State of New Mexico
Medical Assistance Program Manual

Supplement

DATE: March 31, 2011 **NUMBER: 11-03**

TO: ALL PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: JULIE B.WEINBERG, ACTING DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS:

SUBJECT I:

EFFECTIVE MAY 1, 2011, ALL PRACTITIONER ADMINISTERED DRUG ITEMS MUST BE BILLED WITH NDC CODES.

In supplement 10-03, dated May 15, 2010, the New Mexico Medicaid Program announced the implementation of federal requirements for billing for drug items administered in practitioners' offices, outpatient clinics and hospitals.

The first phase of this program became effective on September 1, 2010 and required NDC codes for the "top 20" drug items as required by the federal Centers for Medicare and Medicaid

Services (CMS).

The second phase of this requirement will become effective May 1, 2011. (The second phase was originally announced to be effective on January 1, 2011, but has been delayed until May 1, 2011).

For dates of services on or after May 1, 2011, ACS will begin to deny all claims that do not indicate a valid NDC when billing for the following HCPCS or CPT codes:

Codes in the range J0120 - J9999 (various injections and chemotherapy)
Codes in the range S0012 - S0197 and S4990 - S5014 (various items)
Codes in the range S5550 - S5571 (insulin injections)
Codes in the range 90281 – 90399 (immune globulins)

The same requirement applies to providers billing revenue codes on the UB04 claim form. HCPCS or CPT codes are required whenever the provider bills one of the following revenue codes and the provider is an outpatient hospital, emergency room facility, dialysis facility, other outpatient facility which uses the UB04 claim form. When the reported HCPCS or CPT code is one of the above, the NDC code must also be reported:

Pharmacy revenue codes 0250, 0251, 0252, and 0254
Pharmacy revenue codes 0631, 0632, 0633, 0634, 0635, and 0636

Providers paid on the basis of an encounter rate such as an FQHC, an IHS or tribal compact facility or a bundled rate such as drugs included in a dialysis cap charge do not need to supply an NDC code because they are not reimbursed using one of the above revenue codes.

INSTRUCTIONS FOR BILLING DRUG ITEMS ADMINISTERED IN PROVIDER OFFICES, OUTPATIENT CLINICS AND HOSPITALS

Because reporting the NDC code requires providers to use both the upper and lower rows on a claim line, be certain to line up the information accurately so that all characters fall within the proper box and row.

CMS1500 FORM

Beginning at the left edge of the shaded area of field 24A, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC. For example, the entry for the NDC code 00054352763 will be: N400054352763.

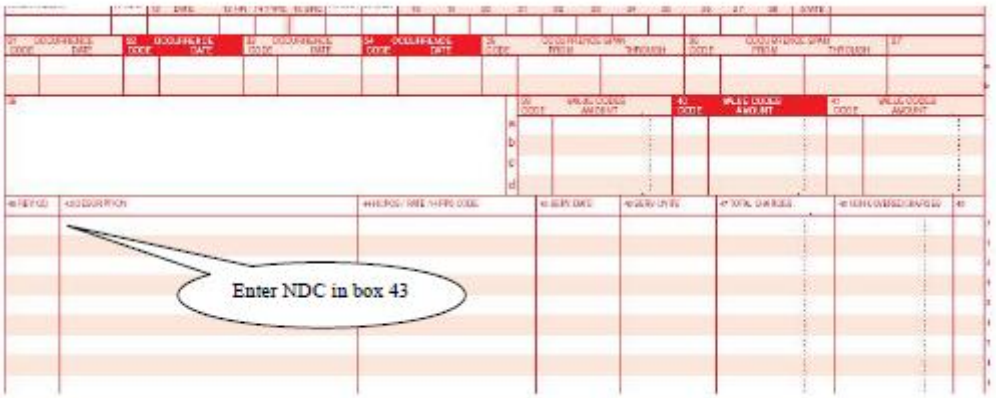
Even though an NDC is entered, a valid HCPCS or CPT code must be entered in the non-shaded area of 24D. The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code. For example, J0610 "Injection Calcium Gluconate, per 10 ml" is billed as 1 unit for each 10 ml ampul used.

