TITLE 8 SOCIAL SERVICES
CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES
PART 2 INTERMEDIATE CARE FACILITIES FOR [~~THE MENTALLY RETARDED~~] INDIVIDUALS WITH INTELLECTUAL DISABILITIES

8.313.2.1 ISSUING AGENCY: Human Services Department (HSD), Medical Assistance Division
[2/1/1995; 8.313.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11/1/2000; A, xx/xx/xxxx]

8.313.2.2 SCOPE: This rule applies to the general public.
[2/1/1995; 8.313.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11/1/2000]

8.313.2.3 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 27-2-12 et. seq. (Repl. Pamp. 1991).
[2/1/1995; 8.313.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11/1/2000]

8.313.2.4 DURATION: Permanent
[2/1/1995; 8.313.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11/1/2000]

8.313.2.5 EFFECTIVE DATE: February 1, 1995.
[2/1/1995; 8.313.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11/1/2000]

8.313.2.6 OBJECTIVE: The objective of these regulations is to govern the service portion of the New Mexico medicaid and medical assistance programs. These policies describe eligible providers, provider responsibilities, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.313.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.7 DEFINITIONS: [RESERVED]
[8.313.2.7 NMAC - N, 11/1/2000]

8.313.2.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of HSD/MAD program eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[2/1/1995; 8.313.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.9 INTERMEDIATE CARE FACILITIES FOR [~~THE MENTALLY RETARDED~~] INDIVIDUALS WITH INTELLECTUAL DISABILITIES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to recipients, including services furnished by intermediate care facilities for [~~the mentally retarded~~] individuals with intellectual disabilities [42 CFR 440.150]. This section describes eligible providers, provider responsibilities, covered services, service restrictions, personal fund accounts, and general reimbursement methodology.
[2/1/1995; 8.313.2.9 NMAC - Rn, 8 NMAC 4.MAD.732, 11/1/2000l; A, xx/xx/xxxx]

8.313.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by New Mexico medical assistance division (MAD), intermediate care facilities for [~~the mentally retarded~~] [~~(ICF-MR)~~] individuals with intellectual disabilities (ICF/IID) which meet the following conditions for participation are eligible to be reimbursed for providing services to eligible medicaid recipients:

(1) the [~~ICF-MR~~] ICF/IID must be licensed and certified by the division of health improvement, health facility licensing and certification bureau of the New Mexico department of health (DOH) to meet the intermediate care facility requirements. See 42 CFR 483 Subpart I;

(2) the [~~ICF-MR~~] ICF/IID must comply with [~~8.313.2.17~~] 8.313.2.18 NMAC, *Recipient Personal Fund Accounts*; and

(3) the [~~ICF-MR~~] ICF/IID must participate in the MAD utilization review process and must agree to operate in accordance with all policies and procedures of that system, including the performance of discharge planning.

B. Once enrolled, providers receive instruction on how to access medicaid and other medical assistance provider program policies, billing instructions, utilization review instructions, and other pertinent material. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. To be eligible for medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement.
[2/1/1995; 8.313.2.10 NMAC - Rn, 8 NMAC 4.MAD.732.1, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.11 APPEALS PROCESS FOR DENIAL, TERMINATION OR NON-RENEWAL OF PARTICIPATION: See Section [~~MAD-967.5, *Appeals for Denial, Termination, or Non-Renewal of Provider Participation*.~~] 8.351.3 NMAC – *Administrative Hearings.*
[2/1/1995; 8.313.2.11 NMAC - Rn, 8 NMAC 4.MAD.732.11, 11/1/2000; A, xx/xx/xxxx]

8.313.2.12 SANCTIONS AND PENALTIES: See Section [~~MAD-967, *Sanctions for Non-Compliance* and Section MAD-968, *Intermediate Remedies*.~~] 8.351.2 NMAC – *Sanctions and Remedies.*
[2/1/1995; 8.313.2.12 NMAC - Rn, 8 NMAC 4.MAD.732.12, 11/1/2000; A, xx/xx/xxxx]

8.313.2.13 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to HSD/MAD program eligible recipients must comply with all specified HSD/MAD participation requirements. See Section [~~MAD-701~~] 8.302.1 NMAC, *General Provider Policies*.

