TITLE 7 HEALTH
CHAPTER 30 FAMILY AND CHILDREN HEALTH CARE SERVICES
PART 3 CHILDREN'S MEDICAL SERVICES AND ADULT CYSTIC FIBROSIS

7.30.3.1 ISSUING AGENCY: The Department of Health, Public Health Division.
[7.30.3.1 NMAC - Rp, 7 NMAC 30.3.1, 10/30/12]

7.30.3.2 SCOPE: General public.
[7.30.3.2 NMAC - 7 NMAC 30.3.2, 10/30/12]

7.30.3.3 STATUTORY AUTHORITY: The regulations set forth herein are promulgated by the secretary of department of health by authority of Subsections E and F of Section 9-7-6 NMSA 1978 and Section 24-2-1 NMSA 1978. Administration and enforcement of these regulations is the responsibility of the public health division of the department of health.
[7.30.3.3 NMAC - Rp, 7 NMAC 30.3.3, 10/30/12]

7.30.3.4 DURATION: Permanent.
[7.30.3.4 NMAC - 7 NMAC 30.3.4, 10/30/12]

7.30.3.5 EFFECTIVE DATE: October 30, 2012, unless a later date is cited at the end of a section.
[7.30.3.5 NMAC - Rp, 7 NMAC 30.3.5, 10/30/12]

7.30.3.6 OBJECTIVE: The objective is to establish criteria for eligibility and application of services from the children's medical services program, to delineate client and provider responsibilities as well as an appeals procedure, and to set forth an index of eligible conditions.
[7.30.3.6 NMAC - Rp, 7 NMAC 30.3.6, 10/30/12]

7.30.3.7 DEFINITIONS:

A. "Application" means the written request, on forms prescribed by the division, for enrollment, and provision of supportive documentation of residence, income, age, and medical diagnosis for eligibility determination under children's medical services program.

B. "Assets" means savings accounts, stocks and bonds, checking accounts, accessible trust funds, and real property. Assets do not include loans which need to be repaid, or homestead acreage used for the production of income if this is the primary source of income, or personal property that is used in the production of income if related to the primary source of income.

C. "Care coordination" means coordination of resources across agency and professional lines to develop and attain the client's service plan with optimal client/family participation.

D. "Care coordinator" means the person employed by the children's medical services program to assist the family in planning, implementing, evaluating and coordinating with other health care professionals to establish and carry out a service plan for the client.

E. "Child" means a person below the age of 18.

F. "Children's medical services ("CMS") means a unit of the public health division in the New Mexico (NM) department of health that engages in:

(1) identification of children and youth with, or at risk for having, special health care needs (CYSHCN);

(2) provision of preventive, diagnostic, and treatment services and care coordination toward the attainment of maximum health for children with special health care needs, and adults with cystic fibrosis;

(3) promotion of the development of quality health care and outcome measures for this population (children and youth with special health care needs and adults with cystic fibrosis);

(4) monitoring these outcomes and the impact of changes in the health care system for this population;

(5) technical assistance and training for individuals serving this population; and

(6) administration of the universal newborn hearing screening program and the newborn genetic screening program, and other necessary administrative services to assess the needs of this population, facilitating access to care, and providing services.

G. **"Client"** means the individual who is applying for or receiving services from the children's medical services program and includes the person with legal authority to consent to medical care.

H. **"Consultant"** means a professional licensed by the appropriate specialty board, such as audiology, ophthalmology, orthodontia, speech or psychology, who provides statements of eligibility and approves care plans within the specialty area.

I. **"Date of referral"** means the calendar date a child or adult in need of services first requested services by telephone, mail, written referral, or application to a representative of the children's medical services program.

J. **"Department"** means the NM department of health.

K. **"Diagnostic services"** means the provision of professional services to determine whether or not the client has a diagnosis within the medical diagnostic categories established in the medical index.

L. **"Division"** means the public health division of the NM department of health, Post Office Box 26110, Santa Fe, New Mexico 87502.

M. **"Eligible individual"** means an individual below the age of 21 who is a resident of NM and has or is at increased risk for chronic medical conditions and who requires health and related services of a type or amount beyond that required by children generally; or an adult with cystic fibrosis; or an individual of any age who requires metabolic clinic services or genetic testing.

