1-14]

8.308.21.15 QUALITY MANAGEMENT COMMITTEE: The MCO must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to its members. A QM committee will provide oversight to quality monitoring and improvement activities, including safety review and the assignment of accountability.

A. **Quality review:**

(1) The MCO shall establish a review committee to act as the leadership body for QI activities. The review committee acts to identify and facilitate the accomplishment of a planned, systematic, valid, and valuable QM plan for members and its providers.

(2) The review committee will

monitor key services delivered to members and associated supportive processes to include:

(a) the utilization of services;

(b) its member satisfaction;

(c) its clinical services, including disease management; and

(d) its administrative services.

(3) The review committee is authorized to take action upon issues related to member care and make recommendations related to contracts, compensation, and provider participation.

B. **Critical incident review:**

(1) The MCO shall establish a review committee to review events that result in a serious and undesired consequence; events that are not a result of an underlying health condition or from a risk inherent in providing health services, including:

(a) death;

(b) disability; and

(c) injury or harm to the member.

(2) The committee is authorized to make recommendations for the prevention from future harm of its members, as well as its system process improvement.

C. **Oversight:** The MCO will provide HSD with reports and records to ensure compliance with quality review and critical incident review requirements.

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

8.308.21.16 MEDICAL RECORDS: The member's medical records shall be legible, timely, current, detailed and organized to permit effective and confidential patient care and quality reviews.

A. The MCO shall have medical record confidentiality policies and procedures and medical record documentation standards for its providers and subcontractors.

B. The MCO shall have:

(1) a process to review medical records to ensure compliance with MCO policy, procedures and standards; and

(2) shall cooperate with the EQRO in its review of medical records to ensure compliance with its medical record policy and standards.

C. The MCO shall:

(1) provide HSD or its designee access to a member's medical and behavioral health records;

(2) include provisions in contracts with providers for MCO and HSD or its designee, access to member medical records for the purposes of compliance or quality review;

(3) ensure that the assigned primary care provider (PCP), the patient centered medical home or the patient centered health home maintain a primary medical and as appropriate, behavioral health record for each member; this record must contain sufficient information from each provider involved in the member's care to ensure continuity of care;

(4) ensure all providers involved in the member's care have access to the primary medical record; and

(5) have policies and processes that ensure the confidential transfer of medical and behavioral health information between its providers, its agencies or other health plans.

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

8.308.21.17 UTILIZATION MANAGMENT: A utilization management (UM) program is an organization-wide, interdisciplinary approach of evaluating the medical necessity, appropriateness, and efficiency of health care services. The MCO shall have an UM program as described in the HSD managed care policy manual.

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

8.308.21.18 ADVISORY BOARDS: Advisory boards are federally mandated bodies that provide ongoing venues for discussions of policy, operations, service delivery and administrative issues for its members. The MCO will convene and facilitate an advisory board of its members and a native American advisory board in accordance with the requirements described in the HSD managed care policy manual.

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

8.308.21.19 SATISFACTION SURVEYS: For the MCO to maintain a comprehensive system of health care that supports quality, as well as cost-effectiveness depends largely on the satisfaction and cooperation of its members and its providers. The MCO will regularly survey these groups following the requirements described in the HSD managed care policy manual.

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

HISTORY OF 8.308.21 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 22 FRAUD, WASTE AND ABUSE

8.308.22.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.308.22.2 SCOPE: This rule applies to the general public.

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

8.308.22.3 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.

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

8.308.22.4 DURATION: Permanent.

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

8.308.22.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.308.22.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

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

8.308.22.7 DEFINITIONS:

A. "Abuse" is provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in unnecessary costs to the medicaid program, or in reimbursement of services that fail to meet professionally recognized standards for health care.

B. "Credible allegation of fraud" means an allegation, which has been verified by the state, from any source, including but not limited to the following:

(1) fraud hotline complaint;

(2) claims data mining;

(3) patterns identified through provider audits;

(4) civil false claims cases; or

(5) law enforcement investigations; see 42 CFR 455.2.

C. "Fraud" means an intentional deception or misrepresentation by a person or an entity, with knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state statutes, regulations and rules.

D. "MFEAD" is the medicaid fraud and elder abuse division of the New Mexico attorney general's office

E. "Overpayment" means any funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

F. "Provider" means a network provider and non-network provider.

G. "Recovery" means money received by HSD or MFEAD for fraud or credible allegations of fraud from a provider.

H. "Refund" means money returned by a provider for overpayment(s).

I. "Waste" is the overutilization of services or other practices that result in unnecessary costs.

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

8.308.22.8 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.

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

8.308.22.9 FRAUD, WASTE AND ABUSE: HSD is committed to aggressive prevention, detection, monitoring, and investigation to reduce provider or member fraud, waste and abuse. This rule applies to all individuals and entities participating in or contracting with HSD or a MCO for provision or receipt of medicaid services. If fraud, waste or abuse is discovered, HSD shall seek all remedies available to it under federal and state statutes, regulations, rules.

A. Program integrity requirements: the MCO shall have a comprehensive internal program integrity and overpayment prevention program to prevent, detect, preliminarily investigate and report potential and actual program violations including detecting potential overutilization of services, drugs, medical supply items and equipment. The MCO shall:

(1) be responsible for preventing and identifying overpayments or improper payments made to its providers;

(2) have specific internal controls for prevention, such as claim edits, prepayment and post-payment reviews, and provider profiling; and

(3) verify that services are actually provided utilizing "explanation of medicaid benefits" (EOB) notices and performing audits, reviews, and preliminary investigations.

B. Investigations and referrals: The MCO shall perform preliminary investigations of alleged fraud. The MCO shall:

(1) after conducting its preliminary investigation, submit to HSD for review all facts, supporting documentation and evidence of alleged fraud;

(2) upon request from MFEAD, release its preliminary investigation, including all supporting documentation and evidence to MFEAD and cease its investigation until otherwise advised by HSD or MFEAD;

(3) upon receipt of notification by HSD, and as directed, impose a suspension of payments to providers pending investigations of credible allegations of fraud and non release the payment suspension until notified in writing by HSD.

C. Overpayments: Are funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

(1) An overpayment shall be deemed to have been identified by a provider when:

(a) the provider reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursements;

(b) the provider learns that a recipient's death occurred prior to the service date on which a claim that has been submitted for payment;

(c) the provider learns that services were provided by an unlicensed or excluded individual on its behalf;

(d) the provider performs an internal audit and discovers that an overpayment exists;

(e) the provider is informed by a governmental agency or its designee of an audit that discovered a potential overpayment;

(f) the provider is informed by the MCO of an audit that discovered a potential overpayment;

(g) the provider experiences a significant increase in medicaid revenue and there is no apparent reason for the increase, such as a new partner added to a group practice or new focus on a particular area of medicine;

(h) the provider has been notified that the MCO or a governmental agency or its designee has received a hotline call or email; or

(i) the provider has been notified that the MCO or a governmental agency or its designee has received information alleging that a member had not received services or been supplied goods for which the provider submitted a claim for payment.

(2) The MCO shall require its contracted providers to report to their MCO by the later of:

(a) the date which is 60 calendar days after the date on which the overpayment was identified; or

(b) the date any corresponding cost report is due, if applicable;

(3) The MCO shall require its providers to complete a self-report of the overpayment within 60 calendar days from the date on which the provider identifies an overpayment and require that the provider send an "overpayment report" to the MCO and HSD which includes:

(a) the provider's name;

(b) the provider's tax identification number and national provider number;

(c) how the overpayment was discovered;

(d) the reason(s) for the overpayment;

(e) the health insurance claim number, as appropriate;

(f) the date(s) of service;

(g) the medicaid claim control number, as appropriate;

(h) the description of a corrective action plan to ensure the overpayment does not occur again;

(i) whether the provider has a corporate integrity agreement (CIA) with the United States department of health and human services (HHS) office of inspector general (OIG) or is under the HHS/OIG self-disclosure protocol;

(j) the specific dates (or time span) within which the problem existed that caused the overpayments;

(k) whether a statistical sample was used to determine the overpayment amount and, if so, a description of the statistically valid methodology used to determine the overpayment; and

(l) the refund amount;

(4) The MCO shall notify its providers of the provision that overpayments identified by a provider but not self-reported by a provider within the 60-day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud;

(5) The MCO shall report claims identified for overpayment recovery:

(a) in a format requested by HSD; and

(b) make 837 encounter adjustments with an identifier specified by HSD for recoveries identified by a governmental entity or its designee.

(6) Provide all records pertaining to overpayment recovery efforts as requested by HSD.

D. Refunds of overpayments:

(1) All self-reported refunds for overpayments shall be made by the provider to his or her MCO and are property of the MCO, unless:

(a) a governmental entity or its designee independently notified the provider that an overpayment existed; or

(b) the MCO fails to initiate recovery within 12 months from the date the MCO first paid the claim;

(c) the MCO fails to complete the recovery within 15 months from the date it first paid the claim; or

(d) provisions in the HSD agreement with the MCO otherwise provide for all or part of the recovery to go to MAD or HSD.

(2) In situations where the MCO and a governmental entity, or its designee, jointly audit its provider, the MCO and the governmental entity or designee shall agree upon a distribution of any refund.

(3) Unless otherwise agreed to by the MCO and HSD, the MCO shall not be entitled to any refund or recovery if the refund or recovery is part of a resolution of a state or federal investigation, lawsuit, including but not limited to False Claims Act cases.

E. Member fraud, abuse and overutilization:

(1) Cases involving one or more of the following situations constitute sufficient grounds for a member fraud referral:

(a) the misrepresentation of facts in order to become or to remain eligible to receive benefits under New Mexico medicaid or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;

(b) the transferring by a member of a medicaid member identification (ID) card to a person not eligible to receive services under New Mexico medicaid or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and

(c) the unauthorized use of a medicaid member ID card by a person not eligible to receive medical benefits under a medical assistance program or is a high utilizer of services without apparent medical justification.

(2) HSD and the MCO shall possess the authority to restrict or lock-in a member to a specified and limited number of providers if he or she is involved in potential fraudulent activities or is identified as abusing services provided under his or her medicaid program.

(a) Prior to placing a member on a provider lock-in, the MCO shall inform him or her of the intent to lock-in, including the reasons for imposing the provider lock-in.

(b) The restriction does not apply to emergency services furnished to this member.

(c) The MCO's grievance procedure shall be made available to the member disagreeing with the provider lock-in.

(d) The member shall be removed from provider lock-in when his or her MCO has determined that the member's utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable.

(e) HSD shall be notified of provider lock-ins and provider lock-in removals.

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

HISTORY OF 8.308.22 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

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 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 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 or acute long term care hospitals are not an ABP benefit.

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.

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.

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. T**ransplant 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]

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 the standard medicaid state plan benefits. All services, services limitations and co-payments that apply to full benefit medicaid recipients are available 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]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 2 GENERAL BENEFIT DESCRIPTION

8.310.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.2.1 NMAC - Rp, 8.310.2.1 NMAC, 1-1-14]

8.310.2.2 SCOPE: The rule applies to the general public.
[8.310.2.2 NMAC - Rp, 8.310.2.2 NMAC, 1-1-14]

8.310.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.310.2.3 NMAC - Rp, 8.310.2.3 NMAC, 1-1-14]

8.310.2.4 DURATION: Permanent.
[8.310.2.4 NMAC - Rp, 8.310.2.4 NMAC, 1-1-14]

8.310.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.2.5 NMAC - Rp, 8.310.2.5 NMAC, 1-1-14]

8.310.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.2.6 NMAC - Rp, 8.310.2.6 NMAC, 1-1-14]

8.310.2.7 DEFINITIONS: [RESERVED]

8.310.2.8 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.
[8.310.2.8 NMAC - Rp, 8.310.2.8 NMAC, 1-1-14]

8.310.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico medical assistance division (MAD) pays for medically necessary health care services furnished by a MAD enrolled medical provider. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991).

B. MAD pays for medically necessary behavioral health professional services including assessments, evaluations, and therapy required by the condition of the medical assistance program (MAP) eligible recipient. See 42 CFR Sections 440.40, 440.60(a) and 441.571.

C. MAD covers services which are medically necessary for the diagnosis or treatment of illnesses, injuries or conditions of a MAP eligible recipient, as determined by MAD or its designee. All services must be furnished within the limits of the MAD New Mexico administrative code (NMAC) rules policies and instructions within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. Any claim submitted for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service. All claims are subject to pre-payment or post-payment review and recoupment.

D. HSD, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to MAP eligible recipients.

E. A provider must be eligible for participation as a MAD approved provider at the time services are furnished. MAD does not cover services performed during a time period when the provider or facility did not meet required licensing or certification requirement.

F. If a MAP eligible recipient is enrolled with a MAD managed care organization (MCO), the provider must contact that member's MCO for specific reimbursement information. A MCO contracted with the state of New Mexico is not required to follow the MAD fee-for-service (FFS) fee schedules or reimbursement methodologies unless otherwise instructed by MAD. Reimbursement arrangements are determined contractually between the MCO and the provider.
[8.310.2.9 NMAC - N, 1-1-14]

8.310.2.10 RELATIONSHIP TO MEDICARE: MAD covers medically necessary health services furnished to a MAP eligible recipient who meets specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to MAP eligible recipient 65 years of age and older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other MAP eligible recipients as specified by other provisions of the Social Security Act.

A. New Mexico has entered into an agreement with the social security administration to pay a medicaid MAP eligible recipient's premium for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, MAD pays for the medicare co-insurance, deductible and copayment amounts for a MAP eligible recipient subject to the following reimbursement limitations.

(1) Medicaid payment for the co-insurance, deductible, copayment or other patient responsibility is limited such that the payment from medicare, plus the amount

allowed by MAD for the co-insurance, copayment and deductible, shall not exceed the MAD allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance, copayment, deductible or other patient responsibility. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance, copayment or deductible from the MAP eligible recipient or his or her authorized representative. For services for which medicare part B applies a 50 percent co-insurance rate, medicare co-insurance, copayment and deductible amounts are paid at an amount that allows the provider to receive more than MAD allowed amount, not to exceed a percentage determined by HSD.

(2) MAD will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance, deductible and copayment together do not exceed the MAD allowable amount. MAD will pay the full medicare co-insurance and deductible when MAD does not have a specific amount allowed for the service. When MAD does not use an equivalent payment methodology for a service, the full coinsurance, deductible and copayment amounts will be paid. This occurs when providers are paid at encounter rates, percent of billed charges followed by cost settlements, or when providers are entitled to a full reimbursement rate such as for federally qualified health centers and hospital outpatient prospective payment system reimbursement.

[8.310.2.10 NMAC - Rp, 8.300.1.10 NMAC, 1-1-14]

8.310.2.11 SERVICE LIMITATIONS AND RESTRICTIONS: MAD covers the following services with the frequency limits indicated. For purpose of this rule, a provider is considered part of the same provider group if he or she practices in the same office or clinic or has direct access to the MAP eligible recipient's medical or behavioral health records. Exceeding these limits requires prior authorization.

A. **Office visits in a practitioner's office:** Visits are limited to one-per-day from the same provider or provider group, unless the claim documents a change in the MAP eligible recipient's condition that could not have been anticipated at the first visit.

B. **Physical medicine modalities in a professional practitioner's office:** These modalities are limited to three-per-month. The limit is met when the same modality is performed three times during a calendar month, when three different modalities are performed during a month, or when three different modalities are performed during one visit.

C. **Physical medicine procedures and kinetic activities in a professional practitioner's office:** These services are limited to three-per-month from the same provider or provider group. The limit is met when the same procedure is performed three times during a calendar month, when three different procedures are performed during a month, or when three procedures are performed during one visit.

D. **Manipulation, osteo-manipulative therapy, or myofacial release in a professional practitioner's office:** These services are limited to three manipulations per calendar month, regardless of the area or areas manipulated. The limit is met when a manipulation of three different areas or of the same area at three different visits is performed during a month.

E. **Medically necessary services:** All services are limited to those that are medically necessary, including the length of time and the frequency of service.

[8.310.2.11 NMAC - Rp, 8.310.2.13 NMAC, 1-1-14]

8.310.2.12 SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope of their practice board and licensure.

A. **Medical practitioner services:**

(1) Second surgical opinions: MAD covers second opinions when surgery is considered.

(2) Services performed in an outpatient setting: MAD covers procedures performed in the office, clinic or as outpatient institutional services as alternatives to hospitalization. These procedures are those for which an overnight stay in a hospital is seldom necessary.

(a) A MAP eligible recipient may be hospitalized if he or she has existing medical conditions that predispose him or her to complications even with minor procedures.

(b) Claims may be subject to pre-payment or post-payment review.

(c) Medical justification for performance of these procedures in a hospital must be documented in the MAP eligible recipient's medical record.

(3) Noncovered therapeutic radiology and diagnostic imaging services: MAD does not pay for kits, films or supplies as separate charges. All necessary materials and minor services are included in the service or procedure charge. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay an additional amount for contrast media except in the following instances:

(a) radioactive isotopes;

(b) non-ionic radiographic contrast material; or

(c) gadolinium salts used in magnetic resonance imaging.

(4) Midwives services: MAD covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and rules and within the scope of their practice board and licensure. Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postnatal care.

(a) Separate trimesters completed and routine vaginal delivery can be covered if a MAP eligible recipient is not under the care of one provider for the entire prenatal, delivery and postnatal periods.

(b) MAD covers laboratory and diagnostic imaging services related to essentially normal pregnancy. These services can be billed separately.

(c) Non-covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(i) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the MAP eligible recipient;

(ii) services furnished by an apprentice; unless billed by the supervising midwife;

(iii) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

B. **Pharmaceutical, vaccines and other items obtained from a pharmacy:** MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to a pharmacy is not a MAD allowed benefit.

C. **Laboratory and diagnostic imaging services:** MAD covers medically necessary laboratory and diagnostic imaging services ordered by primary care provider (PCP), physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialists (CNS) and performed in the office by a provider or under his or her supervision by a clinical

laboratory or a radiology laboratory, or by a hospital-based clinical laboratory or radiology laboratory that are a enrolled MAD provider. See 42 CFR Section 440.30.

(1) MAD covers interpretation of diagnostic imaging with payment as follows: when diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, payment is made only for the professional component of the service. This limitation does not apply if the hospital does not bill for any component of the radiology procedures and does not include the cost associated with furnishing these services in its cost reports.

(2) A provider may bill for the professional components of imaging services performed at a hospital or independent radiology laboratory if the provider does not request an interpretation by the hospital radiologist.

(3) Only one professional component is paid per radiological procedure.

(4) Radiology professional components are not paid when the same provider or provider group bills for professional components or interpretations and for the performance of the complete procedure.

(5) Professional components associated with clinical laboratory services are payable only when the work is actually performed by a pathologist who is not billing for global procedures and the service is for anatomic and surgical pathology only, including cytopathology, histopathology, and bone marrow biopsies, or as otherwise allowed by the medicare program.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless a MAP eligible recipient is an inpatient of nursing facilities or hospitals.

(7) **Noncovered laboratory services:** MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from a MAP eligible recipient who is not a resident of a NF or hospital. MAD does not cover the following specific laboratory services:

(a) clinical laboratory professional components, except as specifically described under covered services above;

(b) specimens, including pap smears, collected in a provider's office or a similar facility and conveyed to a second provider's office, office laboratory, or non-certified laboratory;

(c) laboratory specimen handling or mailing charges;

(d) specimen collection fees other than those specifically indicated in covered services; and

(e) laboratory specimen collection fees for a MAP eligible recipient in NF or inpatient hospital setting.

D. **Reproductive health services:** MAD pays for family planning and other related health services (see 42 CFR Section 440.40(c)) and supplies furnished by or under the supervision of a MAD enrolled provider acting within the scope of his or her practice board or licensure.

(1) Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "*consent to sterilization*" or a "*hysterectomy acknowledgement*" form. MAD covers a medically necessary sterilization under the following conditions. See 42 CFR Section 441.251 et seq:

(a) a MAP eligible recipient 21 years and older at the time consent is obtained;

(b) a MAP eligible recipient is not mentally incompetent; mentally incompetent is a declaration of incompetency as made by a federal, state, or local court; a MAP eligible recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;

(c) a MAP eligible recipient is not institutionalized; for this section, institutionalized is defined as:

(i) an individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or an intermediate care facility for the care and treatment of mental illness;

(ii) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness;

(d) a MAP eligible recipient seeking sterilization must be given information regarding the procedure and the results before signing a consent form; this explanation must include the fact that sterilization is a final, irreversible procedure; a MAP eligible recipient must be informed of the risks and benefits associated with the procedure;

(e) a MAP eligible recipient seeking sterilization must also be instructed that his or her consent can be withdrawn at any time prior to the performance of the procedure and that he or she does not lose any other MAD benefits as a result of the decision to have or not have the procedure; and

(f) a MAP eligible recipient voluntarily gives informed consent to the sterilization procedure. See 42 CFR Section 441.257(a).

(2) Hysterectomies: MAD covers only a medically necessary hysterectomy. MAD does not cover a hysterectomy performed for the sole purpose of sterilization. See 42 CFR Section 441.253.

(a) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by the MAP eligible recipient prior to the operation.

(b) Acknowledgement of the sterilizing results of the hysterectomy is not required from a MAP eligible recipient who has been previously sterilized or who is past child-bearing age as defined by the medical community. In this instance, the PCP signs the bottom portion of the hysterectomy form which states the MAP eligible recipient has been formerly sterilized, and attaches it to the claim.

(c) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

(3) Other covered services: MAD covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy or contraception.

(4) Noncovered reproductive health care: MAD does not cover the following specific services:

(a) sterilization reversal services;

(b) fertility drugs;

(c) in vitro fertilization;

(d) artificial insemination;

(e) hysterectomies performed for the sole purpose of family planning;

(f) induced vaginal deliveries prior to 39 weeks unless medically indicated;

(g) caesarean sections unless medically indicated; and

(h) elective procedures to terminate a pregnancy.

E. **Nutritional services:** MAD covers medically necessary nutritional services which are based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the MAP eligible recipient. MAD covers only those services furnished by PCP, licensed nutritionists or licensed dieticians. MAD covers the following services:

(1) Nutritional assessments for a pregnant MAP eligible recipient and for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnosis and treatment (EPSDT) program. Nutritional assessment is defined as an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

(2) Nutrition counseling to or on behalf of a MAP eligible recipient under 21 years of age who has been

referred for a nutritional need. Nutrition counseling is defined as advising and helping a MAP eligible recipient obtain appropriate nutritional intake by integrating information from the nutrition assessment with information on food, other sources of nutrients and meal preparation, consistent with cultural background and socioeconomic status.

(3) Noncovered nutritional services: MAD covers only those services furnished by a PCP, licensed nutritionist or licensed dietician. MAD does not cover the following specific services:

(a) services not considered medically necessary for the condition of the MAP eligible recipient as determined by MAD or its designee;

(b) dietary counseling for the sole purpose of weight loss;

(c) weight control and weight management programs; and

(d) commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management; see 8.324.4 NMAC.

F. **Transplant services:** Non-experimental transplant services are covered. MAD does not cover any transplant procedures, treatments, use of a drug, a biological product, a product or a device which are considered unproven, experimental, investigational or not effective for the condition for which they are intended or used.

G. **Dental services:** Dental services are covered as an optional medical service for a MAP eligible recipient. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the MAP eligible recipient. See 42 CFR Section 440.100(a). MAD also covers dental services, dentures and special services for a MAP eligible recipient who qualifies for services under the EPSDT program. See 42 CFR Section 441.55.

(1) Emergency dental care: MAD covers emergency care for all MAP eligible recipients. Emergency care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For a MAP eligible recipient under 21 years of age, care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) Prior authorization requirements are waived for emergency care, but the claim can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

(2) Diagnostic services: MAD coverage for diagnostic services is limited to the following:

(a) for a MAP eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(b) one clinical oral examination every 12 months for a MAP eligible recipient 21 years and older; and

(c) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

(3) Radiology services: MAD coverage of radiology services is limited to the following:

(a) one intraoral complete series every 60 months per MAP eligible recipient; this series includes bitewing x-rays;

(b) additional bitewing x-rays once every 12 months per MAP eligible recipient; and

(c) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per MAP eligible recipient.

(4) Preventive services: MAD coverage of preventive services is subject to certain limitations.

(a) Prophylaxis: MAD covers for a MAP eligible recipient under 21 years of age one prophylaxis service every six months. MAD covers for a MAP eligible recipient 21 years of age and older who has a developmental disability, as defined in 8.314.6 NMAC, one prophylaxis service every six months. For a MAP eligible recipient 21 years of age and older without a developmental disability, as defined in 8.314.6 NMAC, MAD covers one prophylaxis service once in a 12 month-period.

(b) Fluoride treatment: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride treatment every six months. For a MAP eligible recipient 21 years of age and older MAD, covers one fluoride treatment once in a 12-month period.

(c) Molar sealants: MAD only covers for a MAP eligible recipient under 21 years of age, sealants for permanent molars. Each MAP eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For a MAP eligible recipient 21 years of age and older, MAD does not cover sealant services.

(d) Space maintenance: MAD covers for a MAP eligible recipient under 21 years of age fixed unilateral and fixed bilateral space maintainers (passive appliances). For a MAP eligible recipient 21 years of age and older, MAD does not cover space maintenance services.

(5) Restorative services: MAD covers the following restorative services:

(a) amalgam restorations (including polishing) on permanent and deciduous teeth;

(b) resin restorations for anterior and posterior teeth;

(c) one prefabricated stainless steel crown per permanent or deciduous tooth;

(d) one prefabricated resin crown per permanent or deciduous tooth; and

(e) one recementation of a crown or inlay.

(6) Endodontic services: MAD covers therapeutic pulpotomy for a MAP eligible recipient under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

(7) Periodontic services: MAD covers for a MAP eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(a) a collaborative practice dental hygienist may provide periodontal scaling and root planning, per quadrant after diagnosis by a MAD enrolled dentist; and

(b) a collaborative practice dental hygienist may provide periodontal maintenance procedures with prior authorization.

(8) Removable prosthodontic services: MAD covers two denture adjustments per every 12 months per MAP eligible recipient. MAD also covers repairs to complete and partial dentures.

(9) Fixed prosthodontics services: MAD covers one recementation of a fixed bridge.

(10) Oral surgery services:

(a) simple and surgical extractions: MAD coverage includes local anesthesia and routine post-operative care; erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(b) autogenous tooth reimplantation of a permanent tooth: MAD covers for a MAP eligible recipient under 21 years of age; and

(c) the incision and the drainage of an abscess for a MAP eligible recipient.

(11) Adjunctive general services: MAD covers emergency palliative treatment of dental pain for a MAP eligible recipient. MAD also covers general anesthesia and intravenous sedation for a MAP eligible

recipient. Documentation of medical necessity must be available for review by MAD or its designee. For a MAP eligible recipient under 21 years of age, MAD covers the use of nitrous oxide analgesia. For a MAP eligible recipient 21 years of age and older, MAD does not cover the use of nitrous oxide analgesia.

(12) Hospital care: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with a prior authorization, unless one of the following conditions exist:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified; or

(c) any service which requires a prior authorization in an outpatient setting must have a prior authorization if performed in an inpatient hospital.

(13) Behavioral management: Dental behavior management as a means to assure comprehensive oral health care for persons with developmental disabilities is covered. This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment of a special needs MAP eligible recipient. Dentists who have completed the training and received their certification from DOH are eligible for reimbursement.

(14) Noncovered dental services: MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. MAD covers orthodontic services only for a MAP eligible recipient under 21 years of age and only when specific criteria are met to assure medical necessary. MAD does not cover the following specific services:

(a) surgical tray is considered part of the surgical procedure and is not reimburse separately for tray;

(b) sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

(c) oral preparations, including topical fluorides dispensed to a MAP eligible recipient for home use;

(d) permanent fixed bridges;

(e) procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

(f) procedures for desensitization, re-mineralization or tooth bleaching;

(g) occlusal adjustments, disking, overhang removal or equilibration;

(h) mastique or veneer procedures;

(i) treatment of TMJ disorders, bite openers and orthotic appliances;

(j) services furnished by non-certified dental assistants, such as radiographs;

(k) implants and implant-related services; or

(l) removable unilateral cast metal partial dentures.

H. **Podiatry and procedures on the foot:** MAD covers only medically necessary podiatric services furnished by a provider, as required by the condition of the MAP eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and rules. MAD covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, post a hazard to a MAP eligible recipient with a medical condition. MAD covers the treatment of warts on the soles of the feet (plantar warts). Medical justification for the performance of routine care must be documented in the MAP eligible recipient's medical record. MAD covers the following specific podiatry services.

(1) Routine foot care: Routine foot care services that do not meet the coverage criteria of medicare part B are not covered by MAD. MAD covers services only when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination. A MAP eligible recipient with diagnoses marked by an asterisk(*) in the list below must be under the active care of a physician or physician assistant (PA). to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60-calendar days after the routine foot care service. A CNP, PA and a CNS do not satisfy the coverage condition of "active care by a PCP".

(2) Common billed diagnoses: The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;

(b) arteriosclerosis obliterans;

(c) buerger's disease;

(d) chronic thrombophlebitis*;

(e) neuropathies involving the feet associated with:

(i) malnutrition and vitamin deficiency*;

(ii) malnutrition (general, pellagra);

(iii) alcoholism;

(iv) malabsorption (celiac disease, tropical sprue);

(v) pernicious anemia;

(vi) carcinoma*;

(vii) diabetes mellitus*;

(viii) drugs or toxins*;

(ix) multiple sclerosis*;

(x) uremia (chronic renal disease)*;

(xi) traumatic injury;

(xii) leprosy or neurosyphilis;

(xiii) hereditary disorders;

(xiv) hereditary sensory radicular neuropathy;

(xv) fabry's disease; and

(xvi) amyloid neuropathy.

(3) Routine foot care services: MAD covers routine foot care services for a MAP eligible recipient who has a systemic condition and meets the severity in the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) class A findings: non-traumatic amputation of foot or integral skeletal portion thereof;

(b) class B findings:

(i) absent posterior tibial pulse;

(ii) absent dorsalis pedis pulse; and

(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness);

(c) class C findings:

(i) claudication;

(ii) temperature changes (e.g., cold feet);

(iii) edema;

(iv) paresthesias (abnormal spontaneous sensations in the feet); or

(v) burning.

(4) Subluxated foot structure: Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

(5) Foot warts: MAD covers the treatment of warts on the feet.

(6) Asymptomatic mycotic nails: MAD covers the treatment of asymptomatic mycotic nails in the presence of a systemic condition that meets the clinical findings and

class findings as required for routine foot care.

(7) Mycotic nails: MAD covers the treatment of mycotic nails in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(a) marked, significant limitation;

(b) pain; or

(c) secondary infection.

(8) Orthopedic shoes and other supportive devices: MAD only covers these items when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics who is a MAP eligible recipient.

(9) Hospitalization: If the MAP eligible recipient has existing medical condition that would predispose him or her to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered.

(10) Noncovered podiatric services: A provider is subject to the limitations and coverage restrictions that exist for other medical services. MAD does not cover the following specific services or procedures.

(a) Routine foot care is not covered except as indicated under "covered services" for a MAP eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(i) trimming, cutting, clipping and debriding toenails;

(ii) cutting or removal of corns, calluses, or hyperkeratosis;

(iii) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast MAP eligible recipient; and

(iv) any other service performed in the absence of localized illness, injury or symptoms involving the foot.

(b) Services directed toward the care or the correction of a flat foot condition are not covered. Flat foot is defined as a condition in which one or more arches of the foot have flattened out.

(c) Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to a diabetic MAP eligible recipient.

(d) Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

(e) MAD will not reimburse for services that have been denied by medicare for coverage limitations.

I. **Anesthesia:** MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the MAP eligible recipient. All services must be provided within the limits of MAD benefit package, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and rules.

(1) When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

(2) An anesthesia service is not covered if the medical or surgical procedure is not a MAD covered service.

(3) Separate payment is not allowed for qualifying circumstances. Payment is considered bundled into the anesthesia allowance.

(4) Separate payment is not allowed for the anesthesia complicated by the physical status of the MAP eligible recipient.

J. **Vision:** MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a MAP eligible recipient. MAD pays for the correction of refractive errors required by the condition of the MAP eligible recipient. All services must be furnished within the limits of the MAD benefits package, 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.

(1) Vision exam: MAD covers routine eye exams. Coverage for an eligible adult recipient 21 years of age and older of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the MAP eligible recipient's visual examination record and indicated by diagnosis on the claim. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

(2) Noncovered vision services: MAD does not cover vision services that are performed for aesthetic or cosmetic purposes. MAD covers orthoptic assessments and treatments only when specific criteria are met to assure medical necessity.

K. **Hearing:** All audiology screening, diagnostic, preventive or corrective services require medical clearance. Audiologic and vestibular function studies are rendered by an audiologist or a PCP. Hearing aid dealers and dispensers are not reimbursed for audiological, audiometric or other hearing tests. Only licensed audiologists and PCPs are reimbursed for providing these testing services.

L. **Client medical transportation:** MAD covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MAP eligible recipient in or out of his or her home community. See 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment. MAD reimburses a MAP eligible recipient or the transportation provider for medically necessary transportation subject to the following.

(1) Free alternatives: Alternative transportation services which may be provided free of charge include volunteers, relatives or transportation services provided by a nursing facility (NF) or another residential center. A MAP eligible recipient must certify in writing that he or she does not have access to free alternatives.

(2) Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before the MAP eligible recipient can use more expensive transportation alternatives.

(3) Non-emergency transportation service: MAD covers non-emergency transportation services for a MAP eligible recipient who does not have primary transportation to a MAD covered service and who is unable to access a less costly form of public transportation.

(4) Long distance common carriers: MAD covers long distance services furnished by a common carrier if the MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the MAP eligible recipient's local county

income support division (ISD) office.

(5) Ground ambulance services: MAD covers services for a MAP eligible recipient provided by ground ambulances when:

(a) an emergency which requires ambulance service is certified by the attending provider or is documented in the provider's records as meeting emergency medical necessity as defined as:

(i) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(ii) medical necessity for ambulance services is established if the MAP eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(b) Scheduled, non-emergency ambulance services: These services are covered when ordered by the MAP eligible recipient's attending provider who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's medical or behavioral condition.

(c) Reusable items and oxygen: MAD covers non-reusable items and oxygen required during transportation. Coverage for these items is included in the base rate reimbursement for a ground ambulance;

(6) Air ambulance services: MAD covers services for a MAP eligible recipient provided by an air ambulance, including a private airplane, if an emergency exists and the medical necessity for the service is certified by his or her attending provider.

(a) An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(b) MAD covers the following services for air ambulances:

(i) non-reusable items and oxygen required during transportation;

(ii) professional attendants required during transportation; and

(iii) detention time or standby time up to one hour without provider documentation; if the detention or standby time is more than one hour, a statement from the attending provider or flight nurse justifying the additional time is required.

(7) Lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical or behavioral health services and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, in-state lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15-calendar days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the attending provider's statement of need. Authorization forms for direct payment to a MAD approved lodging provider by MAD are available through local county ISD offices. In addition, overnight lodging could include the following situations:

(a) a MAP eligible recipient who is required to travel more than four hours each way to receive medical or behavioral health services; or

(b) a MAP eligible recipient who is required to travel less than four hours each way and is receiving daily medical or behavioral health services and is not sufficiently stable to travel or must be near a facility because of the potential need for emergency or critical care.

(8) Meal services: MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to a meal provider by MAD are available through local county ISD offices.

(9) Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for a MAP eligible recipient for one attendant if the medical necessity for the attendant is certified in writing by the MAP eligible recipient's attending provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. MAD only covers transportation services or related expenses for a MAP eligible recipient and as certified, his or her attendant. Transportation services and related expenses will not be reimbursed by MAD for any other individual accompanying the MAP eligible recipient to a MAD covered medical or behavioral health service.

(10) Coverage for a MAP eligible waiver recipient: Transportation of a MAP eligible waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy or an outpatient behavioral health therapy.

(11) Out-of-state transportation and related expenses: All out-of-state transportation, meals and lodging must be prior approved by MAD or its designee. Out-of-state transportation is approved only if the out-of-state medical or behavioral health service is approved by MAD or its designee. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

(a) Requests for out-of-state transportation must be coordinated through MAD or its designee;

(b) Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30-calendar days by MAD or its designee. Re-evaluation authorizations are completed prior to expiration and every 30-calendar days, thereafter.

(c) Border cities: A border city is a city within 100 miles of a New Mexico border (Mexico excluded). Transportation to a border city is treated as in-state provider service. A MAP eligible recipient who receives a MAD reimbursable service from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, to determine when a provider is considered an out-of-state provider or a border area provider.

(12) Client medical transportation fund: In a non-emergency situation, a MAP eligible recipient can request reimbursement from the client medical transportation (CMT) fund through his or her local county ISD office for money spent on transportation, meals and lodging by the MAP eligible recipient; for reimbursement from the CMT fund, a MAP eligible recipient must apply for reimbursement within 30-calendar days from the date of appointment or the date he or she is discharged from the hospital.

(a) Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the MAD approved provider visit to receive reimbursement:

(i) submit a letter on the provider's stationary which indicates that the MAP eligible recipient kept the appointment for which the CMT fund reimbursement is requested; for medical or behavioral health services, written receipts confirming the date of service must be given to the MAP eligible recipient for submission to the local county ISD office;

(ii) proper referral with original signatures and documentation stating that the MAD services are not available within the community from the

MAD requesting provider, when a referral is necessary;

(iii) verification of current eligibility of the recipient for a MAD service for the month the appointment and travel is made;

(iv) certification that free alternative transportation services are not available and that the MAP eligible recipient is not enrolled in a HSD contracted managed care organization (MCO);

(v) verification of mileage; and

(vi) documentation justifying a medical attendant.

(b) Preparation of referrals for travel outside the home community: If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical care, the transportation provider must obtain a written verification from the referring provider or from the service provider containing the following information for the provider to retain with his or her billing records:

(i) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(ii) the name of the out of community medical or behavioral health provider; and

(iii) justification that the medical or behavioral health care is not available in the home community.

(c) Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. An emergency is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical or behavioral health appointment.

(i) The ISD CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate utilization review (UR) contractor verifies that the recipient is eligible for a MAD service and has a medical or behavioral health appointment prior to advancing money from the CMT fund and that the MAP eligible recipient is not enrolled in a HSD contracted MCO;

(ii) written referral for out of community service must be received by the CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate UR contractor no later than 30-calendar days from the date of the medical or behavioral health appointment for which the advance funds were requested. If a MAP eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated; see Section OIG-900, Restitutions.

(d) MAP Eligible recipients enrolled in a HSD contracted MCO: A member enrolled in HSD contracted MCO on the date of service is not eligible to use the client medical transportation fund for services that are the responsibility of the MAP eligible recipient's MCO.

(13) Noncovered transportation services: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a non-covered MAD service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

(a) an attendant where there is not the required certification from the MAP eligible recipient's medical or behavioral health provider;

(b) minor aged children of the MAP eligible recipient that are simply accompanying him or her to medical or behavioral health service;

(c) transportation to a non-covered MAD service;

(d) transportation to a pharmacy provider; see 8.324.7 NMAC.

M. **Telemedicine services:**

(1) The telemedicine originating-site is the location of a MAP eligible recipient at the time the service is being furnished via an interactive telemedicine communications system. The origination-site can be any medically warranted site. An interactive telemedicine communication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant-sites. Coverage for services rendered through telemedicine shall be determined in a manner consistent with medicaid coverage for health care services provided through in person consultation. For telemedicine services, when the originating-site is in New Mexico and the distant-site (consulting telemedicine provider) is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities. Provision of telemedicine services does not require that a certified medicaid healthcare provider be physically present with the patient at the originating site unless the telemedicine consultant at the distant site deems it necessary.

(2) The distant-site is the location where the consulting telemedicine provider is physically located at time of the telemedicine service. All services are covered to the same extent the service and the provider are covered when not provided through telemedicine. For these services, use of the telemedicine communications system fulfills the requirement for a face-to-face encounter.

(3) MAD will reimburse for services delivered through store-and forward. To be eligible for payment under store-and-forward, the service must be provided through the transference of digital images, sounds, or previously recorded video from one location to another; to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation. Store-and-forward telemedicine includes encounters that do not occur in real time (asynchronous) and are consultations that do not require a face-to-face live encounter between patient and telemedicine provider.

(4) Telemedicine providers: Reimbursement for professional services at the originating-site and the distant-site are made at the same rate as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

(5) A telemedicine originating-site communication system fee is covered if the MAP eligible recipient was present at and participated in the telemedicine visit at the originating-site and the system in use meets the definition of a telemedicine system.

(6) Noncovered telemedicine services: A service provided through telemedicine is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine.

N. **Transplantation services:** MAD covered transplantation services include hospital, a PCP, laboratory, outpatient surgical, and other MAD covered services necessary to perform the selected transplantation. Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement.

O. **Pregnancy termination services:** MAD does not cover the performance of 'elective' pregnancy termination procedures. MAD will only pay for services to terminate a pregnancy when certain conditions are met.

(1) A provider of pregnancy termination services must submit with his or her billing, the written certification of a provider that the procedure meets one of the following conditions:

(a) the procedure is necessary to save the life of the MAP eligible recipient as certified in writing by a provider;

(b) the pregnancy is a result of rape or incest, as certified by the treating provider, the appropriate reporting agency,

or if not reported, the MAP eligible recipient is not physically or emotionally able to report the incident; or

(c) the procedure is necessary to terminate an ectopic pregnancy; or

(d) the procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient.

(2) Psychological services: MAD covers behavioral health services for a pregnant MAP eligible recipient.

(3) Oral medications: MAD covers oral medications approved by the FDA have been determined a benefit by MAD for pregnancy termination. MAD will cover oral medications when administered by a provider acting within the scope of his or her practice board and licensure.

(4) Informed consent: Under New Mexico law, the provider may not require any MAP eligible recipient to accept any medical service, diagnosis, or treatment or to undergo any other health service provided under the plan if the MAP eligible recipient objects on religious grounds or in the case of a non-emancipated MAP eligible recipient, the legal parent or guardian of the non-emancipated MAP eligible recipient objects.

(a) Consent: Voluntary, informed consent by a MAP eligible recipient 18 years of age and older, or an emancipated minor MAP eligible recipient must be given to the provider prior to the procedure to terminate pregnancy, except in the following circumstances:

(i) in instances where a medical emergency exists; a medical emergency exists in situations where the attending PCP certifies that, based on the facts of the case presented, in his or her best clinical judgment, the life or the health of the MAP eligible recipient is endangered by the pregnancy so as to require an immediate pregnancy termination procedure;

(ii) in instances where the MAP eligible recipient is unconscious, incapacitated, or otherwise incapable of giving consent; in such circumstances, the consent shall be obtained as prescribed by New Mexico law;

(iii) in instances where pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the MAP eligible recipient;

(iv) consent is valid for 30-calendar days from the date of signature, unless withdrawn by the MAP eligible recipient prior to the procedure.

(b) Required acknowledgements: In signing the consent, the MAP eligible recipient must acknowledge that she has received, at least, the following information:

(i) alternatives to pregnancy termination;

(ii) medical procedure(s) to be used;

(iii) possibility of the physical, mental, or both, side effects from the performance of the procedure;

(iv) right to receive pregnancy termination behavioral health services from an independent MAD provider; and

(v) right to withdraw consent up until the time the procedure is going to be performed.

(c) Record retention: A dated and signed copy of the consent, with counseling referral information, if requested, must be given to the MAP eligible recipient. The provider must keep the original signed consent with the MAP eligible recipient's medical records.

(d) Consent for a MAP eligible recipient under 18 years of age who is not an emancipated minor, in instances not involving life endangerment, rape or incest: Informed written consent for an non-emancipated minor to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or another adult acting 'in loco parentis' to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating PCP shall note the minor's objections or the unavailability of the parent or guardian in the minor's chart, and:

(i) certify in his or her best clinical judgment, the minor is mature enough and well enough informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, certify that the procedure is in the minor's best interests based on the information provided to the treating PCP by the minor; or

(ii) refer the minor to an independent MAD behavioral health provider in circumstances where the treating PCP believes behavioral health services are necessary before a clinical judgment can be rendered on the criteria established in Paragraph (1) above; the referral shall be made on the same day of the visit between the minor and the treating PCP where consent is discussed; the independent MAD behavioral health provider shall meet with the minor and confirm in writing to the treating PCP whether or not the minor is mature enough and sufficiently informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, that the procedure is in the minor's best interests based on the information provided to the independent MAD behavioral health provider by the minor; this provider's written report is due to the treating PCP within 72 hours of initial referral;

(iii) a minor shall not be required to obtain behavioral health services referenced in Paragraph (2) above; however, if the treating PCP is unable or unwilling to independently certify the requirements established in Paragraph (1) above, the minor must be informed by the treating PCP that written consent must be obtained by the parent, legal guardian or parent 'in loco parentis' prior to performing the procedure; or, that the minor must obtain a court order allowing the procedure without parental consent.

P. **Behavioral health professional services:** Behavioral health services are addressed specifically in 8.321.2 NMAC.

Q. **Experimental or investigational services:** MAD covers medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD. Covered transplantation services include a hospital, a PCP, a laboratory, an outpatient surgical and other MAD-covered services necessary to perform the selected transplantation. Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement. MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices, except the following:

(1) Phase I, II, III or IV: MAD may approve coverage for routine patient care costs incurred as a result of the MAP eligible recipient's participation in a phase I, II, III, or IV cancer trial that meets the following criteria. The cancer clinical trial is being conducted with the approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the FDA in the form of an investigational new drug application;

(e) the federal department of veteran affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

(2) Review and approval: The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research

risks of the federal national institutes of health.

(3) Experimental or investigational interventions: Any medical, surgical, or other healthcare procedure or treatment, including the use of a drug, a biological product, another product or device, is considered experimental or investigational if it meets any of the following conditions:

(a) current, authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of a drug, a biological product, another product or device for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting;

(b) the drug, biological product, other product, device, procedure or treatment (the "technology") lacks final approval from the FDA or any other governmental body having authority to regulate the technology;

(c) the medical, surgical, other health care procedure or treatment, including the use of a drug, a biological product, another product or device is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting.

(4) Review of conditions: On request of MAD or its designee, a provider of a particular service can be required to present current, authortative medical and scientific evidence that the proposed technology is not considered experimental or investigational.

(5) Reimbursement: MAD does not reimburse for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products or devices that are considered experimental or investigational, except as specified as follows. MAD will reimburse a provider for routine patient care services, which are those medically necessary services that would be covered if the MAP eligible recipient were receiving standard cancer treatment, rendered during the MAP eligible recipient's participation in phase I, II, III, or IV cancer clinical trials.

(6) Experimental or investigational services: MAD does not cover procedures, technologies or therapies that are considered experimental or investigational.

R. **Smoking cessation:** MAD covers tobacco cessation services for a pregnant MAP eligible recipient and for a MAP eligible recipient under the age of 21 years of age.

(1) Eligible medical, dental, and behavioral health practitioner: Cessation counseling services may be provided by one of the following:

(a) by or under the supervision of a physician; or

(b) by any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law;

(c) generally, eligible practitioners would be medical practitioners, including independently enrolled CNPs, behavioral health and dental practitioners; physician assistants and CNPs not enrolled as independent MAD providers, and registered nurses and dental hygienists may bill for counseling services through the enrolled entity under which their other services are billed, when under the supervision of a dentist or physician;

(d) counseling service must be prescribed by a MAD enrolled licensed practitioner.

(2) Eligible pharmacy providers: For rendering tobacco cessation services, eligible pharmacists are those who have attended at least one continuing education course on tobacco cessation in accordance with the federal public health guidelines found in the United States department of health and human services; public health services' *quick reference guide for clinicians*, and *treating tobacco use and dependence*.

(3) Tobacco cessation drug items: MAD covers all prescribed tobacco cessation drug items for a MAP eligible recipient as listed in this section when ordered by a MAD enrolled prescriber and dispensed by a MAD enrolled pharmacy. MAD does not require prior authorization for reimbursement for tobacco cessation products, but the items must be prescribed by a MAD enrolled practitioner. Tobacco cessation products include, but are not limited to the following:

(a) sustained release buproprion products;

(b) varenicline tartrate tablets; and

(c) prescription and over-the-counter (OTC) nicotine replacement drug products, such as a patch, gum, or inhaler.

(4) Covered services: MAD makes reimbursement for assessing a pregnant or postpartum MAP eligible recipient's tobacco dependence including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, and may bill using the E&M codes. MAD covers face-to-face counseling when rendered by an appropriate provider. The effectiveness of counseling is comparable to pharmacotherapy alone. Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session refers face-to-face MAP eligible recipient contact of either

(a) intermediate session (greater than three minutes up to 10 minutes); or

(b) intensive session (greater than 10 minutes).

(5) Documentation for counseling services: Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered, which may consist of documentation of tobacco use. The rendering practitioner must maintain documentation that face-to-face counseling was prescribed by a practitioner, even if the case is a referral to self, consistent with other NMAC rules and other materials.

(6) Limitations on counseling sessions: A cessation counseling attempt includes up to four cessation counseling sessions (one attempt plus up to four sessions). Two cessation counseling attempts (or up to eight cessation counseling sessions) are allowed in any 12-month period. During the 12-month period, the practitioner and the MAP eligible recipient have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

S. **Other services:** Other covered and noncovered services including hospitalization and other residential facilities, devices for hearing and vision correction, behavioral health services, home and community based services, EPSDT services, case management and other adjunct and specialty services are described in other NMAC rules.

[8.310.2.12 NMAC - Rp, 8.310.2.12 NMAC, 1-1-14]

8.310.2.13 GENERAL NONCOVERED SERVICES

A. **General noncovered services:** MAD does not cover certain procedures, services, or miscellaneous items. See specific provider or service rules or sections of this rule for additional information on service coverage and limitations. A provider cannot turn an account over to collections or to any other factor intending to collect from the MAP eligible recipient or his or her authorized representative; see 8.302.2 NMAC. A provider cannot bill a MAP eligible recipient or his or her authorized representative for the copying of the MAP eligible recipient's records, and must provide copies of the MAP eligible recipient's records to other providers upon request of the MAP eligible recipient.

B. **Appointment, interest and carrying charges:** MAD does not cover penalties on payments for broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts. A provider may not bill a MAP eligible recipient or his or her authorized

representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of CHIP or WDI who may be charged up to $5 for a missed appointment.

C. **Contract services:** Services furnished by a contractor, an organization, or an individual who is not the billing provider must meet specific criteria for coverage as stated in MAD or its designee's NMAC rules, billing instructions, policy manuals; see 8.302.2 NMAC.

D. **Cosmetic services and surgeries:** MAD does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, for hair loss, and personal care items such as non-prescription lotions, shampoos, soaps or sunscreens. MAD does not cover cosmetic surgeries performed for aesthetic purposes. "*Cosmetic surgery*" is defined as a procedure performed to improve the appearance of physical features that may or may not improve the functional ability of the area of concern. MAD covers only a surgery that meets specific criteria and is approved as medically necessary reconstructive surgery.

E. **Postmortem examinations:** MAD does not cover postmortem examinations.

F. **Education or vocational services:** MAD does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for a MAP eligible recipient under 21 years of age, as part of the EPSDT program and for a pregnant MAP eligible recipient. MAD does not cover formal educational or vocational training services, unless those services are included as active treatment services for a MAP eligible recipient in intermediate care facility for individuals with intellectual disabilities (ICF-IID)or for a MAP eligible recipient under 21 years of age receiving inpatient psychiatric services [42 CFR 441.13(b)]. "*Formal educational services*" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of a MAP eligible recipient for paid or unpaid employment.

G. **Hair or nail analysis:** MAD does not cover hair or nail analysis.

H. **Preparations dispensed for home use:** MAD does not cover oral, topical, otic, or ophthalmic preparations dispensed to a MAP eligible recipient by a PCP, a CNP, a P.A., or an optometrist for home use or self administration unless authorized by MAD to assure the availability of medications.

I. **Telephone services:** MAD does not cover any telephone consultations between the MAP eligible recipient and his or her provider.

J. **Routine physical examinations:** MAD only covers a routine physical examination for a MAP eligible recipient residing in a NF or an ICF-IID facility. Physical examinations, screenings, and treatment are available to a MAP eligible recipient under 21 years of age through the tot to teen healthcheck screen, New Mexico's EPSDT screening program.

K. **Screening services:** MAD does not cover screening services that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. MAD covers screening services for a MAP eligible recipient under 21 years of age through the tot to teen healthcheck program. MAD covers screening services ordered by a provider for cancer detection such as pap smears and mammograms for a MAP eligible recipient when medically appropriate.

L. **Services not covered by medicare:** MAD does not cover services, procedures, or devices that are not covered by medicare due to their determination that the service is not medically necessary or that the service is experimental or not effective.

M. **Bariatric surgery services:** Bariatric surgery services are covered only when medically indicated and alternatives are not successful.

N. **Services and tests which are not routinely warranted due to the MAP eligible recipient's age:** MAD does not reimburse for routine screening, tests, or services which are not medically necessary due to the age of the MAP eligible recipient:

(1) Papanicolaou test (pap smear) for women under 21 years of age unless prior history or risk factors make the test medically warranted; and

(2) prostate specific antigen (PSA) test for men under age 40 unless prior history or risk factors make the test medically warranted.

O. **Services for surrogate mothers:** MAD does not pay for services for pregnancy, complications encountered during pregnancy related conditions, prenatal care and post partum care, or delivery for services to a surrogate mother for which an agreement or contract between the surrogate mother and another party exists.

[8.310.2.13 NMAC - Rp, 8.310.2.14 NMAC, 1-1-14]

8.310.2.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization was obtained remain subject to UR at any point in the payment process, including after payment has been made. It is the provider's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

(1) Dental services: MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when a prior authorization is received from MAD or its designee. MAD covers medically necessary orthodontic services to treat handicapping malocclusions for a MAP eligible recipient under 21 years of age by prior authorization.

(2) Transplantation services**:** A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

(3) Pregnancy termination services: Services to terminate a pregnancy do not require a prior authorization from MAD or its designee.

(4) Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for MAD or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if a MAP eligible recipient has other health insurance.

(5) Reconsideration: A provider who disagrees with a prior authorization -request denial or another review decision can request reconsideration; see 8.350.2 NMAC.

B. **Prior authorization and UR:** MAD has developed an UR process to regulate provider compliance with MAD quality control and cost containment

objectives. See 42 CFR Section 456. Specific details pertinent to a service or a provider are contained in NMAC rules or UR instructions for that specific service or provider type. 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, UR instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD provider participation agreement (PPA) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made.

C. **Medical necessity requirements:** MAD reimburses a provider for furnishing MAD covered service to a MAP eligible recipient only when the service is medically necessary. Medical necessity is required for the specific service, level of care (LOC), and service setting, if relevant to the service. A provider must verify that MAD covers a specific service and that the service is medically necessary prior to furnishing the service. Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service that are reviewed and approved by MAD. MAD denies payment for services that are not medically necessary and for services that are not covered by MAD. The process for determining medical necessity is called UR. The UR of a MAD service may be performed directly by MAD or its designee, or another state agency designated by MAD.

D. **Timing of UR:**

(1) A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements. The following are examples of the reviews that may be performed:

(a) prior authorization review (review occurs before the service is furnished);

(b) concurrent review (review occurs while service is being furnished);

(c) pre-payment review (claims review occurring after service is furnished but before payment);

(d) retrospective review (review occurs after payment is made); and

(e) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

(2) Prior authorization reviews: A claim for a service that requires a prior authorization are paid only if the prior authorization was obtained and approved by MAD or MAD's UR contractor, prior to services being furnished. A prior authorization specifies the approved number of service units that a provider is authorized to furnish to a MAP eligible recipient and the date the service must be provided.

(a) A prior authorization does not guarantee that an individual is eligible for a specific MAD service. A provider must verify that individuals are eligible for a specific MAD service at the time the service is furnished.

(b) Information on the specific service or procedure that requires a prior authorization for a specific provider type are contained in the applicable MAD rules and the UR instructions for that provider type or service.

(c) A service that has been approved by MAD or its designee does not prevent a later denial of payment if the service has been determined to be not medically necessary or if the individual was not eligible for the service.

(d) A prior authorization review is used to authorize service for a MAP eligible recipient before a service is furnished. A request for a retroactive prior authorization may be approved only under the following circumstances:

(i) approval is made as part of the process of determining MAD eligibility for certain categories, such as a MAD institutional care or home and community-based services waiver (HCBSW) programs. In these situations, the determination of medical necessity for an institutional LOC of the service is a factor in establishing MAD eligibility and may be made after the MAP eligible recipient receives NF or HCBSW services;

(ii) the service is furnished before the determination of the effective date of the recipient's MAP eligibility for a MAD service or the servicing provider's MAD PPA; a retrospective request for a prior authorization is based on retrospective recipient or provider eligibility must be received in writing by MAD or its designee within 30 calendar days of the date of the eligibility determination;

(iii) in cases of medical emergency; a medical emergency is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in one of the following: an individual's death; placement of an individual's health in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part;

(iv) a service that is furnished to a medicare recipient who is also eligible for a MAD service and medicare has denied payment for a reason that is not based on medical necessity; requests for a retroactive prior authorization must be accompanied by a copy of the document from medicare that denied payment and states the reason for denial; a service denied payment by medicare because of lack of medical necessity is not covered by MAD.

(3) Concurrent review: A concurrent review is conducted while the service is being furnished. A continued stay or continued service review is concurrent review for medical necessity.

(4) Prepayment review: A prepayment review is conducted after a service has been furnished and a claim for payment has been filed by the provider. If a service is not a covered MAD benefit or not medically necessary, payment for that service will be denied.

(5) Retrospective review: A retrospective review is conducted after the claim has been processed and payment is made. Information from the paid claim is compared with the provider records detailing the service and medical necessity.

(a) If MAD determines the service specified on the claim was not performed or, was not a covered benefit or was not medically necessary, the MAD payment is recouped.

(b) Retrospective review involves the review of a specific portion or the entire record of service. Depending on the service, validation of either or both the diagnosis or procedure, validation of diagnostic related groups (DRGs), and quality of care are examples of indicators or issues which may be reviewed.

(c) A retrospective review may be conducted by MAD or its designee on a random or selective basis. In addition to reviews performed by a MAD staff or its designee, MAD analyzes statistical data to determine utilization patterns. Specific areas of overutilization may be identified that result in recoupment or repayment from either or both a provider or the assignment of a MAP eligible recipient to a MAD medical management designated provider.

(d) A selective or scheduled review is conducted to focus on the overutilization and underutilization of a specific service or provider. The service or procedure selected for this focused retrospective review is identified by MAD as potential or actual problems.

E. **Denial of payment:** If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

F. **Review of decisions:** A provider who disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision; see 8.350.2 NMAC. A provider who is not satisfied with the reconsideration determination may request a HSD provider administrative hearing; see 8.352.3 NMAC.

[8.310.2.14 NMAC - Rp, 8.310.2.15 NMAC, 1-1-14]

HISTORY OF 8.310.2 NMAC:

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

ISD 310.0100, Physician Services, filed 1-9-80.
ISD 310.0100, Physician Services, filed 6-16-80.
ISD 310.0100, Physician Services, filed 4-2-82.
ISD-Rule-310.0100, Physician Services, filed 9-2-83.
ISD-Rule-310.0100, Physician Services, filed 3-30-84.
ISD-Rule-310.0100, Physician Services, filed 4-26-84.
ISD-Rule-310.0100, Physician Services, filed 2-25-86.
MAD Rule 310.01, Physician Services, filed 12-15-87.
MAD Rule 310.01, Physician Services, filed 4-27-88.
MAD Rule 310.01, Physician Services, filed 4-20-92.
MAD Rule 310.01, Physician Services, filed 3-10-94.
SP-004.0400, Section 4, General Program Administration Medicaid Quality Control, filed, 1-23-81
SP-003.0103, Standards and Methods for Assuring High Quality Care, filed 1-27-81.
SP-004.1400, Section 4, General Program Administration Utilization Control, filed 3-3-81.
MAD Rule 310.27, Anesthesia Services, filed 7-2-90.
ISD 310.1000, Vision Care Services, filed 2-13-80.
ISD 310.1000, Vision Care Services, filed 7-8-82.
ISD Rule 310.1000, Vision Care Services, filed 2-28-83.
ISD Rule 310.1000, Vision Care Services, filed 8-23-84.
MAD Rule 310.10, Vision Care Services, filed 12-15-87.
MAD Rule 310.10, Vision Care Services, filed 10-26-88.
MAD Rule 310.10, Vision Care Services, filed 4-20-92.
ISD 310.0900, Dental Services, filed 2-13-80.
ISD 310.0900, Dental Services, filed 6-8-81.
ISD 310.0900, Dental Services, filed 10-14-83.
MAD Rule 310.09, Dental Services, filed 4-20-92.
MAD Rule 310.09, Dental Services, filed 11-12-93.
ISD 310.1500, Psychiatric and Psychological Services, filed 2-13-80.
ISD Rule 310.1500, Psychiatric and Psychological Services, filed 2-7-86.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12-15-87.
ISD Rule 310.1900, Certified Nurse Midwife Services, filed 9-19-83.
MAD Rule 310.19, Certified Nurse Midwife Services, filed 12-15-87.
MAD Rule 310.19, Midwife Services, filed 8-31-89.
ISD 310.1100, Podiatry Services, filed 2-13-80.
ISD 310.1100, Podiatry Services, filed 10-14-81.
ISD Rule 310.1100, Podiatry Services, filed 2-28-83.
ISD Rule 310.1100, Podiatry Services, filed 2-21-86.
MAD Rule 310.11, Podiatry Services, filed 12-15-87.
MAD Rule 310.11, Podiatry Services, filed 4-27-88.
MAD Rule 310.11, Podiatry Services, filed 4-20-92.
ISD-Rule 310.2100, Dialysis Services, filed 4-8-85.
SP-003.0400, Section 3, Services: General Provisions Special Requirements Applicable to Sterilization Procedures, filed 1-23-81.
ISD 310.1300, Family Planning Services, filed 2-18-80.
MAD Rule 310.13, Family Planning Services, filed 12-15-87.
ISD 310.0200, Hospital Services, filed 1-9-80.
ISD 310.0200, Hospital Services, filed 12-8-80.
ISD 310.0200, Hospital Services, filed 12-30-81.
ISD 310.0200, Hospital Services, filed 4-2-82.
ISD 310.0200, Hospital Services, filed 7-8-82.
ISD Rule 310.0200, Hospital Services, filed 4-5-83.
ISD Rule 310.0200, Hospital Services, filed 2-15-84.
ISD Rule 310.0200, Hospital Services, filed 4-26-84.
ISD Rule 310.0200, Hospital Services, filed 2-21-86.
MAD Rule 310.02, Hospital Services, filed 12-1-87.
MAD Rule 310.02, Hospital Services, filed 4-27-88.
MAD Rule 310.02, Hospital Services, filed 5-23-88.
MAD Rule 310.02, Hospital Services, filed 8-18-88.
MAD Rule 310.02, Hospital Services, filed 3-20-89.
MAD Rule 310.02, Hospital Services, filed 7-2-90.
MAD Rule 310.02, Hospital Services, filed 3-27-92.
MAD Rule 310.02, Hospital Services, filed 4-21-92.
MAD Rule 310.02, Hospital Services, filed 5-1-92.
MAD Rule 310.02, Hospital Services, filed 7-14-93.
MAD Rule 310.02, Hospital Services, filed 3-10-94.
MAD Rule 310.02, Hospital Services, filed 6-15-94.
MAD Rule 310.02, Hospital Services, filed 12-8-94.
MAD Rule 766, Pregnancy Termination Procedures, filed 11-30-94.

History of Repealed Material:

MAD Rule 310.01, Physician Services, filed 3-10-94 - Repealed effective 2-1-95.
MAD Rule 310.27, Anesthesia Services, field 7-2-90 - Repealed effective 2-1-95.
MAD Rule 310.10, Vision Care Services, filed 4-20-92 - Repealed effective 2-1-95.
MAD Rule 310.09, Dental Services, filed 11-12-93 - Repealed effective 1-18-95.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12-15-87 - Repealed effective 2-1-95.
MAD Rule 310.11, Podiatry Services, filed 4-20-92 – Repealed effective 2-1-95.
ISD-Rule 310.2100, Dialysis Services, filed 4-8-85 - Repealed effective 2-1-95.
MAD Rule 310.13, Family Planning Services, filed 12-15-87 - Repealed effective 2-1-95.
MAD Rule 310.02, Hospital Services, filed 12-8-94 - Repealed effective 2-1-95.
MAD Rule 310.01, Physician Services, filed 3-10-94 - Repealed effective 2-1-95 and 5-1-95.
8 NMAC 4.MAD.718.1, Midwife Services, filed 1-18-95 - Repealed effective 1-1-14.
8 NMAC 4.MAD.718.2, Podiatry Services, filed 1-18-95 - Repealed effective 7-1-04.
8 NMAC 4.MAD.762, Reproductive Health Services, filed 1-18-95 0 Repealed effective 1-1-14.
8.310.2 NMAC, Medical Services Providers, filed 2-16-04 - Repealed effective 1-1-14.
8.301.2 NMAC, General Benefit Description, filed 2-13-06 - Repealed effective 1-1-14.
8.301.3 NMAC, General Noncovered

Services, filed 2-13-06 - Repealed effective 1-1-14.
8.301.6 NMAC, Client Medical Transportation, filed 2-14-11 - Repealed effective 1-1-14.
8.302.5 NMAC, Prior Authorization and Utilization Review, filed 12-11-03 - Repealed effective 1-1-14.
8.310.5 NMAC, Anesthesia Services, filed 5-12-03 - Repealed effective 1-1-14.
8.310.6 NMAC, Vision Care Services, filed 11-12-03 - Repealed effective 1-1-14.
8.310.7 NMAC, Dental Services, filed 9-16-02 - Repealed effective 1-1-14.
8.310.8 NMAC, Behavioral Health Professional Services, filed 10-12-04 - Repealed effective 1-1-14.
8.310.11 NMAC, Podiatry Services, field 6-16-04 - Repealed effective 1-1-14.
8.310.13 NMAC, Telehealth Services, filed 7-17-07 - Repealed effective 1-1-14.
8.324.9 NMAC, Nutrition Services, filed 2-17-12 - Repealed effective 1-1-14.
8.325.2 NMAC, Dialysis Services, filed 10-15-04 - Repealed effective 1-1-14.
8.325.5 NMAC, Transplant Services, filed 2-17-12 - Repealed effective 1-1-14.
8.325.6 NMAC, Experimental or Investigational Procedures, Technologies or Non-Drug Therapies, filed 5-12-03 - Repealed effective 1-1-14.
8.325.7 NMAC, Pregnancy Termination Procedures, filed 10-16-03 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 3 PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT

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

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

8.310.3.3 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, Sections 27-2-12 et seq.
[8.310.3.3 NMAC - N, 1-1-14]

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

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

8.310.3.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.3.6 NMAC - N, 1-1-14]

8.310.3.7 DEFINITIONS: [RESERVED]

8.310.3.8 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.
[8.310.3.8 NMAC - N, 1-1-14]

8.310.3.9 ELIGIBLE PROVIDERS:

A. Health care to eligible medical assistance program (MAP) recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by the HSD medical assistance division (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 a MAP eligible recipient. 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 MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Upon approval of the New Mexico medical assistance PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) medical practitioners:

(a) a physician licensed to practice medicine or osteopathy;

(b) a licensed certified nurse practitioner under the supervision or in collaboration with a physician or as an independent practitioner;

(c) a licensed physician assistant certified by the national commission on certification of physician assistants under the supervision of a physician;

(d) a licensed pharmacist clinician under the supervision of a physician;

(e) a licensed clinical nurse specialist under the supervision or in collaboration with a physician or as an independent practitioner;

(f) a licensed nurse anesthetist certified by the American association of nurse anesthetists council on certification of nurse anesthetists;

(g) a licensed anesthesiologist assistant certified by the national commission for certification of anesthesiologist assistants (NCCAA);

(h) a licensed podiatrist;

(i) a licensed and certified nurse midwife;

(j) a licensed midwife;

(k) a licensed dietician or a licensed nutritionist under the direction of a licensed physician;

(l) a licensed optometrist; or

(m) a licensed audiologist certified by the American speech and hearing association;

(2) dental practitioners:

(a) a licensed dentist; or

(b) a licensed dental hygienist certified for collaborative practice;

(3) therapists:

(a) a physical therapist licensed by the physical therapy board under the state of New Mexico regulations and licensing division (RLD);

(b) an occupational therapist licensed by the board of occupational therapy under RLD; or

(c) a speech pathologist licensed by the board of speech, language, hearing under RLD;

(4) clinical laboratory, radiology, and diagnostic facilities:

(a) an independent clinical laboratory having a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory;

(b) a licensed radiological facility; or

(c) a licensed diagnostic

laboratory;

(5) transplant centers: practitioners and facilities licensed or certified to furnish specialized transplant medical or surgical services;

(6) other providers described in other rules found in NMAC rules eligible to provide services or receive reimbursement, such as behavioral health services, early and periodic screening, diagnostic and treatment (EPDST) services, institutional services, and other specialized services.

B. Upon approval of the New Mexico MAD PPA agreement by MAD or its designee, the clinic, professional association, or other legal entity may be enrolled as a MAD provider in order that payment may be made to the clinic, professional association, or other legal entity formed by one or more individual practitioners. The individual practitioners that are employed by or contracted by the clinic, professional practice or other legal entity must also be enrolled as individual providers. All requirements under state law and regulations or rules regarding supervision, direction, and approved supervisory practitioners must be met. Such entities include:

(1) professional components for inpatient and outpatient institutions;

(2) professional corporations and other legal entities;

(3) licensed diagnostic and treatment centers, including a birthing center licensed as a diagnostic and treatment center;

(4) licensed family planning clinics;

(5) public health clinics or agencies;

(6) Indian health services (IHS) facilities; and

(7) PL.93-638 tribal 638 facilities.

C. All services rendered must be within the legal scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD including meeting requirements for medical necessity.

D. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers outside of New Mexico, a provider's out of state license may be accepted in lieu of licensure in New Mexico if the out of state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

E. Additional licensure or certification requirements may be required for specialized services such as services provided to MAP special needs recipients. Transplantation providers are eligible for enrollment if licensed as state transplantation centers by the licensing and certification bureau of the New Mexico department of health (DOH); or if certified as transplantation centers by the centers for medicare and medicaid services (CMS).

F. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and NMAC rules or meet federal requirements for providing services to IHS facilities or tribal contract facilities.

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

8.310.3.10 COVERED SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of NMAC rules and benefits and within the scope and practice of the provider's professional standards.

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

8.310.3.11 REIMBURSEMENT: Providers must submit claims for reimbursement on the CMS-1500, American dental association (ADA), or universal billing (UB) claim form or their successor or their electronic equivalents, as appropriate to the provider type and service.

A. A provider is responsible for following coding manual guidelines and CMS national correct coding initiatives, including not improperly unbundling or upcoding services, not reporting services together inappropriately, and not reporting an inappropriate number or quantity of the same service on a single day. Bilateral procedures and incidental procedure are also subject to special billing payment policies. The payment for some services includes payment for other services. For example, payment for a surgical procedure may include hospital visits and follow up care or supplies which are not paid separately.

B. General reimbursement:

(1) reimbursement to professional service providers is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure;

(2) the billed charge must be the provider's usual and customary charge for the service or procedure.

(3) "usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.

C. Reimbursement limitations:

(1) Nurses: Reimbursement to a CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

(2) Midwife services: Reimbursement for midwife maternity services is based on one global fee, which includes prenatal care, delivery and postnatal care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at 77 percent of the rate paid to physicians for furnishing the global services and at 100 percent of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule.

(3) Surgery: Surgical assistants are reimbursed at 20 percent of the allowed primary surgeon amount. Surgical assistants are paid only when the surgical code allows for assistants as determined by medicare, CMS, or MAD. Physician assistants (PA), pharmacist clinicians, CNP's, midwives, and CNS's can only be paid as surgical assistants when it is within the scope of their practice as determined by state statute and their licensing boards.

(4) Physician extenders: Physician assistants, pharmacist clinicians and other providers not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works.

(5) Hospital settings: Reimbursement for services provided in hospital settings that are ordinarily furnished in a provider's office is made at 60 percent of the fee schedule allowed amount. MAD follows medicare principles in determining which procedures and places of service are subject to this payment reduction. For services not covered by medicare, the determination is made by MAD. For facility-based providers, costs billed separately as a professional component must be identified for exclusion from the facility cost report prior to cost settlement or rebasing.

(6) Dietician and nutrition services: For nutritional counseling services, physicians, physician extenders and clinics must include the charges for nutritional services in the office visit code when services are furnished by physicians or physician extenders. The level of the office visit reflects the length and complexity of the visit. For services furnished as part of prenatal or postpartum care, nutritional counseling services are included in the reimbursement fees for prenatal and postpartum care and are not reimbursed separately. Nutritional assessment and counseling services can be billed as a separate charge only when services are furnished to a MAP eligible recipient under age 21 by licensed nutritionists or

licensed dieticians who are employed by eligible providers. Reimbursement is made to eligible providers and not directly to the nutritionists or dieticians.

