This is an amendment to 8.312.2 NMAC, Sections 7, 8, 10, 11, 13, 15, 16, 18, 19, 23, 24 and 25, effective 3/1/2025.

8.312.2.7 DEFINITIONS:

A. "**Authorized representative**" means the individual designated to represent and act on the claimant's behalf. The eligible recipient or managed care organization (MCO) member's authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian ad litem, or any other individual or individuals designated in writing by the eligible recipient or MCO member.

B. "**Designee**" means a state agency or an institution MAD has designated to be responsible for:

(1) conducting a preadmission screening and annual resident review (PASRR) level 1 screening to identify if a medical assistance program (MAP) eligible recipient or a MCO member has a mental illness or an intellectual disability; or

(2) conducting a PASRR level 2 evaluation.

C. [~~**"DOH-DDSD"**~~] **"HCA DDSD"** means the developmental disabilities support division of the [~~department of health~~] health care authority, which conducts the PASRR level II evaluation for a MAP eligible recipient or a MCO member that has been identified through a PASRR level 1 screen.

D. "[~~**HSD**~~**] HCA administrative hearing**" or "fair hearing" means an informal evidentiary hearing that is conducted by the [~~HSD fair hearings bureau (FHB)~~] HCA office of fair hearings so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, the MCO or their designees.

E. "**MAD**" means the medical assistance division, which administers medicaid and other medical assistance programs (MAP) under [~~HSD~~] HCA.

F. "**MAP**" means the medical assistance programs administered by MAD.

G. "**MCO**" means a member's [~~HSD~~] HCA contracted managed care organization.

H. "**Member**" means a MAP eligible recipient enrolled in a [~~HSD~~] HCA contracted MCO. Once a member requests a [~~HSD~~] HCA administrative hearing, the member is referred to as a claimant.

I. "**Notice of action**" means the notice issued by MAD, the MCO or their designees of their intent to take an adverse action against an eligible recipient or a member in the form an adverse determination is made with regard to the preadmission or annual resident review requirements.

J. "**Nursing facility (NF)**" means a MAD enrolled, and as appropriate, a MCO contracted, nursing facility which meets the requirements as described in 8.312.2 NMAC. The NF completes a PASRR level one screen for a MAP eligible recipient or a MCO member.

[8.312.2.7 NMAC - Rp, 8.312.2.7 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.8 MISSION STATEMENT: [~~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.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.312.2.8 NMAC - Rp, 8.312.2.8 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients or members is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors or the MCO. MAD makes available on the [~~HSD/MAD~~] HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by [~~HSD~~] HCA or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When enrolled, a provider receives [~~instruction~~] instructions on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact [~~HSD~~] HCA or its authorized agents to obtain answers to questions related

to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD, its selected claims processing contractor or the MCO issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. nursing facilities (NF) which:

(1) are currently licensed and certified by the department of health (DOH) to meet MAD nursing facility conditions of participation; see 42 CFR Part 483, as amended;

(2) comply with the eligible recipient or MCO member resident's personal funds rules;

(3) comply with MAD, its UR or the MCO UR processes and agree to operate in accordance with all MAD NMAC rules, including the performance of discharge planning;

(4) comply with the NMAC MAD rules for the pre-admission screening and resident review (PASRR) of mentally ill and intellectually disabled program;

(5) ensure the required nurse aide training is implemented; and

(6) ensure that facilities with 60 or more MAD beds certify a minimum of four distinct beds in the medicare program;

B. the above requirements can be waived if the NF meets one of the following conditions:

(1) 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;

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

(3) the NF is one of two or more NFs 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 eligible recipients or members 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.

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

(b) medicare is the primary payer for NF services covered under the medicare program; NF services must be provided within the scope of the practice and licensure for each provider; and must be in compliance with the statutes, rules and regulations of the applicable practice and with the New Mexico administrative code (NMAC) MAD rules.

