6. Nursing Facilities (NFs)

6.1. General Information

This policy establishes guidelines for the MCOs regarding NFs. The NF LOC Criteria and instructions is posted on the HCA website at https://www.hca.nm.gov/providers/nursing-facility-level-of-care/.

6.2. NF Procedures for Requests for Prior Approval

All requests for prior approval shall contain appropriate documentation and must be completed for each resident for every situation requiring prior approval. All requests for prior authorization are submitted to the resident's MCO by fax or designated MCO email address.

6.3. Pre-Admission Screening and Resident Review (PASRR)

Federal law requires NFs to perform PASRR screens for mental illness, intellectual disability (ID), and related conditions. There are procedures and information that are applicable to all situations requiring prior approval.

- Purpose of PASRR is as follows:
  - To determine whether a resident requires a specific level of nursing care;
  - To determine if there is suspicion of serious mental illness (SMI) or intellectual disability/related condition (ID/RC);
  - To assess persons suspected of having serious SMI or ID/RC;
  - To assess whether specialized services for SMI or ID/RC are needed; and,
  - To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in a specialized program for those with SMI or ID/RC.
- Organization of the PASRR: PASRR is divided into two levels: Level I Screen and Level II Evaluation.
  - Level I Screen: A Level I Screen must be completed prior to admission on every NF applicant. If, during the Level I Screen, it is determined that the individual is suspected of having either SMI or ID/RC, a Level II Evaluation or PASRR waiver must occur prior to admission. A Level I Screen must also be done if there has been a significant change in the physical or mental condition of a resident who is suspected of having, or previously determined to have, SMI or ID/RC. "Significant change" for PASRR purposes can be tied to the already existing regulatory definition for significant change that prompts an alteration in a resident's MDS. Significant change referrals

must be made to the PASRR Unit no later than 21 business days after the occurrence of the significant change. The PASRR Unit is required to review the completed Level I Screen packet within seven to nine business days of receipt of the completed packet from the NF. Notification of the review decision must be submitted to the NF by phone or in writing within that time period.

- Level II Evaluation: If the Level I Screen identifies a resident who is diagnosed with or suspected of having SMI or ID/RC, a Level II Evaluation or a PASRR waiver must be completed prior to the admission of the resident. The Level II Evaluation includes a comprehensive evaluation of the needs of the resident.

- PASRR Waiver:
  - If an individual falls within one of the following categories, a complete Level II Evaluation may not be performed. A PASRR Waiver is granted on a case-by-case basis.
    - The resident has a primary diagnosis of dementia.
    - The resident is being discharged from an acute care hospital for the purpose of convalescent care medically prescribed for recovery, not to exceed 30 business days.
    - The resident is suspected of having SMI or ID/RC but is certified to be terminally ill with a life expectancy of six months or less and is in need of continuous nursing care and/or medical supervision and treatment due to a physical condition.
    - The severity of the resident's medical condition and medical treatment needs are so extensive that specialized SMI or ID/RC services are not likely to be beneficial.
    - The resident who is suspected of having SMI or ID/RC and is admitted directly to an NF from a home for very brief and finite stay (up to 14 days) for the purpose of providing respite to in home caregivers.
    - If APS directly admits an individual to an NF because the individual is in harm's way, the PASRR Unit is required to complete the Level II assessment within 10 business days.
- Level I Screen Process
  - An NF is required to submit copies of the Level I Screen for each resident with the MDS to the MCO/Utilization Review (UR) Contractor. The Screen and other necessary documentation must be sent with the MDS to avoid delays in the review process.

- The MCO/UR Contractor logs in the date on the recipient screen when the MDS, Level I Screen, and other documentation is received.
- The MCO/UR Contractor scans the Level I Screen. If the resident passes the Screen, the MCO/UR Contractor determines the NF LOC. If the resident fails the Screen, no further NF LOC action is to be taken by the MCO/UR Contractor. The MDS Screen, and other documentation, must be submitted to the PASRR Unit for a Level II determination.
- The MCO/UR Contractor then sends a notice to the NF that the MDS and other documentation have been sent to the PASRR Unit for a Level II Evaluation determination.

