State of New Mexico
Medical Assistance Program Manual

Supplement

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TO: ALL PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: CAROLYN INGRAM, DIRECTOR, MEDICAL ASSISTANCE DIVISION

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SUBJECTS:
I. REMITTANCE ADVICES ON THE WEB AND PHASING OUT PAPER REMITTANCE ADVICES AND CHECKS
II. FINAL DEADLINES FOR USING NATIONAL PROVIDER IDENTIFIER (NPI) ON NEW MEXICO MEDICAID CLAIMS
III. PROVIDER FEE INCREASE NOTICE

This supplement contains very important information regarding (1) phasing out the paper remittance advice; (2) new NPI requirement deadlines; and (3) a notice of provider fee increases.

Please specifically note the following and refer to the detailed information in this supplement:

- **Effective with the remittance advice (RA) dated October 8, 2007, providers who are registered as Web Portal users will no longer be mailed a paper RA. Providers who register as Web Portal users after that date will also no longer receive a paper RA. Instead, the provider will obtain the RA on the web.**

- **New Mexico Medicaid claims received after January 31, 2008 must reflect NPI as described in this document, below.**

I. PHASING OUT PAPER REMITTANCE ADVICES AND CHECKS

The Medical Assistance Division (MAD) has initiated a number of projects that will eventually eliminate the distribution of paper remittance advices (RAs) and checks (also referred to as "warrants"). Providers have expressed a great deal of interest in receiving electronic RAs and in receiving payment via electronic funds transfer (EFT). At the same time, the cost of mailing paper RAs and checks continues to rise. In fact, MAD's postage costs have increased by more than 50 percent since the new postage rates went into effect in May.

When completed, these initiatives will allow providers a choice of downloading RAs from the Internet, receiving HIPAA 835 electronic remittance advice transactions, or both. In addition, providers will receive payment via electronic funds transfer instead of a paper check.

The project is being implemented in four phases, as described below:

Phase 1: Last year, ACS implemented an enhanced Web Portal that allows providers who have registered as web users to access their most recent RAs. These RAs may be downloaded, printed, saved to a computer, or burned to CD. RAs for all providers are currently available on the ACS Web Portal, so you may access your RAs as soon as you register as a Web Portal user. The RAs are usually available on Sunday, and no later than Monday morning.

Phase 2: Effective with the RA dated October 8, 2007, providers who are registered as Web Portal users will no longer receive a paper RA. Providers who register as Web Portal users after that date will no longer receive a paper RA.

Checks will continue to be mailed. Providers who normally pick up their RAs at the ACS office in Santa Fe or Albuquerque will be able to pick up their checks even though their RA is no longer being printed. (Before going to the ACS office, however, such providers should verify via the Web Portal or Automated Voice Response System that they are due a payment that week.) If for some reason your provider organization is not able to access the RA online even though it uses the Web Portal for eligibility or other functions, please contact the ACS HIPAA Help Desk. Exceptions may be made for those providers who can show that not receiving a paper RA will be a hardship for their organization.

Phase 3: The State is working to finalize the system changes required to produce the HIPAA 835 electronic remittance advice. We anticipate that we will begin testing the 835 transaction with those submitters who are able to receive and process this transaction within the next three months. ACS will update you on the status of this project and explain the procedures for receiving the 835 as we get closer to its implementation.

Phase 4: The State is developing the system modifications required to produce electronic payments via electronic funds transfer (EFT). We anticipate that this capability will be available within the next 6 months. Prior to its implementation, you will be informed of the procedures for submitting your banking information so we can start depositing your Medicaid payments directly into your bank account.

After these enhancements have been implemented, MAD will eventually require all providers to receive their RAs via the Web Portal or 835, and to receive payment via EFT instead of a paper check. As noted above, exceptions may be made for those providers who can show that not receiving a paper RA will be a hardship for their organization.