(7) Laboratory and diagnostic imaging reimbursement limitations:

(a) Use of medicare maximums: The MAD payment does not exceed the amount allowed by medicare for any laboratory service. Medicare notifies MAD on an annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums for reimbursement upon implementation by MAD.

(b) Referrals from providers: Physicians and other private practitioners cannot bill for laboratory tests which are sent to an outside laboratory or other facility. Payment for laboratory services cannot be made directly to a practitioner unless the tests were performed in his or her own office. Laboratories can bill for tests sent to other laboratories only if the CLIA number of the other laboratory is identified on the claim form. State facilities which contract for services with other state-operated laboratories, such as the state health laboratory, can bill for those services providing the amount billed for the service does not exceed the amount paid by the state facility to the contractor.

(c) Reimbursement for collection costs: MAD does not reimburse an independent clinical laboratory separately for associated collection costs such as office visits, home visits or nursing home visits.

(d) Services performed as profile or panel: Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel. MAD cannot be billed for individual lab procedures that are considered included in a profile or panel.

(8) Radiology:

(a) Non-profit licensed diagnostic and treatment centers and state facilities: Non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center.

(b) Reimbursement for additional charges: Reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

(c) Reimbursement for inclusive procedures: Reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

(d) Reimbursement for the professional component of a radiology service does not exceed 40 percent of the amount allowed for the complete procedure.

(i) A professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(ii) A claim for "supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

(9) Telemedicine providers: Reimbursement for services at the originating-site (where the MAP eligible recipient is located) and the distant-site (where the provider is located) are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

D. Reimbursement for services furnished by medical interns or residents: Reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in another hospital that participates in a teaching program is only made through an institutional reimbursement process. Medical or surgical services performed by an intern or a resident that are unrelated to educational services, internship, or residency, are reimbursed according to the MAD fee schedule for physician services when all of the following provisions are met:

(1) services are identifiable physician services that are performed by the physician in person;

(2) services must contribute to the diagnosis or treatment of the MAP eligible recipient's medical condition;

(3) an intern or resident is fully licensed as a physician;

(4) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and

(5) services are excluded from outpatient hospital costs; when these criteria are met the services are considered to have been furnished by the practitioner in his or her capacity as a physician and not as an intern or resident.

E. Services of an assistant surgeon in an approved teaching program:

(1) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since the resident is available to perform services unless the following exceptional medical circumstances exist:

(a) an assistant surgeon is needed due to unusual medical circumstances;

(b) the surgery is performed by a team of physicians during a complex procedure; or

(c) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the MAP eligible recipient's medical condition.

(2) This reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

F. Reimbursement for dental residents: Reimbursement can be made for dental residents in an approved teaching program when all the following conditions are met:

(1) the resident is fully licensed as a dentist for independent practice;

(2) the costs of the dental residency program is not included in the direct or graduate medical education payments to a provider operating the teaching program; and

(3) only one dental claim is submitted for the service; the supervising dentist and the rendering dentist will not be both paid for the service or procedure.

G. Non-independent practitioners: Reimbursement for services furnished by a physician assistant, a pharmacist clinician, or another practitioner whose license is not for independent practice, is made only to the billing supervising practitioner or entity rather than directly to the supervised practitioner.

H. Surgical procedures: Reimbursement for surgical procedures is subject to certain restrictions and limitations.

(1) When multiple procedures that add significant time or complexity to care are furnished during the same operative session, the major procedure is reimbursed at 100 percent of the allowable amount, the secondary procedure is reimbursed at 50 percent of the allowable amount and any remaining procedures are reimbursed at 25 percent of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly. "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same MAP eligible recipient on the same date of service.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier. Reimbursement for bilateral procedures is 150 percent of the amount allowed for a unilateral procedure.

(3) Surgeons are not reimbursed for the performance of incidental procedures, such as incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias, or tubal ligations done in conjunction with cesarean sections.

(4) Providers are not reimbursed

for performing complete physical examinations or histories during follow-up treatment after a surgical procedure.

(5) Other health care related to a surgery is considered to be reimbursed in the payment for the surgery and is not paid as a separate cost. Surgical trays and local anesthesia are included in the reimbursement for the surgical procedure.

(6) Under certain circumstances, the skills of two surgeons, usually with different surgical specialties may be required in the management of a specific surgical problem. The total allowed value of the procedure is increased by 25 percent and each surgeon is paid 50 percent of that amount.

I. Maternity services: Reimbursement for maternity care is based on one global fee. Routine prenatal, delivery and post-natal care are included in the global fee. Services related to false labor and induced labor are also included in the global fee.

(1) If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code.

(2) MAD pays based on a modifier for high-risk pregnancies or for complicated pregnancies. The determination of high risk is based on a claims review.

(3) Based on the eligibility category, MAD may pay only for pregnancy-related services. The determination of whether services are related or non-related to pregnancy is based on the diagnosis. Pregnancy-related includes anything which may affect the health of the MAP eligible recipient mother or her fetus, or outcome of her fetus, including pre-existing and chronic conditions.

(4) If partial services are furnished by a midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code.

(5) If the services furnished include a combination of services performed by a midwife and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.

(6) MAD pays supply fees only when a MAP eligible recipient is accommodated for two hours or more in the home or a birthing center prior to delivery. Payment for use of a licensed birthing center includes supplies.

(7) MAD covers postnatal care by a midwife as a separate service only when the midwife does not perform the delivery.

(8) Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.

(9) Reimbursement for cesarean sections and inductions is made only when the service is medically necessary. These services are not covered as elective procedures.

J. Services limited by frequency:

(1) services furnished by another provider: where coverage of services provided to MAP eligible recipient is restricted or limited by frequency of services, procedures or materials, it is a provider's responsibility to determine if a proposed service has already been furnished by another provider, such that the MAP eligible recipient has exhausted the benefit. Examples include but are not limited to dental services, vision exams and eyeglasses.

(2) direct MAP eligible recipient payment for services: a provider can make arrangements for direct payment from a MAP eligible recipient or his or her authorized representative for noncovered services. A MAP eligible recipient or his or her authorized representative can only be billed for noncovered services if:

(a) a MAP eligible recipient or his or her authorized representative is advised by a provider of the necessity of the service and the reasons for the non-covered status;

(b) a MAP eligible recipient or his or her authorized representative is given options to seek treatment at a later date or from a different provider;

(c) a MAP eligible recipient or his or her auhtorized representative agrees in writing to be responsible for payment; and

(d) the provider fully complies with the NMAC rules relating to billing and claims filing limitations.

(3) services considered part of the total treatment: a provider cannot bill separately for the services considered included in the payment for the examination, another service, or for routine post-operative or follow-up care.

K. Anesthesia services:

(1) Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time.

(a) Each anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the conversion factor allowed for each unit.

(b) The reimbursement per anesthesia unit may vary depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) and a non-directed CRNA.

(c) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiologist assistant, one time unit is allowed for each 15-minute period a MAP eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15-minute period.

(2) Medical direction: Reimbursement is made at 50 percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA). Reimbursement is made at 50 percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a MAP eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-MAP eligible recipients and the remaining is a MAP eligible recipient, this represents three concurrent cases.

(a) Time units for medical direction are allowed at one time unit for each 15-minute interval.

(b) Anesthesia claims are not payable if the surgery is not a MAD benefit or if any required documentation was not obtained.

(c) Medical direction is a covered service only if the physician:

(i) performs a pre-anesthesia examination and evaluation; and

(ii) prescribes the anesthesia plan; and

(iii) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(iv) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist; and

(v) monitors the course of anesthesia administration at frequent intervals; and

(vi) remains physically

present and available for immediate diagnosis and treatment of emergencies; and

(vii) provides indicated post-anesthesia care.

(d) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(e) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(f) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(g) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

(3) Monitored anesthesia care: Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(a) "Monitored anesthesia care" is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the MAP eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological MAP eligible recipient reaction to the surgical procedure and includes:

(i) performance of a pre-anesthetic examination and evaluation;

(ii) prescription of the anesthesia care required;

(iii) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the MAP eligible recipient's physiological signs;

(iv) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(v) provision of indicated postoperative anesthesia care.

(b) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

(c) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

(4) Medical supervision: If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed anesthesia services. The MAD payment to the CRNA will be 50 percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.

(5) Obstetric anesthesia: Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

(6) Unusual circumstances: When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the MAP eligible recipient's record.

(7) Pre-anesthetic exams and cancelled surgery: A pre-anesthetic examination and evaluation of a MAP eligible recipient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

(8) Performance of standard procedures: If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units or units for time.

(9) Add-on codes for anesthesia: Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

(10) Anesthesia services furnished by the same physician providing the medical and surgical service:

(a) A physician who both performs and provides moderate sedation for medical or surgical Services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who performs and provides local or minimal sedation for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

(i) local or topical anesthesia; to

(ii) moderate (conscious) sedation; to

(iii) regional anesthesia; to

(iv) general anesthesia.

(b) Moderate sedation is a drug-induced depression of consciousness during which a MAP eligible recipient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines. However, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

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

HISTORY OF 8.310.3 NMAC:

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

ISD 310.0100, Physician Services, filed 1-9-80.

ISD 310.0100, Physician Services, filed 6-16-80.

ISD 310.0100, Physician Services, filed 4-2-82.

ISD-Rule-310.0100, Physician Services, filed 9-2-83.

ISD-Rule-310.0100, Physician Services, filed 3-30-84.

ISD Rule-310.0100, Physician Services, filed 4-26-84.

ISD Rule-310.0100, Physician Services, filed 2-25-86.
MAD Rule 310.01, Physician Services, filed 12-15-87.
MAD Rule 310.01, Physician Services, filed 4-27-88.
MAD Rule 310.01, Physician Services, filed 4-20-92.
MAD Rule 310.01, Physician Services, filed 3-10-94.
MAD Rule 310.27, Anesthesia Services, filed 7-2-90.

History of Repealed Material:
MAD Rule 310.01, Physician Services, filed 3-10-94 - Repealed effective 2-1-95.
MAD Rule 310.27, Anesthesia Services, filed 7-2-90 - Repealed effective 2-1-95.
8.310.2 NMAC, Medical Services Providers, filed 2-16-04 - Repealed effective 1-1-14.
8.310.3 NMAC, Rural Health Clinic Services, filed 2-17-12 - Repealed effective 1-1-14. Replaced by 8.310.9 NMAC, Rural Health Clinic Services, effective 1-1-14.
8.310.5 NMAC, Anesthesia Services, filed 5-12-03 - Repealed effective 1-1-14.
8.310.13 NMAC, Telehealth Services, filed 7-17-07 - Repealed 1-1-14.
8.324.2 NMAC, Laboratory Services, filed 2-17-12 - Repealed 1-1-14.
8.324.3 NMAC, Diagnostic Imaging and Therapeutic Radiology Services, filed 2-17-12 - Repealed 1-1-14.
8.324.9 NMAC, Nutrition Services, filed 2-17-12 - Repealed 1-1-14.
8.325.3 NMAC, Reproductive Services, filed 1-18-95 - Repealed 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 9 RURAL HEALTH CLINIC SERVICES

8.310.9.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.310.9.1 NMAC - Rp, 8.310.3.1 NMAC, 1-1-14]

8.310.9.2 SCOPE: The rule applies to the general public.
[8.310.9.2 NMAC - Rp, 8.310.3.2 NMAC, 1-1-14]

8.310.9.3 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 Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[8.310.9.3 NMAC - Rp, 8.310.3.3 NMAC, 1-1-14]

8.310.9.4 DURATION: Permanent
[8.310.9.4 NMAC - Rp, 8.310.3.4 NMAC, 1-1-14]

8.310.9.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.9.5 NMAC - Rp, 8.310.3.5 NMAC, 1-1-14]

8.310.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.310.9.6 NMAC - Rp, 8.310.3.6 NMAC, 1-1-14]

8.310.9.7 DEFINITIONS: [RESERVED]

8.310.9.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.310.9.8 NMAC - Rp, 8.310.3.8 NMAC, 1-1-14]

8.310.9.9 RURAL HEALTH CLINIC SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help rural New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered medicaid services provided in rural health clinics [42 CFR Section 440.20]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[8.310.9.9 NMAC - Rp, 8.310.3.9 NMAC, 1-1-14]

8.310.9.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following providers are eligible to be reimbursed for furnishing services as rural health clinics:

(1) clinics certified as non-hospital based rural health clinics by the health care financing administration (HCFA) following a survey and recommendation from the licensing and certification bureau of the New Mexico department of health (DOH); or

(2) clinics which are integral parts of institutional providers, such as hospitals, skilled nursing facilities or home health agencies, that have been certified as hospital-based rural health clinics by the licensing and certification bureau of the DOH.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.310.9.10 NMAC - Rp, 8.310.3.10 NMAC, 1-1-14]

8.310.9.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*.
[8.310.9.11 NMAC - Rp, 8.310.3.11 NMAC, 1-1-14]

8.310.9.12 COVERED SERVICES AND SERVICE LIMITATIONS: All services provided by the clinic must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid covered benefits.

A. The following are covered services:

(1) medically necessary diagnostic and therapeutic services, supplies, and treatment of medical conditions, including medically necessary family planning services; see Section MAD-762, *Reproductive Health Services*;

(2) laboratory and diagnostic imaging services for diagnosis and treatment; and

(3) surgical procedures, emergency room physician services, and inpatient hospital visits furnished at a different facility when performed by a physician under contract to a rural health clinic.

B. **Visiting nurse services:** Medicaid covers visiting nurse services through a rural health clinic if the following criteria are met [42 CFR Section 440.20(b)

(4)]:

(1) the rural health clinic is located in an area in which there is a shortage of home health agencies, as determined by the secretary of the federal department of health and human services; the rural health clinic does not need separate or additional home health agency certification to furnish visiting nurse services;

(2) the services are furnished to homebound recipients;

(3) the services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, or receives compensation for the services from the clinic;

(4) the services are furnished under a written plan of treatment that is:

(a) established and reviewed at least every sixty (60) days by supervising physicians at the rural health clinics;

(b) established by certified nurse practitioners, certified physician assistants, certified nurse midwives, licensed nurse midwives, or specialized nurse practitioners and reviewed at least every sixty (60) days by supervising physicians; and

(c) signed by nurse practitioners, physician assistants, nurse midwives, specialized nurse practitioners, or supervisory physicians of the clinic;

(5) prior approval for nursing services must be obtained from the MAD utilization review contractor.

C. **Primary care network restrictions:** All rural health clinics are subject to the primary care network restrictions. See Section MAD-603, Primary Care Network.

[8.310.9.12 NMAC - Rp, 8.310.3.12 NMAC, 1-1-14]

8.310.9.13 NON-CORE MEDICAL SERVICES: Core medical services, as defined in the Rural Health Clinic Act, performed at rural health clinics are included in the encounter rate for purposes of medicaid reimbursement. The following non-core services may be provided in rural clinics, however, reimbursement for these services is not included in the encounter rate:

A. optometric services, including vision examinations and eyeglasses dispensing;

B. hearing aid dispensing and related evaluations;

C. psychological services;

D. rural health drug services; and

(1) pharmacy services are covered by medicaid if the rural health clinic obtains a separate pharmacy provider number; a separate New Mexico medical assistance program provider participation application must be submitted for pharmacy services and be approved by MAD;.

(2) pharmacy dispensing services must be billed with the separate pharmacy provider number;.

(3) the rural health clinic pharmacy must be licensed by the state pharmacy board; see 8.324.4 NMAC, *Pharmacy Services*.

E. **Rural health dental services:**

(1) Certified rural health clinics may participate as rural health dental providers if they obtain a separate dental provider numbers. A separate New Mexico medical assistance program provider participation application must be submitted by a rural health center dental provider and be approved by MAD.

(2) Dental services must be billed under the separate dental provider number, not the rural health clinic provider number. See 8.310.7 NMAC, *Dental Services*.

[8.310.9.13 NMAC - Rp, 8.310.3.13 NMAC, 1-1-14]

8.310.9.14 NONCOVERED SERVICES: Rural health clinic services are subject to the same limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

[8.310.9.14 NMAC - Rp, 8.310.3.14 NMAC, 1-1-14]

8.310.9.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services may require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[8.310.9.15 NMAC - Rp, 8.310.3.15 NMAC, 1-1-14]

8.310.9.16 REIMBURSEMENT: Rural health clinics must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. **Reimbursement for non-hospital based rural health clinics:** Interim reimbursement is made at an encounter rate established for the clinic by the medicare intermediary.

(1) An "encounter" means a face-to-face meeting between a recipient and any health professional whose services are reimbursed as a covered rural health clinic service.

(2) A final cost settlement based on the audit data is made in accordance with applicable medicare regulations following the medicare cost settlement.

(3) Multiple encounters with the same or different health professional(s) that take place on the same date at a single location are considered a single encounter.

(a) Exceptions exist for cases in which the recipient suffers illness or injury requiring additional diagnosis or treatment on the same day, after the first encounter.

(b) All medical, surgical, diagnostic imaging, supplies, and clinical laboratory services furnished during the encounter are considered reimbursed within the encounter rate.

B. **Reimbursement for non-core services:** Reimbursement to rural health clinics for drug services, dental services, vision services, hearing services, psychiatric or psychological services, and other non-core medical services is made according to the regulations applicable to each of these specific program areas. These services are not reimbursed on a reasonable cost basis, but instead are reimbursed as described in the applicable service sections.

C. **Reimbursement for hospital based rural health clinics:** Interim reimbursement to hospital, or other facility, based rural health clinics is made at the percentage determined by MAD. Adjustments and fiscal year reconciliations are made by MAD.

[8.310.9.16 NMAC - Rp, 8.310.3.16 NMAC, 1-1-14]

HISTORY OF 8.310.9 NMAC:

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

ISD Rule 310.1800, Rural Health Clinic Services, filed 2/18/80.

ISD-Rule 310.1800, Rural Health Clinic Services, filed 2/24/86.

MAD Rule 310.18, Rural Health Clinic Services, filed 4/27/88.

MAD Rule 310.18, Rural Health Clinic Services, filed 4/21/92.

History of Repealed Material:
8.310.3 NMAC, Rural Health Clinic Services, filed 2-17-12 - Repealed effective 1-1-14. Replaced by 8.310.9 NMAC, Rural Health Clinic Services, effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES
PART 2 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

8.320.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.320.2.1 NMAC - Rp, 8.320.2.1 NMAC, 1-1-14]

8.320.2.2 SCOPE: The rule applies to the general public.
[8.320.2.2 NMAC - Rp, 8.320.2.2 NMAC, 1-1-14]

8.320.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.320.2.3 NMAC - Rp, 8.320.2.3 NMAC, 1-1-14]

8.320.2.4 DURATION: Permanent.
[8.320.2.4 NMAC - Rp, 8.320.2.4 NMAC, 1-1-14]

8.320.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.320.2.5 NMAC - Rp, 8.320.2.5 NMAC, 1-1-14]

8.320.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.320.2.6 NMAC - Rp, 8.320.2.6 NMAC, 1-1-14]

8.320.2.7 DEFINITIONS: [RESERVED]

8.320.2.8 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.
[8.320.2.8 NMAC - Rp, 8.320.2.8 NMAC, 1-1-14]

8.320.2.9 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES: The medical assistance division (MAD) pays for medically necessary health services including preventive, treatment and ameliorative services for a medical assistance program (MAP) eligible recipient under 21 years of age through the early and periodic screening, diagnostic and treatment (ESPDT) services program. See 42 CFR 441.50 Subpart B.

A. EPSDT description:

(1) early: assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;

(2) periodic: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development;

(3) screening: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;

(4) diagnostic: the determination of the nature or cause of conditions identified by the screening; and

(5) treatment: the provision of services needed to control, correct or lessen health problems.

B. Services provided under EPSDT are accessed following an initial health screening service called the tot to teen healthcheck or health check referral or through other diagnostic evaluations or assessments.
[8.320.2.9 NMAC - Rp, 8.320.2.9 NMAC, 1-1-14]

8.320.2.10 GENERAL EPSDT SCREENINGS AND REFERRALS: EPSDT includes a screening component called the "tot to teen healthcheck". EPSDT also includes diagnostic, treatment, and other necessary health care measures needed to correct or ameliorate physical and behavioral health disorders or conditions discovered during the tot to teen healthcheck or through other diagnostic evaluations or assessments.
[8.320.2.10 NMAC - Rp, 8.320.2.10 NMAC, 1-1-14]

8.320.2.11 INFORMATION GIVEN TO MAP ELIGIBLE RECIPIENTS:

A. A MAP eligible recipient under 21 years of age, or his or her family, is provided with the following information:

(1) benefits of preventive health care;

(2) services available under EPSDT and where and how to access those services;

(3) services provided under EPSDT are furnished at no cost to a MAP eligible recipient;

(4) transportation and scheduling assistance is available upon request; and

(5) the right to request a HSD administrative hearing.

B. Within 30 calendar days of the initial medical assistance application, and annually at each eligibility redetermination period thereafter, a MAP eligible recipient is furnished with information about the tot to teen healthcheck screen and EPSDT services.
[8.320.2.11 NMAC - Rp, 8.320.2.11 NMAC, 1-1-14]

8.320.2.12 EPSDT ELIGIBLE PROVIDERS: Upon MAD's approval of a PPA, a licensed practitioner, agency or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HSD/MAD websites, on other program-specific or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD New Mexico administrative code (NMAC) rules, billing instructions, utilization review (UR) instructions and other pertinent materials. Once enrolled, a provider receives instructions on how to access these documents. 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 is bound by the provisions of the MAD PPA.
[8.320.2.12 NMAC - Rp, 8.320.3.10 NMAC, 8.320.4.10 NMAC & 8.320.5.10 NMAC, 1-1-14]

8.320.2.13 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in

NMAC rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determine if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. Services furnished to a MAP eligible recipient must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority.

[8.320.2.13 NMAC - Rp, 8.320.3.11 NMAC, 8.320.4.11 NMAC & 8.320.5.11 NMAC, 1-1-14]

8.320.2.14 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency or each individual provider. Services must be in compliance with the statutes, rules and regulations of his or her practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.

C. A specific EPSDT service may have additional service restrictions listed in the service's non-covered section. Generally the following are considered to be noncovered by MAD:

(1) services furnished to an individual who is not eligible for MAD EPSDT services;

(2) services furnished without the prior authorization of the MAP eligible recipient's primary care provider (PCP) or HSD or its designee;

(3) services provided by a practitioner who is not in compliance with the statutes, regulations, rules or who renders services outside of the scope of practice as defined by his or her practice board;

(4) services that are not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient;

(5) services that are primarily educational or vocational in nature; and

(6) services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Certain EPSDT procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specific EPSDT service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

E. All EPSDT services are reimbursed as follows, except when otherwise instructed. MAD does not pay a professional component amount to a physical, occupational or speech and language pathologist (SLP) if the therapy is performed in a hospital setting. MAD reimburses the institutional provider for all components of the service.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a provider for covered services at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) the provider's billed charge must be its usual and customary charge for services;

(ii) "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(2) Services not paid according to a fee schedule are reimbursed using the methodology and rate in effect at the time of service.

(3) Reimbursement to the local education agency (LEA), regional educational cooperative (REC), and another state-funded educational agency (SFEA) is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's individual education plan (IEP), and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142. and the services are covered by MAD, then MAD is permitted to pay for such services.

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

8.320.2.15 TOT TO TEEN HEALTHCHECK: MAD developed the tot to teen healthcheck, the screening segment of EPSDT services. The tot to teen healthcheck includes periodic screening and regularly scheduled assessments of the MAP eligible recipient's general physical growth and development as well as behavioral health and social emotional development.

A. Primary care providers (PCP), dentists, psychologists, IHS public health clinics, federally qualified health center (FQHC), rural health clinic (RHC), community mental health centers (CMHC), hospitals, school-based clinics, independent certified or licensed nurse practitioners and other health care providers may perform tot to teen healthcheck screens or partial health screenings. A provider must meet the participation requirements specified in applicable sections of NMAC rules. Tot to

teen healthcheck screens must be furnished within the scope of the provider's practice, as defined by law.

B. Screening services are furnished to a MAP eligible recipient under 21 years of age. Referrals or treatment for conditions detected during a complete or a partial screen which require further treatment are then covered as part of MAD's EPSDT services. A tot to teen healthcheck can be performed during an office visit for an acute illness as long as the illness does not affect the results or the screening process.

(1) Screening schedule for medical components:

(a) The MAD tot to teen healthcheck periodicity schedule allows for a total of 25 screens. Screenings are encouraged at the following intervals:

(i) under age one: six screenings (birth, one, two, four, six and nine months)

(ii) ages one-two: four screenings (12, 15, 18 and 24 months)

(iii) ages three-five: three screenings (three, four and five years)

(iv) ages six-nine: two screenings (six and eight years)

(v) ages 10-14: four screenings (10, 12, 13 and 14 years)

(vi) ages 15-18: four screenings (15, 16, 17 and 18 years)

(vii) ages 19-20: two screenings (19 and 20 years).

(b) Screenings may be performed at intervals other than as described on the periodicity schedule or in addition to those on the periodicity schedule if a MAP eligible recipient receives care at a time not listed on the periodicity schedule or if any components of the screen were not completed at the scheduled ages. Additional screenings can help bring the MAP eligible recipient up to date with the periodicity schedule.

(c) The established schedule must be followed unless the MAP eligible recipient's medical condition is such that a brief deviation is warranted.

(2) Complete medical screens include the following components:

(a) a comprehensive health and developmental history, including an assessment of both physical and behavioral health or social emotional development;

(b) a comprehensive unclothed physical exam;

(c) appropriate immunizations, according to age and health history, unless medically contraindicated at the time;

(d) laboratory tests, including an appropriate blood lead level assessment;

(e) health education, including the MAD anticipatory guidance; and

(f) vision and hearing screenings at the ages indicated in the MAD EPSDT preventative health guidelines.

(3) MAD pays for partial medical screens to a MAP eligible recipient. Partial medical screens are defined as screens where all the required components of a complete medical screen are not completed for medical reasons.

(4) MAD covers additional medical screens as listed below.

(a) Behavioral health screenings are performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of a behavioral health disorders or conditions.

(b) Dental examinations are performed at intervals which meet reasonable dental standards. Usually these examinations are furnished every six months. However, examinations can be furnished at other intervals as medically necessary.

(c) Hearing testing is performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of defects in hearing. A hearing test using an audiogram should be given to a MAP eligible recipient at five years of age or prior to him or her to entering school. Annual examinations should be furnished if abnormalities are identified.

(d) Interperiodic screens can be performed at intervals beyond those specified in the periodicity schedule. Reimbursement for the performance of interperiodic screens is made only to a MAD provider. Interperiodic screens are screening encounters with health care, developmental, or educational professionals to determine the existence of suspected physical or behavioral health disorders or conditions.

(e) Vision examinations are performed at intervals which meet reasonable vision standards or at other intervals as medically necessary. A vision examination should be furnished before the MAP eligible recipient reaches three years of age and again prior to five years of age or prior to entering school. If no abnormalities are found, screenings should be furnished every two years with a complete examination furnished if indicated.

(f) Other necessary health care or diagnostic services are performed when medically necessary.

C. MAD covers services considered medically necessary for the treatment or amelioration of conditions identified as a result of a complete tot to teen healthcheck screen, partial medical screen, or interperiodic screen. Diagnostic or evaluation services furnished during the screening cannot be duplicated as part of the follow-up treatment. If appropriate, treatment is furnished by the screening provider at the time of the tot to teen healthcheck.

(1) A MAP eligible recipient can be referred for treatment as a result of a tot to teen healthcheck, regardless of whether the provider making the referral is a participating MAD provider. If it is inappropriate for a screening provider to furnish treatment needed by the MAP eligible recipient, referrals must be made only to a qualified MAD provider.

(2) A MAP eligible recipient may be identified through a tot to teen healthcheck, self referral, or referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns. For a MAP eligible recipient requiring extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of a MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

(c) The plan must be developed in cooperation with the MAP eligible recipient, his or her parents, or guardians, and other health care professionals, as appropriate. In the case of a MAP eligible recipient under 21 years of age who is placed in the custody of the children, youth and families department (CYFD), its assigned social worker, and those appropriate from CYFD's juvenile justice system (JJS) are to be included in the development of the plan.

(d) See to 8.321.2 NMAC for additional information regarding specialized behavioral health services for an ESPDT MAP eligible recipient.

(3) A MAP eligible recipient, when allowed under state law, has the right to refuse proposed medical and behavioral health treatment. He or she has the freedom to select among enrolled MAD providers. Information in this section does not restrict or limit a MAP eligible recipient's rights or choice.

[8.320.2.15 NMAC - Rp, 8.320.3 NMAC, 1-1-14]

8.320.2.16 EPSDT SPECIAL REHABILITATION (FAMILY INFANT TODDLER EARLY INTERVENTION) SERVICES: MAD special rehabilitation services are furnished through the New Mexico department of health (DOH) family infant toddler (FIT) program. FIT provides early intervention services for a MAP eligible that has or is at risk of having a developmental delay from birth to his or her third birth year. Developmental delay or at risk of is defined by DOH. A MAP eligible recipient with a developmental delay or who is at risk of having a developmental delay is not considered to have a diagnosis of an

intellectual or developmental disability. FIT services include evaluation, diagnostics and treatment necessary to correct or treat any defects or conditions or to teach compensatory skills for deficits that directly result from a medical or behavioral health condition. The appropriate information from evaluation and diagnostics is interpreted and integrated in the individual family service plan (IFSP). If the need for special rehabilitation is identified outside of the tot to teen healthcheck process, the MAP eligible recipient's PCP must be notified of the results and be included in the treatment plan development, if the PCP so elects.

A. MAD EPSDT special rehabilitation eligible providers: An enrolled MAD agency certified by DOH as a special rehabilitation services provider is eligible to be reimbursed for furnishing special rehabilitation services to a MAP eligible recipient. Individual providers rendering special rehabilitation services that are employed by or contracted by a MAD special rehabilitation provider agency must meet applicable DOH standards. A provider shall:

(1) render special rehabilitation services under the direction of a professional acting within his or her scope of practice as defined by state law;

(2) render special rehabilitation services in the most appropriate least restrictive environment;

(3) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services or services funded under the state general fund DOH contract.

B. EPSDT special rehabilitation MAP eligible recipients: An individual who has been determined through a multidisciplinary developmental evaluation to have, or be at risk for, a developmental delay and to be in need of special rehabilitative services as defined by DOH is eligible to receive special rehabilitation services. Any individual that has been diagnosed with an intellectual or developmental disability is not eligible for FIT services.

C. EPSDT special rehabilitation treatment plan for a MAP eligible recipient: The need for special rehabilitation services must be documented in the MAP eligible recipient's treatment plan or in his or her IFSP. The treatment plan must be developed in accordance with applicable DOH policies and procedures and federal regulations governing Part C of the Individuals with Disabilities Education Act. The treatment plan or IFSP must be developed within 45 calendar days of the initiation of services and reviewed every six months or more often as indicated. The following must be contained in the treatment plan or IFSP documents and must be available for review in the MAP eligible recipient's agency file:

(1) a statement of the MAP eligible recipient's present levels of physical development including vision, hearing, and health status;

(2) an assessment of his or her communications development;

(3) an assessment of his or her behavioral health status, to include his or her social or emotional development;

(4) an assessment of his or her cognitive development;

(5) an assessment of his or her adaptive development;

(6) his or her family history and other relevant family information;

(7) a description of his or her intermediate and long-range goals, with a projected timetable for their attainment and dates, and the duration and scope of services;

(8) the procedures and time lines to determine the progress made toward achieving the outcomes and whether modifications to or revisions of the outcomes or services are needed; and

(9) statement of the specific special rehabilitation services needed to meet the MAP eligible recipient's unique needs and also achieve the outcomes specified, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

D. EPSDT special rehabilitation covered services:

(1) MAD only covers special rehabilitation services necessary to enhance development in one or more of the following developmental domains:

(a) physical and motor;

(b) communication;

(c) adaptive;

(d) cognitive;

(e) behavioral health to include social or emotional; or

(f) sensory.

(2) Special rehabilitation services generally involve the MAP eligible recipient's family and are designed to support and enhance the MAP eligible recipient's developmental services and are provided through FIT. The following are a list of covered services:

(a) Developmental evaluation and rehabilitation services are the assessments performed to determine if motor, speech, language and psychological problems exist with the MAP eligible recipient or to detect the presence of his or her developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating a MAP eligible recipient's medical or other health-related condition. Services also include consultation with the family and other professional staff. These services are provided as a result of a referral from the MAP eligible recipient's PCP.

(b) Nursing services are performed by a MAD enrolled certified nurse practitioner (CNP), registered nurse (RN) or licensed practical nurse (LPN) within the scope of his or her practice relevant to the medical and rehabilitative needs of the MAP eligible recipient. These services are provided as the result of a referral from the MAP eligible recipient's PCP. Services include the administration and monitoring of medication, catheterization, tube feeding, suctioning, and the screening and referral for other health needs. Nursing services also include explanations to the MAP eligible recipient's family or other professional staff concerning the treatments, therapies, and physical or social emotional health conditions.

(c) Physical therapy services are provided by or under the direction of a qualified MAD enrolled physical therapist (PT) as a result of a referral from the MAP eligible recipient's PCP. Physical therapy services are the evaluations required to determine the MAP eligible recipient's need for physical therapy and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the family and other professional staff.

(d) Occupational therapy services are provided by or under the direction of a qualified MAD enrolled occupational therapist (OT) as the result of a referral from the MAP eligible recipient's PCP. Occupational therapy services include the evaluation of the MAP eligible recipient to determine if he or she is experiencing problems that interfere with his or her functional performance and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the MAP eligible recipient's family and other professional staff.

(e) Behavioral health services are diagnostic or active treatments with the intent to reasonably improve the MAP eligible recipient's condition; see 8.321.2 NMAC for a detailed description of behavioral health services.

(f) Speech, language and hearing services provided by or under the direction of a MAD enrolled SLP or audiologist, as the result of a referral by the MAP eligible recipient's PCP. Speech, language and hearing services are the evaluations required to determine the MAP eligible recipient's need for these services and recommendations for a course of treatment.

Treatment is provided to a MAP eligible recipient with a diagnosed speech, language or hearing disorder which adversely affects his or her functioning. Services also include consultations with the MAP eligible recipient's family and other professional staff.

E. EPSDT special rehabilitation noncovered services: Special rehabilitation services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

F. EPSDT special rehabilitation prior approval and utilization: All MAD EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. Specifically for special rehabilitation services, a maximum of 14 hours per month of services to a MAP eligible recipient can be furnished by a provider before prior approval is required from DOH.

[8.320.2.16 NMAC - Rp, 8.320.4 NMAC, 1-1-14]

8.320.2.17 EPSDT CASE MANAGEMENT SERVICES: MAD pays for case management services furnished to a medically at risk MAP eligible recipient under 21 years of age as an EPSDT service. The need for case management services must be identified in the tot to teen healthcheck screen or through other diagnostic evaluations or assessments.

A. EPSDT case management eligible providers: A qualified MAD enrolled case management agency is eligible to be reimbursed for furnishing services to a MAP eligible recipient. An agency must demonstrate direct experience in successfully serving medically at risk individuals under the age of 21 years and demonstrate knowledge of available community services and methods for gaining access to those services.

(1) The following agencies can furnish case management services:

(a) a governmental agency;

(b) a native Indian tribal government;

(c) the IHS;

(d) a FQHC; and

(e) a community case management agency.

(2) Case manager qualifications: A case manager employed by a MAD enrolled case management agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have at least one year of experience serving medically at risk individuals under the age of 21 years. Case managers must have the necessary skills to meet the needs of a particular MAP eligible recipient. In some instances, it is important that the case manager have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. In addition, a case manager must meet at least one of the following requirements:

(a) hold a bachelor's degree in social work, counseling, psychology, sociology, education, special education, cultural anthropology or a related health or social service field from an accredited institution; a case manager with a bachelor's degree in another field can substitute two years of direct experience in serving the medically at risk population for the required field of study; or

(b) be licensed as a RN or LPN;

(c) case management services for medically fragile MAP eligible recipients must be provided by a licensed RN; and

(d) if there are no suitable case managers with the previously described qualifications, an agency can employ a case manager with the following education and experience rendering services under the direct supervision of an experienced case manager who meets the qualifications specified above:

(i) hold an associate's degree and has a minimum of three years of experience in community health or social services; or

(ii) hold a high school diploma or a graduate equivalence diploma (GED) and has a minimum of four years of experience in community health or social services.

(3) Agency restrictions: MAD restricts the type of agency that can provide case management services to a MAP eligible recipient with developmental disabilities. See 42 U.S.C. Section 1396n(g)(1)(2). A case management provider for a MAP eligible recipient with developmental disability or severe emotional disturbance must be certified by DOH or CYFD.

(4) MAP eligible recipients: When a MAD enrolled recipient is determined to be medically at risk, he or she is eligible for case management services. "Medically at risk" is defined as an individual who has a diagnosed physical or social emotional condition which has a high probability of impairing his or her cognitive, emotional, neurological, social or physical development.

B. EPSDT case management treatment plan (CMTP) or individualized service plan (ISP): The CMTP or ISP is developed by the case manager in cooperation with the MAP eligible recipient, his or her family or legal guardian, his or her PCP, as appropriate, and others involved with the MAP eligible recipient's care. The CMTP is developed within 30 calendar days of the initiation of services. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated. For a MAP eligible recipient who is medically fragile, the ISP is written and approved within 60 calendar days of the initiation of services which are to start immediately. The ISP is reviewed regularly during the monthly visits; however, the MAP eligible recipient is reassessed annually with a new ISP developed with the MAP eligible recipient, his or her family and the interdisciplinary team. A social worker may be involved in the development of the treatment plan in the case of a MAP eligible recipient who is in the custody of CYFD or another state agency.

(1) The following, as appropriate, must be contained in the CMTP and ISP or documents used in the development of each. The CMTP, the ISP, and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) social emotional or behavioral health status assessment;

(ii) intellectual function assessment;

(iii) psychological assessment;

(iv) educational assessment;

(v) vocational assessment;

(vi) social assessment;

(vii) medical assessment; and

(viii) physical assessment;

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and

(e) statement and rationale of the CMTP or ISP for achieving these intermediate and long-range goals, including provisions of review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued for the MAP eligible recipient.

(2) Assessments must be performed face-to-face with the MAP eligible recipient, his or her family or legal guardian.

(3) The agency must have a statement of the specific case management services needed to meet the MAP eligible recipient's unique needs and to achieve the outcomes specified in the CMTP or

ISP, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

C. EPSDT case management covered services:

(1) MAD covers the following case management services:

(a) face-to-face assessment of the MAP eligible recipient's medical, behavioral health, social needs and functional limitations; the MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated;

(b) the development and implementation of plans of care designed to help the MAP eligible recipient retain or achieve the maximum degree of independence; certain EPSDT enhanced services can be furnished only if included in the CMTP or ISP, including private duty nursing;

(c) the mobilization of the use of natural helping networks such as family members, church members, community organizations, support groups and friends; and

(d) the coordination and monitoring of the delivery of services, the evaluation of the effectiveness and quality of the services, and the revision of the MAP eligible recipient's CMTP or ISP, when appropriate.

(2) When a MAP eligible recipient is in an out-of-home placement, MAD covers comprehensive coordinated support services (CCSS) detailed in 8.321.2 NMAC during the last 30 calendar days of his or her placement.

D. EPSDT case management noncovered services: Case management services are subject to the limitations and coverage restrictions which exist for other MAD services. Case management services may not be billed in conjunction with:

(1) services to an individual who is not eligible or who does not meet the MAD definition of medically at risk;

(2) services furnished by other practitioners such as: therapists, transportation providers, homemakers or personal care service providers;

(3) formal educational or vocation services related to traditional academic subjects or vocational training;

(4) client outreach activities in which a provider attempts to contact potential recipients;

(5) administrative activities, such as MAD eligibility determinations and agency intake processing;

(6) institutional discharge planning which is a required condition for payment of hospital, nursing home, treatment foster care or other residential treatment center services; discharge planning must not be billed separately as a targeted case management service;

(7) services which are not documented by the case manager in the MAP eligible recipient's agency file; or

(8) services to a recipient who receives case management services through a home and community-based services waiver program.

[8.320.2.17 NMAC - Rp, 8.320.5 NMAC, 1-1-14]

8.320.2.18 EPSDT PERSONAL CARE SERVICES: MAD pays for medically necessary personal care services (PCS) furnished to a MAP eligible recipient under 21 years of age as part of the EPSDT program when the services are part of his or her ISP for the treatment of correction, amelioration, or prevention of deterioration of a MAD identified medical or behavioral health condition, see 42 CFR Section 440.167. PCS provides a range of services to a MAP eligible recipient who is unable to perform some or all activities of daily living (ADLs) or instrumental activities of daily living (IADLs) because of a disability or a functional limitation. A prescribed course of regular PCS services and daily living assistance supports the MAP eligible recipient to live in his or her home rather than an institution and allows him or her to achieve the highest possible level of independence. These services include, but are not limited to, activities such as bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance, and communicating. A MAP eligible recipient may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCS services may be required because a cognitive impairment prevents a MAP eligible recipient from knowing when or how to carry out the task. In such cases, PCS services may include cuing along with supervision to ensure that the MAP eligible recipient performs the task properly.

A. EPSDT PCS eligible providers:

(1) agencies that meet the following conditions are eligible to enroll as providers and be reimbursed for providing EPSDT PCS services:

(a) a licensed nursing or home health agency that is a public agency, a private for-profit agency, or private non-profit agency; and

(b) the PCS attendant to the MAP eligible recipient must be supervised by a MAD enrolled RN;

(2) certification for participation as a medicare home health agency is not required; a MAP eligible recipient's family member may not furnish PCS services to him or her; in this instance, a family member is defined as a legally responsible relative, such as parents of minor child or stepparent who is legally responsible for minor child; for a MAP eligible recipient 18 to 21 years of age, parents or other relatives may provide PCS services if they are not legally responsible for the MAP eligible recipient; the parent or another relative must be employed by a MAD approved PCS agency eligible to bill for PCS services and must meet all MAD required training and supervision standards.

B. EPSDT PCS attendant training:

(1) The PCS agency is responsible for ensuring that the PCS attendant has completed a training program and is competent to provide assigned tasks as a PCS attendant specific to the MAP eligible recipient's needs.

(2) The PCS attendant training program must consist of no less than 40 hours of training to be completed by the PCS attendant in the first year of employment. Ten hours of training must be completed prior to placing the employee in a MAP eligible recipient's home. Two of the 10 hours may include agency orientation. Eight of the 10 hours of training must be specific to the MAP eligible recipient.

(3) The training curriculum must include, at a minimum, the following areas:

(a) communication;

(b) MAP eligible recipient's rights;

(c) recording of information in MAP eligible recipient's records;

(d) nutrition and meal preparation;

(e) care of ill and disabled children and adolescents;

(f) emergency response (first aid, CPR, 911, etc.);

(g) basic infection control;

(h) housekeeping skills; and

(i) home safety and fire protection.

C. EPSDT PCS criteria: PCS services are defined as medically necessary tasks pertaining to a MAP eligible recipient's physical or cognitive functional ability. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's functional level. Services are covered under specific criteria.

(1) The MAP eligible recipient must have a need for assistance with at least two or more ADL's or both such as eating, bathing, dressing and toileting activities, appropriate to his or her age.

(2) PCS services must be medically necessary, prescribed by the MAP eligible recipient's PCP and included in the MAP eligible recipient's individual treatment plan (ITP).

(3) The need for PCS services is evaluated based on the availability of the MAP eligible recipient's family members or natural supports, such as other community resources or friends that can aid in providing

such care.

(4) PCS services must be provided with the consent of the MAP eligible recipient's parent or guardian if the MAP eligible recipient is under the age of 18 years. If a MAP eligible recipient is emancipated or is at least 18 years old and is able to provide consent, his or her consent is required.

(5) PCS services are furnished in the MAP eligible recipient's place of residence and outside his or her home when medically necessary and when not available through other existing benefits and programs such as home health, early intervention or school programs. PCS services are services furnished to a MAP eligible recipient who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or an institution for mental illness.

(6) Medically necessary PCS services to support a MAP eligible recipient attend school are furnished in partnership with the MAP eligible recipient's school as an alternative to his or her participation in a homebound program. PCS services should foster the MAP eligible recipient's independence. PCS services are furnished only to a MAP eligible recipient based on MAD or its designee's UR contractor's approval. PCS services may not be furnished to a non-MAP eligible recipient in the school setting.

(7) Only a trained PCS attendant who has successfully demonstrated service competency such as bathing, dressing, eating and toileting may provide PCS services to a MAP eligible recipient. The PCS attendant must be employed by a MAD approved PCS agency and work under the direct supervision of a MAD approved RN.

(8) The supervisory RN must be employed or contracted by the PCS agency and have one year direct patient care experience. The supervisory RN is responsible for conducting and documenting visits at the MAP eligible recipient's residence for the purpose of assessing his or her progress and the PCS attendant's performance. The ITP should be updated as indicated and in cooperation with the MAP eligible recipient's case manager. These visits will be conducted and documented every 62 calendar days or more often if the MAP eligible recipient's condition warrants it.

D. EPSDT PCS covered services: MAD covers the following personal care services:

(1) basic personal care services consist of bathing, care of the teeth, hair and nails, assistance with dressing, and assistance with toileting activities;

(2) assistance with eating and other nutritional activities, when medically necessary, i.e., due to documented weight loss or another physical effect; and

(3) cognitive assistance such as prompting or cuing.

E. EPSDT PCS noncovered services: PCS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities. Specifically, PCS services may not be billed in conjunction with the following services:

(1) any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings, and administration of medications;

(2) services that are not in the MAP eligible recipient's approved ITP and for which prior approval has not been received;

(3) services not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient.

F. EPSDT PCS treatment plan: The MAP eligible recipient's ITP is approved by MAD or its designated UR contractor prior to the initiation of PCS services. The PCS ITP is developed as a result of a face-to-face assessment of the MAP eligible recipient and must include the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient for PCS services;

(2) description of the physical or cognitive functional level of the recipient as evidenced by the PCP's clinical evaluation, including social emotional or behavioral health status, intellectual functioning and the documented medical necessity for PCS services;

(3) description of intermediate and long-range service goals that includes the scope and duration of service, how goals will be attained and the projected timetable for their attainment;

(4) specification of the PCS attendant's responsibilities, including tasks to be performed by the attendant and any special instructions for the health and safety of the MAP eligible recipient;

(5) a statement of the least restrictive conditions necessary to achieve the goals identified in the plan; and

(6) the ITP must be reviewed and revised in cooperation with the MAP eligible recipient's case manager according to his or her clinical needs at least every six months.

[8.320.2.18 NMAC - Rp, 8.323.2 NMAC, 1-1-14]

8.320.2.19 EPSDT PRIVATE DUTY NURSING SERVICES: MAD pays for private duty nursing (PDN) services as part of the EPSDT program, see 42 CFR Section 441.57. Services must be accessed through the tot to teen healthcheck screen. A MAP eligible recipient is under 21 years, who has been referred for PDN services shift care (not intermittent care), must meet the established medically fragile criteria and parameters that have been approved by MAD.

A. EPSDT PDN eligible providers**:** A nurse working for a MAD approved PDN agency must have a RN or LPN on staff that meets MAD requirements. Services must be furnished under the direction of the MAP eligible recipient's PCP. Certification for participation as a medicare home health agency is not required. The following agencies are eligible to be reimbursed for providing EPSDT PDN services:

(1) a licensed nursing agency; or

(2) a FQHC.

B. EPSDT PDN coverage criteria: PDN services must be furnished by a RN or a LPN in the MAP eligible recipient's home or in his or her school setting if it is medically necessary for school attendance. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's function level in a home setting.

(1) EPSDT PDN services are for a MAP eligible recipient under 21 years of age who requires more individual and continuous care than can be received through the MAD home health program.

(2) EPSDT PDN services must be ordered by the MAP eligible recipient's PCP and must be included in his or her approved treatment plan. Services furnished must be medically necessary and be within the scope of the nursing profession. A MAP eligible recipient must have an approved ISP before nursing services can begin. Prior authorization for these services is required.

C. EPSDT PDN treatment plan: The need for skilled nursing services must be included in the MAP eligible recipient's ITP or ISP. The ISP meeting must have been held and the ISP written by the RN or case manager must be approved before nursing services can start. The plan must contain the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(2) description of the functional level of the MAP eligible recipient as documented by the PCP's clinical evaluation, including social, emotional or behavioral health status, intellectual functioning and medical necessity which identify and document the need for a PDN;

(3) specific clinical problems

relating to:

(a) physical assessment needs including the identification of durable medical equipment or medical supplies needed by the MAP eligible recipient;

(b) psychosocial evaluation including level of support from family in reaching projected clinical goals; and

(c) medication history including status of compliance of the MAP eligible recipient;

(4) applicable clinical interventions related to the identified clinical problem including measurable goals;

(5) statement of the least restrictive conditions necessary to achieve the goals identified in the plan;

(6) description of intermediate and long-range goals with the projected timetable for their attainment and duration and scope of services, and strengths and priorities of the family and MAP eligible recipient;

(7) statement and rationale of the nursing care plan for achieving these intermediate and long-range goals including provisions for the review and modification of the plan;

(8) specification of nursing responsibilities, description of the proposed nursing care, orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient; and

(9) a transition plan that identifies what the plan will be after discharge from PDN services.

D. EPSDT PDN covered services: MAD covers the following PDN services:

(1) skilled nursing services furnished to the MAP eligible recipient's at his or her home; and

(2) skilled nursing services which are medically necessary for attending school and furnished to the MAP eligible recipient in the school setting. These services are an alternative to his or her participation in a homebound program. Nursing services are furnished only to a MAP eligible recipient and not to others in the school setting.

E. EPSDT PDN noncovered services: PDN services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

[8.320.2.19 NMAC - Rp, 8.323.4 NMAC, 1-1-14]

8.320.2.20 EPSDT REHABILITATION SERVICES: MAD pays for medically necessary services, including outpatient services furnished to a MAP eligible recipient under 21 years of age by or under the supervision of licensed PT; OT; and master's level SLP. A MAP eligible recipient under 21 years of age who is eligible for a home and community based waiver program receives medically necessary rehabilitation services through the EPSDT rehabilitation services, the home and community based waiver program provides rehabilitation services only for the purpose of community integration.

A. EPSDT rehabilitation eligible providers: A PT, OT and master's level SLP is eligible to be reimbursed for furnishing services to a MAP eligible recipient under 21 years of age in need of EPSDT rehabilitation services. The following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to a MAP eligible recipient:

(1) a master's level SLP licensed by the regulation and licensing department (RLD) board of speech-language pathology and audiology;

(2) a PT licensed as physical therapists by the RLD physical therapy board;

(3) an OT licensed as occupational therapists by the RLD board of examiners for occupational therapy;

(4) certified outpatient rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy, licensed by DOH;

(5) home health agencies licensed and certified by DOH; and

(6) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the DOH;

(7) a PT assistant licensed by the RLD physical therapy board and working under the supervision of a licensed PT;

(8) an OT assistant licensed by the RLD occupational therapy board and working under the supervision of a licensed OT;

(9) a SLP licensed by the RLD board of speech-language pathology and audiology; and

(10) SLP apprentices and clinical fellows licensed by the RLD board of speech-language pathology and working under the supervision of a licensed SLP.

B. EPSDT rehabilitation covered services: MAD covers speech therapy, physical therapy and occupational therapy services provided to a MAP eligible recipient under 21 years of age. MAD covers evaluations, individual therapy and group therapy in an outpatient setting. Services must be medically necessary and provided for the purpose of diagnostic study or treatment. Even though a MAP eligible recipient is receiving therapy services or can access therapy services at his or her school, he or she may require additional medically necessary services in addition to those provided at a school. Services must be designed to improve, restore or maintain the MAP eligible recipient's condition including controlling symptoms and maintaining the functional level to avoid further deterioration as indicated his or her ITP. The provider, following the MAP eligible recipient's PCP orders, will develop the treatment plan.

(1) Physical, occupational, and speech therapy services must be specifically related to the active written treatment plan developed by qualified a PT, OT, SLP therapist with authorization from the MAP eligible recipient's PCP.

(2) Services must be performed within the scope and practice of the RLD practice board and as defined by state statute and rule.

(3) All services provided by or under the supervision of a SLP, OT, PT must be prescribed or ordered by the MAP eligible recipient's PCP. The PCP must be a physician or doctor of osteopathy, certified nurse practitioner, or physician assistant licensed to practice in New Mexico.

C. EPSDT rehabilitation noncovered services:

(1) Services furnished by or under the supervision of a SLP, OT, PT are subject to the limitations and coverage restrictions that exist for other MAD services.

(2) MAD does not cover these specific services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Prior Authorization: All therapy services with the exception of the initial evaluation require prior authorization from MAD or its designee.

[8.320.2.20 NMAC - Rp, 8.323.5 NMAC, 1-1-14]

HISTORY OF 8.320.2 NMAC:

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

ISD 310.1700, EPSDT Services, filed 2-13-80.

ISD 310.1700, EPSDT Services, filed 6-25-80.

ISD Rule 310.1700, EPSDT Services, filed 10-22-84.

MAD Rule 310.17, EPSDT Services, filed 5-1-92.

MAD Rule 310.17, EPSDT Services, filed 7-14-93.

MAD Rule 310.17, EPSDT Services, filed 11-12-93.

MAD Rule 310.17, EPSDT Services, filed 12-17-93.

MAD Rule 310.17, EPSDT Services, filed 3-14-94.

MAD Rule 310.17, EPSDT Services, filed

6-15-94.
MAD Rule 310.17, EPSDT Services, filed 11-30-94.

History of Repealed Material:
MAD Rule 310.17, EPSDT Services, filed 11-30-94 - Repealed effective 2-1-95.
8.320.2 NMAC, Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services, filed 2-17-12 - Repealed effective 1-1-14.
8.320.3 NMAC, Tot to Teen Healthcheck, filed 2-17-12 - Repealed effective 1-1-14.
8.320.4 NMAC, Special Rehabilitation Services, filed 11-12-03 - Repealed effective 1-1-14.
8.320.5 NMAC, EPSDT Case Management, filed 2-17-12 - Repealed effective 1-1-14.
8.323.2 NMAC, EPSDT Personal Care Services, filed 9-16-02 - Repealed effective 1-1-14.
8.323.4 NMAC, EPSDT Private Duty Nursing Services - Repealed effective 1-1-14.
8.323.5 NMAC, EPSDT Rehabilitation Services, filed 6-6-02 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES PART 6 SCHOOL-BASED SERVICES FOR MAP ELIGIBLE RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE

8.320.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.320.6.1 NMAC - Rp, 8.320.6.1 NMAC, 1-1-14]

8.320.6.2 SCOPE: The rule applies to the general public.
[8.320.6.2 NMAC - Rp, 8.320.6.2 NMAC, 1-1-14]

8.320.6.3 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.
[8.320.6.3 NMAC - Rp, 8.320.6.3 NMAC, 1-1-14]

8.320.6.4 DURATION: Permanent.
[8.320.6.4 NMAC - Rp, 8.320.6.4 NMAC, 1-1-14]

8.320.6.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.320.6.5 NMAC - Rp, 8.320.6.5 NMAC, 1-1-14]

8.320.6.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance division's (MAD) medical assistance programs (MAP).
[8.320.6.6 NMAC - Rp, 8.320.6.6 NMAC, 1-1-14]

8.320.6.7 DEFINITIONS: [RESERVED]

8.320.6.8 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.
[8.320.6.8 NMAC - Rp, 8.320.6.8 NMAC, 1-1-14]

8.320.6.9 SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE: MAD pays for medically necessary services for a MAP eligible recipient under twenty-one years of age when the services are part of the MAP eligible recipient's individualized education program (IEP) or an individualized family service plan (IFSP) for treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.
[8.320.6.9 NMAC - Rp, 8.320.6.9 NMAC, 1-1-14]

8.320.6.10 GENERAL PROVIDER INSTRUCTIONS: Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD/MAD or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency or each individual provider. Services must be in compliance with the statutes, rules and regulations of his or her practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.
[8.320.6.10 NMAC - N, 1-1-14]

8.320.6.11 ELIGIBLE PROVIDERS:

A. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, local education agencies (LEAs), regional educational cooperatives (RECs), and other state-funded educational agencies (SFEAs) that meet specified requirements are eligible to be reimbursed for furnishing services to an MAP eligible recipient. The LEA, REC, or other SFEA must enter into a governmental services agreement (GSA) with HSD and abide by the terms and conditions of it.

B. The following individual service providers must be employed by, or under contract to, the LEA, REC, or other SFEA when furnishing treatment and meet other specified qualification criteria:

(1) physical therapists (PT);

(2) physical therapy assistants working under the supervision of a MAD enrolled PT;

(3) occupational therapists (OT);

(4) occupational therapy assistants working under the supervision of a MAD enrolled licensed occupational therapist;

(5) speech and language pathologists (SLP) and clinical fellows;

(6) apprentices in speech-language (ASL) working under the supervision of a MAD enrolled licensed speech therapist;

(7) audiologists;

(8) licensed nutritionists or registered dieticians;

(9) case managers meeting one of the following requirements:

(a) bachelor's degree in social work, counseling, psychology, nursing or a

related health or social services field from an accredited institution;

(b) one year experience serving medically-at-risk children or adolescents; or

(c) a licensed registered (RN).

C. For a LEA, REC, or other SFEA that employs a RN or a licensed practical nurse (LPN) not as a case worker, each is under the oversight of the department of health's (DOH) district health officer, as provided by state statue (NMSA 1978, Section 24-1-4). A LPN must work under the supervision of a RN who is a PED licensed school nurse.

D. As applicable, each provider must be licensed by the public education department (PED) when such licensure exists.

E. As applicable, each provider must be licensed by its specific regulation and licensing division (RLD)'s board of practice or by PED.

[8.320.6.11 NMAC - Rp, 8.320.6.10 NMAC, 1-1-14]

8.320.6.12 PROVIDER RESPONSIBILITIES:

A. **General responsibilities:**

(1) A provider who furnishes services to a MAP eligible recipient must comply with all terms and conditions of his or her MAD PPA and the MAD New Mexico administrative code (NMAC) rules.

(2) A provider must verify that an individual is a MAP eligible recipient at the time services are billed.

(3) A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HSD regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

B. **Documentation requirements:**

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to a MAP eligible recipient who is currently receiving MAD services or has received MAD services in the past. Payment for services billed to MAD that are not substantiated in the MAP eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of creation or until ongoing audit issues are resolved, whichever is longer; see 8.302.2 NMAC.

(2) For services covered under this rule, complete copies of the MAP eligible recipient's IEP or IFSP with the individualized treatment plan (ITP) portions of the IEP or IFSP signed by the primary care provider (PCP) must be maintained as part of the required records.

(3) Documents in the MAP eligible recipient's file must include:

(a) the IEP with the ITP or the IFSP with the ITP; and

(b) evaluation performed by the provider or the annual and current present level of performance;

(c) annual PCP authorization;

(d) treatment notes that relate directly to the IEP or IFSP goals and objectives specific to each MAP eligible recipient; and

(e) billing information recorded in units of time; see 8.302.2 NMAC.

C. **Record availability:** The provider must upon request promptly furnish to HSD, the secretary of the federal department of health and human services, or the state medicaid fraud control unit any information required in this rule, including the MAP eligible recipient and employee records, and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims.

[8.320.6.12 NMAC - Rp, 8.320.6.11 NMAC, 1-1-14]

8.320.6.13 COVERED SERVICES: MAD covers the following services when medically necessary and billed by specified providers in school settings.

A. For services in Subsections A-E of this rule, a provider must first develop and then update the MAP eligible recipient's present level of performance for each of his or her IEP or IFSP cycles. MAD requires the following elements be included in the provider's treatment notes:

(1) the specific activity provided to the MAP eligible recipient for each date of service billed;

(2) a description of the level of engagement and the ability of the MAP eligible recipient for each date of service billed; and

(3) the outcomes of session on the impact on the MAP eligible recipient's exceptionality for each date of service billed.

B. To be reimbursed for a MAD service, all of the requirements in this subsection must be met.

(1) Services must be medically necessary, must be ordered or authorized by the MAP eligible recipient's PCP, and must meet the needs specified in his or her IEP or IFSP. The services must be necessary for the treatment of the MAP eligible recipient's specific identified condition.

(2) The ITP portion of the IEP or IFSP must be signed by the MAP eligible recipient's PCP and be developed in conjunction with the appropriate qualified PT, OT, SLP, audiologist, or a RN.

(3) Services require prior authorization by the PCP. The requirement for prior authorization is met when the PCP signs the ITP portion of the IEP or IFSP and services are performed in accordance with the IEP or IFSP that has been signed by the PCP. If the PCP signature cannot be obtained to meet the prior authorization requirement, the service will require prior authorization by MAD or its designee.

(4) Frequency and duration of services billed may not exceed those specified in the MAP eligible recipient's IEP or IFSP.

(5) Reimbursement is made directly to the LEA, REC, or other SFEA when therapy, licensed nutritionists or registered dieticians, transportation, case manager, or nurse providers furnish services under contract to the LEA, REC, or other SFEA.

C. **Therapy services:** MAD covers physical, occupational, audiological and speech evaluations, and therapy required for treatment of an identified medical condition.

D. **Nutritional assessment and counseling:** MAD covers nutritional assessment and counseling when billed by a licensed nutritionist or dietician for a MAP eligible recipient who has been referred for a nutritional need when part of his or her ITP. A nutritional assessment consists of an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical, and dietary data, including a recommendation for appropriate nutritional intake.

E. **Transportation services:** MAD covers transportation services for a MAP eligible recipient who must travel from his or her school to receive a covered service from a MAD provider when the service is unavailable in the school setting and when the service is medically necessary and is identified in the MAP eligible recipient's IEP or IFSP; see 8.324.7 NMAC. MAD covers transportation to and from the school on the date a medically necessary service is billed in the school setting for a MAP eligible recipient who has a disability.

(1) Medical services are billed on the specific day on which transportation is billed and are specified in the ITP portion of his or her IEP or IFSP.

(2) The MAP eligible recipient requires transportation in a vehicle adapted to serve his or her needs.

(3) Transportation occurs in a modified school bus for disabled students.

F. **Case management:** MAD covers case management services billed in school settings to a MAP eligible recipient who is medically at risk. MAD pays for services billed by a single case

management service provider during a given time period. Medically at risk refers to MAP eligible recipient who has a diagnosed physical condition which has high probability of impairing cognitive, emotional, neurological, social, or physical development.

(1) The service is developed in conjunction with a qualified case manager.

(2) MAD covers the following case management services.

(a) The assessment of the MAP eligible recipient's medical, social and functional abilities at least every six months, unless more frequent reassessment is indicated by the MAP eligible recipient's condition.

(b) The development and implementation of a comprehensive case management plan of care that helps the MAP eligible recipient retain or achieve the maximum degree of independence.

(c) The mobilization of the use of natural helping networks, such as family members, church members, community organizations, support groups, friends, and the school, if the MAP eligible recipient is able to attend.

(d) Coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the case management plan of care as necessary.

(e) All services must be delivered to be eligible for MAD reimbursement.

(3) A MAP eligible recipient has the freedom to choose a case management service provider. MAD will pay for only *one* case management provider to furnish services to a MAP eligible recipient at any given time period. If a MAP eligible recipient has a case manager or chooses to use a case manager who is not employed or under contract to the LEA, REC or other SFEA, the LEA, REC or other SFEA must coordinate with the case manager in the development of the MAP eligible recipient's ITP.

G. **Nursing:** MAD covers certain nursing services required for treatment of a diagnosed medical condition that qualifies a MAP eligible recipient for an IEP or IFSP when provided by a licensed RN or LPN. Nursing services require professional nursing expertise and are provided by a licensed RN or a LPN and must be provided in accordance with the New Mexico Nursing Practice Act and must be a covered MAD service.

H. **Administrative activities**: MAD covers the cost of certain administrative activities that directly support efforts to provide health-related services to a MAP eligible recipient with special education and health care needs. These administrative activities include, but are not limited to, providing information about MAD services and how to access them; facilitating the eligibility determination process; assisting in obtaining transportation and translation services when necessary to receive health care services; making referrals for MAD reimbursable services; and coordinating and monitoring MAD covered medical services.

(1) Payment for an allowable administrative activity is contingent upon the following:

(a) the LEA, REC or other SFEA must complete a MAD PPA to become an approved school-based health services provider;

(b) the LEA, REC or other SFEA must enter into a governmental services agreement (GSA) with HSD and agree to abide by the terms and conditions of the GSA;

(c) the LEA, REC or other SFEA must submit claims for allowable administrative activities in accordance with federal and state regulations, rules and guidelines.

(2) Administrative claiming is subject to compliance reviews and audits conducted by HSD, the state medicaid fraud control unit and CMS. By signing the MAD PPA, the LEA, REC or other SFEA agrees to cooperate fully with HSD, the state medicaid fraud control unit and CMS in the performance of all reviews and audits and further agrees to comply with all review and audit requirements.

[8.320.6.13 NMAC - Rp, 8.320.6.13 NMAC, 1-1-14]

8.320.6.14 INDIVIDUALIZED TREATMENT PLAN:

A. The ITP must specify:

(1) the MAP eligible recipient's objectives and goals; and

(2) the duration, the frequency of the service for the MAP eligible recipient.

B. The plan is developed by the LEA, REC or other SFEA in conjunction with the MAP eligible recipient, his or her family, and applicable service providers. The ITP portion of the IEP or IFSP must be reviewed and signed at least annually by the MAP eligible recipient's PCP to meet requirements for prior authorization of services provided to the MAP eligible recipient. If this review and PCP signature are not performed annually or when there is a change to the current IEP or IFSP, the service will require prior authorization by MAD or its designee.

C. The ITP is a plan of care agreed upon by the MAP eligible recipient, his or her parents or legal guardians, the evaluating therapists, the IEP or IFSP committee, and the MAP eligible recipient's teacher, all of whom are included in the IEP or IFSP. The ITP utilizes the MAP eligible recipient's health history, medical and educational evaluations and recommendations by the PCP and other medical providers, as applicable. If medical needs are identified in the IEP or IFSP, the medical portion of the IEP or IFSP is the MAP eligible recipient's ITP. The ITP must be incorporated into the IEP or IFSP. See 8.321.2 NMAC for behavioral health services.

[8.320.6.14 NMAC - Rp, 8.320.6.14 NMAC, 1-1-14]

8.320.6.15 SCHOOL-BASED SETTING COUNSELING, EVALUTION AND THERAPY: MAD pays for medically necessary services billed to a MAP eligible recipient under 21 years of age when the services are part of his or her individualized education plan (IEP) or individualized family service plan (IFSP) for the treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.

A. Upon approval of the provider's MAD PPA, a local education agencies (LEA), regional educational cooperative (REC), and another state-funded educational agencies (SFEA) that meet specified requirements are eligible to be reimbursed for furnishing services to a MAP eligible recipient. The LEA, REC, or other SFEA must develop a collaborative plan with the community. Requirements for such plans will be described in MAD written guidelines and available on its website. The rendering practitioners listed detailed below must be employed by or under contract with the LEA, REC, or other SFEA when furnishing treatment to a MAP eligible recipient. A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HSD or MAD regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

(1) Social work practitioners who meet one of the following requirements are eligible to receive reimbursement thru the provider for services to a MAP eligible recipient:

(a) is licensed by RLD's as a LISW and a MAD enrolled provider; or

(b) is licensed by RLD as either a LMSW or a licensed bachelor social worker (LBSW), and supervised by a New Mexico licensed Ph.D., Psy.D., Ed.D., or LISW who is a MAD enrolled provider; and

(c) services provided by licensed LBSW or licensed LMSW must be within the scope of his or her practice board respectively, supervised and periodically evaluated in accordance with his or her practice board requirements;

(i) supervision must adhere to the requirements of the

practitioner's applicable licensing board;

(ii) a MAP eligible recipient receiving services from a LBSW or a LMSW must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) or a LISW who is enrolled as a MAD provider; if the MAP eligible recipient has a current diagnosis from another independently licensed practitioner as detailed in Section 9 of this rule, that diagnosis will be accepted; the diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and

(d) meets licensure requirements of PED.

(2) Psychologists meeting one of the following requirements are eligible to receive reimbursement thru the provider for services to a MAP eligible recipient:

(a) psychologists (Ph.D., Psy.D., or Ed.D.) licensed by the New Mexico psychologist
examiners board and meeting licensure requirements of the public education department; or

(b) master's level practitioners licensed by the New Mexico psychologist examiners board as psychologist associates or licensed by PED as school psychologists and supervised by a psychiatrist or a Ph.D., Psy.D., or Ed.D. who is licensed as a psychologist by the New Mexico psychologist examiners board, enrolled as a MAD provider, and meets licensure requirements of PED.

(3) Physicians and psychiatrists licensed by the board of medical examiners and meet licensure requirements of PED are eligible for reimburse by the provider for services to a MAP eligible recipient.

(4) Case managers who meet one of the following requirements:

(a) bachelor's degree in one of the following: social work, counseling, psychology or a related health or social services field from an accredited institution and having one year experience serving medically-at-risk children or adolescents, and must be a MAD enrolled case manager with the appropriate provider type and specialty; or

(b) a licensed registered (RN) or practical nurse (LPN) or

(c) an individual with a bachelor's degree in another field and two years of direct experience in serving medically-at-risk children or adolescents.

(5) LPC, and LMHC licensed by RLD and meeting licensure requirements of PED. A LMHC and LPC must be supervised by a MAD enrolled licensed LPCC, LMFT, licensed psychologist, or licensed psychiatrist. A LMSW and LBSW must be supervised by a MAD enrolled LPCC, or a Ph.D., Psy.D., or Ed.D. and meet the licensure requirements of PED.

(6) A MAD enrolled LISW, LMFT and LPPC practitioner may render services when licensed by RLD and meet licensure requirements of PED:

(7) The following practitioners may render services when supervision is provided by Subparagraph (a) of Paragraph (6) of Subsection B of Section 10 above: a licensed LMHC or a licensed LPC. Services provided by licensed LMHC, and a LPC must be within the scope of their practice respectively and supervised and periodically evaluated in accordance with their practice board requirements. Supervision must adhere to the requirements of the practitioner's applicable licensing board.

(a) A MAP eligible recipient receiving services from a LMHC or LPC must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) who is enrolled as a MAD provider. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and is this

(b) A MAP eligible recipient receiving services from an LBSW or an LMSW must be diagnosed by the practitioner's supervisor: a psychologist (Ph.D., Psy.D., or Ed.D.) or a LISW who is enrolled as a MAD provider. The diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor; and meets licensure requirements of PED.

(8) A MAD enrolled CNS licensed by RLD and meeting licensure requirements of PED.

B. **MAP eligible recipients:** MAD covers medically necessary treatment to a MAP eligible recipient under 21 years of age who has a MAD-reimbursable service identified in his or her IEP or IFSP.

C. **Documentation requirements:**

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to MAP eligible recipient who is currently receiving MAD services or have received MAD services in the past. Payment for services billed to MAD that are not substantiated in the MAP eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of creation or until ongoing audit issues are resolved, whichever is longer. See 8.302.1 NMAC.

(2) For services covered under this rule, complete copies of the IEPs or IFSPs, with the individualized treatment plan (ITP) portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

(3) Provider written documentation must include:

(a) present level of performance; and

(b) description of actual service delivered or rendered; and

(c) billing information recorded in units of time.

D. **Record availability:** The provider must, on request, promptly furnish to HSD, the secretary of the department of health and human services, or the state medicaid fraud control unit any information under documentation requirements, stated above, including MAP eligible recipient and employee records and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims.

E. **Covered services:** For services in subsections A-F, a provider must first develop and then update the MAP eligible recipient's present level of performance for each IEP cycle. For these services, MAD requires the following elements be included in the provider's notes:

(1) specific activity provided to the MAP eligible recipient for each date of service billed;

(2) description of the level of engagement and ability of the MAP eligible recipient for each date of service billed;

(3) outcomes of session on the impact on the MAP eligible recipient's exceptionality for each date of service billed.

F. MAD covers the following services when medically necessary and billed by specified providers in school settings:

(1) For services covered under this rule, complete copies of the IEPs or IFSPs, with the individualized treatment plan (ITP) portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

(2) Provider written documentation must include:

(a) present level of performance; and

(b) description of actual service delivered or rendered; and

(c) billing information recorded in units of time.

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

8.320.6.16 NONCOVERED SERVICES: Services billed in school settings are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.301.3 NMAC. MAD does not cover the following services.

A. Services classified as educational.

B. Services to non-MAP eligible individuals.

C. Services billed by a practitioner outside his or her area of expertise.

D. Vocational training that is related solely to specific employment opportunities, work skills or work settings.

E. Services that duplicate services billed outside the school setting unless determined to be medically necessary and MAD or its designee gave prior authorization for the service.