B. 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. ELIGIBILITY REQUIREMENTS:

(1) To be eligible for an ICF/IID the recipient must meet the level of care (LOC) requirements provided in an ICF/IID in accordance with Section 8.313.2.19 NMAC and meet all other applicable eligibility requirements in Section 8.281.400 NMAC.

(2) An institutional LOC must be recommended for the applicant or recipient by a physician, nurse practitioner or a doctor of osteopathy, licensed to practice in the state of New Mexico. Institutions are defined as acute care hospitals, nursing and ICF/IID. LOC determinations for institutional care medicaid eligibility are made by the MAD utilization review (UR) contractor. See Section 8.350.3 NMAC, *Utilization Review Submission for Level of Care Determinations*.

D. ADMISSION:

(1) No individual shall be admitted into an ICF/IID unless the individual has been pre-screened by the department of health (DOH) developmental disabilities supports division, central registry unit, see Section 8.290.400 NMAC, or the individual is civilly committed, see 7.26.6 NMAC. The DOH pre-screening will determine if the individual has an intellectual disability or related condition as described in 8.281.400 NMAC.

(2) Any person who requests to be placed on the DOH's central registry may choose to be on the registry for both ICF/IID and home and community-based services (HCBS) waivers, consistent with provisions in 42 CFR 431.51.

(3) All individuals who select admission to an ICF/IID may choose to remain on the central registry for HCBS. All persons referred for admission into HCBS waiver services may choose to remain on the central registry for ICF/IID services.

(4) If the person served is found able to consent and the interdisciplinary team (IDT) indicates that the person served would benefit from placement in a community-living setting, but the person served refuses such placement attempt, then the person served may be admitted only upon involuntary commitment under Sections 43-1-13 NMSA 1978, or 43-1-11 NMSA 1978 and 43-1-12 NMSA 1978 of the New Mexico mental health and developmental disabilities code.

(5) The ICF/IID will contact and review each person's request for admission in accordance with federal licensing and certification requirements.

(6) The ICF/IID will refer any person whom the ICF/IID determined appropriate for admission based on its admission decision, to the state Medicaid agency for level of care and financial eligibility determination.

(7) The ICF/IID may admit any person who meets the definition of "readmission" without referral through DOH central registry. A readmission will not be subject to pre-screening.

(8) Prior to admission or before authorization of payment the ICF/IID must develop a plan of care in accordance with provisions of 42 CFR 456.380

E. Transfer:

(1) Providers must coordinate a transfer to another ICF/IID operated by the same entity, or an ICF/IID that operates independent of the ICF/IID where the individual currently resides without referral through the central registry provided:

(a) The individual's interdisciplinary team recommends the transfer;

(b) The individual's transfer is based on the individual's freedom of choice of providers;

(c) The receiving ICF/IID provider has identified a vacancy.

(2) Providers may transfer an individual temporarily to a psychiatric, acute care hospital, or temporarily to a nursing facility for care following a hospital stay. Individuals returning to the ICF/IID under these conditions will be classified a "readmission" and will not be subject to pre-screening by the DOH.

(3) Individuals may be transferred to a HCBS waiver program provided the individual has been allocated to the program by DOH in accordance with policies and procedures.

(4) The ICF/IID shall provide a complete copy of the individuals medical service records, including assessments required for individual program planning to the ICF/IID or community to which the individual is transferred.

F. Discharge:

(1) An individual may be discharged from an ICF/IID when:

(a) The individual or guardian requests to be discharged;

(b) When the individual's interdisciplinary team recommends the facility cannot meet the individual's needs;

(c) The individual no longer requires an active treatment program in an ICF/IID setting;

(d) The discharge would be more beneficial to the individual.