MAD encourages all providers to register as users of the ACS Web Portal. In addition to downloading your RAs, the Web Portal enables you to verify eligibility and obtain claim status, prior authorization, and payment information. To register, go to http://nmmedicaid.acs-inc.com.

Once you have registered as a Web Portal user, accessing your RA is easy:

- Click on the "*Reports & Data Files*" link.
- Click on the "*PDF Reports*" link.
- You will then see links to the "reports" available to your provider number. In most cases, there will be only one link, to your RAs. Click on the Remittance Advice (RA) Report link for the RAs. (IMPORTANT: If you have logged in to the Web Portal using your NPI you will first have to select the NM Medicaid ID for the RAs you want to access. Once you have selected the Medicaid ID, click on "submit" and you will see links to the reports available for that provider number. Click on the link to the RAs. Note that you will have an opportunity to select another provider ID later. You will not have to log out and log in again to access RAs for other NM Medicaid provider IDs associated with your NPI.)
- Click on the link to the RA you want to view.
- After selecting the RA, click on the View Report icon to the right of the page. You may then open and/or save the RA. When you open your RA through Adobe Reader, you may view or print.

If your provider organization uses the ACS Web Portal for some features but not for accessing the RA, please take the following steps to prepare for accessing the RA on-line:

- Determine whether any of your organization's Web Portal users has the security privilege for "Reports & Data Files."
- If none do, assign this privilege to one or more users so they can access the RA on-line. We recommend that more than one user be assigned the "Reports & Data Files" privilege. This takes only a few minutes to accomplish.

If you need help with this activity or with any aspect of the Web Portal, please contact the ACS HIPAA Help Desk at 1-800-299-7304 and select option 5 from the provider services menu.

II. NPI DEADLINE, NPI REQUIREMENTS AND NEW CLAIM FORMS

These instructions are in addition to the previous information we have provided on the National Provider Identifier (NPI). The previous supplements (number 07-01 and number 07-03) can be seen on the MAD website at: http://www.hsd.state.nm.us/mad/npi.html

New Mexico Medicaid claims received after January 31, 2008 must reflect NPI.

A. New Claim Forms

New Mexico Medicaid is currently accepting only those paper claims submitted on the forms identified below. Claims received by ACS prior to February 1, 2008, may reflect either the provider's NPI and taxonomy (as needed) or the Medicaid ID. Beginning February 1, 2008, paper claims must reflect NPI and taxonomy (as needed).

1500 Format – must be a red original form CMS-1500 (08/05 version) that includes fields for the NPI and taxonomy. The NPI and taxonomy must be completed for the billing provider as well as the rendering providers identified on the claim lines.

UB format – must be a red original form UB-04 version that includes fields for the NPI numbers and taxonomy. The NPI and taxonomy must be completed for the billing provider identified for the claim. Identify the attending physician with the NPI and taxonomy.

Dental format – must be the ADA 2006 form that includes fields for the NPI and taxonomy. Knowing that there are issues with dental providers obtaining red copies of the dental claim form, the new dental claim form will continue to be accepted even if it is not a red form until the issue has been resolved. At this time, we can assure dental providers that the ADA form is available in red. The form number is J404. Providers have to ask for form J404, not J400.

Pharmacy format – must be the Universal Drug Claim Form issued by the NCPDP that includes positions for the pharmacy NPI and taxonomy and NPI for the prescribers.

UB and 1500 forms must be original red forms. These requirements apply to all resubmitted claims and claims submitted for adjustments or re-consideration with correspondence. They cannot be photocopied or otherwise duplicated forms. Forms that aren't red will be returned to the provider.

B. Deadlines To Use NPI

Beginning February 1, 2008, paper claims must reflect NPI and taxonomy (as needed). There will be no extensions to this deadline. Paper claims received after January 31, 2008, without appropriate NPI and taxonomy (as needed) will be returned, except in the following cases:

Non-Health Care Providers – only "Atypical" providers (non-healthcare providers) may continue to file claims using their Medicaid provider ID Number, but still must use the new claim forms. These include personal care option (PCO) providers, handivans, taxis, and meals and lodging providers. Some home and community based service (HCBS) waiver providers may be exempt. Schools and behavioral health providers are not exempt and must obtain NPI numbers.

