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TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 2 NURSING FACILITIES

8.312.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.312.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 6/15/10]

8.312.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.312.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 6/15/10]

8.312.2.3 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 and by the state human services department pursuant to state statute. See NMSA 1978 Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.312.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 6/15/10]

8.312.2.4 DURATION: Permanent
[2/1/95; 8.312.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 6/15/10]

8.312.2.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.312.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 6/15/10]

8.312.2.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.312.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6 & A, 6/15/10]

8.312.2.7 DEFINITIONS: [RESERVED]

8.312.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[2/1/95; 8.312.2.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 6/15/10]

8.312.2.9 NURSING FACILITIES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including services furnished in nursing facilities. See 42 Section CFR 440.40. This part describes provider eligibility, covered services, service limitations, recipient fund accounts, and general reimbursement methodology.
[2/1/95; 8.312.2.9 NMAC - Rn, 8 NMAC 4.MAD.731, 6/15/10]

8.312.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), nursing facilities (NF) which meet the following conditions are eligible to be reimbursed for providing services to medicaid recipients: 1) be licensed and certified by the licensing and certification bureau of the department of health (DOH) to meet medicaid nursing facility conditions of participation. See 42 CFR Part 483, as amended; 2) conform to policy regarding medicaid recipients' personal funds; 3) participate in the MAD utilization review process and agree to operate in accordance with all policies and procedures of that system, including the performance of discharge planning; 4) adhere to the rules and regulations relating to the pre-admission screening and resident review (PASRR) of mentally ill and mentally retarded program; 5) conform to the rules and regulations relating to nurse aide training; and 6) facilities with sixty (60) or more medicaid beds must certify a minimum of four (4) distinct beds in the medicare program.

(1) This requirement can be waived if the NF meets one (1) of the following conditions:

(a) the NF is located in a rural area and is unable to attract therapists as required by the medicare program; for a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;

(b) the NF has obtained a waiver of the RN staffing requirement from the DOH, in accordance with applicable federal regulations; or

(c) the NF is one of two or more NF in the same town owned or operated by the same owner/manager and one of the other facilities is medicare-certified; in addition, the NF must demonstrate on a yearly basis that the waiver does not hinder access to medicare part A services for medicaid-eligible recipients and that the facility is using, to the best of its ability, corridor billings to medicare for part B services(s); if medicare removes the ability to do corridor billing, the waiver automatically ceases.

(2) Any requests for a waiver must contain sufficient documentation to support the request and must be submitted in writing to MAD.

(3) Medicare is the primary payer for NF services covered under the medicare program.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

(1) **Appeals process for denial, termination or non-renewal of participation:** See Section MAD-967.5, Appeals of Denial, Termination, or Non-renewal of Provider Participation.

(2) **Sanctions and Incentives:** See Section MAD-967.5, Incentives for Nursing Facilities. See Section MAD-967, Sanctions for Non-Compliance, Section MAD-968, Intermediate Remedies for Non-Compliance.

[2/1/95; 8.312.2.10 NMAC - Rn, 8 NMAC 4.MAD.731.1, 6/15/10]

8.312.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See Section MAD-701, General Provider Policies [8.302.1 NMAC, General Provider Policies]. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, General Provider Policies [8.302.1 NMAC, General Provider Policies].

[2/1/95; 8.312.2.11 NMAC - Rn, 8 NMAC 4.MAD.731.2, 6/15/10]

8.312.2.12 REQUIRED NURSING FACILITY SERVICES: Nursing facilities are required to provide the following:

A. room and board;

B. professional nursing services twenty-four (24) hours a day, seven (7) days a week; professional nursing services are those services which are performed directly by a registered nurse (RN) or a licensed practical nurse (LPN), under the direction of a medical practitioner;

C. services of an RN on an eight (8) hours a day, seven (7) days a week basis, and at least the services of a LPN at all other times; and

D. personal assistance services on a twenty-four (24) hours a day, seven (7) days a week basis; personal assistance services are those services, other than professional nursing services, which can be needed by an individual because of age, infirmity, physical or mental limitations, and/or dependence in accomplishing the activities of daily living.

