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MAD-MR: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM BENEFIT DESCRIPTION EFF: 1-1-14

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM
PART 600 BENEFIT DESCRIPTION

8.252.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.252.600.1 NMAC - Rp, 8.252.600.1 NMAC, 1-1-14]

8.252.600.2 SCOPE: This rule applies to the general public.
[8.252.600.2 NMAC - Rp, 8.252.600.2 NMAC, 1-1-14]

8.252.600.3 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.
[8.252.600.3 NMAC - Rp, 8.252.600.3 NMAC, 1-1-14]

8.252.600.4 DURATION: Permanent.
[8.252.600.4 NMAC - Rp, 8.252.600.4 NMAC, 1-1-14]

8.252.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.252.600.5 NMAC - Rp, 8.252.600.5 NMAC, 1-1-14]

8.252.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.252.600.6 NMAC - Rp, 8.252.600.6 NMAC, 1-1-14]

8.252.600.7 DEFINITIONS: [RESERVED]

8.252.600.8 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.
[8.252.600.8 NMAC - N, 1-1-14]

8.252.600.9 GENERAL BENEFIT DESCRIPTION: A woman who is determined eligible for medicaid coverage under the breast and cervical cancer program (Category 052) can receive the full range of medicaid covered.
[8.252.600.9 NMAC - Rp, 8.252.600.9 NMAC, 1-1-14]

8.252.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant will have time limits explained, and be informed of the date by which the application should be processed.
[8.252.600.10 NMAC - Rp, 8.252.600.10 NMAC, 1-1-14]

8.252.600.11 INITIAL BENEFITS: Eligibility is always prospective and begins the month of application. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, the notice shall include reason(s) for denial and the applicant's right to request a fair hearing.
[8.252.600.11 NMAC - Rp, 8.252.600.11 NMAC, 1-1-14]

8.252.600.12 ONGOING BENEFITS: An eligible recipient is responsible to report changes affecting eligibility within 10 calendar days from the date on which the change took place. Changes in eligibility status will be

effective the first day of the following month. A redetermination of eligibility is made every 12 months.
[8.252.600.12 NMAC - Rp, 8.252.600.12 NMAC, 1-1-14]

8.252.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application.

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid is made by indicating the existence of medical expenses in the three months prior to the month of application on the medicaid application form.

B. **Approval requirements:** To establish retroactive eligibility, verification must be provided to demonstrate that all conditions of eligibility were met for each of the three retroactive months, and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

C. **Notice:**

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

(2) **Recipient responsibility to notify provider:** After the retroactive eligibility has been established, the eligible recipient is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the eligible recipient fails to inform all providers and furnish verification of eligibility that can be used for billing, and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the eligible recipient is responsible for payment of the bill.
[8.252.600.13 NMAC - Rp, 8.252.600.13 NMAC, 1-1-14]

8.252.600.14 CHANGES IN ELIGIBILITY: A recipient's eligibility ends when medical assistance division (MAD) receives information from the treating physician or from the recipient that her course of treatment is completed. A case is closed, with provision of advance notice, when the recipient becomes ineligible. The case is closed the month following the death of an eligible recipient.
[8.252.600.14 NMAC - Rp, 8.252.600.14 NMAC, 1-1-14]

HISTORY OF 8.252.600 NMAC:

History of Repealed Material:
8.252.600 NMAC, Benefit Description, filed 6-14-02 - Repealed effective 1-1-14.