TITLE 8  SOCIAL SERVICES
CHAPTER 243  MEDICAID ELIGIBILITY - WORKING DISABLED INDIVIDUALS (WDI)
               (CATEGORY 043)
PART 600  BENEFIT DESCRIPTION

8.243.600.1  ISSUING AGENCY: Human Services Department.

8.243.600.2  SCOPE: This rule applies to the general public.

8.243.600.3  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 by the state human services department pursuant to state statute. See NMSA 1978 27-2-

8.243.600.4  DURATION: Permanent

8.243.600.5  EFFECTIVE DATE: January 1, 2001, unless a later date is cited at the end of a section.

8.243.600.6  OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures
        for the medicaid program.

8.243.600.7  DEFINITIONS: [RESERVED]

8.243.600.8  [RESERVED]

8.243.600.9  GENERAL BENEFIT DESCRIPTION: An individual who is eligible for medicaid coverage
        under the working disabled individuals program is eligible to receive the full range of medicaid covered services.

8.243.600.10  (A) Co-payment responsibility for WDI recipients: Eligible recipients have co-payment
        requirements as follows:

8.243.600.11    (1)  $5 per prescription, applies to covered prescription and non-prescription drug items;

8.243.600.12    (2)  $7 per dental visit;

8.243.600.13    (3)  $7 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient
         therapy session, or behavioral health session;

8.243.600.14    (4)  $20 per emergency room visit;

8.243.600.15    (5)  $30 per inpatient hospital admission;

8.243.600.16  (B) Co-payment maximum:

8.243.600.17    (1) The co-payment maximum varies depending on the recipient’s income. Once the recipient has
         reached his/her co-payment maximum on covered medicaid services, co-payments cease for the rest of that calendar
         year, only after the recipient has fulfilled the required steps listed below.

8.243.600.18    (2)  Co-payment maximum amounts for WDI recipients are calculated at initial determination, based
         on the income received in the first month of eligibility, and every twelve months thereafter. The co-payment
         maximum amount calculated at the initial determination is prorated for the rest of the calendar year and is also
         determined for the following calendar year. At each annual periodic review, the co-payment maximum will be
         calculated for the following calendar year.

8.243.600.19    (a) Recipients with earned and unearned income below 100% FPL—maximum is $600;

8.243.600.20    (b)  Recipients with earned and unearned income between 100-250% FPL—maximum is $1500.

8.243.600.21    (3) It is the responsibility of the recipient to track and total the co-payments paid.

8.243.600.22    (4)  Once the yearly maximum amount has been paid on co-payment for medicaid covered services,
         the recipient must notify the medical assistance division that the maximum amount has been met

8.243.600.23    (5) Verification must be provided to the medical assistance division that the co-payment maximum
         has been paid.
The first month that co-payments will no longer be required by the WDI recipient is the month following the month in which it has been verified by the medical assistance division that the maximum amount has been met.

If the determination is made after the twenty-fifth (25th) of the month, the change is made effective the second month after the request.

No retroactive eligibility for the “met co-payment maximum” criteria is allowed.

8.243.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within sixty (60) days of the date of application. Individuals will have time limits explained, and be informed of the date by which the application should be processed.

8.243.600.11 INITIAL BENEFITS: Eligibility begins the month of approval. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, this notice includes the individual’s right to request a hearing.

8.243.600.12 ONGOING BENEFITS: A re-determination of eligibility is made every twelve (12) months or at such time the recipient begins receiving medicare benefits.

8.243.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three (3) months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three (3) months prior to the month of application. There is no retroactive medicaid coverage prior to WDI program implementation.

A. Application for retroactive benefit coverage: Application for retroactive medicaid is made by indicating the existence of medical expenses in the three (3) 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 (3) retroactive months, and that the individual received medicaid-covered services. Eligibility for each month is approved or denied on its own merits.

C. Disability determination required: If a disability determination is needed for the date of onset of blindness or disability, a referral will be made to the disability determination contractor.

D. 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 recipient is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the individual does not inform all providers and furnish verification of eligibility which can be used for billing, and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the individual is responsible for payment of the bill.

8.243.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, when the recipient becomes ineligible. If a recipient dies, the case is closed the following month.

HISTORY OF 8.243.600 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]