N. **"Eligibility for clinic only"** means eligibility only for services at any specialty clinics sponsored by the children's medical services program.

O. **"Eligibility for medical management"** means eligibility for purchase of health care services approved by the children's medical services program and payment of expenses related to medical care such as lodging, meals, and transportation as outlined in the service plan and approved by the children's medical services program.

P. **"Eligibility for care coordination only"** means eligibility only for care coordination services.

Q. **"Enrollment"** means a statement, on forms prescribed by the division, and signed by the client accepting services, and acknowledging that acceptance of these services does not restrict eligibility for any other benefits or services.

R. **"Expenditure"** means authorization of funds and payment for services to healthcare professionals, institutions, and others.

S. **"Financial eligibility"** means a household income below 200% of the federal poverty guidelines which are published annually. CMS is always the payor of last resort. Any and all third party payments must be fully utilized before CMS payments are made. Clients who have two or more other payor sources such as insurance, medicare, etc., do not meet financial eligibility for payment by the children's medical services program.

T. **"Health"** means a state of physical and mental well-being, not merely the absence of disease.

U. **"Household"** means those who dwell under the same roof and are related by blood or marriage, excluding those who constitute separate economic units as determined by the service coordinator and documented in the case record.

V. **"Income"** means earned and non-earned gross income of all persons who reside in the household of the client, and have financial responsibility for the client, and any contributions to the household from non-household members with financial responsibility. Irregular and unpredictable contributions in insignificant amounts are not considered income for the purposes of these regulations.

W. **"Medicaid"** means medical assistance eligibility, pursuant to Title XIX of the Social Security Act, by the medical assistance division of the NM human services department.

X. **"Medical director"** means a pediatrician certified by the American board of pediatrics, licensed to practice medicine in the state of NM, who assists the program manager in the determination of medical eligibility for the children's medical services program and approves service plans and payment for eligible children and adults.

Y. **"Medical index"** means a listing of medical diagnoses for which an eligible individual may receive coverage by the children's medical services program.

Z. **"Medical report"** means the written report of a provider giving the diagnosis of the individual and the treatment recommended and provided.

AA. **"Prior approval"** means the requirement of approval for expenditure of funds for services before the service is rendered by a provider.

BB. **"Program manager"** means the person or delegate responsible for the provision of services through the children's medical services program.

CC. **"Provider"** means any individual or entity furnishing health care under a provider agreement with the children's medical services program.

DD. "Residence" means place where client lives with the intent to make the place his permanent and principal home.

EE. "Service plan" means a statement, developed in partnership with the family/parent/guardian, of the identified health needs of the client, how they will be met, by whom, and within a specified time frame.

FF. "Third party" means any person or entity that is liable to pay all or part of the medical cost of injury, disease, or disability of a children's medical services client.

GG. "Youth" means a person at least 18 years of age and less than 21 years of age.

[7.30.3.7 NMAC - Rp, 7 NMAC 30.3.7, 10/30/12]

7.30.3.8 ELIGIBILITY:

A. Medical management eligibility: To be eligible for medical management through CMS an applicant must meet all of the following requirements:

(1) the applicant must be a resident of NM;

(2) the applicant must be financially eligible; (income below 200% of the federal poverty level). CMS is always the payor of last resort; any and all third party payments must be fully utilized before CMS payments are made; clients who have two or more other payor sources such as insurance, medicare, etc., do not meet financial eligibility for payment by the children's medical services program; and

(3) the applicant must be medically eligible as defined in the medical index and the treatment protocols and guidelines adopted by the children's medical services program, and as determined by the medical director.

B. Adult cystic fibrosis eligibility: To be eligible for medical coverage and care coordination services through the adult cystic fibrosis program, an applicant must meet all of the following requirements:

(1) the applicant must be 21 years of age or older;

(2) the applicant must be diagnosed as having cystic fibrosis by pilocarpine iontophoresis or by genetic studies;

(3) the applicant must be a resident of NM; and

(4) the applicant must meet financial eligibility criteria (income below 200% of the federal poverty level); CMS is always the payor of last resort; any and all third party payments must be fully utilized before CMS payments are made; clients who have two or more other payor sources such as insurance, medicare, etc., do not meet financial eligibility for payment by the children's medical services program.

