

TITLE 7 HEALTH
CHAPTER 35 MEDICAL PSILOCYBIN
PART 4 TREATMENT EQUITY FUND

7.35.4.1 ISSUING AGENCY: New Mexico department of health.
[7.35.4.1 NMAC - N, xx/xx/2026]

7.35.4.2 SCOPE: This rule applies to qualified patients seeking financial assistance from the medical psilocybin treatment equity fund, certifying clinicians, practitioners, healing centers, producers, and other persons submitting claims for payment from the fund.
[7.35.4.2 NMAC - N, xx/xx/2026]

7.35.4.3 STATUTORY AUTHORITY: This rule is promulgated pursuant to the following statutory authorities: the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, and the Medical Psilocybin Act, Sections 26-2D-7 and 26-2D-11 NMSA 1978.
[7.35.4.3 NMAC - N, xx/xx/2026]

7.35.4.4 DURATION: Permanent.
[7.35.4.4 NMAC - N, xx/xx/2026]

7.35.4.5 EFFECTIVE DATE: xx/xx/2026, unless a later date is cited at the end of a section.
[7.35.4.5 NMAC - N, xx/xx/2026]

7.35.4.6 OBJECTIVE: The objective of this rule is to establish eligibility, covered medical services, reimbursement, claims submission, payment, recordkeeping and audit requirements for the medical psilocybin treatment equity fund. The fund promotes equitable access to medical psilocybin treatment for qualified New Mexico patients who meet the income requirements established by this rule.
[7.35.4.6 NMAC - N, xx/xx/2026]

7.35.4.7 DEFINITIONS: The definitions in 7.35.2.7 NMAC apply to this part.
[7.35.4.7 NMAC - N, xx/xx/2026]

7.35.4.8 PATIENT ELIGIBILITY:

- A.** A qualified patient may be deemed eligible for assistance from the fund if:
- (1)** the patient is currently enrolled in the New Mexico medical psilocybin program;
 - (2)** the patient is a resident of New Mexico;
 - (3)** the patient's household income does not exceed 200 percent of the applicable federal poverty guidelines; and
 - (4)** sufficient funds are available in the fund and have been appropriated for the requested purpose.
- B.** Subject to the allowable amounts and limitations in this rule, the fund may cover up to 100 percent of the allowable amount for a qualified patient.
- C.** Eligibility for assistance does not create entitlement to payment and does not guarantee that funding will be available for all requested treatment.
- D.** Treatment equity fund eligibility shall be effective from the date of approval, and shall automatically end under the following circumstances:
- (1)** the patient's enrollment in the medical psilocybin program expires or is suspended, revoked or withdrawn;
 - (2)** the patient ceases to be a New Mexico resident;
 - (3)** the department finds that the eligibility determination was based on materially inaccurate or fraudulent information;
 - (4)** available funding is exhausted or otherwise unavailable; or
 - (5)** when 12 months have lapsed from the date of funding approval.

[7.35.4.8 NMAC - N, xx/xx/2026]

7.35.4.9 APPLICATION AND VERIFICATION OF ELIGIBILITY:

A. An applicant for funding from the treatment equity fund shall submit an application via the electronic system designated by the department.

B. An application shall include:

- (1) the patient's name and medical psilocybin program identification number;
- (2) the patient's residential and mailing addresses;
- (3) proof of the patient's New Mexico residency in the form of either:
 - (a) a current and valid New Mexico state-issued identification card or driver's

license;

- (b) a letter of accommodation from a licensed medical or behavioral health provider attesting that the patient is a resident of New Mexico; or

- (c) a current and valid identification card from a native American tribe, pueblo, or nation in New Mexico and a utility bill or other documentation that demonstrates residence in New Mexico.

- (4) proof of income eligibility;

- (5) an authorization permitting the department to verify eligibility information;

- (6) an attestation that the information submitted is true and complete; and

- (7) any additional information reasonably necessary to determine eligibility.

C. An applicant may establish income eligibility by submitting their United States federal tax return for the most recent filing year, or an eligibility verification, approval, certification, or award letter from the respective administering governmental entity that demonstrates current enrollment in either New Mexico Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families (TANF) program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or the Supplemental Security Income (SSI) program.

[7.35.4.9 NMAC - N, xx/xx/2026]

7.35.4.10 REQUEST FOR REIMBURSEMENT:

A. Before submitting a reimbursement request, the claimant shall make a reasonable and documented effort to obtain payment from all other payers who may be legally responsible for the covered treatment.