F. Services not identified in the MAP eligible recipient's IEP or IFSP.

G. Services not authorized by the MAP eligible recipient's PCP unless otherwise approved by MAD or its designee.

H. Transportation services listed below:

(1) transportation that a MAP eligible recipient would otherwise receive in the course of attending school;

(2) transportation for a MAP eligible recipient with special education needs under the Individuals with Disabilities Education Act (IDEA) who rides the regular school bus to and from school with non-disabled children; and

(3) transportation of a minor aged child, such as a sibling of the MAP eligible recipient who is simply accompanying the MAP eligible recipient to a MAD service.

[8.320.6.16 NMAC - Rp, 8.320.6.15 NMAC, 1-1-14]

8.320.6.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: Certain procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specific service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

[8.320.6.17 NMAC - Rp, 8.320.6.16 NMAC, 1-1-14]

8.320.6.18 REIMBURSEMENT: Reimbursement to the LEA, REC, or SFEA is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's IEP or IFSP, and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142., and the services are otherwise covered by MAD, then MAD is authorized to pay for such services. The LEA, REC, or other SFEA must submit claims for reimbursement on the 837P electronic format or its successor unless it received written permission from MAD to bill on paper. Reimbursement to the LEA, REC or other SFEA for covered services billed by individual practitioners is made at the MAD fee schedule for the specific service.

[8.320.6.18 NMAC - Rp, 8.320.6.17 NMAC, 1-1-14]

HISTORY OF 8.320.6 NMAC:

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

MAD-747, School Based Services for Recipients Under Twenty-one Years of Age, filed 12-16-94.

History of Repealed Material:

8.320.6 NMAC, School Based Services for Recipients Under Twenty-One Years of Age, filed 10-16-02 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES

CHAPTER 321 SPECIALIZED BEHAVIORAL HEALTH SERVICES

PART 2 SPECIALIZED BEHAVIORAL HEALTH PROVIDER ENROLLMENT AND REIMBURSEMENT

8.321.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.321.2.2 SCOPE: The rule applies to the general public.

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

8.321.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.

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

8.321.2.4 DURATION: Permanent.

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

8.321.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.321.2.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

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

8.321.2.7 DEFINITIONS: [RESERVED]

8.321.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

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

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by the HSD medical assistance division (MAD). Upon approval of a New Mexico MAD provider participation agreement (PPA) or a MAD electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved 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 New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its

selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency, and for an individual provider. Services must be in compliance with the statutes, rules and regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.2 NMAC and 8.310.3 NMAC.

C. Each specialized behavioral health service may have specific noncovered services. The following are the noncovered services for all specialized behavioral health services:

(1) hypnotherapy;

(2) biofeedback;

(3) conditions that do not meet the standard of medical necessity as defined in MAD rules;

(4) treatment for personality disorders for adults 21 years and older without a diagnosis indicating medical necessity for treatment;

(5) treatment provided for adults 21 years and older in alcohol or drug residential centers;

(6) educational or vocational services related to traditional academic subjects or vocational training;

(7) experimental or investigational procedures, technologies or non-drug therapies and related services;

(8) activity therapy, group activities and other services which are primarily recreational or divisional in nature;

(9) electroconvulsive therapy;

(10) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside his or her scope of practice;

(11) treatment of intellectual disabilities alone;

(12) services not considered medically necessary for the condition of the MAP eligible recipient;

(13) services for which prior authorization is required but was not obtained; and

(14) milieu therapy.

D. All behavioral health services must meet with the current MAD definition of medical necessity found in the NMAC rules.

E. Performance of a behavior health service cannot be delegated to a provider or practitioner not licensed for independent practice except as furnished within the limits of MAD benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local statutes, laws and rules. A behavioral health professional service must be provided directly to the MAP eligible recipient by the licensed behavioral health professional listed in Subsection B, H, I and J of Section 9 of this rule or where specifically allowed in a MAD rule. When a service is performed by supervised master's level provider, nurse, bachelor's level and another health professional not listed in Subsections H-J of Section 9 of this rule, that service cannot be billed by the licensed supervisor even though the services may have been furnished under his or her direction. All specialized behavioral health services are reimbursed as follows, except when instructed within a particular specialized service's reimbursement section.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a behavioral health provider for covered services at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure.

(2) Reimbursement to a provider for covered services is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) The provider's billed charge must be its usual and customary charge for services.

(ii) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(3) Reimbursement is made for an Indian health services (IHS) agency or a federal qualified health center (FQHC) by following its federal guidelines and special provisions and as detailed in 8.310.12 NMAC.

F. All specialized behavioral health services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made, see 8.302.5 NMAC. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specialized behavioral health service may have additional prior authorization requirements listed in the service's prior authorization section.

G. General MAD treatment plan requirements for specialized behavioral health services: A MAD treatment plan and all supporting documentation must be available for review by HSD or its authorized agency in the MAP eligible recipient's file. Specific treatment plan elements may be required for a specialized behavioral health service listed in that service section's the treatment plan subsection. MAD makes available on its website comprehensive treatment plan requirements and requires a provider to use the applicable treatment plan requirements for services he or she renders. At a minimum, following must be contained in the treatment plan and documents used in the development of the treatment plan:

(1) statement of the nature of the specific problem and specific needs of the MAP eligible recipient;

(2) description of the functional level and symptom status of the MAP eligible recipient, including the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) social assessment which includes community support, housing and legal status;

(e) medical assessment;

(f) physical assessment;

(g) substance abuse assessment;

(h) activities of daily living assessment; and

(i) a DSM IV- TR (or its successor) diagnosis;

(3) description of the MAP eligible recipient's intermediate and long-range goals and approaches for the least restrictive conditions necessary to achieve the purposes of treatment with a projected timetable for each goal attainment;

(4) statement of the duration, frequency, and rationale for services included in the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(5) specific staff responsibilities, proposed staff involvement and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient;

(6) criteria for discharge from services and the projected date for discharge;

(7) identification of services to be provided upon discharge and appointments for these services;

(8) regular, periodic review of the plan to determine effectiveness of treatment and modification as indicated.

H. The following independent providers are eligible to be reimbursed for providing behavioral health professional services:

(1) a physician licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry, to include the groups they form;

(2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as clinical psychologist by the New Mexico regulations and licensing department's (RLD) board of psychologist examiners, to include the groups they form;

(3) an independent social worker (LISW) licensed by RLD's board of social work examiners, to include the groups they form;

(4) a professional clinical mental health counselor (LPCC) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(5) a marriage and family therapist (LMFT) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(6) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by RLD's board of nursing and is certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as his or her certification permits.

I. The following agencies are eligible to be reimbursed for providing behavioral health professional services:

(1) a community mental health center (CMHC)

(2) a federally qualified health clinic (FQHC);

(3) an Indian health services (IHS) hospital and clinic;

(4) a PL 93-638 tribally operated hospitals and clinics;

(5) children, youth and families department (CYFD);

(6) a hospital and its outpatient facility; and

(7) a core service agency (CSA).

J. When providing services supervised and billed by an agency listed above in Subsection I of Section 9, the following practitioner's outpatient services may be reimbursed when the services are within his or her legal scope of practice (see Subsection B of Section 9 of this rule):

(1) a masters level social worker (LMSW) licensed by RLD's board of social work examiners;

(2) a professional mental health counselors (LPC) licensed by RLD's counseling and therapy practice board;

(3) a mental health counselor (LMHC) licensed by RLD's counseling and therapy practice board;

(4) a psychologist associates licensed by the RLD's psychologist examiners board;

(5) a professional art therapists (LPAT) licensed by RLD's counseling and therapy practice board;

(6) an alcohol and drug abuse counselor (LADAC) licensed by RLD's counseling and therapy practice board; and

(7) a MAP eligible recipient under 21 years of age may be identified through a tot to teen healthcheck, self referral, referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns; if the MAP eligible recipient requires extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment:

(a) the receiving provider of the MAP eligible recipient must develop an individualized treatment plan;

(b) the plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

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

8.321.2.10 APPLIED BEHAVIOR ANALYSIS: MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) for MAP eligible recipients under 21 years of age who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for MAP eligible recipients under three years of age who has a well-documented risk for the development of ASD. ABA is provided to a MAP eligible recipient by MAD as part of a three-stage comprehensive approach to assessment and treatment which stipulates that ABA be provided in conjunction with other medically necessary services (e.g., occupational therapy, speech language therapy, medication management, etc.). Following a referral to an approved autism assessment provider (AAP) to confirm the presence of, or risk for, ASD (stage one), a behavior analytic assessment is conducted and a behavior analytic treatment plan is developed, as appropriate for the selected service model (stage two). Then, behavior analytic services are rendered by an approved behavior analytic provider in accordance with the MAP eligible recipient's treatment plan (stage three). See MAD billing instructions for detailed and specific requirements for this service. A MAD provider must completely comply with all NMAC rules and billing instructions to be eligible for reimbursement of this service.

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

8.321.2.11 ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) SERVICES: To help a MAP eligible recipient under 21 years of age who has been diagnosed as having SED or a chemical dependency, and for whom a less restrictive setting is not appropriate, MAD pays for services furnished to him or her by a ARTC accredited by joint commission (JC) as part of EPSDT program. The need for ARTC must be identified in the MAP eligible recipient's tot to teen healthcheck screen or other diagnostic evaluation.

A. **Eligible facilities:**

(1) In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing ARTC services to a MAP eligible recipient, an ARTC facility:

(a) must provide a copy of its JC or CARF accreditation as a children's residential treatment facility;

(b) must provide a copy of its CYFD ARTC facility license and certification; and

(c) must have written utilization review (UR) plans in effect which provide for review of the MAP eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245;

(2) If the ARTC is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD ARTC licensing requirements, but is not required to be licensed by CYFD. In lieu of receiving a license, CYFD will provide MAD copies of its facility reviews and recommendations. MAD will work with the facility to address recommendations; and

(3) In lieu of New Mexico CYFD licensure, an out-of-state or MAD border ARTC facility must have JC accreditation and be licensed in its own state as an ARTC residential treatment facility.

B. **Covered services:** MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. An ARTC facility must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient. The ARTC will coordinate with the educational program of the recipient, if applicable.

(1) Treatment must be furnished under the direction of a MAD board eligible or certified psychiatrist;

(2) Treatment must be based on the MAP eligible recipient's individualized treatment plan rendered by the ARTC facility's practitioners, within the scope and practice of their professions as defined by state law. See Subsection B of Section 9 of this rule for general behavioral health professional requirements.

(3) Treatment must be reasonably expected to improve the MAP eligible recipient's condition. The treatment must be designed to reduce or control symptoms or maintain levels of functioning and avoid hospitalization or further deterioration is acceptable expectations of improvement.

(4) The following services must be performed by the ARTC agency to receive MAD reimbursement:

(a) performance of necessary evaluations, psychological testing and development of the MAP eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the MAP eligible recipient's treatment plan;

(c) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the MAP eligible recipient;

(d) assistance to the MAP eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient, make referrals, as necessary, and provide follow-up to the MAP eligible recipient;

(f) consultation with other professionals or allied caregivers regarding the needs of the MAP eligible recipient, as applicable;

(g) non-medical transportation services needed to accomplish the MAP eligible recipient's treatment objective; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the MAP eligible recipient.

C. **Noncovered services:** ARTC services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with ARTC services to a MAP eligible recipient:

(1) CCSS, except when provided by a CCSS agency in discharge planning for the MAP eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals; RTC and group services are covered only for MAP eligible recipients under 21 years of age;

(4) formal educational and services which relate to traditional academic subjects or vocational training; and

(5) activity therapy, group activities, and other services primarily recreational or divisional in nature.

D. **Treatment plan:** The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a ARTC facility. The interdisciplinary team must review the treatment plan at least every 14 calendar days. In addition to the requirements of Subsection G of Section 9 of this rule, all supporting documentation must be available for review in the MAP eligible recipient's file. The treatment plan must also include a statement of the MAP eligible recipient's cultural needs and provision for access to cultural practices.

E. **Prior authorization:** Before any ARTC services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. **Reimbursement:** An ARTC agency must submit claims for reimbursement on the UB 04 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) The MAD fee schedule is based on actual cost data submitted by the ARTC agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The MAD fee schedule reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include other MAD services that a MAP eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD-covered service include services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, an ARTC agency cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

(3) An ARTC agency must submit annual cost reports in a form prescribed by MAD. Cost reports are due 90 calendar days after the close of the agency's fiscal year end.

(a) If an agency cannot meet this due date, it can request a 30 calendar day extension for submission. This request must be made in writing and received by MAD prior to the original due date.

(b) Failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all MAD payments until such time as the cost report is received.

(4) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the New Mexico border (Mexico excluded) are 70 percent of billed charges or a negotiated rate.

[8.321.2.11 NMAC - Rp, 8.321.3 NMAC, 1-1-14]

8.321.2.12 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help a MAP eligible recipient 18 years and older receive medically necessary services, MAD pays for covered assertive community treatment services (ACT) [42 CFR SS 440.40, 440.60(a) and 441.57]. ACT services are therapeutic interventions that address the functional problems associated with the most complex and pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increasing the MAP eligible recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

A. **Eligible providers:**

(1) An ACT agency must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. See Subsections A and B of Section 9 for MAD general provider requirements.

(2) ACT services must be provided by an agency designating a team of 10 to 12 members; see this Paragraph (5) of this subsection for the required

composition. Each team must have a designated team leader. Practitioners on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance abuse treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that a MAP eligible recipient obtains the basic necessities of daily life; and education, support and consultation to the MAP eligible recipient's family and other major supports. The agency must coordinate its ACT services with local hospitals, local crisis units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.

(3) Each ACT team staff member must be successfully and currently certified or trained according to ACT standards developed by HSD or its authorized agents. The approved training will focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices. Each ACT team shall have sufficient numbers of qualified staff to provide treatment, rehabilitation, crisis and support services 24-hours a day, seven days per week.

(4) Each ACT team shall have a staff-to-MAP eligible recipient ratio in keeping with ACT evidence-based practice standards and approved by MAD or its designee.

(5) Each ACT team shall include:

(a) at least one board-certified or board-eligible psychiatrist (full-time position is not required);

(b) two licensed nurses, one of whom shall be a RN;

(c) at least one other MAD recognized independently licensed behavioral health professional, see Subsection H of Section 9 of this rule;

(d) at least one MAD recognized licensed substance abuse professional; see Subsection J of Section 9 of this rule;

(e) at least one employment specialist;

(f) at least one New Mexico certified peer specialist (CPS) through the approved state of New Mexico certification program;

(g) one administrative staff person; and

(h) the MAP eligible recipient shall be considered a part of the team for decisions impacting his or her ACT services.

(6) The agency must have a MAD ACT approval letter to render ACT services to a MAP eligible recipient.

B. **Coverage criteria:**

(1) MAD covers medically necessary ACT services required by the condition of the MAP eligible recipient.

(2) The interventions are strength-based and focused on promoting symptom stability; increasing the MAP eligible recipient's ability to cope and relate to others; and enhancing the highest level of functioning in the community, including learning, working and recreation and making informed choices.

(3) Interventions may address adaptive skill areas such as: housing; school, work and training opportunities; daily activities; health and safety; medication support; harm reduction; money management and entitlements; promotion of the MAP eligible recipient's recovery processes; relapse prevention; and service planning and coordination.

(4) The ACT therapy model shall be based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan of the MAP eligible recipient. Specialized therapeutic and rehabilitative interventions falling within the fidelity of the ACT model are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services.

C. **MAP eligible recipients:**

(1) ACT services are provided to a MAP eligible recipient aged 18 and older who has a diagnosis of SMI, including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression for individuals who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services and who have experienced repeated hospitalizations or incarcerations due to mental illness.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from ACT services.

D. **Covered services:**

(1) ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

(a) the service is available 24-hours a day, seven days a week;

(b) the service is provided by an interdisciplinary ACT team that includes trained personnel as defined in of Subsection A of Section 6 of this rule;

(c) an individualized treatment plan and supports are developed;

(d) at least 90 percent of services are delivered as community-based, non-office-based outreach services (in vivo);

(e) an array of services are provided based on the MAP eligible recipient's medical need;

(f) the service is MAP eligible recipient-directed;

(g) the service is recovery-oriented;

(h) following the ACT evidence-based model guidelines, the ACT team maintains a low staff-to-patient ratio;

(i) mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations; and

(j) the team is not just a consortium of mental health specialists, but includes collaborative assessment and treatment planning for each MAP eligible recipient; cross-training of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each MAP eligible recipient's care and services; and the team will assist the MAP eligible recipient to access other appropriate services in the community that are not funded by MAD.

(2) Quality measurement: An ACT program's success is evaluated based on outcomes which may include but are not limited to: improved engagement by the MAP eligible recipient in medical and social services; decreased rates of incarceration; decreased rates of hospitalization; decreased use of alcohol or illegal drugs; increased housing stability; increased relationships of the MAP eligible recipient with his or her family (as appropriate); increased employment; and increased attainment of goals self-identified by the service MAP eligible recipient for his own life. Fidelity to the specific evidence-based ACT service model will also be measured to assure that ACT, rather than some other form of intensive case management, is being provided.

(3) ACT services must be provided to the MAP eligible recipient by the treatment team members.

(4) ACT program provides three levels of interaction with a MAP eligible recipient:

(a) face-to-face encounters are at least 60 percent of all ACT team activities with approximately 90 percent of ACT encounters occurring outside of the IOP agency's office (in vivo);

(b) a collateral encounter where the collaterals are members of the MAP eligible recipient's family or household or significant others (e.g. landlord, criminal justice staff, and employer) who regularly interact with him or her and are directly affected by or have the capability of affecting the MAP eligible recipient's condition, and are identified in the service plan as having a role in treatment; a collateral contact does not include contacts with other mental health service providers or individuals who

are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff that is assisting an ACT MAP eligible recipient in locating housing);

(c) assertive outreach consists of the ACT team being 'assertive' about knowing what is going on with a MAP eligible recipient and acting quickly and decisively when action is called for, while increasing the MAP eligible recipient's independence; the team must closely monitor the relationships that the MAP eligible recipient has within the community and intervene early if a difficulty arises;

(d) collateral encounters and assertive outreach combined must not exceed 40 percent of the total ACT team activities for each MAP eligible recipient; and

(e) all of the above activities must be indicated in the MAP eligible recipient's service plan.

E. **Noncovered services:** ACT services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for MAD general noncovered behavioral health services. MAD does not cover other psychiatric, mental health nursing, therapeutic, substance abuse or crisis services when billed in conjunction with ACT services to a MAP eligible recipient, except for medically necessary medications and hospitalizations.

F. **Reimbursement:** ACT agencies must submit claims for reimbursement on the CMS 1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements.

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

8.321.2.13 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: To help a MAP eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD furnishes these services as part of the EPSDT program and when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation [42 CFR Section 441.57]. MAD pays for medically necessary behavior management skills development services (BMS) which are services designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the MAP eligible recipient in his or her home or community. BMS services assist in preventing inpatient hospitalizations or out-of-home residential placement of the MAP eligible recipient through use of teaching, training and coaching activities designed to assist him or her in acquiring, enhancing and maintaining the life, social and behavioral skills needed to function successfully within his or her home and community settings. BMS is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the MAP eligible recipient's treatment or service plan.

A. **Eligible providers:**

(1) an agency must be certified by CYFD to provide BMS services; and

(2) see Subsections A and B of Section 9 of this rule for MAD general provider requirements.

B. **Covered services:** MAD reimburses for services specified in the MAP eligible recipient's individualized treatment plan which are designed to improve his or her performance in targeted behaviors, reduces emotional and behavioral episodic events, increases social skills and enhances behavioral skills through a regimen of positive intervention and reinforcement.

(1) Implementation of a MAD eligible recipient's BMS treatment plan must be based on a relevant clinical assessment covering an integrated program of therapeutic services, as applicable. The following tasks must be identified in the MAP eligible recipient's BMS treatment plan:

(a) the treatment plan must identify all targeted behaviors that are to be addressed by the behavior management specialist;

(b) the treatment plan should include, when appropriate, a goal of working with the MAP eligible recipient's foster, adoptive, or natural family in order to assist with the achievement and maintenance of behavior management skills; and

(c) the treatment plan must identify the behavior management specialist who is responsible for implement of the plan, including but not limited to:

(i) assistance in achieving and maintaining appropriate behavior management skills through teaching, training and coaching activities; and

(ii) maintaining case notes and documentation of tasks as required by the agency and pursuant to the standards under which it operates in accordance with NMAC rules, including licensed professional standards.

(2) Supervision of behavioral management staff by an independent level practitioner is required for this service. See Section 9 of this rule. The supervisor must ensure that:

(a) an assessment (within the past 12 months) of the MAP eligible recipient is completed which identifies the need for BMS;

(b) the assessment is signed by the recipient, his parent or legal guardian; and

(c) the BMS specialist receives supervision on a regular basis.

(3) An agency certified for BMS services must:

(a) develop a BMS treatment plan based on a relevant and recent clinical assessment (within the last 12 months), as part of a comprehensive treatment plan covering an integrated program of therapeutic services, as applicable;

(b) identify all targeted behaviors that are to be addressed by the behavioral management specialist;

(c) ongoing assessment of the MAP eligible recipient's progress in behavioral management skills by the BMS supervisor; and

(d) offer 24-hour availability or appropriate staff to respond to the MAP eligible recipient's crisis situations.

(4) A MAP eligible recipient's treatment plan must be reviewed at least every 30 calendar days and notation of this review must be maintained in the recipient's file

C. **MAP eligible recipients:** In order to receive BMS services, a MAP eligible recipient must be under the age of 21 years, be diagnosed with a behavioral health condition and:

(1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;

(2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) require behavior management support following an institutional or other out-of-home placement as a transition to maintain the MAP eligible recipient in his or her home and community.

D. **Noncovered services:** BMS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

(1) activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the BMS treatment plan;

(2) services provided in a residential treatment facilities; and

(3) as services provided in lieu of services that should be provided as part of the MAP eligible recipient's individual educational plan (IEP).

E. **Reimbursement:** A BMS agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and 8.302.2 NMAC.

[8.321.2.13 NMAC - Rp, 8.322.3 NMAC, 1-1-14]

8.321.2.14 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): To help a New Mexico MAP eligible recipient receive medically necessary services, MAD pays for covered CCSS. This culturally sensitive service coordinates and provides services and resources to a MAP eligible recipient and his or her family necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the MAP eligible recipient's community, as well as strengths that may aid the MAP eligible recipient and family in the recovery or resiliency process.

A. **Eligible providers:** In addition to the requirements of Subsections A and B of Section 9, of this rule, in order to be eligible to be reimbursed for providing CCSS services, an agency must be: a FQHC; an IHS hospital or clinic; a PL 93-638 tribally operated hospital or clinic; or be a MAD enrolled CSA. CCSS services are certified by CYFD for MAP eligible recipients under 21 years of age and department of health (DOH) for those recipients over 21 years of age. For MAP eligible recipient ages 18 through 20, the CCSS certification or a license may be from either CYFD or DOH, as appropriate.

(1) Community support workers (CSW) (not a peer or family specialist), must possess the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the CSW must have:

(a) the education, skills, abilities and experience to perform the activities that comprise the full spectrum of CCSS;

(b) a bachelor's degree in a human service field from an accredited university and one year of relevant experience with the target population;

(c) an associate's degree and a minimum of two years of experience working with the target population;

(d) a high school graduation or general educational development (GED) test and a minimum of three years of experience working with the target population; or

(e) a New Mexico peer or family specialist certification and have completed 20 hours of documented training or continuing education, as identified in the CCSS service definition.

(2) CCSS agency supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the supervisory staff must hold:

(a) a bachelor's degree in a human services field from an accredited university or college;

(b) have four years of relevant experience in the delivery of case management or community support services with the target population;

(c) have at least one year of demonstrated supervisory experience; and

(d) completed 20 hours of documented training or continuing education, as identified in the New Mexico behavioral health collaborative CCSS service definition.

(3) CSA clinical supervisory staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of CCSS. Specifically the clinical supervisory staff must:

(a) be a licensed independent practitioner as detailed in Subsections B and H of Section 9 of this rule; and

(b) have one year of documented supervisory training.

(4) Certified peer worker (CPW) must:

(a) be 18 years of age or older;

(b) have a high school diploma or GED;

(c) be self-identified as a current or former consumer of mental health or substance abuse services;

(d) have at least two years of mental health or substance abuse recovery; and

(e) be a currently certified New Mexico CPW.

(5) Certified family specialist (CFS) must:

(a) be 18 years of age or older;

(b) have a high school diploma or GED;

(c) have personal experience navigating any of the child and family-serving systems, advocating for family members who are involved with the child and family behavioral health systems; and must also have an understanding of how these systems operate in New Mexico;

(d) be a currently certified New Mexico CFS; and

(e) must be well-grounded in his or her symptom self-management if the family specialist is a current or former consumer of behavioral health services.

B. **Covered services:** The purpose of CCSS is to surround a MAP eligible recipient and his or her family with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, with at a minimum 60 percent face-to-face and in vivo (where the MAP eligible recipient is located). that address barriers that impede the development of skills necessary for independent functioning in the community.

(1) CCSS activities include:

(a) assistance to the MAP eligible recipient in the development and coordination of his or her treatment plan including a recovery or resiliency management plan, a crisis management plan, and, when requested, his or her advanced directives related to the MAP eligible recipient's behavioral health care; and

(b) assessment support and intervention in crisis situations, including the development and use of crisis plans that recognize the early signs of crisis or relapse, use of natural supports, alternatives to the utilization of emergency departments and inpatient services.

(2) Individualized interventions, with the following objectives:

(a) services and resources coordination to assist the MAP eligible recipient in gaining access to necessary rehabilitative, medical and other services;

(b) assistance in the development of interpersonal and community coping and functional skills (e.g., adaptation to home, school and work environments), including:

(i) socialization skills;

(ii) developmental issues;

(iii) daily living skills;

(iv) school and work readiness activities; and

(v) education on co-occurring illness;

(c) encouraging the development of natural supports in workplace and school environments;

(d) assisting in learning symptom monitoring and illness self-management skills (e.g. symptom management), relapse prevention skills, knowledge of medication and side effects, and motivational and skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms that interfere with the MAP eligible recipient's daily living and to support him or her in maintaining employment and school tenure;

(e) assisting the MAP eligible recipient in obtaining and maintaining stable housing; and

(f) any necessary follow-up to determine if the services accessed have adequately met the MAP eligible recipient's needs.

(3) At least 60 percent of non facility-based CCSS provided must be face-to-face and in vivo (where the MAP eligible recipient is located). The CSW must monitor and follow-up to determine if the services accessed have adequately met the MAP eligible recipient's specific treatment needs.

(4) The CSW will make every effort to engage the MAP eligible recipient and his or her family in achieving the member's treatment or recovery goals.

(5) When the service is provided by a CPS or CFS, the above functions and

interventions should be performed with a special emphasis on recovery values and process, such as:

(a) empowering the MAP eligible recipient to have hope for, and participate in, his or her own recovery;

(b) helping the MAP eligible recipient to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;

(c) helping the MAP eligible recipient to identify and achieve his or her personalized recovery goals; and

(d) promoting the MAP eligible recipient's responsibility related to illness self-management.

(6) Limited CCSS services may be provided by a CSA during discharge planning while a MAP eligible recipient is receiving the following services:

(a) accredited residential treatment (ARTC);

(b) residential treatment (RTC);

(c) group home service;

(d) impatient hospitalization; or

(e) treatment foster care (TFC I and II).

(7) CCSS services may not be provided in conjunction with the following services:

(a) multi-systemic therapy (MST); or

(b) assertive community treatment (ACT).

C. **MAP eligible recipients:**

(1) CCSS is provided to a MAP eligible recipient 21 years and under who meets the criteria for or is diagnosed as either or both: (a) at risk of or experiencing serious emotional disturbances (SED); (b) has a chronic substance abuse disorder.

(2) MAD covers CCSS for a MAP eligible recipient 21 years and older diagnosed with a severe mental illness (SMI). A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from CCSS.

D. **Noncovered services:** CCSS are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.310.2 NMAC for a detailed description of MAD general noncovered services and Subsection C of Section 9 of this rule for all noncovered MAD behavioral health services or activities. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST) or ACT services.

E. **Reimbursement:** CCSS agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives direction on how to access NMAC rules, instructions for documentation, billing, and claims processing. General reimbursement instructions are found in this rule under Subsection D of Section 9.

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

8.321.2.15 DAY TREATMENT: MAD pays for services furnished by a day treatment provider as part of the EPSDT program for eligible MAP recipients under 21 years of age [42 CFR section 441.57]. The need for day treatment services must be identified through an EPSDT tot-to-teen healthcheck or other diagnostic evaluation. Day treatment services include MAP eligible recipient and parent education, skill and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented utilizing a clinical model for service delivery and support.

A. **Eligible providers:** An agency must be certified by CYFD to provide day treatment services in addition to the meeting the general provider enrollment requirements in Subsections A and B of Section 9.

B. **MAP eligible recipients:** MAD covers day treatment services for a MAP eligible recipient under age 21 who:

(1) is diagnosed with an emotional, behavioral, and neurobiological or substance abuse problems;

(2) may be at high risk of out-of-home placement;

(3) requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school;

(4) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services; or

(5) is able to benefit from this LOC.

C. **Covered services:**

(1) Behavioral health day treatment services are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include parent and MAP eligible recipient education, skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the MAP eligible recipient's school or other child serving agencies is included. Counseling services may be provided in addition to the BMS services. The goals of the service must be clearly documented, utilizing a clinical model for service delivery and support.

(2) The goal of day treatment is to maintain the MAP eligible recipient in his or her home or community environment.

(3) Day treatment services must be provided in a school setting or other community setting. However, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered. Programming is designed to complement and coordinate with the MAP eligible recipient's educational system.

(4) Services must be based upon the MAP eligible recipient's individualized BMS treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the MAP eligible recipient's adaptive functioning.

(5) The following services must be furnished by a day treatment service agency to receive reimbursement from MAD:

(a) the assessment and diagnosis of the social, emotional, physical and psychological needs of the MAP eligible recipient and his or her family for treatment planning ensuring that evaluations already performed are not unnecessarily repeated;

(b) development of individualized treatment and discharge plans and ongoing reevaluation of these plans;

(c) regularly scheduled individual, family, multi-family, group or specialized group sessions focusing on the attainment of skills, such as managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention, if applicable;

(d) family education and family outreach to assist the eligible recipient in gaining functional and behavioral skills;

(e) supervision of self-administered medication, as clinically indicated;

(f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each MAP eligible recipient's individualized treatment plan;

(g) availability of appropriate staff to provide crisis intervention during program hours;

(h) day treatment services are provided at a minimum of four hours of structured programming per day, two to five days per week based on acuity and clinical needs of the MAP eligible recipient and his or her family as identified in the treatment plan; and

(i) payment for performance of these services is included in the day treatment reimbursement rate.

(6) Only those activities of daily living and basic life skills that are assessed as being a clinical problem should be addressed in the treatment plan and deemed appropriate to be included in the MAP

eligible recipient's individualized program.

(7) A family who is unable to attend the regularly scheduled sessions at the day treatment facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the day treatment agency.

D. **Noncovered services:** Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

(1) educational programs, other than those indicated above;

(2) pre-vocational training;

(3) vocational training which is related to specific employment opportunities, work skills or work settings;

(4) any service not identified in the treatment plan;

(5) recreation activities not related to the treatment issues;

(6) leisure time activities such as watching television, movies or playing computer or video games;

(7) transportation reimbursement for the therapist who delivers services in the family's home; or

(8) a partial hospitalization program and all residential programs cannot be offered at the same time as day treatment services.

E. **Prior authorization:** See Subsection F of Section 9 of this rule for the general behavioral health services prior authorization requirements.

F. **Treatment plan:** In addition to the General Treatment Plan requirements in Subsection G of Section 9 of this rule, the treatment plan must be reviewed at least every 30 calendar days or more often when indicated based on the changing clinical needs.

G. **Reimbursement:** Day treatment providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how access documentation, billing and claims processing information.

[8.321.2.15 NMAC - Rp, 8.322.4 NMAC, 1-1-14]

8.321.2.16 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS: To assist the MAP eligible recipient receive necessary mental health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program. If the MAP eligible recipient is receiving services immediately before he or she reaches the age of 21 years, services may continue based on the following conditions, whichever comes first: (1) up to the date the MAP eligible recipient no longer requires the services, or (2) the date the MAP eligible recipient reaches the age of 22 years. The need for inpatient psychiatric care in freestanding psychiatric hospital must be identified in the MAP eligible recipient's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

A. **Eligible providers:** An MAD eligible provider must be accredited by at least one of the following:

(1) the joint commission (JC);

(2) the council on accreditation of services for families and children (COA);

(3) the commission on accreditation of rehabilitation facilities (CARF);

(4) another accrediting organization recognized by MAD as having comparable standards;

(5) be licensed and certified by the New Mexico DOH or the comparable agency if in another state;

(6) have a written utilization review (UR) plan in effect which provides for the review of a MAP eligible recipient's need for the facility's services that meet federal requirements; see 42 CFR Sections 456.201 through 456.245; or

(7) be an approved MAD provider before it furnishes services; see 42 CFR Sections 456.201 through 456.245.

B. **Covered services:** MAD covers those inpatient psychiatric hospital services furnished in freestanding psychiatric hospitals which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the MAP eligible recipient. These services must be furnished by eligible providers within the scope and practice of his or her profession (see Section 9 of this rule) and in accordance with federal regulations; see 42 CFR Section 441 Subpart D. Services must be furnished under the direction of a physician.

(1) In the case of a MAP eligible recipient under 21 years of age these services:

(a) must be furnished under the direction of a board prepared, board eligible, board certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist; and

(b) the psychiatrist must conduct an evaluation of the MAP eligible recipient, in person within 24 hours of admission.

(2) In the case of a MAP eligible recipient under 12 years of age, the psychiatrist must be board prepared, board eligible, or board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for a MAP eligible recipient under age 12 and a MAP eligible recipient under 21 years of age can be waived when all of the following conditions are met:

(a) the need for admission is urgent or emergent and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;

(b) at the time of admission, a board prepared, board eligible, or board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located;

(c) another facility which is able to furnish a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(d) the admission is for stabilization only and transfer arrangement to the care of a board prepared, board eligible, board certified psychiatrist, or in the case of a MAP eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible under the understanding that if the MAP eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the MAP eligible recipient is stable for transfer in accordance with professional standards.

(3) The following services must be furnished by a freestanding hospital to receive reimbursement from MAD:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) regularly scheduled structured counseling and therapy sessions for MAP eligible recipient, group, family, or a multifamily group based on individualized needs, as specified in the MAP eligible recipient's treatment plan;

(c) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school, attendance and money management;

(d) assistance to a MAP eligible recipient in his or her self administration of medication in compliance with state policies and procedures;

(e) appropriate staff available on a 24-hour basis to respond to crisis situations; determine the severity of the situation; stabilize MAP eligible recipient by providing support; make referrals, as necessary; and provide follow-up;

(f) a consultation with other professionals or allied care givers regarding a specific MAP eligible recipient;

(g) non-medical transportation services needed to accomplish treatment objectives; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of the MAP eligible recipient.

C. **Noncovered services:** Services furnished in a freestanding psychiatric hospital are subject to the limitations and coverage restrictions which exist for other MAD services; see Subsection C of Section 9 of this rule for MAD general noncovered services. MAD does not cover the following specific services for a MAP eligible recipient in a freestanding psychiatric hospital in the following situations:

(1) conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM);

(2) services in freestanding psychiatric hospital for MAP eligible recipient 21 years of age or older;

(3) services furnished after the determination by MAD or its designee has been made that the MAP eligible recipient no longer needs hospital care;

(4) formal educational or vocational services, other those indicated above, related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active treatment plan for a MAP eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b); or

(5) drugs classified as "ineffective" by the FDA drug evaluation.

D. MAD covers "awaiting placement days" in a freestanding psychiatric hospital when the MAD utilization review (UR) contractor determines that a MAP eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the MAP eligible recipient requires a residential LOC which cannot be immediately located. Those days during which the MAP eligible recipient is awaiting placement to the lower LOC are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for ARTC services to a MAP eligible recipient classified as level III, IV, or IV+, plus five percent. A separate claim form must be submitted for awaiting placement days.

E. **Treatment plan:** The treatment plan must be developed by a team of professionals in consultation with a MAP eligible recipient, his or her parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days.

(1) The treatment team must consist of at a minimum (see CFR 42 441.156(c-d):

(a) either a:

(i) board eligible or board certified psychiatrist;

(ii) a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy;

(iii) a physician licensed to practice medicine;

(iv) osteopathic physician with specialized training and experience in the diagnosis and treatment of mental illness, or

(v) a psychologist who has a master's degree in clinical psychology or who has been certified by the state and his or her RLD practice board;

(b) the team must also include one of the following:

(i) a psychiatric social worker;

(ii) an occupational therapist who is licensed by the state and who has specialized training in treating a MAP eligible recipient under the age of 21 years of age with SED:

(iii) a RN with specialized training or one year's experience in treating a recipient under the age of 21 years; or

(iv) a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by his or her RLD practice board.

(2) The treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file. The following must be contained in the treatment plan or documents used in the development of the treatment plan:

(a) shall be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the MAP eligible recipient's situation and reflects the need for inpatient psychiatric care;

(b) shall be developed by a team of professionals as defined in Paragraph (1) of Subsection E above in consultation with the MAP eligible recipient and, his or her parent, legal guardian, or others in whose care he or she will be released after discharge;

(c) shall have stated treatment objectives;

(d) shall be prescribed in an integrated program of therapies, activities, and experiences designed to meet the objectives;

(e) include, at the appropriate time, a post-discharge plan and coordination of inpatient services with partial a discharge plan, and related community services to ensure continuity of care with the MAP eligible recipient's family, school, and community upon discharge;

(f) shall have a statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(g) shall have a description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;

(h) shall have a statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including the provision for review and modification of the plan;

(i) shall have specification of staff responsibilities, description of proposed staff involvement, and orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the MAP eligible recipient; and

(j) shall have the criteria for release to less restrictive settings for treatment and discharge plans, the criteria for discharge, and the projected date of discharge.

F. **Prior authorization and utilization review:** All MAD services are subject to UR for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.302.5 NMAC. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

(1) All inpatient services for a MAP eligible recipient under 21 years of age in a freestanding psychiatric hospital require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

(2) Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

(3) A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration; see 8.350.2 NMAC.

G. **Discharge planning:** Plans for discharge must begin upon admittance to the facility and be included in the MAP eligible recipient's treatment plan. If the MAP eligible recipient will receive services in the community or in the custody of CYFD, the discharge must

be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the MAP eligible recipient, his or her family, and school and community.

H. **Reimbursement:** A freestanding psychiatric hospital service providers must submit claims for reimbursement on the UB04 claim form or its successor; see 8.302.2 NMAC. Once enrolled, providers receive instructions on how to access information on documentation, billing, and claims processing.

(1) Reimbursement rates for New Mexico freestanding psychiatric hospital is based on TEFRA provisions and principles of reimbursement; see 8.311.3 NMAC. Covered inpatient services provided in freestanding psychiatric hospital will be reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals.

(2) If a provider is not cost settled, the reimbursement rate will be at the provider's cost-to-charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost-to-charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

(3) Reimbursement rates for services furnished by a psychiatrist and licensed Ph.D. psychologist in a freestanding psychiatric hospital are contained in 8.311.3 NMAC. Services furnished by a psychiatrist and psychologist in a freestanding psychiatric hospital cannot be included as inpatient psychiatric hospital charges.

(4) When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the MAD coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

(5) The provider agrees to be paid by a HSD contracted managed care organization (MCO) at any amount mutually-agreed upon between the provider and MCO when the provider enters into contracts with MCO contracting with HSD for the provision of managed care services to a MAP eligible recipient.

(a) If the provider and the HSD contracted MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(b) The "applicable reimbursement rate" is defined as the rate paid by HSD to the provider participating in the medical assistance programs administered by MAD and excludes disproportionate share hospital and medical education payments.

[8.321.2.16 NMAC - Rp, 8.321.2 NMAC, 1-1-14]

8.321.2.17 INTENSIVE OUTPATIENT PROGRAM SERVICES: To help a MAP eligible recipient receive medically necessary services, MAD pays for intensive outpatient program (IOP) services. IOP services provide a time-limited, multi-faceted approach to treatment service for a MAP eligible recipient who requires structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be delivered through a MAD approved agency, as specified in this section.

A. Eligible providers: See Subsection A of Section 9 of this rule for MAD general provider requirements.

(1) Specific to IOP, the following types of agencies are eligible to be reimbursed for providing IOP services when they have a research-based model meeting the requirements of this Section Subsection C of this rule:

(a) a CMHC

(b) a FQHC;

(c) an IHS facility;

(d) a PL.93-638 tribal 638 facility;

(e) a MAD CSA; or

(f) an agency approved by MAD after demonstrating that the agency meets all the requirements of IOP program services and supervision requirements; such a MAD approved IOP agency is allowed to have services rendered by non-independent practitioners as listed in Subsection J of Section 9 of this rule.

(2) Each IOP program must have a clinical supervisor. The clinical supervisor may also serve as the IOP program supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) be licensed as a MAD approved independent practitioner; see Subsection H of Section 9 of this rule;

(b) two years relevant experience with an IOP program;

(c) one year demonstrated supervisory experience; and

(d) expertise in both mental health and substance abuse treatment.

(3) The IOP agency is required to develop and implement a program evaluation system.

(4) The agency must maintain the appropriate state facility licensure if offering medication treatment or medication replacement services.

(5) The agency must hold a MAD IOP approval letter and be enrolled by MAD to render IOP services to a MAP eligible recipient. A MAD IOP agency will be provisionally approved for a specified timeframe to render IOP services to a MAP eligible recipient. During this provisional approved time, MAD or its designee will determine if the IOP agency meets MAD IOP requirements and if so, the agency will receive an approval letter for IOP full enrollment.

B. **Coverage criteria:** The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. Treatment services should address co-occurring mental health disorders, as well as substance use disorders, when indicated. The IOP services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MAD enrolled behavioral health providers, with the intent that the IOP service shall not exclude a MAP eligible recipient with co-occurring disorder.

C. **Covered services:**

(1) MAD covers services and procedures that are medically necessary for the evaluation, assessment, diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. See Subsection C of Section 9 of this rule for general behavioral health provider requirements. Also see 8.310.2 NMAC.

(2) IOP core services include:

(a) individual therapy;

(b) group therapy (group membership may not exceed 15 in number); and

(c) psycho-education for the MAP eligible recipient and his or her family.

(3) A MAP eligible recipient youth or transition-age young adult is defined for this service as 17 years of age and under. This population should engage in IOP treatment in an environment separate from recipients 18 years of age and older who are receiving IOP services.

(4) Co-occurring mental health and substance use disorders: IOP must accommodate the needs of the MAP eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated multi-disciplinary approach or coordinated, concurrent services with MAD behavioral health providers. Medication management services are available to oversee the use of psychotropic medications.

(5) The duration of a MAP eligible

recipient's IOP intervention is typically three to six months. The amount of weekly services per MAP eligible recipient is directly related to the goals and objectives specified in his or her treatment or service plan.

(6) IOP services must be rendered through one of the following research-based models:

(a) matrix model adult treatment model;

(b) matrix model adolescent treatment model;

(c) Minnesota treatment model;

(d) integrated dual disorder treatment; or

(e) other researched-based models than those identified in (a)-(d) above must be approved by MAD or its designee.

(7) IOP services not provided in accordance with the conditions for coverage as specified in this rule are not a MAD covered service and are subject to recoupment.

D. **IOP MAP Eligible recipients:**

(1) IOP services are provided to a MAP eligible recipient, 13 through 17 years of age diagnosed with substance abuse disorder or with co-occurring disorder (SED and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

(2) IOP services are provided to a MAP eligible recipient 18 years of age and over diagnosed with substance abuse disorder or with a co-occurring disorder (SMI and substance abuse) or that meets the ASAM patient placement criteria for level two (II) - intensive outpatient treatment.

(3) Before engaging in an IOP program, the MAP eligible recipient must have a treatment file containing:

(a) one diagnostic evaluation; and

(b) one individualized treatment or service plan that includes IOP as an intervention.

E. **Noncovered services:** IOP services are subject to the limitations and coverage restrictions which exist for other MAD services see Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, and transitional living services);

(3) ACT;

(4) partial hospitalization;

(5) outpatient therapies (individual, family and group therapy may be billed only if there are clinical issues beyond the scope of IOP services);

(6) multi-systemic therapy (MST);

(7) activity therapy; or

(8) psychosocial rehabilitation (PSR) group services.

F. **Reimbursement:** See Subsection E of Section 9 of this rule for MAD behavioral health general reimbursement requirements and Subsection F for general prior authorization requirements; specifically for IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

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

8.321.2.18 MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION: MAD provides coverage for medication assisted treatment for opioid addiction (MAT) to a MAP eligible recipient through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment Programs.

A. **Eligible providers:** An opioid treatment center agency is a public or private facility operating a federally certified program to dispense methadone, other narcotic replacement, or narcotic agonist drug items, as part of a detoxification treatment or maintenance treatment as defined in 42 CFR Part 8 Certification of Opioid Treatment Programs. In addition to the requirements found in Subsections A and B of Section 9 of this rule, the following are requirements of an opioid treatment facility:

(1) The agency must maintain documentation supporting the medical necessity of MAT services in the MAP eligible recipient's medical record per the requirements in 42 CFR Part 8, Certification of Opioid Treatment Programs; and

(2) A MAT agency must provide the following:

(a) its DEA certification to operate an opioid treatment program (OTP);

(b) a copy of substance abuse and mental health services administration (SAMHSA), center for substance abuse treatment (CSAT) approval to operate an OTP;

(c) a copy of accreditation by the joint committee (JC) or a copy of the commission on accreditation of rehabilitation facilities (CARF) accreditation; and

(d) its HSD behavioral health services division (BHSD) approval letter as a methadone provider.

B. **Covered services:** MAT services use a drug or biological that is recognized in the treatment of substance use disorder and provided as a component of a comprehensive treatment program. MAT is also a benefit as a conjunctive treatment regimen for a MAP eligible recipient who is addicted to a substance that can be abused and who meets the DSM-IV-TR and subsequent editions' criteria for a substance use disorder diagnosis.

C. **MAT MAP eligible recipients:**

(1) The agency must ensure through its internal policies and procedures that a MAP eligible recipient is treated for opioid dependency only after the agency's physician determines and documents that:

(a) the MAP eligible recipient meets the definition of opioid dependence using generally accepted medical criteria, such as those contained in DSM-IV-TR and subsequent editions;

(b) the MAP eligible recipient has received an initial medical examination as required by 7.32.8.19 NMAC, *opioid treatment program admissions*;

(c) if the MAP eligible recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting MAT services unless the MAP eligible recipient receives a waiver of this requirement from the agency's physician because the MAP eligible recipient:

(i) was released from a penal institution within the last six months;

(ii) is pregnant, as confirmed by the agency's physician;

(iii) was treated for opioid dependence within the last 24 months; or

(iv) meets any other requirements specified in 7.32.8 NMAC, *opioid treatment program* regarding waivers, consent, and waiting periods.

(2) The agency must ensure that a MAP eligible recipient requesting long-term or short-term opioid withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period be assessed by the agency's medical director or physician to determine if other forms of treatment may be more appropriate.

D. **Noncovered services:** MAT services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services and 8.310.2 NMAC for MAD general noncovered services.

E. **Reimbursement:** See Subsection E of Section 9 of this rule for MAD general reimbursement requirements. Specifically:

(1) the MAT agency, except an IHS or a 638 tribal facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor; see 8.302.2 NMAC and 8.310.12 NMAC for IHS reimbursement details;

(2) the coverage of services provided to a MAP eligible recipient can be greater than the services required under 42 CFR Part 8 or its successor, *certification of opioid treatment programs;* MAD recognizes it is beneficial to the MAP eligible recipient to receive necessary comprehensive medical and behavioral health services when they can be rendered by the MAT agency at the same time as MAT services.

(a) The reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, other narcotic replacement or agonist drug items, and substance abuse and HIV counseling as well as other services performed by the agency, unless otherwise described as separately reimbursed are required by 42 CFR Part 8.12 (f), or its successor.

(b) The following additional MAD reimbursements will be made for the specific drug item if separately reimbursed service payable to the MAT agency:

(i) a narcotic replacement or agonist drug item other than methadone is administered or dispensed;

(ii) outpatient therapy other than the substance abuse and HIV counseling required by 42 CFR Part 8.12 (f) is reimbursable when rendered by a MAD approved independently licensed provider that meets Subsection H of Section 9 of this rule requirements;

(iii) a MAP eligible recipient's initial medical examination when rendered by a MAD approved medical provider who meets 8.310.2 and 8.310.3 NMAC requirements;

(iv) laboratory services provided by a certified laboratory facility when billed by the offsite laboratory, see 8.310.2 and 8.310.3 NMAC;

(v) full medical examination, prenatal care and gender specific services for a pregnant MAP eligible recipient; if she is referred to a provider outside the agency, payment is made to the provider of the service; or

(vi) medically necessary services provided beyond those required by CFR 42 CFR Part 8.12 (f), to address the medical issues of the MAP eligible recipient; see 8.310.2 and 8.310.3 NMAC;

(c) the quantity of service billed for administering or dispensing for each day cannot exceed the combined total of the drug items administered that day plus the number of drug items dispensed on that day; and

(d) for an IHS and a tribal 638 facility, MAD does not consider MAT services to be outside the IHS all inclusive rate and CCSS is therefore reimbursed at the MAT fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC.

(3) Claims billed for MAT services must include the MAP eligible recipient's substance use disorder diagnosis.

[8.321.2.18 NMAC - Rp, 8.325.11 NMAC, 1-1-14]

8.321.2.19 MULTI-SYSTEMIC THERAPY (MST): To help a MAP eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter his or her home and community, MAD pays for MST services as part of EPSDT program. MAD covers medically necessary MST required by the condition of the MAP eligible recipient. MST provides an intensive home, family and community-based treatment for a MAP eligible recipient who is at risk of out-of-home placement or is returning home from an out of home placement and his or her family. The need for MST services must be identified in the MAP eligible recipient's tot to teen healthcheck screen or another diagnostic evaluation. MST provides an intensive home, family and community-based treatment for MAP eligible recipients ages 10 to 18 and their families who are at risk of out of home placement or are returning home from placement.

A. **Eligible providers:** In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST licensure by MST Inc, of Mt. Pleasant, South Carolina, or any of its approved subsidiaries. MST Inc is a national organization located in Mt. Pleasant, South Carolina, deemed by MAD to be the primary authority on licensure of New Mexico MST programs.

(1) The MST program shall include an assigned MST team for each MAP eligible recipient. The MST team must include at minimum:

(a) a master's level independently licensed behavioral health professional clinical supervision; see Subsection H of Section 9 of this rule);

(b) a licensed master's and bachelor's level behavioral health staff able to provide 24 hour coverage, seven days per week; see Subsection J of Section 9 of this rule);

(c) a licensed master's level behavioral health practitioner that is required to perform all therapeutic interventions; aA bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of his or her RLD practice board licensure or practice (see Subsection B of Section 9 of this rule);

(d) a bachelor's level staff that has a degree in social work, counseling, psychology or a related human services field and must have at least three years' experience working with the target population of children, adolescents and their families; and

(e) staffing for MST services shall be comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection H of Section 9) who is MST trained; this supervision, following the MST supervisory protocol, is provided to team members on topics directly related to the needs of the MAP eligible recipient and his or her family on an ongoing basis; and

(b) one hour of local group supervision per week and one-hour of telephone consultation per week with the MST systems supervisor, provided to team members on topics directly related to the needs of MAP eligible recipient and his or her family on an ongoing basis.

(3) All clinical staff are required to participate in and complete a prescribed five-day MST introductory training and subsequent quarterly trainings.

B. **MAP eligible recipients:**

(1) MST is provided to a MAP eligible recipient 10 to 18 years of age who is diagnosed SED, involved in or at serious risk of involvement with the juvenile justice system; have antisocial, aggressive, violent, and substance-abusing behaviors; is at risk for an out-of-home placement; or is returning from an out-of-home placement where the above behaviors were the focus of his or her treatment and family.

(2) A co-occurring diagnosis of substance abuse shall not exclude a MAP eligible recipient from the program.

C. **Covered services and service limitations:** MST is a culturally sensitive service, provided by a MST team, provides an intensive home, family and community-based treatment for a MAP eligible recipient who is at risk of an out-of-home placement or is returning home from an out-of-home placement and his or her family. MST services are primarily provided in the MAP eligible recipient's home, but a MST worker may also intervene at the MAP eligible recipient's school and other community settings. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance abuse, delinquency and violent behavior.

(1) The following services must be furnished as part of the MST service to be eligible for reimbursement:

(a) an initial assessment to identify the focus of the MST intervention;

(b) therapeutic interventions with the MAP eligible recipient and his or her family;

(c) case management; and

(d) crisis stabilization.

(2) MST services are conducted by practitioners using the MST team approach. The MST team must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. MST services shall:

(a) promote the family's capacity to monitor and manage the MAP eligible recipient's behavior;

(b) involves the MAP eligible recipient's family and other systems, such as the school, probation officers, extended families and community connections;

(c) provide access to a variety of interventions 24 hours a day, seven days a week, by staff that will maintain contact and intervene as one organizational unit; and

(d) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains, such as adaptive, communication, psychosocial, problem solving, and behavior management.

(3) The duration of MST intervention is typically three to six months. Weekly interventions may range from three to 20 hours a week; less as a MAP eligible recipient nears discharge.

D. **Noncovered services:** MST services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered specialized behavioral health services.

E. **Reimbursement:** MST agencies must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the provider agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.19 NMAC - Rp, 8.322.6 NMAC, 1-1-14]

8.321.2.20 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS (RTC) AND GROUP HOMES: MAD covers those medically necessary services for a MAP eligible recipient under 21 years of age which are designed to develop skills necessary for successful reintegration into his or her family or transition into his or her community. A LOC determination must indicate that the MAP eligible recipient's needs this LOC services furnished in a RTC or group home. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. MAD pays for services furnished in a RTC or group home as part of EPSDT program. The need for RTC and group home services must be identified in the MAP eligible recipient's tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.

A. **Eligible providers:** In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing RTC or group home services to a MAP eligible recipient, an agency must meet the following requirements:

(1) a RTC and group home must be certified by CYFD. If the provider is certified by CYFD as a RTC, that certification will suffice if all other CYFD group home certification requirements are met; or

(2) if the RTC or group home is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD certifying requirements but is not required to be certified by CYFD; in lieu of receiving a certificate, CYFD will provide MAD copies of the facility review and recommendations; MAD will work with the provider to address the recommendations.

B. **Covered services:** MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of a MAP eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the MAP eligible recipient. The following are covered services:

(1) performance of necessary evaluations and psychological testing of the MAP eligible recipient for the development of his or her treatment plan, while ensuring that evaluations already performed are not repeated;

(2) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the MAP eligible recipient's treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the MAP eligible recipient;

(4) assistance to the MAP eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, making referrals, as necessary, and provide follow-up;

(6) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective; and

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the MAP eligible recipient.

C. **Noncovered services:** RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general MAD behavioral health noncovered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to a MAP eligible recipient:

(1) CCSS except by a CCSS agency when discharge planning with the MAP eligible recipient from the RTC or group home facility;

(2) services not considered medically necessary for the condition of the MAP eligible recipient, as determined by MAD or its designee;

(3) room and board;

(4) services for which prior approval was not obtained; or

(5) services furnished after the a MAD or its designee determination that the recipient no longer meets the LOC for RTC or group home care.

D. **Treatment plan:** The treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, his or her parent, legal guardian and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a RTC or group home. In addition to the requirements of Subsection G of Section 9 of this rule, the interdisciplinary team must review the treatment plan at least every 14 days. The MAP eligible recipient's file must contain the treatment plan and the documents used in the development of the treatment plan and all other supporting documentation.

E. **Prior authorization:** Before a RTC or group home service is furnished to a MAP eligible recipient, a prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. **Reimbursement:** A RTC or group home agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility, MAD considers RTC services to be outside the IHS all inclusive rate and RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD.

(1) The fee schedule is based on

actual cost data submitted by the RTC or group home agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The MAD fee schedule reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include:

(i) direct services furnished by a psychiatrist or licensed Ph.D. psychologist; these services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) other MAD services that a MAP eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD-covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each MAP eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home agency cannot bill nor be reimbursed for days when the MAP eligible recipient is absent from the facility.

[8.321.2.20 NMAC - Rp, 8.321.4 NMAC, 1-1-14]

8.321.2.21 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN A FREESTANDING PSYCHIATRIC HOSPITAL: To help a MAP eligible recipient under 21 years of age receive the level of services needed, MAD pays for outpatient hospital and partial hospitalization services furnished in a freestanding psychiatric hospital as part the EPSDT program. These services are provided upon release of an inpatient stay to address follow-up care. The need for outpatient or partial hospitalization services must be identified in the tot to teen healthcheck screen or other diagnostic evaluation furnished through a healthcheck referral.

A. **Eligible providers:** In addition to the requirements found in Subsections A and B of Section 9 of this rule, an eligible provider includes a facility JO accredited, and licensed and certified by DOH or the comparable agency in another state.

B. **Coverage criteria:** MAD covers only those services which meet the following criteria:

(1) Services that are prescribed by a psychiatrist or licensed Ph.D. psychologist and furnished under an individualized written treatment plan established by the MAD enrolled psychiatrist or licensed Ph.D. psychologist after any necessary consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished, indicate the diagnoses, anticipated goals and must be developed with the MAP eligible recipient and his or her parent or guardian. The treatment plan must be developed within 14 calendar days of admission to the partial hospitalization or outpatient program.

(2) Treatment is supervised and periodically evaluated by a MAD enrolled psychiatrist or licensed Ph.D. psychologist to determine the extent to which treatment goals are being realized. The psychiatrist or licensed Ph.D. psychologist must also provide supervision and direction to any behavioral health practitioner involved in the MAP eligible recipient's treatment. The psychiatrist or licensed Ph.D. psychologist must see the MAP eligible recipient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

(3) Treatment must be reasonably expected to improve the MAP eligible recipient's condition or designed to reduce or control the MAP eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the MAP eligible recipient's level of functioning. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.

C. **Covered services and service limitations:** The following services must be furnished by a MAD enrolled provider delivering outpatient hospital or a partial hospitalization as part of the freestanding psychiatric hospital services to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

(1) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(2) regularly scheduled structured counseling and therapy sessions for a MAP eligible recipient, his or her family, group or multifamily group based on individualized needs furnished by social workers, trained psychiatric nurses, other behavioral health professionals who are employed by the hospital, as specified in the treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management;

(4) assistance to the MAP eligible recipient in his or her self-administration of medication in a manner that complies with state policies and procedures;

(5) appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient by providing support, provide follow-up for crisis situation and schedule follow-up appointments;

(6) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(7) non-medical transportation services needed to accomplish the treatment objective;

(8) consultation with other professionals or allied caregivers regarding a specific MAP eligible recipient;

(9) non-medical transportation services needed to accomplish the treatment objective;

(10) discharge planning and referrals as necessary to community programs as part of the planning.

D. **Noncovered services:** Outpatient and partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for all general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services with outpatient and partial hospitalization:

(1) meals;

(2) transportation by the partial hospitalization provider;

(3) activity therapies, group activities or other services which are primarily recreational or divisional in nature;

(4) programs which provide social and recreational activities to recipients who need some supervision during the day

(5) programs which are generally community support groups in non-medical settings for a SED individual for the purpose of social interaction;

(6) outpatient hospital program consisting entirely of social activities;

(7) formal educational and vocational services related to traditional academic subjects or vocational training;

non-formal education services can be covered if they are part of an active treatment plan for the MAP eligible recipient; see 42 CFR Section 441.13(b);

(8) hypnotherapy or biofeedback; or

(9) services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

E. **Treatment plan:** An individualized treatment plan must be developed by a team of professionals in consultation with the MAP eligible recipient, parent, legal guardian or others in whose care the MAP eligible recipient will be released after discharge within 14 calendar days of the MAP eligible recipient's admission. The interdisciplinary team must participate in the treatment planning at least every 30 calendar days. See Subsection G of Section 9 of this rule for MAD general treatment plan requirements.

F. **Prior authorization:** All outpatient and partial hospitalization services furnished in a freestanding psychiatric hospital must be prior authorization (PA) from MAD or its UR contractor; see Subsection F of Section 9 this rule for MAD general prior authorization requirements.

G. **Reimbursement:** A provider of outpatient and partial hospitalization services must submit claims for reimbursement on the UB 04 claim form or its successor. See 8.302.2 NMAC and Subsection E of Section 9 of this rule for MAD general reimbursement requirements. Specific to outpatient and partial hospitalization services:

(1) are reimbursed at an interim rate established by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles; for those services reimbursed using the medicare allowable cost methodology, MAD reduces the medicare allowable costs by three percent; outpatient and partial hospitalization services that are not cost settled, will be reimbursed at the provider's cost-to-charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012; otherwise, rates are established after considering available cost-to-charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration; and

(2) any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

[8.321.2.21 NMAC - Rp, 8.321.5 NMAC, 1-1-14]

8.321.2.22 OUTPATIENT BEHAVIORAL HEALTH PROFESSIONAL SERVICES:

A. Psychological, counseling and social work: These services mean diagnostic or active treatments with the intent to reasonably improve a MAP eligible recipient's physical, social, emotional and behavioral health or substance abuse condition. Services are provided to a MAP eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling and social work services are performed by licensed psychological, counseling and social work staff acting within their scope of practice (see Subsections B, H-J of Section 9 of this rule). These services include, but are not limited, to testing and evaluation that appraise cognitive, emotional and social functioning and self concept. Therapy and treatment includes the planning, managing and providing a program of psychological services to the MAP eligible recipient with diagnosed behavioral health condition and may include consultation with his or her family and other professional staff.

B. An assessment or evaluation must be conducted at least annually or more frequently if indicated by the MAP eligible recipient's condition or applicable federal or state statute, regulation, rule or law. The assessment must be signed by the practitioner operating within his or her scope of licensure (see Subsection B of Section 9 of this rule). Based on the MAP eligible recipient's annual assessment, the MAP eligible recipient's treatment file must document the extent to which his or her treatment goals are being met and whether changes in direction or emphasis of the treatment are needed.

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

8.321.2.23 PSYCHOSOCIAL REHABILITATION SERVICES: To help adult MAP eligible recipient with SMI receive a range of psychosocial services, MAD pays for psychosocial rehabilitation services (PSR). The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore his or her best possible level of functioning.

A. **Eligible providers:**

(1) The following psychosocial rehabilitation agencies are eligible to be reimbursed for furnishing PSR to a MAP eligible recipient:

(a) an IHS facility;

(b) a CMHC licensed by DOH; or

(c) a CSA with CMHC licensure;

(2) An agency which furnishes PSR services must have direct experience in successfully serving individuals with SMI.

(3) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services. See Subsection A of Section 9 of this rule for MAD general provider requirements. A PSR agency must have the following:

(a) its copy of DOH licenses as a CMHC if so enrolled; and

(b) a copy of its New Mexico behavioral health collaborative letter of approval as a CSA if so enrolled;

B. **Coverage criteria:** MAD covers only those PSR services which comply with DOH mental health standards and are medically necessary to meet the individual needs of the MAP eligible recipient, as delineated in his or her treatment plan. Medical necessity is based upon the MAP eligible recipient's level of functioning as affected by his or her SMI. The services are limited to goal oriented PSR services which are individually designed to accommodate the level of the MAP eligible recipient's functioning and which reduce the disability and restore the recipient to his or her best possible level of functioning.

C. **Covered services:** MAD covers PSR services which include a cadre of services designed to reduce symptomatology and restore basic skills necessary to function independently in the MAP eligible recipient's community. MAD covers the following PSR services detailed below for a MAP eligible recipient. These services are further defined by current procedure terminology (CPT) and healthcare common procedure coding system (HCPCS) identified for PSR.

(1) Psychosocial therapy interventions designed to address the functional limitations, deficits, and behavioral excesses through capitalizing on personal strengths and developing coping strategies and supportive environments.

(2) Community-based crisis intervention which must include:

(a) the availability of appropriate staff to respond to a crisis situation on a 24-hour a day basis;

(b) determining the severity of the crisis situation;

(c) stabilizing the MAP eligible recipient; and

(d) making referrals to appropriate agency(ies) and provider follow-up.

(3) Psychosocial clinical consultations by professionals to assess the MAP eligible recipient's status, if applicable.

(4) Therapeutic interventions designed to meet the MAP eligible recipient's clinically determined needs through scheduled structured sessions.

(5) Medication services that are

goal-directed interventions such as the evaluation of the need for psychotropic medication and subsequent assessment and management of the MAP eligible recipient's pharmacologic treatment.

(6) Services must be individualized for each MAP eligible recipient and identified in his or her treatment plan.

D. **MAP eligible recipients:** A MAP eligible recipient is 21 years or older diagnosed with SMI and for whom the medical necessity for PSR services was determined. A resident in an institution for mental illness is not eligible for this service.

E. **Noncovered services:** PSR services are subject to the limitations and coverage restrictions which exist for other MAD services. See Subsection C of Section 9 of this rule for all general noncovered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. **Prior authorization:** For PSR, reviews are retrospective.

(1) Retrospective review: An assessment, diagnostic summary formulation and a treatment plan determine the type of PSR services rendered to a MAP eligible recipient. An agency's staff determines medical necessity of services based upon the service guidelines included in the DOH manual for evidencing medical necessity. All plans are subject to retrospective review to determine whether services provided met the service guidelines.

(2) Reviews for crisis intervention: When crisis intervention services are required, the claim is subject to retrospective review in accordance with the definition and requirements of the service criteria. Reviews must be submitted to DOH.

G. **Treatment plan:** See Subsection G of Section 9 of this rule for MAD general treatment plan requirements. The following must be contained in the treatment plan and documents used in the development of the MAP eligible recipient's treatment plan. The treatment plan and all supporting documentation must be available for review by HSD, DOH or their agents in the MAP eligible recipient's file.

H. **Reimbursement:** A PSR agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC.

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

8.321.2.24 SMOKING CESSATION COUNSELING: See 8.310.2 NMAC for a detailed description of tobacco cessation services and approved behavioral health providers.

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

8.321.2.25 TREATMENT FOSTER CARE I: MAD pays for medically necessary services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level I (TFC I) and meets this LOC as part of the EPSDT program. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into the community. TFC I agency provides therapeutic services to a MAP eligible recipient who is experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a TFC I setting. The need for TFC I services must be identified in the tot to teen healthcheck or other diagnostic evaluation furnished through the MAP eligible recipient's healthcheck referral.

A. **Eligible agencies:** In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing TFC I services to a MAP eligible recipient, the agency must be certified as provider of TFC by CYFD. A MAP eligible recipient has the right to receive services from any MAD TFC enrolled agency of his or her choice.

B. **Covered services:** The family living experience is the core treatment service to which other individualized services can be added, as appropriate to meet the MAP eligible recipient's needs.

(1) A TFC I parent is either employed or contracted by the TFC I agency and receives appropriate training and supervision by the TFC I agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when the MAP eligible recipient is normally at home, and is able to be physically present to meet the MAP eligible recipient's emotional and behavioral needs. The treatment foster parent responsibilities include, but are not limited to:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in the MAP eligible recipient's treatment plan;

(c) recording the MAP eligible recipient's information and documentation of activities, as required by the TFC I agency and the standards under which it operates;

(d) assisting the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals;

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan; and

(g) work with all appropriate and available community-based resources to secure services for and to advocate for the MAP eligible recipient.

(2) The following services must be furnished by the TFC I agency. Payment for performance of these services is included in the TFC I agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC I foster parents initial and ongoing training;

(b) providing support, assistance and training to the TFC I foster parents;

(c) assessment, pre placement and placement to determine the MAP eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC I and assessment of family interactions and stress;

(e) treatment planning as defined Subsection G of Section 9 of this rule and treatment team meetings;

(f) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group setting for the MAP eligible recipient;

(g) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the MAP eligible recipient;

(h) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations;

(i) when a MAP eligible recipient's return to his or her family is planned, assessment of the family's strengths, needs and the development of a family service plan.

(j) for TFC I, the treatment coordinator must conduct a private face to face visit with the MAP eligible recipient within the first two weeks of placement and at least twice monthly thereafter;

(k) for TFC I, the treatment coordinator has a face to face interview with the MAP eligible recipient's treatment foster parents within the first two weeks of placement and at least twice monthly thereafter;

(l) for TFC I, the treatment coordinator must have a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not

necessary in the same week as the face to face contact.

C. **Noncovered service:** TFC I services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for all noncovered MAD behavioral health services or activities. Specific to TFC I services MAD does not cover:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS except when planning a discharge from the MAP eligible recipient's TFC I placement.

D. **Prior authorization:** Before any TFC I service is furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. **Treatment plan:** The treatment plan must be developed by MAP eligible recipient's treatment team in consultation with the MAP eligible recipient, family or legal guardian, primary care provider, if applicable, and others in whose care he or she will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC I program.

(1) The treatment team must review the treatment plan every 30 calendar days.

(2) In addition to the requirements of Subsection G of Section 9 of this rule, the following must be contained in the treatment plan or documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) substance abuse assessment;

(ii) educational assessment; and

(iii) vocational assessment;

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and TFC I foster parent responsibilities and the description and frequency of the following components: (i) proposed staff involvement, (ii) orders for medication, (iii) treatments, restorative and rehabilitative services, (iv) activities, therapies, social services, (v) special diet, and (vi) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for his or her release to less restrictive settings for treatment, including TFC II.

F. **Reimbursement:** A TFC I agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.25 NMAC - Rp, 8.322.2 NMAC, 1-1-14]

8.321.2.26 TREATMENT FOSTER CARE II: MAD pays for behavioral health services furnished to a MAP eligible recipient under 21 years of age who has an identified need for treatment foster care level II (TFC II) and meets this LOC as part of the EPSDT. The therapeutic family living experience is the core treatment service to which other individualized services can be added. MAD covers those services included in the MAP eligible recipient's individualized treatment plan which are designed to help him or her develop skills necessary for successful reintegration into his or her family or transition back into his or her community. The need for TFC II services must be identified in the MAP eligible recipient's tot to teen healthcheck or other diagnostic evaluation furnished through a health check referral.

A. **Eligible agencies:** In addition to the requirements of Subsections A and B of Section 9 of this rule, in order to be eligible to be reimbursed for providing TFC II services to a MAP eligible recipient, the agency must be certified as provider of TFC by CYFD. A MAP eligible recipient has the right to receive services from any MAD enrolled TFC agency of his or her choice.

B. **Covered services:** All services covered in TFC I are required in TFC II. TFC II allows for a step down from TFC I when the MAP eligible recipient's symptoms improve and allow for less intensive supervision by the family, age appropriate activities are allowed with some degree of independence or gains have been met in TFC I; however,t continued monitoring is required to maintain these achievements as identified in the treatment plan. TFC II also allows for entry into this LOC for those MAP eligible recipients who would benefit optimally from a treatment foster care placement but who do not have the severity of symptoms and behaviors as required for TFC I.

(1) A TFC II parent is either employed or contracted by the TFC II agency and receives appropriate training and supervision by the TFC II agency. Treatment foster care families must have one parent readily assessable at all times, cannot schedule work when the MAP eligible recipient is normally at home, and is able to be physically present to meet the MAP eligible recipient's emotional and behavioral needs. The treatment foster parent responsibilities include:

(a) participation in the development of treatment plans for the MAP eligible recipient by providing input based on his or her observations;

(b) assumption of primary responsibility for implementing the in-home treatment strategies specified in the MAP eligible recipient's treatment plan;

(c) recording the MAP eligible recipient's information and documentation of activities, as required by the TFC I agency and the standards under which it operates;

(d) assisting the MAP eligible recipient maintain contact with his or her family and enhance that relationship;

(e) supporting efforts specified by the treatment plan to meet the MAP eligible recipient's permanency planning goals;

(f) assisting the MAP eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan; and

(g) work with all appropriate and available community-based resources to secure services for and to advocate for the MAP eligible recipient.

(2) The following services must be furnished by the TFC II agency. Payment for performance of these services is included in the TFC II agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC II foster parents initial and ongoing training;

(b) providing support, assistance and training to the TFC II foster parents;

(c) assessment, pre placement and placement to determine the MAP eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the MAP eligible recipient's progress in TFC II and assessment of family interactions and stress;

(e) treatment planning as defined Subsection G of Section 9 of this rule and treatment team meetings;

(f) providing or contracting for regularly scheduled counseling and therapy sessions in an individual, family or group

setting for the MAP eligible recipient;

(g) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the MAP eligible recipient;

(h) providing crisis intervention as needed, including 24 hour availability of appropriate staff to respond to crisis situations; and

(i) when a MAP eligible recipient's return to his or her family is planned, assessment of the family's strengths, needs and the development of a family service plan.

