TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 1 GENERAL PROVIDER POLICIES

8.302.1.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.302.1.1 NMAC - Rp, 8.302.1.1 NMAC, 1/1/2023]

8.302.1.2 SCOPE: The rule applies to the general public.
[8.302.1.2 NMAC - Rp, 8.302.1.2 NMAC, 1/1/2023]

8.302.1.3 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 state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).
[8.302.1.3 NMAC - Rp, 8.302.1.3 NMAC, 1/1/2023]

8.302.1.4 DURATION: Permanent.
[8.302.1.4 NMAC - Rp, 8.302.1.4 NMAC, 1/1/2023]

8.302.1.5 EFFECTIVE DATE: January 1, 2023, unless a late date is cited at the end of a section.
[8.302.1.5 NMAC - Rp, 8.302.1.5 NMAC, 1/1/2023]

8.302.1.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.302.1.6 NMAC - Rp, 8.302.1.6 NMAC, 1/1/2023]

8.302.1.7 DEFINITIONS: "**Medically necessary services"**

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;

(3) are provided within professionally accepted standards of practice and national guidelines; and

(4) are required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

B. Application of the definition:

(1) A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

(2) The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient shall do so by:

(a) evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the eligible recipient or their personal representative 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) Physical and behavioral health services shall not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.

(4) Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

(5) Medically necessary service requirements apply to all medical assistance program rules.

[8.302.1.7 NMAC - Rp, 8.302.1.7 NMAC, 1/1/2023]

8.302.1.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.302.1.8 NMAC - Rp, 8.302.1.8 NMAC, 1/1/2023]

8.302.1.9 GENERAL PROVIDER POLICIES: Medically necessary services are reimbursed by the MAD under Title XIX of the Social Security Act as amended, or by state statute.

[8.302.1.9 NMAC - Rp, 8.302.1.9 NMAC, 1/1/2023]

8.302.1.10 ELIGIBLE PROVIDERS:

A. Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program 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 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, billings instructions, utilization review instructions, and other pertinent materials. When enrolled, providers receive instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement and all applicable statutes, regulations and executive orders.

B. When services are billed to and paid by a coordinated services contractor authorized by HSD, 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.

[8.302.1.10 NMAC - Rp, 8.302.1.10 NMAC, 1/1/2023]

8.302.1.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS: A provider who furnishes services to a medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. A provider also must conform to MAD program rules, instructions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. A provider must verify that individuals are eligible for a specific health care program administered by the HSD and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an 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 eligible recipient.

A. Eligibility determination: A provider must verify recipient eligibility prior to providing services and verify that the recipient remains eligible throughout periods of continued or extended services.

(1) A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting MAD or designated contractor eligibility help desks, contracting with an eligibility verification system vendor, or by using the New Mexico medicaid portal.

(2) An eligible recipient becomes financially responsible for a provider claim if the eligible recipient:

(a) fails to identify themselves as a MAD eligible recipient; or

(b) fails to state that an eligibility determination is pending; or

(c) fails to furnish MAD identification before the service is rendered and MAD denies payment because of the resulting inability of the provider to be able to file a claim timely; or

(d) receives services from a provider that lacks MAD enrollment, is not eligible to provide the services or does not participate in MAD programs.

B. Requirements for updating information: A provider must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the provider or person. MAD or the appropriate MAD claims processing contractor must receive this information at least 60 calendar days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment or provider repayment. The provider must provide MAD with information, in writing, updating their provider participation agreement of any conviction of delineated criminal or civil offenses against the provider or parties with direct or indirect ownership or controlling interest within ten calendar days after the conviction.

C. Additional requirements: A provider must meet all other requirements stated in the program rules, billing instructions, manual revisions, supplements, and signed application forms or re-verification forms, as updated. MAD may require a letter of credit, a surety bond, or a combination thereof, from the provider. The letter of credit, surety bond or combination thereof may be required if any one of the following conditions is met:

(1) the provider is the subject of a state or federal sanction or of a criminal, civil, or departmental proceeding in any state;

(2) a letter of credit, surety bond, or any combination thereof is required for each provider of a designated provider type;

(3) the provider cannot reasonably demonstrate that they have assumed liability and are responsible for paying the amount of any outstanding recoveries to MAD as the result of any sale, merger, consolidation, dissolution, or other disposition of the provider or person; or

(4) the secretary determines that it is in the best interest of MAD to do so, specifying the reasons.