Waiver Providers – if an HCBS waiver provider ONLY renders administrative services such as helping coordinate non-medical services, supports living arrangements (assisted, family, independent, supported, and environmental modifications), supplies homemaker, respite or transportation services, the provider would be "Atypical" and will not need an NPI number. Generally, however, an HCBS waiver provider will need to apply for and use an NPI, particularly if any of their services are provided by a licensed healthcare provider such as an RN, an LPN, a therapist, etc.

C. Use Of Taxonomy

If a professional services provider (that is, not a hospital or nursing facility) renders multiple types of service under the same business address and the same federal tax ID, the provider may choose to use just one NPI number because the provider's "taxonomy" on the claim form will direct ACS to the appropriate provider to pay. Absence of a valid taxonomy may cause New Mexico Medicaid claim denials for providers using one NPI for multiple types of service.

Taxonomy – providers must select a taxonomy when applying for the NPI number. However, the provider is not restricted to using this same taxonomy on all claims if the provider has other types of claims or business that are best described by a different taxonomy.

Selecting Taxonomy for a Claim – providers that need to reflect taxonomy must select an approved taxonomy for their provider type from the tables available at: http://www.hsd.state.nm.us/mad/pdf_files/Supplements/REG_S_07-03.pdf for use on New Mexico Medicaid claims. Taxonomy will be used by ACS to locate the appropriate Medicaid provider ID number when the provider has one ID number for two or more lines of business. For example, if a home health agency also has a hospice Medicaid provider ID number and a private duty nursing number, and the provider chooses to apply for only one NPI, different taxonomies are used by the provider to indicate when the claim is for home health, hospice, or private duty nursing.

Placement of Taxonomy on Claim Form

- The billing provider's taxonomy code must be placed in Form Locator (FL) 81a, b, c, or d of the UB-04 claim form. There are two fields on each line of FL 81. The first field is for the two-digit qualifier 'B3' which identifies the next form field as a taxonomy code. The next field must contain the billing provider's taxonomy code.

- For inpatient claims on the UB-04 claim form, the attending provider's NPI must be placed in FL 76 in the first un-shaded field on the first line. The second un-shaded field of FL 76 is for qualifier 'B3' which will indicate the following field contains a taxonomy code.

- The billing provider's taxonomy code must be placed in FL 33b of the CMS-1500 claim form with a preceding two-digit qualifier 'ZZ' (no spaces between values).

- The rendering provider's taxonomy code on the CMS-1500 must be placed in FL 24J (shaded) with the corresponding qualifier 'ZZ' placed in FL 24I (shaded) when an NPI is populated in FL 24J (unshaded).

- The referring provider's taxonomy is optional for NM Medicaid submissions but may be placed in FL 17a of the CMS-1500 claim form with the qualifier 'ZZ' in first box.

- The service facility NPI must be placed in FL 32a of the CMS-1500 claim form when any valid service line contains a place of service equal to 21, 22, 23, 31, 32, 51, or 54. The

service facility taxonomy is optional for NM Medicaid submissions but may be placed in FL 32b with the appropriate preceding two-digit qualifier 'ZZ' (no spaces between values).

Should you have questions on any NPI requirements, please contact ACS at: 1-800-299-7304 option 5 after you have entered your provider number.

III. Notice of Provider Fee Increase

The budget approved by the Legislature and Governor included money to the Human Services Department (HSD) to increase payments to providers of services paid by the Medicaid Program. This notice is being published to inform providers of the proposed increase in reimbursement, the method for implementing the increase, and the providers and services for which a reimbursement change is planned.