(j) for TFC II, the treatment coordinator must conduct a private face to face visit with the MAP eligible recipient within the first two weeks of placement and at least once monthly thereafter;

(k) for TFC I, the treatment coordinator has a face to face interview with the MAP eligible recipient's treatment foster parents within the first two weeks of placement and at least once monthly thereafter;

(l) for TFC II, the treatment coordinator must have a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week as the face to face contact.

C. **Noncovered service:** TFC II services are subject to the limitations and coverage restrictions that exist for other MAD services. See Subsection C of Section 9 of this rule for general noncovered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with TFC II services to a MAP eligible recipient:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS, except when planning discharge from the TFC II placement.

D. **Prior authorization:** Before any TFC II services are furnished to a MAP eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

E. **Treatment plan:** The treatment plan must be developed by treatment team in consultation with the MAP eligible recipient, his or her family or legal guardian, primary care provider, if applicable, and others in whose care the MAP eligible recipient will be released after discharge. The plan must be developed within 14 calendar days of the MAP eligible recipient's admission to a TFC II program. The treatment plan must meet all requirements found in Subsection G of Section 9 of this rule.

(1) The treatment coordinator must review the treatment plan every 30 calendar days;

(2) In addition to the requirements of Subsection G of Section 9 of this rule, the following must be contained in the treatment plan and documents used in the development of the treatment plan and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) a statement of the nature of the specific problem and the specific needs and strengths of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) mental status assessment;

(ii) intellectual function assessment;

(iii) psychological assessment;

(iv) educational assessment;

(v) vocational assessment;

(vi) social assessment;

(vii) medication assessment; and

(viii) physical assessment.

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of intermediate and long-range goals with the projected timetable for their attainment;

(e) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;

(f) specification of staff and TFC II foster parent responsibilities and the description and frequency of the following components: (i) proposed staff involvement, (ii) orders for medication, (iii) treatments, restorative and rehabilitative services, (iv) activities, therapies, social services, (v) special diet, and (vi) special procedures recommended for the health and safety of the MAP eligible recipient; and

(g) criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge and projected date of discharge of the MAP eligible recipient.

F. **Reimbursement:** A TFC II agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection E of Section 9 of this rule for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.26 NMAC - Rp, 8.322.5 NMAC, 1-1-14]

HISTORY OF 8.321.2 NAMC:

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

ISD 310.1700, EPSDT Services, filed 2-13-80.

ISD 310.1700, EPSDT Services, filed 6-25-80.

ISD Rule 310.1700, EPSDT Services, filed 10-22-84.

MAD Rule 310.17, EPSDT Services, filed 5-1-92.

MAD Rule 310.17, EPSDT Services, filed 7-14-93.

MAD Rule 310.17, EPSDT Services, filed 11-12-93.

MAD Rule 310.17, EPSDT Services, filed 12-17-93.

MAD Rule 310.17, EPSDT Services, filed 3-14-94.

MAD Rule 310.17, EPSDT Services, filed 6-15-94.

MAD Rule 310.17, EPSDT Services, filed 11-30-94.

History of Repealed Material:

MAC Rule 310.17, EPSDT Services, filed 11-30-94 - Repealed effective 2-1-95.

8.321.2 NMAC, Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals, filed 10-8-10 - Repealed effective 1-1-14.

8.321.3 NMAC, Accredited Residential Treatment Center Services, filed 2-17-12 - Repeal effective 1-1-14.

8.321.4 NMAC, Non-Accredited Residential Treatment Center Services, filed 2-17-02 - Repeal effective 1-1-14

8.321.5 NMAC, Outpatients and Partial Hospitalization Services in Freestanding Psychiatric Hospitals, filed 1-5-12 - Repealed effective 1-1-14.

8.322.2 NMAC, Treatment Foster Care, filed 2-17-12 - Repealed effective 1-1-14.

8.322.3 NMAC, Behavioral Management Skills Development Services, filed 10-12-05 - Repealed effective 1-1-14.

8.322.4 NMAC, Day Treatment, filed 10-12-05 - Repealed effective 1-1-14.

8.322.5 NMAC, Treatment Foster Care II, filed 2-17-12 - Repealed effective 1-1-14.

8.322.6 NMAC, Multi-Systemic Therapy, filed 11-16-07 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 4 PHARMACY SERVICES, PRESCRIBING, AND PRACTITIONER ADMINISTERED DRUG ITEMS

8.324.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.324.4.1 NMAC - Rp, 8.324.4.1 NMAC, 1-1-14]

8.324.4.2 SCOPE: The rule applies to the general public.
[8.324.4.2 NMAC - Rp, 8.324.4.2 NMAC, 1-1-14]

8.324.4.3 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 27-2-12 et seq.
[8.324.4.3 NMAC - Rp, 8.324.4.3 NMAC, 1-1-14]

8.324.4.4 DURATION: Permanent.
[8.324.4.4 NMAC - Rp, 8.324.4.4 NMAC, 1-1-14]

8.324.4.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.4.5 NMAC - Rp, 8.324.4.5 NMAC, 1-1-14]

8.324.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.324.4.6 NMAC - Rp, 8.324.4.6 NMAC, 1-1-14]

8.324.4.7 DEFINITIONS: [RESERVED]

8.324.4.8 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.
[8.324.4.8 NMAC - Rp, 8.324.4.8 NMAC, 1-1-14]

8.324.4.9 PHARMACY SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to MAP eligible recipients, including covered pharmacy services and practitioner administered drugs [42 CFR Section 440.120(a)]. Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by MAD.
[8.324.4.9 NMAC - Rp, 8.324.4.9 NMAC, 1-1-14]

8.324.4.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP 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 instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement (PPA), an agreement with a HSD contracted managed care organization (MCO) and all applicable statutes, regulations, rules, 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. Eligible providers include:

(1) pharmacies licensed by the New Mexico pharmacy board;

(2) clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(3) institutional pharmacies licensed for outpatient dispensing by the New Mexico pharmacy board;

(4) family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(5) prescribing practitioners practicing in communities more than 15 miles from a licensed pharmacy;

(6) Indian health service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care; and

(7) mail order pharmacies licensed to dispense in New Mexico.

B. When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

C. Properly licensed practitioners and facilities may also be enrolled for the purpose of being reimbursed for practitioner administered drug items that cannot be self-administered by the medical assistance program (MAP) eligible recipient.
[8.324.4.10 NMAC - Rp, 8.324.4.10 NMAC, 1-1-14]

8.324.4.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include but are not limited to supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if an MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.310.3 NMAC.

D. Retention and storage of the original prescription, electronic

prescription, and records of phone or fax orders must meet all pharmacy board requirements and must be retained for six years. If the prescriber certifies that a specific brand is medically necessary, by handwriting "brand medically necessary" or "brand necessary" on the face of the prescription, the allowed ingredient cost is the estimated acquisition cost (EAC) of the brand drug. The documentation of the provider's handwritten certification must be maintained by the pharmacy provider and furnished upon request. Checked boxes, rubber stamps and requests by telephone do not constitute appropriate documentation, pursuant to 42 CFR 447.512. "Brand necessary" prescriptions may be subject to prior authorization. Any claim for which "brand necessary" is claimed must be supported with documentation in the prescriber's medical records. Electronic alternatives approved by the secretary of the federal department of health and human services are acceptable.

E. A pharmacy provider must discuss any matters with the MAP eligible recipient or their personal representative that in the provider's professional judgment are significant. See 42 USC 1396r-8(g)(2)(A)(ii)(I) of the Social Security Act. Pharmacy counseling services are subject to the standards for counseling established under the state Pharmacy Practice Act. Counseling must be furnished unless declined by the MAP eligible recipient or his or her authorized representative.

F. A pharmacy must follow all federal and state laws, regulations and rules regarding management of pain with controlled substances, use of the drug monitoring program database, limiting dispensing of controlled substances, and reporting dispensing of controlled substances to state monitoring programs.

[8.324.4.11 NMAC - Rp, 8.324.4.11 NMAC, 1-1-14]

8.324.4.12 COVERED SERVICES: MAD covers medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated in this section of this rule. Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications may be reviewed for medical necessity before or after reimbursement. Providers must consult MAD, or its designated contractor, before supplying items not specifically listed in this policy or billing instructions. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards are considered.

A. For a MAP eligible recipient 21 years of age and older not in an institution, coverage of over-the-counter items is limited to insulin**,** diabetic test strips, prenatal vitamins, electrolyte replacement system, ophthalmic lubricants, pediculosides and scabicides, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. MAD, or its designee, may expand the list of covered over-the-counter items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over the counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is incorporated as part of the generic-first coverage provisions. Otherwise, the MAP eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item. Prior authorization for coverage of other over the counter products may be requested when a specific regimen of over the counter drugs is required to treat chronic disease conditions.

B. When drugs are provided through a preferred drug list, drugs are subject to generic-first coverage provisions. The MAP eligible recipient must first use one or more generic items available on the preferred drug list to treat a condition before MAD covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD, or its designee, including HSD contracted managed care organization (MCO), based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items.

[8.324.4.12 NMAC - Rp, 8.324.4.12 NMAC, 1-1-14]

8.324.4.13 COVERAGE REQUIREMENTS:

A. **Legal requirements:** All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. A prescription must meet all federal and state laws, regulations and rules. A pharmacy provider and a prescriber must fulfill all the requirements of federal and state laws relating to his or her practice and ethics.

B. **Rebate requirements:** MAD pays only for the drugs of pharmaceutical manufacturers that have entered into and have in effect a rebate agreement with the federal department of health and human services. This limitation does not apply to dispensing a single-source or innovator multiple-source drug if MAD has determined that the availability of the drug is essential to the health of a MAP eligible recipient.

C. **Prescribing:** A prescriber must be enrolled as a MAD provider in order to prescribe drug items for a MAP eligible recipient. A provider who has been terminated or suspended by MAD or is not enrolled as a provider must notify his or her MAP eligible recipients that he or she cannot prescribe drug items for them.

[8.324.4.13 NMAC - Rp, 8.324.4.13 NMAC, 1-1-14]

8.324.4.14 NONCOVERED SERVICES OR SERVICE RESTRICTIONS: Pharmacy services are subject to the limitations and coverage restrictions that exist for other MAD services.

A. MAD does not cover the following specific pharmacy items:

(1) medication supplied by state mental hospitals to a MAP eligible recipient on convalescent leave from the center;

(2) methadone for use in drug treatment programs except as part of a MAD approved medication assisted treatment program (MAT);

(3) personal care items such as non-prescription shampoos, soaps;

(4) cosmetic items, such as retin-A for aging skin, rogaine for hair loss;

(5) drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the federal food and drug administration (FDA), known as DESI (drug efficacy study implementation) drugs;

(6) fertility drugs;

(7) antitubercular drug items available from the New Mexico department of health (DOH) or the United States public health service;

(8) weight loss/weight control drugs;

(9) barbiturate hypnotic drugs whose primary action is to induce sleep unless the MAP eligible recipient resides in a nursing home;

(10) drug items used to treat sexual dysfunction;

(11) compounded drug items which lack an ingredient approved by the federal food and drug administration (FDA) for the indication for which the drug is intended;

(12) compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and

(13) cough and cold preparations for a MAP eligible recipient under the age of four.

B. MAD covers non-prescription drug items without prior authorization when prescribed by a licensed practitioner authorized to prescribe for a MAP eligible recipient who resides in a nursing facility (NF) or an intermediate

care facility for individuals with intellectual disabilities (ICF-IID), when such items are not routinely included in the facility's reimbursable cost and a specific prescription for the item is dispensed based on a practitioner's order. The following cannot be charged to the MAP eligible recipient or billed to MAD, or a HSD contracted managed care organization, by a provider:

(1) diabetic testing supplies and equipment;

(2) aspirin and acetaminophen;

(3) routine ointments, lotions and creams, and rubbing alcohol; and

(4) other non-prescription items stocked at nursing stations and distributed for use individually in small quantities.

C. MAD does not cover drug items for a MAP eligible recipient who is eligible for medicare Part D when the drug item or class of drug meets the federal definition of a medicare Part D covered drug. MAD does not cover any copayment due from the MAP eligible recipient towards a claim paid by medicare Part D nor any medicare Part D covered drug or class of drug where the MAP eligible recipient has a gap in medicare Part D coverage due to a medicare coverage limit. Items or drug classes specifically excluded by medicare Part D are covered, non-covered or limited to the same extent that MAD covers the excluded drug items for a MAP eligible recipient who is not dually-eligible.

[8.324.4.14 NMAC - Rp, 8.324.4.14 NMAC, 1-1-14]

8.324.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and, before payment is made or after payment is made; see 8.302.5 NMAC. Once enrolled, providers receive directions on how to access instructions and documentation forms necessary for prior authorization and claims processing. Review or prior authorization may be required for items for which a less expensive or therapeutically preferred alternative should be used first. In addition to the generic-first coverage provisions, applicable therapeutic "step" requirements will be based on published clinical practice guidelines, professional standards of health care and economic considerations.

A. **Prior authorization:** MAD or its designee reviews all requests for prior authorizations. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request reconsideration; see 8.350.2 NMAC.

D. **Drug utilization review:** The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the MAP eligible recipient's service providers or governmental entities legally authorized to receive such information.

(1) **Prospective drug use review:** Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interactions**,** clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

(2) **Counseling:** Pursuant to 42 CFR 456.705, each dispensing pharmacist must offer to counsel each MAP eligible recipient or his or her authorized representative receiving services who presents a new prescription, unless the MAP eligible recipient or his or her authorized representative refuses such counsel. Pharmacists must document these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review has taken place. A reasonable effort must be made to record and maintain the pharmacist's comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide a MAP eligible recipient access to a toll-free number.

[8.324.4.15 NMAC - Rp, 8.324.4.15 NMAC, 1-1-14]

8.324.4.16 REIMBURSEMENT: Pharmacy providers must submit claims for reimbursement on the separate pharmacy claim form or its successor, see 8.302.2 NMAC and Section 17 of this rule.

A. **General reimbursement methodology:** The estimated ingredient cost will not exceed the lowest of the estimated acquisition cost (EAC), the maximum allowable cost (MAC), the actual acquisition cost of a 340B drug, or the federal upper limit (FUL).

(1) **Estimated acquisition cost (EAC).** MAD determines EAC as follows:

(a) MAD establishes EAC, defined as MAD's approximation of the net or actual acquisition costs of such drugs;

(b) the factors MAD considers in setting rates for drugs under this subparagraph include:

(i) product cost, which may vary among purchasing contracts;

(ii) clinical concerns;

(iii) MAD's budget limits;

(iv) the actual package size dispensed; and

(v) payments by other payers in New Mexico and other state MAD and medicare pricing policies;

(c) MAD uses the EAC as its reimbursement for a drug when the EAC, plus a dispensing fee established by MAD, is the lowest of the rates calculated under the methods listed in general reimbursement methodology;

(d) EAC is calculated using the current published average wholesale price (AWP) of a drug less a percentage established by MAD, the average manufacturer price (AMP) plus a percentage established by MAD, or the wholesale acquisition cost (WAC) plus a percentage established by HSD, and other pricing limits determined by other pricing information sources selected by MAD; and

(e) MAD uses the ingredient cost indicated in the ingredient cost field on the billing transaction as the EAC when that indicated ingredient cost is lower than the MAD EAC.

(2) **Maximum allowable cost**

(MAC) MAC methodology. MAD establishes a MAC applicable for certain multiple-source drugs with FDA rated therapeutic equivalents and for certain over-the-counter drugs and non-drug items on the following basis:

(a) at least one A-rated generic (as listed in the FDA orange book) is readily available to New Mexico pharmacies;

(b) the MAC for the brand name drug products and for all A-rated therapeutic equivalents shall be determined by arraying costs for the A-rated therapeutic equivalent drugs regardless of manufacturer, and selecting a reasonable price from the arrayed list in a manner consistent with the state plan or any waiver approved by CMS subjecting that price to cost factors and tests for reasonableness;

(c) when a state MAC price has not been calculated by MAD, a baseline price calculated by a national supplier of drug pricing information is used as the state MAC;

(d) MAC will not be applied if a specific brand has been determined to be medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's billed usual and customary charge; and

(e) for over-the-counter drugs and non-drug items, MAC may be established using the pricing sources in Subsection B of this section.

(3) **Federal upper limit (FUL) methodology:**

(a) MAD adopts the FUL that is set by CMS or recommended by the federal department of justice.

(b) MAD's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAD under the dispensing fee determination.

(c) MAD will not use the individual drug FUL as MAD's reimbursement rate when the prescribing practitioner has certified that a specific brand is medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's usual and customary billed charge.

(4) **340B drug discount actual acquisition cost:**

(a) The actual ingredient cost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must placed in the ingredient cost field and indicated on the billing transaction as a 340B drug item.

(b) Drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must be billed at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item. If a MAP eligible recipient with a prescription written at a 340B entity requests the item to be dispensed by a 340B pharmacy under contract to the 340B entity then the pharmacist must dispense 340B purchased items when filling the prescription.

(5) **Usual and customary charge:**

(a) The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(c) Usual and customary charges must reflect discounts given to a MAP recipient for certain reasons, such as age or NF resident, when a MAP eligible recipient meets the standards for the discount. MAD must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-MAP recipient.

(d) Providers cannot add additional costs for their time, paperwork, or anticipated turnaround time for payment.

(6) **Medicare reimbursement:** Reimbursement may be limited to medicare reimbursement limits where the total of the medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in this Section Subsection A of this rule.

(7) Practitioner administered drug items are reimbursed according to the MAD fee schedule.

B. **Pricing information to set EAC and MAC:** MAD selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers, manufacturers, federal agencies, drug data information clearinghouses and pharmacy invoices.

C. **Assistance in establishing EAC and MAC:** MAD may solicit assistance from pharmacy providers, pharmacy benefit managers (PBMs), other government agencies, actuaries, or other consultants when establishing EAC or MAC.

D. **Pharmacy price reductions:** If the pharmacy provider offers a discount, rebate, promotion or other incentive that results in a reduction of the price of a prescription to the individual non- MAP recipient, the provider must similarly reduce its charge to MAD for the prescription.

E. **No claims for free products:** If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a MAP eligible recipient.

F. **Solutions:** Solutions, such as saline for nebulizers, intravenous (IV) solutions without additives, electrolyte and irrigation solutions, and diluents are considered medical supply items for reimbursement purposes; see 8.310.2 NMAC.

G. **Non-drug items:** Urine test reagents, electrolyte replacement and nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies, see 8.310.2 NMAC.

[8.324.4.16 NMAC - Rp, 8.324.4.16 NMAC, 1-1-14]

8.324.4.17 POINT OF SALE: The point-of-sale system provides relevant drug utilization information that the pharmacist must consider before dispensing a drug. If utilization information indicates that a MAP eligible recipient has an adequate supply of the drug item or that the quantity being dispensed is excessive, the claim will initially be denied. The pharmacist is responsible for resolving the issue and obtaining an authorization to dispense the drug, if necessary.

A. **General requirements:** All MAD in-state and border area pharmacy providers are required to submit claims through the point-of-sale system.

B. **Exceptions to general requirements:** The following are exceptions to this general requirement:

(1) the provider is out-of-state and is not a border area provider;

(2) the provider is a family planning clinic dispensing prescriptions;

(3) the provider submitted on average less than 50 claims per month to MAD for the preceding six-month period;

(4) the claim requires an attachment or explanation; or

(5) a required data element on the claim cannot be entered in the current standard point-of-sale format.

[8.324.4.17 NMAC - Rp, 8.324.4.17 NMAC, 1-1-14]

8.324.4.18 PRESCRIPTIONS AND REFILLS:

A. **Dispensing frequencies:** MAD limits the frequency for which it reimburses the same pharmacy for dispensing the same drug to the same MAP eligible recipient.

(1) The limitation is established individually for each drug.

(2) Maintenance drugs are subject to a maximum of three times in 90 days with

a 14-calendar day grace period to allow for necessary early refills.

(3) Certain drugs are given more flexibility due to their specific dosage forms, packaging or clinical concerns.

(4) The excessive dispensing limitation applies regardless of whether the claim is for a new prescription or refill.

(5) Schedule II controlled substances are limited to a maximum 34-day supply. Initial use of controlled substances may also be further limited by state law.

B. **Refill requirements:** Refills must be consistent with the dosage schedule prescribed and with all applicable federal and state laws, regulations and rules. Consistent use of early refills will result in a calculation that the MAP eligible recipient has sufficient stock of the drug item on hand and allowed refill dates will be adjusted accordingly.

C. **Quantities dispensed:** Maintenance drugs are those on the MAD-approved maintenance drug list.

(1) For a MAP eligible recipient with likely continuous eligibility due to age, disability or category of eligibility, prescriptions for maintenance drugs may be dispensed in amounts up to a 90-day supply.

(2) Prescriptions for non-maintenance drugs are limited to 34-day supplies.

(3) Oral contraceptives may be dispensed for up to a one-year supply if the appropriate contraceptive for the MAP eligible recipient has been established.

(4) Controlled substances may not be refilled until 75 percent of the drug has been used based on the days supply of the previous prescription unless the prescriber has been notified and given approval. A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or other dispensing of drugs through a point-of-sale system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database. Dispensed drug items which do not meet these criteria are subject to recoupment.

(5) Pharmacy providers shall not reduce prescriptions for maintenance drugs that are written for quantities larger than a 34-day supply and may dispense up to a 90-day supply. MAD considers prescription splitting to be fraudulent. Pharmacies that do not have the entire prescribed amount on hand may dispense a partial fill.

(6) Coverage may be limited by the end date of the MAP eligible recipient's span of eligibility at the time of dispensing.

(7) Pharmacists are encouraged to consult with prescribers to achieve optimal drug therapy outcomes, consistent with NMSA 1978, Section 61-11-2(V).

(8) Controlled substances may have specific controls on the quantities dispensed.

D. **Unit dose packaging:** MAD does not pay additional for unit dose packaging.

E. **Prevention of abuse:** Drug items are to be dispensed for legitimate medical needs only. If the pharmacist suspects the MAP eligible recipient of over-utilizing or abusing drug services, the pharmacist must contact the provider and MAD so that the MAP eligible recipient's use of medications can be reviewed. Excessively high doses and overlapping use of multiple drug items with the same therapeutic uses that are potentially abusive or otherwise dangerous may result in subjecting the prescriptions to the prior authorization process or recoupment from the pharmacy if the prescriber is not contacted and the contact documented.

F. **Mail service pharmacy:** MAD may provide a mail service pharmacy for a MAP eligible recipient use.

(1) The mail service pharmacy is available as an option to all MAP eligible recipients.

(2) Retail pharmacies may mail, ship or deliver prescriptions to all MAP eligible recipients consistent with applicable state and federal statutes, rules and regulations.

[8.324.4.18 NMAC - Rp, 8.324.4.18 NMAC, 1-1-14]

HISTORY OF 8.324.4 NMAC:

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

ISD 310.0700, Pharmacy Services, filed 2-29-80.

ISD 310.0700, Drug Services, filed 2-10-81.

ISD 310.0700, Drug Services, filed 7-8-82.

ISD Rule 310.0700, Drug Services, filed 3-1-83.

ISD Rule 310.0700, Drug Services, filed 2-15-89.

ISD Rule 310.0700, Drug Services, filed 7-9-84.

MAD Rule 310.07, Drug Services, filed 3-31-89.

MAD Rule 310.07, Drug Services, filed 1-3-92.

MAD Rule 310.07, Drug Services, filed 4-20-92.

MAD Rule 310.07, Drug Services, filed 12-8-94.

History of Repealed Material:

MAD Rule 310.07, Drug Services, filed 12-8-94 - Repealed effective 2-1-95.

8 NMAC 4.MAD.753, Pharmacy Services, filed 1-18-95 - Repealed effective 8-13-04.

8.324.4 NMAC, Pharmacy Services, filed 8-2-04 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES

CHAPTER 324 ADJUNCT SERVICES

PART 5 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS

8.324.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.324.5.1 NMAC - Rp, 8.324.5.1 NMAC, 1-1-14]

8.324.5.2 SCOPE: The rule applies to the general public.

[8.324.5.2 NMAC - Rp, 8.324.5.2 NMAC, 1-1-14]

8.324.5.3 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.

[8.324.5.3 NMAC - Rp, 8.324.5.3 NMAC, 1-1-14]

8.324.5.4 DURATION: Permanent.

[8.324.5.4 NMAC - Rp, 8.324.5.4 NMAC, 1-1-14]

8.324.5.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

[8.324.5.5 NMAC - Rp, 8.324.5.5 NMAC, 1-1-14]

8.324.5.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.324.5.6 NMAC - Rp, 8.324.5.6 NMAC, 1-1-14]

8.324.5.7 DEFINITIONS: [RESERVED]

8.324.5.8 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.

[8.324.5.8 NMAC - Rp, 8.324.5.8 NMAC, 1-1-14]

8.324.5.9 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to a medical assistance program (MAP) eligible recipient, including covered vision appliances, hearing aids and related services [42 CFR Section 440.60(a) and Section 440.110(c)], durable medical equipment and medical supplies, [42 CFR Section 440.70 (c)] and covered prosthetic and orthotic services [42 CFR Section 440.120(c)].

[8.324.5.9 NMAC - Rp, 8.324.5.9 NMAC, 1-1-14]

8.324.5.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient 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), a licensed practitioner of a facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. 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 materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided, to comply with the requirements and to update his or her knowledge as new material is provided by MAD. The provider must contact HSD or its authorized agents to request hard copies of any MAD New Mexico administrative code (NMAC) program rules, MAD billing and UR instructions and other pertinent material, and to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD PPA and all applicable statutes, regulations, rules and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made. Upon approval of his or her MAD PPA, the following practitioners and facilities may be enrolled as MAD providers:

A. **Vision appliance provider:**

(1) an ophthalmologist licensed to practice medicine in New Mexico, who limits his or her practice to ophthalmology (ophthalmologist) and the groups, corporations, and professional associations they form;

(2) an optometrist licensed to practice optometry in New Mexico and the groups, corporations, and professional associations they form;

(3) an optician qualified to provide eyeglasses, contact lenses, supplies, and other vision-related materials; or

(4) Indian health service (IHS) or a tribal facility operating under Public Law 93-638.

B. **Hearing appliances providers:**

(1) an individual licensed to practice medicine or osteopathy; or

(2) a hearing aid dealer registered and licensed by the New Mexico regulations and licensing division (RLD) practice boards for speech language pathology, audiology, and hearing aid dispensing.

C. **Durable medical equipment (DME), oxygen and medical supplies provider:** A DME, oxygen and medical supplies provider must hold a current PPA with MAD.

D. **Prosthetics and orthotics provider:** A prosthetics or orthotics provider must hold a current PPA with MAD.

[8.324.5.10 NMAC - Rp, 8.324.5.10 NMAC, 1-1-14]

8.324.5.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of his or her PPA. A provider must adhere to the NMAC program rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service, as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to the MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.302.2 NMAC.

D. **Vision appliances providers:** A provider must ensure that a prescription for eyeglasses or contact lenses is accurate to the extent that the prescription corrects the MAP eligible recipient's vision to the degree of acuity indicated on his or her vision examination record. An eyeglass and contact lens supplier is responsible for verifying that the correct prescription is provided.

(1) If a prescription is inaccurate and the MAP eligible recipient is unable to use his or her eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

(2) If the eyeglasses or contact lenses are not ground to the correct prescription, payment for the eyeglasses or contact lenses is subject to recoupment.

[8.324.5.11 NMAC - Rp, 8.324.5.11 NMAC, 1-1-14]

8.324.5.12 COVERED SERVICES:

A. **Vision appliances:** MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases. MAD pays a provider for the correction of refractive errors that are required by the condition of the MAP eligible recipient. All services must be furnished within the limits of MAD benefits, 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 his or her New Mexico regulation and licensing division's (RLD) practice board.

(1) Exam: MAD covers routine eye exams. Coverage for a MAP eligible recipient over 22 years of age is limited to one routine eye exam in a 36-month period. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period. If a MAP eligible recipient has transitioned from the early, periodic screening, diagnosis and treatment (EPSDT) program at age 21, the date of service for his or her last exam starts the 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma will be covered for required follow-up and treatment. The medical condition must be clearly documented on his or her visual examination record and indicated by diagnosis on the claim form.

(2) Corrective lenses: MAD covers one set of corrective lenses for a MAP eligible recipient 21 years of age and older

not more frequently than once in a 36-month period. For a MAP eligible recipient under 21 years of age, one set of corrective lenses is covered no more frequently than once every 12 months. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service for his or her last corrective lenses starts the 36-month period. For either age group, MAD covers corrective lenses more frequently when an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the MAP eligible recipient's visual examination record and indicated by a diagnosis on the claim.

(a) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

(i) -1.00 myopia (nearsightedness);

(ii) + 1.00 for hyperopia (farsightedness);

(iii) 0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal 0.75 will be accepted;

(iv) ±1.00 for presbyopia (farsightedness of aging); or

(v) diplopia (double vision) - prism lenses.

(b) When a MAP eligible recipient's existing prescription is updated and the frequency of replacement lenses meets the requirements in Paragraph (2) above, the lenses may be replaced when there is a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal 0.75 will be accepted. An exception is considered for the following:

(i) a MAP eligible recipient over 21 years of age with cataracts;

(ii) an ophthalmologist or optometrist recommends a change due to a medical condition; or

(iii) a MAP eligible recipient is under 21 years of age.

(3) Bifocal lenses: MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

(4) Tinted lenses: MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the comments section of the visual examination record, and the prescription meets the dioptic correction purchase criteria:

(a) aniridia;

(b) albinism, ocular;

(c) traumatic defect in iris;

(d) iris coloboma, congenital;

(e) chronic keratitis;

(f) sjogren's syndrome;

(g) aphakia, U.V. filter only if intraocular lens is not U.V. filtered;

(h) rod monochromaly;

(i) pseudophakia; or

(j) other diagnoses confirmed by ophthalmologist or optometrist that is documented in the MAP eligible recipient's visual examination form.

(5) Polycarbonate lenses: MAD covers polycarbonate lenses for:

(a) a MAP eligible recipient for medical conditions which require prescriptions for high power lenses;

(b) a MAP eligible recipient with monocular vision;

(c) a MAP eligible recipient who works in a high-activity physical job;

(d) a MAP eligible recipient under 21 years of age; or

(e) a MAP eligible recipient 21 years and older that has a developmental or intellectual disability.

(6) Balance lenses: MAD covers balance lenses for a MAP eligible recipient under 21 years of age without a prior authorization in the following situations:

(a) lenses used to balance an aphakic eyeglass lens; or

(b) a MAP eligible recipient under 21years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

(7) Frames: MAD covers frames for corrective lenses. Coverage for a MAP eligible recipient 21 years of age and older is limited to one frame in a 36-month period. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service of his or her last frames starts the 36-month period. Coverage for a MAP eligible recipient under 21 years of age is limited to one frame in a 12-month period unless:

(a) an ophthalmologist or optometrist has documented a medical condition that requires replacement; or

(b) other situations that will be reviewed on a case-by-case basis.

(8) Contact lenses: MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient 21 years of age and older is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. If a MAP eligible recipient is transition from the EPSDT program at age 21, the date of service for his or her last contact lenses starts as the 24-month period. A request for prior authorization will be evaluated on dioptic criteria or visual acuity, the MAP eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(a) the MAP eligible recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian or at least 3.00 diopters of anisometropia; or

(b) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

(9) Replacement: Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the MAP eligible recipient, may be replaced. Two items must be documented in the provider's request for the replacement in addition to being found in the MAP eligible recipient's visual examination record: The MAP eligible recipient's eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion; and an explanation of the loss, deterioration or breakage is provided. The following are the criteria that an MAP eligible recipient must be meet for the replacement of his or her eyeglasses or contact lenses:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient is 21 years of age and older and has a developmental or intellectual disability.

(10) Prisms: Prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the MAP eligible recipient's visual examination record.

(11) Lens tempering: MAD covers lens tempering only on new glass lenses.

(12) Lens edging: MAD covers lens edging and lens insertion.

(13) Minor repairs: MAD covers minor repairs to eyeglasses.

(14) Dispensing fee: MAD pays a dispensing fee to an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames at the same time. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not approved by MAD to prescribe and fit contact lenses.

(15) Eye prosthesis: MAD covers eye prostheses (artificial eyes); see Subsection D below.

B. **Hearing appliances:**

(1) Within specified limitations, MAD covers the following services when furnished by primary care provider (PCP), licensed audiologists or by licensed hearing aid dealers:

(a) hearing aid purchase, rental repairs, hearing aid repair and handling, replacements, and the loan of equipment while repairs or replacements are made:

(i) binaural hearing aid fitting will be covered for a MAP eligible recipient with bilateral hearing loss who is attending an educational institution, seeking employment, is employed, or for a MAP eligible recipient with a current history of binaural fitting; or

(ii) binaural hearing aid fitting will be considered on a case-by-case basis for a MAP eligible recipient determined to be legally blind;

(b) hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed; and

(c) hearing aid insurance against loss and breakage for up to four years for all purchased hearing aids; hearing aid insurance is required when the aid is dispensed; four years of hearing aid insurance is required for: (i) a MAP eligible recipient under 21 years of age; (ii) a MAP eligible recipient residing in a nursing facility (NF); or (iii) a MAP eligible recipient who has a developmental or intellectual disability;

(d) replacement of hearing aids is limited to the provisions of the MAP eligible recipient's hearing aid insurance; the provider is responsible for obtaining insurance for every hearing aid purchased for a MAP eligible recipient.

C. **DME, oxygen and medical supplies:** MAD covers DME that meets the MAD definition of DME, the medical necessity criteria, and MAD prior authorization requirements. MAD covers the repair, maintenance, delivery of durable medical equipment, and the disposable and non-reusable items essential for the use of the equipment, subject to the limitations specified in this rule. All items purchased or rented must be ordered by a provider who has an approved MAD PPA. Coverage for DME is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, intermediate care facility for individuals with intellectual disabilities (ICF-IID), and a rehabilitation facility. A MAP eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover duplicates of items, for example, a MAP eligible recipient is limited to one wheelchair, one hospital bed, one oxygen delivery system, or one of any particular type of equipment. A back-up ventilator is covered.

(1) DME is defined by MAD as: (a) equipment that can withstand repeated use; (b) primarily and customarily used to serve a medical purpose; (c) not useful to an eligible recipient in the absence of an illness or injury; and (d) appropriate for use at home.

(2) Equipment used in a MAP eligible recipient's residence must be used exclusively by the MAP eligible recipient for whom it was approved.

(3) To meet the medical necessity criterion, DME must be necessary for the MAP eligible recipient's treatment of an illness, injury, or to improve the functioning of a specific body part.

(4) Replacement of equipment is limited to the same extent as it is limited by medicare regulation. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in the MAP eligible recipient's medical necessity or as otherwise indicated in this rule.

(5) Medical supplies: MAD covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items.

(a) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order. A provider must keep documentation in its files available for auditing that shows compliance with this requirement.

(b) MAD coverage for DME and medical supplies is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, ICF-IID, and a rehabilitation facility.

(6) Covered services and items: MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized MAP eligible recipient:

(a) trusses and anatomical supports that do not need to be made to measure;

(b) family planning devices;

(c) repairs to DME and replacement parts if a MAP eligible recipient owns the equipment for which the repair is necessary and the equipment being repaired is a covered MAD benefit; some replacement items used in repairs may require prior authorization; see Section 13 of this rule;

(d) repairs to augmentative and alternative communication devices require prior authorization;

(e) monthly rental includes monthly service and repairs; and

(f) replacement batteries and battery packs for augmentative and alternative communication devices owned by the MAP eligible recipient.

(7) Covered services for a non-institutionalized MAP eligible recipient: MAD covers certain medical supplies, nutritional products and DME provided to a non-institutionalized MAP eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare regulation. When medicare does not specify a limitation, an item is limited to a reasonable amount as defined by MAD and published in its DME and medical supplies billing instructions which are available on the HSD/MAD website. MAD covers the following for a non-institutionalized MAP eligible recipient:

(a) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings;

(b) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(c) gauze, bandages, dressings, pads, and tape;

(d) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(e) parenteral nutritional support products prescribed by a PCP on the basis of a specific medical indication for a MAP eligible recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet the MAP eligible recipient's medical needs;

(f) apnea monitors: prior authorization is required if the monitor is needed for six months or longer; and

(g) disposable gloves (sterile or non-sterile) are limited to 200 per month.

(8) Covered oxygen and oxygen administration equipment: MAD covers the following oxygen and oxygen administration systems, within these specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase with prior authorization; oxygen administration equipment may be supplied on a rental basis for one month without prior authorization; rental beyond the initial month requires a prior authorization;

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems. MAD approves the most economical oxygen delivery system available that meets the medical needs of the MAP eligible recipient;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(g) MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If MAD pays rental charges for a system, tank rental is included in the rental payments. MAD follows the medicare rules for: (i) limiting or capping reimbursement for oxygen rental at 36 months; (ii) requirements for the provider to maintain and repair the equipment; and (iii) to providing ongoing services and disposable supplies after the capped rental;

(h) a NF is administratively responsible for overseeing oxygen supplied to the MAP eligible recipient resident.

(9) Augmentative and alternative communication devices: MAD covers medically necessary electronic or manual augmentative communication devices for a MAP eligible recipient. Medical necessity is determined by MAD or its designee. Communication devices whose purpose is also educational or vocational are covered only when it has been determined the device meets medical criteria. A MAP eligible recipient must have the cognitive ability to use the augmentative communication device, and not be able to functionally communicate verbally or through gestures.

(a) All of the following criteria must be met before an augmentative communication device can be considered for prior authorization. The communication device must be:

(i) a reasonable and necessary part of the MAP eligible recipient's treatment plan;

(ii) consistent with the MAP eligible recipient's symptoms, diagnosis or medical condition of the illness or injury under treatment;

(iii) not furnished for the convenience of the MAP eligible recipient, the family, the attending practitioner or other practitioner or supplier;

(iv) necessary and consistent with generally accepted professional medical standards of care;

(v) established as safe and effective for the MAP eligible recipient's treatment protocol;

(vi) furnished at the most appropriate level suitable for use in the MAP eligible recipient's home environment;

(vii) augmentative and alternative communication devices are authorized every 60 months for a MAP eligible recipient 21 years of age and older and every 36 months for a MAP eligible recipient under 21 years of age, unless earlier authorization is dictated by medical necessity; and

(viii) repairs to, and replacement parts for augmentative and alternative communication devices owned by the MAP eligible recipient.

(10) Rental of DME: MAD covers the rental of DME.

(a) MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace the MAP eligible recipient's equipment during the rental period.

(b) Low cost items, defined as those items for which the MAD allowed payment is less than $150, may only be purchased. For these items, the purchased DME becomes the property of the MAP eligible recipient for whom it was approved.

(c) MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

(11) Delivery of equipment and shipping charges: MAD covers the delivery of a DME item only when the equipment is initially purchased or rented and the round trip delivery is over 75 miles. A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to its clients who are not a MAP eligible recipient of the service. MAD does not pay delivery charges for equipment purchased by medicare, for which MAD is responsible only for the coinsurance and deductible. MAD covers the shipping charges for DME and medical supplies when it is more cost effective or practical to ship items to the MAP eligible recipient rather than have him or her travel to pick up items. Shipping charges are defined as the actual cost of shipping an item from a provider to a MAP eligible recipient by a means other than that of provider delivery. MAD does not pay shipping charges for an item purchased by medicare for which MAD is only responsible for the coinsurance and deductible.

(12) Wheelchairs and seating systems:

(a) MAD covers customized wheelchairs and seating systems made for a specific MAP eligible recipient, including a MAP eligible recipient who is institutionalized. Written prior authorization is required by MAD or its designee. MAD or its designee cannot give verbal authorizations for customized wheelchairs and seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific MAP eligible recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(b) Repairs to a wheelchair owned by a MAP eligible recipient residing in an institution are covered.

(c) A customized or motorized wheelchair required by a MAP eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, but must be reviewed on a case-by-case basis by MAD or its designee.

D. Prosthetics and orthotics supplies: MAD covers medically necessary prosthetics and orthotics supplied by a MAD provider to a MAP eligible recipient only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. MAD covers prosthetics and orthotics only when all the following conditions are met:

(1) the device has been ordered by the MAP eligible recipient's PCP or other appropriate practitioner and is medically necessary for MAP eligible recipient's mobility, support or physical functioning;

(2) the need for the device is not satisfied by the existing device the MAP eligible recipient currently has;

(3) the device is covered by MAD and all prior approval requirements have been satisfied;

(4) coverage of compression stockings for a MAP eligible recipient 21 years and older is limited to stockings that are custom-fabricated to meet his or her medical needs;

(5) coverage of orthopedic shoes for a MAP eligible recipient 21 years and older is limited to the shoe that is attached to a leg brace;

(6) replacement of items is limited to one item every three years, unless there is a change in the MAP eligible recipient's medical necessity; and

(7) therapeutic shoes furnished to a diabetic is limited to one of the following within one calendar year:

(a) no more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; and

(b) no more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

[8.324.5.12 NMAC - Rp, 8.324.5.12 NMAC, 1-1-14]

8.324.5.13 UTILIZATION REVIEW AND PRIOR AUTHORIZATION: All MAD services are subject to UR for medical necessity and program compliance. Reviews can be

performed before services are furnished, after services are furnished, and before payment is made or after payment is made; see 8.302.5 NMAC. MAD makes available on its website and other websites UR instructions. It is the provider's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. Prior authorization does not guarantee that an individual is eligible for a MAD service.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. When services are billed to and paid by a coordinated services contractor authorized by MAD, the provider must follow that contractor's instructions for the authorization of a service. Written requests for items not included in the categories listed or for a quantity greater than that covered by MAD in this rule may be submitted by the MAP eligible recipient's PCP, with a prior authorization request to MAD or its designee for consideration of medical necessity.

B. **Eligibility determination:** The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with a prior authorization denial or another review decision may request a reconsideration; see 8.350.2 NMAC.

D. **Prior authorization for specific services:** The following services and procedures require prior authorization from MAD or its designee:

(1) hearing appliances:

(a) hearing aid dispensing, purchase, rental and replacement;

(b) hearing aid repairs for which the provider's billed charge exceeds $100;

(c) services for which prior authorization was obtained remain subject to review at any point in the payment process; and

(d) medical clearance: PCP medical approval is required on any request for prior authorization for hearing aids; the MAP eligible recipient's PCP must certify that her or she is a suitable candidate for hearing aids by signing the hearing aid evaluation and information MAD prior authorization form; documentation must be on the PCP's letterhead or prescription pad; this documentation must be submitted with the prior approval request; a MAP eligible recipient under 16 years of age, must be examined by a physician who is board certified in the diagnosis and treatment of diseases and conditions of the ear for all hearing aid fittings.

(2) DME, oxygen and medical supplies: MAD covers certain medical supplies, nutritional products and DME provided to a MAP eligible recipient with prior authorization. Please refer to criteria in 8.301.3 NMAC for DME or medical supplies that are not covered. MAD covers the following benefits with prior authorization for a non-institutionalized MAP eligible recipient:

(a) enteral nutritional supplements and products for a MAP eligible recipient who must be tube fed oral nutritional supplements;

(b) oral nutritional support products prescribed by the MAP eligible recipient's PCP:

(i) on the basis of a specific medical indication for a MAP eligible recipient who has a defined need for which nutritional support is considered therapeutic, and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet his or her medical needs;

(ii) when medically necessary due to inborn errors of metabolism;

(iii) medically necessary to correct or ameliorate physical illnesses or conditions in a MAP eligible recipient under 21 years of age; or

(iv) coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance;

(c) either disposable diapers or underpads prescribed for a MAP eligible recipient age three years and older who suffers from neurological or neuromuscular disorders or who has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;

(d) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for a specialized wheelchair;

(e) protective devices, such as helmets and pads;

(f) bathtub rails and other rails for use in the bathroom;

(g) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(h) passive motion exercise equipment;

(i) decubitus care equipment;

(j) equipment to apply heat or cold;

(k) hospital bed and full length side rails;

(l) compressor air power sources for equipment that is not self-contained or cylinder driven;

(m) home suction pump and lymph edema pump;

(n) hydraulic patient lift;

(o) ultraviolet cabinet;

(p) traction equipment;

(q) prone stander and walker;

(r) trapeze bar or other patient-helpers that are attached to bed or freestanding;

(s) home hemodialysis or peritoneal dialysis system and its replacement supplies or accessories;

(t) wheelchair and functional attachments to a wheelchair; a wheelchair is authorized every 60 months for a MAP eligible recipient 21 years and older; for a MAP eligible recipient under 21 years of age, a wheelchair can be authorized every 36 months; and earlier authorization is possible when dictated by his or her medical necessity;

(u) wheelchair tray;

(v) whirlpool bath designed for home use;

(w) intermittent or continuous positive pressure breathing equipment;

(x) manual or electronic augmentative and alternative communication device;

(y) truss and anatomical supports that require fitting or adjusting by trained individuals, including a JOBST hose;

(z) custom-fitted compression stockings; and

(aa) artificial larynx prosthesis.

(3) Prosthetics and orthotics: All prosthetic devices require prior authorization from MAD or its designee. The only prior authorization requirement exception is for a prosthetic limb attached immediately following a surgery for a traumatic injury while the MAP eligible recipient is a hospital inpatient. Prior authorization is required for orthotic devices for the foot or for shoes. Services for which prior authorization was obtained remain subject to UR at any point in the payment process.

[8.324.5.13 NMAC - Rp, 8.324.5.13 NMAC, 1-1-14]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

A. **Special requirements for the purchase of wheelchairs:** Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to a MAP eligible recipient must make a final evaluation to ensure that

the wheelchair and seating system meets the medical, social and environmental needs of the MAP eligible recipient for whom it was authorized.

(1) The provider assumes responsibility for correcting defects or deficiencies in the wheelchair and seating systems that make them unsatisfactory for use by the MAP eligible recipient.

(2) The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians as necessary to ensure that the wheelchair meets the MAP eligible recipient's needs.

(3) Evaluations by a physical therapist or occupational therapist are required when ordering customized wheelchair and seating system. The therapist should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the MAP eligible recipient and those consultants listed in Paragraph (2) above to assure that the selected system matches physical seating needs. The physical or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

(4) MAD does not pay for special modifications or replacement of a customized wheelchair after the wheelchair is furnished to the MAP eligible recipient.

(5) When the equipment is delivered to the MAP eligible recipient and the MAP eligible recipient accepts the order, the provider will submit the claim for reimbursement.

B. **Special requirements for purchase of augmentative and alternative communication devices:**

(1) The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by the MAP eligible recipient's PCP, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the MAP eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the MAP eligible recipient's ability to use the communication device must be provided showing that the MAP eligible recipient's ability to use the device is improving and that the MAP eligible recipient is motivated to continue to use this device.

(3) MAD does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to: paper, printer ribbons, and computer discs.

(4) Prior authorization is required for equipment repairs.

(5) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the MAP eligible recipient. A provider must keep documentation in his or her files available for audit that show compliance with this requirement.

[8.324.5.14 NMAC - Rp, 8.324.5.14 NMAC, 1-1-14]

8.324.5.15 NONCOVERED SERVICES: The following services are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.302.1 NMAC and 8.310.2 NMAC. The provider must notify the MAP eligible recipient of the coverage limitations prior to providing services.

A. **Vision appliances:** MAD does not cover the following specific vision services:

(1) orthoptic assessment and treatment;

(2) photographic procedures, such as fundus or retinal photography and external ocular photography;

(3) polycarbonate lenses other than those listed in Subsection A of Section 13 of this part;

(4) ultraviolet (UV) lenses;

(5) trifocals;

(6) progressive lenses;

(7) tinted or photochromic lenses, except in cases of documented medical necessity; see Subsection D of Section 12 of this part;

(8) oversize frames and oversize lenses;

(9) low vision aids;

(10) eyeglass cases;

(11) eyeglass or contact lens insurance; and

(12) anti-scratch, anti-reflective, or mirror coating.

B. **Hearing appliances:** Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and will not be reimbursed separately.

C. **DME, oxygen and medical supplies:** MAD does not cover certain DME and medical supplies. See 8.301.3 NMAC for an overview of which DME or supply item is not covered by MAD.

D. **Prosthetic and orthotics:** The following services are not covered:

(1) orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics; and

(2) prosthetic devices or implants that are used primarily for cosmetic purposes.

[8.324.5.15 NMAC - Rp, 8.324.5.15 NMAC, 1-1-14]

8.324.5.16 REIMBURSEMENT: Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following: (1) the provider's billed charge; or (2) the MAD fee schedule for the specific service or procedure.

A. The provider's billed charge must be his or her usual and customary charge for services.

B. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

C. **Vision appliances:** A vision service provider, except an IHS facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor.

D. **Hearing appliances:** A hearing aid or related service provider must submit claims for reimbursement on the CMS 1500 claim form or its successor. Reimbursement for hearing aids is made at the lesser of the provider's billed charge, at the cost to the billing provider as indicated by the manufacturer's, the distributor's or wholesaler's invoice, which shall not exceed MAD's maximum reimbursement limitation amounts.

(1) Reimbursement for rental of hearing aids includes the following:

(a) rental charge for hearing aid; and

(b) hearing aid mold and batteries.

(2) Rental payments apply to the allowed amount for purchase. When the rental payments equal the amount allowed for purchase, the aid is considered purchased and owned by the MAP eligible recipient.

(3) Reimbursement for repairs to hearing aids is based on the MAD fee schedule. Reimbursement for repairs to hearing aids done by a manufacturer is the lesser of the provider's billed charge or the manufacturer's charge for the repairs plus a predetermined handling fee. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.

(4) Reimbursement is made for additional accessories and supplies, including batteries, when required. Reimbursement is made for an additional mold when a single aid type is used for both ears.

(5) Reimbursement is made for replacement ear molds.

(6) Reimbursement for insurance for hearing aid loss and accidental damage is paid at the lesser of the provider's billed charge or the maximum fee allowed by MAD. If the insurance policy cost exceeds the maximum fee established by MAD, reimbursement can be made at the actual policy rate if the actual cost is documented.

(7) Hearing appliances reimbursement limitations:

(a) Hearing aid purchase: Hearing aid purchase is limited to one monaural or binaural purchase per four year period with the following exceptions:

(i) a MAP eligible recipient under 21 years of age and is subject to prior approval;

(ii) progressive hearing loss, such as otosclerosis;

(iii) changes due to surgical procedures;

(iv) traumatic injury; and

(v) replacement of lost hearing aid in accordance with his or her insurance coverage.

(b) Dispensing fees: The hearing aid dispensing fee includes payment for the services listed below. If a binaural dispensing fee is paid, it includes payment for all services listed below for both hearing aids:

(i) hearing aid selection and the fitting of the aids;

(ii) testing of the hearing aids;

(iii) one ear mold per hearing aid;

(iv) one package of batteries per hearing aid;

(v) any other accessories required to fit the aid;

(vi) all follow-up visits and adjustments necessary for a successful fitting;

(vii) cleaning and adjustments for the life of the aid; and

(viii) shipping and handling.

(c) Hearing aid evaluation: MAD covers the evaluation of a MAP eligible recipient for the hearing aid, subject to the following limitations:

(i) the evaluation for hearing aid is not payable to the same billing provider who bills for the hearing aid dispensing fee incidental to the purchase of a hearing aid;

(ii) the evaluation for hearing aid is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incidental to the purchase of the hearing aid; therefore,

(iii) physicians and audiologists can be reimbursed for audiologic and vestibular function studies in addition to a dispensing fee.

[8.324.5.16 NMAC - Rp, 8.324.5.16 NMAC, 1-1-14]

8.324.5.17 REIMBURSEMENT OF DME, MEDICAL SUPPLIES AND NUTRITIONAL PRODUCTS:

A. **Reimbursement for purchase or rental:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for DME, medical supplies and nutritional products is made at the lesser of:

(1) the provider's billed charges or the MAD fee schedule; or

(2) when there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows.

(a) DME, medical supplies and nutritional products:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(b) for a custom specialized wheelchair and its customized related accessories, payment is limited to the provider's actual acquisition cost plus 15 percent.

B. **Rental payments must be applied towards the purchase with the exception of ventilators:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. Reimbursement for rental of DME is made at the lesser of:

(1) the provider's billed charges; or

(2) the MAD fee schedule, when applicable; payment for the month of rental is limited to the provider's acquisition invoice cost plus a percentage as follows:

(a) the provider must keep a running total of rental payments for each piece of equipment;

(b) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when 13 rental payments have been made for the item;

(c) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when the rental payments total the lesser of the provider's usual and customary charge for the purchase of the item or the MAD fee schedule for the purchase of the item;

(d) or for an item for which a fee schedule purchase price has not been established by MAD when the provider has received rental payments equal to one of the following:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(3) MAD follows medicare regulations regarding capped rental; for rental months one through three, the full fee schedule rental fee is allowed; for rental months four through 13, the rental fee schedule rental fee is reduced by 25 percent; no additional rental payments are made following the 13th month or to the most current schedule determined by medicare; the provider may only bill for routine maintenance and for repairs, and oxygen contents to the extent as allowed by medicare;

(4) oxygen is paid using the medicare billing, capped rental period, and payment rules;

(5) the provider must retain a copy of his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request;

(6) set-up fees are considered to be included in the payment for the equipment or supplies and are not reimbursed as a separate charge.

C. **Reimbursement for home infusion drugs:** Unless otherwise specified in this rule, the provider's billed charges must be the usual and customary charge for the item or service. Home infusion drugs are reimbursed at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee schedule;

(3) for home infusion drugs for which a fee schedule price has not been established by MAD, or for which the description associated with the appropriate billing code is too broad to establish a reasonable payment level, payment is limited to the provider's acquisition cost plus 20 percent; a provider must retain a copy of his or her acquisition invoice showing the

provider's purchase of an item and make it available to MAD or its designee upon request.

D. **Reimbursement for delivery and shipping charges:** Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method. MAD does not pay for charges for shipping items from a supplier to the provider.

E. **Reimbursement limitations:** MAD does not cover DME or medical supplies that do not meet the definition of DME as described in Section 12 of this rule. The following criteria are applied to each request as part of the determination of non-coverage:

(1) items that do not primarily serve a therapeutic purpose or are generally used for comfort or convenience purposes;

(2) environment-control equipment that is not primarily medical in nature;

(3) institutional equipment that is not appropriate for home use;

(4) items that are not generally accepted by the medical profession as being therapeutically effective or are determined by medicare regulations to be ineffective or unnecessary;

(5) items that are hygienic in nature;

(6) hospital or physician diagnostic items;

(7) instruments or devices manufactured for use by PCP;

(8) exercise equipment not primarily medical in nature or for the sole purpose of muscle strengthening or muscle stimulation without a medically necessary purpose;

(9) support exercise equipment primarily for institutional use;

(10) items that are not reasonable or necessary for monitoring the pulse of a homebound MAP eligible recipient with or without a cardiac pacemaker;

(11) items that are used to improve appearance or for comfort purposes;

(12) items that are precautionary in nature except those needed to prevent urgent or emergent events; and

(13) a provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have an excess of a 15 calendar day supply of the item before releasing the next supply to the MAP eligible recipient.

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

8.324.5.18 REIMBURSEMENT FOR PROSTHETICS AND ORTHOTICS:

A. A prosthetic and orthotic service provider must submit claims for reimbursement on the CMS-1500 claim form or its successor. Reimbursement for repairs made by the provider is made at the actual repair cost plus 50 percent. Repairs made by the manufacturer are reimbursed to the provider at the actual manufacturer's repair cost plus a handling fee of $20. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented. Reimbursement for additional accessories and supplies is made at the lower of the actual cost of the supply or accessory or the MAD fee schedule for the particular item.

B. **Reimbursement limitations:** The amount billed for the item includes all minor attachments, adjustments, additions, modifications, fittings and other services necessary to make the device functional. These items cannot be billed separately.

(1) MAD does not cover an additional charge for a hospital visit or home visit if fittings or measurements take place away from the provider's office.

(a) If the place of service is outside the provider's city limits, mileage can be billed for travel to the place of service.

(b) A prosthetic or orthotic device for a MAP eligible recipient hospitalized in a diagnostic related group (DRG) reimbursed hospital is reimbursed by the DRG methods described in 8.311.3 NMAC.

(2) Date of service: The date of service declared on a claim is the date when the device is supplied to the MAP eligible recipient, not the fitting date or measuring date.

(3) No specification of brand or quality: When an ordering provider requests an item and does not specify the brand or quality of the item to be dispensed, the item chosen must be of a quality and minimal cost which adequately serves the purpose for which the device is required.

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

HISTORY OF 8.324.5 NMAC:

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

ISD 310.0800, Medical Supplies, filed 2-29-80.

MAD Rule 310.08, Medical Supplies, filed 12-1-87.

MAD Rule 310.08, Medical Supplies, filed 5-31-88.

MAD Rule 310.08, Medical Supplies, filed 4-3-92.

MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4-21-92.

History of Repealed Material:

MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4-21-92 - Repealed effective 2-1-95.

8.324.5 NMAC, Durable Medical Equipment and Supplies, filed 6-16-04 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 7 TRANSPORTATION SERVICES AND LODGING

8.324.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, 1-1-14]

8.324.7.2 SCOPE: The rule applies to the general public.

[8.324.7.2 NMAC - Rp, 8.324.7.2 NMAC, 1-1-14]

8.324.7.3 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.

[8.324.7.3 NMAC - Rp, 8.324.7.3 NMAC, 1-1-14]

8.324.7.4 DURATION: Permanent.

[8.324.7.4 NMAC - Rp, 8.324.7.4 NMAC, 1-1-14]

8.324.7.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

[8.324.7.5 NMAC - Rp, 8.324.7.5 NMAC, 1-1-14]

8.324.7.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.324.7.6 NMAC - Rp, 8.324.7.6 NMAC, 1-1-14]

8.324.7.7 DEFINITIONS: [RESERVED]

8.324.7.8 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.

[8.324.7.8 NMAC - Rp, 8.324.7.8 NMAC, 1-1-14]

8.324.7.9 TRANSPORTATION SERVICES: The New Mexico medical assistance division (MAD) covers expenses for transportation and other related expenses that MAD or its coordinated services contractor determines are necessary to secure covered medical and behavioral health examinations and treatment for a medical assistance program (MAP) eligible recipient in or out of his or her home community [42 CFR Section 440.170]. Travel expenses include the cost of transportation by long distance common carriers, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. Related travel expenses include the cost of meals and lodging made necessary by receipt of medical or behavioral health care away from the MAP eligible recipient's home community. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment.

[8.324.7.9 NMAC - Rp, 8.324.7.9 NMAC, 1-1-14]

8.324.7.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are 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 a MAP eligible recipient. Providers 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, and in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, 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. Providers must contact HSD, or its authorized agents, for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and applicable statutes, regulations, rules, 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. The following providers are eligible to be reimbursed for providing transportation or transportation related services to MAP eligible recipients:

A. air ambulances certified by the state of New Mexico department of health (DOH), emergency medical services bureau;

B. ground ambulance services certified by the New Mexico public regulation commission (NMPRC) or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the NMPRC;

C. non-emergency transportation vendors (taxicab, vans and other vehicles) and certain bus services certified by the NMPRC, within those geographic regions in the state specifically authorized by the NMPRC;

D. long distance common carriers, that include buses, trains and airplanes;

E. certain carriers exempted or warranted by the NMPRC within those geographic regions in the state specifically authorized by the NMPRC;

F. lodging and meal providers; and

G. when services are billed to and paid by a MAD MAP coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.324.7.10 NMAC - Rp, 8.324.7.10 NMAC, 1-1-14]

8.324.7.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in the New Mexico MAD administrative code (NMAC) rules, and policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. MAD services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. See 8.302.1 NMAC.

[8.324.7.11 NMAC - Rp, 8.324.7.11 NMAC, 1-1-14]

8.324.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: MAD reimburses a transportation provider for transportation only when the transport is of a MAP eligible recipient and is subject to the following conditions.

A. **Free alternatives:** Alternative transportation services that can be provided free of charge include volunteers, relatives or transportation services provided by nursing facilities (NF) or other residential centers.

B. **Least costly alternatives:** MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before a MAP eligible recipient can use more expensive transportation alternatives.

C. **Non-emergency transportation service:** MAD covers non-emergency transportation services for a MAP eligible recipient who has no primary transportation and who is unable to access a less costly form of public transportation except as described under non-covered services. See 8.324.7.13 NMAC.

D. **Long distance common carriers:** MAD covers long distance services furnished by a common carrier if a MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through local county income support division (ISD) offices.

E. **Ground ambulance services:** MAD covers services provided by ground ambulances when:

(1) an emergency that requires ambulance service is certified by a physician or is documented in the provider's records

as meeting emergency medical necessity criteria: terms are defined as follows:

(a) "emergency" is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part;

(b) "medical necessity" is established for ambulance services if the MAP eligible recipient's physical, or behavioral health condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(2) Scheduled, non-emergency ambulance services are ordered by a primary care provider (PCP) who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's physical, or behavioral health condition. MAD covers non-reusable items and oxygen required during transportation, if needed; coverage for these items is included in the base rate reimbursement for ground ambulance.

F. **Air ambulance services:** MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the PCP certifies the medical necessity for the service.

(1) An emergency that would require air over ground ambulance services is defined as a medical or behavioral health condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

(a) a MAP eligible recipient's death;

(b) placement of a MAP eligible recipient's health is in serious jeopardy (or with respect to a pregnant woman, the health of the woman or her unborn child);

(c) serious impairment of bodily functions; or

(d) serious dysfunction of any bodily organ or part.

(2) Coverage for the following is included in the base rate reimbursement for air ambulance:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation;

(c) detention time or standby time; and

(d) use of equipment required during transportation.

G. **Lodging services:** MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical or behavioral health provider's statement of need. Authorization forms for direct payment by MAD to its lodging providers are available through local county ISD offices.

H. **Meal services:** MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to MAD meal providers by MAD are available through local county ISD offices.

I. **Coverage for attendants:** MAD covers transportation, meals and lodging for one attendant if the medical necessity for the attendant is certified in writing justified by the MAP eligible recipient's medical provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. The attendant for a child under 18 years of age should be the parent or legal guardian. If the medical appointment is for an adult MAP eligible recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult MAP eligible recipient.

J. **Coverage for medicaid home and community-based services waiver recipients:** Transportation of a medicaid waiver recipient to or from a provider of waiver service is only covered when the service is a physical therapy, occupational therapy, speech therapy or a behavioral health service.

[8.324.7.12 NMAC - Rp, 8.324.7.12 NMAC, 1-1-14]

8.324.7.13 NONCOVERED SERVICES: Transportation services are subject to the same limitations and coverage restrictions that exist for other MAD services. See 8.301.3 NMAC. Payments for transportation for any non-covered service is subject to retroactive recoupment.

A. MAD does not pay to transport a MAP eligible recipient to a medical or behavioral health service or provider that is not covered under the MAD program.

B. A provider will not be eligible to seek reimbursement from a MAP eligible recipient if the provider fails to notify the MAP eligible recipient or his or her authorized representative that the service is not covered by MAD. See 8.302.1 NMAC.

C. Transportation services will not be provided when other alternatives are available, such as mail delivery or free delivery. Retail pharmacies may mail, ship or deliver prescriptions to medicaid recipients consistent with applicable state and federal statutes and regulations.

[8.324.7.13 NMAC - Rp, 8.324.7.13 NMAC, 1-1-14]

8.324.7.14 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES: Out-of-state transportation and related expenses require prior authorization by MAD or its designee. Out-of-state transportation is authorized only if the out-of-state medical or behavioral health service is approved by MAD or its designated contractor. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in New Mexico.

A. Requests for out-of-state transportation must be coordinated through MAD.

B. Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30 days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, is defined as those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as an in-state provider service. See 8.302.4 NMAC.

[8.324.7.14 NMAC - Rp, 8.324.7.14 NMAC, 1-1-14]

8.324.7.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review (UR) for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made or after payment is made. See 8.302.5 NMAC. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or request hard copies to be provided, to understand the information, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a MAD fee-for-service coordinated services contractor, the provider must follow that contractor's instructions for authorization of

services.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization is received remain subject to UR at any time during the payment process.

B. **Referrals for travel outside the home community:**

(1) If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical or behavioral health care, the transportation provider must obtain and retain in its billing records written verification from the referring provider or the service provider containing the following:

(a) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(b) the name of the out of community provider; and

(c) justification that the medical or behavioral health care is not available in the home community.

(2) Referrals and referral information must be obtained from a MAD provider. For continued out-of-community, non-emergency transportation, the required information must be obtained every six months.

C. **Eligibility determination:** Prior authorization does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

[8.324.7.15 NMAC - Rp, 8.324.7.15 NMAC, 1-1-14]

8.324.7.16 REIMBURSEMENT:

A. Transportation providers must submit claims for reimbursement on the CMS-1500 form or its successor. See 8.302.2 NMAC. Reimbursement to transportation, meal or lodging providers for covered services is made at the lesser of the following:

(1) the provider's billed charge:

(a) the billed charge must be the provider's usual and customary charge for services; for a provider with a tariff, the billed charge must be the lesser of the charges allowed by the provider's tariff or the provider's usual and customary charge.

(b) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure; reimbursement by the MAD program to a transportation provider is inclusive of gross-receipts taxes and other applicable taxes; an air ambulance provider is exempt from paying gross receipts tax; therefore, the rates paid for air ambulance service do not include gross receipts tax.

B. **Ground ambulance:** A provider of ground ambulance services is reimbursed at the lesser of their billed charge for the service or the MAD maximum allowed amount.

(1) The MAD maximum allowed amount for transports up to 15 miles is limited to the base rate amount. The allowable base rate for advanced life support (ALS) or basic life support (BLS) includes reimbursement for the ALS or BLS equipped service, oxygen, disposable supplies and medications used in transport. The base rate reimbursement includes mileage reimbursement for the first 15 miles of transport.

(2) The allowable base rate for a scheduled non-emergency transport includes reimbursement for oxygen, disposable supplies and medications used in transport. The base rate includes mileage reimbursement for the first 15 miles of transport.

C. **Air ambulance:** A provider of air ambulance services is reimbursed at the lesser of billed charges or the MAD maximum allowed rate.

D. **Non-emergency transportation services:**

(1) A provider of non-emergency transportation is reimbursed at the lesser of their approved tariff or the MAD rate for one or multiple MAP eligible recipient transports not meeting the "additional passenger" criteria below.

(2) Reimbursement will be limited to the MAD reimbursement limitation per one-way trip for a MAP eligible recipient being transported for medical care. MAD does not provide reimbursement for any portion of the trip for which the MAP eligible recipient is not in the vehicle.

(3) An "additional passenger transport" is a non-emergency transport of two or more MAP eligible recipients who are picked up at the same location and are being transported to the same provider. Additional passenger transport services will not be covered. When more than one MAP eligible recipient is being transported from the same location to the same provider and each MAP eligible recipient has a scheduled MAD-covered medical or behavioral health appointment, MAD will allow coverage for one MAP eligible recipient.

(4) MAD covers transportation for one attendant when the MAP eligible recipient is a child 10 years of age or younger not meeting the additional passenger criteria if the medical necessity for the attendant is justified in writing by the MAP eligible recipient's medical or behavioral health provider for each transport. In cases where the MAP eligible recipient's condition is ongoing and the need for a medical attendant will not change, the attestation must be renewed every six months, unless the MAP eligible recipient who is receiving medical or behavioral health service is under 18 years of age. If the medical or behavioral health appointment is for a MAP eligible recipient 21 years of age and older, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the MAP eligible recipient.

(5) MAD covers transportation to scheduled, structured counseling and therapy sessions for a MAP eligible recipient, family, or multi-family groups, based on individualized needs as specified in the treatment plan. Claims for services are to be filed under the name of the MAP eligible recipient being primarily treated through these sessions.

[8.324.7.16 NMAC - Rp, 8.324.7.16 NMAC, 1-1-14]

HISTORY OF 8.324.7 NMAC:

History of Repealed Material:
8.324.7 NMAC, Transportation Services, filed 6-16-04 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 351 SANCTIONS OR REMEDIES
PART 2 SANCTIONS AND REMEDIES

8.351.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.351.2.1 NMAC - Rp, 8.351.2.1 NMAC, 1-1-14]

8.351.2.2 SCOPE: The rule applies to the general public.

[8.351.2.2 NMAC - Rp, 8.351.2.2 NMAC, 1-1-14]

8.351.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.

[8.351.2.3 NMAC - Rp, 8.351.2.3 NMAC, 1-1-14]

8.351.2.4 DURATION: Permanent.

[8.351.2.4 NMAC - Rp, 8.351.2.4 NMAC, 1-1-14]

8.351.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.351.2.5 NMAC - Rp, 8.351.2.5 NMAC, 1-1-14]

8.351.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.351.2.6 NMAC - Rp, 8.351.2.6 NMAC, 1-1-14]

8.351.2.7 DEFINITIONS: [RESERVED]

8.351.2.8 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.
[8.351.2.8 NMAC - Rp, 8.351.2.8 NMAC, 1-1-14]

8.351.2.9 SANCTIONS AND REMEDIES: The medical assistance division (MAD) is required to impose sanctions or penalties against providers for fraud, violations of federal or state law, violations of HIPAA regulations, failure to meet professional standards of conduct, non-compliance with the medical assistance division's New Mexico administrative code (NMAC) rules, violations of the Medicaid Provider Act, and other misconduct. See 42 CFR Part 455; Section 30-44-3 NMSA 1978 (Repl. Pamp. 1998). HSD recovers overpayments made to MAD enrolled providers, to include HSD contracted managed care organizations (MCO) contracted providers; and to a MCO's out-of-network providers who have billed and received payments from a HSD contracted MCO. For applying sanctions and remedies, any of the following are considered a MAD enrolled provider.

A. Any individual or other entity who has signed a provider participation agreement (PPA) with MAD, or who has signed an agreement or contract with a HSD contracted MCO.

B. Any individual or other entity who has otherwise received payment for treating or providing services to a medical assistance program (MAP) eligible recipient as an out-of-network provider, a participating or non participating provider, a subcontracted provider, or who participates in an entity contracted by HSD or a HSD contracted MCO, including but not limited to, pharmacy benefit managers, dental benefit administrators, and contracted transportation services.

C. Any individual or other entity that provides a service to a MAP eligible recipient which results in a claim for payment by MAD, the HSD contracted fiscal agent, or by a HSD contracted MCO or coordinated care organization with or without a contractual basis for the claim submission.

D. Any individual or other entity who submits a claim to medicare or to a medicare advantage plan for a MAP eligible recipient, for which a copayment, coinsurance, or deductible is applied.

E. An employee, owner, or contractor to any of the above.
[8.351.2.9 NMAC - Rp, 8.351.2.9 NMAC, 1-1-14]

8.351.2.10 SANCTIONS: MAD is required to impose sanctions against a provider for violation of the provisions outlined in the MAD NMAC rules and federal and state laws and regulations. MAD has discretion to impose monetary or non-monetary sanctions against providers for fraud or other forms of misconduct.

A. **Provider fraud:** Fraud is the intentional misappropriation, deception or misrepresentation made by a provider with the knowledge that the deception could result in some unauthorized benefit to the provider, other entity or some other person. The term includes any act that constitutes fraud under applicable federal or state law or regulation.