(2) The ICF/IID will ensure the following when a discharge takes place:

(a) The individual's family or guardian and the individuals advocate are involved in the interdisciplinary team process, involving discussion and proposed decision regarding discharge;

(b) A transition plan is developed 30 working days prior to discharge in accordance with provisions of 42 CFR 456.380;

(c) The individual and their guardian is fully informed of their right to a fair hearing in accordance with 42 CFR 431.200 - 431.250.

(3) Discharge without prior notice is only permitted in emergency situations for the following reasons:

(a) The transfer or discharge is necessary for the individual's safety and welfare;

(b) The individual's needs cannot safely be met in the facility; or

(c) The safety and health of other residents and staff in the facility are endangered.

(4) Any decision to discharge a person from an ICF/IID based on good cause must be adequately justified in writing by the ICF/IID and reviewed by the department prior to discharge.

[~~C~~] **G.** Providers must maintain any and all medical or business records as necessary to fully disclose the type and extent of services provided to recipients. See Section [~~MAD-701~~] 8.302.1 NMAC, *General Provider Policies*.

[2/1/1995; 8.313.2.13 NMAC - Rn, 8 NMAC 4.MAD.732.2, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.14 REQUIRED SERVICES: Medicaid does not reimburse [~~ICFs-MR~~] ICF/IIDs for furnishing services, unless they provide at least the following, see 42 CFR [~~483.440(a)~~] 440.150:

A. room and board;

B. continuous active treatment program, including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the following:

(1) acquisition of the behaviors necessary for the [~~recipient~~] individual to function with as much self-determination and independence as possible; and

(2) prevention or deceleration of regression or loss of current functional status.

C. personal assistance services [~~twenty-four (24)~~] 24 hours a day, seven [~~(7)~~] days a week; personal assistance services are those services, other than professional nursing services, which may be needed by an individual because of age, infirmity, physical or mental limitations, [and/or] dependence in accomplishing the activities of daily living.
[2/1/1995; 8.313.2.14 NMAC - Rn, 8 NMAC 4.MAD.732.3 & A, 11/1/2000; A, xx/xx/xxxx]

8.313.2.15 COVERED SERVICES: Medicaid covers the costs of [~~ICF-MR~~] ICF/IID services identified as allowable. See Section [~~MAD-732-D~~] 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for [~~the Mentally Retarded~~] Individuals with intellectual disabilities*, [~~Section III.G~~]. Pharmacy services furnished in the [~~ICF-MR~~] ICF/IID are reimbursed separately and are subject to specific requirements. See Section [~~MAD-753~~] 8.324.4 NMAC, *Pharmacy Services*.
[2/1/1995; 8.313.2.15 NMAC - Rn, 8 NMAC 4.MAD.732.4 & A, 11/1/2000; A, xx/xx/xxxx]

8.313.2.16 NONCOVERED SERVICES:

A. Medicaid does not cover the costs of [~~ICF-MR~~] ICF/IID services that are not allowable. See Section [~~MAD-732-D~~] 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for [~~the Mentally Retarded~~] Individuals with intellectual disabilities*.

B. Medicaid does not pay for residents with a primary diagnosis of [~~mental retardation~~] intellectual disability who are receiving care in a general nursing facility setting. Coverage of these residents is included only when they are residing in an [~~ICF-MR~~] ICF/IID facility or in a nursing facility when they have a medical condition which by and of itself would justify NF care.
[2/1/1995; 8.313.2.16 NMAC - Rn, 8 NMAC 4.MAD.732.5 & A, 11/1/2000; A, xx/xx/xxxx]

8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for participation in medicaid, each [~~ICF-MR~~] ICF/IID 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 483.10[~~(c)~~](f)(10).

(1) Requests for [~~ICF-MR~~] ICF/IIDs to care or not care for a resident's funds must be made in writing and secured by a request to handle recipient's fund form or a letter signed by the resident or [~~his/her~~] their representative. The form or letter is retained in the recipient's file at the facility.