B. Requests for reimbursement shall include an attestation that the claimant has pursued reimbursement from other legally liable and potentially liable third parties prior to requesting reimbursement from the treatment equity fund, and was not able to obtain reimbursement. Such third parties may include private insurance, Medicaid, Medicare, and other sources of funding. The request shall include attached proof of denial or ineligibility for reimbursement, which may consist of any of the following:

- (1) notification of denial;

- (2) an explanation of benefits;

- (3) a remittance advice;

- (4) documentation that the service or product is categorically excluded from coverage; or

- (5) other documentation accepted by the department.

C. A claim shall disclose payments received or reasonably anticipated from another payer. The amount payable from the fund shall not exceed the allowable amount after deducting all confirmed and anticipated payments and credits from other payers.

D. A claimant is not required to submit a claim to an entity that does not legally cover the service or product when the department has documented that the category of service or product is excluded from that entity's coverage.

E. If another payer makes payment after the fund has paid a claim, the claimant shall notify the department within 30 calendar days and return the resultant overpayment to the department.

[7.35.4.10 NMAC - N, xx/xx/2026]

7.35.4.11 REIMBURSEMENT:

A. The reimbursement payment shall be limited to the lesser of:

- (1) the claimant's usual and customary charge;

- (2) the amount remaining after payment by another payer; or

- (3) the applicable New Mexico Medicaid or Medicare reimbursement rate.

B. When no directly applicable Medicaid or Medicare rate exists, the department may establish an allowable amount based on the most analogous Medicaid or Medicare service or payment methodology.

C. For a psilocybin product or other covered item for which no analogous Medicaid or Medicare rate exists, the department shall establish a uniform fee schedule based on documented acquisition cost and reasonable program safeguards.

D. A claimant accepting payment from the fund shall accept the allowable amount as payment in full and shall not bill the patient for the difference between the claimant's charge and the amount paid by the fund.

E. Nothing in this section requires payment for a service or product that is not otherwise covered under this rule.

[7.35.4.11 NMAC - N, xx/xx/2026]

7.35.4.12 ELECTRONIC CLAIM AND INVOICE SUBMISSION:

A. Certifying clinicians, practitioners, producers, healing centers and other authorized claimants shall submit claims through the electronic system designated by the department.

B. A claim shall include, as applicable:

- (1) the claimant's legal name, address, tax identification number, and SHARE vendor identification number;
- (2) the claimant's department certification or permit number;
- (3) the patient's program identification number;
- (4) the date, location, and type of each service;
- (5) the applicable billing code, service unit (i.e., preparation, administration, or integration session), quantity, and charge;
- (6) identification of the individual(s) who furnished each service;
- (7) for a psilocybin product, product unique identification number, quantity, and any acquisition charge;
- (8) documentation of amounts billed to and received or denied by other payers;
- (9) receipts and documentation required for a travel claim using the State of New Mexico mileage reimbursement rate;
- (10) the amount requested from the fund;
- (11) an attestation that the claim is accurate, the treatment was furnished as reported, no duplicate payment has been requested or received and all other payer payments have been disclosed; and
- (12) additional documentation reasonably required by the department.

C. A claimant seeking direct payment shall complete a federal form W-9 and all enrollment documents required for payment through SHARE.

D. A claimant shall submit a claim not later than 180 calendar days after the date of service. The department may extend the deadline upon a showing of good cause.

E. A claimant shall not bill the same service unit more than once. Individuals participating in the same administration-day session may be included separately for distinct services or roles authorized by the department.

F. The department may reject or return an incomplete claim and request correction or additional documentation.

[7.35.4.12 NMAC - N, xx/xx/2026]

7.35.4.13 PAYMENT NOTICE AND INTERNAL TRACKING:

A. The department when issuing a payment shall identify:

- (1) the claim number;
- (2) name of the claimant; and
- (3) the amount paid from the fund.

B. Payment shall be made through SHARE or a successor system designated by the department.

C. The department shall maintain an internal record of each application, authorization, claim, payment, denial, adjustment, hold, suspension, overpayment and recovery.

D. Internal records shall permit the department to identify duplicate billing, monitor available money and evaluate equitable distribution of the fund while protecting patient confidentiality.

[7.35.4.13 NMAC - N, xx/xx/2026]

7.35.4.14 ALLOWABLE EXPENSES FOR TREATMENT EQUITY FUND REIMBURSEMENT:

A. A qualified patient's expenses are eligible for reimbursement for up to a maximum of:

- (1) one initial administration session, with a combined total of six preparatory and integrative sessions included;
- (2) a second administration session, with a combined total of two preparatory and integrative sessions included; and
- (3) a third administration session, with a combined total of two preparatory and integrative sessions included.