B. **Misconduct defined:** Provider misconduct includes, but is not limited to, any of the following:

(1) engaging in a course of conduct or performing an act that violates any provision of federal or state statutes, laws, regulation, and rules, to include HIPAA, or the continuation of his or her conduct after the receipt of the notice that the conduct should cease;

(2) failure to meet federal or state licensing or certification standards required of the provider or other entity, including the revocation or suspension of his or her license. The provider or other entity must notify MAD of such failure;

(3) failure to correct deficiencies in provider or other entity operations within time limits specified by HSD or its authorized agent after receiving written notice of these deficiencies;

(4) failure to maintain and retain any medical, behavioral health or business records as are necessary to:

(a) verify the treatment or care of a MAP eligible recipient for which the provider or other entity received payment from MAD or a HSD contracted MCO to provide the benefit or service;

(b) services or goods provided to any MAP eligible recipient for which the provider or other entity received payment from MAD or a HSD contracted MCO;

(c) amounts paid by MAD or a HSD contracted MCO on behalf of a MAP eligible recipient;

(d) identify the practitioners and qualifications of practitioners providing the service, and

(e) other records required by MAD for at least six years from the date of creation or until ongoing audits are settled, whichever is longer;

(5) furnishing services to a MAP eligible recipient or billing MAD or a HSD contracted MCO for services which fall outside the scope of the provider's practice board or outside the scope of his or her prescribed practice or as limited by MAD's NMAC rules;

(6) failure to comply with the terms of the provider certification, electronic signature, or terms of submission for the claim form;

(7) failure to provide complete, accurate, and current information on his or her MAD provider participation agreement (PPA);

(8) breach of the terms of the provider's MAD PPA;

(9) failure to provide or maintain services which meet professionally recognized standards of care and quality;

(10) engaging in negligent or abusive practices which result in death or physical, emotional, or psychological injury to a MAP eligible recipient;

(11) failure to repay or make arrangements to repay identified overpayments;

(12) failure to make records available upon request to HSD or its delegated agent;

(13) violation of any laws, regulations or code of ethics governing the conduct of providers;

(14) conviction of crimes relating to the neglect or abuse of any of his or her patients;

(15) conviction of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(16) conviction of program-related crimes under medicare to include any other programs administered by the federal government or any state health care program or the suspension or termination of a provider's participation by this or another state's medicaid agency;

(17) seeking payment for a furnished service or for work related charges and penalties from a MAP eligible recipient or his or her personal or authorized agent, except as allowed and specifically delineated by HSD;

(18) refusing to furnish services to a MAP eligible recipient because he or she has third-party coverage; or

(19) advising a MAP eligible recipient to terminate his or her third-party coverage;

(20) failing to follow federal or state regulations and rules regarding the management of pain with controlled substances, the prescription monitoring program, and prescribing controlled substances;

(21) injudicious or excessive prescribing;

(22) failing to maintain a practitioner-to-patient relationship while prescribing controlled substances;

(23) failure of a provider or other entity to report overpayments identified by the provider or other entity within 60 calendar days of identification which, at that point, are presumed to be false claims and are subject to determination as credible allegations of fraud.

C. **Violation of Medicaid Provider Act:** Violations of the Medicaid Provider Act include the following:

(1) a material breach of a provider's obligation to furnish services to a MAP eligible recipient or any other duty specified under the terms of his or her PPA;

(2) a violation of any provision of the Public Assistance Act or the Medicaid Provider Act or any regulations and rules issued pursuant to those acts;

(3) the provider or other entity intentionally or with reckless disregard made false statements with respect to any report or statement required by the Public Assistance Act, Medicaid Provider Act or rules issued pursuant to either of act;

(4) the provider or other entity intentionally or with reckless disregard advertised or marketed or attempted to advertise or market, services to a MAP eligible recipient in a manner to misrepresent its service or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing;

(5) the provider or other entity hindered or prevented the HSD secretary, MAD director, or HSD's authorized agent from performing any duty imposed by the Public Assistance Act, the Human Services Act, the Medicaid Provider Act or any regulations and rules issued pursuant to those acts; or

(6) the provider or other entity fraudulently procured or attempted to procure any benefit from MAD or a HSD contracted MCO.

[8.351.2.10 NMAC - Rp, 8.351.2.10 NMAC, 1-1-14]

8.351.2.11 TYPES OF SANCTIONS: HSD is allowed to impose monetary or non-monetary sanctions against any provider or other entity for misconduct. HSD is required to impose certain sanctions against a provider or other entity for fraud, HIPAA violations, and other actions. Sanctions may be applied to any provider or other entity receiving payment for services either directly through MAD or through its managed care contractor, subcontractor, or other provider.

A. **Prior approval:** As a condition of payment, MAD or a HSD contracted MCO can require a provider to obtain prior approval before delivering all or certain services including prior to prescribing or ordering services. The prior approval request must be submitted to the HSD's contracted MCO or the MAD UR contractor in a manner prescribed for general utilization review. Failure to obtain prior approval prior to furnishing a service may result in imposition of sanctions. In addition, MAD may sanction a provider or other entity by requiring him or her to obtain prior approval before furnishing all or certain services, including prior to prescribing or ordering services, even if other providers may furnish that service without the requirement of obtaining prior approval; see 8.302.5 NMAC.

B. **Education:** As a condition of payment, MAD or a HSD contracted MCO can require a provider or other entity to attend an educational program if misconduct could be remedied with the provision of identified education. MAD or a HSD contracted MCO may also require a provider or other entity who is seeking reinstatement to attend a specific educational program prior to the approval of his or her new PPA application. Provider education programs may include, but are not limited to, the following:

(1) claim form completion;

(2) use and format of the MAD NMAC rules;

(3) use of procedure codes;

(4) substantive provisions of MAD's NMAC rule, policy, and requirement;

(5) reimbursement rates;

(6) assistance in claims coding and billing; and

(7) continuing medical or behavioral health education.

C. **Closed-end agreements:** MAD can transfer the provider to a closed-end PPA. A closed-end PPA is for a specified period of time which terminates on a defined date not to exceed 12 months. At the end of this term, a new PPA must be executed for continued MAD participation.

D. **Suspension:** "Suspension" is an exclusion from participation in MAD or a HSD contracted MCO for a specified period of time.

(1) MAD suspension: MAD may suspend a provider from MAD or a HSD contracted MCO participation for misconduct or fraud.

(a) HSD is permitted to suspend a provider for up to 36 months. The period of suspension is not less than the term of any court-imposed suspension.

(b) If the suspension is imposed by MAD, the effective date of the suspension is the date on the notice of suspension. If the suspension is concurrent with a court-imposed suspension, the effective date is the date of the court-imposed suspension.

(c) MAD is permitted to suspend a provider when the provider's license is terminated, suspended, or moved to an inactive status whether the action is voluntary on the part of the provider or is an action of his or her practice or licensing board. When a provider is reinstated by his or her practice or licensing board, the provider may reapply to MAD. Approval of the provider's PPA will be based on the history, nature, and financial magnitude of the provider's prior misconduct and not solely on the basis of reinstatement of the provider's license.

(2) Medicare suspension: MAD must suspend a provider or other entity that is suspended by medicare or any other federal or state-funded health program. When a MAD suspension is concurrent with a medicare suspension, the effective date of the MAD suspension is the same date of the medicare suspension.

(3) Special exception for health manpower shortage areas: After assessing the nature of the violation or misconduct, MAD has the option of requesting action from the secretary of the federal department of health and human services (DHHS) if the suspension of a provider would result in the lack of adequate medical or behavioral health services for MAP eligible recipients in a given area. The secretary of DHHS can be asked to:

(a) designate the community as a health manpower shortage area and place national health services corps personnel in the community; or

(b) waive the provider's suspension based upon submission of adequate documentation that the suspension would deprive the provider's community of needed medical or behavioral health services because of a shortage of practitioners in the area.

(4) Submission of claims following suspension:

(a) If a provider is suspended from MAD or a HSD contracted MCO participation, the provider is prohibited from submitting claims for payment to MAD, its MAD claims processing contractor, or to a HSD contracted MCO.

(b) MAD or a HSD contracted MCO will not pay claims submitted by clinics, groups, corporations, associations or other entities associated with a provider who is suspended from MAD participation for services furnished by such provider after the effective date of the suspension.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the suspension can be

submitted. The claims may be subject to pre-payment review.

(5) Reinstatement: A provider can apply for reinstatement at the end of a suspension period. Reinstatement is not automatic or guaranteed. A provider must furnish written documentation that he or she meets all relevant licensing, certification, or registration requirements as specified by MAD, HSD's behavioral health services division (BHSD), the children, youth and families department (CYFD), or the department of health (DOH).

E. **Termination:** Termination is the ending of the provider's MAD PPA for a specified period of time. MAD must terminate the provider's PPA in certain specified instances and is permitted to terminate the PPA in other instances.

(1) Mandatory termination: MAD must terminate the PPA when any of the following events occur:

(a) provider is convicted of MAP or medicare fraud;

(b) provider has a previous suspension from MAD with failure to correct identified deficiencies; or

(c) provider is terminated from participation in the medicare program or another federal or state-funded health program.

(2) Discretionary termination: MAD may terminate the provider's PPA when the violation is so egregious, in the discretionary opinion of MAD, that other sanctions are not sufficient to address, reduce or eliminate the violation or when the identified deficiency or violation reflects a pattern of violation.

(3) Effective date of termination: The effective date of the MAD PPA termination is the date of a MAD or a medicare fraud conviction or the date of the provider's medicare termination. If termination follows a prior suspension from MAD or the termination is discretionary, the date of termination is set by MAD.

(4) Termination of a nursing facility (NF) or intermediate care facility's PPA:

(a) MAD or a HSD contracted MCO can terminate a NF or an intermediate care facility for individuals with intellectual disabilities (ICF-IID) PPA instead of or in addition to other alternative remedies. Termination can occur in the instances which include, but are not limited to, the following:

(i) immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident's health and safety which have not been removed;

(ii) the provider is not in substantial compliance with participation requirements regardless of whether immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident is present;

(iii) the provider fails to submit an acceptable plan of correction within the specified timeframes;

(iv) provider fails to relinquish control to temporary manager; or

(v) DOH recommends termination as the most appropriate remedy.

(b) Termination of the provider's PPA ends payment to the NF or ICF-IID provider.

(c) Notwithstanding other sections of this rule, payment to the NF or ICF-IID provider can be continued for up to 30 calendar days after the effective date of his or her PPA termination if the following conditions are met:

(i) the payment is for a NF or ICF-IID MAP eligible recipient resident admitted to the NF or ICF-IID before the effective date of the provider's PPA termination; and

(ii) MAD or a HSD contracted MCO is making reasonable efforts to transfer a MAP eligible recipient resident to another MAD enrolled facility or to alternate care;

(iii) for purposes of this provision, the 30 calendar day period begins on the effective date of the provider's PPA termination by the centers for medicare and medicaid services (CMS), MAD, or by the NF or ICF-IID provider.

(d) Before termination of a provider's NF or ICF-IID PPA, MAD or a HSD contracted MCO must notify the provider and the public at least 15 calendar days before the effective date of the termination with non-immediate jeopardy deficiencies that constitute the noncompliance. For termination due to deficiencies that pose immediate jeopardy to a MAP eligible recipient resident, MAD or a HSD contracted MCO must notify the provider and the public at least two working days before the effective date of the termination.

(e) If the termination of the provider's PPA is selected due to immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident, the effective date of the termination is within 23 calendar days of the last date of its DOH survey.

(5) Submission of claims following termination:

(a) If a provider is terminated from MAD participation, the provider is prohibited from submitting claims for payment to a HSD contracted MCO or to the MAD claims processing contractor.

(b) MAD or an HSD contracted MCO will not pay claims submitted by clinics, groups, corporations, associations, or other entities associated with a provider who is terminated from MAD participation for services furnished by such provider after the effective date of the termination.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the termination can be submitted. The claims may be subject to pre-payment review.

(6) Re-application for MAD participation: A provider or other entity must submit a new PPA application after the end of the termination period to MAD, before requesting enrollment in one of HSD's contracted MCOs. A provider must meet certification and licensing requirements specified by MAD, CYFD or DOH to be eligible to once again become a provider.

F. **Civil monetary penalties:** MAD is permitted to impose civil monetary penalties in addition to other penalties, and in accordance with the federal and state laws, regulations and rules.

(1) Amount of penalty: the provider or other entity is liable for the following:

(a) payment of interest on the amount received by the provider or other entity from MAD or a HSD contracted MCO in excess of payment at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to HSD;

(b) a civil monetary penalty in an amount of up to the maximum allowable under federal or state law, regulations or rules;

(c) a civil monetary penalty of $500 for each false or fraudulent claim submitted for furnishing treatment, services, or goods; and

(d) payment of legal fees and costs of investigation and enforcement of civil remedies.

(2) Payment of penalty amounts: Penalties and interest amounts must be remitted to the state of New Mexico (the state). Any legal fees, costs of investigation and costs of enforcement of civil remedies recovered on behalf of the state must also be remitted to the state.

(3) Criminal action: The filing of a criminal action is not a condition precedent to MAD's imposition of civil monetary penalties.

G. **Reduction of payment:** MAD may reduce the amount of any payment due a provider or other entity, in addition to other sanctions, if the provider or other entity seeks to collect an amount in excess of the MAD or a HSD contracted MCO's allowable amount from a MAP eligible recipient, his or her family, his or her authorized agent or any other source. See 42 CFR Section 447.20 - 447.21.

(1) The reduction may be equal to up to three times the amount that the provider sought to collect.

(2) For purposes of this provision, the MAD allowable amount is equal to the amount payable under the state plan or MAD NMAC rules, a MAD or a HSD contracted MCO fee schedule. The provider may not

charge a MAP eligible recipient for any effort or penalties such as researching eligibility, not having cards, completing paper work or billing forms, missed appointments, or any other add-on cost unless specifically allowed in a MAD NMAC rule.

H. **Sanctions and remedies for noncompliance with nursing facility or intermediate care facility certification requirements:** MAD is required to impose additional remedies against a NF provider who fails to comply with federal medicaid and state MAD participation requirements with respect to his or her licensing and certification. One or more of the following remedies can be imposed by MAD for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance: termination of the NF provider's MAD PPA and all provider contracts with the HSD contracted MCO; temporary management; denial of payment for new admissions; civil money penalties; NF closure or the transfer of MAP eligible recipient residents or both; state monitoring; directed plan of correction; directed inservice training; and other state remedies approved by CMS. MAD is also required to impose remedies against an ICF-IID provider who fail to comply with federal medicaid and state MAD licensing and certification requirements. MAD may terminate an ICF-IID provider's certification or deny payment for new admissions if the provider fails to meet the conditions for participation or certain deficiencies are identified by DOH.

(1) Authority of survey agency: DOH is the survey agency designated by MAD. When the rationale for imposition of the remedies is tied to DOH's licensing and certification responsibilities, criteria for imposition of remedies and description of these specific remedies are based on NMAC rules promulgated by the DOH.

(2) Recommendations for imposition of additional remedies: Following completion of a survey, DOH may recommend that specified remedies be imposed against a NF or an ICF-IID provider for failure to meet certification or licensing requirements which are based on the type, extent and seriousness of an identified deficiency. MAD has five working days from receipt of DOH's recommendations to impose remedies or to oppose the recommendations. Unless a response from MAD is received in writing prior to the expiration of the time period, the recommendations are accepted by MAD as submitted and the recommended remedy is imposed.

(3) Informal reconsideration for an ICF-IID provider: An ICF-IID provider can request an informal reconsideration of the decision to deny, terminate or not renew his or her MAD PPA when the HSD administrative hearing final decision will not be completed prior to the effective date of the termination. The informal reconsideration must be completed prior to the effective date of the termination. The informal reconsideration includes the following:

(a) written notice to the ICF-IID provider of the denial, termination or nonrenewal of his or her MAD PPA;

(b) reasonable opportunity for the ICF-IID provider to refute the findings upon which the decision was based; and

(c) a written affirmation or reversal of the denial, termination or nonrenewal of the provider's MAD PPA.

I. **Sanction for violation of the Medicaid Provider Act:** MAD may take any or any combinations of the following delineated actions against a provider or other entity for a violation of the Medicaid Provider Act.

(1) imposition of an administrative penalty of not more than $5,000 for engaging in any practice that violates the act; each separate occurrence of such practice constitutes a separate offense;

(2) MAD issues an administrative order requiring the provider or other entity to:

(a) cease or modify any specified conduct or practices engaged in by the provider or other entity or his or her employees, subcontractors, or agents;

(b) fulfill its contractual obligations in the manner specified in the order;

(c) provide any service that has been denied;

(d) take steps to provide or arrange for any service that it has agreed to or is otherwise obligated to make available; or

(e) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by the opposing parties;

(3) suspend or terminate the provider's MAD PPA and the provider contracts with a HSD contracted MCO.

[8.351.2.11 NMAC - Rp, 8.351.2.11 NMAC, 1-1-14]

8.351.2.12 IMPOSITION OF SANCTIONS:

A. **Mandatory sanctions:** MAD must impose sanctions when a provider receives a formal reprimand or censure for unethical practice by a professional association of the provider's peers or when a provider is suspended or terminated from participation in medicare or any federal or state-funded health care program. Imposition of sanctions are applied to any provider or other entity receiving payment for services either directly through MAD, its contractor, or through any HSD contracted MCO, subcontractor, or provider.

B. **Permissive sanctions:** MAD can impose monetary or non-monetary sanctions against a provider or other entity for fraud or other forms of misconduct.

C. **Criteria used in assessment of permissive sanctions:** MAD uses the following criteria to determine the type of permissive or mandatory sanction to impose:

(1) seriousness of the violation;

(2) number and nature of a violation;

(3) history of a prior violation or prior sanction;

(4) action or recommendation of peer review group or licensing board;

(5) nature and degree of adverse impact of the sanction upon a MAP eligible recipient;

(6) cost to MAD or a HSD contracted MCO of the violation;

(7) mitigating circumstances; and

(8) other relevant facts.

[8.351.2.12 NMAC - Rp, 8.351.2.12 NMAC, 1-1-14]

8.351.2.13 RECOVERY OF OVERPAYMENTS: MAD can seek recovery of overpayments through the recoupment or repayment process. Overpayments are amounts paid to a MAD provider or other entity in excess of the MAD allowable amount. Overpayment amounts must be collected within 24 months of the initiation of recovery. Overpayment includes, but is not limited to, payment for any claim for which the provider or other entity was not entitled to payment because an applicable MAD NMAC rule and its requirements were not followed. Payment made to a pharmacy for a controlled substance or another prescribed drug item for which the prescriber did not follow all state and federal regulations, laws or rules may be subject to recoupment from the prescriber or entity to which the prescriber is associated. Recovery of overpayments through a HSD contracted MCO is also subject to the provisions of 8.308.22 NMAC.

A. **Auditing procedures:**

(1) Prima facie evidence: The audit findings generated through the audit procedure shall constitute prima facie evidence in all MAD proceedings of the number and amount of requests for payment as submitted by the provider or other entity.

(2) Use of statistical sampling techniques: MAD's procedures for auditing a provider or other entity may include the use of random sampling and extrapolation. When this procedure is used, all sampling will be performed using generally accepted statistical methods and will yield statistically significant results at a confidence level of at least 90 percent. Findings of the sample will be extrapolated to the universe for the audit period.

(3) Burden of proof: When MAD's final audit findings have been generated through the use of sampling and

extrapolation, and the provider or other entity disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider or other entity. The provider or other entity may present evidence to show that the sample was invalid. The evidence must include a 100 percent audit of the universe of provider records used by MAD in the drawing of its sample. Any such audit must:

(a) be arranged and paid for by the provider or other entity;

(b) be conducted by a certified public accountant;

(c) demonstrate that a statistically significantly higher number of claims and records not reviewed in MAD sample were in compliance with MAD NMAC rules, and

(d) be submitted to MAD with all supporting documentation.

B. **Repayment process:** A provider or other entity can repay all or part of an overpayment with a lump sum payment or a series of payments based on a schedule developed and mutually agreed to by MAD and the provider or other entity. If a provider or other entity fails to comply with the schedule, HSD will recover the overpayment and interest or initiate other collection efforts.

C. **Recoupment process:** Upon written notice, MAD may withhold all or a portion of a provider or other entity's payment on pending and subsequently received claims in order to recover an overpayment, or it may suspend payment on all pending or subsequently submitted claims, pending a final determination of the amount of overpayment. All amounts must be recouped within 24 months. Recoupments may be applied to other providers owned by the same entity when necessary to recoup overpayments timely.

D. **Combination of processes:** MAD can use both recoupment and repayment process to collect an overpayment if:

(1) the provider is unlikely to remain a MAD provider long enough for full recovery using recoupment alone;

(2) the provider is not enrolled through a MAD PPA or contract; or

(3) the average monthly payment to a provider or other entity is so low that recoupment within 12 months is not feasible.

E. **Prepayment review:** MAD may require pre-payment review of claims submitted during a recoupment or repayment process to ensure that subsequent claims are not inflated to compensate for amounts recovered during the recoupment or repayment process. Prepayment review may also be conducted as part of MAD's administrative responsibilities.

[8.351.2.13 NMAC - Rp, 8.351.2.13 NMAC, 1-1-14]

8.351.2.14 NOTICE REQUIREMENTS:

A. **Content of provider notice:** With the exception of a referral based on a credible allegation of fraud, as that term is defined in federal statute or regulation or both, when MAD seeks overpayment recovery, or to impose sanctions or remedies, written notice is sent to the provider or other entity. The notice sent to a non-nursing facility provider or other entity contains the following information:

(1) nature of the violation or misconduct;

(2) dollar value, if applicable, the method, criteria or both used for determining the overpayment, intended sanction, or amount of civil monetary penalty to be imposed;

(3) provider's right to a HSD provider administrative hearing, the right to be represented by counsel at the hearing proceeding, and the process necessary to request a HSD provider administrative hearing.

(4) statement notifying the provider that if he or she does not request a HSD provider administrative hearing, the action proposed by MAD will be deemed final for purposes of collection of overpayment and imposition of sanctions; and

(5) a statement that provider has 30 calendar days from the date of the notice to request a HSD provider administrative hearing.

B. **Notice requirements for credible allegations of fraud:**

(1) The notice for contains the following information; see 42 CFR Section 455.23 (b):

(a) a statement that payments are being withheld on a temporary basis and delineate which types or type of MAD claim to which the termination applies, when appropriate;

(b) a statement informing the provider of his or her right to submit written information for MAD's consideration regarding release of payments, in whole or in part, for a good cause exception; and

(c) the information listing the conditions or circumstances under which the withholding is terminated.

(2) Time limits for withholding for fraud or misrepresentation: If payments are to be withheld in instances of credible allegations of fraud, the notice is sent to the provider within five calendar days of taking such action.

(3) The provider is not afforded any HSD administrative hearing for temporary payment suspension based on refunds or denial of a partial or in whole good cause exception for a credible allegation of fraud.

C. **Notice to other organizations:** When a MAD provider or other entity is sanctioned, MAD notifies the applicable professional society, board of certification, licensing or registration, and state or federal agencies of the sanctions imposed and rationale for imposition of sanctions. If MAD learns that a provider or other entity is convicted of a MAD-related offense, MAD also notifies the federal secretary of DHHS of the conviction.

D. **Notice to a MAP eligible recipient:** When MAD terminates or suspends a provider from participation, it notifies each MAP eligible recipient for whom the provider has submitted claims for services after the date of the alleged fraud or misconduct.

E. **Notice deadlines for a NF or ICF-IID provider:** The notice period begins on the date of the MAD notice. In no event will the effective date of the action be later than 20 calendar days after MAD sends the notice.

(1) The notice informing the NF or ICF-IID provider of MAD's intent to impose remedies is given at least two calendar days before the effective date of the action in instances where there is immediate jeopardy to a NF or ICF-IID MAP eligible resident.

(2) The notice informs the NF or ICF-IID provider of MAD's intent to impose remedies is given at least 15 calendar days before the effective date of the remedies in instances where immediate jeopardy to a NF or ICF-IID MAP eligible resident is not involved.

F. **Exceptions to the notice requirements:** Notice is not sent and a HSD provider administrative hearing is not available if the basis for the provider sanction is the non-nursing facility provider's failure to meet standards for licensing, certification, or registration required by federal or state laws and rules for MAD participation Additional notice is not required if MAD has notified the provider in writing of the failure to meet standards and has given the provider 30 calendar days notice to correct or produce necessary documentation curing the failure and the provider fails to respond.

[8.351.2.14 NMAC - Rp, 8.351.2.14 NMAC, 1-1-14]

8.351.2.15 REQUEST FOR PROVIDER HEARING: A provider can request a hearing if he or she disagrees with any of the aforementioned actions taken or sanctions or remedies imposed by MAD, as applicable. Requests for a HSD provider administrative hearing must be made within 30 calendar days or within the time limit specified on the notice of MAD action. A NF or ICF-IID provider must submit the request to DOH within 60 calendar days of the notice of the proposed imposition of remedies related to noncompliance with certification or licensing requirements. If a provider fails to request a HSD provider administrative

hearing during this time frame, the provider waives its right to an appeal. See 8.352.3 NMAC for information on the MAD provider administrative hearing process and a provider rights and responsibilities.

A. **Imposition of remedies:** MAD can impose all remedies on a MAD enrolled provider after notifying the provider in a timely manner of the deficiencies an impending sanction, or remedy. Except for the imposition of civil monetary penalties against a NF provider, imposition of sanctions for violation of the Medicaid Provider Act and referrals based on credible allegations of fraud, any applicable sanctions or remedy may be imposed prior to the HSD provider administrative hearing.

B. **Stay granted:** As applicable, the provider can request that the imposition of sanctions or remedies be stayed while the HSD provider administrative hearing process is pending by submitting such request in writing to MAD. Granting of a stay is at the discretion of the MAD director upon consideration of health service available and other related concerns. Interest on civil money penalties or overpayments accrues from the date of the initial determination.

C. **Collection of civil monetary penalties for noncompliance:** MAD may not collect a civil money penalty against a NF provider until a final decision is made that supports the imposition of the penalty. In instances where imposition of civil money penalties are proposed due to noncompliance with certification requirements, a NF provider may waive its right to a HSD provider administrative hearing by submitting a written request to DOH. Waiver of the right to such a hearing reduces the amount of the specified penalty by 35 percent. A NF provider may submit a plan of correction or request a resurvey without prejudicing its position during the hearing.

[8.351.2.15 NMAC - Rp, 8.351.2.15 NMAC, 1-1-14]

HISTORY OF 8.351.2 NMAC:

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

ISD 305.3000, Provider Sanctions, filed 1-7-80.

ISD 305.4000, Provider Notification and Right to Review, filed 1-7-80.

ISD 305.5000, Repayment of Medicaid Funds, filed 1-7-80.

ISD 305.6000, Periods of Suspension, filed 1-7-80.

SP-004.0500, Section 4, General Program Administration Medicaid Agency Fraud Detection and Investigation Program, filed 1-23-81.

SP-004.3000, Section 4, General Program Administration Suspension of Practitioners Convicted of Crimes Related to Medicare or Medicaid, filed 3-17-81.

History of Repealed Material:

8.351.2 NMAC, Sanctions and Remedies, filed 6-16-03 - Repealed effective 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 352 ADMINISTRATIVE HEARINGS
PART 2 CLAIMANT HEARINGS

8.352.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.352.2.1 NMAC - Rp, 8.352.2.1 NMAC, 1-1-14]

8.352.2.2 SCOPE: The rule applies to the general public.

[8.352.2.2 NMAC - Rp, 8.352.2.2 NMAC, 1-1-14]

8.352.2.3 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 under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.

[8.352.2.3 NMAC - Rp, 8.352.2.3 NMAC, 1-1-14]

8.352.2.4 DURATION: Permanent.

[8.352.2.4 NMAC - Rp, 8.352.2.4 NMAC, 1-1-14]

8.352.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

[8.352.2.5 NMAC - Rp, 8.352.2.5 NMAC, 1-1-14]

8.352.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.

[8.352.2.6 NMAC - Rp, 8.352.2.6 NMAC, 1-1-14]

8.352.2.7 DEFINITIONS:

A. "Administrative law judge (ALJ)" means the HSD fair hearings bureau's appointed judge to oversee the claimant's administrative hearing process and render a recommendation to the medical assistance division direction.

B. "Authorized representative" means an individual that has been legally appointed by the appropriate court to act on behalf of the claimant.

C. "Date of action" means the date on which an adverse action becomes effective.

D. "Denial" means the decision not to authorize the claimant's requested service, prior approval, utilization review request, or level of care (LOC).

E. "Hearing" or "administrative hearing" or "fair hearing" means an evidentiary hearing that is conducted so that evidence may be presented as it relates to the denial or an adverse action by HSD, the MAD UR contractor, or the HSD managed care organization(MCO). This hearing is conducted by the HSD fair hearings bureau (FHB).

F. "HSD" or "the department" means the New Mexico human services department.

G. "MAD" means the medical assistance division which administers medicaid and medical assistance programs under HSD.

H. "MAP" means the medical assistance programs administered by MAD.

I. "MCO final decision" means the HSD managed care organization (MCO) final decision regarding an appealed adverse action it intends to take or has taken against its member.

J. "Parties to the hearing" are HSD and as appropriate its designee and the claimant. If the hearing issue is a decision made by a HSD contractor, the parties are then HSD and as appropriate its designee, the contractor, and the claimant.

K. "Request for an administrative hearing" means a clear expression by the claimant or his or her authorized representative that the claimant wants the opportunity to present his or her case to the FHB.

L. "State coverage insurance (SCI)" means the SCI- health insurance flexibility and accountability waiver program for coverage of uninsured working adults. Effective January 1, 2014, only adverse actions that occurred prior to this date may a claimant file a request for an administrative hearing.

M. "Utilization review (UR) contractor" is a HSD contractor responsible for medical and behavioral health level of care reviews and medical necessity reviews for only medical assistance programs services, prior approvals, LOC or other UR actions.

N. "Premium assistance" is a premium assistance program for children and pregnant women who are ineligible for other federally and state funded public assistance programs. Effective January 1,

2014, only adverse actions that occurred prior to this date may a claimant file a request for an administrative hearing.
[8.352.2.7 NMAC - Rp, 8.352.2.7 NMAC, 1-1-14]

8.352.2.8 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.
[8.352.2.8 NMAC - Rp, 8.352.2.8 NMAC, 1-1-14]

8.352.2.9 CLAIMANT: A claimant is a MAP enrolled recipient or an individual not currently a MAP enrolled recipient. When a MCO member requests a HSD administrative hearing, he or she is referred to as a claimant. The claimant may have an authorized representative act on behalf of him or her. To assist a claimant to whom an adverse action is intended or has been taken by MAD or its MAD UR contractor resulting in a denial of service, prior approval, UR action, or a specific level of care (LOC), MAD has established the process for a claimant to:

A. request a HSD administrative hearing;

B. request continuation of a benefit; and

C. present evidence on behalf of the claimant's request for approval of a specific services, prior approval, UR action, or LOC.
[8.352.2.9 NMAC - N, 1-1-14]

8.352.2.10 ADVERSE ACTION: The following listings are adverse actions.

A. The termination, modification, reduction, or suspension of a covered MAD service.

B. The denial or limiting of a MAD authorized service, including type or level of service (with the exception of a HSD contracted MCO value-added service); request for a prior authorization of such service; or a utilization review (UR) decision or the UR's reconsideration decision.

C. The denial in whole or in part of the claimant's provider claim by MAD, its UR contractor, or a HSD MCO which results in the claimant becoming liable for the payment.

D. The failure of MAD, its UR contractor or a HSD MCO to approve a service in a timely manner.

E. The failure of a MAP UR contractor to act on an appeal within the timeframes specified in 42 CFR 438.408 (b).

F. A claimant's MCO final decision upholding its denial or limitation of a MAD authorized service, with the exception of the MCO's value-added services.
[8.352.2.10 NMAC - Rp, 8.352.2.9 NMAC, 1-1-14]

8.352.2.11 RIGHT TO AN ADMINISTRATIVE HEARING: An administrative hearing is an evidentiary hearing that is conducted so that evidence may be presented as it relates to an adverse action by MAD, its UR contractor, or a HSD MCO. The hearing is conducted by the HSD fair hearing bureau (FHB). MAD, its UR contractor, or the claimant's MCO must grant a claimant the opportunity for a HSD administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and New Mexico Statutes Annotated 1978, 27-3-3.

A. A claimant or the claimant's authorized representative may request a HSD administrative hearing based on his or her belief that MAD, its UR contractor or the claimant's MCO has taken an adverse action erroneously.

B. A claimant or the claimant's authorized representative may request a HSD administrative hearing when the service, prior approval, UR action or LOC of a claimant is terminated, modified, reduced, suspended, or denied. A member of a HSD MCO shall have the right to request a HSD administrative hearing after the member has exhausted his or her MCO's appeal process. See 8.100.970 NMAC for hearings procedures on MAP eligibility determination issues.

C. A MCO member may request a HSD administrative hearing when:

(1) the member has exhausted his or her internal MCO appeal process;

(2) the member does not agree with his or her MCO's final decision;

(3) the member has requested a HSD administrative hearing within 90 calendar days of his or her MCO's final decision; and

(4) the member's request for a HSD administrative hearing meets one of the definitions of an adverse action in Section 10 of this rule.
[8.352.2.11 NMAC - Rp, 8.352.2.10 NMAC, 1-1-14]

8.352.2.12 HEARING PROCESS REFERENCE: HSD has established a hearing process for a claimant who meets the criteria described above in Section 10 of this rule and who disagrees with a MAD decision concerning his or her MAD or MCO services or his or her LOC determination.

A. See 8.354.2 NMAC for rules on HSD administrative hearings requests that may be made by a resident of a nursing facility: (1) who believes the facility's determination that he or she be transferred or discharged is erroneous; or (2) for requests by the claimant who believes that the HSD determination with regard to the preadmission and annual resident review requirements is erroneous.

B. See 8.308.15 NMAC for a detailed description of a member's MCO appeal process for resolving a member's dispute with his or her MCO, its contractors or subcontractors.

C. See 8.349.2 NMAC for a detailed description for services and level of care determinations made through a MAD coordinated service contractor.

D. Issues of late premium payment or failure to pay the premium addressed through the MCO appeal process which is not resolved at that level may be appealed to the New Mexico (the State) district court at the appellant's (member's) expense. Effective January 1, 2014, only eligibility determination actions that occurred prior to this date for an applicant or a recipient of MAD premium assistance may file an appeal through the HSD administrative hearing process.
[8.352.2.12 NMAC - Rp, 8.352.2.11 NMAC, 1-1-14]

8.352.2.13 NOTICES, TIME LIMITS, POSTPONEMENTS, AND DISMISSAL OF ADMINISTRATIVE HEARINGS:

A. **Notices:** MAD shall issue a notice to a claimant when it or its UR contractor intends to take an adverse action, deny prior authorization request or an UR action leading to the termination, modification, reduction, or suspension of a MAD service or LOC. The "notice of action" is issued within three working days of HSD or its contractor's determination of its intent to take action and not less than 13-calendar days prior to MAD's or its contractor's intended date to take the action.

B. **Exceptions to advance notice:** MAD or its contractor will mail an "advance notice of action" to terminate, modify, reduce, or suspend a MAD service, denial of a prior authorization request, an UR action, or a change in the claimant's LOC no later than the actual date the action will take place by MAD or its contractor:

(1) has factual information that confirms the death of the claimant;

(2) receives a clear written statement signed by the claimant that the service is no longer wanted, or he or she provides information which requires a termination, modification, reduction or suspension of a MAD service, prior authorization request or an UR action which indicates the claimant's understanding that such information may result in the termination, modification, reduction or suspension of a service, the denial of a prior authorization request or an UR adverse action;

(3) learns the claimant is residing in a public institution which makes the

claimant ineligible for MAP enrollment and MAD services while he or she resides in such an institution;

(4) does not know the claimant's whereabouts and the claimant's United States postal office returns mail directed to the claimant indicating he or she has no known forwarding address;

(5) has established the fact the claimant has been accepted for medicaid services outside of the state; or

(6) the primary care provider for the claimant has prescribed a change in his or her LOC.

C. **Time limits:** There are two specific time limits to which a claimant must adhere. One is for a request for a continuation of a benefit and the second is for a request for a HSD administrative hearing.

(1) Continuation of a benefit: A continuation of a benefit may be provided to a claimant who requests a hearing within 13 calendar days of issuance of MAD or its UR contractor's "advance notice of action." The notice will include information on the rights to continued benefits and on the claimant's responsibility for repayment if the hearing decision is not in his or her favor. The continuation of a benefit is only available to a claimant that is currently receiving the appealed service. In order to receive a continuation of a benefit while the hearing process goes forward, this request must be received by the claimant's MAD UR contractor no later than the close of business on the 13th calendar day of the date of the "advance notice of action." His or her MAD UR contractor is responsible for the determination to either approve or deny the request for the continuation of a claimant's benefit. The continuation of a benefit will be the same as the claimant's current allocation, budget or LOC.

(2) A claimant has 90 calendar days from the date of the "notice of action" to request a HSD administrative hearing. To be considered timely, the request must be received by the FHB or the claimant's local income support division (ISD) office or by MAD's director's office no later than the close of business on the 90th calendar day.

(3) The HSD administrative hearing is conducted within the 90 calendar day requirement unless the claimant or the claimant's authorized agent agrees to extend the administrative hearing in order facilitate the process.

(4) For a MCO member, the time limit to request a HSD administrative hearing is within 90 calendar days of his or her MCO's final decision.

(a) Upon requesting a HSD administrative hearing within this time limit, the member is referred to as the claimant and is governed by the remaining sections of this rule.

(b) The member may request a continuation of benefits from his or her MCO within 13 calendar days of the MCO's final decision.

D. **Dismissal of a hearings request:** The FHB may recommend to the MAD director or designee a dismissal of a request for hearing when:

(1) the request is not received in a timely manner or within the time period set out in the "notice of action" or the claimant's MCO final decision;

(2) the request is withdrawn or cancelled in writing, by the claimant or the claimant's authorized agent;

(3) the sole issue presented concerns a federal or state statue, regulation or rule requiring an adjustment of benefits for all or certain classes of individuals, including, but not limited to, a termination, modification, reduction, or suspension of a service;

(4) the same issue has already been appealed or decided upon as to this claimant and fact situation;

(5) the sole issue presented is regarding a MAD New Mexico administrative code (NMAC) rule rather than the application of the rule to the claimant; or

(6) the claimant fails to appear at a scheduled hearing without good cause; a request for a hearing may be considered abandoned and therefore dismissed if the claimant or the claimant's authorized representative appears at the time and place of the hearing, unless, within 10 calendar days after the date of the scheduled hearing, the claimant, or the claimant's authorized representative presents good cause for failure to appear; good cause includes a death in the family, a disabling personal illness, or another significant emergency, or at the discretion of the ALJ for another exceptional circumstance is considered good cause.

[8.352.2.13 NMAC - Rp, 8.352.2.12 NMAC, 1-1-14]

8.352.2.14 INFORMAL RESOLUTION CONFERENCE: Any party may request an informal resolution conference by contacting the FHB. The parties are encouraged to hold an informal resolution conference before the administrative hearing to discuss the issues in dispute. The informal resolution conference is optional and does not delay or replace the hearing process. Conference parties may include the claimant or the claimant's authorized representative, MAD, its UR contractor, or the claimant's MCO. The purpose of the informal resolution conference is to informally review MAD or the MCO's action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the administrative hearing may also be clarified or further defined. Regardless of the outcome of the informal resolution conference, an administrative hearing is still held, unless the claimant or the claimant's authorized representative makes a written withdrawal of the request of the hearing.

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

8.352.2.15 NOTICE OF PRE-HEARING AND ADMINISTRATIVE HEARING DATES:

A. **Scheduling:**

(1) Pre-hearing: Not less than 30 calendar days before the pre-hearing, the assigned ALJ provides written notice to all parties involved detailing the time, date, and place of the both pre-hearing and administrative hearing. If an accommodation is necessary, the party must notify the ALJ at least 10 calendar days prior to the pre-hearing or administrative hearing. The claimant or the claimant's authorized representative is provided in the notice an explanation of the hearing process and procedures, and informed that MAD, its UR contractor or his or her MCO does not pay fees or costs incurred by the claimant or the claimant's authorized representative as a result of the hearing or if he or she files an appeal of the hearing decision to a state district court.

(2) Administrative hearing: If all matters in the request for a hearing are not resolved at the pre-hearing conference, the ALJ sets an administrative hearing date within 30 calendar days of the last conference date, or at a later time agreed to by the parties, recognizing the 90-calendar-day time constraint.

B. **Rescheduling:** Any party may request, and is entitled to receive, one postponement of the scheduled pre-hearing and administrative hearing, as long as it does not interfere with the decision time frames. A request for more than one postponement is at the ALJ's discretion on a case-by-case basis.

C. **Expedited hearing:** Any party may request an expedited hearing in cases involving a claimant's health, safety, or service availability issues. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. The granting of an expedited hearing is at the discretion of the ALJ.

D. **Group hearing:** An ALJ may respond to a series of individual requests for hearings by conducting a single group hearing. In all group hearings, the rules governing individual hearings are followed. Each claimant or the claimant's representative is permitted to present his or her own case. If a group hearing is arranged, any claimant or a claimant's representative has the right to withdraw from the group hearing in favor of an individual hearing.

[8.352.2.15 NMAC - Rp, 8.352.2.13 NMAC,

1-1-14]

8.352.2.16 PRE-HEARING CONFERENCE: Within 30 calendar days of the receipt of a request for an administrative hearing, the ALJ assigned to a case schedules a pre-hearing conference. A pre-hearing conference is an informal proceeding and may occur telephonically.

A. **Purpose of conference:** The purposes of the pre-hearing conference include, but are not limited to:

(1) expediting the disposition towards a final decision;

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

(3) resolution of some or all issues;

(4) exchange of documents and information;

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

(6) review of audit findings;

(7) review of MAD, its UR contractor, or the MCO's adverse action of termination, modification, reduction, or suspension of a covered service or a LOC;

(8) identification the number of witnesses; and

(9) facilitation towards a settlement of the case.

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

C. **Written summaries:** The ALJ may request the parties to submit written summaries of all issues resolved at the pre-hearing conference.

D. **Pre-hearing order:** The ALJ may, at his or her sole discretion, prepare or ask the parties to prepare a pre-hearing order after the pre-hearing is completed. The pre-hearing order may contain:

(1) statements of any contested facts and issues;

(2) stipulation of matters not in dispute;

(3) list of witnesses to be called and the subject of their testimony;

(4) list of exhibits;

(5) discovery directives; or

(6) other matters relevant to the issues.

E. **Points of law:** The ALJ may direct the parties to submit memoranda on points of law to inform the final decision, and may dictate the length and scope of these submissions.

F. **Summary of evidence:** A summary of evidence (SOE) is a document submitted by MAD that provides preliminary information concerning the basis of its, its contractor or the HSD MCO's action. The SOE may be amended by MAD at any point prior to the pre-hearing if the ALJ and the claimant or the claimant's authorized representative receives copies of the amended SOE at least two working days of the pre-hearing conference.

(1) The SOE must be provided at least 10 working days prior to the pre-hearing conference or if the pre-hearing conference is not held, within 10 working days prior to the administrative hearing.

(2) The failure of MAD to timely provide the SOE may at the ALJ's discretion, result in its exclusion or a continuance of the hearing.

(3) MAD staff or its designee is responsible for preparation of the SOE and coordination of parties and witnesses. MAD is responsible for the submission of the SOE to all parties.

(4) The summary of evidence shall contain:

(a) the claimant's name, telephone number and address and the status of any previous or concurrent appeal through the MAD UR contractor;

(b) the action, proposed action or inaction being appealed;

(c) information on which the action or proposed action is based with supporting documentation and correspondence; and

(d) applicable federal and state statutes, regulations, rules or any combination of these.

G. **Availability of claimant evidence:**

(1) The claimant or the claimant's authorized representative will provide at least 10 calendar days prior to the hearing to the FHB assigned ALJ any document to be introduced as evidence at the pre-hearing conference. The SOE may be amended by the claimant or the claimant's authorized representative at any point prior to the pre-hearing if the ALJ and HSD receive copies of the amended SOE at least within two working days of the pre-hearing conference. The FHB will forward to the MAD administrative hearings unit copies of such evidence. MAD will then make these available to its MAP UR contractor or the claimant's MCO as appropriate.

(2) Failure of the claimant or the claimant's authorized representative to timely provide the documentary evidence may result in its exclusion or a continuance of the hearing at the discretion of the ALJ.

H. **Availability of information to the claimant or the claimant's representative:** HSD must:

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

(2) allow the claimant or the claimant's authorized representative to examine all documents to be used at the pre-hearing and administrative hearing at least 10 working days before the date of the hearing and at the pre-hearing and administrative hearing; HSD documents or records which the claimant or the claimant's authorized representative would not otherwise have an opportunity to challenge or contest may not be introduced at the hearing or be considered by the ALJ.

[8.352.2.16 NMAC - Rp, 8.352.2.13 NMAC, 1-1-14]

8.352.2.17 ADMINISTRATIVE HEARING STANDARDS:

A. **Administrative law judge:**

(1) Hearings are conducted by an impartial official who:

(a) does not have any personal stake or involvement in the case; and

(b) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, he must disqualify himself as the ALJ for that case.

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

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

(b) administer oaths and affirmations;

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

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

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

(f) produce the hearing report that includes findings of fact and his or her recommendation for resolution of the hearing.

(3) **Appointment of ALJ:** The ALJ is appointed by HSD upon receipt of the request for hearing. All communications are to be addressed to the assigned ALJ.

B. **Record of the hearing:** The administrative hearing is electronically recorded. The recording is placed on file at the FHB and is available to the parties for 60 calendar days following the final decision. In addition to the recorded proceedings,

the record of the administrative hearing includes the SOEs of HSD, the MCO or MAD UR contractor and the claimant, pleadings, documents, or other exhibits admitted into evidence. Any of the parties to the hearing may request one digital copy of the recordings without charge. Subsequent copies will be charged at a rate HSD sets for any other digital request.

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

(1) present his or her case or have it presented by the authorized representative;

(2) bring witnesses to present information relevant to the case;

(3) submit evidence to establish all pertinent facts and circumstances in the case;

(4) advance arguments without undue interference; and

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

D. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply to a HSD administrative hearing. A free, orderly exchange of relevant information is necessary for the decision-making process. The ALJ will provide HSD a copy of the claimant's SOE and any amendments to the SOE within one working day of his or her receipt. HSD will provide the MCO or MAD UR contractor a copy of the claimant's SOE within one working day of receipt. The HSD or claimant's SOE may be amended at any point prior to the pre-hearing if the all parties receive a copy of the amended SOE at least within two working days of the pre-hearing conference.

(1) **Admissibility:** All relevant evidence is admissible subject to the ALJ's authority to limit repetitive or unduly cumulative evidence and his or her ability to conduct an orderly hearing. The ALJ must admit evidence that is relevant to the contemplated action or the action taken by HSD, the MAD UR contractor, or the HSD MCO.

(2) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the hearing in the presence of the claimant or the claimant's authorized representative and HSD representative may not be used by the ALJ in making the hearing recommendation except as allowed by Subsection B of Section 17 of this rule.

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

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

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

E. **Burden of proof:** HSD has the burden of proving the basis to support its proposed action by a preponderance of the evidence.

[8.352.2.17 NMAC - Rp, 8.352.2.14 NMAC, 1-1-14]

8.352.2.18 CONDUCTING THE HEARING: An administrative hearing is conducted in an orderly manner and in an informal atmosphere. The hearing is conducted telephonically and is not open to the public. The ALJ has the authority to limit the number of persons in attendance as necessary for the ALJ to control the hearing.

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

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

(1) opening statements of parties or authorized representatives;

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

(a) examination by HSD authorized representative;

(b) cross examination by the claimant or the claimant's authorized representative; and

(c) opportunity to redirect the witness;

(3) presentation of the claimant's case; if witnesses are called, the order of examination of each witness is:

(a) examination by claimant or the claimant's authorized representative;

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

(c) opportunity to redirect the witness;

(4) presentation of rebuttal evidence by HSD and the claimant or the claimant's authorized representative, respectively;

(5) the ALJ may direct further questions to the HSD authorized representative, claimant or the claim representative, or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record; and

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

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

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

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

F. **Re-opening a hearing:** The ALJ, at his or her discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision time frames. Written notice of the date, time and place of the re-opened hearing is sent to the parties not less than 10 calendar days before the re-opened hearing.

[8.352.2.18 NMAC - Rp, 8.352.2.15 NMAC, 1-1-14]

8.352.2.19 HEARING DECISION: The final decision concerning the hearing is made by the MAD director after review of the record and the ALJ's report and recommendation.

A. **Decision based on the record:** The ALJ's recommendation must be based on the record created by the hearing. This includes the record of the testimony, all reports, documents, forms, and other appropriate material made available at the hearing, provided that all parties were given an opportunity to examine them as part of the

hearing and the additional evidence allowed; see Section 13 Subsection E of this rule.

B. **ALJ recommendation:** The ALJ reviews the record of the hearing and all appropriate rules, and evaluates the evidence submitted. The ALJ submits the complete record of the hearing, along with his or her written recommendation to the MAD director.

(1) Content of recommendation: The ALJ specifies the reasons for his or her conclusions, identifies the supporting evidence, references the pertinent MAD rules, and responds to the arguments of the parties in a written report and recommendation.

(2) The ALJ recommends:

(a) in favor of the eligible recipient if HSD's action or proposed action is not supported by a preponderance of the evidence available as a result of the hearing. The ALJ will provide specific recommendations to each appealed adverse action.

(b) in favor of HSD, if the preponderance of the evidence available supports the adverse action or proposed adverse action; or

(c) any other result supported by the record. The ALJ will provide specific recommendations to each appealed adverse action.

C. **Review of recommendation:** The hearing file and recommendation are reviewed by the MAD director or designee to ensure conformity with applicable federal and state statutes, regulations, and rules.

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

E. **Notice to parties:** The parties receive the written decision. When the claimant is represented by legal counsel or another authorized representative, each must receive a copy of the final decision. The decision letter includes an explanation that the parties have exhausted all HSD administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.

[8.352.2.19 NMAC - Rp, 8.353.2.14 NMAC, 1-1-14]

8.352.2.20 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL OF HEARING DECISION:

A. A continuation of a benefit may be provided to a claimant who requests a hearing within 13 calendar days of issuance of HSD's a*dvance notice of action* or within 13 calendar days of the claimant's MCO final decision. The notice will include information on the rights to the continued benefit and on the claimant's responsibility for repayment if the hearing decision is not in his or her favor. The continuation of a benefit is only available to a claimant that is currently receiving the appealed service. The continuation of a benefit will be the same as the claimant's current allocation or LOC.

B. Repayment responsibility:

(1) When a claimant or the claimant's authorized representative appeals an issue of medical assistance program eligibility as described in 8.100.970 NMAC, has requested a continued of a benefit pursuant to timely appeal, and the hearing decision upholds HSD, the MCO or the involved contractor's proposed action, the re-payment amounts will be calculated as follows:

(a) MAD month: The paid amount (paid claims amount) is owed to HSD.

(b) MCO enrolled month: HSD is owed the capitation amount plus the paid claim amount for any carved-out services.

(2) When a claimant or the claimant's authorized representative appeals a termination, modification, reduction, or suspension of a service as described in this rule, and has requested a benefit continuation pursuant to timely appeal, and the hearing decision upholds HSD, the MCO or the contractor's proposed action, the amount owed by the claimant will be calculated as follows:

(3) HSD will be owed the reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision. The MCO will be owed and is responsible to collect the reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision when the service was provided by the MCO. The repayment amount must be used by the MCO to benefit its members.

C. For SCI-enrolled claimant only: If the claimant is granted a continuation of a benefit, the notice will include information about the rights to continued benefits and about the claimant's responsibility for repayment if the hearing decision is not in the claimant's favor. If the SCI enrolled claimant has met his or her claim benefit maximums (dollars or bed days or prescriptions for the month) or has not paid premiums or paid premiums late, he or she will not be granted a continuation of a benefit. Effective January 1, 2014, a SCI enrolled claimant may only be granted a continuation of benefits if:

(1) the *advance notice of action* was issued on or before December 31, 2013 and the claimant or the claimant's authorized representative requests a continuation of benefits within his or her 13 calendar day requirement; or

(2) the claimant or the claimant's authorized representative filed a request for an administrative hearing within 90 calendar days of the notice of action.

[8.352.2.20 NMAC - Rp, 8.352.2.16 NMAC, 1-1-14]

8.352.2.21 IMPLEMENTATION OF DECISION: The MAD director's final decision is binding on all issues that have been the subject of a hearing as to that claimant unless stayed by court order. HSD is responsible for ensuring that the final decision is fulfilled.

A. **Decision favorable to HSD, the MCO, or the involved MAD UR contractor:** If assistance or a benefit has been continued while the hearing decision was pending, and the decision is favorable to HSD, the MCO, or the involved MAD UR contractor, it will take action to file an overpayment claim to the claimant for the service received while the hearing decision was pending. A request for a hearing concerning the overpayment claim is limited to alleged computation errors. The hearing decision serves as the claimant's *advance notice of action* for the resulting benefit termination, modification, reduction, or suspension. If the hearing decision is that the claimant received a benefit to which he or she was not entitled, HSD, the MCO, or the MAD UR contractor will start collection proceedings.

B. **Decision favorable to claimant:** When an administrative hearing decision is favorable to the claimant, HSD, the MCO or the MAD UR contractor will authorize the service and coverage approved in the final decision letter.

[8.352.2.21 NMAC - Rp, 8.352.2.17 NMAC, 1-1-14]

8.352.2.22 JUDICIAL APPEAL: If the final hearing decision upholds the HSD, MCO, or MAD UR contractor's original action or proposed action, the claimant or the claimant's authorized representative has the right to pursue judicial review of the decision and is so notified of that right in the HSD final decision letter. Judicial appeals for the final decision letter are governed by New Mexico statutes and court rules. While the following subsections highlight applicable procedures, they should not be considered a substitute for examining the statutes and rules themselves.

A. **Jurisdiction:**

Administrative appeals for a claimant are governed by the NMSA 1978 Section 39-3-1.1 and by Rule 1-074, Rules of Civil Procedures for the District Courts. The appropriate venue for such appeals is the first judicial district court, or the state district court having jurisdiction over the location the claimant's participated in the hearing in person or telephonically.

B. **Timeliness:** Unless otherwise provided by law, a claimant or the claimant's authorized representative must appeal the final decision letter within 30 calendar days by filing a notice of appeal with the clerk of the appropriate state district court, and sending a copy to the HSD office of general counsel (OGC).

C. **Jurisdiction and standard of review:** All judicial appeals are based on the record made at the administrative hearing, and in accordance with state statute and court rules. The HSD OGC files a copy of the hearing record with the court clerk and furnishes one copy to the claimant within 30 calendar days after receipt of the notice of appeal. The court may set aside the HSD hearing decision if it finds the decision is: (1) arbitrary, capricious, or an abuse of discretion; (2) is not supported by substantial evidence in the record as a whole; or (3) is otherwise not in accordance with the applicable law.

D. **Benefits pending appeal:** The filing of a notice of appeal shall not stay the enforcement of the HSD decision, but the claimant or the claimant's authorized representative may seek a stay upon motion to the court. If the court orders a stay, HSD, the MCO or the MAD UR contractor will maintain the service at issue in accordance with the court's order. If the final decision is in favor of HSD, and a termination, modification, reduction, or suspension of service was pending the decision on appeal, see Section 19 of this rule for the repayment process.

[8.352.2.22 NMAC - Rp, 8.352.2.18 NMAC, 1-1-14]

HISTORY OF 8.352.2 NMAC:

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

SP-004.0200 Section 4, General Program Administration Hearing For Applicants, 1-23-81

SP-004.2800 Section 4, General Program Administration Appeals Process For Skilled Nursing Facilities And Intermediate Care Facilities, 3-5-81

NMAC History: 8 NMAC 4.MAD.970 Oversight Policies, Recipient Hearing Policies, Recipient Hearings, 10-16-96

8 NMAC 4.MAD.970 Oversight Policies, Recipient Hearing Policies, Recipient Hearings; 12-15-99.

History of Repealed Material:

8.352.2 NMAC, Recipient Hearings, filed 6-15-01 - Repealed effective, 1-1-14.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 352 ADMINISTRATIVE HEARINGS
PART 3 PROVIDER HEARINGS

8.352.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

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

8.352.3.2 SCOPE: The rule applies to the general public.

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

8.352.3.3 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 27-2-12 et seq.

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

8.352.3.4 DURATION: Permanent.

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

8.352.3.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.

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

8.352.3.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

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

8.352.3.7 DEFINITIONS: [RESERVED]

8.352.3.8 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.

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

8.352.3.9 PROVIDER ADMINISTRATIVE HEARINGS: With the exception of referrals for credible allegations of fraud, HSD has established a hearing process for MAD fee-for-service (FFS) providers who disagree with its decision concerning his or her participation as a MAD provider, recoupment of overpayments due to a provider billing error, and the imposition of MAD sanctions. For the provider administrative hearing process concerning decisions on noncompliance with nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) provider certification requirements also see hearing regulations promulgated by the department of health (DOH) and specific MAD New Mexico administrative code (NMAC) rules applicable to the provider. See 8.311.3 NMAC, 8.312.2 NMAC, and 8.313.3 NMAC for a detailed description of the appeals process for audit settlements. See 8.308.14 NMAC for a detailed description of the grievance and appeal process for resolving provider disputes between a HSD contracted managed care organization (MCO) and its contractor or subcontractor. For applicable rules for services and items provided through a MAD coordinated service contractor, see 8.349.2 NMAC.

A. **Provider administrative hearing rights:** The right to a provider administrative hearing includes the right to:

(1) be advised of the nature and availability of a provider administrative hearing;

(2) be represented by his or her authorized representative or legal counsel;

(3) have a provider administrative hearing which safeguards the provider's opportunity to present a case;

(4) have prompt notice and implementation of the final provider administrative hearing decision; and

(5) be advised that judicial review may be invoked to the extent such review is available under state law.

B. **Notice of rights:** Upon enrollment, a MAD provider receives written notice of provider administrative hearing rights along with any MAD action notice concerning provider participation agreement (PPA) termination, recoupment of overpayment due to provider billing error, or notice of sanction. This information includes a description of the method by which a provider administrative hearing may be requested and a statement that the provider's presentation may be made by the provider or by his or her authorized representative or legal counsel.

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

8.352.3.10 INITIATION OF FFS PROVIDER ADMINISTRATIVE HEARING PROCESS:

A. **Notice:** When applicable, the provider administrative hearing process is initiated by a provider's request for hearing made in response to a

MAD action notice. See Section 8.351.2 NMAC for a detailed description of notice requirements when the action is a MAD sanction.

B. **Time limits:** A MAD FFS provider has 30 calendar days from the date of the MAD action notice to request a provider administrative hearing. To be considered timely, the request must be received by the HSD fair hearings bureau (FHB) no later than the close of business of the 30th day. Provider administrative hearings are conducted and a written decision is issued by the MAD director or designee to the provider within 120 calendar days from the date the FHB receives the provider administrative hearing request, unless the parties otherwise agree to an extension. See 8.351.2 NMAC for information concerning time limits when the action is a MAD sanction. The right to request a stay is cited in 8.351.2.15 NMAC.

C. **Scope and limits on provider administrative hearings:**

(1) A provider administrative hearing is available to all MAD FFS providers, including providers applying for electronic health record incentive payments, who submit a request in accordance with all sections of this rule. A provider can request a hearing if:

(a) his or her PPA or renewal of his or her PPA is denied;

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

(c) the provider disagrees with a decision of MAD or its designee with respect to recovery of overpayments due to provider billing error including incorrect billing, or lack of documentation to support the medical necessity of a service, or that the service was provided, or imposition of a sanction or other remedy, with the exception of a temporary payment suspension for credible allegations of fraud; or

(d) the provider believes the requirements for timely filing of a claim as stated in 8.302.2 NMAC were met but a decision by MAD has been made that the timely filing requirements were not met.

(2) **Denial or dismissal of request for provider administrative hearing:** The assigned fair hearing FHB's administrative law judge (ALJ) may recommend to the MAD director in writing to deny or dismiss a provider's request for an administrative hearing when:

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

(b) the request is withdrawn or canceled in writing by the provider, the provider's authorized representative or legal counsel;

(c) the sole issue presented concerns a federal or state statute, regulation or rule which requires an adjustment of compensation for all or certain classes of FFS providers or services unless the reason for the provider administrative hearing request involves an alleged error in the computation of a provider's compensation;

(d) the provider fails to appear at a scheduled provider administrative hearing without good cause; a request for a provider administrative hearing may be considered abandoned and therefore dismissed if the provider, his or her authorized representative or legal counsel fails to appear at the time and place of the hearing, unless, within 10 calendar days after the date of the scheduled provider administrative hearing, the provider presents good cause for failure to appear; good cause includes death in the family, disabling personal illness, or other significant emergencies; at the discretion of the ALJ, other exceptional circumstances may be considered good cause;

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

(f) the matter presented for the provider administrative hearing is outside the scope of issues which are subject to the HSD provider administrative hearing process;

(g) the sole issue presented concerns a HSD contracted MCO or its subcontractor's utilization management decision, such as a decision to terminate, suspend, reduce, or deny services to its member, untimely utilization review, and provider payment issues raised by the MCO or its subcontractor; or

(h) the sole issue presented is regarding a MAD New Mexico administrative code (NMAC) rule rather than the application of the MAD NMAC rule to that provider.

D. **Method:** A request for a provider administrative hearing must be made in writing and must identify the provider and the one or more of the actions stated in Subsection C above.

E. **Acknowledgment of request:** The FHB sends acknowledgment of its receipt of a provider administrative hearing request to the provider in writing, as well as sends an electronic copy via email to the MAD designated administrative hearing staff.

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

8.352.3.11 PRE-HEARING PROCEDURE:

A. **Notice of hearing:** Not less than 30 calendar days before the provider administrative hearing, written notice is given to all parties involved of the time, date, and place of the hearing. If an accommodation is necessary, the party must notify the assigned ALJ at least 10 calendar days prior to the hearing. The FHB includes in its written notice to the provider an explanation of the HSD provider administrative hearing process and procedures, and informs the provider HSD does not pay fees or costs incurred by the provider as a result of the provider administrative hearing or district court appeals of the final HSD provider administrative hearing decision.

B. **Postponement:** A provider may request, and is entitled to receive, one postponement of the scheduled provider administrative hearing, as long as it does not interfere with the 120 calendar day timeframe. Requests for more than one postponement are considered on a case-by-case basis at the ALJ's discretion.

C. **Expedited hearing:** The parties may request an expedited hearing in cases involving a medical assistance program (MAP) eligible recipient's health, safety, or service availability concerns. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. Granting an expedited hearing is at the discretion of the ALJ.

D. **Group hearing:** The ALJ may respond to a series of individual requests for hearings by conducting a single group hearing. In all group hearings, the HSD administrative hearing process governing an individual hearing is followed. Each provider, his or her authorized representative or legal counsel may present his or her case individually. If a group hearing is arranged, each affected provider has the right to withdraw from the group hearing in favor of an individual HSD provider administrative hearing.

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

F. **Pre-hearing conference:** The assigned ALJ schedules a pre-hearing conference within 30 calendar days of the receipt of the provider's request for a HSD provider administrative hearing.

A pre-hearing conference is an informal proceeding and may occur telephonically.

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

(a) expediting the disposition of the action;

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

(c) resolution of some or all issues;

(d) exchange of documents and information;

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

(f) review of audit findings;

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

(h) identifying the number of witnesses; and

(i) facilitating the settlement of the case.

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

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

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

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

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

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

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

(a) statements of any contested facts and issues;

(b) stipulation of matters not in dispute;

(c) list of witnesses to be called and the subject of their testimony;

(d) list of exhibits;

(e) discovery directives; or

(f) other matters relevant to the issues.

(9) **Points of law:** The ALJ may direct the parties to submit memoranda on points of law to inform the final decision, and may dictate the length and scope of the submissions.

G. **Summary of evidence (SOE):** A summary of evidence (SOE) is a document submitted by MAD that provides preliminary information concerning the basis of its or its selected claims and provider enrollment processing contractor's action. The SOE may be amended by MAD at any point prior to the pre-hearing if the ALJ and the provider, his or her authorized representative or legal counsel receives copies of the amended SOE at least two working days of the pre-hearing conference.

(1) The SOE must be provided at least 10 working days prior to the pre-hearing conference or if the pre-hearing conference is not held, within 10 working days prior to the scheduled provider administrative hearing date.

(2) The failure of MAD to timely provide the SOE may, at the ALJ's discretion, result in its exclusion or a continuance of the hearing.

(3) MAD staff or its designee is responsible for the preparation of the SOE and coordination of parties and witnesses. MAD is responsible for the submission of the SOE to all parties.

(4) The summary of evidence shall contain:

(a) the provider's name, telephone number and address and the status of any previous or concurrent appeal through the MAD or its selected claims and provider enrollment processing contractor;

(b) the action, proposed action or inaction being appealed;

(c) information on which the action or proposed action is based with supporting documentation and correspondence; and

(d) applicable federal and state law, regulations, statutes, rules or any combination of these.

H. **Availability of provider evidence:**

(1) The provider, his or her authorized representative or legal counsel will provide at least ten calendar days prior to the hearing to the FHB assigned ALJ any document to be introduced as evidence at the pre-hearing conference. The SOE may be amended by the provider, his or her authorized representative or legal counsel at any point prior to the pre-hearing if the ALJ and MAD receive copies of the amended SOE at least within two working days of the pre-hearing conference. The FHB will forward to the MAD administrative hearings unit copies of such evidence. MAD will then make these available to its selected claims and provider enrollment processing contractor.

(2) Failure of the provider, his or her authorized representative or legal counsel to timely provide the documentary evidence may result in its exclusion or a continuance of the provider administrative hearing at the discretion of the ALJ.

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

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

(2) allow the provider, his or her authorized representative or legal counsel to examine all documents to be used at the provider administrative hearing at a reasonable time before the date of the provider administrative hearing and during such hearings; documents or records which the provider would not otherwise have an opportunity to challenge or contest, may not be introduced at the provider administrative hearing or be taken into consideration by the ALJ.

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

8.353.3.12 HEARING STANDARDS:

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

(1) present their case or have it presented by his or her authorized representative or legal counsel;

(2) bring witnesses to present information relevant to the case;

(3) submit evidence to establish all pertinent facts and circumstances in the case;

(4) advance arguments without undue interference; and

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

B. **ALJ:** Hearings are

conducted by an impartial official, the ALJ, who:

(1) does not have any personal stake or involvement in the case; and

(2) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify him or herself as the ALJ for that specific case.

(3) **Authority and duties of the ALJ:** The ALJ must:

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

(b) administer oaths and affirmations;

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

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

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

(f) produce the provider administrative hearing report and recommendation for review and final decision by the MAD director or designee.

(4) **Appointment of ALJ:** The ALJ is appointed by the HSD FHB chief upon receipt of the request for hearing. All communications are to be addressed to the assigned ALJ.

C. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) **Admissibility:** All evidence is admissible subject to the ALJ's authority to limit irrelevant, repetitive or unduly cumulative evidence and his or her ability to conduct an orderly hearing. The ALJ must admit evidence that is relevant to those allegations against the provider included in the notice of recovery of overpayment, sanction or other remedy, application denial, or application termination.

(2) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the provider administrative hearing in the presence of the provider, his or her authorized representative or legal counsel, and the MAD representative may not be used by the ALJ in making the provider administrative hearing recommendation except as allowed by Subsection E of Section 13 of this part.

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

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

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

D. **Burden of proof:** MAD has the burden of proving the basis to support its proposed action by a preponderance of the evidence. In cases involving the imposition of civil money penalties against a NF provider, MAD's conclusion about the NF's level of noncompliance must be upheld unless clearly erroneous.

E. **Record of the provider administrative hearing:** A hearing is electronically recorded. The recording is placed on file at the FHB and is available to the parties for 60 calendar days following the decision. In addition to the recorded proceedings, the record of the provider administrative hearing includes any pleadings, documents, or other exhibits admitted into evidence. Any of the parties to the provider administrative hearing may request one digital copy of the recordings without charge. Subsequent copies will be charged at a rate HSD sets for any other digital request.

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

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

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

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

(1) opening statements of parties or their representatives;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by the MAD representative;

(b) cross examination by the provider, his or her authorized representative or legal counsel; and

(c) opportunity to redirect the witness;

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

(a) examination by provider, his or her authorized representative or legal counsel;

(b) cross examination by MAD or its selected claims and provider enrollment processing contractor; and

(c) opportunity to redirect the witness;

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

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

(6) the ALJ may ask parties to summarize and present closing arguments.

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

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

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

F. **Re-opening a hearing:** The ALJ, at his or her discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to

resolution of a provider administrative hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision timeframes. Written notice of the date, time and place of the re-opened hearing is sent by the FHB to the parties not less than 10 calendar days before the date of the re-opened provider administrative hearing.
[8.352.3.13 NMAC - N, 1-1-14]

8.352.3.14 HEARING DECISION: The final HSD provider administrative hearing decision concerning the hearing is made by the MAD director or designee after review of the record and the ALJ's report and recommendation.

A. **Decision based on the record:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director or designee specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these. No person who participated in the original action under appeal or in the provider administrative hearing may participate in arriving at a final decision.

B. **ALJ recommendation:** The ALJ reviews the record of the provider administrative hearing and all applicable federal and state law, regulations and NMAC rules, policy and instructions or any combination of these, and evaluates the evidence submitted. The ALJ submits the complete record of the hearing, along with his or her written recommendation to the MAD director.

(1) Content of recommendation. The ALJ specifies the reasons for his or her conclusions, identifies the supporting evidence, references the applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these, and responds to the arguments of the parties in a written report and recommendation.

(2) The ALJ recommends:

(a) in favor of the provider if MAD's action or proposed action is not supported by a preponderance of the evidence available as a result of the provider administrative hearing;

(b) in favor of MAD, if the preponderance of the evidence available supports the action or proposed action; or

(c) any other result supported by the record.

C. **Review of recommendation:** The provider administrative hearing file and recommendation are reviewed by the MAD director or designee to ensure conformity with applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these.

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

E. **Notice to parties:** The parties receive the written decision, including the effective date of sanctions, terms of sanctions, and amounts of overpayment to be recovered by MAD. When the provider is represented by legal counsel, counsel must receive the decision. The notice of the decision includes an explanation that the parties have exhausted all administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.
[8.352.3.14 NMAC - N, 1-1-14]

8.352.3.15 IMPLEMENTATION OF DECISION: The final HSD provider administrative hearing decision is binding on all issues that were the subject of a hearing, as to the provider, unless stayed by court order pending appeal. The decision is implemented within the time frames specified below.

A. **Decision favorable to HSD:** Decisions favorable to MAD are implemented immediately, unless stayed by court order.

B. **Decision favorable to provider:** If the decision is in favor of the provider, MAD must immediately lift any sanctions in place and remit to the provider any funds being held pending the decision.
[8.352.3.15 NMAC - N, 1-1-14]

8.352.3.16 JUDICIAL REVIEW:

A. **Right of appeal:** If the final HSD provider administrative hearing decision upholds MAD's original action or proposed action, the provider has the right to pursue judicial review of the decision and is so notified of that right in the decision.

B. **Timeliness:** The provider has 30 calendar days from the date of the provider administrative hearing decision to appeal that decision by filing an appropriate action for judicial review with the clerk of the first judicial district court and sending a copy of the notice of action to HSD and the ALJ.

C. **Jurisdiction and standard:** All appeals to the district court are based on a review of the record made at the hearing. The HSD office of general counsel files one copy of the hearing record with the clerk of the first judicial district court and furnishes one copy to the provider and his or her counsel within 20 calendar days after receipt of the notice of appeal.

D. **Stay pending appeal:** The district court decides, upon motion duly filed, whether the filing of the appeal will operate as a stay of the HSD final provider administrative hearing decision. If a stay is granted, the office of general counsel notifies appropriate staff concerning any necessary action.
[8.352.3.16 NMAC - N, 1-1-14]

HISTORY OF 8.352.3 NMAC: [RESERVED]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.10.2 NMAC, Sections 9 and 10, effective January 15, 2014.

16.10.2.9 MEDICAL LICENSE BY EXAMINATION.

A. Prerequisites for licensure. Each applicant for a license to practice as a medical doctor in New Mexico must possess the following qualifications:

(1) graduated and received a diploma from a board approved school, completed a program determined by the board to be substantially equivalent to a U.S. medical school, based on board review of an evaluation by a board approved credential evaluation service, or the board shall, in its sole discretion, determine if the applicant's total educational and professional clinical experience is substantially equivalent to that which is required for licensure in New Mexico; and

(2) successfully passed one of the examinations or combinations of examinations defined in 16.10.3 NMAC; and

(3) completed two years of postgraduate training or been approved by the board in accordance with the provisions of Subsection B of Section 61-6-11 NMSA 1978;

(4) when the board has reason to believe that an applicant for licensure is not competent to practice medicine it may require the applicant to complete a special competency examination or to be evaluated for competence by other means that have been approved by the board; and

(5) a qualified applicant who has

not been actively and continuously in practice for more than two years prior to application may be required to successfully complete a special examination or evaluation such as, but not limited to, the SPEX (special purpose examination), the PLAS (post-licensure assessment system of the federation of state medical boards), or specialty re-certification.

B. Required documentation for all applicants. Each applicant for a license must submit the required fees as specified in 16.10.9.8 NMAC and the following documentation:

(1) a completed signed application with a passport-quality photo taken within the previous six months; applications are valid for one year from the date of receipt by the board;

(2) verification of licensure in all states or territories where the applicant holds or has held a license to practice medicine, or other health care profession; verification must be received directly from the other state board(s), and must attest to the status, issue date, license number, and other information requested and contained on the form; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board;

(3) two recommendation forms from physicians, chiefs of staff or department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine; the recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance; forms must be sent directly to the board from the recommending physician; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board;

(4) verification of all work experience and hospital affiliations in the last [~~five~~] two years, if applicable, not to include postgraduate training; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board;

(5) a copy of all American board of medical specialties (ABMS) specialty board certifications, if applicable; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board; and

(6) the board may request that applicants be investigated by the biographical section of the American medical association (AMA), the drug enforcement administration (DEA), the federation of state medical boards (FSMB), the national practitioner data bank, and other sources as may be deemed appropriate by the board;

(7) applicants who are not United States citizens must provide proof that they are in compliance with the immigration laws of the United States.