(2) A [~~recipient's~~]resident's personal fund consists of a monthly maintenance allowance 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) 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 provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. Fund custodians: 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. Another individual, other than those employees who have daily responsibility for the fund, must do the following:

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

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

(3) authorize checks for the withdrawal of funds from the bank account; and

(4) 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: Facilities must establish a bank account for the deposit of all 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 dollars ($50)~~] $50 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 fund up to [~~fifty dollars ($50)~~] $50 in a non-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 30 days of the death of residents whose personal funds are deposited with the facility, the [~~ICF-MR~~] ICF/IID must convey the resident's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the resident's estate.

D. Establishment of individual accounts: 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 loose-leaf 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 facility must retain 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. Any 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 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 person, the resident can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: Facilities must balance the individual accounts, the collective bank accounts and the petty cash fund at least once a month. The facility must provide medicaid residents or their authorized representatives with an accounting of the resident's funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. Petty cash fund: Facilities must maintain a cash fund to accommodate the small cash requirements of medicaid residents. [~~Five dollars ($5.00)~~] $5.00 or less per individual recipient may be adequate. The amount of money maintained in the petty cash fund is determined by the number of residents 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 [~~ICF-MR~~] ICF/IID 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) recipients or their authorized representatives request small amounts of spending money;

(b) the amount disbursed is entered on individual ledger record; and

(c) the resident or representative signs an account record and receives a receipt.

(3) To replenish the fund, the following procedures should be used:

(a) money in the cash box is counted and added to the total of all disbursements made since the last replenishment; and

(b) the total of the disbursements plus cash on hand equals the beginning amount;

(c) money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures must be established and used at least once each month:

(a) count money on hand; and

(b) total cash disbursed either from receipts or individual account records; the cash on hand plus total disbursements equals the petty cash total.

(5) To close the resident's account, [~~ICF-MR~~] ICF/IID 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;

(d) notify the local ISD office if closure is caused by the death of the recipient so that action can be taken to terminate assistance; and

(e) within 30 days of the death of a resident who had no relatives, the ~~[ICF-MR]~~ ICF/IID 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 483.10~~[(c)(6)]~~(f)(10)(v).

G. Retention of records: All account records other than financial and statistical cost reports must be retained until after an audit is complete or six years, whichever is greater. For details on retention of financial and statistical cost reports, see Subsection D of ~~[8.313.3.12]~~ 8.313.3.11 NMAC, *Retention of Records*.

H. Non-acceptable uses of recipients' personal funds:

(1) Facilities cannot impose charges against a resident's 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 representative to request any item or services as a condition of admission or continued stay.

(2) Facilities must inform residents or representative requesting non-covered items or services that there is a charge for the item and the amount of the charge.

(3) Non-acceptable uses of residents' personal funds include the following:

(a) payment for services or supplies covered by medicaid or medicare; see 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for ~~[the Mentally Retarded]~~ Individuals with intellectual disabilities*;

(b) difference between the facility billed charge and the medicaid payment; or

(c) payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

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

(1) The division of health improvement, health facility licensing & certification bureau of the DOH verifies that facilities have a system of accounting for residents' personal funds, including the components described above. Failure to provide 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 fund accounts at HSD's discretion.

[2/1/1995; 8.313.2.17 NMAC - Rn, 8 NMAC.MAD.732.6 & A, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.18 LEVEL OF CARE DETERMINATION: Medical necessity, level of care or length of stay determinations, and on-site review activities are carried out in accordance with the MAD utilization review policy and procedures, authorized under Title XIX of the Social Security Act. See ~~[MAD-954]~~ 8.350.3 NMAC, ~~*[Abstract]*~~ *Submission for Level of Care Determinations*.

