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8.311.5 SWING BED HOSPITAL SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 5 SWING BED HOSPITAL SERVICES

8.311.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.311.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

8.311.5.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.311.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.311.5.3 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; 8.311.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

8.311.5.4 DURATION: Permanent
[2/1/95; 8.311.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.311.5.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.311.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.311.5.6 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; 8.311.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.311.5.7 DEFINITIONS: [RESERVED]

8.311.5.8 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; 8.311.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.311.5.9 SWING BED HOSPITAL SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for services furnished in general hospital settings which can also be used interchangeably as high or low nursing facility beds. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[2/1/95; 8.311.5.9 NMAC - Rn, 8 NMAC 4.MAD.723, 3/1/12]

8.311.5.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, small rural hospitals that meet the following requirements are eligible to be reimbursed for providing services as swing bed providers:

(1) hospital is licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH) to participate in the medicare and/or the medicaid programs and has received additional certification from the DOH to act as a swing bed provider;

(2) hospital must have fewer than 100 inpatient hospital beds, counting all inpatient hospital beds maintained by the hospital, exclusive of beds for newborns and intensive care beds; and

(3) hospital must be located in a rural area; any geographic area not designated as “urban” in the most recent census is considered “rural” for the purpose of this regulation.

B. Since a swing bed hospital already has an approved provider agreement for the provision of acute care services, a separate agreement for swing bed services is not required. An addendum to the current provider agreement grants approval for swing bed participation.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[2/1/95; 8.311.5.10 NMAC - Rn, 8 NMAC 4.MAD.723.1, 3/1/12]

8.311.5.11 CONDITIONS OF PARTICIPATION: To participate as a swing bed hospital, the facility must comply with the following conditions:

A. be licensed and certified as meeting all the requirements for participation as a hospital;

B. meet the requirements for hospital providers of long term care services. See 42 CFR 405.1041;

C. conform to MAD policy regarding recipient's personal funds; and

D. have an addendum to the medicaid provider agreement which conveys approval for swing bed participation; hospitals which have a waiver of the twenty-four (24) hour coverage requirement of Section 1861(e)(s) of the Social Security Act are not eligible to participate as swing bed hospitals.
[2/1/95; 8.311.5.11 NMAC - Rn, 8 NMAC 4.MAD.723.2, 3/1/12]

8.311.5.12 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC *General Provider Policies*.
[2/1/95; 8.311.5.12 NMAC - Rn, 8 NMAC 4.MAD.723.3, 3/1/12]

8.311.5.13 COVERED SERVICES: Medicaid covers hospital and nursing facility (low or high level) services which are medically necessary for the diagnosis and/or treatment of an illness or injury as indicated by the condition of the recipient.
[2/1/95; 8.311.5.13 NMAC - Rn, 8 NMAC 4.MAD.723.4, 3/1/12]

8.311.5.14 NONCOVERED SERVICES: Swing bed services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.
[2/1/95; 8.311.5.14 NMAC - Rn, 8 NMAC 4.MAD.723.5, 3/1/12]

8.311.5.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid 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 approval and claims processing.

A. **Prior approval:** All utilization review activities, including level of care determinations and length of stay assignments for recipients at a nursing facility are carried out according to established MAD policy. All physical therapy, occupational therapy, and speech therapy furnished to inpatients in swing bed facilities at a high or low level require prior approval. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. 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. **Reconsideration:** Providers who disagree with prior approval request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.
[2/1/95; 8.311.5.15 NMAC - Rn, 8 NMAC 4.MAD.723.6, 3/1/12]

8.311.5.16 RECIPIENT PERSONAL FUNDS ACCOUNTS:

A. As a condition for participation in medicaid, each swing bed provider must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that his/her personal funds be cared for by the facility. See 42 CFR 483.10(c).