[2/1/95; 8.312.2.12 NMAC - Rn, 8 NMAC 4.MAD.731.3, 6/15/10]

8.312.2.13 COVERED SERVICES:

A. Medicaid covers NF services identified as allowable costs. See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities, Section III.G [Subsection G of 8.312.3.11 NMAC, Cost Related Reimbursement of Nursing Facilities].

B. Medicaid covers physical, occupational and speech therapy services furnished to medicaid residents in the following manner:

(1) if the resident is also eligible for medicare and the facility does part B billing, the co-payment for services is paid by medicaid;

(2) if the resident receives high NF level services, services are included in the medicaid facility rate;

or

(3) if the resident receives low NF level services, services are billed separately by participating therapy providers.

[2/1/95; 8.312.2.13 NMAC - Rn, 8 NMAC 4.MAD.731.4, 6/15/10]

8.312.2.14 NONCOVERED SERVICES: Medicaid does not cover services which are not included as allowable costs. See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities, Section III.G [Subsection G of 8.312.3.11 NMAC, Cost Related Reimbursement of Nursing Facilities]. See Section MAD-753, Pharmacy Services [8.324.4 NMAC, Pharmacy Services], for covered pharmacy services which are billed directly by pharmacy providers.
[2/1/95; 8.312.2.14 NMAC - Rn, 8 NMAC 4.MAD.731.5, 6/15/10]

8.312.2.15 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for participation in medicaid, each NF must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that his or her personal funds be cared for by the facility. See 42 CFR Section 483.10(c).

(1) Requests for NFs to care or not care for a resident's funds must be made in writing and secured by a request to handle recipient funds form or letter signed by the recipient or his or her representative. The form or letter is kept in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowable, established by MAD. If the resident receives any income in excess of this allowance, the excess is applied to the cost of the resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) All facilities must have procedures on the handling of medicaid residents' funds. These procedures must not allow the facility to commingle medicaid residents' funds with facility funds.

(4) Nursing facilities should use these medicaid guidelines to develop procedures for handling resident funds.

(5) Residents have the right to manage their financial affairs and no facility can require residents to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or furnish self-insurance to ensure the security of all personal funds deposited with the facility.

B. Fund custodians: Nursing facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of the individual medicaid residents' accounts with the collective bank account;

(d) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) Facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the resident's behalf.

C. Bank account: Nursing facilities must establish a bank account for the deposit of all money for medicaid residents who request the facility to handle their funds. Residents' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any resident's personal funds of more than fifty (\$50) dollars in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the resident's account to that account.

(2) Facilities must maintain residents' personal funds up to fifty (\$50) in an interest bearing account or a petty cash fund. Residents must have convenient access to these funds.

(3) Individual financial records must be available on the request of residents or their legal representatives.

(4) Within thirty (30) days of the death of residents whose personal funds are deposited with the facility, a NF must convey the resident's funds and a final accounting of these funds to the individual or probate jurisdiction administering the resident's estate.

D. Establishment of individual accounts: Nursing facilities must establish accounts for each medicaid resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or looseleaf binder.

(1) For money received, the source, amount and date must be recorded. Residents or their authorized representatives must be given receipts for the money. The NF retains a copy of the deposit in the resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of residents must be recorded. All money spent either on behalf of residents or withdrawn by residents or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid resident when the account balance is two hundred (\$200) dollars less than the supplemental security income (SSI) resource limit for one (1) person specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the resident's other nonexempt resources reach the SSI resource limit for one (1) person, the resident can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: The NF must balance the individual accounts, the collective bank accounts and the petty cash fund at least once each month. The NF must furnish medicaid residents or their authorized representatives with an accounting of the residents' funds at least quarterly. Copies of individual account records can be used to furnish this information.

F. Petty cash fund: The NF must maintain a cash fund in the facility to accommodate the small cash requirements of the medicaid residents. Five dollars (\$5.00) or less per individual resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of recipients using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund.

(1) To establish the fund, the NF must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

- (a) residents or their authorized representative request small amounts of spending money;
- (b) the amount disbursed is entered on the individual ledger record; and
- (c) the resident or representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used.

(a) The money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount.