[8.302.1.11 NMAC - Rp, 8.302.1.11 NMAC, 1/1/2023]

8.302.1.12 ELIGIBLE MEDICAID RECIPIENTS: To comply with Title XIX of the Social Security Act, as amended, MAD is required to serve certain groups of eligible recipients and has the option of paying for services provided to other eligible recipient groups [42 CFR 435.1]. MAD is also required to pay for emergency services furnished to non-citizens residing in New Mexico who are not lawfully admitted for permanent residence but who otherwise meet the eligibility requirements. Coverage is restricted to those services necessary to treat an emergency medical condition, which includes labor and delivery services. See 8.325.10.3 NMAC.

A. Recipient eligibility determination: To be eligible to receive MAD benefits, an applicant/recipient must meet general eligibility or resource and income requirements. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on medicaid eligibility requirements.

(1) An otherwise eligible recipient who is under the jurisdiction or control of the correctional system or resides in a public institution is not eligible for medicaid.

(2) MAD eligibility determinations are made by the following agencies:

(a) the staff of the income support division (ISD) county offices determines eligibility for medicaid categories of eligibility;

(b) the staff of the New Mexico children, youth and families department (CYFD) determines eligibility for child protective services, adoptive services and foster care children;

(c) the staff of the social security administration determines eligibility for social security income (SSI); and

(d) the staff of a federally qualified health center, a maternal and child health services block grant program, the Indian health service, and other designated agents make presumptive eligibility determinations.

B. Recipient freedom of choice: Unless otherwise restricted by specific health care program rules, an eligible recipient has the freedom of choice to obtain services from in-state and border providers who meet the requirements for MAD provider participation. Some restrictions to this freedom of choice apply to an eligible recipient who is assigned to a provider or providers in the medical management program (45 CFR 431.54 (e)). See 301.5 NMAC, *Medical Management.* Some restrictions to this freedom of choice may also apply to purchases of medical devices, and laboratory and radiology tests and other services and items as allowed by federal law (42 CFR 431.54 (d)).

C. Recipient identification: An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

(1) A provider must verify the eligibility of the recipient to assure the recipient is eligible on the date the services are provided. Verification of eligibility also permits the provider to be informed of any restrictions or limitations on services associated with the recipient's eligibility; of the applicability of co-payments on services; of the need for the eligible recipient's care to be coordinated with or provided through a managed care organization, a hospice provider, a PACE provider, a medical management provider, or similar health care plan or provider. Additionally, information on medicare eligibility and other insurance coverage may be provided.

(2) An eligible recipient whose health care program coverage or benefits may be limited include:

(a) qualified medicare beneficiary (QMB) recipient; and

(b) family planning benefits.

[8.302.1.12 NMAC - Rp, 8.302.1.12 NMAC, 1/1/2023]

8.302.1.13 PATIENT SELF DETERMINATION ACT: A hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, hospice agency and home health agency is required to give an eligible recipient or personal representative information about their right to make their own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. An eligible recipient is not required by this legislation to execute advance directives. Advance directives, such as living wills or durable power of attorney documents, must be established in a manner which is recognized under New Mexico state law. See applicable state law. A health care provider cannot object on the basis of conscience when an eligible recipient or personal representative wishes to implement an advance directive.

A. Information requirements: At the time of admission, a provider is required to provide written information to an adult eligible recipient or personal representative concerning their right to do the following:

(1) make decisions about their medical care;

(2) accept or refuse medical or surgical treatment;

(3) execute advance directives;

(4) execute their rights under HIPAA; and

(5) if an eligible recipient who is already incapacitated is admitted, the provider must provide their personal representatives with this information; if an eligible recipient is no longer incapacitated, the provider must discuss these rights with the eligible recipient.

B. Policies, rules and procedures: A provider must give written information to an eligible adult recipient or their personal representative about provider rules and procedures concerning advance directive rights. A provider must verify that the advance directive complies with state law.