(1) Requests for swing bed providers to care or not care for a recipient's funds must be made in writing and secured by the request to handle recipient's fund form or a letter signed by the recipient or his/her representative. The form or letter is kept in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowable, established by MAD. If the recipient receives any income in excess of this allowance, the excess is applied to the cost of the recipient's medical care at the facility. This excess is reported as a medical care credit to the swing bed provider by the local county income support division (ISD) office, when applicable.

(3) All swing bed facilities must have procedures for handling of medicaid recipients' funds. These procedures must not allow the facility to commingle medicaid recipients' funds with facility funds.

(4) Swing bed facilities should use medicaid guidelines to develop procedures for handling recipient funds.

(5) Recipients have the right to manage their financial affairs and no facility can require recipients 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:** Swing bed 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.

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

(a) reconcile balances of the individual medicaid recipients' 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) Facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each recipient's personal funds entrusted to the facilities on the recipient's behalf.

C. **Bank account:** Swing bed facilities must establish a bank account for the deposit of all money for medicaid recipients who request the facility to handle their funds. Recipients' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any recipient's personal funds more than fifty ($ 50) dollars in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the recipient's account to that account.

(2) Facilities must maintain recipients' personal funds up to fifty ($50) in a non-interest bearing account or a petty cash fund. Recipients must have convenient access to these funds.

(3) Individual financial records must be available on the request of recipients or their legal representatives.

(4) Within thirty (30) days of the death of a recipient whose personal funds are deposited with the facility, a swing bed provider must convey the recipient's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the recipient's estate.

D. **Establishment of individual accounts:** Swing bed facilities must establish an account for each medicaid recipient in which all transactions can be recorded. Accounts can be maintained in a general ledger book, a card file or looseleaf binder.

(1) For money received, the source, amount and date is recorded. Recipients or their authorized representatives must be given receipts for the money. The swing bed facility retains a copy of the deposit in the recipient's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of recipients must be recorded. Any money spent either on behalf of recipients or withdrawn by recipients or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid recipient 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 recipient's other nonexempt resources reach the SSI resource limit for one person, the recipient can lose eligibility for medicaid or SSI.

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

F. **Petty cash fund:** A swing bed facility must maintain a cash fund in the facility to accommodate the small cash requirements of medicaid recipients. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money kept in the petty cash fund is determined by the number of recipients using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all action regarding money in this fund.

(1) To establish the fund, the swing bed facility 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 the individual ledger record; and

(c) the recipient or 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 procedure should be used 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 petty cash total.

(5) To close the recipient account, the swing bed facility should to 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; and

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

(6) Within thirty (30) days of the death of a recipient who has no relatives, the swing bed facility conveys the recipient's funds and a final accounting of the funds to the individual or probate jurisdiction administering the recipient's estate. See 42 CFR 483.10(c)(6).

G. **Retention of records:** All account records are retained for a minimum of three (3) years or, in case of an audit, until the audit is completed.

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

(1) Non-acceptable uses of recipients' personal funds include the following:

(a) payment or charges for services or supplies covered by medicaid or medicare-specified as allowable costs; see Subsection G of 8.312.3.11 NMAC, *Costs Related Reimbursement of Nursing Facilities*;

(b) difference between the swing bed facility's billed charge and the medicaid payment; and

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

(2) A swing bed facility cannot impose charges against recipients' personal funds for any item or service for which payment is made by medicaid or for any item recipients or their representatives did not request. Facilities must not require recipients or representatives to request any item or service as a condition of admission or continued stay. Swing bed facilities must inform recipients or representatives who request a noncovered item or service that there is a charge for the item and the amount of the charge.

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

(1) The licensing and certification bureau of the DOH verifies that facilities have established systems to account for recipients' 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 recipients' personal funds at HSD's discretion.

[2/1/95; 8.311.5.16 NMAC - Rn, 8 NMAC 4.MAD.723.7, 3/1/12]

8.311.5.17 PATIENT SELF DETERMINATION ACT: All adult recipients must be informed of their right to make health decisions, including their right to accept or refuse medical treatment, as specific in the Patient Self-Determination Act. See 8.302.1.18 NMAC, *General Provider Policies*.
[2/1/95; 8.311.5.17 NMAC - Rn, 8 NMAC 4.MAD.723.8, 3/1/12]

8.311.5.18 RESERVE BED DAYS: To allow recipients to visit family or friends for short periods of approved therapeutic leave or to allow trial placement to adjust to a new environment as part of a discharge plan, MAD pays the routine rate to hold or reserve the bed for the recipient's return.