Optional Information:
While the minimal new information required by MAD is the qualifier, the NDC and correct reporting of units for the HCPCS or CPT code, there are additional national standards for reporting more information on drug items that other payers may eventually require. MAD is also capable of receiving the additional information when submitted on a claim but it is not required at this time. A provider changing their billing system may want to also add information according to the following format:

- At the left edge of the shaded area of field 24A, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC, followed by 3 spaces, followed by one of the four (4) qualifiers for unit of measurement followed immediately by the quantity.

- The four (4) units of measure qualifiers are:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Units

UB04 FORM
Even though an NDC is entered, a valid revenue code must be entered in form locator 42 and a HCPCS or CPT code must be entered in form locator 44. The NDC must be entered in box 43, which is currently labeled as "description". Beginning at the left edge of form locator 43, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC. An example of an entry for the NDC code 00054352763 will be: N400054352763.



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837 P and 837 I
You will need to notify your billing or software vendor that the NDC code is to be reported in the following fields in the 837 format:
loop 2410
seg LIN
field LIN02: use the qualifier "N4"
field LIN03: place the 11 digit NDC here

Follow the companion guides for more information.

SUBJECT II

EFFECTIVE APRIL 1, 2011: BILLING FOR VACCINES FOR CHILDREN

MAD has reconsidered how providers should bill the Medicaid Fee-for-Service program for vaccine codes.

Effective for dates of service April 1, 2011, new immunization administration CPT codes 90460 and 90461 will replace codes 90465, 90466, 90467, and 90468.

90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

90461 – Each additional vaccine/toxoid component

When these vaccines are supplied to the provider by the Vaccines for Children Program (VFC)-the Medicaid program does not make payment to the provider for the vaccine, but only for the service of injecting the vaccine.

Use of 90460: Effective for dates of service beginning April 1, 2011 for the Medicaid Fee-for-Service program, when administering the first vaccine to a child and providing the consultation as described in the code, the first injection should be billed using code 90460. The quantity of service must be billed

as “1”, because the Medicaid program will pay the set amount of $10.97 regardless of the number of individual components in the vaccine.

Use of 90461: Effective for dates of service beginning April 1, 2011 for the Medicaid Fee-for-Service program, when administering the second or more vaccines to a child and providing the consultation as described in the code, the injection should be billed using code 90461. The quantity of service must be billed as “1” for each additional injection, and billed on a separate line. MAD will allow $10.97 for each injection, not for each component of a single injection.

Medicaid managed care organizations, including the Salud! and CoLTS programs, are able to establish their own payment agreements with providers. However, the funding provided by the Medicaid program for the MCOs only enables them to pay approximately the same reimbursement amounts as indicated above, and to follow the same policy of not necessarily paying additionally for each component.

SUBJECT III

EFFECTIVE FEBRUARY 15, 2011: PLACING THE TCN NUMBER ON CLAIMS BEING RESUBMITTED TO DOCUMENT A CLAIM WAS ORIGINALLY FILED TIMELY

As previously noted on the New Mexico Medicaid Portal (https://nmmedicaid.acs-inc.com/nm/general/home.do) and in remittance advice newsletters sent out by ACS, the Medicaid fiscal agent, all providers’ claims are subject to the new timely filing rules that went into effect on September 1, 2010. The rule may be viewed on the Medical Assistance Division website at:

http://www.hsd.state.nm.us/mad/pdf_files/provmanl/8%20302%202.pdf

Effective February 15, 2011, a remittance advice is no longer being accepted as proof of timely filing. Rather, the provider must place the Transaction Control Number (TCN) that appeared on the earlier remittance advice on the claim that is being resubmitted.

Previously, a provider submitted a copy of a remittance advice (RA) to establish that a resubmitted claim was originally submitted within the filing limit or to show that an adjustment request is within the filing limit.

In order to provide a consistent and efficient response to providers requesting a “filing limit waiver” on a claim with a filing limit issue, please note the following changes:

- When resubmitting a claim that is past the filing limit but was originally submitted within the filing limit, the “TCN” number which appears on the RA will be used by ACS to evaluate the claim. The provider must supply that TCN number in order for ACS to be able to evaluate the claim.