C. Documentation requirements: A provider must document in each eligible recipient's medical record whether their personal representative has established an advance directive. If the eligible recipient or their personal representative presents an advanced directive, a provider must comply with the terms of the document, as directed by state law. If an eligible recipient is incapacitated, unable to communicate, or their personal representative does not present an advance directive, the provider must document that the eligible recipient was unable to receive information or communicate whether advance directives exist. A provider must inform the eligible recipient or their personal representative that it furnishes information and proper forms for completion of advance directives.

D. Provision of care: A provider must not condition the provision of care or discriminate against an eligible recipient based on whether they have established advance directives. If an eligible recipient is entitled to necessary care ordered by a physician, which providers under normal procedures must furnish, care cannot be delayed while waiting for the execution of an advance directive. Once the existence of an advance directive is documented, the directive takes precedence over normal procedures.

E. Changing the advanced directives: A provider must inform an eligible recipient or their personal representative that they have a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements.

[8.302.1.13 NMAC - Rp, 8.302.1.13 NMAC, 1/1/2023]

8.302.1.14 NONDISCRIMINATION: A provider must furnish covered services to an eligible recipient in the same scope, quality and manner as provided to the general public. Within the limits of medical assistance programs, a provider may not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity,

religion, sexual orientation, sexual preference, health status, disability, marital status, political belief, or source of payment, (45 CFR 80.3 (a)(b); 45 CFR 84.52 (a); 42 CFR 447.20; and PL 101-366, 104 Stat. 327 (1990)).
[8.302.1.14 NMAC - Rp, 8.302.1.14 NMAC, 1/1/2023]

8.302.1.15 BILLING AND CLAIMS PROCESSING: Reimbursement to a provider for services or procedures is based on the MAD reimbursement fee schedule, reimbursement rate, or reimbursement methodology in place at the time the services were furnished by the provider. A provider who furnishes services to an eligible recipient agrees to accept the amount paid by MAD as payment in full, except as otherwise allowed by rule or regulation (42 CFR 447.15).

A. Requirements for reimbursement: A provider is reimbursed for performing a service or procedure only if any required prior authorization, documentation, certifications, or acknowledgements are submitted with the claim and the claim is received by the appropriate claims processing contractor within the filing limits.

B. Electronic billing requirements: Effective December 1, 2008, electronic billing of claims is mandatory unless an exemption has been allowed by MAD. Electronic billing improves the accuracy of claims submission and payment; provides consistency in billing information; and improves the speed of payment. Exemptions will be given on a case by case basis with consideration given to barriers the provider may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which paper attachments must accompany the claim form.

C. Responsibility for claims: A provider is responsible for all claims submitted under their national provider identifier (NPI) or other provider number including responsibility for accurate coding that represents the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, and the CMS correct coding initiative.

D. No billing of recipients or third parties: With the exception of WDI and SCHIP or other specified program co-payments or cost-sharing, a provider may not bill, turn over to collection, or accept payment from an eligible recipient, their personal representative or other third parties determined to be legally responsible for the balance of a claim except as specifically allowed by MAD regulations. Following MAD payment, a provider cannot seek additional payment from an eligible recipient or their personal representative in addition to the amount paid by MAD. Following MAD denial of payment due to provider administrative error in filing a claim, a provider cannot seek payment from an eligible recipient or their personal representative or turn the balance over to collection. See 8.302.3 NMAC, *Third Party Liability Provider Responsibilities*.
[8.302.1.15 NMAC - Rp, 8.302.1.15 NMAC, 1/1/2023]

8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS: A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:

A. The eligible recipient is advised by the provider before services are furnished that a particular service is not covered by MAD or that the particular provider does not accept patients whose medical services are paid for by MAD.

B. The eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment.

C. The eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.
[8.302.1.16 NMAC - Rp, 8.302.1.16 NMAC, 1/1/2023]

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. (42 CFR 431.107(b)). Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act NMSA 1978 section 27-11-1, et. seq., and a crime punishable under the Medicaid Fraud Act, NMSA, section 30.44-5. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. Services billed by units of time: Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

D. Recipient funds accounting systems: If an eligible recipient entrusts their personal funds to a nursing facility, intermediate care facility for the intellectually disabled, or swing bed hospital, or any other facility, the facility provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of medicaid.