C. Additional documentation for applicants using the FCVS. Applicants are encouraged to use the FCVS as once a credential file is created future applications for medical licensure will be streamlined. However, application through FCVS is not required. Applicants using the FCVS must submit a completed application to the FCVS, who will provide primary source documentation to the board. Only the documents required in Subsection B of 16.10.2.9 are required in addition to the FCVS report.

D. Additional documentation for applicants using HSC or another board-approved credentials verification service.

(1) status report of educational commission for foreign medical graduates (ECFMG) certification sent directly to the board from ECFMG, if applicable;

(2) copy of ECFMG interim letter documenting additional postgraduate training for international medical graduates applying through the fifth pathway process, if applicable;

(3) certified transcripts of exam scores as required in 16.10.3 NMAC sent directly to the board from the testing agency;

(4) proof of identity may be required; acceptable documents include birth certificate, passport, naturalization documents, and visas.

E. Additional documentation for applicants applying directly to New Mexico and not using FCVS or HSC or another board-approved credentials verification service.

(1) verification of medical education form with school seal or notarized, sent directly to the board from the school;

(2) transcripts sent directly to the board from the medical school;

(3) status report of ECFMG certification sent directly to the board from ECFMG, if applicable;

(4) copy of ECFMG interim letter documenting additional postgraduate training for international medical graduates applying through the fifth pathway process, if applicable;

(5) postgraduate training form sent to the board directly from the training program;

(6) certified transcripts of exam scores as required in 16.10.3 NMAC sent directly to the board from the testing agency; and

(7) proof of identity may be required; acceptable documents include birth certificate, passport, naturalization documents, and visas;

(8) certified copies of source documents obtained directly from another state licensing jurisdiction who has the original document on file will be accepted in lieu of original documents when the originals cannot be obtained for a valid cause.

F. Licensure process. Upon receipt of a completed application, including all required documentation and fees, the applicant may be scheduled for a personal interview before the board, a board member designated by the board, or an agent of the board and must present original documents as requested by the board. The initial license will be issued following completion of any required interview, or approval by a member or agent of the board.

G. Initial license expiration. Medical licenses shall be renewed on July 1 following the date of issue. Initial licenses are valid for a period of not more than thirteen months or less than one month. If New Mexico is the first state of licensure, initial licenses are valid for a period of not less than twenty-four months or more than thirty-five months and shall be renewed on July 1.

[16.10.2.9 NMAC - N, 5/1/02; A, 1/20/03; A, 7/1/03; A, 4/3/05; A, 10/7/05; A, 7/1/06; A, 1/10/07; A, 1/3/08; A, 10/11/13; A, 01/15/14]

16.10.2.10 MEDICAL LICENSE BY ENDORSEMENT.

A. Prerequisites for licensure. Each applicant for a license to practice as a medical doctor in New Mexico by endorsement must be of good moral character, hold a full and unrestricted license to practice medicine in another state, and possess the following qualifications:

(1) have practiced medicine in the United States or Canada immediately preceding the application for at least three years;

(2) be free of disciplinary history, license restrictions, or pending investigations in all jurisdictions where a medical license is or has been held;

(3) graduated from a board approved school or hold current ECFMG certification; and

(4) current certification from a medical specialty board recognized by the ABMS.

B. Required documentation for all applicants. Each applicant for a license must submit the

required fees as specified in 16.10.9.8 NMAC and the following documentation:

(1) a completed signed application with a passport-quality photo taken within the previous six months; applications are valid for one year from the date of receipt by the board;

(2) verification of licensure in all states or territories where the applicant holds or has held a license to practice medicine, or other health care profession; verification must be received directly from the other state board(s), and must attest to the status, issue date, license number, and other information requested and contained on the form;

(3) two recommendation forms from physicians, chiefs of staff or department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine; the recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance; forms must be sent directly to the board from the recommending physician; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board;

(4) verification of all work experience and hospital affiliations in the last [~~five~~] three years, if applicable, not to include postgraduate training; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board;

(5) a copy of all ABMS specialty board certifications, if applicable; this information will be provided by HSC or another board-approved credentials verification service for applicants using that service, or directly to the New Mexico medical board; and

(6) the board may request that applicants be investigated by the biographical section of the AMA, the DEA, the FSMB, the national practitioner data bank, and other sources as may be deemed appropriate by the board;

(7) applicants who are not U.S. citizens must provide proof that they are in compliance with the immigration laws of the United States.

C. Licensure process. Upon receipt of a completed application, including all required documentation and fees, the applicant may be scheduled for a personal interview before the board, a board member designated by the board, or an agent of the board and must present original documents as requested by the board. The initial license will be issued following completion of any required interview, or approval by a member or agent of the board.

D. Initial license expiration. Medical licenses shall be renewed on July 1 following the date of issue. Initial licenses are valid for a period of not more than thirteen months or less than one month.

[16.10.2.10 NMAC - N, 1/20/03; A, 7/1/03; A, 4/3/05; A, 10/7/05; A, 7/1/06; A, 1/10/07; A, 10/11/13; A, 01/15/14]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.10.15 NMAC, Sections 7 and 9, effective January 15, 2014.

16.10.15.7 DEFINITIONS:

A. "AAPA" means American academy of physician assistants.

B. "Alternate supervising physician" means a physician who holds a current unrestricted New Mexico medical license, is a cosignatory on the notification of supervision, agrees to act as the supervising physician in the supervising physician's absence and is approved by the board.

C. "Interim permit" means a document issued by the board that allows a physician assistant to practice pending completion of all licensing requirements.

D. "Effective supervision" means the exercise of physician oversight, control, and direction of services rendered by a physician assistant. Elements of effective supervision include:

(1) on-going availability of direct communication, either face-to-face or by electronic means;

(2) active, ongoing review of the physician assistants services, as appropriate, for quality assurance and professional support;

(3) delineation of a predetermined plan for emergency situations, including unplanned absence of the primary supervising physician; and

(4) identification and registration of alternate supervising physicians, as appropriate to the practice setting.

E. "Lapsed" means a license that has not been renewed by March 1 of the expiration year and has been suspended for non-renewal. A license that has lapsed is not valid for practice in New Mexico.

F. "Nationwide criminal history record" means information concerning a person's arrests, indictments, or other formal criminal charges and any dispositions arising there from, including convictions, dismissals, acquittals, sentencing and correctional supervision, collected by criminal justice agencies and stored in the computerized databases of the federal bureau of investigation, the national law enforcement telecommunications systems, the department of public safety or the repositories of criminal history information in other states.

G. "Nationwide criminal history screening" means a criminal history background investigation of an applicant for licensure by examination or endorsement, or a licensee applying for licensure renewal, through the use of fingerprints reviewed by the department of public safety and submitted to the federal bureau of investigation, resulting in the generation of a nationwide criminal history record for that applicant.

H. "NCCPA" means national commission on certification of physician assistants.

I. "Direct communication" means communication between the supervising physician and physician assistant, in person, telephonically, by two-way radio, by email or other electronic means.

J. "Scope of practice" means duties and limitations of duties placed upon a physician assistant by their supervising physician and the board; includes the limitations implied by the field of practice of the supervising physician.

K. "Statewide criminal history record" means information concerning a person's arrests, indictments, or other formal criminal charges and any dispositions arising there from, including convictions, dismissals, acquittals, sentencing and correctional supervision, collected by criminal justice agencies and stored in the computerized database of the department of public safety or the repositories of criminal history information in municipal jurisdictions.

L. "Statewide criminal history screening" means a criminal history background investigation of a licensee applying for licensure renewal through the use of fingerprints submitted to the department of public safety and resulting in the generation of a statewide criminal history record for that licensee.

M. "Supervising physician" means a physician who holds a current unrestricted license, provides a notification of supervision, assumes legal responsibility for health care tasks performed by the physician assistant and is approved by the board. A physician under an active monitoring contract with the New Mexico monitored treatment program who meets the other qualifications of this subsection may also act as a supervising physician.

N. "Suspended for non-renewal" means a license that has not been renewed by May 31 of the expiration year, and has at the discretion of the board, been lapsed.

O. "Emergency

supervising physician" means a physician who is responsible for the operations of a team or group of health professionals, including physician assistants, who are responding to a major disaster.

P. "Major disaster" means a declaration of a major disaster by the federal emergency management agency (FEMA).

Q. "Military service member" means a person who is serving in the armed forces of the United States or in a reserve component of the armed forces of the United States, including the national guard.

R. "Recent veteran" means a person who has received an honorable discharge or separation from military service within the two years immediately preceding the date the person applies for a physician assistant license pursuant to section 16.10.15.20 NMAC. The veteran shall submit a copy of form DD214, or its equivalent, as part of the application process.

[16.10.15.7 NMAC - Rp 16 NMAC 10.15.7, 7/15/01; A, 10/7/05; A, 12/30/05; A, 7/1/06; A, 9/27/07; A, 9/21/09; A, 10/11/13; A, 01/15/14]

16.10.15.9 LICENSURE PROCESS: Each applicant for a license as a physician assistant shall submit the required fees and following documentation.

A. A completed application for which the applicant has supplied all information and correspondence requested by the board on forms and in a manner acceptable to the board. Applications are valid for one year from the date of receipt.

B. Two letters of recommendation from physicians licensed to practice medicine in the United States or physician assistant program directors, or the director's designee, who have personal knowledge of the applicant's moral character and competence to practice. Letters of recommendation must be sent directly to the board from the individual recommending the applicant.

C. Verification of licensure in all states where the applicant holds or has held a license to practice as a physician assistant, or other health care profession. Verification must be sent directly to the board from the other state board(s). Verification must include a raised seal; attest to current status, issue date, license number, and all other related information.

D. Verification of all work experience in the last [~~five~~] two years, if applicable, provided directly to the board.

E. All applicants may be required to personally appear before the board or the board's designee for an interview and must present original documents, as the board requires. The initial license will be issued following completion of any required interview, or approval by a member or agent of the board.

F. The initial license is valid until March 1 of the year following NCCPA expiration.

G. License by endorsement from New Mexico board of osteopathic examiners. Applicants who are currently licensed in good standing by the New Mexico board of osteopathic examiners may be licensed by endorsement upon receipt of a verification of licensure directly from the New Mexico board of osteopathic examiners, a supervising physician form signed by the M.D. who will serve as supervising or alternate supervising physician, and a fee of $25.00.

H. All applicants for initial licensure as a physician assistant are subject to a state and national criminal history screening at their expense. All applicants must submit two full sets of fingerprints, completed fingerprint certificate form, signed authorization for criminal background screening and fee at the time of application.

(1) Applications for licensure will not be processed without submission of fingerprints, completed fingerprint certificate form, signed authorization for criminal background screening and fee.

(2) Applications will be processed pending the completion of the nationwide criminal background screening and may be granted while the screening is still pending.

(3) If the criminal background screening reveals a felony or a violation of the Medical Practice Act, the applicant/licensee will be notified to submit copies of legal documents and other related information to the board which will make the determination if the applicant is eligible for licensure or if disciplinary action will be taken.

[16.10.15.9 NMAC - N, 7/15/01; A, 10/5/03; A, 8/6/04; A, 10/7/05; A, 7/1/06; A, 9/27/07; A, 10/11/13; A, 01/15/14]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.100 NMAC, amending Section 7, effective 12/30/13.

2.80.100.7 DEFINITIONS: As used in the Public Employees Retirement Act:

A. "Accumulated member contributions" means amounts deducted from the salary of a member and credited to the member's individual account, together with interest if any, credited to that account; it also includes repaid withdrawn contributions not including interest paid thereon, or amounts paid to purchase service credit as allowed under the PERA Act.

B. "Active duty" for purposes of acquiring service credit under NMSA 1978, Section 10-11-7, as amended, for periods of active duty with uniformed service of the United States, means full-time duty in the active uniformed service of the United States, including full-time training duty, annual training duty, and attendance while in the active military service, at a school designated as a service school by law or by the secretary of the military department concerned. "Active duty" does not include full-time national guard duty, which is training or other duty performed by a member of the air or army national guard of a state or territory, for which the member is entitled to pay from the United States or for which the member has waived pay from the United States. "Active duty" includes duty in the full-time military service reserve components activated pursuant to a federal call to duty, deployment for a peacekeeping mission or other declared national emergency.

C. "Adult correctional officer member" means a person who is an adult correctional officer or an adult correctional officer specialist employed by the corrections department or its successor agency.

D. "Another retirement program" means retirement plans established by the Judicial Retirement Act, Magistrate Retirement Act, and the Educational Retirement Act.

E. "Elected official" means a person elected to a public office by registered voters, who is paid a salary; "elected official" includes a person who is appointed to fill an unexpired term of an elected public office, who is paid a salary.

F. "Filed" means that PERA has received the complete document as evidenced by a writing on the document indicating the date of receipt by PERA.

G. "Fire member" means any member who is employed as a firefighter by an affiliated public employer, is paid a salary and has taken the oath prescribed for firefighters. The term shall not include volunteer firefighters or any civilian employees of a fire department.

H. [~~"Hazardous duty member" means a juvenile correctional officer employed by the children, youth and families department or its successor agency, but does not include any member who is a "police member" or a "fire member". A hazardous duty member shall, however, be considered a state policeman for federal Social Security Act purposes.~~] "Juvenile correctional officer member" means a member who is employed as a juvenile correctional officer by the children, youth and families department or its successor agency, but does not include any member who is a

"police member" or a "fire member".

I. "Leave office" means an elected official's successor has been duly elected or appointed and qualified for office, or upon the date of death of an elected official.

J. "Legal representative" means "personal representative" as defined in the Probate Code of New Mexico which includes executor, administrator, successor personal representative, special administrator and persons who perform substantially the same functions under the law governing their status, or an attorney or a person acting pursuant to a power of attorney for a member, retired member or beneficiary.

K. "Municipal detention officer" means a member who is employed by an affiliated public employer other than the state who has inmate custodial responsibilities at a facility used for the confinement of persons charged or convicted of a violation of a law or ordinance. "Municipal detention officer" includes both juvenile and adult municipal detention officers.

L. "Permissive service credit" means service credit recognized by the retirement system for purposes of calculating a member's retirement benefit, which is available only by making a voluntary additional contribution which does not exceed the amount necessary to fund the benefit attributable to such service credit.

M. "Police member" means any member who is employed as a police officer by an affiliated public employer, who is paid a salary, and who has taken the oath prescribed for police officers. The term shall not include volunteers,[~~hazardous duty members~~] juvenile correctional officer members, or employees who do not perform primarily police functions including, but not limited to jailers, cooks, matrons, radio operators, meter checkers, pound employees, crossing guards, police judges, park conservation officers, and game wardens. A member who is employed by an affiliated public employer as a police officer and as a non-police officer employee shall be regarded as a police member if more than fifty percent of the member's total salary is paid as a police officer.

N. "Private retirement program" for the purpose of exclusion from membership under NMSA 1978, Section 10-11-3(B)(5) means a retirement program of the affiliated public employer which meets the internal revenue service minimum standards regarding benefits as outlined in 26 C.F.R. Section 31.3121(b) (7)F of the Employment Tax Regulations and IRS Rev. Proc. 91-40.

O. "Reenlistment" as used in NMSA 1978, Section 10-11-6(A)(3), means enlistment or voluntary entry into one of the armed services as either enlisted personnel or as a commissioned officer.

P. "Retired member" means a person who is being paid a normal, deferred or disability pension on account of that person's membership in the association. "Retired member" shall not include any persons receiving a pre-retirement survivor pension, post-retirement survivor pension, or reciprocity retirement pension where the payer system is not PERA, or any other person unless specifically included by definition as a "retired member".

Q. "Salary" means the base salary or wages paid a member, including longevity pay, for personal services rendered to an affiliated public employer. "Salary" includes a member's fixed, periodical compensation from full or part time employment; shift differentials; and wages paid while absent from work on account of vacation, holiday, injury or illness, which means payment made by continuing the member on the regular payroll. "Salary" includes incentive pay that is not temporary and becomes part of member's base salary. "Salary" also includes temporary promotions, temporary salary increases, but no other temporary differentials. "Salary" shall not include overtime pay, allowances for housing, clothing, equipment or travel, payments for unused sick leave, unless the unused sick leave payment is made through continuation of the member on the regular payroll for the period represented by that payment. "Salary" also does not include lump sum payments which are not part of the member's fixed periodical compensation, such as lump sum annual and sick leave or occasional payments to elected officials for attending meetings, allowances for any purpose, employer contributions to a private retirement program, or other fringe benefits, even if they are paid to or for a member on a regular basis, and any other form of remuneration not specifically designated by law as included in salary for Public Employees Retirement Act purposes.

R. "State legislator member" means a person who is currently serving or who has served as a state legislator or lieutenant governor and who has elected to participate in a state legislator member coverage plan. A former legislator or former lieutenant governor may be a "state legislator member" whether or not currently receiving a pension under a state legislator member coverage plan.

S. "State system" means a retirement program provided for in the Public Employees Retirement Act, Magistrate Retirement Act, or Judicial Retirement Act.

T. "Terminate employment" means that a member has a complete break in service and an absolute cessation of employment with all affiliated public employers, including employment as an elected official, as evidenced by a personnel action form or other equivalent document, and the member is not reemployed by an affiliated public employer for 30 days; or upon the date of death of a member.

[10-15-97; 11-15-97; 1-15-99; 12-15-99; 2.80.100.7 NMAC - Rn & A, 2 NMAC 80.100.7, 12-28-00; A, 12-28-01; A, 9-30-03; A, 6-30-05; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.500 NMAC, amending Section 8, effective 12/30/13.

2.80.500.8 REMITTANCE OF CONTRIBUTIONS

A. In accordance with the Public Employees Retirement Act each state agency or affiliated public employer shall be responsible for deducting the applicable contribution from the salary or wages paid to each member for each payroll period.

B. The employer shall transmit to PERA the member and employer contributions for every member in its employ for each pay period on or before the fifth working day following the payday applicable to the pay period. The contributions shall be accompanied by a transmittal report in a format designated by PERA, which shall clearly set forth the amount of employer and member contributions, and adjustments for prior pay periods if applicable, transmitted.

C. Except as provided in subsection H below, interest will be assessed on any remittance of employee and employer contributions not made by the due date of the remittance. The rate of interest shall be set annually by the board at a July meeting and shall be effective beginning the next succeeding January 1st. Any interest paid on unremitted contributions shall not be posted to the member's account or refunded to the member or the employer.

D. Except as provided in subsection H below, a penalty of fifty dollars ($50) per day shall be assessed for any employee and employer contribution transmittal report that is untimely. For purposes of this subsection, "untimely" is defined as fifteen (15) days after the end of the month in which the transmittal report was due.

E. In the event the employer fails to make the necessary deductions, the employer shall be responsible to remit to PERA the total amount due for both the member and employer contributions plus interest as provided in subsection C above.

F. Pick-up of member contributions

(1) If an employer has adopted

a resolution or executed a collective bargaining agreement pursuant to NMSA 1978, Section 10-11-5 which obligates the employer to pay up to 75% of the members' contributions, the resolution or collective bargaining agreement shall become effective on the first day of the first full pay period of the month following filing of the resolution or collective bargaining agreement with the retirement board. PERA may refuse for filing a resolution containing conditions or contingencies, or not prepared in compliance with requirements for such resolutions approved by the PERA board. "First full pay period" for purposes of adopting a new coverage plan shall mean the first pay period that ends within the month in which the new coverage plan becomes applicable to a member.

(2) Under the Internal Revenue Code Section 414(h), an employer can pick up 100% of member contributions, but only 75% of the contributions are additional salary.

(3) Member contributions picked-up by the employer under NMSA 1978, Section 10-11-125 are not considered compensation for purposes of Internal Revenue Code Section 415(c).

G. Current employer contributions may not be made by members except as authorized by law.

H. If an employer, for good cause, is unable to timely transmit employee and employer contributions or transmittal report, the employer shall notify PERA in writing at least twenty-four (24) hours prior to the due date, and may request waiver of the interest or penalty that would otherwise be assessed. The executive director may waive interest or penalty for up to thirty-one (31) calendar days. Interest shall thereafter be charged at the rate set in subsection C above.

I. [~~Beginning January 1, 2009, to the extent required by Internal Revenue Code Sections 3401(h) and Section 414(u)(2), an individual receiving differential wage payments (as defined under Internal Revenue Code Section 3401(h)(2)) while the individual is performing qualified military service as defined in Chapter 43 of Title 38, United States Code, from an affiliated public employer shall be treated as employed by that employer and the differential wage payment shall be treated as earned compensation. However, contributions attributable to such differential wage payments shall not be made unless and until the member returns to active employment and makes up the missed contributions. This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.~~] Beginning January 1, 2009, to the extent required by Internal Revenue Code Section 414(u)(2), an individual receiving differential wage payments (as defined under Internal Revenue Code Section 3401(h)(2)) from an affiliated public employer shall be treated as employed by that employer and the differential wage payment shall be treated as compensation for purposes of applying the limits on annual additions under Internal Revenue Code Section 415(c). This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

[10-15-97; 11-15-97; 12-15-99; 2.80.500.8 NMAC - Rn & A, 2 NMAC 80.500.8, 12-28-01; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.600 NMAC, amending Sections 7, 10 and 20, effective 12/30/13.

2.80.600.7 DEFINITIONS: [~~Reserved~~]

A. "Full-time employee" means an employee who normally works eighty (80) hours in an eighty (80) hour pay period or forty (40) hours in a week.

B. "Part-time employee" means an employee who works forty (40) or more hours but less than eighty (80) hours in an eighty (80) hour pay period or twenty (20) or more hours but less than forty (40) hours in a week.

[2.80.600.7 NMAC - Rn, 2 NMAC 80.600.7, 8-15-01; A, 12-30-13]

2.80.600.10 GENERAL PROVISIONS

A. Service shall be credited to the nearest month.

(1) Members may receive one month of service credit for any calendar month in which the member becomes a member on or before the sixteenth day of that month, or for any calendar month in which the member leaves office or terminates employment on or after the fifteenth day of the month, provided that all other requirements for awarding service credit are met.

(2) A member who is a full-time employee of an affiliated public employer shall acquire one month of service credit for every calendar month in which the member is paid 50% or more of his or her monthly salary as reported by the member's affiliated public employer.

(3) If a member who is a full-time employee of an affiliated public employer is paid less than 50% of the member's monthly salary as reported by the member's affiliated public employer, employer and member contributions shall be paid on any salary paid during that month, and the member contributions shall be posted to the member's individual member contribution account, but no service credit shall be acquired for that month, even if unpaid leave was taken pursuant to the Family Medical Leave Act.

(4) On and before June 30, 2014, a member who is a part-time employee of an affiliated public employer shall acquire one month of service credit for every calendar month in which the member works twenty (20) or more hours per week, totaling forty (40) or more hours in an eighty (80) hour pay period as reported by the member's affiliated public employer. [~~A part-time employee is an employee who works forty (40) or more hours but less than eighty (80) hours in an eighty (80) hour pay period or twenty (20) or more hours but less than forty (40) hours in a week.~~]

(a) Notwithstanding any other provision of 2.80.600.10 NMAC, part-time employees who normally work at least twenty (20) hours in a week and who were furloughed pursuant to executive order issued between July 1, 2009 and June 30, 2010 shall acquire one month of service credit for each month affected by a furlough day. This amendment was adopted as an emergency rule to allow part-time employees to acquire service credit they would otherwise be eligible for absent the executive order. Immediate adoption of this amendment is necessary for the general welfare of the association.

(b) Notwithstanding any other provision of 2.80.600.10 NMAC, part-time employees who normally work at least twenty (20) hours in a week and who were furloughed in January and February, 2010 as a result of the second judicial district court's furlough plan shall acquire one month of service credit for each month affected by a furlough day.

(c) Notwithstanding any other provision of 2.80.600.10 NMAC, part-time employees who normally work at least twenty (20) hours in a week and who were furloughed in May and June, 2010 as a result of the city of Rio Rancho's resolution no. 43 furlough plan shall acquire one month of service credit for each month affected by a furlough day.

(5) On and after July 1, 2014, a member who is a part-time employee of an affiliated public employer shall acquire one (1) month of service credit for every calendar month in which the member works thirty two (32) or more hours per week, totaling sixty four (64) or more hours in an eighty (80) hour pay period as reported by the member's affiliated public employer. On and after July 1, 2014, a member who is a part-time employee of an affiliated public employer shall acquire one (1) month of service credit for every two (2) calendar months in which the member works twenty (20) or more, but less than thirty two (32) hours per week, totaling forty (40) or more hours in an eighty (80) hour pay period as

reported by the member's affiliated public employer.

(6) If a member who is a part-time employee does not qualify for service credit, employer and member contributions shall be paid on any salary paid during that month, and the member contributions shall be posted to the member's individual member contribution account, but no service credit shall be acquired.

B. [~~A part-time~~] An employee who works fewer than forty (40) hours in an eighty (80) hour pay period or fewer than twenty (20) hours in a forty (40) hour week shall be exempt from membership by filing a PERA exclusion from membership form pursuant to 2.80.400.40 NMAC.

C. If a member has an incomplete contract to purchase service credit at the time of termination of employment, the contract must be paid in full within thirty (30) days of termination or the amount already paid under the contract will be refunded and no corresponding service credit will be granted.

D. Overlapping service credit.

(1) If a member has service credit for the same period of time for employment by public employers covered under different state systems, service credit may only be acquired under one state system for the period of overlapping service credit. In no case shall a member be credited with more than one month of service credit for all service in any calendar month.

(2) If a member accrues service credit under PERA and another state system for an overlapping period, the member shall be granted service credit for this overlapping period in accordance with all applicable statutes and rules that provide for the highest pension factor.

[10-15-97; 11-15-97; 12-15-99; 2.80.600.10 NMAC - Rn, 2 NMAC 80.600.10, 8-15-01; A, 9-30-03; A/E, 5-28-10; A, 9-30-10; A, 12-30-13]

2.80.600.20 SERVICE CREDIT

A. In order to claim service credit for service rendered prior to August 1, 1947 or for a period prior to the employer becoming an affiliated public employer, a member shall:

(1) file a claim for the period of employment showing specific beginning and ending dates of employment;

(2) provide certification of employment to the association for the period or periods claimed as prior service;

(3) file an affidavit, to be certified and signed by two other persons who know of the employment, together with any additional documentary evidence available which may be required by the board if no records are available for the period of prior service claimed;

(4) provide payroll records, personnel action forms showing hire date(s), term of employment, full-time or part-time, job classification, salary amounts and dates of personnel actions, job description, if any;

(5) contribution history from the federal social security administration for the claimed period of employment, if applicable.

B. Forfeited service credit may be reinstated by repayment of withdrawn member contributions, together with interest from the date of withdrawal to the date of repayment at the rate or rates set by the board, under the following conditions:

(1) Service credit may be reinstated in one-year increments, beginning with the most recently forfeited service credit. A one-year increment is 12 consecutive but not necessarily continuous months of service credit. For the purpose of eligibility to retire only, less than one year of service credit may be purchased. After reinstatement of all 12-month "years" as defined herein, any remaining service credit that totals less than 12 months may be reinstated by payment in one lump sum as provided herein.

(2) All forfeited service credit may also be reinstated by repayment of the total amount of all member contributions withdrawn from each period of service together with interest from the date of withdrawal to the date of repayment at the rate set by the board.

(3) A former member who is employed by an employer covered under the Educational Retirement Act must provide evidence of current contributing membership in the educational retirement association; such evidence shall be either certification by the employer, in the form prescribed by the association, or certification by the educational retirement association (ERA).

(4) Payment for reinstated service credit must be received by the association prior to the member's effective date of retirement.

(5) Interest received to reinstate forfeited service credit under this subsection shall not be refunded to the member. The purchase cost received to reinstate forfeited service credit which is determined to be unnecessary to provide the maximum pension applicable to the member and which is purchased in reliance on information provided by PERA shall be refunded to the member.

C. "Actual credited service" for purposes of NMSA 1978, Section 10-11-27 and Section 10-11-115.2 means only that service credit earned during periods of employment with the New Mexico state police in the positions of patrolman, sergeant, lieutenant, captain or aircraft division pilot, with the corrections department or its successor agency after July 1, 2004 in the positions of adult correctional officer or adult correctional officer specialist, or as a municipal detention officer member. No permissive service credit which is purchased by state police members, adult correctional officer members, or municipal detention officer members shall be increased by 20% as provided in NMSA 1978, Section 10-11-27 or Section 10-11-115.2. With respect to service credit acquired for periods of military service, only that service credit which is acquired for intervening military service during a period of employment as a state police member, an adult correctional officer member after July 1, 2004 or as a municipal detention officer member shall be increased by 20%, provided that the member was a retired member or a member on June 30, 2013.

D. Military service credit is free in some cases and may be purchased in other cases as provided by statute.

(1) Where a member wishes to claim service credit pursuant to NMSA 1978, Section 10-11-6 the association shall, upon the member's request, furnish that member a form of affidavit for completion and certification of such service. The affidavit shall be accompanied by documentary evidence of the member's entry and discharge from service in a uniformed service of the United States.

(2) The affiliated public employer by whom the member was employed immediately prior to entering a uniformed service of the United States shall certify in writing the date the member stopped rendering personal service to the employer. This requirement may be waived if PERA records contain sufficient documentation to support the date the member stopped rendering personal service.

(3) The affiliated public employer by whom the member was employed immediately after discharge from a uniformed service of the United States shall certify in writing to the association the date the member started rendering personal service to the employer. This requirement may be waived if PERA records contain sufficient documentation of the date of return to employment. Members who are not reemployed by an affiliated public employer within ninety days following termination of the period of intervening service but who nevertheless claim reemployment rights under federal law shall provide to the association written certification from the affiliated public employer that the member is entitled to reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

(4) The affidavit, employer certifications, and documentary evidence of uniformed service shall be presented to the association for approval.

(5) Service credit for periods of

intervening service in the uniformed services following voluntary enlistment, reenlistment or appointment shall be awarded only upon compliance by the member and the affiliated public employer with the provisions of NMSA 1978, Section 10-11-6, as amended, and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, including but not limited to the payment to the association of contributions required from the member and the employer.

(6) PERA members who are also members of the military service reserve components who are activated pursuant to a federal call to duty, deployment or peacekeeping mission or other declared national emergency may receive free service credit subject to the conditions of this section. The member must provide a form DD 214 or other documentation as required by PERA to support an award of free service credit.

(7) Payment for military service credit must be received by the association prior to the member's effective date of retirement.

E. A member who claims service credit for one or more periods of employment for which an employer failed to remit the required contributions to the association may receive service credit only after receipt by the association of payment by the employer of the delinquent contributions plus applicable interest and penalties, if any, along with the following documentation:

(1) payroll records for the claimed periods of employment, indicating the salary for the claimed employment dates;

(2) personnel action forms showing hire date(s), term of employment, job classification, salary amounts and dates of personnel actions;

(3) job description;

(4) contribution history from the federal social security administration for the claimed period of employment, if applicable;

(5) explanation from the employer as to why contributions were not withheld or paid to the association;

(6) any other information requested by the association; if original records have been lost or destroyed, affidavits in a form acceptable to the association may be submitted for the purpose of substantiating the employment; the association may accept such affidavits in lieu of original records if it deems them sufficient to establish the required employment information.

F. At any time prior to retirement, a member may purchase service credit at its full actuarial present value as determined by the association, under the following conditions:

(1) Service credit may be purchased in one-month increments.

(2) The amount of service credit purchased under this Subsection F shall not exceed one year.

(3) Service credit purchased cannot be used for the purpose of calculating final average salary or eligibility for pension factor of a coverage plan for pension calculation and retirement purposes.

(4) For purposes of calculating the full actuarial present value purchase cost of service credit under Subsection F of this section, the member's final average salary [~~at the time of purchase and the member's applicable coverage plan~~] and coverage plan at the time of purchase shall be used.

(5) Payment for service credit under this subsection must be received within sixty (60) days of the date the member is informed in writing of the purchase price of the service credit.

(6) The purchase cost received to purchase service credit under this subsection shall not be refunded to the member.

[10-15-97; 11-15-97; 1-15-99; 12-15-99; 2.80.600.20 NMAC - Rn & A, 2 NMAC 80.600.20, 8-15-01; A, 12-28-01; A, 9-30-03; A, 8-31-04; A, 6-30-05; A, 12-15-09; A, 7-16-12; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.700 NMAC, amending Sections 10 and 20, effective 12/30/13.

2.80.700.10 PROCEDURE FOR RETIREMENT

A.

(1) The member shall request an application for retirement from PERA. To insure that the member may retire on the date the member has chosen, the completed application should be returned to PERA, with the required documents described in subsection B below, at least 60 days prior to the selected date of retirement. The completed application and all supporting documentation must be filed with PERA no later than the close of business on the last working day of the month prior to the selected date of retirement. Any changes to an application for retirement that has already been submitted to PERA, including, but not limited to, retirement date, designation of survivor beneficiary or form of payment option, must be in writing and filed with PERA no later than the close of business on the last working day of the month prior to the selected date of retirement.

(2) PERA shall furnish the member an estimate of retirement pension payable under form of payment A within a reasonable time of receipt of the properly completed application and required documents. If the member also desires an estimate of retirement pension payable under forms of payment B, C and D, the member shall request such an estimate in writing.

(3) When the application is filed, PERA shall furnish the member's last affiliated public employer with an employer's certification of earnings form to be completed and returned to PERA. The final calculation of pension cannot be processed until PERA receives the properly completed employer's certification form.

(4) PERA will furnish the member a final calculation of retirement pension based on the information provided by the affiliated public employer.

(5) The completed application form must either include or be accompanied by a signed notarized statement of consent by the member's spouse to the form of payment and beneficiary elected by the member or an affidavit that the member is not married. An affidavit naming all former spouses must also accompany the final application form. If a married member does not provide spousal consent, the member shall execute an affidavit that:

(a) states why the member has been unable to obtain spousal consent;

(b) provides the most recent contact information for the member's spouse; and

(c) acknowledges that the member understands that because he or she is married and has not provided spousal consent, the PERA Act provides that the member will be retired under form of payment C with his or her spouse named as survivor beneficiary.

(6) The application shall be considered to be "filed" when PERA receives the completed application as evidenced by a writing on the application indicating the date of receipt by PERA.

(7) Retirement will be effective on the first day of the month following: a) the filing with PERA of the completed, signed application with all required documentation; b) the member's qualifying for retirement based on service and age; and c) the member's termination of [~~non-exempt~~] covered employment with all [~~affiliated public~~] employers covered by any state system or the educational retirement system.

(8) The retirement of the member shall be submitted to the board for ratification at the next regular meeting following the effective date of retirement.

B. The retiring member shall furnish the following documents to PERA:

(1) Proof of age of the member and any designated beneficiary or beneficiaries. Acceptable documents are a birth certificate, a baptismal certificate, a religious record of birth established before age 5 years, a current passport, a current New Mexico driver's license or a current New Mexico motor vehicle division issued identification card, or any two of the following documents showing the date of birth of the member or

designated beneficiary or beneficiaries:

(a) copy of a life or automobile insurance policy;

(b) current voter registration or voter identification record;

(c) tribal census record;

(d) childhood immunization record made prior to age eighteen (18) years;

(e) military record, including a valid United States active-duty, retiree or reservist military identification card;

(f) birth certificate of child showing age of parent;

(g) physician's or midwife's record of birth;

(h) immigration record;

(i) naturalization record;

(j) social security records.

(2) For any designated beneficiary to be identified as a spouse, a copy of a marriage certificate, other proof of marital status acceptable in a court of law or any two of the following documents showing marital status:

(a) financial institution or bank records;

(b) joint real estate deeds or mortgages;

(c) insurance policies.

(3) Complete endorsed copies of all court documents necessary to ascertain the current marital status of the member and whether any ex-spouse of the member is entitled to any portion of the member's benefits. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment with an affiliated public employer. If the member's only divorce was prior to becoming a PERA member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a PERA member, then only the most recent final decree is required. The requirement for providing a copy of a final decree may be waived, in PERA's discretion, when PERA can establish through online court records that a divorce decree was entered on a specific date and no further documentation is deemed necessary to administer benefits.

(4) Any member with an effective retirement date on or after [~~December 31, 1998~~] January 1, 2014 shall provide authorization to the association for the electronic transfer of pension payments to the retiree's banking institution [~~, or a waiver in lieu thereof~~]. Such authorization [~~or waiver~~] shall be executed, in writing, in the form prescribed by the association.

C. No adjustments to the pension based on failure to claim free service credit may be made after the first pension payment.

D. [~~If a member has three or more years of service credit under each of two or more coverage plans, the pension factor and pension maximum provided under the coverage plan which produces the highest pension shall apply.~~] The pension of a member who has earned service credit under more than one (1) coverage plan with different pension factors shall be calculated pursuant to Section 10-11-8(I), NMSA 1978. If a member has earned service credit under one (1) coverage plan on or before July 1, 2013 and under one (1) or more coverage plans after July 1, 2013 with different pension factors, each pension factor shall be used to calculate the member's pension. The coverage plan from which the member was last employed shall govern the age and service requirements for retirement. Permissive service credit purchased pursuant to Section 10-11-7(H), NMSA 1978 cannot be used to determine final average salary, pension factor or pension maximum for pension calculation purposes.

E. Upon meeting the membership requirements in 2.80.400 NMAC, a member shall combine concurrent salaries received from two affiliated public employers. In the case of concurrent full-time and part-time employment or full-time and elected official service, service credit shall be earned only for the full-time employment. In the case of two part-time employments, service credit shall be earned only for the employment which has the lowest pension factor and pension maximum. In the case of concurrent employment, termination from all affiliated public employers is required before retirement. No combining of concurrent salary may occur for employees who are on extended annual or sick leave until retirement.

F. [~~A member is vested in his or her accrued benefits when the member reaches normal retirement age of the plan in which he or she is a member at the time of retirement or was last a member. If there is a termination of the PERA retirement system, or if employer contributions to the PERA fund are completely discontinued, the rights of each affected member to the benefits accrued at the date of termination or discontinuance, to the extent then funded, are non-forfeitable.~~] In addition to any other vesting provided by state law, a member's normal retirement benefit is non-forfeitable when the member reaches normal retirement age, which is:

(1) age sixty-five (65), with five (5) or more years of credited service, whichever is later, for individuals who were members on June 30, 2013;

(2) age sixty-five (65), with eight (8) or more years of credited service, whichever is later, for individuals who became general plan members on or after July 1, 2013; and

(3) age sixty (60), with six (6) or more years of credited service, whichever is later, for individuals who became public safety plan members on or after July 1, 2013.

G. In addition to any other vesting provided by state law, a member is also vested in his or her accrued benefits when the member reaches such lesser age and specified years of credited service as provided under the plan in which he or she is a member at the time of retirement or was last a member. If there is a termination of the PERA retirement system, or if employer contributions to the PERA fund are completely discontinued, the rights of each affected member to the benefits accrued at the date of termination or discontinuance, to the extent then funded, are non-forfeitable.

[10-15-97; 11-15-97; 1-15-99; 12-15-99; 2.80.700.10 NMAC - Rn & A, 2 NMAC 80.700.10, 12-28-00; A, 8-15-01; A, 12-28-01; A, 9-30-03; A, 8-31-04; A, 6-30-05; A, 12-15-09; A, 9-30-10; A, 12-30-13]

2.80.700.20 BENEFIT PAYMENT: The maximum annual benefit limits contained in Internal Revenue Code Section 415(b), as amended and adjusted, are incorporated herein by reference. Notwithstanding any other provision of the PERA Act and regulations, all benefits paid from the PERA trust fund shall be distributed in accordance with the requirements of Internal Revenue Code Section 401(a)(9) and the regulations under that section. In order to meet these requirements, the trust fund must be administered in accordance with the following provisions:

A. The entire interest of the member shall:

(1) be completely distributed to the member not later than the required beginning date defined in subsection (B) below, or

(2) shall be distributed, beginning not later than the required beginning date, in accordance with internal revenue service regulations, over a period not extending beyond the life expectancy of such member or the life expectancy of such member and a designated beneficiary.

B. Distribution of a member's benefit must begin by the "required beginning date," which is defined as the later of the:

(1) April 1 of the calendar year following the calendar year in which the member attains the age of seventy and one-half (70½), or

(2) April 1 of the calendar year after the calendar year in which the member retires.

C. The life expectancy of the member or the member's spouse may not be recalculated after the benefits commence.

D. If a member dies before the distribution of the member's benefits has begun, distribution to beneficiaries must begin no later than December 31 of the

calendar year immediately following the calendar year in which the member died.

E. The amounts payable to a member's beneficiary may not exceed the maximum determined under the incidental death benefit requirements of the Internal Revenue Code Section 401(a)(9)(G) and regulations thereunder. PERA shall adjust the percentage of the member's pension payable to a non-spouse survivor beneficiary who is more than ten (10) years younger than the member at the time of the member's retirement as required by 26 C.F.R. Section 1.401(a)(9)-6.

[2.80.700.20 NMAC - N, 12-28-00; A, 8-15-01; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.900 NMAC, amending Section 8, effective 12/30/13.

2.80.900.8 PRE-RETIREMENT SURVIVOR PENSIONS: The procedure for payment of a pre-retirement survivor pension is:

A. Applicants for pre-retirement survivor pensions shall notify PERA of the death of the member and complete an application for benefits.

B. The completed application shall be returned to PERA with the following documents:

(1) A certified copy of the death certificate or other proof of death acceptable in a court of law.

(2) Copy of marriage license or other proof of marital status acceptable in a court of law if the application is for a surviving spouse.

(3) Affidavit of surviving spouse that he or she and the deceased member were married at the time of death and stating whether there are any surviving minor children of the deceased member.

(4) Proof of age of the surviving spouse, surviving minor children or other designated beneficiary. Acceptable documents for proof of age shall be a birth certificate, a baptismal certificate, a copy of a life insurance policy, a certified copy of a voter registration issued over ten (10) years prior, or proof of age meeting a standard at least equivalent to that applied by the social security administration.

(5) Documents required under the Probate Code for payments to a minor if the application is on behalf of eligible surviving children.

(6) Affidavit that the applicant is unmarried if the applicant is a child of the deceased member.

(7) Copies of social security cards for all prospective payees.

(8) If the member has been divorced, the applicant shall provide PERA with complete endorsed copies of all court documents the association deems necessary to ascertain the marital status of the member at the time of death and whether any ex-spouse of the member is entitled to any portion of any benefits payable. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment with an affiliated public employer. If the member's only divorce was prior to becoming a PERA member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a PERA member, then only the most recent final decree is required.

C. When the application and accompanying documentation as required in Subsection B of 2.80.900.8 NMAC above are filed, PERA will determine whether a pension is payable. The application shall be considered to be "filed" when PERA receives the completed application as evidenced by a writing on the application indicating the date of receipt by PERA. PERA will calculate the pension payable and begin paying the pension effective the first day of the month following the date of the member's death. The amount of survivor pension shall be submitted to the board for ratification at the next regular meeting following the date of the first payment of survivor pension to the applicant.

D. Duty death.

(1) If the application is for a survivor pension resulting from duty death, the application shall be accompanied by documentation supporting the claim, in addition to the documentation required in Subsection B of 2.80.900.8 NMAC above. Documentation may include but is not limited to the following:

(a) a certified copy of the death certificate or other proof of death acceptable in a court of law;

(b) employer's report of accident;

(c) determination of duty death by another agency such as workers compensation administration or social security administration although such a determination does not necessarily prove the death was a duty death for PERA purposes;

(d) autopsy report;

(e) attending physician's narrative report containing the conclusion of duty death and stating the basis therefor;

(f) any other information requested by the association.

(2) The burden of proof of duty death is on the applicant.

(a) "Solely and exclusively" means the member's work is so substantial a factor of the death that the death would not have occurred at the time without it.

(b) "Course of the member's performance of duty" means place or activity for which the employer's business required the presence of the employee, but shall not include travel or time on the way to assume the duties of employment or travel or time leaving such duties, except when the employee is temporarily assigned to a destination other than his or her normal work station or is within the "special errand" rule in which case such time will be considered in the course of employment.

(3) The board hereby authorizes the director of member services to determine whether the death was the natural and proximate result of causes arising solely and exclusively out of and in the course of the member's performance of duty with an affiliated public employer. Such determination shall be presented to the board for ratification at the next regular meeting of the board. The board may remove the matter from the consent calendar and substitute its own determination for that of the director of member services, or it may assign the matter to an administrative hearing officer for determination.

E. Military death. Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service, as defined in Chapter 43 of Title 38, United States Code, to the extent required by Internal Revenue Code Section 401(a)(37), survivors of such member are entitled to any additional benefits that the plan would provide if the member had resumed employment and then died, such as accelerated vesting or survivor benefits that are contingent on the member's death while employed. In any event, a deceased member's period of qualified military service must be counted for vesting purposes.

[10-15-97; 11-15-97; 2.80.900.8 NMAC - Rn, 2 NMAC 80.900.8, 12-28-01; A, 9-30-03; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.1100 NMAC, Amending Sections 11 and 30, Effective 12/30/13.

2.80.1100.11 POST-RETIREMENT SELECTION OF NEW BENEFICIARY OR CHANGE TO FORM OF PAYMENT A:

A. To exercise his or her one-time irrevocable option to change the beneficiary designated at retirement to another survivor beneficiary under the same form of payment or to have future payments made under form of payment A pursuant to NMSA 1978, Section 10-11-116 (D), the

retired member shall submit the request in writing to PERA, including a statement that the beneficiary designated at retirement is still living.

B. If the retired member requests a beneficiary change, he or she shall provide a copy of the new beneficiary's certificate of birth with the written request.

C. If the retired member was married at the time of retirement and is still married to the same person at the time of the request, he or she shall provide a new signed notarized statement of consent by the member's spouse to the new beneficiary or to the election of form of payment A.

D. If the retired member has been divorced, he or she shall provide PERA with complete endorsed copies of all court documents necessary to ascertain the current marital status of the member and whether any ex-spouse of the member is entitled to any portion of the member's benefits. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment with an affiliated public employer. If the member's only divorce was prior to becoming a PERA member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a PERA member, then only the most recent final decree is required. The requirement for providing a copy of a final decree may be waived, in PERA's discretion, when PERA can establish through online court records that a divorce decree was entered on a specific date and no further documentation is deemed necessary to administer benefits.

E. A retired member who was divorced prior to retirement and named his or her former spouse as survivor beneficiary may exercise his one-time irrevocable option to deselect his or her former spouse as survivor beneficiary in accordance with NMSA 1978, Section 10-11-116 (E) provided that there is no court order requiring the election of a specific form of payment or designation of a specific survivor pension beneficiary.

[~~E.~~] F. PERA shall provide the retired member with a new benefit estimate and an agreement for selection of new beneficiary or change to form of payment A after retirement in the form required by PERA within a reasonable time of receipt of the written request and required information and documents.

[~~F.~~] G. If the signed notarized agreement is received at PERA by the ninth day of the month, the requested change shall be effective for the pension payment for that month. Agreements received after the ninth day of the month shall be effective for the following month's pension payment.

[2.80.1100.11 NMAC - N, 9-30-10; A, 12-30-13; A, 12-30-13]

2.80.1100.30 SUSPENSION [~~AND REINSTATEMENT~~] OF PENSION:

A. A previously retired member who is subsequently employed by an affiliated public employer and whose pension is suspended pursuant to NMSA 1978, Section 10-11-8 (C) shall not become a member. The previously retired member will be eligible to reinstate his or her pension upon termination of the subsequent employment under the following conditions:

(1) the member files an application for reinstatement of pension in the form required by PERA; and

(2) the member's pension, under form of payment A, shall not be less than the amount of the previous pension under form of payment A; and

(3) reinstatement of the pension does not constitute the member's latest retirement for purposes of cost-of-living adjustment eligibility pursuant to NMSA 1978, Section 10-11-118 (C).

B. A previously retired member who is subsequently employed by an affiliated public employer and whose pension is suspended upon one of the following grounds shall become a member:

(1) he or she has been employed as an employee of an affiliated public employer or retained as an independent contractor by the affiliated public employer from which the retired member retired within twelve consecutive months from the date of retirement to the commencement of employment or reemployment with an affiliated public employer; or

(2) he or she makes an election pursuant to NMSA 1978, Section 10-11-8 (F).

C. [~~The~~] A previously retired member who has subsequently become a member will be eligible [~~to reinstate his or her pension~~] re-retire at the termination of the subsequent employment period under the following conditions:

(1) The member files an application for retirement in accordance with the provisions of 2.80.700.10 NMAC.

(2) The recalculated pension, under form of payment A, shall not be less than the amount of the suspended pension under form of payment A.

(3) If the re-retiring member acquires three or more years of service credit during the subsequent employment with an affiliated public employer, the following provisions apply:

(a) the re-retiring member may re-retire under the coverage plan applicable at the time of re-retirement;

(b) the pension payment shall be made employing the form of payment selected by the re-retiring member upon the member's application for re-retirement; and

(c) the re-retiring member may designate any person as survivor beneficiary, subject to the provisions of NMSA 1978, Section 10-11-116.

[10-15-97; 2.80.1100.30 NMAC - Rn, 2 NMAC 80.1100.30, 12-28-00; A, 9-30-03; A, 8-31-04; A, 9-30-10; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.2100 NMAC, Adding Section 9, Effective 12/30/13.

2.80.2100.9 UNCLAIMED CONTRIBUTIONS

A. A member's accumulated member contributions, plus interest, shall constitute unclaimed member contributions pursuant to NMSA 1978, Section 10-11-128 if the following conditions are met:

(1) the member has applied for and received a refund of member contributions;

(2) a balance of $500 or less remains on the member's account;

(3) PERA has sent a letter to the member's last known address on file with the association notifying the member that the funds are available for disbursement and received no response within sixty (60) days of the mailing.

B. Unclaimed member contributions, plus interest, shall be credited to the income fund, and the member's account shall be closed.

C. PERA shall perpetually maintain a list of members and the value of the accounts which were closed in accordance with this provision.

D. No interest shall accrue on unclaimed member contributions which have been credited to the income fund.

E. A member, beneficiary or estate of a member may at any time apply to receive a refund of unclaimed member contributions and interest accrued before the account was closed in accordance with the provisions of this rule.

F. If a member whose account has been closed is subsequently employed by an affiliated public employer, the member's account shall be reopened effective the date of reemployment, and the account balance, accrued interest and service credit shall be restored to the amounts in effect at the time the account was closed.

[2.80.2100.9 NMAC - N, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.83.400 NMAC, amending Section 8, effective 12/30/13.

2.83.400.8 GENERAL PROVISIONS:

A. Members may receive one month of service credit for any calendar month in which the member becomes a member on or before the sixteenth day of that month, or for any calendar month in which the member leaves office on or after the fifteenth day of the month, provided that all other requirements for awarding service credit are met.

B. Service credit that was forfeited when a member left office and withdrew his or her accumulated member contributions may be reinstated by repayment of withdrawn member contributions, together with interest from the date of withdrawal to the date of repayment at the rate or rates set by the board under the following conditions.

(1) Service credit may be reinstated in one-year increments, beginning with the most recently forfeited service credit. A one-year increment is 12 consecutive, but not necessarily continuous, months of service credit. For the purpose of eligibility to retire only, less than one year of service credit may be purchased. After reinstatement of all 12-month "years" as defined herein, any remaining service credit that totals less than 12 months may be reinstated by payment in one lump sum as provided herein.

(2) All forfeited service credit may also be reinstated by repayment of the total amount of all member contributions withdrawn from each period of service together with interest from the date of withdrawal to the date of repayment at the rate set by the board.

(3) The rate or rates of interest for the purchase or reinstatement of service credit shall be set annually by the board at a July meeting and shall be effective beginning the next succeeding January 1.

(4) A former member who is employed by an employer covered under the Educational Retirement Act must provide evidence of current contributing membership in the educational retirement association; such evidence shall be either certification by the employer, in the form prescribed by the association, or certification by the educational retirement association (ERA).

(5) Payment for reinstated service credit must be received by the association prior to the member's effective date of retirement.

(6) Interest received to reinstate forfeited service credit under this subsection shall not be refunded to the member. The purchase cost received to reinstate forfeited service credit, which is determined to be unnecessary to provide the maximum pension applicable to the member and which is purchased in reliance on information provided by PERA shall be refunded to the member.

C. Service credit that a member would have earned if the member had not elected to be excluded from membership may be purchased under the following conditions:

(1) the member first reinstates all previously withdrawn JRA service credit;

(2) the member may purchase service credit in increments of not less than one year except where the total excluded service credit is less than one year;

(3) the member pays the full cost as determined under NMSA 1978, Section 10-12B-5(F) within sixty days of the notification of that amount.

D. Military service credit is free in some cases and may be purchased in other cases as provided by statute.

(1) Where a member wishes to claim service credit pursuant to NMSA 1978, Section 10-12B-5 the association shall, upon the member's request, furnish that member a form of affidavit for completion and certification of such service. The affidavit shall be accompanied by documentary evidence of the member's entry and discharge from service in a uniformed service of the United States.

(2) The administrative office of the courts shall certify in writing the date the member left office to enter a uniformed service of the United States. This requirement may be waived if PERA records contain sufficient documentation of the date of termination.

(3) The administrative office of the courts shall certify in writing to the association the member's date of return to office within thirty days of reemployment. This requirement may be waived if PERA records contain sufficient documentation of the date of return, to office. Members who do not return, to office within ninety days following termination of the period of intervening service but who nevertheless claim reemployment rights under federal law shall provide to the association written certification from the administrative office of the courts that the member is entitled to reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

(4) The affidavit, employer certifications, and documentary evidence of uniformed service shall be presented to the association for approval.

(5) Service credit for periods of intervening service in the uniformed services following voluntary enlistment, reenlistment or appointment shall be awarded only upon compliance by the member and the administrative office of the courts with the provisions of NMSA 1978, Section 10-12B-5, as amended, and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, including but not limited to the payment to the association of contributions required from the member and the employer.

(6) JRA members who are also members of the military service reserve components who are activated pursuant to a federal call to duty, deployment or peacekeeping mission or other declared national emergency may receive free credit service subject to the conditions of this section. The member must provide a form DD 214 and other documentation as required by PERA to support an award of free service credit.

(7) Payment for military service credit must be received by the association prior to the member's effective date of retirement.

E. No installment payment contracts may be used for the purchase of any service credit. A member may purchase a total of five (5) years of permissive service credit as allowed under the Judicial Retirement Act in one lump-sum or in one-year increments.

F. A member may rollover funds from an Internal Revenue Code Section 457, 403(b), 401(k), IRA or another 401(a) qualified account to pay for forfeited or permissive service credit allowed by the Judicial Retirement Act. The rollover of funds must be made by a trustee-to-trustee transfer and the account from which the funds come must be in the name of the member requesting the transfer.

[10-15-97; 11-15-97; 2.83.400.8 NMAC - Rn & A, 2 NMAC 83.400.8, 12-28-00; A, 12-28-01; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.83.700 NMAC, amending Sections 10 and 20, effective 12/30/13.

2.83.700.10 PROCEDURE FOR RETIREMENT

A. Application

(1) The member shall request an application for retirement from PERA. To insure that the member may retire on the date the member has chosen, the completed application should be returned to PERA, with the required documents described in Subsection B below, at least 60 days prior to the selected date of retirement. The completed application and all supporting

documentation must be filed with PERA no later than the close of business on the last working day of the month prior to the selected date of retirement.

(2) PERA shall furnish the member an estimate of retirement pension payable within a reasonable time of receipt of the properly completed application and required documents.

(3) When the application is filed, PERA shall furnish the member's last judicial agency with an employer's certification of earnings form to be completed and returned to PERA. The final calculation of pension cannot be processed until PERA receives the properly completed employer's certification form.

(4) PERA will furnish the member a final calculation of retirement pension based on the information provided by the judicial agency.

(5) The completed application form must either include or be accompanied by a signed notarized statement of consent by the member's spouse to the survivor beneficiary elected by the member or an affidavit that the member is not married. An affidavit naming all former spouses must also accompany the final application form.

(6) Retirement will be effective on the first day of the month following: a) the filing with PERA of the completed, signed application with all required documentation; b) the member's qualifying for retirement based on service credit and age; and c) the member's leaving office. An application will be deemed to be "filed" when received by PERA as evidenced by a writing on the application indicating the date of receipt by PERA.

(7) The retirement of the judge shall be submitted to the board for ratification at the next regular meeting following the effective date of retirement.

B. Documentation: The retiring member shall furnish the following documents to PERA:

(1) Proof of age of the member and any designated beneficiary or beneficiaries. Acceptable documents are a birth certificate, a baptismal certificate, or religious record of birth established before age 5 years, or any two of the following documents showing the date of birth of the member or designated beneficiary or beneficiaries:

(a) copy of a life insurance policy;

(b) certified copy of voter registration issued over ten years prior;

(c) tribal census record;

(d) childhood immunization record made prior to age eighteen (18) years;

(e) military record;

(f) birth certificate of child showing age of parent;

(g) physician's or midwife's record of birth;

(h) passport;

(i) immigration record;

(j) naturalization record.

(2) A copy of a marriage certificate or other proof of marital status acceptable in a court of law for any designated survivor beneficiary to be identified as a spouse.

(3) Complete endorsed copies of all court documents the association deems necessary to ascertain the current marital status of the member and whether any ex-spouse of the member is entitled to any portion of the member's benefits. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment as a judge or justice. If the member's only divorce was prior to becoming a member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a member, then only the most recent final decree is required.

(4) Any member with an effective retirement date on or after [~~December 31, 1998~~] January 1, 2014 shall provide authorization to the association for the electronic transfer of pension payments to the retiree's banking institution[~~, or a waiver in lieu thereof~~]. Such authorization [~~or waiver~~] shall be executed, in writing, in the form prescribed by the association.

C. No adjustments to the pension based on failure to claim free or any other service credit may be made after the first pension payment.

D. Under the provisions of NMSA 1978, Section 10-12B-12, the Public Employees Retirement Reciprocity Act applies to members covered under the Judicial Retirement Act early retirement.

E. In addition to any other vesting provided by state law, a judge's normal retirement benefit is non-forfeitable when the judge reaches normal retirement age, which is age sixty-four (64), with five (5) or more years of credited service, whichever is later. A judge is also vested in his or her accrued benefits when the judge reaches [~~normal retirement age or early retirement with the sufficient amount of service credit~~] such lesser age and specified years of credited service as provided under the plan. If there is a termination of the judicial retirement system, or if employer contributions to the judicial retirement plan are completely discontinued, the rights of each affected member to the benefits accrued at the date of termination or discontinuance, to the extent then funded, are non-forfeitable. [10-15-97; 11-15-97; 2.83.700.10 NMAC - Rn & A, 2 NMAC 83.700.10, 12-28-00, A, 12-28-01; A, 12-30-13]

2.83.700.20 BENEFIT PAYMENT: The maximum annual benefit limits contained in Internal Revenue Code Section 415(b), as amended and adjusted, are incorporated herein by reference. Notwithstanding any other provision of the Judicial Retirement Act and regulations, all benefits paid from the Judicial Retirement trust fund shall be distributed in accordance with the requirements of Internal Revenue Code Section 401(a)(9) and the regulations under that section. In order to meet these requirements, the trust fund must be administered in accordance with the following provisions:

A. The entire interest of the judge shall:

(1) be completely distributed to the judge not later than the required beginning date as defined in subsection (B) below, or

(2) shall be distributed, beginning not later than the required beginning date, in accordance with internal revenue service regulations, over a period not extending beyond the life expectancy of such judge or the life expectancy of such judge and a designated beneficiary.

B. Distribution of a judge's benefit must begin by the "required beginning date," which is defined as the later of the:

(1) April 1 of the calendar year following the calendar year in which the judge attains the age of seventy and one-half (70½), or

(2) April 1 of the calendar year after the calendar year in which the judge retires.

C. The life expectancy of the judge or the judge's spouse may not be recalculated after the benefits commence.

D. If a judge dies before the distribution of the judge's benefits has begun, distribution to beneficiaries must begin no later than December 31 of the calendar year immediately following the calendar year in which the judge died.

E. The amounts payable to a judge's beneficiary may not exceed the maximum determined under the incidental death benefit requirements of the Internal Revenue Code Section 401(a)(9)(G) and regulations thereunder. PERA shall adjust the percentage of the judge's pension payable to a non-spouse survivor beneficiary who is more than ten (10) years younger than the judge at the time of the judge's retirement as required by 26 C.F.R. Section 1.401(a)(9)-6. [10-15-97; R, 11-15-97; 2.83.700.20 NMAC - Rn & A, 2 NMAC 83.700.20, 12-28-00; A, 12-28-01; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.83.800 NMAC, amending Section 10, effective 12/30/13.

2.83.800.10 PROCEDURE: The

procedure for payment of a survivor pension is:

A. Applicants for pre-retirement survivor pensions shall notify PERA of the death of the member and complete an application for benefits.

B. The completed application shall be returned to PERA along with the following documents:

(1) A certified copy of the death certificate or other proof of death acceptable in a court of law.

(2) If the application is for a surviving spouse: copy of the marriage license or other proof of marital status acceptable in a court of law, and an affidavit of the surviving spouse that he or she and the deceased member were married at the time of death and stating whether there are any surviving minor children of the deceased.

(3) Proof of age of the surviving spouse, surviving minor children or other designated beneficiary. Acceptable documents for proof of age shall be a birth certificate, a baptismal certificate, a copy of a life insurance policy, a certified copy of a voter registration issued over ten (10) years prior, or proof of age meeting a standard at least equivalent to that applied by the social security administration.

(4) Documents required under the Probate Code for payments to a minor if the application is on behalf of minor and dependent children.

(5) Affidavit that the applicant is not married or otherwise emancipated if the applicant is a child of the deceased member.

(6) Copies of social security cards for all prospective payees.

(7) If the member has been divorced, the applicant shall provide PERA with complete endorsed copies of all court documents the association deems necessary to ascertain the marital status of the member at the time of death and whether any ex-spouse of the member is entitled to any portion of any benefits payable. Such documents shall include the final decrees and marital property settlements for all marriages during the member's covered employment as a judge or justice. If the member's only divorce was prior to becoming a member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a member, then only the most recent final decree is required.

C. The application shall be considered to be "filed" when PERA receives the completed application as evidenced by a writing on the application indicating the date of receipt by PERA. Upon filing of the application, and accompanying documentation as required in subsection B above, PERA will calculate the pension payable and begin paying the pension effective the first day of the month following the date of the death resulting in the pension. The amount of survivor pension shall be submitted to the board for ratification at the next regular meeting following the date of the first payment of survivor pension to the applicant.

D. Military death. Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service, as defined in Chapter 43 of Title 38, United States Code, to the extent required by Internal Revenue Code Section 401(a)(37), survivors of such member are entitled to any additional benefits that the plan would provide if the member had resumed employment and then died, such as accelerated vesting or survivor benefits that are contingent on the member's death while employed. In any event, a deceased member's period of qualified military service must be counted for vesting purposes.

[10-15-97; 11-15-97; 2.83.800.10 NMAC - Rn, 2 NMAC 83.800.10, 12-28-01; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.83.1200 NMAC, amending Section 8, effective 12/30/13.

2.83.1200.8 GENERAL PROVISIONS

A. In accordance with the Judicial Retirement Act each judicial agency, as employer, shall be responsible for deducting the applicable contribution from the salary or wages paid to each member for each payroll period.

B. The employer shall transmit to PERA the member and employer contributions for every member in its employ for each pay period on or before the fifth working day following the payday applicable to the pay period. The contributions shall be accompanied by a transmittal report in a format designated by PERA, which shall clearly set forth the amount of employer and member contributions, and adjustments for prior pay periods if applicable, transmitted.

C. Except as provided in Subsection G below, interest will be assessed on any remittance of employer and employee contributions not made by the due date of the remittance. The rate of interest shall be set annually by the board at a July meeting and shall be effective beginning the next succeeding January 1st. Any interest paid on unremitted contributions shall not be posted to the member's account or refunded to the member or the employer.

D. Except as provided in Subsection G below, a penalty of fifty dollars ($50) per day shall be assessed for any employee and employer contribution transmittal report that is untimely. For purposes of this subsection, "untimely" is defined as fifteen (15) days after the end of the month in which the transmittal report was due.

E. In the event the judicial agency fails to make the necessary deductions, the judicial agency shall be responsible to remit to PERA the total amount due for both the member and employer contributions plus interest as provided in subsection C above.

F. Current employer contributions may not be made by members except as authorized by law.

G. If a judicial agency, for good cause, is unable to timely transmit employee and employer contributions or transmittal report, the employer shall notify PERA in writing at least twenty-four hours prior to the due date, and may request waiver of the interest or penalty that would otherwise be assessed. The executive director may waive interest or penalty for up to thirty-one calendar days. Interest shall thereafter be charged at the rate set in subsection C above.

H. Member contributions picked-up by the employer under NMSA 1978, Section 10-12B-10 are not considered compensation for purposes of Internal Revenue Code Section 415(c).

I. Beginning January 1, 2009, to the extent required by Internal Revenue Code [~~Sections 3401(h) and~~] Section 414(u)(2), an individual receiving differential wage payments [~~, while the individual is performing qualified military service as defined in Chapter 43 of Title 38, United States Code,~~] (as defined under Internal Revenue Code Section 3401(h)(2)) from an affiliated public employer shall be treated as employed by that employer and the differential wage payment shall be treated as [~~earned~~] compensation for purposes of applying the limits on annual additions under Internal Revenue Code Section 415(c). [~~However, contributions attributable to such differential wage payments shall not be made unless and until the member returns to active employment and makes up the missed contributions.~~] This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

[10-15-97; 11-15-97; 2.83.1200.8 NMAC - Rn & A, 2 NMAC 83.1200.8, 12-28-00; A, 12-28-01; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.84.400 NMAC, amending Section 8, effective 12/30/13.

2.84.400.8 GENERAL PROVISIONS

A. Members may receive one month of service credit for any calendar month in which the member becomes a member on or before the sixteenth day of that month, or for any calendar month in which the member leaves office on or after the fifteenth day of the month, provided that all other requirements for awarding service credit are met.

B. Service credit that was forfeited when a member left office and withdrew his or her accumulated member contributions may be reinstated by repayment of withdrawn member contributions, together with interest from the date of withdrawal to the date of repayment at the rate or rates set by the board under the following conditions:

(1) Service credit may be reinstated in one-year increments, beginning with the most recently forfeited service credit. A one-year increment is 12 consecutive, but not necessarily continuous, months of service credit. For the purpose of eligibility to retire only, less than one year of service credit may be purchased. After reinstatement of all 12-month "years" as defined herein, any remaining service credit that totals less than 12 months may be reinstated by payment in one lump sum as provided herein.

(2) All forfeited service credit may also be reinstated by repayment of the total amount of all member contributions withdrawn from each period of service together with interest from the date of withdrawal to the date of repayment at the rate set by the board.

(3) The rate or rates of interest for the purchase or reinstatement of service credit shall be set annually by the board at a July meeting and shall be effective beginning the next succeeding January 1.

(4) A former member who is employed by an employer covered under the Educational Retirement Act must provide evidence of current contributing membership in the educational retirement association; such evidence shall be either certification by the employer, in the form prescribed by the association, or certification by the educational retirement association (ERA).

(5) Payment for reinstated service credit must be received by the association prior to the member's effective date of retirement.

(6) Interest received to reinstate forfeited service credit under this subsection shall not be refunded to the member. The purchase cost received to reinstate forfeited service credit, which is determined to be unnecessary to provide the maximum pension applicable to the member and which is purchased in reliance on information provided by PERA shall be refunded to the member.

C. Service credit that a member would have earned if the member had not elected to be excluded from membership may be purchased under the following conditions:

(1) the member first reinstates all previously withdrawn MRA service credit;

(2) the member may purchase service credit in increments of not less than one year except where the total excluded service credit is less than one year;

(3) the member pays the full cost as determined under NMSA 1978, Section 10-12C-5(F) within sixty days of the notification of that amount.

D. Military service credit is free in some cases and may be purchased in other cases as provided by statute.

(1) Where a member wishes to claim service credit pursuant to NMSA 1978, Section 10-12C-5 the association shall, upon the member's request, furnish that member a form of affidavit for completion and certification of such service. The affidavit shall be accompanied by documentary evidence of the member's entry and discharge from service in a uniformed service of the United States.

(2) The judicial agency shall certify in writing the date the member left office to enter a uniformed service of the United States. This requirement may be waived if PERA records contain sufficient documentation of the date of termination.

(3) The judicial agency shall certify in writing to the association the member's date of return to office within thirty days of reemployment. This requirement may be waived if PERA records contain sufficient documentation of the date of return, to office. Members who do not return, to office within ninety days following termination of the period of intervening service but who nevertheless claim reemployment rights under federal law shall provide to the association written certification from the judicial agency that the member is entitled to reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

(4) The affidavit, employer certifications, and documentary evidence of uniformed service shall be presented to the association for approval.

(5) Service credit for periods of intervening service in the uniformed services following voluntary enlistment, reenlistment or appointment, shall be awarded only upon compliance by the member and the judicial agency with the provisions of NMSA 1978, Section 10-12C-5, as amended, and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, including but not limited to the payment to the association of contributions required from the member and the employer.

(6) MRA members who are also members of the military service reserve components who re activated pursuant to a federal call to duty, deployment or peacekeeping mission or other declared national emergency may receive free credit service subject to the conditions of this section. The member must provide a form DD 214 and other documentation as required by PERA to support an award of free service credit.

(7) Payment for military service credit must be received by the association prior to the member's effective date of retirement.

E. No installment payment contracts may be used for the purchase of any service credit. A member may purchase a total of five (5) years of permissive service credit as allowed by the Magistrate Retirement Act in one lump-sum or in one-year increments.

F. A member may rollover funds from an Internal Revenue Code Section 457, 403(b), 401(k), IRA or another 401(a) qualified account to pay for forfeited or permissive service credit allowed by the Magistrate Retirement Act. The rollover of funds must made be by a trustee- to-trustee transfer and the account from which the funds come must be in the name of the member requesting the transfer.

[10-15-97; 11-15-97; 2.84.400.8 NMAC - Rn & A, 2 NMAC 84.400.8, 12-28-00; A, 12-28-01; A, 9-30-03; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.84.700 NMAC, amending Sections 10 and 20, effective 12/30/13.

2.84.700.10 PROCEDURE FOR RETIREMENT

A. Application

(1) The member shall request an application for retirement from PERA. To insure that the member may retire on the date the member has chosen, the completed application should be returned to PERA, with the required documents described in subsection B below, at least 60 days prior to the selected date of retirement. The completed application and all supporting documentation must be filed with PERA no later than the close of business on the last working day of the month prior to the selected date of retirement.

(2) PERA shall furnish the member an estimate of retirement pension payable within a reasonable time of receipt of the properly completed application and required documents.

(3) When the application is filed, PERA shall furnish the member's last judicial agency with an employer's certification of

earnings form to be completed and returned to PERA. The final calculation of pension cannot be processed until PERA receives the properly completed employer's certification form.

(4) PERA will furnish the member a final calculation of retirement pension based on the information provided by the judicial agency.

(5) The completed application form must either include or be accompanied by a signed notarized statement of consent by the member's spouse to the survivor beneficiary elected by the member or an affidavit that the member is not married. An affidavit naming all former spouses must also accompany the final application form.

(6) Retirement will be effective on the first day of the month following: a) the filing with PERA of the completed, signed application with all required documentation; b) the member's qualifying for retirement based on service credit and age; and c) the member's leaving office. An application will be deemed to be "filed" when received by PERA as evidenced by a writing on the application indicating the date of receipt by PERA.

(7) The retirement of the member shall be submitted to the board for ratification at the next regular meeting following the effective date of retirement.

B. Documentation: The retiring member shall furnish the following documents to PERA:

(1) Proof of age of the member and any designated beneficiary or beneficiaries. Acceptable documents are a birth certificate, a baptismal certificate, or religious record of birth established before age 5 years, or any two of the following documents showing the date of birth of the member or designated beneficiary or beneficiaries:

(a) copy of a life insurance policy;

(b) certified copy of voter registration issued over ten years prior;

(c) tribal census record;

(d) childhood immunization record made prior to age eighteen (18) years;

(e) military record;

(f) birth certificate of child showing age of parent;

(g) physician's or midwife's record of birth;

(h) passport;

(i) immigration record;

(j) naturalization record.

(2) A copy of a marriage certificate or other proof of marital status acceptable in a court of law for any designated survivor beneficiary to be identified as a spouse.

(3) Complete endorsed copies of all court documents the association deems necessary to ascertain the current marital status of the member and whether any ex-spouse of the member is entitled to any portion of the member's benefits. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment as a magistrate. If the member's only divorce was prior to becoming a member, then the final decree is required, but no marital property settlement is required. If the member was divorced more than once prior to becoming a member, then only the most recent final decree is required.