(b) Money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures should be used once each month:

- (a) count money at hand; and
- (b) total cash disbursed either from receipts or individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close the resident account, the NF should do the following:

- (a) enter date of and reason for closing the account;
- (b) write a check against the collective bank account for the balance shown on the individual account record;
- (c) get signature of the recipient or their authorized representative on the individual recipient account record, as receipt of payment; and
- (d) notify the local ISD office if closure is caused by death of a recipient so that prompt action can be taken to terminate assistance; within thirty (30) days of the death of recipient who has no relatives, the NF conveys the resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate. See 42 CFR Section 483.10(c)(6).

G. Retention of records: All account records are retained for at least three (3) years or, in case of an audit, until the audit is completed.

H. Non-acceptable uses of residents' personal funds: Non-acceptable uses of residents' personal funds include the following:

(1) payment or charges for services or items covered by medicaid or medicare-specified as allowable costs. See Appendix 731-D, Cost Related Reimbursement of Nursing Facilities, Section III.G [Subsection G of 8.312.3.11 NMAC, Cost Related Reimbursement of Nursing Facilities];

(2) difference between the NF's billed charge and the medicaid payment; and

(3) payment for services or supplies routinely furnished by the NF, such as linens or nightgowns.

NFs cannot impose charges against residents' personal funds for any item or service for which payment is made by medicaid or for any item residents or their representatives did not request; facilities must not require residents or representatives to request any item or service as a condition of admission or continued stay; facilities must inform residents or representatives who request noncovered items or services that there is a charge for the item and the amount of the charge.

I. Monitoring of residents' personal funds: NFs must make all files and records involving residents' personal funds available for inspection by authorized state personnel or federal auditors.

(1) The licensing and certification bureau of the DOH verifies that NFs have established systems to account for residents' personal funds, including components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The human services department (HSD) or its designee can complete a thorough audit of residents' personal funds accounts at HSD's discretion.

[2/1/95; 8.312.2.15 NMAC - Rn, 8 NMAC 4.MAD.731.6, 6/15/10]

8.312.2.16 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident in a nursing facility to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below.

A. Coverage of reserve bed days: Medicaid covers six reserve bed days per calendar year for every long term care resident for hospitalization without prior approval. Medicaid covers three reserve bed days per calendar year for a brief home visit without prior approval. Medicaid covers an additional six reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan.

(1) A resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.

(2) The prior approval request must include the resident's name, medicaid number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the resident during the visit or placement and a written physician order for trial placement.

B. Documentation of reserve bed days: When a resident leaves the NF for any reason, appropriate documentation must be placed in the resident's chart. A physician order must be obtained if residents are hospitalized, request home visits or trial placement.

C. Level of care determinations: A new level of care determination must be performed by the MAD utilization review (UR) contractor if a resident is gone from the NF for more than three midnights. An abstract must be completed, including information on the reason for the resident's absence, outcome of the leave and any other pertinent information concerning the leave.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the NF is limited to the rate applicable for the level of care medically necessary for the eligible resident, as determined and approved by MAD or its designee. The reserve bed day reimbursement is equal to 50 percent of the regular payment rate for medicaid fee-for-service clients or as otherwise negotiated between the NF provider and the medicaid designated contractor. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. Under normal circumstance, medicaid or the medicaid designated contractor, pays for the admission day but not for the discharge day.

[2/1/95; 8.312.2.16 NMAC - Rn, 8 NMAC 4.MAD.731.7 & A, 6/15/10]

8.312.2.17 LEVEL OF CARE DETERMINATION: Medical necessity, level of care, and length of stay determinations are carried out in accordance with MAD utilization review (UR) policy and procedures, as authorized under Title XIX of the Social Security Act. See Section MAD-705, Prior Approval and Utilization Review [8.302.5 NMAC, Prior Authorization and Utilization Review]. See Section MAD-955, Reconsideration of Level of Care Determinations [8.350.4 NMAC, Reconsideration of Audit Settlements].

[2/1/95; 8.312.2.17 NMAC - Rn, 8 NMAC 4.MAD.731.8, 6/15/10]

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS: As part of the initial abstract for a new admission and/or as part of a subsequent specified review as determined by PASRR or a significant change review as indicated by the minimum data set (MDS) for residents with identified mental illness or mental retardation, NFs must complete a level I pre-admission screening and resident review of mentally ill and mentally retarded (PASRR) screening. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42 CFR Section 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.