C. Clinic only eligibility: To be eligible for clinic services, an applicant must meet the following requirements:

(1) the applicant must be under 21 years of age, except for metabolic clinics where applicant may be any age;

(2) the applicant must be a resident of NM; and

(3) the applicant must be referred by a physician, physician's assistant, or pediatric nurse practitioner.

D. No fee for clinic: There is no charge for the children's medical service sponsored clinic, however, there may be a charge for tests ordered by physicians and completed outside of the clinics. Third party payment will be sought if available.

E. Care coordination only eligibility: To the extent resources are available, care coordination shall be provided for any child with special health care needs, adult with cystic fibrosis, or individual at risk of having a child with special needs, regardless of income.

[7.30.3.8 NMAC - Rp, 7 NMAC 30.3.8, 10/30/12]

7.30.3.9 APPLICATION, ENROLLMENT AND REFERRAL: Application for CMS services must be made in person, by telephone, or by letter from the client or another referral source to any children's medical services office, located in most counties in NM, generally in the public health division's county health offices.

A. If an application is submitted within 30 days of referral, eligibility begins on the date of referral. If the application is submitted after the 30-day time limit has expired, eligibility begins on the date the application was submitted.

B. The application shall include medical and financial information, as appropriate. Medical records and documentation of income and resources such as income tax returns, insurance policies, checks, check stubs, or deeds to real property may be required before the application will be deemed complete.

C. The care coordinator shall assist in obtaining medical and financial documentation insofar as she/he will define for the client what information is necessary to complete the application. The care coordinator

may deny any application pending more than 30 days which has not been completed. Individuals whose application is denied may reapply at any time.

D. Upon receipt of a completed application, including medical records and documentation of income and assets, the division shall have 20 working days to determine eligibility for children with special health care needs or adults with cystic fibrosis. Written notification of application approval or denial will be sent to the client no later than 20 working days after receipt of a completed application.

[7.30.3.9 NMAC - Rp, 7 NMAC 30.3.9, 10/30/12]

7.30.3.10 RESIDENCY: To be eligible for any program under children's medical services, applicant/recipients must be living in NM on the date of application or determination of eligibility and have demonstrated intent to remain in NM.

A. Establishing residence: Residence in NM is established by living in the state and carrying out the types of activities normally associated with everyday life, such as occupying a home, enrolling child(ren) in school, getting a driver's license, or renting a post office box. An applicant/recipient who is homeless is considered to have met residency requirements if he intends to remain in the state.

B. Abandonment of residence: Residence is not abandoned by temporary absences from the state. Temporary absences occur when recipients leave NM for specific purposes with time-limited goals. If a client will be absent from NM for more than 30 days, he must notify the care coordinator of his intent to maintain residency and eligibility for CMS services. Residence is considered abandoned when any of the following occur:

(1) applicant/recipient leaves NM and indicates that he intends to establish residence in another state;

(2) applicant/recipient leaves NM for no specific purpose with no clear intention of returning;

(3) applicant/recipient leaves the state and applies for financial, food, or medical assistance in another state that makes residence a condition of eligibility; or

(4) applicant/recipient has been absent from NM for more than 30 days without notifying the care coordinator of departure and intention of returning.

[7.30.3.10 NMAC - N, 10/30/12]

7.30.3.11 CLIENT RESPONSIBILITIES:

A. Clients are responsible for providing the division with accurate information concerning their financial and medical eligibility when requested by the children's medical services program.

B. Clients must apply for and inform the service coordinator of insurance, medicaid or other possible source of payment for medical expenses. Clients who meet eligibility criteria for medicaid must apply.

C. Clients must report the following changes to their care coordinator within 10 working days of the date the client becomes aware of the change: changes in income exceeding $100.00 per month; changes in household composition, insurance or medicaid coverage; or change of address or telephone number.

D. Private donations, if regular and predictable, will be considered income. If irregular or unpredictable, private donations for the care of the child must be reported to the service coordinator within ten working days of receipt of the donation if it exceeds $1,000.00.

E. Third party tort liability: The client must notify the care coordinator within 30 working days of knowledge of potential liability if a third party may be liable for medical expenses. The client must advise the care coordinator of the name of the potentially liable third party, and the names of all attorneys representing the client.

(1) Any funds received from a third party because of liability for injuries to a client for whom the division is making medical payments must be used to repay the division for money expended on behalf of the client.