[8.312.2.10 NMAC - Rp, 8.312.2.10 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient or member must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD PPA. A provider also must conform to MAD program rules and instructions as specified in the MAD NMAC rule manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) national correct coding initiatives (NCCI), including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by [~~HSD~~] HCA and its authorized agents, and must verify the recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient or member has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient or member.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by [~~HSD~~] HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services; see 8.302.1 NMAC.

[8.312.2.11 NMAC - Rp, 8.312.2.11 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.13 COVERED SERVICES:

A. MAD covers NF services identified as allowable costs; see 8.312.3 NMAC.

B. MAD covers physical, occupational and speech therapy services furnished to an eligible recipient or member residing in a NF in the following manner:

(1) if the eligible recipient or member is also eligible for medicare and the NF does part B billing, the co-payment or deductible is processed by MAD or the MCO for services is paid by MAD or the MCO;

(2) if the eligible recipient or member receives high NF level services, services are included in the MAD facility rate; or

(3) if eligible, the recipient or member receives low NF level services, services are billed separately by participating therapy providers.

C. MAD covers a NF per diem add-on for ventilator services in long-term and skilled nursing facilities in New Mexico.

(1) The per diem add-on costs of providing services to the ventilator dependent resident or member shall be maintained separately (as a distinct part) of each facility's annual cost report.

(2) Ventilator dependent per diem add-on rates will cover skilled nursing care services and will be all-inclusive.

(3) Ventilator dependent per diem add-on services must be prior authorized by the MCO. The resident's or member's clinical condition shall be reviewed every 90 days to determine if the resident's or member's medical condition continues to warrant services at the ventilator dependent NF rate. Prior authorization (PA) through the MCO spans a 90-day maximum time period. The NF is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident or member no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the New Mexico medicaid nursing home per diem rate determined for the facility.

(4) Long-term and skilled nursing facilities in New Mexico must be certified by the department of health to provide ventilator services.

(5) Eligible ventilator dependent recipients residing in a NF must meet the following criteria:

(a) Have a health condition that requires close medical supervision defined as 24 hours a day of licensed nursing care along with specialized services or equipment;

(b) Require mechanical ventilation greater than or equal to six hours a day;

(c) Have tracheostomy (with daily care) and require mechanical ventilation for a portion of each day for stabilization;

(d) Require continuous pulse oximetry monitoring to check the stability of oxygen saturation levels;

(e) Require respiratory assessment and daily documentation by a licensed respiratory therapist or registered nurse;

(f) Have a provider's order for respiratory care to include suctioning as needed;

(g) Have tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the four treatment procedures listed below:

(i) total parenteral nutrition;

(ii) inpatient physical, occupational, or speech therapy;

(iii) tube feeding (nasogastric or gastrostomy); or

(iv) inhalation therapy treatments every shift and a minimum of four times per 24-hour period.

(h) The recipient's diagnosis must be consistent with ICD diagnosis codes for ventilator dependency;

(i) The skilled nursing facility must be approved for ventilator care; and

(j) Providers must be specially trained and competent in respiratory and vent care.

[8.312.2.13 NMAC - Rp, 8.312.2.13 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.15 ELIGIBLE RECIPIENT AND MEMBER PERSONAL FUND ACCOUNTS:

A. As a condition for MAD provider participation, each NF must establish and maintain an acceptable system of accounting for an eligible recipient or member resident's personal funds when an eligible recipient or member requests that [~~his or her~~] their personal funds be cared for by the facility. See 42 CFR Section 483.10(c) and see 7.9.2.22 NMAC.

(1) Requests for a NF to care or not care for an eligible recipient or member resident's funds must be made in writing and secured by a request to handle recipient or member funds form or letter signed by the eligible recipient or member or [~~his or her~~] their authorized representative. The form or letter is kept in the eligible recipient or member's file at the facility.

(2) An eligible recipient or member's personal fund consists of a monthly maintenance allowable, established by MAD. If the eligible recipient or member resident receives any income in excess of this

allowance, the excess is applied to the cost of the eligible recipient or member resident's medical care at the NF. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) A NF must have procedures on the handling of eligible recipient or member residents' funds. These procedures must not allow the facility to commingle eligible recipient or member residents' funds with facility funds.