A. Pre-admission screens not required: Pre-admission screens do not need to be performed on the following residents:

(1) residents admitted from the hospital whose attending physicians certify before admission to the NF that the residents are likely to require NF care for less than thirty (30) days (as determined by PASRR review of the individuals Level I screen data prior to NF admission);

(2) residents who are readmitted to NFs from hospitals to which they were transferred for the purpose of receiving care; and

(3) residents who are transferred from one NF to another without an intervening hospital stay.

B. Purpose of the screens: The purpose of the PASRR screen is to determine whether residents have a mental illness or mental retardation, need the level of services furnished in a NF and need specialized services based on the mental illness or mental retardation. NFs perform the level I screen which identifies residents who can have a mental illness or mental retardation. When residents are identified, the NF refers them to the developmental disabilities division of the department of health for a PASRR level II evaluation.

C. Level II screen determination: The PASRR level II screen determines the following:

(1) the resident's total needs are such that his or her needs can be met in an appropriate community setting;

(2) the resident's total needs are such that they can be met only on an inpatient basis, which can include the option of placement in a home and community-based service waiver program, but for which inpatient care is necessary;

(3) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or

(4) if inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs, another setting, such as an intermediate care facility for the mentally retarded can be indicated.

D. Right to an administrative hearing: Residents who believe that an erroneous determination was made with regard to the PASRR can request administrative hearings. See Section MAD-990, PASRR and Patient Status Hearings [8 NMAC 4.MAD.990] for more information. The NF must give residents notice of proposed transfers or changes of status. The notice must inform residents of their right to request a hearing, the method by which a hearing can be requested and their right to present evidence in person or through representatives. A resident who requests a hearing has ninety (90) calendar days after the date of the notice to request a hearing. Within sixty (60) days of receipt of the request for a hearing, the hearing is conducted, decisions reached and notice furnished to the recipient and the NF.

E. Restriction on reimbursement for medicaid residents: Nursing facilities are not reimbursed for any service furnished to medicaid recipients when pre-admission screens, subsequent specified reviews or significant change reviews are not performed in a timely manner. Medicaid pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to NFs during periods of noncompliance. Medicaid payment for services does not begin until a Level II screening has been performed, if applicable. [2/1/95; 8.312.2.18 NMAC - Rn, 8 NMAC 4.MAD.731.9, 6/15/10]

8.312.2.19 MINIMUM DATA SET:

A. Long term care facilities participating in the medicare and medicaid programs are required to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. See Sections 4201 (a)(3) and 4211 (a)(3) of the Omnibus Reconciliation Act (OBRA) of 1987.

B. The capacity assessment describes the resident's ability to perform daily life functions and any significant impairments in functional capacity. The assessment is based on a uniform minimum data set (MDS) of core elements and common definitions specified by the secretary of the federal health and human services department.

(1) The resident assessment instrument (RAI) is specified by the state. State RAIs include at least the health care financing administration MDS, triggers, resident assessment protocols (RAPs) and utilization guidelines.

(2) On a date to be specified by the federal government, NFs will be required to encode the MDS in machine-readable form. After that date, all MDS reporting will be done by computer.

[2/1/95; 8.312.2.19 NMAC - Rn, 8 NMAC 4.MAD.731.10, 6/15/10]

8.312.2.20 MEDICAL CARE CREDITS: If a resident has income beyond the maintenance allowance, MAD reimburses the NF for the difference between the NF's reimbursable rate and the medical care credit. The NF is responsible for collecting the amount reported as the medical care credit. These medical care credit requirements apply to co-payments and deductibles for medicare crossover payments.

[2/1/95; 8.312.2.20 NMAC - Rn, 8 NMAC 4.MAD.731.11, 6/15/10]

8.312.2.21 NURSE AIDE TRAINING: Nursing facilities participating in medicaid agree to comply with nurse aide training requirements as a condition of participation. See 42 CFR Section 483 Subpart D. The NF program is not approved if the NF has been out of compliance with certain federal requirements within the previous two (2) years.