[8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 1/1/2023]

8.302.1.18 PATIENT CONFIDENTIALITY: A provider is required to comply with the HIPAA privacy regulations. Confidential medical information regarding medicaid information on the applicant or eligible recipient must be released by providers to MAD, and to other state or federal agencies, or their employees at no cost when:

A. the agency is involved in the administration of medicaid;

B. the information is to be used to establish eligibility, determine the amount of assistance or provide services related to medicaid;

C. the agency is subject to the same standards of confidentiality as MAD; and

D. the agency has the actual consent of applicant or eligible recipient or their personal representative for release of the information, or consent is obtained when an eligible recipient or their personal representative or a member of the assistance group makes application for benefits or services with the human services department.

[8.302.1.18 NMAC - Rp, 8.302.1.18 NMAC, 1/1/2023]

8.302.1.19 PROVIDER DISCLOSURE: A provider must furnish MAD with the following information. See 42 CFR 431.107(b)(2)(3): name and address of each person with an ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent or more, and any relationship (spouse, child or sibling) of these persons to another; name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest; name of any person with an ownership or controlling interest in the entity who has been convicted of a criminal offense related to that person's involvement in any program established under the medicare or medical assistance programs; and name of any provider who employs or uses the services of an individual who, at any time during the year preceding this employment, was employed in a managerial, accounting, auditing or similar capacity, by an agency or organization which currently serves or at any time during the preceding year served as a medicare or MAD fiscal intermediary or carrier for the provider. A provider must notify MAD of any change in the status of these disclosure provisions.

A. Reports furnished by providers: A provider must give MAD, the appropriate MAD claims processing contractor, MAD audit contractor, MAD utilization review contractor or MAD designated representative financial reports, audits, certified cost statements, medical and other records, or any other data needed to establish a basis for reimbursement at no cost.

(1) All information regarding any claim for services must be provided. See 42 CFR 431.107(b) (2).

(2) Required cost statements must be furnished no later than 150 calendar days of the close of the provider's fiscal accounting period.

(3) MAD records and other documentation needed by MAD or its designee must be available within a defined period, upon request.

B. Penalties: MAD suspends payment for services until the required statements are furnished by the provider.

C. Conflict of interest: MAD does not enter into a provider participation agreement or other contract with a public officer, employee of the state, legislator, or business in which the individual has a substantial interest, unless the individual discloses their substantial interest and provider participation agreement is accepted by MAD and any other contract is awarded pursuant to the state procurement code Section 10-16-7 NMSA 1978 (Repl. Pamp. 1993).

[8.302.1.19 NMAC - Rp, 8.302.1.19 NMAC, 1/1/2023]

8.302.1.20 TERMINATION OF PROVIDER STATUS:

A. Provider status may be terminated if the provider or MAD gives the other written notice of termination at least 60 calendar days before the effective termination date.

(1) Facility provider must also give at least 15 calendar days notice to the public by publishing a statement of the date services are no longer available at the facility in one or more newspapers of general circulation within the affected county or region.

(2) Normal termination and notice limits do not apply if the state survey agency or health care financing administration determines that the health and safety of residents in a nursing facility or intermediate care facility for the intellectually disabled or the children, youth and families department determines that the health and safety of children or adolescents in a residential treatment center, group home, or treatment foster care are in jeopardy.