(4) A NF should use these applicable federal statutes, regulations and state rules to develop procedures for handling eligible recipient or member resident's funds.

(5) An eligible recipient or member resident has the right to manage [~~his or her~~] their financial affairs and no NF can require an eligible recipient or member resident to deposit [~~his or her~~] their personal funds with the NF.

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

(7) Failure of a NF to furnish an acceptable accounting system constitutes a deficiency that must be corrected by the provider and verified by DOH survey teams.

B. Fund custodians: A NF must designate a full-time employee and an alternate to serve as fund custodians for handling an eligible recipient or member resident's money on a daily basis; see 7.9.2.22 NMAC.

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

(a) reconcile balances of each eligible recipient or member accounts with the collective bank account;

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

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

(2) A NF must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each eligible recipient or member resident's personal funds entrusted to [~~his or her~~] their NF on the eligible recipient or member resident's behalf.

C. Bank account: A NF must establish a bank account for the deposit of all money for each eligible recipient or member resident who requests the NF to handle [~~his or her~~] their funds. An eligible recipient or member resident's personal funds are to be held separately and not commingled with the NF funds; see 7.9.2.22 NMAC.

(1) A NF must deposit an eligible recipient or member's personal funds of more than $50 in an interest bearing account that is separate from any of the NF operating accounts and which credits all interest earned on the eligible recipient or member resident's account to that account. An eligible recipient or member resident must have convenient access to these funds.

(2) A NF must maintain an eligible recipient or member resident's personal funds up to $50 in an interest bearing account or a petty cash fund that is separate from any of the NF operating accounts. An eligible recipient or member resident must have convenient access to these funds.

(3) Individual financial records must be available on the request of an eligible recipient or member resident or [~~his or her~~] their authorized representative.

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

D. Establishment of individual accounts: A NF must establish accounts for each eligible recipient or member resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or loose leaf binder; see 7.9.2.22 NMAC.

(1) For money received, the source, amount and date must be recorded. The NF must provide the eligible recipient or member resident or [~~his or her~~] their authorized representative receipts for the money. The NF still retains a copy of the deposit in the eligible recipient or member resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of an eligible recipient or member resident must be recorded. All money spent either on behalf of the eligible recipient or member resident or withdrawn by the eligible recipient or member resident or [~~his or her~~] their authorized representative must be validated by receipts or signatures on each eligible recipient or member resident's individual ledger sheet.

(3) The NF must notify each eligible recipient or member resident when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person specified in Subparagraph (a) of Paragraph (3) of Subsection B of Section 1611 of the Social Security Act. If the amount of the account and the

value of the eligible recipient or member resident's other nonexempt resources reach the SSI resource limit for one person, the eligible recipient or member resident can lose eligibility for a medical assistance program (MAP) or SSI.

E. Personal fund reconciliation: The NF must balance each eligible recipient or member resident's individual accounts, the collective bank accounts and the petty cash fund at least once each month. The NF must furnish each eligible recipient or member resident or [~~his or her~~] their authorized representative with an accounting of the eligible recipient or member residents' funds at least quarterly. Copies of each eligible recipient or member resident's individual account records can be used to furnish this information; see 7.9.2.22 NMAC.

F. Petty cash fund: The NF must maintain a cash fund in the facility to accommodate the small cash requirements of an eligible recipient or member resident. $5 or less per each eligible recipient or member resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of NF 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; see 7.9.2.22 NMAC.

(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) an eligible recipient or member resident or [~~his or her~~] their authorized representative request small amounts of spending money;

(b) the amount disbursed is entered on each eligible recipient resident's individual ledger record; and

(c) the eligible recipient or member resident or [~~his or her~~] their authorized 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 each eligible recipient or member resident's individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close each eligible recipient or member 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 each eligible recipient or member resident's individual account record;

(c) get signature of the eligible recipient resident or [~~his or her~~] their authorized representative on the eligible recipient or member resident's individual account record, as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of an eligible recipient or member resident so that prompt action can be taken to terminate assistance; within 30 calendar days of the death of an eligible recipient or member resident who has no relatives; the NF conveys the eligible recipient or member resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the eligible recipient or member resident's estate; see 42 CFR Section 483.10(c)(6).