- Level II Evaluation Process: There are two types of Level II PASRR reviews.
  - SMI PASRR II screens are completed by the BHSD contractor for residents living in an NF or individuals being admitted from a hospital or home to an NF.
    - The PASRR Unit sends the documents to the BHSD contractor to complete an evaluation and makes the Level II determination on the review portion of the MDS and the NF LOC determination, then returns to the PASRR Unit. The PASRR Unit sends the NF LOC determination and MDS to the NF. The NF then sends the MCO/UR Contractor the MDS and other documentation with the NF LOC determination if a waiver was not granted.
    - Within 24 hours of the MCO/UR Contractor receiving the NF LOC determination from the NF determined by the BHSD contractor, the MCO/UR Contractor transmits the NF LOC determination via the appropriate interface file.
    - If a subsequent specified review or significant change review is required, the review portion of the MDS must be completed by the PASRR Unit. All subsequent reviews follow the process above by the PASRR Unit instead of the MCO/UR Contractor.
    - If a subsequent specified review or significant change review is not required, the MDS is returned to the MCO/UR Contractor for an NF LOC determination.
  - ID and RC PASRR II screens are completed by the PASRR Unit for residents living in an NF or individuals being admitted from a hospital or from home to an NF.
    - The PASRR Unit completes an evaluation and makes the Level II determination on the review portion of the MDS and returns the MDS to the NF. The NF then sends the MCO/UR Contractor the MDS and other documentation for an NF LOC determination if a waiver was not granted.

- All subsequent PASRR Level II reviews are performed by the PASRR Unit unless waived by the PASRR Unit.
- All subsequent NF LOC determinations are made by the MCO/UR contractor.

- PASRR and readmission from a hospital: The NF contacts the PASRR Unit if the hospitalization of a resident results in a change in the Level I Screen. If an individual is hospitalized from the NF, the hospital will complete a new Level I screen prior to discharge.
- PASRR and Medicaid eligibility pending: If a resident is in a "Pending Medicaid" status at the time of MDS submission and the resident fails the Level I Screen, the MDS is forwarded to the PASRR Unit as notification while the following actions occur:
  - The NF LOC determination is made by the MCO/UR Contractor.
  - The MCO/UR Contractor transmits the NF LOC determination via the appropriate interface within 24 hours of making the NF LOC determination. The information is processed by the appropriate Income Support Division (ISD) office once received. The MCO also sends the NF notification form to the NF with the NF LOC effective dates and prior authorization information.
  - Once eligibility is established, the ISD office notifies the NF and the MCO.
  - The NF must notify the PASRR Unit of the status of the resident's eligibility.
  - The MDS, which includes the Medicaid number and the certified length of stay, is completed by the PASRR Unit.
  - Upon completion, the MDS is submitted to the MCO/UR Contractor.

6.4. Level of Care Packet for Nursing Facilities

- PASRR
- NF LOC Notification Form used for all prior approval reviews
  - All requests for prior approval will be submitted on the NF LOC Notification Form.
  - The NF should document what type of review is being requested at the top of the NF LOC Notification Form:
    - LNF initial
    - LNF- Continued Stay
    - HNF- Initial
    - HNF- Continued Stay

- Medicaid Pending- Initial
- Medicaid Pending- Continued Stay
- NF Transfer
- LOC Change
- Discharge Status
- Re- Admission
- Re-Review
- Reconsideration
- Reserve Bed Days (PA Request)
- All other required fields must be completed.

- MDS
  - An MDS and all other appropriate documentation must be completed for each resident for every situation requiring prior approval.
  - All locator fields must be clearly marked on the MDS.
  - When the resident goes from Medicare copay to Medicaid, the NF submits an Internal MDS that begins the UR process for the resident.
  - Appropriate documentation must accompany the MDS. Generally, appropriate documentation includes a valid order and must:
    - Be signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant;
    - Be dated; and
    - Indicate the LOC – either high NF (HNF) or low NF (LNF).

The NF must submit the initial NF LOC packet to the MCO no later than 30 calendar days after admission, which includes all of the above documentation and the physician's order. The MCO may assign unexcused late days if the NF submits the LOC packet later than 30 calendar days. Please refer to the Current/Retrospective Reviews Section above for more information about assignment of late days.

Once an order is signed and dated, it cannot be changed. If a change is required, a new order must be written, signed, and dated by the physician, nurse practitioner or physician assistant.

Verbal or telephone orders are permitted. The order must be taken by an RN or LPN who must also sign and date the order. It must be clearly indicated the order is a telephone or verbal order with the name of

the physician, nurse practitioner or physician assistant who gave the order and LOC. The date of the call or verbal communication is the date of the order.