(2) Clients must assign to the division any right to recover or cause of action against a liable third party and all proceeds recovered from liable third parties to the extent that the division has made payment on behalf of the client.

(3) Failure to assign any right to recover or cause of action, or proceeds described above shall be grounds for denial of application or termination of payment for services by division for a period not to exceed six months.

(4) Failure to advise the division of anticipated court action as described above shall be grounds for termination of payment for services for a period not to exceed six months, and client shall be liable to the division for any sums expended by the division for which the client receives compensation from a third party.

F. Failure to provide correct and complete information necessary to determine eligibility and failure to report changes, third party resources, including insurance recoveries, potential liability or private donations as required above may result in termination of benefits under these regulations and disqualification from receipt of benefits for a period not to exceed six months, or civil action to recover benefits wrongfully received.

G. Eligibility review: The client receiving benefits must have his/her eligibility reviewed annually. If the client does not respond to a request for review, services may be denied, and the case may be closed 30 days after the first letter of request is sent. Closure date may be extended in certain circumstances at the discretion of the CMS program manager or medical director.

H. If a client does not follow treatment recommendations or directions made by a CMS care coordinator, consultant or provider, services may be terminated and the children's medical services program manager or medical director may refuse to pay for services because of the failure to follow treatment recommendations or directions. Prior to termination of services or failure to pay for services due to failure to follow treatment recommendations or directions, a client may request a consult to review treatment recommendations or directions he does not wish to follow.

[7.30.3.11 NMAC - Rp, 7 NMAC 30.3.10, 10/30/12]

7.30.3.12 PROVIDER RESPONSIBILITES:

A. Any person wishing to provide health care in the children's medical services program must be a medicaid provider and shall operate under a provider agreement with CMS.

B. Failure to comply with the terms of the provider agreement may result in termination of provider status and immediate cessation of payment for services rendered to the client.

C. Providers must submit legible and complete medical records for each service or set of related services authorized by the program to the care coordinator. Failure to submit medical reports may result in termination of the provider agreement. Medical reports submitted to the program are the property of the program. The program shall follow applicable federal and state laws regarding release of these reports.

D. Providers must meet standards of care established by appropriate licensing boards, certifying bodies and standards as may be established by the CMS services program manager.

E. Providers must seek and obtain prior approval for all services other than routine primary care. Prior approval is obtained through the client's CMS care coordinator and may require review of the CMS medical director.

F. Providers must submit legible and complete medical reports for each service or set of related services authorized by the program to the service coordinator. Failure to submit medical reports may result in termination of the provider agreement.

G. Violations: Sanctions may be imposed by CMS against a provider for any one or more of the following reasons.

(1) Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact by:

(a) presenting or causing to be presented for payment under children's medical services any false or fraudulent claim for services or merchandise;

(b) submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

(c) submitting or causing to be submitted false information for the purpose of meeting prior approval status; and

(d) submission of a false or fraudulent application for provider status.

(2) Failure to disclose or make available to the department or its authorized agent records of services provided to children's medical services clients and records of payments for those services.

(3) Failure to provide and maintain quality services which meet professionally recognized standards of care.

(4) Engaging in a course of conduct or performing an act that is unreasonably improper or abusive of the children's medical services program, or continuing such conduct following notification that said conduct should cease.

(5) Breach of the terms of the provider agreement.

(6) Over utilizing the children's medical services program by inducing, furnishing or otherwise causing a recipient to receive service(s) or merchandise substantially in excess of the needs of the recipient.

(7) Rebating or accepting a fee or portion of a fee or charge for a children's medical services patient referral.

(8) Violating any provision of state or federal statutes or any rule or regulation promulgated pursuant thereto.

(9) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries directly relating to children's medical services.

(10) Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent or abusive practice resulting in death or injury to patients.

(11) Failure to meet standards required by state or federal law for participation, as a given type of provider (e.g., licensure or certification).

(12) Soliciting, charging, or accepting payments from recipients for services for which the provider has billed the children's medical services program.

(13) Failure to correct deficiencies in provider operations within time limits specified by program guidelines after receiving written notice of these deficiencies from the human services department.

(14) Formal reprimand or censure by a professional association of the provider's peers for unethical practices or malpractice.