A. **Coverage of reserve bed days:** Medicaid covers six (6) reserve bed days per calendar year for every swing bed recipient at a high or low nursing facility level without prior approval of the reserve days for any reason other than acute hospitalization, including home visits and acclimation to a new environment. Medicaid covers an additional six (6) days per calendar year with prior approval for visits which help the recipient adjust to a new environment, as part of a discharge plan.

(1) In these cases, the recipient's discharge plan must clearly state objectives including how the home visit or visit to alternative placement relates to discharge implementation.

(2) The prior approval request must include the recipient's name, medicaid number, requested approval dates, and a copy of the discharge plan.

B. **Reserve bed days and services not covered:** Medicaid does not cover reserve bed days used for transfer to a nursing facility. Medicaid does not pay for ancillary services associated with reserve bed days.

C. **Level of care determinations needed:** A new level of care determination must be performed if a recipient is gone from the facility for more than three (3) midnights. An abstract must be completed which includes the reason the recipient was absent, outcome of the leave and any other pertinent information.

D. **Reimbursement and billing:** Reimbursement to a hospital is limited to the rate applicable for the level of care medically necessary for the eligible recipient as determined and certified by MAD. Billing for reserve beds days is based on the nursing census, which runs from midnight to midnight. Under normal circumstances, medicaid pays for the admission day but does not pay for the discharge day. The same principle applies in calculating and billing reserve bed days.
[2/1/95; 8.311.5.18 NMAC - Rn, 8 NMAC 4.MAD.723.9, 3/1/12]

8.311.5.19 REIMBURSEMENT: Swing bed providers must submit claims for reimbursement on the long term care turn around document (TAD) or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Swing bed hospitals are paid for high and low nursing facility routine services at the statewide average rates paid under the state plan during the previous calendar year to nursing facilities, as appropriate.

A. The following services or items are considered routine and are reimbursed as part of the routine rate:

(1) regular room;

(2) dietary and nursing services;

(3) medical and surgical supplies, including syringes, catheters, ileostomy, and colostomy supplies;

(4) use of equipment and facilities;

(5) general services, including administration of oxygen and related medications, hand feeding, incontinence care, tray service and enemas;

(6) standard items furnished routinely to all patients, such as patient gowns, water pitchers, basins and bed pans;

(7) items stocked at nursing stations in gross supply and distributed or used individually in small quantities such as cotton balls, band aids, laxatives, stool softeners, aspirin, antacids, OTC ointments and tongue depressors;

(8) reusable items expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment and other durable medical equipment;

(9) laundry services, including basic personal laundry;

(10) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician; and

(11) oxygen.

B. **Ancillary services:** Ancillary services are reimbursed at the same rate as outpatient services. Swing bed providers must submit claims using its hospital provider number for ancillary services on the UB-92 claim form or its successor. The reasonable costs of ancillary services for swing bed facility levels of care are

determined in the same manner as for outpatient hospital services. Ancillary services are those services not considered routine, such as lab, radiology, pharmacy, and therapies.

C. **Cost allocation:** To allocate costs between hospital and long term care services, the total reimbursement due for all classes of long-term care recipients is subtracted from the hospital's total routine costs, before determining reimbursement for routine hospital services.

D. **Medical care credits:** If a recipient has income above the maintenance allowance, MAD reimburses the provider facility the difference between the allowed rate and the medical care credit. The facility is responsible for collecting the amount reported as a medical care credit.

[2/1/95; 8.311.5.19 NMAC - Rn, 8 NMAC 4.MAD.723.10, 3/1/12]

HISTORY OF 8.311.5 NMAC: [RESERVED]