The MCO approves the documentation and makes a LOC determination following the New Mexico Medicaid NF LOC Instructions and Criteria within five business days of receiving a completed packet. The MCO shall review the documentation provided to determine the appropriate NF LOC and transmits the determination via the appropriate interface file within 24 hours of making the NF LOC determination. A packet that requests LNF but meets HNF criteria shall be upgraded to HNF; a packet that requests HNF but only meets LNF criteria shall be downgraded to LNF. A new doctor's order is not required.

When required documentation is missing, an RFI sheet will be generated by the MCO and sent to the NF. If the required documentation is not provided to the MCO within 14 business days of the request, it will be technically denied. The MCO will make three attempts during the 14-business day period to contact the NF to obtain the information. The MCO will transmit a technical denial via the ASPEN interface file within 24 hours of no response from the NF. Please see Current/Retrospective Reviews for more information on assignment of late days.

Note: A formal RFI to the NF to justify the HNF request is required when reviewing and processing HNF requests that clearly do not meet HNF criteria but do meet LNF criteria or vice versa. In the event a determination is upgraded or downgraded from the physician's order the MCO shall assign the LOC and provide the NF with technical assistance to educate the NF on determination criteria. The MCO will provide the NF with a written explanation of why a HNF request is downgraded to LNF, that includes applicable citations from the NF LOC Criteria and Instructions.

The MCO faxes the NF notification form with authorization and date spans to the NF.

Short-term skilled stays:

For short term stays (90 days or less) the MCO will provide ISD with NF LOC determination dates but will only issue a prior authorization to the NF for the authorized bed days, if appropriate and after eligibility has been established.

The updated NF LOC criteria published on 01/ 01/2019 includes General Eligibility Requirements under Section V. This section explains the minimum requirements for LOC and includes information on when the MCO should not assign a LOC, but rather issue a skilled nursing authorization.

Not appropriate for NF care: The Member's needs are too complex or inappropriate for NF, such that:

- The Member requires acute level of care for adequate diagnosis, monitoring and treatment or

requires inpatient based acute rehabilitation services.

- Members who reside in a NF long-term and have a clinical episode which requires hospitalization, should be evaluated for skilled nursing services once readmitted to the facility to determine if the Member requires acute therapy related to the hospitalization.
- Members who reside in a NF long-term and have a clinical episode which does not require hospitalization, but may indicate a change in LOC, should be evaluated for HNF.
- Members who do not reside in the NF but have been hospitalized and require inpatient based acute rehabilitation services should be evaluated for skilled nursing services.

6.5. Denied NF LOC Determinations

If the NF LOC criteria is not met and the request for initial NF placement or Medicaid pending is denied, the MCO will send the referring party and the applicant a denial letter within five business days of receipt of a completed packet, with the reason for denial as determined by the MCO. The requesting provider then has the opportunity to request a re-review and/or reconsideration of the MCO's decision per the timelines indicated in section 6.15. The MCO will transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. The applicant will receive a Notice of Case Action from the ISD office, which explains the right to request an administrative hearing.
Providers who disagree with the initial review decision must request a re-review of the decision(s) before requesting a reconsideration. Please see section 6.15 for timelines and requirements.
If the NF LOC criteria are not met for an existing resident, the MCO will send the referring NF and the Member a denial letter with information regarding the right to appeal to the MCO before requesting an administrative hearing. The MCO will not transmit the denial via the ASPEN until a final appeal decision has been made or until after the allowed time to request an appeal has lapsed, whichever is later.

6.6 MCO NF LOC ASPEN Inquiries

The purpose of this section is to outline the process for MCOs to obtain additional information from HCA/MAD/Long-Term Services & Supports Bureau (LTSSB) related to NF LOC, ASPEN 112 Triggers for NF LOC, or other information that may be impacting the NF LOC status, such as:

- Receiving a Nursing Facility Packet from a facility requesting a Level of Care completion but no 112 Trigger from the ASPEN file;
- Receiving a 112 Trigger from ASPEN but no Nursing Facility Packet from a facility; or,
- MCOs wanting more information for a specific member or potential member related to NF LOC.