(15) Suspension or termination from participation in another governmental medical program such as, but not limited to, worker's compensation, medicaid, rehabilitation services, and medicare.

(16) Indictment for fraudulent billing practices, or negligent practice resulting in physical, emotional or psychological injury or death to the provider's patients.

(17) Failure to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

H. Sanctions: One or more of the following sanctions may be invoked against a provider:

(1) termination from participation in the children's medical services program;

(2) suspension of participation in the children's medical services program;

(3) suspension or withholding of payments to a provider;

(4) referral to peer review;

(5) one-hundred percent review of the provider's claims prior to payment; and

(6) referral to the appropriate state licensing board or other appropriate authority for investigation.

I. A provider found by the division to have committed a violation shall be given notice and an opportunity for hearing in accordance with this rule.

[7.30.3.12 NMAC - Rp, 7 NMAC 30.3.11, 10/30/12]

7.30.3.13 PROVIDER BILLING:

A. Providers must seek payment from insurance, medicaid, and other sources, if known, prior to billing the children's medical services program. This includes billing the medicaid program using the child's recipient medicaid identification number and not the CMS billing number.

B. Inpatient care shall be paid at the negotiated per diem rate and under the term established by the provider participation agreement. For other services covered under the program; including approved inpatient days, providers must agree to accept as payment in full the amounts established by the division.

C. If a provider receives a payment from a source other than the program which is equal to or exceeds the amount of the program fee schedule for the authorized services rendered, the provider is prohibited from seeking additional payment from either the client or the division.

D. Providers must submit all bills to the fiscal agent for payment on forms prescribed by the program and within the billing time limits established by the program. Unless the provider receives a waiver of the time limit from the program manager and medical director, failure to comply with the time limits may result in denial of claim. Providers may not hold clients responsible for bills denied because of failure to meet time limits. Providers must also follow all billing instructions in submitting claims for payment to the fiscal agent. If claims are denied due to not following instructions, providers may not hold clients responsible for payment of these bills.

[7.30.3.13 NMAC - N, 10/30/12]

7.30.3.14 EXPENDITURE OF FUNDS:

A. Expenditure of children's medical services program funds are based on the availability of funds, the eligibility of the client for services, and the receipt of prior approval by the provider for the services, if required.

B. Emergency services may be paid for if:

(1) the care coordinator is notified of the services rendered and the necessity of the services before the end of the fifth working day after the emergency expense is incurred; or

(2) the medical director determines that the services were consistent with the service plan, if applicable, are eligible for payment, and were rendered in an emergency.

C. Limit on yearly expenditure of funds:

(1) children's medical services program shall not expend more than $15,000.00 per client per year for medical management; or

(2) the CMS program manager in concurrence with the medical director may raise the $15,000.00 financial limit to provide additional coverage for good cause when monies are available.

D. Purchase of services related to educational activities is excluded under these regulations.

E. Purchase of services related to psychiatric disorders is excluded under these regulations except for psychological problems specifically related to an eligible condition, and with approval from the psychological consultant or medical director.

F. Children's medical services program shall be the last resource after other available sources of payment, such as insurance, medicaid, tortfeasors, the UNM care plan, and the NM department of education.

G. Children's medical services program shall not pay for any eligible services provided more than five working days before the date of referral.

H. Clients who have two or more other payor sources, such as insurance, medicare, or medicaid are not eligible for payment by CMS.

[7.30.3.14 NMAC - Rp, 7 NMAC 30.3.12, 10/30/12]

7.30.3.15 OUT-OF-STATE PROVIDER POLICY: Services must be purchased within the state of NM, unless the need to purchase services elsewhere is documented and approved by the CMS medical director.

A. Services may be purchased outside the state of NM when:

(1) the specific service is not available in NM; or

(2) an eligible client is temporarily out of state and does not qualify for medical assistance in the state of temporary residence, and the health of the client would be endangered if services were postponed until return to NM or by travel to NM; or

(3) excessive time, distance, and expense would be involved in order to obtain outpatient services in NM. Inpatient services are eligible out of state if urgent or emergency hospitalization is needed when distance is excessive or in-state tertiary centers are full.

B. Services may not, under any circumstances, be purchased out of state without approval of the medical director or designee.

C. Out-of-state providers are subject to the same fee schedule, time limitations, standards, and requirements, including operating under a provider agreement, as in-state providers.