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

H. Non-acceptable uses of residents' personal funds: Non-acceptable uses of an eligible recipient or member resident's personal funds include the following:

(1) payment or charges for services or items covered by MAD or medicare specified as allowable costs; see 8.312.3 NMAC;

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

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

(4) a NF cannot impose charges against eligible recipient resident's personal funds for any item or service for which payment is made by MAD or for any item the eligible recipient or member resident or [~~his or her~~] their authorized representative did not request;

(5) a NF must not require eligible recipient or member resident or [~~his or her~~] their authorized representative to request any item or service as a condition of admission or continued stay;

(6) a NF must inform an eligible recipient or member resident or [~~his or her~~] their authorized representative who requests non-covered 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 an eligible recipient or member resident's personal funds available for inspection by authorized state or federal auditors. DOH survey teams verify that a NF has established systems to account for an eligible recipient or member resident's personal funds, including the components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected; see 7.9.2.22 NMAC.

[8.312.2.15 NMAC - Rp, 8.312.2.15 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.16 RESERVE BED DAYS: MAD pays to hold or reserve a bed for an eligible recipient or member resident in a NF to allow for the eligible recipient or member resident 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: MAD covers six reserve bed days per calendar year for every long term care eligible recipient or member resident for hospitalization without prior approval. MAD covers three reserve bed days per calendar year for a brief home visit without prior approval. MAD covers an additional six reserve bed days per calendar year with prior approval to support an eligible recipient or member resident to adjust to a new environment as part of the discharge plan.

(1) An eligible recipient or member 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 eligible recipient or member resident's name, MAP identification number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the eligible recipient or member resident during the visit or placement and a written medical order for trial placement.

B. Documentation of reserve bed days: When an eligible recipient or member resident is discharged from a NF for any reason, appropriate documentation must be placed in the eligible recipient or member resident's chart. A medical order must be obtained if the eligible recipient or member resident is hospitalized, requests a home visit or a trial placement.

C. Re-admission review: A new level of care (LOC) determination must be performed by MAD, its UR contractor or the MCO if an eligible recipient or member resident is gone from [~~this or her~~] their NF for more than three midnights. A NF notification form must be completed, including information on the reason for the eligible recipient or member resident's absence, outcome of the leave and any other pertinent information concerning the leave; see the MAD managed care policy manual.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the NF is limited to the rate applicable for LOC medically necessary for the eligible recipient or member resident, as determined and approved by MAD, its UR contractor or the MCO. The reserve bed day reimbursement is equal to 50% of the regular payment rate for MAD fee-for-service or as otherwise negotiated between the NF provider and the MCO. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. MAD or the MCO pays for the admission day but not for the discharge day.

[8.312.2.16 NMAC - Rp, 8.312.2.16 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF MENTALLY ILL AND INTELLECTUALLY DISABLED INDIVIDUALS: As part of the initial NF communication form for a new admission 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 an eligible recipient or member resident with identified mental illness or is intellectually disabled, the NF must complete a level I 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 eligible recipient or member resident:

(1) when admitted from the hospital whose attending physicians certify before admission to the NF that the eligible recipient or member resident is likely to require NF care for less than 30 days (as determined by PASRR review of [~~the his or her~~] their level I screen data which was done prior to NF admission);

(2) when readmitted to NFs from a hospital to which [~~he or she was~~] they were transferred for the purpose of receiving care; and

(3) when 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 an intellectual disability, need the level of services furnished in a NF and need specialized services based on the mental illness or intellectual disability. A NF performs the level I screen which identifies an eligible recipient or member resident who has a mental illness or an intellectual disability. When an eligible recipient or member resident is identified, the NF refers [~~him or her~~] them to the [~~DOH~~] HCA DDSD for a PASRR level II evaluation.