The Excel Spreadsheet Template *((MCO) MCO Inquiries for Nursing Facility – NFLOC)* has been provided to each MCO to submit and request information from LTSSB. An MCO can request more specific information that is shown in ASPEN or Omnicaid such as:

- 112 Trigger Date and Category of Eligibility (COE)
- Request that a 112 Trigger be sent
- MCO Verification
- MCIID Number
- Name of Nursing Facility
- Long Term Care Status date at Nursing Facility
- SOC (Setting of Care) Status
- COE status or general information related to approval or eligibility denial that affects if a 112 Trigger will be sent to the MCO

To request information, the MCO submits (upload/send) the *(MCO) MCO Inquiries for Nursing Facility - NFLOC Excel Spreadsheet Form* over the Conduent (DMZ) Enterprise Managed File Transfer to: Distribution/NM Operations/(*MCO Name)*/NF-ASPEN/To State. LTSSB will receive notification from the DMZ and download the MCO request spreadsheet and review each submission.

(MCO) MCO Inquiries for Nursing Facility - NFLOC Excel Spreadsheet Form:

The MCO will list each individual alphabetically and include the following information:

Last Name	First Name	DOB	SSN	Nursing Facility Name	NF Packet Received (Yes or No)	COE (if known)	112 Trigger Date (if received)	Applied for IC? (if known)	MCO Action Requested to LTSSB

The MCO is to include the date of the request on the spreadsheet, which should be the same date as the submission date to the DMZ.

LTSSB will send the spreadsheet back to the MCO with the following:

LTSSB Response	MCO Assigned	ASPEN MCIID #	LTSSB Inquiry to ISD (Date)

LTSSB will review each submission request by the MCO and provided information. Response time from LTSSB will vary depending upon additional information requests to ISD or other parties relative to the request.

LTSSB will complete the HCA/LTSSB section of the spreadsheet and return it to the individuals the MCO has supplied as respondents to this request. LTSSB will send the information via email and will encrypt the spreadsheet with an identified “password” that is utilized by the MCO for this purpose. The MCO should review the returned information and determine any next steps.

The spreadsheet returned to the MCO will have a “reply” or “follow-up” and date in the document name.

When information is not yet available to LTSSB the MCO may receive one or more follow-up spreadsheets with updated information.

6.7. Reserve Bed Days

Medicaid pays to hold or reserve a bed for a resident in an NF to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below.

- Medicaid covers six reserve bed days per calendar year for every LTC resident for hospitalization without prior approval. Medicaid covers three reserve bed days per calendar year for a brief home visit without prior approval.
- Medicaid covers an additional six reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan.
    - Resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.
    - The prior approval request must include the resident's name, Medicaid number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the resident during the visit or placement and a written physician order for trial placement.

Requests for additional discharge reserve bed days must be submitted by the NF to the MCO that the resident is enrolled with for prior approval. The NF follows the written process of the MCO for submission of the request, and receipt of documentation of the approval. The written process of the MCOs must also indicate if any documentation or procedures are required of the NF to assure payment of claims for approved discharge reserve bed days.

6.8. Initial Determination, Redetermination, and Pending Medicaid Eligibility

- Initial Determination: All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the NF Procedures for Requests for Prior Approval Section above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30 calendar days of admission.

  Initial length of stays:
    - Initial HNF is not to exceed thirty (30) days; however, a shorter length of stay can be assigned based on the needs of the resident;
    - Initial LNF cannot exceed ninety (90) days; however, a shorter length of stay can be assigned based on the needs of the resident.
- Redetermination: The medical documentation must be faxed and received by the MCO a minimum of 60 calendar days prior to the start date of the new certification period for LNF and 30 calendar days prior for HNF.

  Continued stay length of stays:

- HNF continued stay reviews can be certified by the MCO for up to 90 days based on the medical needs and stability of the resident.
- LNF continued stay reviews can be certified by the MCO up to 365 days based on the medical needs and stability of the resident.

Prior approval reviews are required for all requests for the continued stay of a resident in a NF. These reviews are based on the medical necessity of NF services being continually provided to the resident. The medical necessity decision is made during the continued stay review. Thirty days before the expiration of the current certification, a request for continued stay must be received by the MCO.