B. A qualified patient is eligible for reimbursement for travel expenses when the shortest reasonable one-way distance between the patient's residence and the location of an authorized appointment, healing center or other approved location exceeds 100 miles. Covered travel expenses are limited to reasonable and necessary transportation expenses directly related to covered treatment and shall not exceed the New Mexico department of finance and administration maximum allowable rates for mileage and lodging applicable to public officers and employees. The department may pay:

- (1) mileage for use of a privately owned vehicle at the applicable department-approved rate;
- (2) the actual cost of public or commercial transportation, not exceeding the least costly reasonable means of transportation; and
- (3) lodging expenses.

C. A claim for travel reimbursement shall include:

- (1) the patient's residence address;
- (2) the treatment location;
- (3) the treatment date;
- (4) the travel dates;
- (5) the distance traveled and method used to calculate mileage;
- (6) itemized receipts, except when reimbursement is based on a mileage rate;
- (7) documentation connecting the travel to authorized treatment; and
- (8) any prior authorization required by the department.

D. Reimbursement for allowable expenses shall be reduced by amounts paid or otherwise available from Medicaid, an insurer, or another payer.

E. The cost of meals, entertainment, and upgrades, as well as personal expenses and costs unrelated to covered treatment, shall not be eligible for reimbursement.

[7.35.4.14 NMAC - N, xx/xx/2026]

7.35.4.15 RECORD RETENTION AND ACCESS:

A. A claimant shall retain all records supporting a claim for at least seven years after the date of payment or final resolution of an audit, investigation or recovery action, whichever is later.

B. Records shall include clinical documentation, service logs, invoices, receipts, other-payer documentation, authorizations, payment records and communications concerning the claim.

C. Records shall be maintained in a manner that protects confidential patient information and shall be made available to the department or its designee upon request.

D. Failure to produce requested records may result in denial, suspension, recovery of payment, delay, and other action authorized by law.

[7.35.4.15 NMAC - N, xx/xx/2026]

7.35.4.16 AUDITS AND PROGRAM INTEGRITY:

A. The department or its designee may conduct prepayment reviews, post-payment audits, random audits, risk-based audits, and investigations of fund applications, authorizations, claims and payments.

B. An audit may determine whether:

- (1) the patient satisfied income, residency and program-enrollment requirements;
- (2) the treatment was covered, authorized and actually furnished;
- (3) the claimant furnishing or billing for treatment held all required licenses, certifications, or permits;
- (4) the treatment was furnished within the provider's scope of practice and certification;
- (5) the number and type of services complied with applicable limits;
- (6) the claim was accurate and supported by contemporaneous records;
- (7) another payer or assistance program made payment;
- (8) a duplicate, false, misleading or inflated claim was submitted;
- (9) the claimant complied with recordkeeping and patient-confidentiality requirements; and

- (10) fund payments were used for authorized purposes.
- C. The department may:
- (1) request records and written responses;
 - (2) compare claim information with program, licensing, tax, Medicaid and other payment records to the extent permitted by law;
 - (3) interview claimants and patients;
 - (4) conduct remote or on-site reviews during normal business hours; and
 - (5) refer suspected fraud, false claims, professional misconduct or other violations to the appropriate governmental or licensing authority.

D. A claimant shall provide requested records within 10 business days unless the department authorizes additional time.

[7.35.4.16 NMAC - N, xx/xx/2026]

7.35.4.17 PAYMENT DENIAL AND SUSPENSION:

- A. The department may deny an individual claim or suspend a payment to a claimant when:
- (1) required information or supporting documentation is missing;
 - (2) the department identifies a duplicate, inconsistent or potentially inaccurate claim;
 - (3) the claimant fails to cooperate with an audit or records request;
 - (4) there is a credible allegation of fraud, material misrepresentation, or misuse of fund money;
 - (5) the claimant's applicable license, certification, or permit is expired, suspended, restricted, or revoked;
 - (6) the department determines that continued payment presents a material risk to patients or the fund;
 - (7) an overpayment has not been repaid to the department or otherwise resolved; or
 - (8) the department determines that funds are unavailable.