- INSTRUCTIONS: All claim types (UB-04, CMS-1500 and ADA 2006) must indicate the prior TCN number on the claim form.

CMS 1500 form: Put the TCN in block 22 on the paper form. Leave the "Code" blank, and put the TCN in the "Original Reference No." field.

UB Form: Put the TCN in Form Locator 64 "Document Control Number" (DCN) matching the appropriate payer line, using a paper form.

Dental Claim Form: Put the TCN on the left side in box 35 "Remarks".

- As of February 15, 2011 ACS stopped accepting copies of ACS's Remittance Advice as proof of timely filing. The evaluation on the timeliness of resubmitting a claim will be based on the prior TCN supplied by the provider following the above instructions.

- If the provider has submitted the claim more than once, the TCN of the most recent claim which met the initial 90-day filing limit must be used. There is no longer a provision that allows repeated or sequential 90-day periods. There is only one 90-day grace period allowed.

- Note that currently a provider cannot file a claim electronically if the claim requires an evaluation of the filing limit.

All requests for filing limit waivers must be submitted to ACS, not to the Medical Assistance Division (MAD). Claims that are sent to MAD will be forwarded directly to ACS for evaluation of timely filing. So it will be more efficient for the provider to send the claims directly to ACS.

ACS has the rules used for waiving the filing limits. If there is a case that merits special consideration, ACS will contact MAD. Providers should understand that the new filing limit rules are being strictly enforced by MAD and ACS. When regulations are published, such as filing limit rules, the staff of the Medical Assistance Division as well as ACS staff are required to follow those rules.

ACS Claims Address:	ACS, Inc. P.O. Box 26500 Albuquerque, NM 87125-6500
ACS Provider Relations Help Desk:	800-299-7304 or 505-246-0710 Enter provider ID, then press Option 2

SUBJECT IV:

SUBMITTING CLAIMS TO ACS WHEN RECOUPMENTS ARE MADE BY A MANAGED CARE ORGANIZATION FOR SALUD, CoLTS, OR SCI OR BY MEDICARE

When a provider receives notice of payment recoupment for a Medicaid client from a Medicaid Managed Care Organization including SALUD, CoLTS, or SCI, and the reason for the recoupment is that the Medicaid Program has retroactively disenrolled the recipient from the Managed Care Organization, the recipient may still be eligible for Medicare, the Medicaid Fee-For-Service (FFS) program, or eligible for both. The provider is responsible for reviewing the recipient's updated eligibility information using the Medicaid Web Portal, the automated voice response system at ACS, or using other available means to determine if the recipient remains eligible for Medicaid and/or Medicare.

If the recipient is eligible for Medicare and the service is covered by Medicare, the provider should file the claim with the Medicare carrier, Medicare intermediary, or the Medicare replacement plan, as appropriate.

If the recipient is eligible for Medicaid and if the claim is still within the filing limit of 90 days from the date of recoupment by the MCO, the claim may be filed with ACS as follows:

When filing a claim because an MCO or Medicare has recouped payment because of retroactive disenrollment, send a paper claim to ACS within 90 calendar days of the date that the recoupment was made, with one of the following attachments. The claim should be submitted directly to ACS.

1. An Explanation of Benefits (EOB) or Remittance Advice (RA) documentation from the MCO that has recouped payment that clearly documents the date of service, billing code, amount billed and amount recouped. The EOB/RA date will be used to determine if the 90 day filing limit has been met; OR
2. A recoupment letter that reports that the previously paid amount has been recouped. The date of the letter will be used to determine if the 90 day filing limit has been met; OR
3. A recoupment letter requesting payment for the amount to be recouped AND proof of payment from provider. Payment by the provider must be made in accordance with the instructions in the recoupment letter.

If the recipient remains eligible for the Medicaid FFS program for the dates of service on the claim and the provider is not enrolled as a Medicaid FFS provider, the provider must enroll as a Medicaid FFS provider in order to be paid by the Medicaid FFS Program. Enrolling as a provider to receive payment does not obligate the provider to see other recipients.