- Pending Medicaid Eligibility: Prior approval reviews can be done when the service is furnished before the determination of the effective date of the resident's financial eligibility for Medicaid. If the resident is applying for Medicaid, both financial and medical eligibility at the same time, please write "Medicaid Pending" in the type of request box on the Notification form. Note: A resident on SSI is not considered Medicaid Pending.
  - When an individual is admitted to a NF pending Medicaid financial eligibility, the NF submits a completed Minimum Data Set (MDS) with required documentation and a Physician's, Nurse Practitioner's or Physician Assistant's order for LOC. The Notification Form - Section I. Nursing Facility Prior Authorization Request - should have **"MEDICAID PENDING"** selected for Type of Request (Choose an item from the drop-down menu).
  - The MCO will review the information submitted and determine the NF LOC.
  - The MCO will issue NF LOC, if appropriate but will only issue a prior authorization to the NF for the authorized bed days, and after eligibility is established.
  - The MCO will review the information submitted and determine the NF LOC.
  - The Prior Authorization form will be completed by the MCO and sent to the NF.
  - The MCO will transmit the NF LOC determination via the ASPEN interface within 24 hours of making the determination.

6.9. Care Plan and Emergency Preparedness

Care Plan

The NF must develop a care plan, per 42 CFR 483.21, for each resident within 48 hours of admission, to include instructions needed to provide effective and person-centered care that meets professional

standards of quality of care. The care plan must include all specialized or rehabilitation services the NF will provide as a result of PASRR recommendations.

Emergency Preparedness

The NF must be in compliance with 42 CFR 483.73 including, but not limited to:

- Self-Assessment and Planning:
  - Develop an emergency plan based on a risk assessment;
  - Perform risk assessment using an "all-hazards" approach, focusing on capacities and capabilities; and
  - Update emergency plan at least annually.
- Policies and Procedures:
  - Develop and implement policies and procedures based on the emergency plan and risk assessment;
  - Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency; and
  - Review and update policies and procedures at least annually.
- Communication Plan
  - Develop a communication plan that complies with both Federal and State laws;
  - Coordinate patient care within the facility, across health care providers, and with State and local public health departments and emergency management systems;
  - Review and update plan annually; and
  - Share information from the emergency plan with residents, family Members or representatives, and the Member's MCO.
- Training and Testing Requirements
  - Develop and maintain training and testing programs, including initial training in policies and procedures;
  - Demonstrate knowledge of emergency procedures and provide training at least annually; and
  - Conduct drills and exercises to test the emergency plan.

6.10. Retroactive Medicaid Eligibility

Written requests for prior approval based on a resident's retroactive financial eligibility must be reviewed by the MCO within 30 calendar days of the date of the eligibility determination. The NF must submit all appropriate medical documentation to the MCO for the NF LOC determination. The MCO will transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. Requests for retroactive eligibility will not be accepted after 180 days of the Medicaid eligibility determination date. Please see NMAC 8.281.600.13.

6.11. Re-Admission Reviews

When the resident leaves the NF for three or more midnights for an inpatient hospital stay, a readmission review is required.

The NF must submit a readmit MCO approval request form within 30 calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident's admission note back to the NF.

- When the resident is readmitted to the NF and has more than 30 calendar days left on their certification, days will be assigned from the readmit date. The NF sends the notification form to the MCO along with supporting documentation.
- If the resident has less than 30 calendar days left on their certification, the NF will not submit a readmit notification form. Instead the NF should submit a redetermination (annual or continued stay) request on the notification form along with supporting documentation.

6.12. Current/Retrospective Reviews

Medical documentation for initial, redetermination, readmit and changes in LOC reviews can be reviewed retrospectively if requested by the NF.

A request for a current or a retrospective review for initial (including Medicaid pending), redetermination or readmit reviews will be considered; however, the below outlines the procedure for unexcused and excused assignment of late days by the MCO.

Unexcused late reviews

Starting July 1, 2014, the NF may lose payment for each day that the NF LOC review is submitted late. The MCOs may establish a process for unexcused late reviews and will communicate the established process to providers and HCA before implementing.

Excused Late Reviews

Prior authorization forms not submitted in a timely manner due to reasons beyond the control of the NF must be submitted to the MCO with a detailed written explanation and documentation that supports the request for an excusable late review. Reimbursement and retrospective reviews:

- If the reason for the delay in documentation submission was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO.
- Medicaid will not reimburse NFs for DOS not covered by the MCO prior authorization form. In addition, the Medicaid Member and their family Member(s)cannot be billed for the services provided by the NF. The NF will not discharge the resident due to assignment of late days by the MCO.

