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8.350.3 ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS

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TITLE 8 SOCIAL SERVICES
CHAPTER 350 RECONSIDERATION OF UTILIZATION REVIEW
PART 3 ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS

8.350.3.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.350.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.350.3.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.350.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.350.3.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.350.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.350.3.4 DURATION: Permanent
[2/1/95; 8.350.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.350.3.5 EFFECTIVE DATE: November 1, 1996
[11/1/96; 8.350.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.350.3.6 OBJECTIVE: The objective of these regulations 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; 8.350.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.350.3.7 DEFINITIONS: [RESERVED]

8.350.3.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.350.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.350.3.9 ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS: The medical assistance division (MAD) utilization review (UR) contractor performs prior approval and abstract review on admissions, readmissions, and continued stay requests for all long-term care nursing facilities (NF) and intermediate care facilities for the mentally retarded (ICF-MR). Within ten (10) working days after a recipient's admission to a nursing facility or intermediate care facility for the mentally retarded (ICF-MR), the facility must submit a long-term care abstract to the UR contractor for review. The initial admission abstract describes the recipient's functional level and level of care needs and includes the physician's history and physical examination and preadmission screening and annual resident review (PASARR). Readmissions and continued-stay request abstracts must be submitted to the UR contractor ten (10) working days before the expiration of the currently certified length of stay.
[11/1/96; 8.350.3.9 NMAC - Rn, 8 NMAC 4.MAD.954, 3/1/12]

8.350.3.10 REQUESTS FOR RETROACTIVE PRIOR APPROVAL REVIEW: MAD permits facilities to request retroactive prior approval review of long-term care abstracts which are not submitted for level-of-care reviews within the applicable time period if certain conditions are met.

A. **Initial abstracts:** Facilities must submit a request for retroactive prior approval review when delays in the submission of an initial abstract beyond the ten (10) working day period are caused by circumstances beyond the facility's control, including:

(1) physician does not sign orders or history and physical within the time period; or

(2) medicaid eligibility decisions have not been completed.

B. **Initial continued-stay abstract:** Facilities must submit a request for retroactive prior approval review when continued-stay abstracts are not submitted at least ten (10) working days before the expiration of the

currently certified length of stay. The delay in submission must be attributed to circumstances beyond the facility's control.

C. **Subsequent continued-stay abstract:** Facilities must submit a request for retroactive prior approval review when subsequent continued-stay abstracts are not submitted at least ten (10) working days prior to the expiration of the currently certified length of stay. The delay in submission must be caused by circumstances beyond the facility's control.

D. **Delays caused by circumstances within the facility's control:** Medicaid allows its UR contractor to accept ten (10) total late abstracts per facility per calendar year when delays in submission are caused by circumstances within the control of the facility, such as staff illness or staff turnover. Initial admission abstracts and initial and subsequent continued stay abstracts are included in this number.

E. **Denial of request for retroactive prior approval reviews:** Medicaid does not reimburse facilities for dates of service not covered by an approved abstract. Facilities cannot bill medicaid recipients for those days.

[11/1/96; 8.350.3.10 NMAC - Rn, 8 NMAC 4.MAD.954.1, 3/1/12]

8.350.3.11 SUBMITTING ABSTRACTS FOR RETROACTIVE PRIOR APPROVAL REVIEW:

A. To request retroactive prior approval review, a facility must submit the abstract, a request for retroactive prior approval review form and supporting documentation to the UR contractor. Facilities must provide at least the following supporting documentation:

(1) pertinent information, such as physician orders, history and physical, physician progress notes or hospital discharge summaries; all documentation must be date-stamped by the facility verifying date of receipt from the physician or hospital.

(2) dated facility entries and records that document telephone calls to physicians reminding them of the need to complete the abstract, physician orders, history and physical or progress notes;

(3) date-stamped copy of the notification of medicaid eligibility; and

(4) documentation of other reasons for delay.

B. Any request for retroactive prior approval review received without the required supporting documentation is returned to the facility.

[11/1/96; 8.350.3.11 NMAC - Rn, 8 NMAC 4.MAD.954.2, 3/1/12]

8.350.3.12 REVIEW OF RETROACTIVE PRIOR APPROVAL REVIEW DENIALS: Providers who disagree with abstract review decisions or denials of retroactive prior approval review can request a re-review and reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions* for specific information on the review process.

[11/1/96; 8.350.3.12 NMAC - Rn, 8 NMAC 4.MAD.954.3, 3/1/12]

8.350.3.13 PAYMENT FOLLOWING APPROVAL OF RETROACTIVE PRIOR APPROVAL REVIEW ABSTRACTS: Medicaid reimburses facilities in the following manner after approval of a retroactive prior approval review:

A. for late initial abstracts caused by delayed physician signature, reimbursement is effective back to the date of admission;

B. for late initial abstracts caused by delayed medicaid eligibility decisions, reimbursement is effective back to the date the recipient became medicaid-eligible;

C. for late continued-stay abstracts caused by delays in obtaining physician signature or retroactive medicaid eligibility, reimbursement is effective from the beginning of the certification period for continued stay;

D. for the first ten (10) late abstracts per facility per calendar when delay is attributed to circumstances within the facility's control, reimbursement is effective back to the date of admission or the beginning of the certification period for continued stay applicable to the situation; and

E. for late abstracts beyond the ten (10) allowed by medicaid attributed to circumstances within the facility's control, the earliest possible effective date is the date the late abstract was received by the UR contractor.

[11/1/96; 8.350.3.13 NMAC - Rn, 8 NMAC 4.MAD.954.4, 3/1/12]

HISTORY OF 8.350.3 NMAC: [RESERVED]