[2/1/1995; 8.313.2.18 NMAC - Rn, 8 NMAC 4.MAD.732.8, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.19 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All HSD/MAD program 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 ~~[~~8.302.5~~]~~ 8.310.2 NMAC, *General Benefit Description- Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

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

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for HSD/MAD programs. Providers must verify that individuals are eligible for HSD/MAD programs at the time services are furnished and determine if HSD/MAD program recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See Section ~~[MAD-953]~~ 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[2/1/1995; 8.313.2.19 NMAC - Rn, 8 NMAC 4.MAD.732.9, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.20 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident of an [~~ICF-MR~~] ICF/IID for the following reasons: [~~1)~~] to allow the resident to make home and community visits, e.g., vacations; [~~2)~~] to adjust to a new living environment; or [~~3)~~] for hospitalizations.

A. Coverage of reserve bed days: Without prior authorization, medicaid covers 65 reserve bed days per calendar year for every resident for family visits, vacations, home visits, hospitalizations and adjustment to a new living environment. Reserve bed days used under this section require documentation in the facility or the client records for all absences from the facility. If the absence from the facility is not documented in the facility or the client records, medicaid will recoup the reserve bed day payment. If the resident is away from the facility with facility staff supervision, the absence is not considered a reserve bed day.

B. Prior authorization: After the 65 days have been expended, medicaid covers, with prior authorization, an additional six reserve bed days per calendar year for discharge planning.

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

(2) To obtain medicaid prior authorization, the facility must submit the following information in writing to MAD:

(a) the resident's name;
(b) social security number;
(c) requested approval dates;
(d) copy of the discharge plan;
(e) name and address of the individual who will care for the resident; and
(f) written physician order for trial placement.

(3) Documentation of the resident's absence from the facility for these six additional reserve bed days must be in the facility or the client records.

C. Documentation of reserve bed days: If residents leave the [~~ICF-MR~~] ICF/IID for any reason, documentation of the absence from the facility must be in the facility or client records. Hospitalizations must be documented in the client records at the [~~ICF-MR~~] ICF/IID.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the [~~ICF-MR~~] ICF/IID is limited to the provider's level III rate. Billing for reserve bed days is based on the facility census, which runs from midnight to midnight. Medicaid pays for the admission day but does not pay for the discharge day. To receive payment for the additional six reserve bed days, which require prior authorization, the provider must attach a copy of the written notification of approval by MAD to the claim.

[2/1/1995; 8.313.2.20 NMAC - Rn, 8 NMAC 4. MAD.732.7 & A, 11/1/2000; A, 5/1/2007; A, xx/xx/xxxx]

8.313.2.21 Reimbursement: [~~Intermediate care providers must submit claims for reimbursement on the long term care turn around documents (TAD) or its successor.~~] See Section [~~MAD-702~~] 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. MAD reimburses [~~ICF-MR~~] ICF/IID the lower of the following:

(1) the provider's billed charges; or

(2) the prospective rate as constrained by the ceilings established by MAD. See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Reimbursement limitations: Medicaid pays only those [~~ICF-MRs~~] ICF/IIDs which meet the conditions for participation, specified in this section. Payments to [~~ICF-MRs~~] ICF/IIDs for services are limited to those services which are included as allowable service costs under the approved state plan. All claims for payment submitted to MAD are subject to utilization review and control.

C. Reimbursement methodology: See Section [~~MAD-732-D~~] 8.313.3, *Cost Related Reimbursement of Intermediate Care Facilities for*[~~*the Mentally Retarded*~~] Individuals with Intellectual Disabilities.

[2/1/1995; 8.313.2.21 NMAC - Rn, 8 NMAC 4.MAD.732.10, 11/1/2000]

HISTORY OF 8.313.2 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
ISD 310.0300, Care In Skilled Nursing Facility And Intermediate Care Facility, 2/27/1980.
SP-004.1401, Utilization Review Plan for Intermediate Care Facilities, 6/10/1981.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 12/1/1987.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 1/6/1988.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility For The Mentally Retarded, 3/27/1992.

History of Repealed Material: [**RESERVED**]