6.13. Transfer from Another NF

If a resident transfers from one NF to another NF, the following procedures apply:

- The receiving NF must notify the MCO by telephone that a transfer to its NF is to occur. The receiving NF will provide the MCO with the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid by the MCO.
  - If there are more than 30 calendar days on the resident's current authorization, the MCO will fax the receiving NF the completed notification form which will include the prior authorization and date span.
  - If there are less than 30 calendar days remaining on the resident's current authorization, the receiving NF shall request a continued stay on the notification form to the MCO. The MCO shall make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay. Please write "Transfer" in the type of request box on the notification form.
- The NF receiving the resident receives the status of resident's reserve bed days from the MCO through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records.

6.14. Changes in the LOC

All changes in LOC require a new notification form that should be submitted within 30 calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write "LOC

Change" in the type of request box on the notification form. The NF must provide a signed and dated order from the physician, nurse practitioner or physician assistant as well as any documentation to support the LOC request (see New Mexico NF LOC Instructions and Criteria). The date the LOC change occurred must be clearly stated.

6.15. Discharge Status

Discharge status occurs when a resident no longer meets the LOC that qualifies for NF placement, but there is no option for community placement at that time. Individuals are often already residing in an NF at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in an NF may clinically improve to the point that they no longer meet an NF LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the NF. Community-based health care and support services may be limited or unavailable. Residents may be at risk for failure to thrive outside the supportive structured environment of the NF. Physically discharging the resident under such circumstances may put the resident's health at risk.

To accommodate this health care issue, the New Mexico Medicaid program allows for temporary continuation of coverage at LNF level of reimbursement while the NF and the MCO actively address the development of community placement on an ongoing basis to meet the resident's lower level of need. The temporary continuation of coverage while discharge planning is taking place for a resident is termed "Discharge Status;" however, Discharge Status does not mean the resident is being discharged from the facility. Families and residents should not be told the resident is being discharged from the facility. The MCO Care Coordinator, family, resident, and NF will work together to develop a transition plan to safely transition the resident to an alternate SOC per Section 5 of this Manual.

- Initial Discharge Status is authorized at LNF for a maximum of 90 calendar days, based upon the MCO physician determination.
- Continued Stay Discharge Status is authorized at LNF for not less than 180 calendar days and up to 365 calendar days. Submission of a continued stay on a prior authorization form for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility staff's and MCO Care Coordinator's ongoing attempts to find and develop appropriate community placement options for the resident. The facility should document why the resident must remain in an NF environment if the resident is at risk for failure to thrive upon discharge to a community

placement. Failure to submit sufficient documentation specifying the facility's discharge planning efforts could result in the denial of prior authorization. The resident's inability to afford assisted living services may be a consideration in discharge planning.

6.16. Re-Review, Reconsideration, Appeal, Administrative Hearing

- **Re-review:** The Re-review must be requested within ten (10) calendar days after the date on the written notification of the MCO decision or action. Requests for a Re-review must be submitted in writing directly to the MCO. The MCO completes and submits a written Re-review decision to the NF within six (6) business days from receipt and will include the decision and information on the Reconsideration process. Providers who do not meet the ten (10) calendar days for a Re-review may request a Reconsideration.
- **Reconsideration:** Providers who disagree with a Re-Review NF LOC determination can request reconsideration. Members who disagree with a NF LOC determination may request the provider to pursue reconsideration on their behalf. Requests for reconsideration must be in writing and received by the MCO within thirty (30) calendar days after the date on the Re-Review decision notice. The MCO completes and submits a written Reconsideration decision to the NF within ten (10) business days of receipt and will include the decision and information on the MCO Appeals and HCA Administrative Hearing process, as appropriate. The provider or eligible recipient may file a written request for Reconsideration up to 14 calendar days past the 30-calendar day limit if the MCO finds there was "good cause" for failure to file a timely request. The provider or the eligible recipient is responsible for providing written documentation supporting "good cause" for failure to file a timely request. "Good cause" includes a death in the family, disabling personal illness, other significant emergency or executional circumstance.
    - The request for reconsideration must include the following:
        - Statement that reconsideration is requested;
        - Reference to the challenged decision or action;
        - Basis for the challenge;
        - Copies of any document(s) pertinent to the challenged decision or action; and
        - Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a decision.