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

(1) the eligible recipient or member resident's total needs are such that [~~his or her~~] their needs can be met in an appropriate community setting;

(2) the eligible recipient or member 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 eligible recipient or member resident's needs, another setting, such as an intermediate care facility for individuals with intellectual disabilities (ICF-IID) can be indicated.

D. Right to an administrative hearing: An individual who has been adversely affected by the preadmission screening or resident review screening is entitled to a [~~HSD~~] HCA administrative hearing. See 8.354.2 NMAC for a detailed description of this specific type of [~~HSD~~] HCA administrative hearings.

(1) An eligible recipient or member or [~~his or her~~] their authorized representative may request a [~~HSD~~] HCA administrative hearing.

(2) MAD, the MCO or their designees do not pay fees or costs, including attorney's fees, incurred by the individual or [~~his or her~~] their authorized representative as a result of a [~~HSD~~] HCA pre-hearing conference or a [~~HSD~~] HCA administrative hearing, or if [~~he or she files~~] they file an appeal of the [~~HSD~~] HCA administrative hearing final decision.

E. Restriction on reimbursement for medicaid residents: A NF is not reimbursed for any service furnished to an eligible recipient or member resident when pre-admission screens, subsequent specified reviews or significant change reviews are not performed in a timely manner. MAD or the MCO pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to a NF during periods of noncompliance. MAD or the MCO payment for services does not begin until a level II screening has been performed, if applicable.

[8.312.2.18 NMAC - Rp, 8.312.2.18 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.19 MINIMUM DATA SET:

A. A long term care facility participating in the medicare and is an enrolled MAD provider is required to conduct a comprehensive, accurate, standardized, reproducible assessment of each eligible recipient or member 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 impairment in functional capacity. The assessment is based on a uniform MDS of core elements and common definitions specified by the secretary of the federal health and human services department. A NF is required to use the most current iteration of the MDS. A section of the MDS requires a NF to identify eligible recipient or member residents who may be interested in transitioning back to [~~his or her~~] their community.

(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 electronically.

[8.312.2.19 NMAC - Rp, 8.312.2.19 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING: An eligible recipient or member resident who believes that the NF has erroneously determined that [~~he or she~~] they should be

transferred or discharged may request a [~~HSD~~] HCA administrative hearing. A NF must provide an eligible recipient or member resident notice of the proposed transfer or discharge. The notice must inform the eligible recipient or member resident of [~~his or her~~] their right to request a hearing, the method by which a hearing can be requested and [~~his or her~~] their right to present evidence in person or through [~~his or her~~] their authorized representative; see 8.354.2 NMAC and the MAD MCO policy manual.
[8.312.2.23 NMAC - Rp, 8.312.2.23 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity, inspection of care, 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 8.310.2 NMAC. The provider must contact [~~HSD~~] HCA or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials.

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

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient or member has other health insurance.

C. Reconsideration: A provider who disagrees with a prior approval request denial or other review decisions can request a reconsideration of utilization review; see 8.350.2 NMAC.
[8.312.2.24 NMAC - Rp, 8.312.2.24 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.25 REIMBURSEMENT: A NF provider must submit claims for reimbursement on the long term care turn around document (TAD) or its successor; see 8.302.2 NMAC.

A. MAD reimburses a NF at the lesser of the following:

(1) the NF's billed charges;

(2) the prospective reimbursement rates constrained by the ceilings established by MAD; see 8.312.3 NMAC; and

(3) the NF's billed charge must be its usual and customary charge for services; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

B. Reimbursement limitations: Payments are made only to a MAD enrolled, and as appropriate a [~~HSD~~] HCA MCO contracted NF. Payments to a NF are limited to those service costs which are included as allowable costs under approved provisions of the medicaid state plan or the MAD alternative benefit; see 8.312.3 NMAC. All claims for payment from MAD or the MCO are subject to utilization review and control.

C. Reimbursement methodology: See 8.312.3 NMAC for a detailed description of this methodology.
[8.312.2.25 NMAC - Rp, 8.312.2.25 NMAC, 8/1/2014; A/E, 3/1/2025]