If a provider is not enrolled as a Medicaid FFS provider, the amount recouped for services cannot be billed to the client. The provider must enroll as a Medicaid FFS provider in order to be paid for recouped payments.

If the service provided by the MCO is not covered by the Medicaid FFS program, but is an "enhanced" service from the MCO, MAD cannot pay the claim.

SUBJECT V:

NATIONAL CORRECT CODING INITIATIVE

The Centers for Medicare and Medicaid Services (CMS) is requiring state Medicaid programs implement the National Correct Coding Initiative (NCCI) editing of claims prior to payment as part of the Patient Protection and Affordable Care Act (H.R. 3590).

Many providers should already be experienced with NCCI editing as the program has been in existence for Medicare since 1996. The process of NCCI involves the procedure codes that are reported on a claim being checked by an NCCI computer program that determines if any of the services should not be billed together for various reasons , including if the service described by one code is considered to be included in another, before any payment is made on that claim. NCCI editing also includes a component for medically unlikely edits (MUEs) which defines for each HCPCS/CPT code the number

of units of service beyond which the reported number of units is unlikely to be correct. Starting April 1, 2011, a line on a claim may be denied if either of these situations is determined to exist.

The Medicaid program has been reviewing claims that will be affected by NCCI editing. Only a small number of claims are detected as having a correct coding initiative issue. Often, it may not be that there is a problem with the services being provided; but, rather, how the services are being billed. Providers must be especially careful to bill accurately when bilateral services are involved or when codes should include modifiers. If a claim is denied for NCCI reasons, the provider should examine the way the claim was billed and determine if it was billed correctly.

The details of NCCI can be viewed on the CMS website at:
http://www.cms.gov/MedicaidNCCICoding/

SUBJECT VI:

SLEEP STUDIES AND ALLERGY TESTING

New Mexico Human Services Register Vol. 33 Number 48, dated October 15, 2010, issued proposed changes to 8.301.3 NMAC, *General Noncovered Services*. This register proposed to not reimburse for allergy testing and/or sleep study services, among other changes. A public hearing was held on December 15, 2010 to receive public comments on the proposed rules.

The comments included alternative recommendations such as developing guidelines for referral and to educate primary care providers to properly select allergy patients; establishing skin testing limitations without prior authorization and developing criteria for prior approval for services beyond the basic testing; limiting immunotherapy injections and extracts to be covered for no more than a 5-year course of treatment without reevaluation; reviewing outliers for medical necessity; and limiting delivery of these services to only physicians with advanced training such as a fellowship-trained, board eligible or certified allergists or ear/nose/throat physicians with evidence of additional training in allergy immunotherapy.

The Department believes there were sufficient comments and recommendations to indicate that there are ways of controlling inappropriate utilization of sleep studies and allergy testing that will accomplish the Department's intent to limit payment only to cases of medical necessity. The Department will work with organizations and providers with the necessary expertise to limit unnecessary use of these tests and treatments through other administrative means.

This topic-will be covered in a future supplement. Until future notice is given to providers, sleep studies and allergy testing will continue to be covered as they currently are, with no changes.

SUBJECT VII:

PAP SMEARS, PSA TESTS, and CESAREAN SECTIONS

New Mexico Human Services Register Vol. 34 Number 2, dated February 10, 2011, issued final changes to 8.301.3 NMAC, *General Noncovered Services* that were first proposed in register Vol. 33 Number 48, dated October 15, 2010.

The changes put into effect by this register include:

1. BILLING FOR CESAREAN SECTIONS
   Effective April 1, 2011, cesarean sections will be paid at the same rate as vaginal deliveries unless one of the following conditions applies:

   - The mother has already had a cesarean section in a previous pregnancy.
   - The mother has a serious medical condition that requires emergency treatment.
   - The mother has an infection that may be transmitted to the baby, such as herpes or HIV (Human Immunodeficiency Virus).
   - The mother is delivering twins, triplets, or more.
   - The baby is in a breech or transverse position.
   - The baby is showing signs of severe fetal distress requiring immediate delivery.