Individuals employed with the MCO, who were not participants in the initial decision, conduct the Reconsideration review.

The MCO reviews the information and findings upon which the initial action was based, and any additional information submitted to, or otherwise obtained by, the MCO. The information can include the following:

- case records and other applicable documents submitted to the MCO by the provider when the request for services was initially submitted;
- findings of the reviewer resulting in the initial decision;
- complete record of the service(s) provided, including hospital or medical records; and
- additional documents submitted by the provider to support a Reconsideration review.

The MCO performs the Reconsideration and furnishes the Reconsideration decision within ten (10) business days of receipt of the Reconsideration request.

The MCO gives the provider and the eligible recipient written notice of the reconsideration determination. If the decision is adverse to the eligible recipient the notice includes information on the eligible recipient's right to an MCO appeal, HCA Administrative Fair Hearings, timeframes to file an appeal or fair hearing, and how to request continuation of benefits, as applicable.

- **Appeal:** If a reconsideration determination is adverse to the Member, the Member may request an appeal with their MCO in accordance with 8.308.15 NMAC.
- **State Administrative Fair Hearing:** After the parties have exhausted the MCO appeals process, the parties may request an administrative hearing according to State administrative rule 8.352.2 NMAC. The MCO/UR Contractor is responsible for the development of the Summary of Evidence (SOE) to ISD and for the testimony of the NF LOC denial during the fair hearing, including denied NF LOCs for Medicaid Pending residents.

6.17. Communication Forms

The MCO shall use the approved HCA forms at https://www.hca.nm.gov/providers/nursing-facility-level-of-care for communication and notification with the NFs.

6.18. External Audits of NF LOC Determinations

HCA or its designee will audit a sample of each MCO's NF LOC determinations to ensure the LOC criteria are being appropriately applied by the MCOs. Each MCO will submit a universe of NF LOC determinations to HCA or its designee for review. HCA or its designee will meet with the MCO to discuss audit findings.

6.19. MCO Internal Audits of NF LOC Determinations

Each MCO will conduct internal random sample audits of both facility and Community Benefit NF LOC determinations based on HCA NF LOC instructions and tool guidelines each quarter. The audit will include, at a minimum: accuracy, timeliness, training documentation of reviewers, and consistency of reviewers. The results and findings will be reported to HCA by the 7th day of the month following the end of the quarter along with any Quality Performance Improvement Plan via DMZ (NF LOC reviews folder). The naming convention for the results and findings file is MCO, quarter, year, internal audit results. For example, if the MCO is submitting first quarter reviews, the file shall be named "MCOname.Q1.18.internal audit results."

6.20. Nursing Facility (NF) Ventilator Services

MCOs shall be required to implement an add-on rate for Ventilator Services provided in long-term and skilled nursing facilities in New Mexico.

1. The nursing facility per diem add-on for a ventilator dependent resident will be $305.66.

2. The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report.

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

4. The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. If a resident 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.

Long-term and skilled nursing facilities in New Mexico must be certified by the Department of Health (DOH) to provide ventilator services.

Clinical Criteria for Vent Wing

To be eligible for the ventilator add-on services, the recipient must:

1. Have a health condition that requires close medical supervision defined as 24 hours a day of licensed nursing care along with specialized service or equipment;
2. Require mechanical ventilation greater than or equal to six hours a day;
3. Have tracheostomy (with daily care) and require mechanical ventilation for a portion of each day for stabilization;
4. Require continuous pulse oximetry monitoring to check the stability of oxygen saturation levels;
5. Require respiratory assessment and daily documentation by a licensed respiratory therapist or registered nurse;
6. Have a provider's order for respiratory care to include suctioning as needed;
7. Have tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the four treatment procedures listed below:
    - o Total parenteral nutrition
    - o Inpatient physical, occupational, and/or speech therapy
    - o Tube feeding (nasogastric or gastrostomy)
    - o Inhalation therapy treatments every shift and a minimum of four times per 24-hour period
8. The recipient's diagnosis must be consistent with ICD diagnosis codes for ventilator dependency;
9. The skilled nursing facility must be approved for ventilator care;
10. Providers must be specially trained and competent in respiratory and vent care.