B. Grounds for denial or revocation of enrollment: MAD may, with a 30-calendar days notice, deny or terminate a provider's enrollment in its medical assistance program including, but not limited to, medicaid (Title XIX of the Social Security Act) and other health insurance programs funded by the department, if any of the following are found to be applicable to the health care provider, their agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) misrepresentation by commission or omission of any information on the MAD provider participation agreement enrollment form;

(2) previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in New Mexico medical assistance programs, any other states medicaid program, medicare, or any other public or private health or health insurance program;

(3) conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under New Mexico medical assistance programs any other states medicaid program, medicare, or any other public or private health or health insurance program;

(4) conviction under federal or state law of a criminal offense relating to the neglect, or abuse of a patient in connection with the delivery of any goods, services, or supplies;

(5) conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(6) conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(7) conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude, or acts against the elderly, children, or infirmed;

(8) conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this subsection;

(9) sanction pursuant to a violation of federal or state laws or rules relative to New Mexico medical assistance programs, any other state's medicaid program, medicare, or any other public health care or health insurance program;

(10) violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided;

(11) failure to pay recovery properly assessed or pursuant to an approved repayment schedule under New Mexico medical assistance programs; and

(12) see 8.351.2 NMAC, *Sanctions and Remedies,* and 8.353.2 NMAC, *Provider Hearings*.

[8.302.1.20 NMAC - Rp, 8.302.1.20 NMAC, 1/1/2023]

8.302.1.21 CHANGE IN OWNERSHIP: As soon as possible, but at least 60 calendar days after a change in ownership, MAD reserves the right to withhold payment on all pending or current claims until any right MAD has to recoup portions or all of those payments is determined. Payment will not be withheld if MAD received written confirmation that the new owner or previous medical assistance program provider agrees to be responsible for any potential overpayment.
[8.302.1.21 NMAC - Rp, 8.302.1.21 NMAC, 1/1/2023]

8.302.1.22 PUBLIC DISCLOSURE OF SURVEY INFORMATION: The findings of a MAD survey used to determine the ability of facility provider to begin or continue as medicaid participating provider is available to the public within 90 calendar days of completion.

A. Documents subject to disclosure: Documents subject to public disclosure include:

(1) current survey reports prepared by the survey agency;

(2) official agency notifications of findings based on these reports, including statements of deficiencies;

(3) pertinent parts of written statements furnished by providers to the survey agency related to these reports and findings, including any corrective action taken or planned; and

(4) information regarding the ownership of nursing facility. See 42 CFR 455.104(a).

B. Release of performance reports: Reports on provider's or contractor's performance reviews and formal performance evaluations are not available to the public until the provider or contractor have a reasonable opportunity (not to exceed 30 calendar days) to review the reports and offer comments. These comments become part of the reports.

C. Availability of cost reports: Provider cost reports used as a basis for reimbursement are available to the public upon receipt of a written request by the MAD audit contractor.

(1) Information disclosure is limited to cost report documents required by social security administration regulations, and in the case of a settled cost report, the notice of medicaid settlement.

(2) The request for information must identify the provider and the specific reports requested.

(3) The cost for supplying copies of the cost reports is billed to the requester.

[8.302.1.22 NMAC - Rp, 8.302.1.22 NMAC, 1/1/2023]

HISTORY OF 8.302.1 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.
ISD 301.2000, Provider Agreement; 12/21/1979.
ISD 301.2000, Provider Agreement, 12/4/1980.
MAD RULE 301, Procedures and Requirements for Provider Participation, 11/8/1989.
ISD 301.3000, Confidentiality, 12/21/1979.
ISD 301.4000, Public Disclosure of Information, 1/17/1980.
ISD 301.4000, Public Disclosure of Information, 11/24/1980.
SP-004.1300, Section 4, General Program Administration Required Provider Agreement, 3/3/1981.
SP-007.0200, Section 7, General Provisions Nondiscrimination, 3/4/1981.
SP-004.2300, Section 4, General Program Administration Use of Contracts, 3/5/1981.
SP--004.2700, Section 4, General Program Administration Disclosure of Survey Information and Provider or Contractor Evaluation, 3/5/1981.
SP-004.3100, Section 4, General Program Administration Disclosure of Information By Providers and Fiscal Agents, 3/5/1981.
SP-007.0201, Section 7, Nondiscrimination, 6/10/1981.
SP-003.0100, Medical and Remedial Care and Services- Amount, Duration and Scope, 6/18/1981.
SP-003.0100, Section 3, Services: General Revisions - Amount, Duration and Scope of Service, 6/24/1981.

History of Repealed Material: 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 Repealed effective 1/1/2023.

Other: : 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 Replaced by 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies effective 1/1/2023.