(4) Any member with an effective retirement date on or after [~~December 31, 1998~~] January 1, 2014 shall provide authorization to the association for the electronic transfer of pension payments to the retiree's banking institution[~~, or a waiver in lieu thereof~~]. Such authorization [~~or waiver~~] shall be executed, in writing, in the form prescribed by the association.

C. No adjustments to the pension based on failure to claim free service credit may be made after the first pension payment.

D. In addition to any other vesting provided by state law, a magistrate's normal retirement benefit is non-forfeitable when the magistrate reaches normal retirement age, which is age sixty-four (64), with five (5) or more years of credited service, whichever is later. A magistrate is also vested in his or her accrued benefits when the magistrate reaches [~~normal retirement age with the sufficient amount of service credit~~] such lesser age and specified years of credited service as provided under the plan. If there is a termination of the magistrate retirement system, or if employer contributions to the magistrate retirement plan are completely discontinued, the rights of each affected member to the benefits accrued at the date of termination or discontinuance, to the extent then funded, are non-forfeitable.

[10-15-97; 11-15-97; 2.84.700.10 NMAC - Rn & A, 2 NMAC 84.700.10, 12-28-00; A, 12-28-01; A, 12-30-13]

2.84.700.20 BENEFIT PAYMENT: The maximum annual benefit limits contained in Internal Revenue Code Section 415(b), as amended and adjusted, are incorporated herein by reference. Notwithstanding any other provision of the Magistrate Retirement Act and regulations, all benefits paid from the magistrate retirement trust fund shall be distributed in accordance with the requirements of Internal Revenue Code section 401(a)(9) and the regulations under that section. In order to meet these requirements, the trust fund must be administered in accordance with the following provisions:

A. The entire interest of the magistrate shall:

(1) be completely distributed to the magistrate not later than the required beginning date as defined in Subsection (B) below, or

(2) shall be distributed, beginning not later than the required beginning date, in accordance with internal revenue service regulations, over a period not extending beyond the life expectancy of such magistrate or the life expectancy of such magistrate and a designated beneficiary.

B. Distribution of a magistrate's benefit must begin by the "required beginning date," which is defined as the later of the:

(1) April 1 of the calendar year following the calendar year in which the magistrate attains the age of seventy and one-half (70½), or

(2) April 1 of the calendar year after the calendar year in which the magistrate retires.

C. The life expectancy of the magistrate or the magistrate's spouse may not be recalculated after the benefits commence.

D. If a magistrate dies before the distribution of the magistrate's benefits has begun, distribution to beneficiaries must begin no later than December 31 of the calendar year immediately following the calendar year in which the magistrate died.

E. The amounts payable to a magistrate's beneficiary may not exceed the maximum determined under the incidental death benefit requirements of the Internal Revenue Code Section 401(a)(9)(G) and regulations thereunder. PERA shall adjust the percentage of the magistrate's pension payable to a non-spouse survivor beneficiary who is more than ten (10) years younger than the magistrate at the time of the magistrate's retirement as required by 26 C.F.R. Section 1.401(a)(9)-6.

[10-15-97; 11-15-97; 2.84.700.20 NMAC - N, 12-28-00; A, 12-28-01; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.84.800 NMAC, amending Section 8, effective 12/30/13.

2.84.800.8 PROCEDURE: The procedure for payment of a survivor pension is:

A. Applicants for pre-retirement survivor pensions shall notify PERA of the death of the member and complete an application for benefits.

B. The completed application shall be returned to PERA along with the following documents:

(1) A certified copy of the death certificate or other proof of death acceptable in a court of law;

(2) If the application is for a

surviving spouse: copy of the marriage license or other proof of marital status acceptable in a court of law, and an affidavit of the surviving spouse that he or she and the deceased member were married at the time of death and stating whether there are any surviving minor children of the deceased;

(3) Proof of age of the surviving spouse, surviving minor children or other designated beneficiary. Acceptable documents for proof of age shall be a birth certificate, a baptismal certificate, a copy of a life insurance policy, a certified copy of a voter registration issued over ten (10) years prior, or proof of age meeting a standard at least equivalent to that applied by the social security administration.

(4) Documents required under the Probate Code for payments to a minor if the application is on behalf of minor and dependent children.

(5) Affidavit that the applicant is not married or otherwise emancipated if the applicant is a child of the deceased member.

(6) Copies of social security cards for all prospective payees.

(7) If the member has been divorced, the applicant shall provide PERA with complete endorsed copies of all court documents the association deems necessary to ascertain the marital status of the member at the time of death and whether any ex-spouse of the member is entitled to any portion of any benefits payable. Such documents shall include the final decrees and marital property settlements of all marriages during the member's covered employment as a magistrate. If the member's only divorce was prior to becoming a member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a member, then only the most recent final decree is required.

C. The application shall be considered to be "filed" when PERA receives the completed application as evidenced by a writing on the application indicating the date of receipt by PERA. Upon filing of the application, and accompanying documentation as required in subsection B above, PERA will calculate the pension payable and begin paying the pension effective the first day of the month following the date of the death resulting in the pension. The amount of the survivor pension shall be submitted to the board for ratification at the next regular meeting following the date of the first payment of survivor pension to the applicant.

D. Military death. Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service, as defined in Chapter 43 of Title 38, United States Code, to the extent required by Internal Revenue Code Section 401(a)(37), survivors of such member are entitled to any additional benefits that the plan would provide if the member had resumed employment and then died, such as accelerated vesting or survivor benefits that are contingent on the member's death while employed. In any event, a deceased member's period of qualified military service must be counted for vesting purposes.

[10-15-97; 11-15-97; 2.84.800.8 NMAC - Rn, 2 NMAC 84.800.8, 12-28-01; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.84.1200 NMAC, amending Section 8, effective 12/30/13.

2.84.1200.8 GENERAL PROVISIONS

A. In accordance with the Magistrate Retirement Act each judicial agency, as employer, shall be responsible for deducting the applicable contribution from the salary or wages paid to each member for each payroll period.

B. The employer shall transmit to PERA the member and employer contributions for every member in its employ for each pay period on or before the fifth working day following the payday applicable to the pay period. The contributions shall be accompanied by a transmittal report in a format designated by PERA, which shall clearly set forth the amount of employer and member contributions, and adjustments for prior pay periods if applicable, transmitted.

C. Except as provided in Subsection G below, interest will be assessed on any remittance of employer and employee contributions not made by the due date of the remittance. The rate of interest shall be set annually by the board at a July meeting and shall be effective beginning the next succeeding January 1st. Any interest paid on unremitted contributions shall not be posted to the member's account or refunded to the member or the employer.

D. Except as provided in Subsection G below, a penalty of fifty dollars ($50) per day shall be assessed for any employee and employer contribution transmittal report that is untimely. For purposes of this subsection, "untimely" is defined as fifteen (15) days after the end of the month in which the transmittal report was due.

E. In the event the judicial agency fails to make the necessary deductions, the judicial agency shall be responsible to remit to PERA the total amount due for both the member and employer contributions plus interest as provided in subsection C above.

F. Current employer contributions may not be made by members except as authorized by law.

G. If a judicial agency, for good cause, is unable to timely transmit employee and employer contributions or transmittal report, the employer shall notify PERA in writing at least twenty-four hours prior to the due date, and may request waiver of the interest or penalty that would otherwise be assessed. The executive director may waive interest or penalty for up to thirty-one calendar days. Interest shall thereafter be charged at the rate set in subsection C above.

H. Member contributions picked-up by the employer under NMSA 1978, Section 10-12C-10 are not considered compensation for purposes of Internal Revenue Code Section 415(c).

I. Beginning January 1, 2009, to the extent required by Internal Revenue Code [~~Sections 3401(h) and~~] Section 414(u)(2), an individual receiving differential wage payments [~~, while the individual is performing qualified military service as defined in Chapter 43 of Title 38, United States Code,~~] (as defined under Internal Revenue Code Section 3401(h)(2)) from an affiliated public employer shall be treated as employed by that employer and the differential wage payment shall be treated as [~~earned~~] compensation for purposes of applying the limits on annual additions under Internal Revenue Code Section 415(c). [~~However, contributions attributable to such differential wage payments shall not be made unless and until the member returns to active employment and makes up the missed contributions.~~] This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

[10-15-97; 11-15-97; 2.84.1200.8 NMAC - Rn & A, 2 NMAC 84.1200.8, 12-28-00; A, 12-28-01; A, 12-15-09; A, 12-30-13]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.87.100 NMAC, Amending Sections 10 and 20 and Adding Section 11, Effective 12/30/13.

2.87.100.10 GENERAL PROVISIONS

A. The chief of each fire department shall file an executed member enrollment form for each new volunteer firefighter member within thirty (30) days after the firefighter joins the department.

[~~A.~~] B. Service shall be credited by calendar year.

[~~B.~~] C. In order to post service credit for any member, [~~the following completed records must be postmarked~~

~~or received by PERA~~] the chief of each fire department shall electronically report those members who met and those who did not meet the minimum qualifications for service credit through the PERA website, and shall submit an annual reporting form, as prescribed by the association, which acknowledges the truth of the reporting under oath before a notary public no later than March 31 of the year following the year for which service credit is to be credited[~~;~~

~~(1) membership application form; and~~

~~(2) volunteer firefighter service credit qualification record as prescribed by the association~~].

[~~C.~~] D. The failure to timely provide these records to PERA shall result in the loss of the member's service credit for the preceding calendar year.

[10-15-97; 1-15-99; 12-15-99; 2.87.100.10 NMAC - Rn, 2 NMAC 87.100.10, 12-28-01; A, 12-15-09; A, 12-30-13]

2.87.100.11 APPEAL OF DENIAL OF CLAIM OF BENEFITS: The denial of any claim for volunteer firefighters retirement benefits may be appealed by a claimant. Appeals shall follow the procedures set forth in 2.80.1500 NMAC.

[2.87.100.11 NMAC - N, 12-30-13]

2.87.100.20 SERVICE CREDIT FOR PRIOR CALENDAR YEARS

A. Service shall be credited by calendar year.

B. In order to post or adjust service credit for any member for one or more prior calendar years beginning on or after January 1, 1979, the member must file with the association the following completed records:

(1) membership [~~application~~] enrollment form;

(2) "corrected qualification record" or "adjusted qualification record" as prescribed by the association;

(3) adjusted qualification record executed under oath before a notary public.

[10-15-97; 2.87.100.20 NMAC - Rn, 2 NMAC 87.100.20, 12-28-01; A, 12-15-09; A, 12-30-13]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

Notice of Repeal

1.18.370 NMAC, Executive Records Retention and Disposition Schedule for the Secretary of State is being repealed and replaced with the new 1.18.370 NMAC, Executive Records Retention and Disposition Schedule for the Secretary of State effective January 5, 2014. The New Mexico Commission of Public Records at their December 3, 2013 meeting repealed the current rules and approved the new rules.

Notice of Repeal

1.18.508 NMAC, Executive Records Retention and Disposition Schedule for the New Mexico Livestock Board is being repealed and replaced with the new 1.18.508 NMAC, Executive Records Retention and Disposition Schedule for the New Mexico Livestock Board effective January 5, 2014. The New Mexico Commission of Public Records at their December 3, 2013 meeting repealed the current rules and approved the new rules.

Notice of Repeal

1.18.950 NMAC, Executive Records Retention and Disposition Schedule for the Commission on Higher Education is being repealed and replaced with the new 1.18.950 NMAC, Executive Records Retention and Disposition Schedule for the Higher Education Department effective January 5, 2014. The New Mexico Commission of Public Records at their December 3, 2013 meeting repealed the current rules and approved the new rules.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

December 3, 2013

Jackie Garcia, Agency Analysis Bureau Chief
NM Commission of Public Records
1205 Camino Carlos Rey
Santa Fe, New Mexico 87507

Ms. Garcia:

You recently requested to publish a synopsis in lieu of publishing the full content of the following rules:

1.18.370 NMAC ERRDS, Secretary of State
1.18.420 NMAC ERRDS, Regulation and Licensing Department
1.18.508 NMAC ERRDS, New Mexico Livestock Board
1.18.950 NMAC ERRDS, Higher Education Department

A review of the rules shows that their impact is limited to the individual agency to which it pertains, and it is "unduly cumbersome, expensive or otherwise inexpedient" to publish. Therefore, your request to publish a synopsis for each of the rules listed is approved.

Sincerely,

John Hyrum Martinez
State Records Administrator

JHM/jg

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.370 NMAC ERRDS, Office of the Secretary of State

1. Subject matter: 1.18.370 NMAC, Executive Records Retention and Disposition Schedule for the Office of the Secretary of State. This is a replacement to 1.18.370 NMAC, ERRDS, Office of the Secretary of State. The records retention and disposition schedule is a timetable for the management of specific records series of the Office of the Secretary of State. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Office of the Secretary of State.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Office of the Secretary of State. Persons and entities normally subject to the rules and regulations of the Office of the Secretary of State may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Office of the Secretary of State.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Office of the Secretary of State. Any person or entity outside the covered geographical area that conducts business with or through the Office of the Secretary of State may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 is used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: January 5, 2014

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.370 NMAC ERRDS, Office of the Secretary of State.

_____
SRCA Legal Representative

_____
Date

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.508 NMAC ERRDS, New Mexico Livestock Board

1. Subject matter: 1.18.508 NMAC, Executive Records Retention and Disposition Schedule for the New Mexico Livestock Board. This is a replacement to 1.18.508 NMAC, ERRDS, New Mexico Livestock Board. The records retention and disposition schedule is a timetable for the management of specific records series of the New Mexico Livestock Board. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the New Mexico Livestock Board.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the New Mexico Livestock Board. Persons and entities normally subject to the rules and regulations of the New Mexico Livestock Board may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the New Mexico Livestock Board.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the New Mexico Livestock Board. Any person or entity outside the covered geographical area that conducts business with or through the New Mexico Livestock Board may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 is used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: January 5, 2014

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.508 NMAC ERRDS, New Mexico Livestock Board.

_____
SRCA Legal Representative

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Date

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.950 NMAC ERRDS, New Mexico Higher Education Department

1. Subject matter: 1.18.950 NMAC, Executive Records Retention and Disposition Schedule for the New Mexico Higher Education Department. This is a replacement to 1.18.950 NMAC, ERRDS, New Mexico Higher Education Department. The records retention and disposition schedule is a timetable for the management of specific records series of the New Mexico Higher Education Department. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the New Mexico Higher Education Department.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the New Mexico Higher Education Department. Persons and entities normally subject to the rules and regulations of the New Mexico Higher Education Department may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the New Mexico Higher Education Department.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the New Mexico Higher Education Department. Any person or entity outside the covered geographical area that conducts business with or through the New Mexico Higher Education Department may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: January 5, 2014

Certification

As counsel for the State Records Center

and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.950 NMAC ERRDS, New Mexico Higher Education Department.

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Tania Maestas
Assistant Attorney General

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Date

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.420 NMAC ERRDS, Regulation and Licensing Department

1. Subject matter: 1.18.420 NMAC, Executive Records Retention and Disposition Schedule for the Regulation and Licensing Department. This is an amendment to 1.18.420 NMAC, ERRDS, Regulation and Licensing Department, amending Sections 217, 231, 241, 691, 731, 851, 871, 872, 875, 878, 880-882, 884, 931, 981, 989, 1116, 1136, 1138-1140, 1143 adding Sections 218, 242, 732, 852, 895, 896-901, 982-984, 1051-1055, 1057-1059, 1119, 1137, 1156, 1159 and repealing Sections 218, 242, 693-697, 733-739, 852, 853, 855-860, 873, 874, 876, 877, 879, 883, 886-894, 895, 896, 932, 934-939, 982, 983, 985-988, 990, 1051-1058, 1117, 1119-1124, 1137, 1141, 1142 and 1145-1158, effective 01/05/2014. The records retention and disposition schedule is a timetable for the management of specific records series of the Regulation and Licensing Department. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Regulation and Licensing Department.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Regulation and Licensing Department. Persons and entities normally subject to the rules and regulations of the Regulation and Licensing Department may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Regulation and Licensing Department.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Regulation and Licensing Department. Any person or entity outside the covered geographical area that conducts business with or through the Regulation and Licensing Department may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: January 5, 2014

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.420 NMAC ERRDS, Regulation and Licensing Department.

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Tania Maestas
Assistant Attorney General

_____

Date

NEW MEXICO RACING COMMISSION

This is an amendment to 15.2.1 NMAC, Section 9, effective January 1, 2014.

15.2.1.9 DUE PROCESS AND DISCIPLINARY ACTION:

A. PURPOSE OF CHAPTER: This chapter contains the rules of procedure for stewards' hearings and commission proceedings.

B. PROCEEDINGS BEFORE THE STEWARDS:

(1) Rights of the licensee. A person who is the subject of the disciplinary hearing conducted by the stewards is entitled to: proper notice of all charges; confront the evidence presented including: the right to counsel at the person's expense; the right to examine all evidence to be presented against them; the right to present a defense; the right to call witnesses; the right to cross examine witnesses; and waive any of the above rights.

(2) Complaints.

(a) On their own motion or on receipt of a complaint from an official or other person regarding the actions of a licensee, the stewards may conduct an inquiry and disciplinary hearing regarding the licensee's actions. The stewards shall not conduct a disciplinary hearing regarding a licensee's action that results in detection of a Class 1 or 2 drug as found in 15.2.6 NMAC. Hearings on these matters shall proceed directly to the commission and shall be conducted in accordance with 15.2.1.9 NMAC.

(b) A complaint made by someone other than the stewards must be in writing and filed with the stewards not later than 72 hours after the action that is the subject of the complaint.

(c) In case of a notice from the state of New Mexico human services department that a licensee is in non-compliance with the Parental Responsibility Act, the licensee shall be notified by the board of stewards. Thereafter the licensee shall have 30 days to provide documentation of compliance to the board of stewards and failure to do so will result in the suspension of the licensee's license.

(3) Summary suspension.

(a) If the stewards determine that a licensee's actions constitute an immediate danger to the public health, safety, or welfare, the stewards may summarily suspend the license pending a hearing.

(b) A licensee whose license has been summarily suspended is entitled to a hearing on the summary suspension not later than the third day after the license was summarily suspended. The licensee may waive their right to a hearing on the summary suspension within the three-day limit.

(c) The stewards shall conduct a hearing on the summary suspension in the same manner as other disciplinary hearings. At a hearing on a summary suspension, the sole issue is whether the licensee's license should remain suspended pending a final disciplinary hearing and ruling.

(d) If a positive test arises in a trial race, the horse is eligible for entry during the period the split is tested and reported to the commission. If the report confirms a positive test, the horse is disqualified from both the trial and the race for which the trial was conducted.

(4) Notice.

(a) Except as provided by these rules regarding summary suspension, jockey riding infractions and trial races, the stewards shall provide written notice, at

least 10 days before the hearing, to a person who is the subject of a disciplinary hearing. The person may waive their right to 10 days notice by executing a written waiver.

(b) Notice given under this section must include: a statement of the time, place and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing is to be held; a reference to the particular sections of the statutes or rules involved; a short, plain description of the alleged conduct that has given rise to the disciplinary hearing; the possible penalties that may be imposed.

(c) If possible, the stewards or their designee shall hand deliver the written notice of the disciplinary hearing to the person who is the subject of the hearing. If hand delivery is not possible, the stewards shall forthwith mail the notice to the person's last known address, as found in the commission's licensing files, by regular mail [~~and by certified mail, return receipt requested~~]. If the disciplinary hearing involves an alleged medication violation that could result in the disqualification of a horse, the stewards shall provide notice of the hearing to the owner of the horse in the manner provided by this subsection.

(d) Nonappearance of a summoned party after adequate notice shall be construed as a waiver of the right to a hearing before the stewards. The stewards may suspend the license of a person who fails to appear at a disciplinary hearing after written notice of the hearing has been sent, in compliance with this subsection.

(5) Continuances.

(a) Upon receipt of a notice, a person may request a continuance of the hearing.

(b) The stewards may grant a continuance of any hearing for good cause shown.

(c) The stewards may at any time order a continuance on their own motion.

(6) Evidence.

(a) Each witness at a disciplinary hearing conducted by the stewards must be sworn by the presiding steward.

(b) The stewards shall allow a full presentation of evidence and are not bound by the technical rules of evidence. The stewards may admit hearsay evidence if the stewards determine the evidence is of a type that is commonly relied on by reasonably prudent people. The rules of privilege recognized by state law apply in hearings before the stewards. Hearsay evidence alone is insufficient basis for a ruling.

(c) The burden of proof is on the person bringing the complaint to show, by a preponderance of the evidence that the licensee has violated or is responsible for a violation of the act or a commission rule.

(d) The stewards shall make a tape recording of a disciplinary hearing and make a copy of the recording available on request, at the expense of the requesting person.

(7) Ruling.

(a) The issues at a disciplinary hearing shall be decided by a majority vote of the stewards. If the vote is not unanimous, the dissenting steward shall include with the record of the hearing a written statement of the reasons for the dissent.

(b) A ruling by the stewards must be on a form prescribed by the commission and include: the full name, date of birth, license type and license number of the person who is the subject of the hearing; a statement of the charges against the person, including a reference to the specific section of the Racing Act or rules of the commission that the licensee is found to have violated; the date of the hearing and the date the ruling was issued; the penalty imposed; any changes in the order of finish or purse distribution; other information required by the commission.

(c) A ruling must be signed by a majority of the stewards.

(d) If possible, the stewards or their designee shall hand deliver a copy of the ruling to the person who is the subject of the ruling. If hand delivery is not possible, the stewards shall mail the ruling to the person's last known address, as found in the commission's licensing files, by regular mail. If the ruling includes the disqualification of a horse, the stewards shall provide a copy of the ruling to the owner of the horse, the horsemen's bookkeeper, and the appropriate past performance service.

(e) At the time the stewards inform a person who is the subject of the proceeding of the ruling, the stewards shall inform the person of the person's right to appeal the ruling to the commission and apply for a stay.

(f) All fines imposed by the stewards shall be paid to the commission within 30 days after the ruling is issued, unless otherwise ordered.

(8) Effect of rulings.

(a) Rulings against a licensee apply to another person if continued participation in an activity by the other person would circumvent the intent of a ruling by permitting the person to serve, in essence, as a substitute for the ineligible licensee.

(b) The transfer of a horse to avoid application of a commission rule or ruling is prohibited.

(c) The stewards shall honor the rulings issued by other pari-mutuel racing commissions.

(9) Appeals.

(a) A person who has been aggrieved by a ruling of the stewards may appeal to the commission. A person who fails to file an appeal by the deadline and in the form required by this section waives the right to appeal the ruling.

(b) An appeal under this section must be filed not later than 10 days after the date of the ruling. If the deadline falls on a Saturday, Sunday or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday or legal holiday. The appeal must be received by noon, at the main commission offices or with the stewards who issued the ruling and must be accompanied by a fee in the amount of $500. The fee must be in the form of cash, a cashier's check, money order or personal check.

(c) An appeal must be in writing on a form prescribed by the commission. The appeal must include the name, address, telephone number and signature of the person making the appeal; a statement of the basis for the appeal.

(d) On notification by the commission that an appeal has been filed, the stewards shall forward to the commission the record of the proceeding on which the appeal is based, and a statement of the reasons for their rulings.

(e) If a person against whom a fine has been assessed files an appeal of the ruling that assesses the fine, the person shall pay the fine in accordance with these rules.

(10) Stay.

(a) A person who has been disciplined by a ruling of the stewards may apply to the agency director for a stay of the ruling [~~within 20 days from the date of the ruling.~~] not later than 10 days after the date of the ruling. If the deadline falls on a Saturday, Sunday or legal holiday, the period is extended to the next business day. A request for a stay must be received by noon at the main commission offices.

(b) An application for a stay must be filed with the agency director not later than the deadline for filing an appeal.

(c) An application for a stay must be in writing and include the name, address and telephone number and signature of the person requesting the stay; a statement of the justification for the stay.

(d) On a finding of good cause, the agency director may grant the stay. The agency director shall notify the person in writing of the agency director's decision on the stay application. On a finding of changed circumstances or upon appellant's request for a continuance, the agency director may rescind a stay granted under this subsection. No such stay shall be rescinded with less than a 72 hours notice.

(e) The fact that a stay is granted is not a presumption that the ruling by the stewards is invalid.

C. PROCEEDINGS BY THE COMMISSION:

(1) Party designations.

(a) A person who is the subject of a disciplinary hearing, who filed an appeal from a stewards' ruling or who otherwise

seeks relief from the commission is a party to that proceeding.

(b) A party to a proceeding has the right to present a direct case, cross-examine each witness, submit legal arguments and otherwise participate fully in the proceeding.

(c) A party summoned to appear at a hearing must appear unless [~~he/she~~] the party is excused by the commission presiding officer. Parties may appear with counsel or other representatives of their choice. Counsel must be an attorney licensed to practice law in this state or with the permission of the commission is associated with an attorney licensed to practice law in this state and must submit an entry of appearance no later than ten (10) days prior to the hearing date.

(d) A non-party to a proceeding who wishes to appear in a contested case pending before the commission must prove that [~~he/she has~~] they have an effected interest sufficient to create standing in the case. The burden of proof is on the party asserting standing in such a contested case.

(2) Notice.

(a) Not less than twenty (20) days before the date set for a hearing, the agency director, or acting agency director, shall serve written notice on each party of record to the proceeding. The person may waive [~~his/her~~] their right to said notice by executing a written waiver.

(b) The agency director[~~, or acting agency director,~~] shall mail the notice to the person's last known address, as found in the commission's licensing files, by regular mail [~~and by personal service or certified mail, return receipt requested~~]. If a party is being represented by an attorney or other representative, notice will be provided to the attorney or representative instead of on the party and is deemed properly served.

(c) A notice of the hearing must include: statement of time, place and nature of hearing; statement of the legal authority and jurisdiction under which the hearing is to be held; reference to the particular section of the statutes and rules involved; short, plain statement of the matters asserted; and any other statement required by law.

(d) If the commission determines that a material error has been made in a notice of hearing, or that a material change has been made in the nature of a proceeding after notice has been issued; the commission shall issue a revised notice. The party who has caused the change or error requiring revised notice shall bear the expense of giving revised notice.

(e) A party to a proceeding may move to postpone the proceeding. The motion must be in writing, set forth the specific grounds on which it is sought and be filed with the commission before the date set for hearing. If the person presiding over the proceeding grants the motion for postponement, the commission shall cause new notice to be issued.

(f) After a hearing has begun, the presiding officer may grant a continuance on oral or written motion, without issuing new notice, by announcing the date, time and place for reconvening the hearing before recessing the hearing.

(3) Subpoenas and depositions.

(a) A member of the commission, the agency director, the stewards, the presiding officer of a commission proceeding or other person authorized to perform duties under the act may require by subpoena the attendance of witnesses and the reproduction of books, records, papers, correspondence and other documents.

(b) A member of the commission, the agency director, a presiding officer of a commission proceeding or other person authorized by the commission may administer an oath or affirmation to a witness appearing before the commission or a person authorized by the commission.

(c) Each party is responsible for proper service of any subpoenas it requests and for the payment of witness fees and expenses as provided by this jurisdiction's civil procedures statute.

(4) Pleadings.

(a) Pleadings filed with the commission include appeals, applications, answers, complaints, exceptions, replies and motions. Regardless of an error in designation, a pleading shall be accorded its true status in the proceeding in which it is filed.

(b) A request for discovery or a response to a request for discovery is not a pleading and is not a part of the administrative record of a contested case unless the request or response is offered into evidence.

(c) A pleading or brief filed with the commission must be typewritten or printed on 8 1/2 inch by 11-inch white paper with one-inch margins. Exhibits, unless prepared according to other commission rules pertaining to maps, plats, or similar documents, must be folded to the same size. Unless printed, the impression must be on one side of the paper only. The documentation must be double-spaced, except for footnotes and lengthy quotations, which may be single-spaced. Reproductions are acceptable, provided all copies are clear and permanently legible. The original copy of each pleading must be signed in ink by the pleader or the pleader's representative.

(d) If the commission staff prepares a form for a pleading, the commission staff shall furnish the form on request. A pleading for which an official form has been developed must conform substantially to the form. A pleading for which the commission staff has not prepared an official form must contain: the name of the pleader; the telephone number and street address of the pleader's residence or business and the telephone number and street address of the pleader's representative, if any; a concise statement of the facts relied on by the pleader; a request stating the type of commission action desired by the pleader; the name and address of each person who the pleader knows or believes will be affected if the request is granted; any other matter required by statute or commission rule; a certificate of service.

(e) A party filing a pleading shall mail or deliver a copy of the pleading to each party of record. If a party is being represented by an attorney or other representative, service must be made on the attorney or representative instead of on the party.

(f) An objection to a defect, omission, or fault in the form or content of a pleading must be specifically stated in a motion or an exception presented not later than the prehearing conference if one is held and not later than 15 days before the date of the hearing if a prehearing conference is not held. A party who fails to timely file an objection under this subsection waives the objection.

(g) Except as otherwise provided by this subsection, a pleader may amend or supplement a pleading at any time before the 21st day after the date the pleading was filed, but not later than five days before the date of the hearing. A pleader may amend or supplement a pleading at any time: on written consent of each party of record; or, as permitted by the presiding officer for the proceeding, when justice requires the amendment or supplementation and when the amendment or supplementation will not unfairly surprise another party.

(h) A pleading may adopt or incorporate by specific reference any part of a document in the official files and records of the commission. This subsection does not relieve the pleader of the duty to allege in detail all facts necessary to sustain the pleader's burden of proof.

(5) Filing pleadings.

(a) Except as otherwise provided by this section, an original of each pleading must be filed with the commission. An original of each pleading relating to discovery must be filed with the commission. A pleading is considered filed only when actually received by the commission. Each pleading must include a certification that a copy has been mailed or delivered on each party of record, stating the name of each party served and the date and manner of service.

(b) If a pleading is sent to the commission by first-class United States mail in an envelope or wrapper properly addressed and stamped and is deposited in the mail one day or more before the last day for filing the pleading, the pleading

is considered received and filed in time if the pleading is actually received not more than 10 days after the deadline. A legible postmark affixed by the United States postal service is prima facie evidence of the date of mailing. For purposes of responsive pleadings for which the deadline for filing is set by the filing of another pleading, the pleading to be filed first is considered filed when actually received by the commission.

(c) Unless otherwise provided by statute, the presiding officer for a proceeding may extend the time for filing a pleading on a motion made by a party before the filing deadline if the presiding officer determines that there is good cause for the extension and that the need for the extension is not caused by the neglect, indifference, or lack of diligence of the party making the motion. A copy of a motion made under this section must be served on all parties of record contemporaneously with the filing of the motion.

(d) A pleading may be filed by facsimile, provided an original and the required number of copies are received in the commission's office not later than 5:00 p.m. of the third day after the date the document was filed by facsimile. The inability to transmit a document due to equipment malfunction or any other cause does not relieve the person attempting to file the document of the filing deadline.

(e) If the deadline for filing a pleading falls on a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday.

(f) The failure to file a pleading in accordance with this section may result in the pleading being struck.

(6) Place and nature of hearings.

(a) A hearing in a commission proceeding is open to the public.

(b) A hearing shall be held in Albuquerque unless: for good cause stated, the commission designates another place for the hearing; or, the act require otherwise.

(c) Unless precluded by law or objected to by a party, the commission may allow informal disposition of a proceeding without a hearing. Informal disposition includes, but is not limited to, disposition by stipulation, agreed settlement, consent order, dismissal, and default.

(7) Presiding officers.

(a) One or more members of the commission, an administrative law judge, or a duly designated hearing officer may serve as the presiding officer for a commission proceeding. Objections to the presiding officer must be made in writing to the agency director at least twenty (20) days prior to the hearing.

(b) The presiding officer may: authorize the taking of depositions; issue subpoenas to compel the attendance of witnesses and the production of papers and documents; administer oaths; receive evidence; rule on the admissibility of evidence and amendments to pleadings; examine witnesses; set reasonable times within which a party may present evidence and within which a witness may testify; permit and limit oral argument; issue interim orders; recess a hearing from day to day and place to place; request briefs before or after the presiding officer files a report or proposal for decision; propose findings of fact and conclusions of law; propose orders and decisions; perform other duties necessary to a fair and proper hearing.

(c) An administrative law judge designated as the presiding officer must be an attorney licensed to practice in this state.

(d) A person may not serve as the presiding officer of a proceeding in which the person has an economic interest. A person is considered to have an economic interest in a proceeding if the person, a member of the person's immediate family, or a dependent, business partner, or client of the person has an economic interest in the proceeding.

(8) Conferences.

(a) On written notice, the presiding officer may, on the officer's own motion or on the motion of a party, direct each party to appear at a specified time and place for a prehearing conference to formulate issues and consider any of the following: simplifying issues; amending the pleadings; making admissions of fact or stipulations to avoid the unnecessary introduction of proof; designating setting the order of procedure at a hearing; identifying and limiting the number of witnesses; resolving other matters that may expedite or simplify the disposition of the controversy, including settling issues in dispute.

(b) The presiding officer shall record the action taken at the prehearing conference unless the parties enter into a written agreement as to the action. The presiding officer may enter appropriate order concerning prehearing discovery, stipulations of uncontested matters, presentation of evidence and scope of inquiry.

(c) During a hearing, on written notice or notice stated into the record, the presiding officer may direct each party or the representative of each party to appear for a conference to consider any matter that may expedite the hearing and serve the interests of justice. The presiding officer shall prepare a written statement regarding the action taken at the conference and the statement must be signed by each party and made a part of the record.

(9) Discovery.

(a) On written request by a party, the presiding officer or the agency director may issue a subpoena to require the attendance of witnesses and the production of books, records, papers, or other objects as may be necessary and proper for the purposes of a proceeding.

(b) A motion for a subpoena to compel the production of books, records, papers, or other objects shall be addressed to the appropriate person, shall be sworn to and shall specify the books, records, papers, or other objects desired and the relevant and material facts to be proved by them.

(c) Discovery on behalf of commission shall only be provided to the licensee or to counsel who has submitted an entry of appearance.

(10) Order of hearing.

(a) The presiding officer shall open the hearing, make a concise statement of its scope and purposes and announce that a record of the hearing is being made.

(b) When a hearing has begun a party or a party's representative may make statements off the record only as permitted by the presiding officer. If a discussion off the record is pertinent, the presiding officer shall summarize the discussion for the record.

(c) Each appearance by a party, a party's representative, or a person who may testify must be entered on the record.

(d) The presiding officer shall receive motions and afford each party of record an opportunity to make an opening statement.

(e) Except as otherwise provided by this subsection, the party with the burden of proof is entitled to open and close. The presiding officer shall designate who may open and close in a hearing on a proceeding if the proceeding was initiated by the commission or if several proceedings are heard on a consolidated record.

(f) After opening statements, the party with the burden of proof may proceed with the party's direct case. Each party may cross-examine each witness.

(g) After the conclusion of the direct case of the party having the burden of proof, each other party may present their direct case and their witnesses will be subject to cross-examination.

(h) The presiding officer may allow nonparty participants to cross examine a witness if the presiding officer determines that the cross examination may lead to significantly fuller disclosure of the facts without unduly delaying the hearing or burdening the record.

(i) At the conclusion of all evidence and cross-examination, the presiding officer shall allow closing statements.

(j) Before writing a report or proposal for decision if required by law, the presiding officer may call on a party for further relevant and material evidence on an issue. The presiding officer may not consider the evidence or allow it into the record without giving each party an opportunity to

inspect and rebut the evidence.

(11) Behavior.

(a) Each party, witness, attorney, or other representative shall behave in all commission proceedings with dignity, courtesy and respect for the commission, the presiding officer and all other parties and participants. Attorneys shall observe and practice the standards of ethical behavior prescribed for the profession by the code of professional responsibility.

(b) An individual who violates this section may be excluded from a hearing by the presiding officer for a period and on conditions that are just, or may be subject to other just, reasonable and lawful disciplinary action prescribed by the presiding officer.

(12) Evidence.

(a) All testimony must be given under oath administered by the presiding officer. The presiding officer may limit the number of witnesses and shall exclude all irrelevant, immaterial, or unduly repetitious evidence.

(b) The presiding officer may, unless precluded by statute, admit evidence of a type commonly relied on by reasonably prudent persons in the conduct of their affairs. The rules of privilege recognized by law in this jurisdiction apply in commission proceedings.

(c) A party may object to offered evidence and the objection shall be noted in the record. Formal exceptions to rulings by the presiding officer during a hearing are unnecessary. A party, at the time a ruling is made or sought, shall make known to the presiding officer the action the party desires.

(d) When the presiding officer rules to exclude evidence, the party offering the evidence may make an offer of proof by dictating or submitting in writing the substance of the proposed evidence, before the closing of the hearing. The offer of proof preserves the point for review. The presiding officer may ask a witness or offered witness questions necessary to indicate that the witness would testify as represented in the offer of proof. An alleged error in sustaining an objection to questions asked on cross-examination is preserved without making an offer of proof.

(e) The presiding officer may take official notice of judicially cognizable facts and of facts generally recognized within the area of the commission's specialized knowledge. The commission shall notify each party of record before the final decision in a proceeding of each specific fact officially noticed, including any facts or other data in staff memoranda. A party must be given an opportunity to rebut the facts to be noticed.

(f) The special skills and knowledge of the commission and the commission staff may be used in evaluating the evidence.

(g) The presiding officer may receive documentary evidence in the form of copies or excerpts if the original is not readily available. On request, the presiding officer shall allow a party to compare the copy with the original. If many similar documents are offered in evidence, the presiding officer may limit the documents admitted to a number which are representative of the total number, or may require that the relevant data be abstracted from the documents and presented as an exhibit. If the presiding officer requires an abstract, the presiding officer shall allow each party or the party's representative to examine the documents from which the abstracts are made.

(h) The presiding officer may require prepared testimony in a hearing if the presiding officer determines that it will expedite the hearing without substantially prejudicing the interests of a party. Prepared testimony consists of any document that is intended to be offered as evidence and adopted as sworn testimony by a witness who prepared the document or supervised its preparation. A person who intends to offer prepared testimony at a hearing shall prefile the testimony with the commission on the date set by the presiding officer and shall serve a copy of the prepared testimony on each party of record. The presiding officer may authorize the late filing of prepared testimony on a showing of extenuating circumstances. The prepared testimony of a witness may be incorporated into the record as if read or received as an exhibit, on the witness being sworn and identifying the writings as a true and accurate record of what the testimony would be if the witness were to testify orally. The witness is subject to clarifying questions and to cross examination and the prepared testimony is subject to a motion to strike either in whole or in part.

(i) Documentary exhibits must be of a size, which will not unduly encumber the record. Whenever practicable, exhibits must conform to the size requirements in these rules for pleadings. The first sheet of the exhibit must briefly state what the exhibit purports to show and the pages of the exhibit must be numbered consecutively. Exhibits may include only facts material and relevant to the issues of the proceedings. Maps or drawings must be rolled or folded so as not to encumber the record. Exhibits not conforming to this subsection may be excluded.

(j) The party offering an exhibit shall tender the original of the exhibit to the presiding officer for identification. The party shall furnish one copy to the presiding officer and one copy to each party of record. A document received in evidence may not be withdrawn except with the permission of the presiding officer. If an exhibit has been offered, objected to and excluded, and the party offering the exhibit withdraws the offer, the presiding officer shall return the exhibit to the party. If the party does not withdraw the offered exhibit, the exhibit shall be numbered for identification, endorsed by the presiding officer with the ruling on the exhibit and included in the record to preserve the exception.

(k) The presiding officer may allow a party to offer an exhibit in evidence after the close of the hearing only on a showing of extenuating circumstances and a certificate of service on each party of record.

(13) Reporters and transcripts.

(a) If necessary, and with concurrence of the parties, the commission shall engage a court reporter to make a stenographic record of a hearing. The commission may allocate the cost of the reporter and transcript among the parties.

(b) If a person requests a transcript of the stenographic record, the commission may assess the cost of preparing the transcript to the person.

(c) A party may challenge an error made in transcribing a hearing by noting the error in writing and suggesting a correction not later than 10 days after the date the transcript is filed with the commission. The party claiming errors shall serve a copy of the suggested corrections on each party of record, the court reporter and the presiding officer. If proposed corrections are not objected to before the 15th day after the date the corrections were filed with the commission, the presiding officer may direct that the suggest corrections be made and the manner of making them. If the parties disagree on the suggested corrections, the presiding officer shall determine whether to change the record.

(14) Findings of fact and conclusions of law.

(a) The presiding officer may direct a party to draft and submit proposed findings of fact and conclusions of law or a proposal for decision that includes proposed findings of fact and conclusions of law. The presiding officer may limit the request for proposed findings to a particular issue of fact.

(b) Proposed findings of fact submitted under this section must be supported by concise and explicit statements of underlying facts developed from the record with specific reference to where in the record the facts appear.

(15) Proposal for decision.

(a) Where a hearing officer conducts a hearing, the hearing officer shall, within 30 days of the hearing prepare a report containing his or her findings of fact, conclusions of law and recommendations for commission action. Any commissioner who had not heard the case may not participate in a decision in which the commission rejects, modifies, adds to, or makes substitutions for the findings of fact in a hearing officer's

report unless the commission has reviewed all portions of the record that pertain to such findings of fact. Where the commission itself is the hearing body, the commission shall issue prepare and issue findings of fact, conclusions of law and order, and, in that case, no commissioner may participate who has not either heard the case or reviewed the entire record.

(b) The person preparing a proposal for decision under this section shall serve a copy of the proposal on each party of record.

(c) A party of record may, not later than 10 working days after the date of service of a proposal for decision, file exceptions to the proposal. A reply to an exception filed under this subsection must be filed not later than [5] five working days after the last day for filing the exceptions. A copy of each exception and reply must be served on all parties of record.

(d) After the expiration of time for filing exceptions and replies, the commission shall consider the proposal for decision in open meeting. The commission may: adopt the proposal for decision, in whole or in part; decline to adopt the proposal for decision, in whole or in part; remand the proceeding for further examination by the same or a different presiding officer; or direct the presiding officer to give further consideration to the proceeding with or without reopening the hearing.

(e) If on remand additional evidence is received which results in a substantial revision of the proposal for decision, a new proposal for decision shall be prepared, unless a majority of the commission, on remand, has heard the case or read the record. A new proposal for decision must be clearly labeled as such and all parties of record are entitled to file exceptions, replies and briefs.

(16) Dismissal. On its own motion or a motion by a party, the presiding officer may dismiss a proceeding, with or without prejudice, under conditions and for reasons that are just and reasonable, including: failure to timely pay all required fees to the commission; unnecessary duplication of proceedings; withdrawal; moot questions or obsolete petitions; and lack of jurisdiction.

(17) Orders.

(a) Except as otherwise provided by these rules, the commission shall issue its final order not later than 60 days after the date the commission votes on the ultimate issues in the proceeding. A final order of the commission must be in writing and be signed by at least one member of the members of the commission who voted in favor of the action taken by the commission. A final order must include findings of facts and conclusions of law, separately stated.

(b) The commission staff shall mail or deliver a copy of the order to each party or the party's representative.

(c) A final order of the commission takes effect on the date the order is issued, unless otherwise stated in the order.

(d) If the commission finds than an imminent peril to the public health, safety, or welfare requires an immediate final order in a proceeding, the commission shall recite that finding in the order in addition to reciting that the order is final from the date issued. An order issued under this subsection is final and appealable from the date issued and a motion for rehearing is not a prerequisite to appeal.

(18) Rehearing.

(a) Within 10 days following issuance of a final commission order, a party adversely affected by the order may file a petition for a rehearing stating the reasons for requesting a rehearing. The commission shall grant a rehearing only in cases of newly discovered material evidence, which the party could not reasonably have discovered at an earlier time, or other good cause.

(b) An order granting a motion for rehearing vacates the preceding final order. The order granting a motion for rehearing may direct that the hearing be reopened or may incorporate a new final decision. Except as otherwise provided by these rules, if the commission renders a new decision, a motion for rehearing directed to the new decision is a prerequisite to appeal.

(19) Ex parte communications: No party to a proceeding before the commission shall, at any time prior to the issuance of a final commission decision, discuss or otherwise communicate with a hearing officer assigned to hear the case or with any commission member who will or may participate in the commission's decision in the case, regarding any issue in the case, without at the same time making the same communication to all other parties, including the commission's administrative prosecutor. This rule shall not apply to communications limited to such items as ascertaining the time or place of a hearing or the procedures to be followed at a hearing.

(20) Administrative penalties.

(a) If the commission determines that a person regulated under the act has violated the act or a rule or order adopted under the act in a manner that constitutes a ground for disciplinary action under the act, the commission may assess an administrative penalty against that person as provided by this section.

(b) The commission delegates to the agency director the authority to prepare and issue preliminary reports pursuant to the act. If, after examination of a possible violation and the facts relating to that possible violation, the agency director determines that a violation has occurred, the agency director shall issue a preliminary report that states the facts on which the conclusion is based, the fact that an administrative penalty is to be imposed and the amount to be assessed. The amount of the penalty may not exceed $1,000 for each violation. Each day/occurrence that a violation continues may be considered a separate violation. In determining the amount of the penalty, the agency director shall consider the seriousness of the violation.

(c) Not later than the 10th day after the date on which the agency director issues the preliminary report, the agency director shall provide a copy of the report to the person charged with the violation, together with a statement of the right of the person to a hearing relating to the alleged violation and the amount of the penalty. If possible, the agency director shall hand deliver the preliminary report. If hand delivery is not possible, the agency director shall mail the preliminary report to the person's last known address, as found in the commission's files, by regular mail and by certified mail, return receipt requested.

(d) Not later than the 20th day after the date on which the agency director delivers or sends the preliminary report, the person charged may make a written request for a hearing or may remit the amount of the administrative penalty to the commission. Failure to request a hearing or to remit the amount of the administrative penalty within the period prescribed by this subsection results in a waiver of a right to a hearing on the administrative penalty. If the person charged requests a hearing, the hearing shall be conducted in the same manner as other hearings conducted by the commission.

(e) If it is determined after the hearing that the person has committed the alleged violation, the commission shall give written notice to the person of the findings established by the hearing and the amount of the penalty and shall enter an order requiring the person to pay the penalty.

(f) Not later than the 30th day after the date on which the above notice is received, the person charged shall pay the administrative penalty in full or exercise the right to appeal to the appropriate court either the amount of the penalty or the fact of the violation. If a person exercises a right of appeal either as to the amount of the penalty or the fact of the violation, the amount of the penalty is not required to be paid until the 30th day after the date on which all appeals have been exhausted and the commission's decision has been upheld.

(21) Exclusion.

(a) The steward, agency director, or commission may order an individual ejected or excluded from all or part of any premises under the regulatory jurisdiction of the commission if the stewards, agency director, or commission determine that the individual's presence on association grounds is inconsistent with maintaining the honesty

and integrity of racing.

(b) An exclusion may be ordered separately or in conjunction with other disciplinary action taken by the stewards or commission. If exclusion is ordered separately, the excluded individual is entitled to a hearing before the stewards or commission. A hearing on exclusion shall be conducted in the same manner as other hearings conducted by the stewards or commission.

(c) If an individual is excluded under this section, a race animal owned or trained by or under the care or supervision of the individual is ineligible to be entered or to start in a race in this jurisdiction.

(22) Rulings in other jurisdictions.

(a) Reciprocity. The stewards shall honor rulings from other pari-mutuel jurisdictions regarding license suspensions, revocation or eligibility of horses.

(b) Appeals of reciprocal rulings. Persons subject to rulings in other jurisdictions shall have the right to request a hearing before the commission to show cause why such ruling should not be enforced in this jurisdiction. Any request for such hearing must clearly set forth in writing the reasons for the appeal.

[15.2.1.9 NMAC - Rp, 15 NMAC 2.1.9, 03/15/2001; A, 03/31/2003; A, 05/30/2003; A, 06/15/2004; A, 06/30/2009; A, 09/15/2009; A, 12/1/2010; A, 05/01/2013; A, 01/01/2014]

NEW MEXICO RACING COMMISSION

This is an amendment to 15.2.5 NMAC, Section 12, effective 01/01/2014.

15.2.5.12 HORSES INELIGIBLE: A horse shall be ineligible to start in a race when:

A. it is not stabled on the grounds of the association or present by the time established by the commission;

B. its breed registration certificate is not on file with the racing secretary or horse identifier; unless it has been verified that the certificate has been submitted to the appropriate breed registry for correction;

C. it is not fully identified and tattooed on the inside of the upper lip [~~or fully identified by other approved methods of positive identification as described in Subsection F of 15.2.3.8 NMAC~~]; however, there may be extenuating circumstances where a horse will be eligible to start in a race without the tattoo as referenced above, as long as the horse idenitifer has written verification that the tattooing process has been initiated;

D. it has been fraudulently entered or raced in any jurisdiction under a different name, with an altered registration certificate or altered lip tattoo;

E. it is wholly or partially owned by a disqualified person or a horse is under the direct or indirect training or management of a disqualified person;

F. it is wholly or partially owned by the spouse of a disqualified person or a horse is under the direct or indirect management of the spouse of a disqualified person, in such cases, it being presumed that the disqualified person and spouse constitute a single financial entity with respect to the horse, which presumption may be rebutted;

G. the stakes or entrance money for the horse has not been paid, in accordance with the conditions of the race;

H. the losing jockey mount fee is not on deposit with the horsemen's bookkeeper;

I. its name appears on the starter's list, stewards' list or veterinarian's list;

J. it is a first time starter and has not been approved to start by the starter;

K. it is owned in whole or in part by an undisclosed person or interest;

L. it lacks sufficient official published workouts or race past performance(s);

M. it has been entered in a stakes race and has subsequently been transferred with its engagements, unless the racing secretary has been notified of such prior to the start;

N. it is subject to a lien which has not been approved by the stewards and filed with the horsemen's bookkeeper;

O. it is subject to a lease not filed with the stewards;

P. it is not in sound racing condition;

Q. it has had a surgical neurectomy performed on a heel nerve, which has not been approved by the official veterinarian;

R. it has been trachea tubed to artificially assist breathing;

S. it has been blocked with alcohol or otherwise drugged or surgically denerved to desensitize the nerves above the ankle;

T. it has impaired eyesight in both eyes;

U. it is barred or suspended in any recognized jurisdiction;

V. it does not meet the eligibility conditions of the race;

W. its owner or lessor is in arrears for any stakes fees, except with approval of the racing secretary;

X. its owner(s), lessor(s) and/or trainer have not completed the licensing procedures required by the commission;

Y. it is by an unknown sire or out of an unknown mare;

Z. there is no current negative test certificate for equine infectious anemia attached to its breed registration certificate, as required by the commission.

[15.2.5.12 NMAC - Rp, 15 NMAC 2.5.12, 03/15/2001; A, 07/15/2002; A; 08/30/2007; A, 06/15/2009; A, 01/01/2014]

NEW MEXICO RACING COMMISSION

Explanatory paragraph: This is an amendment to 16.47.1 NMAC, Section 8, effective 01/01/2014. In 16.47.1 NMAC, Section 8, Subsection B through K and Subsection M through V were not published as there were no changes.

16.47.1.8 GENERAL PROVISIONS:

A. LICENSES REQUIRED: A person as defined by Subsection P, Paragraph (7) of 15.2.1.7 NMAC shall not participate in pari mutuel racing under the jurisdiction of the commission, or be employed by an association who is a gaming operator, without a valid license issued by the commission.

(1) License categories shall include the following and others as may be established by the commission: **GROUP A** - racing participants eligible for an optional annual or triennial year license to include owners, trainers, veterinarians, jockeys, and stable name registrations. **GROUP B** - associations, racing professionals, concession operators, contractors, and managerial racing officials. **GROUP C** - supervisory racing officials. **GROUP D** - persons employed by the association, or employed by a person or concern contracting with the association, to provide a service or commodity, which requires their presence in a restricted area, or anywhere on association grounds while pari mutuel wagering is being conducted. **GROUP E** - racetrack employees and authorized agents.

(2) Persons required to be licensed shall submit a completed application on forms furnished by the commission and accompanied by the required fee. The following fees are assessed for the issuance of the specified licenses. In addition to license fees listed herein, $20.00 is assessed for each identification picture and badge.

Announcer	$55.00

Assistant general manager	$80.00
Assistant racing secretary	$15.00
Association	$80.00
Auditor, official	$55.00
Authorized agent	$ 5.00
Clerk of scales	$15.00
Clocker	$15.00
Club, racetrack	$80.00
Concession employee	$ 5.00
Concession operator	$80.00
Custodian of jockey room	$15.00
Director or corporate officer	$80.00
Director of operations	$55.00
Director of racing	$55.00
Exercise person	$15.00
General manager	$80.00
Groom	$ 5.00
Horseman's bookkeeper	$15.00
Identifier (horse)	$15.00
Janitor	$ 5.00
Jockey (3 year)	$100.00
Jockey (1 year)	$80.00
Jockey (apprentice) (3 year)	$100.00
Jockey (apprentice) (1 year)	$80.00
Jockey agent	$55.00
Jockey valet	$ 5.00
Laborer	$ 5.00
Official personnel (specify position)	$ 5.00
Official veterinarian (3 year)	$100.00
Official veterinarian (1 year)	$80.00
Outrider	$15.00
Owner (3 year)	$100.00
Owner (1 year)	$80.00
Paddock judge	$15.00
Pari mutuel employee	$ 5.00
Pari mutuel manager	$55.00
Placing judge	$15.00
Photo employee	$ 5.00
Plater	$80.00
Pony person	$ 5.00
Private barns	$ 80.00
Racing secretary-handicapper	$55.00
Security chief	$55.00
Security staff	$ 5.00
Simulcast company employee	$ 5.00
Simulcast coordinator	$55.00
Simulcast operator	$80.00
Special event, 1 or 2 day	$100.00
Stable name (3 year)	$100.00
Stable name (1 year)	$80.00

Stable superintendent	$55.00
Starter	$55.00
Starter assistant	$15.00
Ticket seller (admissions)	$ 5.00
Timer	$15.00
Totalisator employee	$ 5.00
Totalisator operator	$80.00
Track maintenance, employee	$ 5.00
Track physician	$80.00
Track superintendent	$55.00
Trainer (3 year)	$100.00
Trainer (1 year)	$80.00
Trainer assistant	$15.00
Veterinarian assistant	$15.00
Veterinarian, practicing (3 year)	$100.00
Veterinarian, practicing (1 year)	$80.00
Veterinarian, racing (3 year)	$100.00
Veterinarian, racing (1 year)	$80.00
Watchman	$ 5.00

(3) [~~License applicants may be required to furnish to the commission a set(s) of fingerprints and a recent photograph and may be required to be refingerprinted or rephotographed periodically as determined by the commission. The requirements for fingerprints may be fulfilled by submission of prints or verification of such, accepted by a member jurisdiction of the racing commissioners' international, and obtained within two years for annual licenses and four years for three-year licenses. License applicants for owner, trainer or jockey will only need to be fingerprinted upon first application, or if there is a break of three years or more in license continuity. If the commission determines it is necessary, reprinting will be undertaken on the basis of alleged criminal activity on the part of the owner, trainer or jockey.~~] License applicants shall be required to furnish to the commission a set(s) of fingerprints and a recent photograph.

(a) All license applicants may be required to be re-fingerprinted or re-photographed periodically as determined by the commission.

(b) Requirements for fingerprints may be fulfilled by

(i) submission of fingerprints; or

(ii) verification that fingerprints were submitted for processing; or

(iii) submission of a fingerprint reciprocity affidavit.

(c) License applicants for owner, trainer or jockey will only need to be fingerprinted upon first application. If there is a break of three years or more in license continuity or if the commission determines it is necessary, reprinting will be undertaken by the owner, trainer or jockey.

(4) License applicants for groom, watchman, exercise and pony persons must submit to a drug (controlled substances) and alcohol-screening test when making application for license.

***

L. GROUNDS FOR REFUSAL, DENIAL, SUSPENSION, OR REVOCATION OF LICENSE:

(1) The commission may refuse to issue a license to an applicant, or may suspend or revoke a license issued, or order disciplinary measures, if the applicant:

(a) has been convicted of a felony;

(b) has been convicted of violating any law regarding gambling or a controlled dangerous substance;

(c) who is unqualified, by experience or otherwise, to perform the activities for which a license is required, or who fails to pass an examination prescribed by the commission;

(d) has failed to disclose or falsely states any information required in the application;

(e) has been found in violation of rules governing racing in this state or other jurisdictions;

(f) has been or is currently excluded from association grounds by a recognized racing jurisdiction;

(g) has had a license denied, suspended, or revoked by any racing jurisdiction;

(h) is a person whose conduct or reputation may adversely reflect on the honesty and integrity of horse racing or interfere with the orderly conduct of a race meeting; interfering with the orderly conduct of a race meeting shall include, but is not limited to, disruptive or intemperate behavior or behavior which exposes others to danger anywhere on the racetrack grounds; the fact that the race meet was not actually interrupted is not a defense to the imposition of discipline under this rule;

(i) demonstrates a lack of financial responsibility by accumulating unpaid obligations, defaulting on obligations or issuing drafts or checks that are dishonored, or payment refused; for the purpose of this sub-section, non-compliance with the Parental Responsibility Act shall be considered grounds for refusal, denial, suspension, or revocation of a license; the application, or license as applicable, shall be reinstated if within thirty (30) days of the date of the notice, the applicant provides the commission with a certified statement from the department that [~~he/she is~~] they are in compliance with a judgment and order for support;

(j) is ineligible for employment pursuant to federal or state law concerning age or citizenship.

(2) A license suspension or revocation shall be reported in writing to the applicant and the association of racing commissioners international, inc., whereby other racing jurisdictions shall be advised.

(3) Any license denied, suspended or revoked by the commission pursuant to these rules shall state the time period for the effect of its ruling. When the action is taken for a misdemeanor or felony conviction, the time period shall be the period of the licensee's or applicant's imprisonment; or if not imprisoned, the period of probation, deferral, unless the person can satisfy the commission of sufficient rehabilitation. This rule shall also apply to licensees who voluntarily turn in their license because of, or in anticipation of, a conviction.

(4) If a license is suspended or revoked by the commission or stewards pursuant to these rules the commission or stewards may probate all or any portion of the suspension.

(a) The order or ruling entered placing a licensee on probation shall state the specific probationary period and the terms and conditions of the probation.

(b) The terms and conditions of the probation must have a reasonable relationship to the violation and may include:

(i) passing a prescribed examination in a specific area;

(ii) periodic reporting

to the commission, stewards or other designated person on any matter that is the basis of the probation;

(iii) a medical evaluation and completion of a prescribed treatment program; and

(iv) other terms and condition as specified in the order or ruling that are reasonable and appropriate.

(c) If the commission or stewards determine the licensee has failed to comply with the terms of the probation, the probation may be revoked on three days' notice to the licensee and the licensee may be required to appear before the New Mexico racing commission. Failure to comply with the terms of the probation may subject the licensee to additional disciplinary action.

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[16.47.1.8 NMAC - Rp, 16 NMAC 47.1.8, 03/15/2001, A, 08/30/2001; A, 11/15/2001; A, 12/14/2001; A, 02/14/2002; A, 11/14/2002; A, 03/31/2003; A, 07/15/2003; A, 09/29/2006; A, 03/30/2007; A, 08/14/2008; A, 06/15/2009; A, 09/15/2009; A, 01/01/2014]

NEW MEXICO SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 28 SIGNED LANGUAGE INTERPRETERS
PART 7 LICENSURE FOR MILITARY SERVICE MEMBERS, SPOUSES AND VETERANS

16.28.7.1 ISSUING AGENCY: New Mexico Regulation and Licensing Department, Signed Language Interpreting Practices Board.
[16.28.7.1 NMAC - N, 01/15/14]

16.28.7.2 SCOPE: This part sets forth application procedures to expedite licensure for military service members, spouses and veterans.
[16.28.7.2 NMAC - N, 01/15/14]

16.28.7.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to 61-1-34 NMSA 1978.
[16.28.7.3 NMAC - N, 01/15/14]

16.28.7.4 DURATION: Permanent.
[16.28.7.4 NMAC - N, 01/15/14]

16.28.7.5 EFFECTIVE DATE: January 15, 2014, unless a later date is cited at the end of a section.
[16.28.7.5 NMAC - N, 01/15/14]

16.28.7.6 OBJECTIVE: The purpose of this part is to expedite licensure for military service members, spouses and veterans pursuant to 61-1-34 NMSA 1978.
[16.28.7.6 NMAC - N, 01/15/14]

16.28.7.7 DEFINITIONS:

A. Military service member: means a person who is serving in the armed forces of the United States or in an active reserve component of the armed forces of the United States, including the national guard.

B. Recent veteran: means a person who has received an honorable discharge or separation from military service within the two years immediately preceding the date the person applied for an occupational or professional license pursuant to this section.
[16.28.7.7 NMAC - N, 01/15/14]

16.28.7.8 APPLICATION REQUIREMENTS:

A. Applications for registration shall be completed on a form provided by the department.

B. The information shall include.

(1) Completed application and fee.

(2) Satisfactory evidence that the applicant holds a license that is current and in good standing, issued by another jurisdiction, including a branch of armed forces of the United States, that has met the minimal licensing requirements that are substantially equivalent to the licensing requirements for the occupational or professional license the applicant applies for pursuant to Chapter 61, Articles 2 through 34 NMSA 1978.

C. Electronic signatures will be acceptable for applications submitted pursuant to Section 14-16-1 through 14-16-19 NMSA 1978.
[16.28.7.8 NMAC - N, 01/15/14]

16.28.7.9 FEES:

A. The fee for application for community and educational license is $65.00.

B. The fee for application for provisional license is $40.00.

C. The fee for renewal of community and educational license is $50.00.

D. The fee for compliance review of provisional license is $25.00.
[16.28.7.9 NMAC - N, 01/15/14]

16.28.7.10 RENEWAL REQUIREMENTS:

A. A license issued pursuant to this section shall not be renewed unless the license holder satisfies the requirements for the issuance and for the renewal of a license pursuant to Chapter 61, Articles 2 through 34 NMSA 1978.

(1) An application for a community signed language interpreter license must also include: a copy of the applicant's current RID membership card showing that the applicant holds one or more certifications recognized by RID at the time of application for licensure with the exception of ED: K-12 (educational certificate: K-12).

(2) An application for an educational signed language interpreter license must also include: proof of EIPA rating of 4.0 – 5.0 and a copy of the applicant's current RID membership card showing that the applicant holds the ED: K-12 certified member status by virtue of EIPA rating; or a copy of the applicant's current RID membership card showing that the applicant holds one or more certifications currently recognized by RID.

(3) An application for a provisional signed language interpreter license must also include: proof of completion of an interpreter education program or interpreter preparation program at an accredited institution; or proof of employment as a community signed language interpreter or an educational signed language interpreter at the time the act became effective (June 15, 2007) and after the applicant reached the age of 18; and a copy of the applicant's current RID membership card showing that the applicant is an associate member (for purposes of tracking CEU requirements through the ACET program as outlined in Subsection B of 16.28.2.9 NMAC).

B. Original and renewed community and educational license shall be valid for a period of two years.

C. Original and completed compliance reviewed provisional license shall be valid for a period of one year, not to exceed four consecutive annual compliance review cycles.

D. Prior to the expiration of the license, all licensed interpreters shall apply for license renewal and shall pay the renewal fee as set forth in 16.28.6.9 NMAC.
[16.28.7.10 NMAC - N, 01/15/14]

HISTORY OF 16.28.7 NMAC: [RESERVED]

NEW MEXICO SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

This is an amendment to 16.28.1 NMAC, Section 7, effective 01/15/2014.

16.28.1.7 DEFINITIONS: As used in these regulations, the following

words and phrases have the following meanings, unless the context or intent clearly indicates a different meaning:

A. "Accredited" means approved by the:

(1) New England association of schools and colleges;

(2) middle states association of colleges and secondary schools;

(3) north central association of colleges and schools;

(4) northwest association of schools and colleges;

(5) southern association of colleges and schools; or

(6) western association of schools and colleges.

B. "ACET" refers to the associate continuing education tracking system within RID.

C. "Act" means the Signed Language Interpreting Practices Act, Section 61-34-1 through 61-34-17.

D. "Administrator" or "board administrator" means the staff person assigned certain express or implied executive and administrative functions of the board as defined by board regulations or as required to carry out the provisions of the act.

E. "Adult" means the all persons 18 years of age or older.

F. "Applicant" means a person who has completed all educational requirements of the eligibility requirements for licensure and has submitted a complete application to the board. An applicant is seeking approval of his or her application by the board to advance him or her to candidacy for licensure.

G. "Board" means the signed language interpreting practices board.

H. "Board regulations" or "regulations" means any part adopted by the board pursuant to authority under the act and includes any superseding regulation.

I. "CEU" refers to continuing education units as is used by the registry of interpreters for the deaf.

J. "CMP" means the certification maintenance program as is used by the registry of interpreters for the deaf.

K. "Community signed language interpreter" means an interpreter holding one or more certifications recognized by RID with the exception of ED: K-12 (educational certificate: K-12) and holding a community signed language interpreter's license. A community signed language interpreter's license entitles its holder to provide signed language interpreting services in community, K-12 educational, and post-secondary educational settings as appropriate under the NAD-RID code of professional conduct.

L. "Annual compliance review" means an annual review conducted by the board ensuring that interpreters holding a provisional signed language interpreting license are in compliance with all requirements established by the statute and rules.

[~~K.~~] **M.** "Consumer" means a person using the services of a signed language interpreter.

[~~L.~~] **N.** "Confidential communication" means a communication that is not intended to be disclosed to third persons other than those present to further the interest of the person requiring the interpreting.

[~~M.~~] **O.** "Deaf person" means a person who has either no hearing or who has significant hearing loss.

[~~N.~~] **P.** "Deaf-blind person" means a person who has either no hearing or who has significant hearing loss and a significant vision loss.

[~~O.~~] **Q.** "Department" means the New Mexico regulation and licensing department.

R. "Educational signed language interpreter" means an interpreter holding the ED:K-12 credential from the registry of interpreters for the deaf and holding an educational signed language interpreter's license. An educational signed language interpreter's license entitles its holder to provide signed language interpreting services in K-12 educational settings as appropriate under the NAD-RID code of professional conduct.

[~~P.~~] **S.** "EIPA" refers to the educational interpreter performance assessment, a diagnostic tool that measures proficiency in interpreting for children or young adults in an educational setting.

[~~Q.~~] **T.** "Filed with the board" means hand delivered or postal mail received during normal business hours by the board office in Santa Fe, New Mexico.

[~~R.~~] **U.** "Hard-of-hearing person" means a person who has either no hearing or who has significant hearing loss.

[~~S.~~] **V.** "Interpreter" means a person who practices signed language interpreting.

[~~T.~~] **W.** "Interpreter education program" or "interpreter preparation program" means a post-secondary degree program of at least two year's duration accredited by the state or similar accreditation by another state, district or territory; or a substantially equivalent education program approved by the board.

[~~U.~~] **X.** "Interpreting" means the process of providing accessible communication between deaf, hard of hearing, or deaf-blind persons and hearing persons, including communication between signed language and spoken language and other modalities such as visual, gesture and tactile methods, not to include written communication. A person is interpreting if the person advertises, offers to practice, is employed in a position described as interpreting or holds out to the public or represents in any manner that the person is an interpreter in New Mexico

[~~V.~~] **Y.** "Licensee" means an interpreter who holds a current license issued under the act and these rules.

[~~W.~~] **Z.** "NAD" means the national association of the deaf.

[~~X.~~] **AA.** "New Mexico administrative code" or "NMAC", Section 14-4-7.2 NMSA 1978 is the official compilation of current rules filed by state agencies in accordance with New Mexico statutes.

[~~Y.~~] **BB.** "New Mexico statutes annotated 1978 or NMSA 1978" is the official compilation of state laws.

[~~Z.~~] **CC.** "Open Meetings Act" or "OMA", 10-15-1 through 10-15-4 NMSA 1978 is the statutory provision requiring that public business be conducted in full public view; providing guidelines governing both public and closed meetings, and regulating the notice, agenda and minutes of such meetings.

[~~AA.~~] **DD.** "Properly made application" means a completed application form for a signed language interpreter license filed with the board that is complete in all particulars and appears on its face to satisfy all minimum age, educational, supervision, payment and other requirements for licensure as required by the act and these regulations.

EE. "Provisional signed language interpreter" means an interpreter who holds a provisional signed language interpreter's license. A provisional signed language interpreter's license entitles its holder to provide signed language interpreting services in community and educational settings as appropriate under the NAD-RID code of professional conduct for a maximum of five years while working to satisfy the requirements for a community signed language interpreter's license or an educational signed language interpreter's license.

[~~BB.~~] **FF.** "RID" refers to the registry of interpreters for the deaf, which is a national association of signed language interpreters.

[~~CC.~~] **GG.** "Rule" means board regulations.

[~~DD.~~] **HH.** "State Rules Act", Sections 14-4-1 through 14-4-5 NMSA 1978, is the statutory provision that ensures that state agencies file with the state records center and archives all rules and regulations including amendments or repeals.

[~~EE.~~] **II.** "Statute" means a law that governs conduct within its scope. A bill passed by the legislature becomes a statute; and "statutory authority" means the boundaries of the board's lawful responsibility as laid out by the statute that

created it.

[~~FF.~~] **JJ.** "Substantial compliance" means sufficient compliance with the statutes or rules so as to carry out the intent for which the statutes or rules were adopted and in a manner that accomplished the reasonable objective of the statutes or rules.

[~~GG.~~] **KK.** "Supervised interpreter intern or student" means a person who is currently enrolled in an interpreter education program, interpreter preparation program, or a program of study in signed language interpreting at an accredited institution of higher learning.

[~~HH.~~] **LL.** "Uniform Licensing Act" or "ULA", Section 61-1-1 through 61-1-33 NMSA 1978 is the statutory provision that governs the major duties of the board in area of:

(1) procedures which must be followed to accord due process to applicants for licensure and to licensees if the board takes action against the licensee for acts of misconduct that would adversely affect public health, safety and welfare, and

(2) rulemaking procedures that the board shall follow in adopting valid regulations affecting signed language interpreters.

[16.28.1.7 NMAC - N, 07/21/09; A, 08/18/11; A, 01/15/14]

NEW MEXICO SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

This is an amendment to 16.28.2 NMAC, Section 9, effective 01/15/2014.

16.28.2.9 CONTINUING EDUCATION REQUIREMENTS:

A. Community or educational signed language interpreter license shall submit a copy of the applicant's current RID membership card documenting compliance with the requirements of the certification maintenance program (CMP) which requires eight RID-approved continuing education units (CEUs) (80 contact hours) per four-year CMP cycle. Should RID change its number of CEUs required an interpreter must comply with the new requirement in order to maintain licensure in New Mexico.

B. Provisional license: Two CEUs (20 hours) of continuing education annually documented on the applicant's associate continuing education tracking (ACET) transcript from RID. [~~This requirement will be pro-rated for applicants who receive their license after October 30 of any calendar year.~~]

C. Provisional licensees who are within their first year may provide certificates of completion to the board office if the approved CEUs are not on ACET transcripts.

[16.28.2.9 NMAC - N, 07/21/09; A, 08/18/11; A, 01/15/14]

NEW MEXICO SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

This is an amendment to 16.28.3 NMAC, Section 11, 14, 15, 16 and 17, effective 01/15/2014.

16.28.3.11 APPLICATION FOR LICENSURE:

A. An application for any license to be issued or renewed by the board shall be made on the official form provided by the board for that purpose.

B. All applications for licensure must include:

(1) a completed and signed application;

(2) applicant name;

(3) proof of age indicating applicant is at least eighteen years of age (copy of birth certificate, driver's license, state issued identification card, or baptismal certificate);

(4) mailing address;

(5) business address;

(6) phone number;

(7) non-refundable application fee as required by the board;

(8) photograph: applicants for original licensure shall attach a recent [~~passport size,~~] color photograph, front-view of face.

C. An application for a community signed language interpreter license must also include: a copy of the applicant's current RID membership card showing that the applicant holds one or more certifications recognized by RID at the time of application for licensure with the exception of ED: K-12 (educational certificate: K-12).

D. An application for an educational signed language interpreter license must also include: proof of EIPA rating of 4.0 – 5.0 and a copy of the applicant's current RID membership card showing that the applicant holds the ED: K-12 certified member status by virtue of EIPA rating; or a copy of the applicant's current RID membership card showing that the applicant holds one or more certifications currently recognized by RID.

E. An application for a provisional signed language interpreter license must also include: proof of completion of an interpreter education program or interpreter preparation program at an accredited institution; or proof of employment as a community signed language interpreter or an educational signed language interpreter at the time the act became effective (June 15, 2007) and after the applicant reached the age of 18; and a copy of the applicant's current RID membership card showing that the applicant is an associate member (for purposes of tracking CEU requirements through the ACET program as outlined in Subsection B of 16.28.2.9 NMAC).

F. If an applicant submits an incomplete license application they will be requested to submit any missing documentation; failure to do so within six months of receipt of the original application will result in the application file being closed. After the file has been closed, the applicant will be required to submit a new application and application fee to apply again.

G. ELECTRONIC APPLICATIONS: In accordance with Section 14-16-1 thru 14-16-21 NMSA 1978 of the Uniform Electronic Transactions Act, the board or its designee will accept electronic applications.