Vent Wing Procedure Codes, Diagnosis Code and Rate

Long-term and skilled nursing facilities in New Mexico that provide Ventilator Services that meet the clinical criteria can bill the add-on service with the following claim information:

Provider Type	Revenue Code	Description	Rate	Effective Date
211 or 212	0947	Other therapeutic svcs-complex medical equipment ancillary	$305.66	March 14, 2022

Append CPT 94004-Nursing facility ventilation assistance and management to revenue code on above table. The claim must also reflect an ICD-10 diagnosis code of Z99.11-Dependence on respirator (ventilator) status.

6.21. Short-Term Stays

Providers will use revenue code 0190 when billing for non-skilled, non-hospice short-term stays in a Nursing Facility (NF) for less than 90 days. These stays do not require a Nursing Facility Level of Care (NF LOC). The MCOs must reimburse the NF at the NF's contracted rate for a Low NF (LNF) stay, and there are no High NF (HNF) determinations or Institutional Settings of Care (SOCs) issued for these types of stays. The non-skilled, non-hospice short-term stay is provided under the Member's physical health benefit.

6.22. MCO Termination on NF Contract

If an MCO decides to terminate its contract with a Nursing Facility, it must follow the approved process in the MCO contract with HCA and submit a transition plan to HCA for all impacted Members per Section 2 of this manual. The MCO will collaborate with HCA, ALTSD and DOH staff to ensure a successful transition for all of its Members to another MCO, to another NF or to the community. The MCO will provide documents to include the rationale for its decision to terminate the contract to the HCA upon request. The MCO will work closely with the NF to ensure that all authorization and claims issues are addressed. The HCA will communicate the termination to other MCOs.

6.23 Closure of a Nursing Facility

When HCA is notified about a pending closure of a NF, it will notify the MCOs of the closure and will request a census of impacted Members from each MCO. The MCOs must follow the process outlined in Section 2 of this manual. HCA will require ongoing weekly updates from each MCO on their progress with transitioning Members to other settings. Throughout the closure and transition process, the MCOs will collaborate with HCA, ALTSD and DOH staff, including the ALTSD ombudsman. The MCOs will work closely with the NF to ensure that all authorization and claims issues are addressed.

6.24. Tribal 638 Nursing Facilities

Tribal 638 Nursing Facilities (NFs) are to be reimbursed for NF services at the Outpatient OMB rate. Approved NFs will have an Indian Health Service (IHS) indicator on the provider enrollment file.

MCOs will not pay less than the current calendar year OMB rate for Tribal 638 nursing facilities under the authority of 42 CFR 438.14(c)(2).

For approved NFs, there will be one single daily rate for both High Nursing Facility (HNF) and Low Nursing Facility (LNF). The rate is published annually by CMS as the Outpatient OMB rate. For an approved NF to receive the Outpatient OMB rate, the member must meet a LNF in accordance with the NF LOC Criteria Instructions 2019 that may be found at

https://www.hsd.state.nm.us/providers/nursing-facility-level-of-care/

The MCOs are to reimburse for reserve bed days at a rate of one-half of the Outpatient OMB rate in accordance with 8.312.2.16D NMAC.

6.25. Denial of Payment for New Admissions (DPNA)

Under the Social Security Act at §§1819(h) and 1919(h) and CMS's regulations at 42 CFR 488.417, CMS may impose a Denial of Payment for New Admissions (DPNA) against a Nursing or Long-Term Care Facility when CMS finds that a facility (1) fails to be in substantial compliance for three months after the last day of the survey identifying the noncompliance, or (2) is found to have provided substandard quality of care on the last three consecutive standard surveys. DPNA notifications are sent to HCA from CMS. HCA will then, in turn, send the information to all MCOs through the deliverable process. The alert will include information about the facility with the penalty and the dates which the DPNA will apply. Alerts may be for dates which have already passed.

MCO must determine if they have members who are admitted into the named facility during the listed dates. MCO should continue to monitor billing for the dates in question to make sure all potential admissions are included. Please note, the DPNA applies to new admissions into the facility and not established residents. If the MCO determines the criteria does not apply to any of their members, no action is needed. If it does apply to any member, the MCO is required to recover any payments made to the facility for said member for the outlined time period. The entity (facility) is responsible and subject to the financial penalty, not the MCO or the member. Therefore, the MCO must ensure that the resident/member is not then held responsible for the payment recovered by the MCO. Also, this will not impact the capitation received by the MCO for the member. The member will still have Medicaid eligibility and will still need to complete all steps to keep eligibility, including paying any required PPA.