A. Requirements for nurse aide training: NFs cannot employ individuals as nurse aides for more than four (4) months unless they have completed a nurse aide training and competency evaluation program (NATCEP). The NATCEP program must have a minimum duration of seventy-five (75) hours.

(1) Nurse aides who have not performed nursing or nursing-related services for monetary compensation for a period of twenty-four (24) consecutive months since completion of a NATCEP must take either a new NATCEP or a new competency evaluation program (CEP).

(2) NFs must not use temporary nurse aides who have not completed a NATCEP or a CEP.

(3) NFs must ensure that students in the NATCEP programs do not perform any services for which they have not been trained and found proficient by instructors. NFs must ensure that all students in NATCEP programs are under the general supervision of licensed or registered nurses when they perform services for residents.

(4) NFs must furnish regular performance reviews and in-service education to ensure that individuals who serve as nurse aides are competent to perform nurse aide services.

B. Other nurse aide requirements: NFs must not employ individuals who have been convicted by the court of abuse or neglect of residents or misappropriation of residents' property.

C. Nurse aide registry: The licensing and certification bureau of the DOH maintains a registry of all individuals who have successfully completed, who have been considered to have completed a NATCEP or CEP program or who have had the NATCEP or CEP requirement waived by the state.

[2/1/95; 8.312.2.21 NMAC - Rn, 8 NMAC 4.MAD.731.12, 6/15/10]

8.312.2.22 PATIENT SELF DETERMINATION ACT: All adult residents of nursing facilities must be informed of their right to make their own health decisions, including the right to accept or refuse medical treatment as specified in the Patient Self-Determination Act. See Section MAD-701, General Provider Policies [8.302.1 NMAC, General Provider Policies].

[2/1/95; 8.312.2.22 NMAC - Rn, 8 NMAC 4.MAD.731.13, 6/15/10]

8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING: Residents who believe that the NF has erroneously determined that they should be transferred or discharged can request an administrative hearing. NFs must give residents notice of the proposed transfer or discharge. The notice must inform residents of their right to request a hearing, the method by which a hearing can be requested and their right to present evidence in person or through representatives. See Section MAD-970, Recipient Hearings [8.352.2 NMAC, Recipient Hearings].

[2/1/95; 8.312.2.23 NMAC - Rn, 8 NMAC 4.MAD.731.14, 6/15/10]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, Prior Approval and Utilization Review [8.302.5 NMAC, Prior Authorization and Utilization Review]. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, Reconsideration of Utilization Review Decisions [8 NMAC 4.MAD.953].

[2/1/95; 8.312.2.24 NMAC - Rn, 8 NMAC 4.MAD.731.15, 6/15/10]

8.312.2.25 REIMBURSEMENT: Nursing facility providers must submit claims for reimbursement on the long term care turn around document (TAD) or its successor. See Section MAD-702, Billing for Medicaid Services

[8.302.2 NMAC, Billing for Medicaid Services]. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. MAD reimburses NF the lesser of the following:

- (1) The provider's billed charges; or
- (2) See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities [8.312.3 NMAC,

Cost Related Reimbursement of Nursing Facilities] for prospective reimbursement rates constrained by the ceilings established by MAD.

B. Reimbursement limitations: Payments are made only to NFs which meet the conditions for participation, specified in this section. Payments to NFs are limited to those service costs which are included as allowable costs under approved provisions of the state plan. See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities [8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities]. All claims for payment from MAD are subject to utilization review and control.

C. Reimbursement methodology: See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities [8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities.

[2/1/95; 6/1/98; 8.312.2.25 NMAC - Rn, 8 NMAC 4.MAD.731.16, 6/15/10]

HISTORY OF 8.312.2 NMAC:

Pre- NMAC History: The material in this part was derived from that previously filed with the State Records Center: ISD 310.0300, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 2/27/80.

MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 12/1/87.

MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 1/6/88.

MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92.

SP-004.1903, Section 4, General Program Administration Reserve Beds, filed 6/10/81.

SP-004.1101, Section 4, General Program Administration Standards for Institutions, filed 6/26/81.

History of Repealed Material:

MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92 - Repealed effective 2/1/95.