(1) Any person seeking a New Mexico signed language interpreting license may do so by submitting an electronic application. Applicants are required to also submit all required information as stated in 16.28.3.11 NMAC.

(2) Any licensee may renew his or her license electronically through a designated website provided by the board. All license holders renewing their signed language interpreting license are also required to submit all documentation as stated in 16.28.3.17 NMAC.

(3) Any person whose license has been expired may apply electronically to the board for renewal of the license at any time within 60 days of the expiration. Any persons seeking renewal are also required to submit all supporting documents as stated in 16.28.3.17 NMAC.

(4) Any person whose license has been lapsed may apply electronically to the board for reinstatement of the license at any time. Any persons seeking reinstatement are also required to submit all supporting documents as stated in 16.28.3.17 NMAC.

H. ELECTRONIC SIGNATURES: Electronic signatures will be acceptable for applications submitted pursuant to Sections 14-16-1 through 14-16-19 NMSA 1978.

[16.28.3.11 NMAC - N, 07/21/09; A, 08/18/11; A, 01/15/14]

16.28.3.14 REQUIREMENTS FOR A ONE-TIME, FIVE-YEAR PROVISIONAL LICENSE TO A PERSON NOT MEETING THE COMMUNITY SIGNED LANGUAGE

INTERPRETER OR EDUCATIONAL SIGNED LANGUAGE INTERPRETER REQUIREMENTS FOR LICENSURE: A one-time, five-year provisional license shall be granted to a person who:

A. files a completed application that is accompanied by the required fees; and,

B. has completed an interpreter education program or interpreter preparation program at an accredited institution; or

C. provides verifiable documentation that he or she was employed as a community signed language interpreter or an educational signed language interpreter at the time the act became effective on [~~July 21, 2009~~] June 15, 2007 and that the applicant had reached the age of 18 at the time;

D. provides proof of associate membership in the registry of interpreters for the deaf (RID) (for purposes of meeting the CEU requirements outlined in Subsection B of 16.28.2.9 NMAC).

[16.28.3.14 NMAC - N, 07/21/09; A, 08/18/11; A, 01/15/14]

16.28.3.15 [~~INITIAL LICENSE:~~ ~~Initial community and educational licenses expire on September 30th, in the second year of licensure. Initial provisional licenses expire on September 30th (following issue date). No license will be issued for longer than 28 months.~~] [RESERVED]

[16.28.3.15 NMAC - N, 07/21/09; A, 08/18/11; Repealed, 01/15/14]

16.28.3.16 LICENSE EXPIRATION:

A. [~~After the initial license period,~~] Community signed language interpreter licenses expire [~~every two years on September 30th~~] two years from the last day of the month in which they were issued.

B. [~~After the initial license period,~~] Educational signed language interpreter licenses expire [~~every two years on September 30th~~] two years from the last day of the month in which they were issued.

C. [~~After the initial license period, provisional signed language interpreter licenses expire every year on September 30th~~] Provisional signed language interpreter licenses expire five years from the last day of the month in which they were issued, but are subject to an annual compliance review. Revocation proceedings may be initiated by the board if the holder of a provisional license fails to pass the annual compliance review:

(1) provisional signed language interpreter licenses issued prior to August 15, 2013 must complete the compliance review each year by September 30;

(2) provisional signed language interpreter licensees with provisional licenses issued after August 15, 2013 must complete the compliance review each year by the last day of the month in which the license was issued.

[16.28.3.16 NMAC - N, 07/21/09; A, 01/15/14]

16.28.3.17 LICENSE RENEWAL:

A. A licensee may renew a community signed language interpreter license or an educational signed language interpreter license every two years by:

(1) submitting a completed renewal application provided by the board that is accompanied by the required fees; and

(2) submitting the continuing education requirements as specified in 16.28.2.9 NMAC.

B. A licensee [~~may renew~~] must complete the mandatory annual compliance review for a provisional interpreter license [~~every year for up to four years~~] four consecutive times by:

(1) submitting a completed [~~renewal~~] compliance review application provided by the board that is accompanied by the required fees; and

(2) submitting the continuing education requirements as specified in 16.28.2.9 NMAC.

C. If a community or educational license is not renewed by the expiration date, the license shall be considered expired, and the licensee shall refrain from practicing. The licensee may renew within a sixty-day grace period, which begins the first day the license expires, by submitting payment of the renewal fee and late fee and complying with all renewal requirements. Upon renewal of the license, the licensee may resume practice.

D. If a provisional license does not complete the annual compliance review by the due date, the license shall be considered expired, and the licensee shall refrain from practicing. The licensee may complete the review within a 60-day grace period, which begins the first day the license expires, by submitting payment of the compliance review fee and late fee and complying with all compliance review requirements. Upon passing the compliance review, the licensee may resume practice.

[~~**D.**~~] **E.** Any person whose provisional license has lapsed may apply to the board for reinstatement of the license.

(1) In making application for reinstatement, the applicant must state why the license should be reinstated and should specifically set forth an explanation of why the license lapsed and how changed circumstances would justify reinstatement. Documentation must be provided.

(2) Any licensed interpreter applying for reinstatement of a license must submit an application fee as set forth in 16.28.6.8 NMAC and provide proof of attendance of continuing education hours as set forth in 16.28.2.9 NMAC for each year of lapse.

(3) Provisionally licensed interpreters will still be limited to a total of five years from the time the initial license was granted.

(4) If the board approves the reinstatement application, the original license number will be issued to the applicant.

[16.28.3.17 NMAC - N, 07/21/09; A, 08/18/11; A, 01/15/14]

NEW MEXICO SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

This is an amendment to 16.28.4 NMAC, Section 3, effective 01/15/2014.

16.28.4.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to the Signed Language Interpreting Practices Act, Section [~~61-44-1 through 61-44-17~~] 61-34-1 through 61-34-17.

[16.28.4.3 NMAC - N, 07/21/09; A, 01/15/14]

NEW MEXICO SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

This is an amendment to 16.28.6 NMAC, Sections 8, 9 and 10, effective 01/15/2014.

16.28.6.8 INITIAL APPLICATION FEES: A non-refundable application fee is due at the time of each initial application, as outlined below.

A. A fee of $65.00 is required for a community signed language interpreter license.

B. A fee of $65.00 is required for an educational signed language interpreter license.

C. A fee of $40.00 is required for a provisional signed language interpreter license.

[~~D.~~ ~~The board shall pro-rate initial fees for license applications submitted after April 1 as follows:~~

~~**(1)** community or educational licenses: initial fee shall be $53.00; the license shall be valid until September 30 of the year following the issuance of the initial license;~~

~~**(2)** provisional licenses: initial fee shall be $28.00; the license shall be valid until September 30 of the year of the issuance of the initial license.~~]

[16.28.6.8 NMAC - N, 07/21/09; A,

01/15/14]

16.28.6.9 LICENSE RENEWAL FEES:

A. for community signed language interpreter licensure a nonrefundable biennial licensure fee of $50.00;

B. for educational signed language interpreter licensure a nonrefundable biennial license renewal fee of $50.00;

C. for provisional signed language interpreter licensure a nonrefundable annual [~~provisional licensure~~] compliance review fee of $25.00, limited to four [~~years that the licensee may renew~~] consecutive compliance review cycles.

[16.28.6.9 NMAC - N, 07/21/09; A, 01/15/14]

16.28.6.10 OTHER FEES: [~~Late license renewal: $20.00.~~]

A. Late license renewal or compliance review: $20.00.

B. Replacement license: badge or license certificate is lost or destroyed: $10.00.

[16.28.6.10 NMAC - N, 07/21/09; A, 01/15/14]

NEW MEXICO WATER TRUST BOARD

This is an amendment to 19.25.10 NMAC, Sections 7, 8, 9 and 15, effective December 30, 2013.

19.25.10.7 DEFINITIONS:

A. "Act" means the Water Project Finance Act, Sections 72-4A-1 through 72-4A-10, NMSA 1978, as the same may be amended and supplemented.

B. "Agreement" means the document or documents signed by the board and a qualifying entity which specify the terms and conditions of obtaining financial assistance from the water project fund.

C. "Applicant" means a qualifying entity which has filed a water project proposal with the authority for initial review and referral to the board's project review committee.

D. "Authority" means the New Mexico finance authority.

E. "Authorized representative" means one or more individuals duly authorized to act on behalf of the qualifying entity in connection with its financial application, water project proposal or agreement.

F. "Board" means the New Mexico water trust board created by the act.

G. "Bylaws" means the bylaws of the board adopted on September 25, 2001, and amended on June 27, 2007, and as may be further amended and supplemented.

H. "Financial application" means a written document filed with the authority by an applicant for the purpose of evaluating the applicant's qualifications for types of financial assistance which may be provided by the board.

I. "Financial assistance" means loans, grants and any other type of assistance authorized by the act, or a combination thereof, provided from the water project fund to a qualified entity for the financing of a qualifying water project.

J. "Policy committee" means a standing committee, appointed by the chairman of the board from the members of the board pursuant to the bylaws to review policies and policy related matters and make recommendations to the full board.

[~~J.~~] K. "Political subdivision" means a municipality, county, land grant-merced controlled and governed pursuant to Section 49-1-1 through 49-1-18 or 49-4-1 through 49-4-21 NMSA 1978, regional or local public water utility authority created by statute, irrigation district, conservancy district, special district, acequia or soil and water conservation district, water and sanitation district, or an association organized and existing pursuant to the Sanitary Projects Act, Chapter 3, Article 29 NMSA 1978.

[~~K.~~] **L. "Project review committee"** means a standing committee, appointed by the chairman of the board from the members of the board pursuant to the bylaws to review water projects to be recommended for funding from the water project fund.

[~~L.~~] **M. "Qualifying entity"** means a state agency, a political subdivision of the state, an intercommunity water or natural gas supply association or corporation organized under Chapter 3, Article 28 NMSA 1978, a recognized Indian nation, tribe or pueblo, the boundaries of which are located wholly or partially in New Mexico or an association of such entities created pursuant to the Joint Powers Agreement Act, Chapter 11, Article 1 NMSA 1978 or other authorizing legislation for the exercise of their common powers.

[~~M.~~] **N. "Qualifying water project"** means a project recommended by the board for funding by the legislature which includes a water project serving an area wholly within the boundaries of the state for (i) storage, conveyance or delivery of water to end users; (ii) implementation of federal Endangered Species Act of 1973 collaborative programs; (iii) restoration and management of watersheds; (iv) flood prevention; or (v) conservation, recycling, treatment or reuse of water as provided by law and which has been approved by the state legislature pursuant to Section 72-4A-9(B), NMSA 1978.

[~~N.~~] **O. "State"** means the state of New Mexico.

[~~O.~~] **P. "State agency"** means any agency or institution of the state.

[~~P.~~] **Q. "Water project account"** means a fund designated by a qualifying entity exclusively for receipt of financial assistance.

[~~Q.~~] **R. "Water project fund"** means the fund of that name created in the authority by Section 72-4A-9, NMSA 1978.

[~~R.~~] **S. "Water project proposal"** means a written proposal submitted by a qualifying entity for review by the project review committee.

[~~S.~~] **T. "Water trust fund"** means the fund of that name created in the state treasury by Section 72-4A-8, NMSA 1978.

[19.25.10.7 NMAC - Rp, 19.25.10.7 NMAC, 7/31/08; A, 12/30/13]

19.25.10.8 ELIGIBILITY: PRIORITIZATION OF WATER PROJECTS: The board will develop and consider a variety of factors in reviewing and evaluating water project proposals to determine which [~~water projects to recommend as~~] qualifying water projects [~~for appropriation by~~] to recommend to the [~~state legislature~~] authority for funding. The board shall give priority to projects that have urgent needs, that have been identified for implementation of a completed regional water plan that is accepted by the interstate stream commission and that have matching contributions from federal or local sources as provided for in Section 72-4A-5, NMSA 1978. Pursuant to Section 72-4A-5.1, NMSA 1978, the board, in conformance with the state water plan and pursuant to the provisions of the Water Project Finance Act, shall prioritize the planning and financing of water projects required to implement the plan. The board shall identify opportunities to leverage federal and other funding. The board shall establish policies for prioritization of water projects.

[19.25.10.8 NMAC - Rp, 19.25.10.8 NMAC, 7/31/08; A, 12/30/13]

19.25.10.9 WATER PROJECT PROPOSAL, PROCEDURES AND APPROVAL PROCESS:

A. The board and the authority will administer an outreach program to notify qualifying entities that water project proposals are being accepted to identify water projects for review by the project review committee and the board for recommendation for funding to the state legislature as qualifying water projects.

B. The authority will provide forms [~~and/or~~] and guidelines

for water project proposals and financial applications.

C. The authority staff will forward all completed water project proposals [~~and the initial evaluation of financial applications and water project proposals~~] to the project review committee. The project review committee will consider the water project and may confer with outside parties, including any local interdisciplinary teams familiar with the water project, as necessary to obtain more information on the feasibility, merit, and cost of the water project. The project review committee will make a recommendation to the board on each water project proposal.

D. Upon the recommendation of the project review committee, the board will [~~prioritize~~] compile the qualifying water projects for recommendation to the legislature.

E. After completion of the review process by the project review committee and the board and receipt of a favorable recommendation on the water project proposal, the water project will be recommended by the board for approval by the state legislature, which recommendation and approval are required by Sections 72-4A-5 and 72-4A-9, NMSA 1978.

F. No later than January of each year, the board will [~~recommend~~] present to the legislature a [~~final~~] list of projects recommended for funding. After the legislature authorizes qualifying water projects, the project review committee will review evaluations of financial applications and water project proposals prepared by staff and recommend to the board a prioritized list of projects to be authorized by the board for funding by the authority. The authority will provide financial assistance for qualifying projects as authorized by the legislature under policies jointly established by the board and authority.

[19.25.10.9 NMAC - Rp, 19.25.10.9 NMAC, 7/31/08; A, 12/30/13]

19.25.10.15 FINANCIAL ASSISTANCE AGREEMENT:

A. The [~~board~~] authority and the qualified entity will enter into an agreement to establish the terms and conditions of financial assistance from the [~~board~~] water project fund. The agreement will include the terms of repayment and remedies available to the [~~board~~] authority in the event of a default. The [~~board, or the~~] authority, [~~on behalf of the board,~~] will monitor terms of the agreement and enforce or cause to be enforced all terms and conditions thereof, including prompt notice and collection.

B. The interest on any financial assistance extended shall be determined by the authority based on the cost of funds and ability of a qualified entity to repay a loan. The interest rate shall not change during the term of the financial assistance unless refinanced or unless the financial assistance is structured as a variable rate obligation.

C. The agreement will contain provisions which require financial assistance recipients to comply with all applicable federal, state and local laws and regulations.

D. In the event of default under a financial assistance agreement by a qualified entity, the [~~board, or the~~] authority [~~,on behalf of the board,~~] may enforce its rights by suit or mandamus and may utilize all other available remedies under state and applicable federal law.

[19.25.10.15 NMAC - Rp, 19.25.10.15 NMAC, 7/31/08; A, 12/30/13]

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

11 NMAC 4.6, Judicial Selection, filed 6-15-1999 is repealed and replaced by 11.4.6 NMAC, Judicial Selection, effective 12/31/2013.

11.4.7 NMAC, Payments for Health Care Services, filed 12-17-2012 is repealed and replaced by 11.4.7 NMAC, Payments for Health Care Services, effective 12-31-2013.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

TITLE 11 LABOR AND WORKERS COMPENSATION
CHAPTER 4 WORKERS' COMPENSATION
PART 6 JUDICIAL SELECTION

11.4.6.1 ISSUING AGENCY: Workers' Compensation Administration.
[11.4.6.1 NMAC - Rp, 11 NMAC 4.6.1, 12/31/13]

11.4.6.2 SCOPE: All appointments and reappointments of judges.
[11.4.6.2 NMAC - Rp, 11 NMAC 4.6.2, 12/31/13]

11.4.6.3 STATUTORY AUTHORITY: Section 52-5-2 NMSA 1978 (Repl. Pamp. 1991).
[11.4.6.3 NMAC - Rp, 11 NMAC 4.6.3, 12/31/13]

11.4.6.4 DURATION: Permanent.
[11.4.6.4 NMAC - Rp, 11 NMAC 4.6.4, 12/31/13]

11.4.6.5 EFFECTIVE DATE: December 31, 2013, unless a later date is cited at the end of a section.
[11.4.6.5 NMAC - Rp, 11 NMAC 4.6.5, 12/31/13]

11.4.6.6 OBJECTIVE: The purpose of this rule is to provide a mechanism for selection of Judges that allows for public notice of vacancies, public comment on reappointment of judges and public inspection of judicial applications.
[11.4.6.6 NMAC - Rp, 11 NMAC 4.6.6, 12/31/13]

11.4.6.7 DEFINITIONS: See 11 NMAC 4.1.7.
[11.4.6.7 NMAC - Rp, 11 NMAC 4.6.7, 12/31/13]

11.4.6.8 JUDICIAL SELECTION:

A. The director may review the performance of workers' compensation judges at least once each year in a manner determined by the director.

B. The director shall announce the expiration of the term of a current workers' compensation judge not later than one hundred twenty (120) days prior to the expiration of that term. Any incumbent seeking reappointment must apply to the director by filing an application for reappointment not later than one hundred five (105) days prior to the expiration of the term to which the incumbent was appointed.

C. The director shall review the performance of each current judge on the ninetieth (90th) day prior to the expiration of each judge's term, or the closest business day thereto. The director shall consider any relevant factor including, but not limited to the performance of an incumbent judge, the continuing and projected need for judicial staffing and any factor that may be considered by the New Mexico judicial nominations commission for the district court in making a decision regarding reappointment.

D. Upon announcement of a judicial vacancy by the director, any candidate seeking appointment to the vacancy shall submit an application to the director in a standard format prepared by the director.

(1) All such applications shall be considered public records, not a record of the WCA for the purposes of Section 52-5-21 NMSA 1978 (1991).

(2) The director shall consider any relevant factor including, but not limited to the performance of a judicial candidate before the WCA, the continuing and projected need for judicial staffing and any factor that may be considered by the New Mexico judicial nominations commission for the district court in making a decision concerning appointment.

E. Notwithstanding the above, the director may appoint judges pro tempore when necessary for the efficient and orderly disposition of workers' compensation claims.
[11.4.6.8 NMAC - Rp, 11 NMAC 4.6.8, 12/31/13]

HISTORY OF 11.4.6 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
WCA 91-1, Miscellaneous Proceedings and Preliminary Questions of Fact, filed 1/24/91.
WCA 91-1, Miscellaneous Proceedings and Preliminary Questions of Fact, filed 5/29/91.
WCA 92.1, Rules Governing Miscellaneous Proceedings and Preliminary Questions of Fact, filed 10/30/92.
WCA 93-1, Rules Governing Miscellaneous Proceedings and Preliminary Questions of Fact, filed 10/28/93.
WCA 93.11.2, Rules Governing Mandatory Forms, filed 3/3/94.

History of Repealed Material:
11 NMAC 4.6, Judicial Selection, filed 6/15/99 - Repealed effective 12/31/13.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

TITLE 11 LABOR AND WORKERS' COMPENSATION
CHAPTER 4 WORKERS' COMPENSATION
PART 7 PAYMENTS FOR HEALTH CARE SERVICES

11.4.7.1 ISSUING AGENCY: Workers' Compensation Administration (WCA).
[11.4.7.1 NMAC - Rp, 11.4.7.1 NMAC, 12-31-13]

11.4.7.2 SCOPE: This rule applies to all workers' compensation health care services providers, caregivers, pharmacies, and suppliers and all payers for such services and supplies.
[11.4.7.2 NMAC - Rp, 11.4.7.2 NMAC, 12-31-13]

11.4.7.3 STATUTORY AUTHORITY: NMSA 1978, Sections 52-1-1, 52-3-1, 52-4-1, 52-4-2, 52-4-3, 52-4-5, 52-5-4, and 52-10-1.
[11.4.7.3 NMAC - Rp, 11.4.7.3 NMAC, 12-31-13]

11.4.7.4 DURATION: Permanent.
[11.4.7.4 NMAC - Rp, 11.4.7.4 NMAC, 12-31-13]

11.4.7.5 EFFECTIVE DATE: December 31, 2013, unless a later date is cited at the end of a section.
[11.4.7.5 NMAC - Rp, 11.4.7.5 NMAC, 12-31-13]

11.4.7.6 OBJECTIVE: The purpose of these rules is to establish and enforce a system of maximum allowable fees and reimbursements for health care services and related non-clinical services provided by all practitioners, to establish billing dispute procedures and to establish the procedures for cost containment.
[11.4.7.6 NMAC - Rp, 11.4.7.6 NMAC, 12-31-13]

11.4.7.7 DEFINITIONS: The definitions in11.4.1.7 NMAC shall apply to this rule. In addition, the following definitions apply to the provision of all services.

A. "Business day" means any day on which the WCA is open for business.

B. "Caregiver" means any provider of health care services not defined and specified in NMSA 1978, Section 52-4-1.

C. "Case management" means the on-going coordination of health care services provided to an injured or disabled worker including, but not limited to:

(1) developing a treatment plan to provide appropriate health care service to an injured or disabled worker;

(2) systematically monitoring the treatment rendered and the medical progress of the injured or disabled worker;

(3) assessing whether alternate health care services are appropriate and delivered in a cost-effective manner based upon acceptable medical standards;

(4) ensuring that the injured or disabled worker is following the prescribed health care plan; and,

(5) formulating a plan for the return to work.

D. "Contractor" means any organization that has a legal services agreement currently in effect with the workers' compensation administration (WCA) for the provision of utilization review or case management or peer review services.

E. "*Current procedural terminology* ("CPT")" means a systematic listing and coding of procedures and services performed by HCPs of the American medical association, adopted in the director's annual order. Each procedure or service is identified with a numeric or alphanumeric code (CPT code). This was developed and copyrighted by the American medical association. The five character codes included in the rules governing the health care provider fee schedule are obtained from current procedural terminology (CPT®), copyright 2012 by the American medical association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of the rules governing the health care provider fee schedule is with WCA and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in rules governing the health care provider fee schedule. Fee schedules, relative value units, conversion factors or related components are not assigned by the AMA, are not part of CPT, and AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of rules governing the health care provider fee schedule should refer to the most recent edition of the current procedural terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DRARS apply. CPT is a registered trademark of the American medical association.

F. "Diagnostic and statistical manual of mental disorders (DSM)" means the current edition of the manual, which lists and describes the scientifically diagnosed mental disorders and is commonly referred to as "DSM".

G. "Director" means director of the workers' compensation administration (WCA) or designee.

H. "Durable medical equipment (DME)" means supplies and equipment that are rented, leased, or permanently supplied to a patient and which have been prescribed to aid the recovery or improve the function of an injured or disabled worker.

I. "Employer" means, collectively: an employer subject to the act; a self-insured entity, group or pool; a workers' compensation insurance carrier or its representative; or any authorized agent of an employer or insurance carrier, including any individual owner, chief executive officer or proprietor of any entity employing workers.

J. "Freestanding ambulatory surgical center (FASC)" means a separate facility that is licensed by the New Mexico department of health as an ambulatory surgical center.

K. "Health care provider (HCP)" means any person, entity, or facility authorized to furnish health care to an injured or disabled worker pursuant to NMSA 1978,

Section 52-4-1, including any provider designated pursuant to NMSA 1978, Section 52-1-49, and may include a provider licensed in another state if approved by the director, as required by the act. The director has determined that certified registered nurse anesthetists (CRNAs) and certified nurse specialists (CNSs) who are licensed in the state of New Mexico are automatically approved as health care providers pursuant to NMSA 1978, Section 52-4-1(P).

L. "Hospital" means any place currently licensed as a hospital by the department of health pursuant to NMSA 1978, Section 52-4-1(A), where services are rendered within a permanent structure erected upon the same contiguous geographic location as are all other facilities billed under the same name.

M. "Implants, instrumentation and hardware" means:

(1) surgical implants are defined as any single-use item that is surgically inserted, deemed to be medically necessary and approved by the payer which the physician does not specify to be removed in less than six weeks, such as bone, cartilage, tendon or other anatomical material obtained from a source other than the patient; plates, screws, pins, cages; internal fixators; joint replacements; anchors; permanent neurostimulators; and pain pumps;

(2) disposable instrumentation includes ports, single-use temporary pain pumps, external fixators and temporary neurostimulators and other single-use items intended to be removed from the body in less than six (6) weeks.

N. "Independent medical examination (IME)" means a specifically requested evaluation of an injured or disabled worker's medical condition performed by an HCP, other than the treating provider, as provided by NMSA 1978, Section 52-1-51.

O. "Medical records" means:

(1) all records, reports, letters, and bills produced or prepared by an HCP or caregiver relating to the care and treatment rendered to the worker;

(2) all other documents generally kept by the HCP or caregiver in the normal course of business relating to the worker, including, but not limited to, clinical, nurses' and intake notes, notes evidencing the patient's history of injury, subjective and objective complaints, diagnosis, prognosis or restrictions, reports of diagnostic testing, hospital records, logs and bills, physical therapy records, and bills for services rendered, but does not include any documents that would otherwise be inadmissible pursuant to NMSA 1978, Section 52-1-51(C).

P. "New Mexico gross receipts tax (NMGRT)" means the gross receipts tax or compensating tax as defined in Chapter 7, Article 9 of the New Mexico Statutes Annotated 1978 (the "Gross Receipts and Compensating Tax Act"). This tax is collected by the New Mexico taxation and revenue department.

Q. "Peer review" means an individual case by case review of services for medical necessity and appropriateness conducted by an HCP licensed in the same profession as the HCP whose services are being reviewed.

R. "Physical impairment ratings (PIR)" means an evaluation performed by an MD, DO, or DC to determine the degree of anatomical or functional abnormality existing after an injured or disabled worker has reached maximum medical improvement. The impairment is assumed to be permanent and is expressed as a percent figure of either the body part or whole body, as appropriate, in accordance with the provisions of the Workers' Compensation Act and the most current edition of the American medical association's *guides to the evaluation of permanent impairment* (AMA guide).

S. "Prescription drug" means any drug, generic or brand name, which requires a written order from an authorized HCP for dispensing by a licensed pharmacist or authorized HCP.

T. "Referral" means the sending of a patient by the authorized HCP to another practitioner for evaluation or treatment of the patient and it is a continuation of the care provided by the authorized HCP.

U. "Services" means health care services, the scheduling of the date and time of the provision of those services, procedures, drugs, products or items provided to a worker by an HCP, pharmacy, supplier, caregiver, or freestanding ambulatory surgical center which are reasonable and necessary for the evaluation and treatment of a worker with an injury or occupational disease covered under the New Mexico Workers' Compensation Act or the New Mexico Occupational Disease Disablement Law.

V. "Unlisted service or procedure" means a service performed by an HCP or caregiver which is not listed in the edition of the American medical association's *current procedural terminology* referenced in the director's annual order or has not otherwise been designated by these rules.

W. "Usual and customary fee" means the monetary fee that a practitioner normally charges for any given health care service. It shall be presumed that the charge billed by the practitioner is that practitioner's usual and customary charge for that service unless it exceeds the practitioner's charges to self-paying patients or non-governmental third party payers for the same services and procedures.

X. "Utilization review" means the evaluation of the necessity, appropriateness, efficiency, and quality of health care services provided to an injured or disabled worker.

Y. "Worker" means an injured or disabled employee.

[11.4.7.7 NMAC - Rp, 11.4.7.7 NMAC, 12-31-13]

11.4.7.8 GROUND RULES FOR BILLING AND PAYMENT

A. Basic ground rules

(1) These rules apply to all charges and payments for medical, other health care treatment, and related non-clinical services covered by the New Mexico Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law.

(2) These rules shall be interpreted to the greatest extent possible in a manner consistent with all other rules promulgated by the workers' compensation administration (WCA). In the event of an irreconcilable conflict between these rules and any other rules, the more specific set of rules shall control.

(3) Nothing in these rules shall preclude the separate negotiation of fees between a provider and a payer within the health care provider fee schedule for any health care service as set forth in these rules.

(4) These rules and the director's annual order adopting the health care provider fee schedule utilize the edition of the c*urrent procedural terminology* referenced in the director's annual order, issued pursuant to Subsection A of 11.4.7.9 NMAC. All references to specific CPT code provisions in these rules shall be modified to the extent required for consistency with the director's annual order.

(5) Employers are required to inform a worker of the identity and source of their coverage for the injury or disablement.

B. Authorization for treatment and services

(1) A provider or inpatient facility may seek pre-authorization from payer for all services or treatment plans. If authorization is sought, all requests for authorization of referrals and all other procedures shall be approved or denied by the payer within five (5) business days of receipt of all supporting documentation and no later than five (5) business days before the procedure.

(2) Once a worker has been admitted to an inpatient facility, all requests for authorization of referrals and procedures during the inpatient stay shall be approved or denied by the payer by the close of the next business day after receipt of all supporting documentation.

(3) If an authorization or denial is not received by the provider by the deadlines

set forth in this rule, the requested service or treatment will be deemed authorized. The provider shall document all attempts to obtain authorization from the date of the initial request.

(4) A payer shall not be required to respond to a provider's request for authorization within the deadlines set forth in this rule if the payer has previously denied a claim in writing.

(5) Pre-authorization is required prior to scheduling or performing any of the following services:

(a) independent medical examinations;

(b) physical impairment ratings;

(c) functional capacities evaluations;

(d) physical therapy;

(e) caregiver services; and

(f) durable medical equipment (DME).

C. Billing provision ground rules

(1) Billing shall be made in accordance with billing instructions issued by the director in conjunction with the annual fee order.

(2) Submitting a bill to any party for the difference between the usual and customary charges and the maximum amount of reimbursement allowed for compensable health care services or items, also known as balance billing, is prohibited.

(3) Coding and billing separately for procedures that do not warrant separate identification because they are an integral part of a service for which a corresponding CPT code exists, also known as unbundling, is prohibited.

(4) The appropriate CPT code must be used for billing by providers.

(5) Initial billing of outpatient services by providers, hospitals and FASC's, shall be submitted no later than thirty (30) calendar days from the end of the month in which services were rendered. Initial billing of inpatient services shall be issued no later than sixty (60) calendar days from the date of discharge.

(6) Failure of the provider to submit the initial billing within the time limits provided by these rules shall constitute a violation of these rules but does not absolve the employer of financial responsibility for the bill.

(7) Unlisted services or procedures are billable and payable on a by-report (BR) basis as follows:

(a) The fee for the performance of any BR service shall be negotiated between the provider and the payer prior to delivery of the service. Payers should ensure that a CPT code with an established fee schedule amount is not available.

(b) Performance of any BR service requires that the provider submit a written report, for which no separate charge is allowed, with the billing to the payer. The report shall substantiate the rationale for not using an established CPT code and shall include pertinent information regarding the nature, extent, and special circumstances requiring the performance of that service and an explanation of the time, effort, personnel, and equipment necessary to provide the service.

(c) Information provided in the medical record(s) may be submitted in lieu of a separate report if that information satisfies the requirements of Paragraph (10) of Subsection C of 11.4.7.8 NMAC.

(d) In the event a dispute arises regarding the reasonableness of the fee for a BR service, the provider shall make a prima facie showing that the fee is reasonable. In that event, the burden of proof shall shift to the payer to show why the proposed fee is not reasonable.

(8) If payer and provider agree to enter into a global fee agreement at any time, a global fee can be used. All services not covered by the global fee agreement shall be coded and paid separately, to the extent substantiated by medical records. Agreement to use a global fee creates a presumption that the HCP will be allowed to continue care throughout the global fee period.

(9) If a service that is ordinarily a component of a larger service is performed alone for a specific purpose it may be considered a separate procedure for coding, billing, and payment purposes. Documentation in the medical records must justify the reasonableness and necessity for providing such services alone.

(10) Initial bills for every visit shall be accompanied by appropriate office notes (medical records) which clearly substantiate the service(s) being billed and are legible.

(11) Records provided by hospitals and FASCs shall have a copy of the admission history and physical examination report and discharge summary, hospital emergency department medical records, imaging, ambulatory surgical center medical records or outpatient surgery records.

(12) No charge shall be made to any party to the claim for the initial copy of required information.

(13) The patient/worker shall not be billed for health care services provided by an authorized HCP as treatment for a valid workers' compensation claim unless payer denies compensability of a claim or payer does not respond to a bill within the time limit set forth in Paragraph (2) of Subsection D of 11.4.7.8 NMAC.

(14) Diagnostic coding shall be consistent with the most current version of the *international classification of diseases, clinical modification* or *diagnostic and statistical manual of mental disorders* guidelines required by CMS as appropriate.

(15) For any reimbursement under the fee schedule or these rules that is based upon provider's cost, the provider shall submit a copy of the invoice showing that cost either at the time of billing or upon the payer's request.

(16) Effective July 1, 2015, the payer shall be capable of receiving bills electronically and of submitting electronic payment pursuant to a system generally recognized and used in the medical community.

(17) The health care facility is required to submit all requested data to the payer. Failure to do so could result in fines and penalties imposed by the WCA. All payers are required to notify the economic research bureau of unreported data fields within ten (10) days of payment of any inpatient bill.

D. Payment provision ground rules

(1) The provision of services gives rise to an obligation of the employer to pay for those services. Accordingly, all services are controlled by the rules in effect on the date the services were provided.

(2) For all reasonable and necessary services provided to a patient/worker with a valid workers' compensation claim, payer is responsible for timely good faith payment within thirty (30) days of receipt of a bill for services unless payment is pending in accordance with the criteria for contesting bills and an appropriate explanation of benefits has been issued by the payer. Payment for non-contested portions of any bill shall be timely.

(3) Effective July 1, 2013, all medical services rendered pursuant to recommended treatment contained in the most recent edition of the official disability guidelines™ (ODG) is presumed reasonable and necessary pursuant to NMSA 1978, Section 52-1-49(A); there is no presumption regarding any other treatment.

(4) If a service has been pre-authorized or is provided pursuant to a treatment plan that has been pre-authorized by an agent of the payer, it shall be presumed that the service provided was reasonable and necessary. The presumption may be overcome by competent evidence that the payer, in the exercise of due diligence, did not know that the compensability of the claim was in doubt at the time that the authorization was given.

(5) An employer who subcontracts bill review services remains fully responsible for compliance with these rules.

(6) Fees and payments for all physician professional services, regardless of where those services are provided, are reimbursed within the health care provider fee schedule.

(7) Bills may be paid individually

or batched for a combined payment; however, each service, date of service and the amount of payment applicable to each procedure must be appropriately identified.

(8) All bills shall be paid in full unless one or more of the following criteria are met. These criteria are the only permissible reasons for contesting workers' compensation bills submitted by authorized providers:

(a) compensability is denied;

(b) services are deemed not to be reasonable and necessary;

(c) incomplete billing information or support documentation;

(d) inaccurate billing or billing errors; or

(e) reduction specifically authorized by this rule.

(9) Whenever a payer contests a bill or the payment for services is denied, delayed, reduced or otherwise differs from the amount billed, the payer shall issue to the provider a written EOB which shall clearly relate to each payment disposition by procedure and date of service. Only the EOBs listed in WCA billing instructions may be used.

(10) Failure of the payer to indicate the appropriate EOB(s) constitutes an independent violation of these rules.

(11) The prorating of the provider's fees for time spent providing a service, as documented in the provider's treatment notes, is not prohibited by these rules provided an appropriate EOB is sent to the provider. Evaluation and management CPT codes shall not be prorated. The provider's fees should not be prorated to exclude time spent in pre- and post-treatment activity, such as equipment setup, cleaning, disassembly, etc., if it is directly incidental to the treatment provided and is adequately documented.

[11.4.7.8 NMAC - Rp, 11.4.7.8 NMAC, 12-31-13]

11.4.7.9 FEES FOR HEALTH CARE SERVICES

A. Health care provider fee schedule

(1) The director shall issue an order pursuant to NMSA 1978, Section 52-4-5 not less than once per annum setting the health care provider fee schedule which shall list the maximum amount of reimbursement for, or the method for determining the maximum amount of reimbursement for medical services, treatments, devices, apparatus, and medicine.

(2) In addition to the fee schedule, the order shall contain a brief description of the technique used for derivation of the fee schedule and a reasonable identification of the data upon which the fee schedule was based.

(3) The health care provider fee schedule is procedure-specific and provider-neutral. Any code listed in the edition of the *current procedural terminology* adopted in the director's annual order may be used to designate the services rendered by any qualified provider within the parameters set by that provider's licensing regulatory agencies combined with applicable state laws, rules, and regulations.

(4) The fee schedule shall be released to the public not less than thirty (30) days prior to the date upon which it is adopted and public comments will be accepted during the thirty (30) days immediately following release.

(5) After consideration of the public comments the director shall issue a final order adopting a fee schedule, which shall state the date upon which it is effective. The final fee schedule order shall be available at the WCA clerk's office not less than twenty (20) days prior to its effective date.

B. Hospital ratio

(1) All hospitals shall be reimbursed at the hospital ratio set forth in the health care provider fee schedule. A new hospital shall be assigned a ratio of 67%.

(2) The assigned ratio is applied toward all charges for compensable services provided during a hospital inpatient stay and emergency department visit.

(3) The ratio does not apply to procedures that are performed in support of surgery, even if performed on the same day and at the same surgical site as the surgery.

(4) By February 1 of each calendar year, all hospitals shall provide to the WCA the most recent full year filing of their HCFA/CMS 2552 G-2 worksheet prepared on behalf of the organization. A hospital may specifically designate this worksheet as proprietary and confidential. Any worksheet specifically designated as proprietary and confidential in good faith shall be deemed confidential pursuant to NMSA 1978, Section 52-5-21 and the rules promulgated pursuant to that provision. Failure to comply may result in fines and penalties.

(5) Appeal of assigned ratio by hospitals. A written appeal may be filed with the director within thirty (30) days of the assignment of the ratio. The director will review the appeal and respond with a written determination. The director may require the hospital to provide additional information prior to a determination and in his discretion may conduct a hearing. The director's written determination shall be issued within thirty (30) days of the final submission of all information regarding the appeal to the director. The director's written determination shall be final.

C. Prescription medicine

(1) The maximum payment that a pharmacy or authorized HCP is allowed to receive for any prescription medicine shall be determined by the method set forth in health care provider fee schedule.

(2) Pharmacies shall not dispense more than a thirty (30) day supply of medication unless authorized by the payer.

(3) Only generic equivalent medications shall be dispensed unless a generic does not exist and unless specifically ordered by the HCP.

(4) Compounded medication prepared by pharmacists shall be paid on a by-report (BR) basis.

(5) Any medications dispensed and administered in excess of a twenty four (24) hour supply to a registered emergency room patient shall be paid according to the hospital ratio.

(6) Health care provider dispensed medications shall not exceed a ten (10) day supply for new prescriptions only. The payment for health care provider dispensed medications shall not exceed the cost of a generic equivalent.

D. Referrals

(1) If a referral is made within the initial sixty (60) day care period as identified by NMSA 1978, Section 52-1-49(B), the period is not enlarged by the referral.

(2) When referring the care of a patient to another provider, the referring provider shall submit pertinent medical records for that patient, including imaging, upon request of the referral provider, at no charge to the patient, referral provider or payer.

(3) When transferring the care of a patient to another provider, the transferring provider shall submit complete medical records, including imaging, for that patient to the subsequent provider at no charge to the patient, subsequent provider or payer.

E. Independent medical examinations

(1) All IMEs and their fees must be authorized by the claims payer prior to the IME scheduling and service, regardless of which party initiates the request for an IME.

(2) In the event that an IME is authorized and the HCP and claims payer are unable to agree on a fee for the IME, the judge may set the fee or take other action to resolve the fee dispute.

F. Physical impairment ratings

(1) All PIRs and their fees shall be authorized by the claims payer prior to their scheduling and performance regardless of which party initiated the request for a PIR. The PIR is inclusive of any evaluation and management code.

(2) Impairment ratings performed for primary and secondary mental impairments shall be billed using CPT code 90899 and shall conform to the guidelines, whenever possible, presented in the most

current edition of the AMA guides to the evaluation of permanent impairment.

(3) A PIR is frequently performed as an inherent component of an IME. Whenever this occurs, the PIR may not be unbundled from the IME. The HCP may only bill for the IME at the appropriate level.

(4) In the event that a PIR with a specific HCP is ordered by a judge and the HCP and claims payer are unable to agree on a fee for the PIR, the judge may set the fee or take other action to resolve the fee dispute.

[11.4.7.9 NMAC - Rp, 11.4.7.9 NMAC, 12-31-13]

11.4.7.10 QUALIFICATION OF OUT OF STATE HEALTH CARE PROVIDERS

A. An HCP that is not licensed in the state of New Mexico must be approved by the director to qualify as an HCP under the act.

B. No party shall have recourse to the billing and payment dispute resolution provisions of these rules with respect to the services of an HCP who is not licensed in New Mexico or approved by the director.

C. The director's approval may be obtained by submitting a written motion and order, supported by an original affidavit of the HCP seeking approval, on forms acceptable to the director. Nothing in this rule shall prevent the director from entering into agreements with any party or HCP to provide for simplified and expeditious qualification of HCPs in individual cases, provided, however, that all such agreements shall be considered public records.

D. The director's approval of a health care provider in a particular case, pursuant to the provisions of NMSA 1978, Section 52-4-1, will be deemed given when an out of state health care provider provides services to that injured worker and the employer/insurer pays for those services. Unless otherwise provided, the approval obtained by this method will not apply to the provision of health care by that provider to any other worker, except by obtaining separate approval as provided in these rules.

[11.4.7.10 NMAC - Rp, 11.4.7.9 NMAC, 12-31-13]

11.4.7.11 BILLING AND PAYMENT DISPUTE RESOLUTION

A. In the event of a billing or payment dispute any party may submit to the medical cost containment bureau a request for director's determination.

B. The request shall be made in writing within thirty (30) calendar days of the documented receipt date of the payer's disposition or nonpayment of the bill. A request for director's determination shall consist of a brief explanation of the disputed billing and payment issue(s) and shall be accompanied by a copy of the bill(s) in question, a copy of the payer's explanation, and all supporting documentation necessary to substantiate the performance of the service(s) and the accuracy of the associated charges.

C. Upon receipt of a request, the administration will initially attempt to resolve the dispute informally. If this is unsuccessful, a notice of receipt of request for director's determination shall be issued to both parties along with a copy of the request for director's determination.

D. Both parties shall have fifteen (15) days from the date of the notice of receipt of request for director's determination to present to the director and opposing party any pertinent additional documentation.

E. The director or his designee in his discretion may conduct such hearings and receive such evidence as is necessary to make a determination concerning the reasonableness and necessity of the services provided. A final determination shall issue within forty-five (45) days of the issuance of the notice of receipt of request for director's determination or the close of the hearing, whichever is later.

F. The director's determination of the billing and payment dispute is final. Any further attempt, directly or indirectly, to charge any party for any disallowed services or to fail to pay within thirty (30) days of documented receipt of the director's determination for such services as may have been found to be due and owing shall be considered a violation of this rule.

G. The director's determination shall not be considered with regard to the compensability of the claim and shall have no legal force or effect beyond the resolution of the billing and payment disputes.

H. Any time frame set forth in 11.4.7.11 NMAC may be waived by the director, in writing, for good cause shown.

[11.4.7.11 NMAC - Rp, 11.4.7.13 NMAC, 12-31-13]

11.4.7.12 INPATIENT ADMISSIONS/CASE MANAGEMENT/ PEER REVIEW

A. Basic provisions

(1) All workers and their legal representatives are required to cooperate with the WCA or its contractor, if any, with respect to all reasonable requests for information necessary for any provision of service.

(2) All employers, insurers, and third party administrators are required to communicate and provide information to the contractor for the purpose of facilitating the provision of services. The employer, insurer or third party administrator shall be required to cooperate and provide information, without charge, to the WCA or its contractor, if any.

(3) The WCA or its contractor, if any, shall report any refusal to cooperate to the director. Failure to provide requested information shall be presumed to be a refusal to cooperate. Any dispute concerning the reasonableness of any request for information may be submitted, in writing, to the director. The determinations of the director concerning the reasonableness of such requests are final.

(4) In any hearing before the WCA, the patient/worker's refusal to cooperate in any services may be considered by a workers' compensation judge on the issues of reasonableness and necessity of medical charges or reasonableness, necessity, or appropriateness of medical treatment.

(5) The WCA or its contractor, if any, shall provide to the worker's employer, legal representative, insurer, or third party administrator a copy of written reports upon written request.

B. Inpatient admission review

(1) For every inpatient admission the following information shall be provided to the WCA or its contractor at least forty eight (48) hours prior to the admission or before the close of the next business day after any emergency admission:

(a) worker's/patient's name;

(b) worker's/patient's social security number;

(c) worker's/patient's employer;

(d) employer's insurance carrier or third party administrator and a statement of whether they have authorized the admission;

(e) date of injury/onset of symptoms;

(f) admitting diagnosis, including primary, secondary, and tertiary, if any;

(g) planned treatment(s) and procedures;

(h) planned date of admission; and

(i) proposed length of stay.

(2) For planned or elective hospital admissions any practitioner ordering the admission of a worker for evaluation or treatment of their injury or occupational disease disablement shall report the admission to the WCA.

(3) For emergency hospital admissions, the hospital shall report the admission to the WCA.

(4) Any practitioner or hospital discharge planner ordering or arranging a transfer of a worker to another facility shall report to the WCA at least twenty four (24) hours prior to any transfer all of the information in required by Paragraph (1) of Subsection B of 11.4.7.12 NMAC.

(5) Throughout the period

of time in which inpatient services are being provided, the WCA shall monitor the worker's treatment regime, including treatments, procedures, and length of stay.

(6) If a hospital or practitioner reports that an employer's insurance carrier or third party administrator has not authorized the admission, the WCA shall issue a recommendation concerning the medical necessity and appropriateness of the admission service and the assigned length of stay before the close of the next business day after the report is submitted to the WCA.

C. Case management and peer review

(1) Any party may refer a case to the WCA, for case management or peer review. The WCA in its sole discretion will assign cases to its contractor for case management or peer review, as provided by the contract in effect.

(2) Upon assignment of a case by the WCA for case management, the contractor shall notify the worker, his/her legal representative, employer, insurer, or third party administrator of the selection.

(3) The contractor shall have the right to contact the worker, insurer, third party administrator, legal representative, and all practitioners involved in the case.

(4) The contractor shall give reasonable notice and an opportunity to the worker or his or her representative to be present during all contacts by a case manager with the insurer, third party administrator, legal representative(s), and practitioners.

[11.4.7.12 NMAC - Rp, 11.4.7.14 NMAC, 12-31-13]

11.4.7.13 NON-CLINICAL SERVICES

A. A practitioner may charge up to one dollar ($1.00) per page for the first ten (10) pages and up to twenty cents ($0.20) for each page thereafter for copying medical records and reports, except as provided in Paragraphs (10), (11), (12) and (13) of Subsection C of 11.4.7.8 NMAC. This fee is inclusive of any and all fees, including, but not limited to, administrative, processing, and handling fee of any kind.

B. A practitioner may charge up to forty five dollars ($45.00) for completion of the form letter to health care provider.

C. Depositions

(1) An HCP may not charge more than four hundred dollars ($400) for the first hour or any portion thereof; and not more than three hundred sixty dollars per hour ($360/hour) for the second and subsequent hours, prorated in five (5) minute increments.

(2) No compensation shall be paid for travel time to or from the deposition, waiting time prior to the scheduled beginning of the deposition, time spent reading or correcting depositions or preparation time. For good cause shown, a judge may enter a written order providing recompense to an HCP for reading and correcting a deposition.

(3) An HCP may require that they be paid for the first hour of the deposition testimony either before or at the time of the deposition.

(4) A non-refundable fee of up to four hundred dollars ($400) may be charged by an HCP for deposition appointments at which the attorney making the appointment is a no-show or fails to cancel at least forty eight (48) hours in advance.

(5) Any notice of deposition to a practitioner shall contain the following language: "The rules of the WCA provide a schedule of maximum permissible fees for deposition testimony. No more than four hundred dollars ($400.00) for the first hour and three hundred sixty dollars ($360.00) for each subsequent hour is permitted. Fees for the second and subsequent hours shall be prorated in five (5) minute increments."

D. Live testimony by a health care provider: Such testimony is allowed only pursuant to an order by a judge.

(1) Fees for live testimony shall be set by the judge.

(2) Travel and lodging expenses shall be limited by order of the judge.

(3) No fee for preparation time may be charged or collected.

E. The party paying for medical treatment shall pay the fees set forth in this rule. Ultimate responsibility for payment for copies of medical records and reports shall be determined pursuant to 11.4.4 NMAC pertaining to discovery costs.

F. When a dispute arises regarding compliance with this non-clinical fee schedule any party, or the judge, may request a hearing to determine compliance with this rule.

(1) If a hearing to determine compliance is requested, or on the judge's own motion, the judge shall enter an order confirming or denying compliance with this rule.

(2) The judge's order may assess costs, expenses, and attorney fees against a non-complying party or practitioner.

[11.4.7.13 NMAC - Rp, 11.4.7.15 NMAC, 12-31-13]

11.4.7.14 ENFORCEMENT:

Any complaint of a violation of these rules shall be made, in writing, to the WCA director through the medical cost containment bureau.

[11.4.7.14 NMAC - Rp, 11.4.7.16 NMAC, 12-31-13]

11.4.7.15 DATA ACQUISITION:

A. The insurer must report an inpatient hospital bill to the WCA within ten (10) to ninety (90) days of payment of the bill. Reports may be submitted by mail, fax, or electronic media in batches daily, weekly, or monthly from the insurer or insurer's representative. In any event, the insurer must report the inpatient bill no later than the ninety second (92nd) day from the date of payment.

B. The paid inpatient services data shall be submitted in a format acceptable to the WCA. The economic research bureau shall distribute a specific set of instructions for the submission of required data.

C. If the required paid inpatient services data is not received from payer as stated under Subsection A of this section, the economic research bureau may petition for a hearing before the WCA director or his designee and seek penalties pursuant to NMSA 1978, Section 52-1-61.

[11.4.7.15 NMAC - Rp, 11.4.7.17 NMAC, 12-31-13]

HISTORY OF 11.4.7 NMAC:

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

WCD 90-1, Nonprofessional Fees Schedule, filed 10-15-90.

WCA 91-6, Nonprofessional Fees Schedule, filed 5-29-91.

WCA 92.6, Rules Governing Fees for Non-Clinical Services, filed 10-30-92.

WCA 91-7, Hospital Fee Schedule, filed 4-1-91.

WCA 91-7, Hospital Fee Schedule, filed 7-15-91.

WCA 92.7, Rules Governing Hospital and Ambulatory Surgical Center Fees, filed 10-30-92.

WCA 93.7, Rules Governing Hospital Inpatient Stays, Outpatient Surgeries, Emergency Department Visits and Ambulatory Surgical Center Fees, filed 3-3-94.

WCA 92-8, Workers' Compensation Administration Rules Governing Utilization Review, Peer Review and Case Management, filed 2-24-92.

WCA 92.8, Rules Governing Utilization Review, Peer Review and Case Management, filed 10-30-92.

WCA 93-8, Rules Governing Utilization Review, Peer Review and Case Management, filed 10-28-93.

WCD 91-9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 12-30-91.

WCA 92.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 11-18-92.

WCA 92.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 12-21-92.

WCA 93.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 2-23-94.

WCA 95.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 11-18-94.
WCA 95.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 1-17-95.

History of Repealed Material:
11.4.7 NMAC, Payments for Health Care Services, filed 12-15-2011 - Repealed effective 12-31-2013.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.2 NMAC, Section 9, effective 12/31/13.

11.4.2.9 SAFETY:

A. Annual inspections:

(1) All employers, as identified in NMSA 1978, Section 52-1-6.2, are required to have [~~a~~] an annual safety inspection [~~at least once per year~~]. All other employers are encouraged to do so.

(2) Standards for annual inspections: The minimum standards for the annual safety inspection are contained in the WCA publication, annual safety inspections. This publication may be obtained from the WCA's website at: http://www.workerscomp.state.nm.us/pdf/booklets/D1.pdf.

(3) Who may conduct the inspection and reporting:

(a) A senior manager or dedicated safety professional employed by the business.

(b) A third party safety organization.

(c) A safety professional from the insurance company.

(d) Safety consultants from the WCA may be contacted to provide training to an employer's management staff on how to conduct a proper safety inspection.

(e) Businesses shall submit proof of a safety inspection to the WCA within thirty (30) days of the completion of inspection. The agency's publication on inspections, mentioned above, also contains an affidavit that shall be completed and submitted to the WCA's safety program manager. The business may attach a list with the address of all facilities that were included on the inspection.

(f) Though the responsibility for reporting is with the business, the insurance carrier may report completed inspections, provided the insurance carrier conducted the inspection.

(4) Failure to comply with the annual safety inspection requirement may subject an employer to penalties under Section 52-1-6.2 NMSA 1978.

B. Extra-hazardous employers:

(1) The extra-hazardous employer program is hereinafter referred to as the risk reduction program ("RRP").

(2) [~~The WCA has developed a program to identify employers that meet the criteria, specified below, for classification into the risk reduction program.~~

~~(3) An employer who receives this classification is an employer whose experience modifier is identified as among the highest in the state and such other employers as may be identified by the WCA director.~~] An employer may be classified for the RRP if its experience modifier (e-mod) is higher than the state average for that industry or if a safety audit reveals a need for assistance based on the employer's accident frequency or severity of injury caused by the accident(s).

[~~(4)~~] (3) The WCA shall notify the employer and its insurance carrier if that the employer meets the criteria, under the above guidelines, to be enrolled in the RRP and is selected for enrollment in the RRP.

(a) Notice shall be given to the employer, and the insurer or self-insurance entity, if any, by personal service upon any person of suitable age and discretion at the business location or by certified mail addressed to the owner, proprietor, managing partner, president, majority stockholder, chief operational officer or manager of the business.

(b) Employers who have received a notice of classification shall have five (5) working days to file a written request for reconsideration with the director. [~~No requirement under these rules shall be stayed during the pendency of a request for reconsideration.~~] The director may hold hearings upon a request for reconsideration and make a determination as appropriate. Appeal of a ruling by the director shall be by writ of certiorari to the district court, pursuant to S.C.R.A. Rule 1-075.

[~~(5)~~] (4) Within thirty (30) days of service of a notice of classification or within thirty (30) days of the director's decision if a request for reconsideration is filed, an employer who is classified and enrolled in the RRP shall obtain a safety consultation. The consultation must be performed by a WCA safety consultant, the employer's insurer or a professional independent safety consultant approved by the director. A WCA safety consultant may assist employers in interpreting the requirement for a safety consultation and in conducting the consultation.

[~~(6)~~] (5) The safety consultant performing the safety consultation shall submit within ten (10) days a written report to WCA and the employer detailing any identified hazardous conditions or practices identified through the safety consultation. The written report must be in a form acceptable to the director.

[~~(7)~~] (6) Within thirty (30) working days of the submission of the written report concerning the safety consultation, the employer participating in the RRP shall submit a specific accident prevention plan to resolve the hazards and practices identified in the written report.

[~~(8)~~] (7) The WCA may investigate accidents occurring at the work site(s) of an employer for whom a plan has been formulated under Paragraph [~~(7)~~] (6) of Subsection B of this section and the WCA may otherwise monitor the implementation of the accident prevention plan as it finds necessary.

[~~(9)~~] (8) Six (6) months after the formulation of an accident prevention plan prescribed by Paragraph [~~(7)~~] (6) of Subsection B of this section, the WCA shall conduct a follow-up inspection of the employer's premises. The WCA may require the participation of the safety consultant who performed the initial consultation and formulated the safety plan.

(a) If the WCA determines that the employer has complied with the terms of the accident prevention plan or has implemented other acceptable corrective measures, the WCA shall so certify.

(b) If, at the time of the inspection required under Paragraph [~~(9)~~] (8) of Subsection B of this section, the employer continues to exceed the injury frequencies that may reasonably be expected in that employer's business or industry, the WCA shall continue to monitor the safety conditions at the work site(s) and may formulate additional safety plans reasonably calculated to abate hazards. The employer shall comply with the plans and may be subject to additional penalties for failure to implement the plan or plans.

[~~(10)~~] (9) For good cause shown, the director may extend any time limit required by this part for up to thirty (30) additional days.

(a) All applications for extension shall be submitted in writing and shall state with specificity the reasons for requested additional time.

(b) The director may hold hearings to determine the appropriateness of extensions of time for submission of specific accident prevention plans.

(c) The director's determination on a request for an extension is final.

(d) In the case of an RRP employer whose employees are assigned to furnish services to other employers, the responsibility for the development and submission of an accident prevention plan as required by these rules shall be with the employer who controls and provides direct on-site supervision of the workers who

are exposed to the hazards and practices identified in the written report of the safety consultant.

[~~(11)~~] (10) Any employer who fails to develop, submit, cause to be submitted, implement or comply with a specific accident prevention plan as provided for in these rules shall be subject to imposition of a penalty of up to $5,000.00. Each incident of failure to formulate, submit, cause to be submitted, implement or comply with a specific accident prevention plan persisting for a period of fifteen (15) working days shall constitute a separate violation and subject the employer to additional penalties. The enforcement procedures established in Part Five (5) of these rules shall be utilized in all proceedings under this subsection.

[~~(12)~~] (11) An employer shall no longer be designated to participate in the RRP when the provisions of Paragraphs [~~(5)~~] (4) through (8) of Subsection B of 11.4.2.9 NMAC, inclusive, have been satisfied.

C. The employer, its insurer and all agents of the employer or insurer have the duty of compliance with reasonable requests for information from workers' compensation administration personnel. WCA personnel shall collect data regarding all work-place fatalities in New Mexico.

[2/24/92, 10/30/92, 6/1/96, 4/30/98; 11.4.2.9 NMAC - Rn & A, 11 NMAC 4.2.9, 11/30/04; A, 4/16/12; A, 12/31/13]

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.13 NMAC, Sections 13, 14, 15 and 16, effective 12/31/13.

11.4.13.13 REPORTS AND OFFICIAL VISITS.

A. The controlled insurance plan shall submit a report on a quarterly basis or as otherwise determined by the director.

B. The director may require an official visit to the controlled insurance plan site to keep apprised of the progress of the controlled insurance plan and its compliance with the Workers' Compensation Act and WCA rules.

[11.4.13.13 NMAC - N, 11/15/04; 11.4.13.13 NMAC - N, 12/31/13]

[~~11.4.13.13~~] 11.4.13.14 DISPUTES CONCERNING APPROVAL OF THE APPLICATION FOR APPROVAL OF A CONTROLLED INSURANCE PLAN AND FOR THE REQUIRED SAFETY PLAN

A. All application materials, and safety plan materials shall be submitted to the director at least 30 days before the planned commencement of construction.

B. Amendments to the application or safety plan, and any waivers of requirements, that are negotiated between the WCA and the applicant shall only be effective if reduced to writing and signed by both parties.

C. In the event that an impasse develops in negotiations or disputes arising from the application process, the safety plan or request for waivers of requirements, the director shall designate an informal dispute resolution coordinator to attempt to bring the parties together to help them reach a mutually agreeable solution.

D. In the event the informal dispute resolution fails to resolve the dispute, either the applicant or the WCA can request a formal hearing before the director.

E. The director, or his hearing officer, shall hear the positions of both sides and render an initial ruling within 15 days of the hearing. Motions practice and discovery procedures shall not be allowed. The rules of evidence are relaxed to the extent possible, consistent with the need to maintain order in the hearing and reach a fair decision.

F. Appeal from the ruling the director or his hearing officer after a formal hearing shall be by writ of certiorari to the district court, pursuant to SCRA 01-075.

[11.4.13.14 NMAC - N, 11/15/04; 11.4.13.14 NMAC - Rn, 11.4.13.13 NMAC, 12/31/13]

[~~11.4.13.14~~] 11.4.13.15

PROHIBITED ACTS. The following acts are prohibited:

A. The establishment of the controlled insurance plan for projects that do not have an aggregate construction value in excess of $150 million, including equipment and furnishings, expended within a five-year period as provided in NMSA 1978, Section 52-1-4.2 (A) and Section 11.4.7.9 of these rules.

B. The establishment of a rolling wrap-up plan or establishment of a construction project insured under a rolling wrap-up plan.

C. Establishment of a controlled insurance plan on a site other than the single construction site, or establishment of the controlled insurance plan on a noncontiguous construction site.

D. Failure to include appropriate notice of the controlled insurance plan in request for bids or request for proposals to construction contractors and subcontractors, and failure to include an accurate description of the single construction site or failure to include a copy of the proposed controlled insurance safety plan with the request for bids or request for proposals.

E. Failure to include copies of specifications for the controlled insurance plan with request for bids or request for proposals to construction contractors and subcontractors and failure to provide a mechanism for contractors and subcontractors to have their questions concerning the controlled insurance plan answered before the bid or proposal is due.

F. Failure to timely file the contract for a controlled insurance plan and evidence of compliance with NMSA 1978, Section 52-1-4.2 (A-E) with the WCA and the superintendent insurance at least 30 days before the date on which the applicant is to begin receiving bids or proposals on the project.

G. Failure to request and obtain written approval from the WCA of the application for approval and the site safety plan for the controlled insurance project, prior to the commencement of work on the project.

H. Failure to distribute project performance based refunded premiums or dividends to each participating contractor or subcontractor on a proportional basis, if such refunded premiums or dividends are provided for in the contract.

I. Failure to establish a method for timely reporting of job related injuries to employees of the contractor and subcontractors to their specific employer, the controlled insurance plan insurer and the WCA.

J. Failure to maintain and report unit statistical data to the insurance company writing the workers' compensation insurance policies for the contractors and subcontractors participating in the controlled insurance plan project within the time frame required by the insurance company.

K. Failure by contractors and subcontractors participating in the controlled insurance plan project to allow access to payroll records for payroll auditing purposes.

L. Failure to provide contractors and subcontractors with actual specific payroll audit data following the end of the annual policy period.

M. Failure to provide information to contractors and subcontractors concerning injuries to their workers in a form and format designed to quickly and accurately inform the contractors and subcontractors concerning the nature and extent of injuries and the circumstances in which the injury occurred.

N. Failure to cover the injury to an employee of any contractor or subcontractor that occurs within the physical confines of the single construction site.

O. Failure to update and keep current the application, safety plan, narrative description of the single construction site and visual diagram of the

single construction site.

P. Failure to take steps to conform the controlled insurance plan policy to the single construction site definition before work is done, or knowingly allowing work to be commenced in any area intended to be covered by the controlled insurance plan, without ensuring that the controlled insurance plan policy is written to conform its geographic scope of coverage to the single construction site.

Q. Failure to comply with any provision of these rules, or to knowingly allow any contractor, subcontractor or employee or independent contractor of the general contractor to violate any provision of these rules.

[11.4.13.15 NMAC - N, 11/15/04; 11.4.13.15 NMAC - Rn, 11.4.13.14 NMAC, 12/31/13]

[~~11.4.13.15~~] 11.4.13.16
ENFORCEMENT

A. In the event of violation of any of these rules, or in the event of the occurrence of any prohibited acts specified in these rules, the WCA may seek any or all of the following penalties singly or in combination, against the applicant, any individual responsible for the performance or non-performance of any duty or prohibited act and, with respect to injunctive relief, against the continuation of the controlled insurance project:

(1) A fine of up to $1000 for each violation pursuant to NMSA 1978, Section 52-1-61.

(2) A fine of up to $1000 for each day of the continuing violation, after notice is served upon the designated representative of the applicant that the director has made a finding of probable cause that a continuing violation of these rules has occurred.

(3) Injunctive relief for the cessation of construction activities at the single construction site for the noncontiguous construction site until full compliance with these rules is achieved, as specifically authorized in these rules.

B. The procedures to be utilized in enforcement proceedings pursuant to this section as set forth in 11 NMAC 4.5.

[11.4.13.16 NMAC - N, 11/15/04; 11.4.13.16 NMAC - Rn, 11.4.13.15 NMAC, 12/31/13]

End of Adopted Rules Section

Other Material Related to Administrative Law

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

RESPONSE TO PUBLIC COMMENT

The proposed changes to the WCA Healthcare Provider Fee Schedule, Parts 2, 6, 7 and 13 of the WCA Rules were released for public comment on October 18, 2013. The public comment period was from October 18, 2013 through November 18, 2013. The WCA accepted comment at the public hearing on the proposed amendments and in writing.

PART 2

Annual inspections: One commenter questioned whether an employer will be classified as extra hazardous if their experience modifier (e-mod) exceeds 1.0. Written comment was also received requesting that the annual inspection be waived for qualified employers who have had an annual inspection within the past three (3) years and have an e-mod of <1.0 or a loss ratio of <0.50. A request was made to clarify the objective industry standards or authorities relied upon to set the minimum standards for annual safety inspections set forth in the WCA publication since those requirements may represent significant compliance costs to the industry and could be arbitrarily or capriciously set, interpreted or enforced by regulators.

Extra-hazardous employers: Clarification was requested for proposed changes to 11.4.2.9.B.(2) which classifies an employer for the risk reduction program (RRP) if its e-mod is higher than the state average. The commenter questions whether it is a general state average, the state average for the employer's industry or the employer's hazard group that will be applied and if there is any consideration to be given to an employer's loss ratio? It was recommended that the WCA change its proposed amendment to an e-mod of either >1.25 (TPS/insurer standard) or >1.10 (NCCI standard) and include a loss ratio of >0.50 to qualify for the RRP. It was also requested that the WCA make clear that Subparagraphs 3 through 11 of Paragraph B, 11.4.2.9 NMAC, apply only to employers classified as extra-hazardous. An extension of time was received requesting fifteen (15) days to submit a safety report with the WCA after the completion of the safety inspection instead of the ten (10) days proposed. The commenter also questioned whether these timeframes are calendar days or working days.

Response: The WCA has amended its proposal to specify an e-mod higher than the state average for that industry for qualification into the RRP. Additionally, not all employers who qualify for the RRP will be selected for enrollment. Language in the rule has been added to reflect this circumstance. The existing rule will continue to provide a mechanism for an employer to challenge its selection into the RRP. Language has also been added to Subparagraph 4 of 11.4.2.9.B requiring an employer to obtain a safety consultation within thirty (30) days of service of a notice of classification "or within thirty (30) days of service of a director's decision on a request for reconsideration." Additionally, the WCA removed the language stating that all deadlines were not stayed pending a request for reconsideration. The rule will otherwise be promulgated as proposed. The WCA looks forward to meeting with the workers' compensation industry to discuss further refinements to the safety rules in the next WCA rules cycle.

PART 6

No comments were received concerning amendments to Part 6 of the WCA Rules and, therefore, the rules will be promulgated as initially proposed.

PART 7

Pharmaceutical Issues:

* Repackaging: National drug codes (NDCs) are typically changed for repackaged drugs which allows for a new average wholesale price which inflates prices above what a pharmacy would charge and drives system costs higher. It was suggested by two submissions that the WCA follow other states in requiring the physician to bill at the original manufacturer's NDC and AWP.
* Compounding: One comment suggested a more rigorous regulation for billing compounded medications in New Mexico. Currently, the rule allows for a by-report billing, which the commenter believes is ambiguous, costly and ultimately bad for New Mexico business. This commenter suggested a cost plus system for billing compound medications. Two other commenters submitted that since compounds do not have a corresponding NDC, the WCA should follow other jurisdictions in requiring ingredient-level billing and reimbursement for compounds based on the NDCs and AWPs of each individual ingredient in the compound in order to provide greater transparency and control costs. One commenter suggested a $5.00 dispensing fee be added.
* NDC numbers: One commenter observed that rule F(1)(d) requiring that any bill submitted without an NDC number will be paid at the lowest AWP available for the month in which the drugs were dispensed" was removed from the new Rule 7 and inquired into the reasoning for its removal.
* Billing for drug screens: Written comment was received concerning drug screening procedures using CPT code 80101, which cost between $549.48 to $671.85 for one drug screen for multiple classes, compared with 80104, which includes screening for multiple classes and is billed at a cost of $58.55. Other comments addressed the intent of CPT code 80101 which the commenter utilizes and charges for screening each drug class at a rate of $45.79 for each drug class screened. That commenter contends that the description for CPT code 80104 allows for billing each drug class screened at a higher rate of $58.55.
* Pharmaceutical Billing Form: One written comment suggested the adoption of the NCPDP Workers' Compensation/ Property & Casualty Universal Claim Form (WC/PC UCF) for billing pharmaceutical transactions. The commenter argued that other states and the federal workers' compensation program use the form and, also, that IAIABC has adopted the form as part of its model billing rules and that the form contains important transactional and clinical information that may not be included in other billing forms.

CMS-1500 form: Comments were received concerning the adoption of the CMS-1500 (02/12) form which will go into effect on April 1, 2014. It was suggested that the WCA update language to require the use of the most current version of the form in effect and amend its billing instructions to accommodate the fields required by the new form.

Electronic Billing: Written comment was received that the language requiring electronic billing by July 1, 2014 is too vague to enable compliance since it requires payers and healthcare providers to "be capable of" electronically billing and payment but does not specifically require it. A commenter requested that the WCA clarify whether electronic payment is required, as other states do not currently require this, and consider the financial and administrative impact of the requirement. Additionally, requests were received to specify standards or systems for electronic billing to eliminate disagreement

between parties or to otherwise add language allowing for electronic billing or alternate billing formats upon mutual agreement between parties. It was suggested that the WCA adopt the IAIABC eBilling standards and guidance, ASC X12-5010 standards for medical care (professional and institutional providers) and the NCPDP D.0/Batch standards for pharmacy care (retail and mail-order pharmacies) as well as instructions for use. Public comment was received stating that the deadline for electronic billing which was extended during last year's rulemaking should be further extended.

Hospital Ratio: Comment was received that the hospital ratio methodology allows provider to shift costs to the workers' compensation system, particularly in light of the implementation of the Affordable Healthcare Act and its cost reduction mandates. Further study was requested.

ODG: A comment at the public hearing was received that providers are not getting services cleared for treatment, testing is being limited while treatment is being standardized because of the implementation of the Official Disability Guidelines (ODG). While they can prevent fraud and overuse of services, they are guidelines that are supposed to be flexible. The ODG board accepts articles if providers are willing to submit them.

Failed Appointments: A question was posed at the public hearing whether a failed appointment includes follow ups.

Response: The changes to part 7 are intended to streamline the rule and make it easier to read and comprehend. The new rule creates a separate fee schedule and billing instruction document. All fee setting provisions formerly in the rule are now included in the fee schedule document, including the provision setting the amount to paid for bills submitted without an NDC number. As part of the fee schedule it is intended they will be reviewed as part of the director's annual order. Pharmaceutical issues clearly have an effect on overall medical costs in New Mexico. The WCA intends to convene the Medical Advisory Committee in the coming year and evaluate pharmaceutical issues before it makes changes to the existing rule. The proposal to change the hospital ratio methodology will be taken under advisement and studied in the coming year. The WCA Billing Instructions will add the new CMS-1500 form and instructions for completion of the form. The Billing Instructions will also include language allowing the use of both ICD-9 and ICD-10. The WCA deleted the language in the proposed rule which addressed the standard of medical care in New Mexico since it does not properly belong in the WCA Rules. Charges for failed appointments are only allowed when it is an initial appointment or for an IME or FCE, which are paid at reduced rates. The WCA is still evaluating the effect of the implementation of the ODG, which went into effect July 1, 2013. While the WCA is reluctant to move back the implementation of electronic billing it will extend the deadline to July 1, 2015 to allow time for the industry to put its systems in place. The WCA will continue to accept feedback on clarifying the electronic billing requirement and may revisit the rule in the next rulemaking cycle.

PART 13

No comments were received concerning amendment to Part 13 of the WCA Rules and, therefore, the rules will be promulgated as initially proposed.

FEE SCHEDULE

The WCA received public comment recommending it assign a fixed fee to certain "BR" or "By Report" EMG codes to ensure for consistent predictable payment rates. The commenter recommended rates for the following CPT codes: 95907, $130.01; 95908, $160.46; 95909, $192.30; 95910, $253.24; 95911, $306.95; 95912, $359.76; and 95913, $417.32.
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Response: After careful consideration, the WCA has opted to adopt the recommended rates for the CPT codes specified.

These rules will be adopted pursuant to NMSA 1978, §52-5-4 and 52-4-4.

The public record of this rulemaking shall incorporate this Response to Public Comment and the formal record of the rulemaking proceedings shall close upon execution of this document.

_____/s/_____
DARIN A. CHILDERS,
Director
N.M. Workers' Compensation Administration
December 13, 2012

End of Other Related Material Section

Submittal Deadlines and Publication Dates
2014

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Issue Number 3	February 3	February 14
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Issue Number 5	March 3	March 14
Issue Number 6	March 17	March 31
Issue Number 7	April 1	April 15
Issue Number 8	April 16	April 30
Issue Number 9	May 1	May 15
Issue Number 10	May 16	May 30
Issue Number 11	June 2	June 13
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