[7.30.3.15 NMAC - Rp, 7 NMAC 30.3.13, 10/30/12]

7.30.3.16 CONFIDENTIALITY: Information shall be released by the program only as permissible per state and federal law.

[7.30.3.16 NMAC - Rp, 7 NMAC 30.3.14, 10/30/12]

7.30.3.17 NOTICE AND APPEALS PROCEDURE:

A. Record review. All applicants whose application for services from CMS has been denied and all clients who have been denied requested services by the program may request a record review from CMS.

B. Procedure for requesting informal administrative review.

(1) The applicant or client may submit a written request for a record review. To be effective, the written request shall:

(a) be made within 30 calendar days, as determined by the postmark, from the date of the notice of action issued by CMS;

(b) be properly addressed to CMS;

(c) state the applicant's name, address, and telephone numbers; and

(d) provide a brief narrative rebutting the circumstances of the denial.

(2) If the applicant or client wishes to submit additional documentation for consideration, such additional documentation must be included with the request for a record review.

C. Record review proceeding. The review proceeding is intended to be an informal, non-adversarial administrative review of written documentation. It shall be conducted by an administrative review committee designated for that purpose by CMS. In cases where the administrative review committee finds the need for additional or clarifying information, the review committee shall request that the applicant or client supply such additional information within the time set forth in the committee's request.

D. Final determination.

(1) Content: the administrative review committee shall render, sign, and enter a written decision within 60 days setting forth the reasons for the decision and the evidence upon which the decision is based.

(2) Effect: the decision of the administrative review committee is the final decision of the informal administrative review proceeding.

(3) Notice: a copy of the decision shall be mailed by registered or certified mail to the applicant.

E. Judicial review. Judicial review of the administrative review committee's final decision is permitted to the extent provided by law. The party requesting the appeal shall bear the cost of such appeal.
[7.30.3.17 NMAC - Rp, 7 NMAC 30.3.15, 10/30/12]

7.30.3.18 ELIGIBLE MEDICAL CONDITIONS: The division shall periodically issue an index of conditions which identifies eligible medical conditions. The index shall be reviewed at least annually and revised as necessary. Coverage may change dependent upon available funds. Coverage is provided subject to the further guidelines in the index of children's medical services eligible conditions and treatment protocols. Conditions that are similar in course and outcome to those in the index may be eligible pending review by the medical director. The current index of children's medical services eligible conditions is attached hereto as attachment A.
[7.30.3.18 NMAC - Rp, 7 NMAC 30.3.19, 10/30/12]

7.30.3.19 PEDIATRIC SUBSPECIALISTS: For children age 18 years and under with chronic, complex cardiac, endocrine, neurology, and pulmonary conditions, the CMS program will authorize payment for consultation and follow up services only to board certified pediatric subspecialists when they are available within the state.
[7.30.3.19 NMAC - Rp, 7 NMAC 30.3.20, 10/30/12]

7.30.3.20 VOLUNTEERS: The children's medical services program may use volunteers as allowed by program, division, and department guidelines.
[7.30.3.20 NMAC - Rp, 7 NMAC 30.3.22, 10/30/12]

7.30.3.21 SEVERABILITY: If any part or application of the children's medical services program regulations is held invalid, the remainder, or its application to other situations or persons, shall not be affected.
[7.30.3.21 NMAC - Rp, 7 NMAC 30.3.23, 10/30/12]

HISTORY OF 7.30.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
HSSD 76-5, Regulations Governing Crippled Children's Services, 9/14/76.
HSSD 77-9, Regulations Governing Crippled Children's Services, 12/5/77.
HED-79-7 (HSD), Regulations Governing the Crippled Children's Services Program, 1/11/80.
HED-81-1 (HSD), Regulations Governing the Crippled Children's Services Program, 4/17/81.
HED-82-9 (HSD), Regulations Governing the Children's Medical Services, 8/30/82.
HED 86-8 (HSD), Regulations Governing the Children's Medical Services, 7/18/86.
HED-81-8 (HSD), Regulations Governing the Adult Cystic Fibrosis Program, 11/17/81.

History of Repealed Material:
7 NMAC 30.3, Children's Medical Services and Adult Cystic Fibrosis, filed 10/18/1996 - Repealed effective 10/30/2012.