B. Except when immediate action is necessary to protect patients or public funds, the department shall provide electronic written notice before suspending or denying payment. The notice shall be issued via the electronic system designated by the department, and shall state:

- (1) the factual and legal basis for the action;
- (2) the claims or payments affected;
- (3) the effective date;
- (4) the documentation or corrective action required; and
- (5) the procedure and deadline for requesting review.

C. The department may immediately deny or suspend payment when necessary to prevent payment of a potentially fraudulent or unauthorized claim, or when funding is exhausted or otherwise unavailable.

D. A payment suspension shall remain in effect until the department determines that:

- (1) the claim is payable;
- (2) the deficiency has been corrected;
- (3) the claim should be denied;
- (4) an overpayment has been resolved; or
- (5) funding becomes available.

E. A suspension based solely on fund availability does not constitute a determination that the claimant or patient violated this rule.

[7.35.4.17 NMAC - N, xx/xx/2026]

7.35.4.18 OVERPAYMENTS AND RECOVERY:

A. A payment is an overpayment when:

- (1) the patient or treatment was not eligible for payment;
- (2) the claim contained inaccurate or incomplete material information;
- (3) another payer was responsible for all or part of the payment;
- (4) the payment exceeded the allowable amount;
- (5) the department paid the same treatment more than once; or
- (6) the claimant cannot produce records sufficient to support payment.

B. The department shall issue a written notice via the department approved electronic system stating the basis and amount of the overpayment.

C. The claimant shall repay the overpayment within 30 calendar days after the notice is issued, unless the department approves a repayment agreement.

D. The department may recover an overpayment by direct repayment, offset against future payments, and any other lawful collection method.

E. Recovery of an overpayment shall not preclude referral for collection or other remedies authorized by law.

[7.35.4.18 NMAC - N, xx/xx/2026]

7.35.4.19 PROGRAM MONITORING:

A. The department shall periodically evaluate whether fund money is being distributed equitably throughout New Mexico.

B. The evaluation may consider:

- (1) patient income level;
- (2) county and geographic region;
- (3) rural, frontier and tribal access;
- (4) qualifying condition;
- (5) type and amount of assistance requested, approved and paid;
- (6) application and claim approval and denial rates;
- (7) processing and waiting times;
- (8) distance traveled for treatment; and
- (9) other identified barriers to access.

C. Information used for program monitoring or public reporting shall be aggregated or de-identified so that individual patients cannot be identified.

D. The department may use the results to improve outreach, allocation methods, application assistance, and access to covered treatment, consistent with available appropriations and applicable law.

[7.35.4.19 NMAC - N, xx/xx/2026]

7.35.4.20 ADMINISTRATIVE REVIEW OF ADVERSE PAYMENT DETERMINATIONS:

A. A patient or claimant may request administrative review of a denial, reduction, suspension, or overpayment determination (adverse payment determination).

B. A request for administrative review shall be submitted in writing via the electronic system designated by the department within 30 calendar days after the date of notice, shall be properly addressed to the medical psilocybin program, and shall include:

- (1) the requestor's name and contact information;
- (2) the claim or application number;
- (3) the determination being challenged;
- (4) a concise statement explaining why the adverse payment determination should be changed; and
- (5) supporting documentation.

C. The administrative review shall consist of a review of relevant documents; the administrative review is not an adjudicatory proceeding.

D. The program manager or another person designated by the director shall conduct an initial review of the request for administrative review, shall review relevant documentation, and may request additional information or further clarification from the patient or claimant. In the event that the program manager or designated person identifies an additional basis for an adverse payment determination or proposes to take an adverse payment determination that was not previously identified, the patient or claimant shall be informed and shall be allowed to submit additional information or documentation, as appropriate, and within a stated deadline.

E. The program manager or designated person shall recommend that the director affirm, modify, or deny the adverse payment determination. Within 10 business days of receipt of the request for administrative review or the date of last submission of any additional information or documentation from the patient or claimant (whichever is later), the program manager or designated person shall provide to the director a written recommended decision, which shall include a brief statement of the basis.

F. Within 10 business days of receipt of the recommended decision, the director or the director's designee shall issue a final decision regarding the request for administrative review, which shall include a brief statement of the basis. The final decision of the director or the director's designee may affirm, deny, or modify the adverse payment determination. The final decision of the director or the director's designee shall be issued to the

patient or claimant via the electronic system designated by the department and shall constitute the final decision of the department.

G. A request for administrative review shall not stay a payment denial, suspension, or recovery action.

H. An adverse payment determination that is based solely on the lack or unavailability of funding shall not be subject to administrative review.

[7.35.4.20 NMAC - N, xx/xx/2026]