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 (HSD).

8.243.600.2 SCOPE: This rule applies to the general public.
[8.243.600.2 NMAC - N, 1-1-01]

8.243.600.3 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.
[8.243.600.3 NMAC - N, 1-1-01; A, 10-15-14]

8.243.600.4 DURATION: Permanent
[8.243.600.4 NMAC - N, 1-1-01]

8.243.600.5 EFFECTIVE DATE: January 1, 2001, unless a later date is cited at the end of a section.
[8.243.600.5 NMAC - N, 1-1-01]

8.243.600.6 OBJECTIVE: The objective of these rules is to provide eligibility policy and procedures for the medical assistance programs.
[8.243.600.6 NMAC - N, 1-1-01; A, 10-15-14]

8.243.600.7 DEFINITIONS: [RESERVED]

8.243.600.8 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.
[8.243.600.8 NMAC - N, 10-15-14]

8.243.600.9 GENERAL BENEFIT DESCRIPTION: An individual who meets a medical assistance programs (MAP) category of eligibility for the working disabled individual program (WDI) is eligible to receive full state plan benefits.
[8.243.600.9 NMAC - N, 1-1-01; A, 1-1-02; A, 6-1-04; A, 12-15-04; A, 10-15-14]

8.243.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within 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.
[8.243.600.10 NMAC - N, 1-1-01; A, 10-15-14]

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.
[8.243.600.11 NMAC - N, 1-1-01]

8.243.600.12 ONGOING BENEFITS: A re-determination of MAP eligibility is made every 12 months or at such time the MAP eligible recipient begins receiving medicare benefits. Services provided may be subject to cost sharing requirements. Please see 8.302.2 NMAC for more information on any required recipient co-payments.
[8.243.600.12 NMAC - N, 1-1-01; A, 6-1-04; A, 10-15-14]

8.243.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive MAP eligibility can be furnished to applicants who have received MAD 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. There is no retroactive MAP eligibility prior to WDI program implementation.

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

B. **Approval requirements:** To establish retroactive MAP eligibility, verification must be provided to demonstrate that all conditions of eligibility were met for each of the three retroactive months, and that the individual received MAD 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) **MAP eligible recipient responsibility to notify provider:** After the retroactive MAP eligibility has been established, the MAP eligible recipient is responsible for informing all MAD providers with outstanding bills of the retroactive MAP eligibility determination. If the individual does not inform all MAD providers and furnish verification of MAP eligibility which can be used for billing, and the MAD provider consequently does not submit the billing within 90 calendar days from the date of approval of retroactive MAP eligibility, the MAP eligible recipient is responsible for payment of the bill.

[8.243.600.13 NMAC - N, 1-1-01; A, 10-15-14]

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

[8.243.600.14 NMAC - N, 1-1-01; A, 10-15-14]

HISTORY OF 8.243.600 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]