In determining Medicaid reimbursement changes, several guiding principles were considered. Among these principles were the following:

- Promoting preventative and cost effective care, including early periodic screening, diagnosis, and treatment (EPSDT) of children and prenatal care.
- Establishing parity among similar services when disparity currently exists.
- Considering the national fee schedule on a one-time basis for the purpose of comparing the relative valuations between procedures.
- Considering when payment includes reimbursement for materials which have increased in cost.
- Considering the frequency and history of past fee increases and decreases for the service or provider, and situations where a provider type may be almost exclusively dependent on Medicaid levels of reimbursement.
- Meeting the federal definition, levels, and requirements for reasonableness of reimbursement; not exceeding federal limits on reimbursement; and following Medicaid program policy.
- Considering available funding and legislative language.

Following is a description of the planned changes in reimbursement:

A. Professional, Practitioner, and Other Services

For physicians and practitioners, most services billed using Current Procedural Terminology (CPT) will be increased to 105% of the 2006 Medicare fee schedule. However, reimbursement for nursing facility visits and Early Periodic Screening Diagnosis and Treatment (EPSDT) well child screenings will be increased to 115% of the 2006 Medicare fee schedule. Obstetrical services will be increased to 125% of the 2006 Medicare fee schedule. Dental services will be increased, at a minimum, to 85% of the ADA 2003 fee survey with some services for children at 100% of that fee survey amount. Laboratory codes will continue to be reimbursed at rates established by the Centers for

Medicare and Medicaid Services (CMS). All other limitations in payment will continue to apply.

The maximum reimbursement level applicable to air ambulance flight services for which bid prices are not required will be increased by 20%. Case management will be increased by 3% for services billed in 15 minute increments.

B. Institutional, Clinic Facility, and Alternatives to Institutional Care

For inpatient hospital services the DRG base rate and capital (pass through) rate will be increased by 3.8%. ICF-MR facility rates will be increased by 3%.

FQHC and rural health clinic rates will be increased by 4.1% using the Consumer Price Index-Urban (CPI-U), not to exceed the maximum allowed by CMS.

Personal care option delegated and directed services will be increased by approximately 1%. The first 100 hours of delegated services will be reimbursed at a blended rate rather than a tiered rate. A detailed separate notice is being sent to personal care option providers giving more detail on how this change will be implemented.

C. Behavioral Health Services

For a 50-minute diagnosis session the rate was established at $120 for a psychologist and $104.25 for a psychiatric nurse specialist. For 50 minutes of therapy the rate was established at $100 for a physician, $75 for a psychologist, and $69 for an MS/MA or psychiatric nurse specialist. Similar services were compared to these rates adding additional amounts for additional complexity. A complete detailed fee schedule is available as indicated below.

The PSR group rate was established at $5.25, the individual PSR rate at $14.00, the case management rate at $14.00, and the behavior management service at $8.00; all for 15 minute units.

D. Home and Community Based Services Waivers

Most services funded from this appropriation were increased by 3%, not including the case management assessment fee, the private duty nursing rate, or old codes for older definitions of service for which new codes with new definitions are now available. Additional funding directly through the DD waiver for services will increase DD rates for some supported living and supported employment services. A complete fee schedule will be sent directly to waiver providers and be available on the website listed below.

The total amount of these expenditures will be approximately $45,200,000.

For more detailed information, please visit the Medical Assistance website at http://www.state.nm.us/hsd/mad/Index.html or contact the Medical Assistance Division. Comments may also be sent to the Medical Assistance Division at P.O. Box 2348, Santa Fe, NM 87504-2348.

If you would like to discuss this fee increase with someone in the Medical Assistance Division, please contact (505) 827-3181. You will then be referred to the appropriate staff member.

The fee increases are anticipated to be implemented retroactive to dates of service beginning July 1, 2007. ACS will reprocess any claims with dates of service between July 1, 2007 and the date that ACS begins to pay the new rate. Providers will not be required to send claim adjustment requests to ACS in order to be paid the increased rate.

We are pleased that this is the second year in a row that the Medicaid Program has been able to give significant fee increases. We appreciate your participation in the Medical Assistance Program.