   When a provider bills for a cesarean section using codes 59510, 59514, or 59515, payment will be made at the rate for the corresponding vaginal delivery code. No change in payment is being made for other cesarean section codes. If the provider is billing with code 59510, 59514, or 95915, and one of the situations above is documented in the medical record, the provider may bill the code with the modifier U1; in which case, MAD will pay the claim at the cesarean section rate.

2. No coverage or reimbursement for routine screening, tests or services which are not medically necessary due to the age of the eligible recipient, including Papanicolaou tests (pap smears) for women under the age of 21 and prostate specific antigen (PSA) tests for men under age 40, unless prior history or risk factors make the tests medically warranted.

   When billing for these tests for recipients under the age limits given, be certain to add diagnoses to the claim which indicate the high risk situation (family history, etc.).

3. No coverage for bariatric or other weight loss and weight reduction surgeries or procedures;

4. No coverage or payment for pregnancy, complications encountered during pregnancy related conditions, prenatal care and post partum care, or delivery for services for a surrogate mother for which an agreement or contract between the surrogate mother and another party exists.

SUBJECT VIII:

DOCUMENTATION AND CORRECT BILLING REQUIREMENTS

A random sampling of claims reviewed by an ongoing federal audit has revealed several common provider billing errors, some of which resulted in recoupments from providers. Because of these findings, we would like to remind you of the importance of the following:

- Provider records must substantiate the services rendered during a patient visit and/or document the performance of any procedure billed on the claim. Claims must accurately reflect the date(s) of service and the quantity of service.

- Admissions to hospitals must be medically necessary. Diagnoses on the claim must be supported by the hospital records. If there is any lack of clarity on the primary diagnosis, the provider must clarify the issue with the practitioner prior to billing the claim.

Claims are subject to recoupment when proper documentation is not available in the provider's records.

SUBJECT IX:

HEALTH CARE ACQUIRED CONDITIONS (HCAC)

CMS recently released a proposed rule implementing section 2702 of the Affordable Care Act which requires that Medicaid programs promulgate regulations effective as of July 1, 2011, providing a "payment adjustment for health care-acquired conditions (HCAC)."

Section 2702(b) of the Affordable Care Act defines the term "health care-acquired condition" as "a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Act."

Specifically, the statute prohibits Medicaid from making payment for 3 general types of situations which can be thought of as "Provider-Preventable Conditions" (PPC's) that can occur in outpatient hospital, nursing facility, ambulatory care settings, and other healthcare settings.

1. When the wrong procedure was performed on a recipient or a procedure was performed on the wrong recipient.

2. When lack of appropriate care resulted in a recipient healthcare issue. Examples would be when a bed-ridden recipient develops decubitus ulcers due to lack of proper attention; an institutionalized recipient's diabetes is not properly controlled due to lack of attention; or, a recipient is dropped while being moved from bed to a wheelchair.

3. When improper procedures result in a recipient getting an infection that was not present on admission or prior to care from the provider.

Future updates in the HIPAA claim transaction will allow providers to report these events on the claim form. Until those updates are made a provider responsible for an HCAC or a PPC cannot bill the Medicaid program for costs associated with treating the recipient's condition.

Providers who may be uncertain about how to bill a claim under such circumstances may contact the Medical Assistance Division at (505) 827-3171.

SUBJECT X:

REVIEW OF HOSPITAL CLAIMS

The Medicaid Utilization Review (UR) Contractor, Molina, will increase the number of reviews for hospital stays.

In addition to reviewing documentation for the claims, the purpose of the reviews will be to assure that the admission was necessary, the length of the stay was necessary, or that the discharge was not premature.

SUBJECT XI:

NATIONAL PROVIDER IDENTIFIER FOR REFERRING PROVIDERS

The National Provider Number (NPI) is required on all claims for which the services are due to a referral.

The most common examples are when a laboratory or radiology facility bills for services that were provided when ordered by a practitioner; or when a practitioner is billing a consultation code.

Be certain to provide this information on every claim form and electronic claim transaction.
If you have questions regarding the above information, you may contact the Benefits Bureau at (505) 827-3171.

We appreciate your participation in the Medicaid program.