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TITLE 8 SOCIAL SERVICES
CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES
PART 2 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

8.313.2.1 ISSUING AGENCY: Human Services Department, Medical Assistance Division
[2-1-95; 8.313.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11-1-00]

8.313.2.2 SCOPE: This rule applies to the general public.
[2-1-95; 8.313.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11-1-00]

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).
[2-1-95; 8.313.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11-1-00]

8.313.2.4 DURATION: Permanent
[2-1-95; 8.313.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11-1-00]

8.313.2.5 EFFECTIVE DATE: February 1, 1995.
[2-1-95; 8.313.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11-1-00]

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, covered services, noncovered services, utilization review, and provider reimbursement.
[2-1-95; 8.313.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11-1-00; A, 5-1-07]

8.313.2.7 DEFINITIONS: [RESERVED]
[8.313.2.7 NMAC - N, 11-1-00]

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.
[2-1-95; 8.313.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11-1-00; A, 5-1-07]

8.313.2.9 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED: 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 [42 CFR 440.150]. This section describes eligible providers, covered services, service restrictions, personal fund accounts, and general reimbursement methodology.
[2-1-95; 8.313.2.9 NMAC - Rn, 8 NMAC 4.MAD.732, 11-1-00]

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) which meet the following conditions for participation are eligible to be reimbursed for providing services to eligible medicaid recipients:

(1) the ICF-MR 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 must comply with 8.313.2.17 NMAC, *Recipient Personal Fund Accounts*; and

(3) the ICF-MR 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.
[2-1-95; 8.313.2.10 NMAC - Rn, 8 NMAC 4.MAD.732.1, 11-1-00; A, 5-1-07]

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*.
[2-1-95; 8.313.2.11 NMAC - Rn, 8 NMAC 4.MAD.732.11, 11-1-00]

8.313.2.12 SANCTIONS AND PENALTIES: See Section MAD-967, *Sanctions for Non-Compliance* and Section MAD-968, *Intermediate Remedies*.
[2-1-95; 8.313.2.12 NMAC - Rn, 8 NMAC 4.MAD.732.12, 11-1-00]

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, *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. 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, *General Provider Policies*.
[2-1-95; 8.313.2.13 NMAC - Rn, 8 NMAC 4.MAD.732.2, 11-1-00; A, 5-1-07]

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

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 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) 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.
[2-1-95; 8.313.2.14 NMAC - Rn, 8 NMAC 4.MAD.732.3 & A, 11-1-00]

8.313.2.15 COVERED SERVICES: Medicaid covers the costs of ICF-MR services identified as allowable. See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*, Section III.G. Pharmacy services furnished in the ICF-MR are reimbursed separately and are subject to specific requirements. See Section MAD-753, *Pharmacy Services*.
[2-1-95; 8.313.2.15 NMAC - Rn, 8 NMAC 4.MAD.732.4 & A, 11-1-00]

8.313.2.16 NONCOVERED SERVICES:

A. Medicaid does not cover the costs of ICF-MR services that are not allowable. See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Medicaid does not pay for residents with a primary diagnosis of mental retardation 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 facility or in a nursing facility when they have a medical condition which by and of itself would justify NF care.
[2-1-95; 8.313.2.16 NMAC - Rn, 8 NMAC 4.MAD.732.5 & A, 11-1-00]

8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for participation in medicaid, each ICF-MR 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).

(1) Requests for ICFs-MR 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 representative. The form or letter is retained in the recipient's file at the facility.

(2) A recipient'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) 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) 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 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 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 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) 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 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, ICFs-MR 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 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).

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 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*;

(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.

[2-1-95; 8.313.2.17 NMAC - Rn, 8 NMAC.MAD.732.6 & A, 11-1-00; A, 5-1-07]

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*.
[2-1-95; 8.313.2.18 NMAC - Rn, 8 NMAC 4.MAD.732.8, 11-1-00; A, 5-1-07]

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 NMAC, *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, *Reconsideration Of Utilization Review Decisions*.
[2-1-95; 8.313.2.19 NMAC - Rn, 8 NMAC 4.MAD.732.9, 11-1-00; A, 5-1-07]

8.313.2.20 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident of an ICF-MR 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 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.

D. **Reimbursement and billing for reserve bed days:** Reimbursement for reserve bed days to the ICF-MR 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.
[2-1-95; 8.313.2.20 NMAC - Rn, 8 NMAC 4. MAD.732.7 & A, 11-1-00; A, 5-1-07]

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, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. MAD reimburses ICF-MR 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 which meet the conditions for participation, specified in this section. Payments to ICF-MRs 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, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

[2-1-95; 8.313.2.21 NMAC - Rn, 8 NMAC 4.MAD.732.10, 11-1-00]

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, 2-27-80.
SP-004.1401, Utilization Review Plan for Intermediate Care Facilities, 6-10-81.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 12-1-87.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 1-6-88.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility For The Mentally Retarded, 3-27-92.

History of Repealed Material: [RESERVED]