State of New Mexico
Medical Assistance Program Manual

Supplement

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TO: HCBS WAIVER PROVIDERS, HOME HEALTH AGENCIES, PRIVATE DUTY NURSING AGENCIES, AND REHABILITATION SERVICES PROVIDERS

FROM: CAROLYN INGRAM, DIRECTOR

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SUBJECTS: (I) GUIDELINES FOR BILLING FEE-FOR-SERVICE MEDICAID FOR SERVICES BEING TRANSFERRED FROM THE HCBS WAIVER and (II) NEW WAIVER FEE SCHEDULE.

I. GUIDELINES FOR BILLING FEE-FOR-SERVICE MEDICAID

Beginning July 1, 2006, certain services previously delivered through the Home and Community-Based Services (HCBS) waivers will be provided as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services under the Medicaid Fee-for-Service (FFS) Program or, if the recipient is enrolled in SALUD! Managed Care, by the appropriate SALUD! Managed Care Organization.

This change is being made to remain in compliance with federal regulations that mandate that waiver services cannot duplicate EPSDT Medicaid benefits but, rather, must be billed to the appropriate SALUD! managed care organization or Medicaid fee-for-service program, and not as a waiver service. Therefore, these guidelines have been prepared to clarify for FFS providers how to bill for services rendered. The guidelines are attached and entitled "*Guide for Waiver Services Transferring to Medicaid Fee for Service*". Also, refer to the online fee-for-service billing instructions at http://www.state.nm.us/hsd/mad/OtherDocs/BillingInstructions.htm

To bill Medicaid fee-for-service, the provider must have a provider number other than the one used to bill for waiver services. For information on becoming a Medicaid provider, call Jeanne Cournoyer at (505) 827-3181.

Medicaid fee-for-service providers must bill their usual and customary charge for services (see billing instructions) The Medicaid FFS fee schedule may be found at http://www.state.nm.us/hsd/mad/FeeSchedule_070106.htm

Please address Fee-for-services questions concerning this material to Maria Varela at (505) 827-3113.

II. NEW WAIVER SERVICES FEE SCHEDULE

For services remaining in the waiver, new rates for services have been approved, effective for dates of service beginning July 1, 2006. Note that in order to be paid the full amount allowed for the service, the provider must bill using the new rate. The provider must also add gross receipts tax to the billed amount when appropriate.

The new waiver online Fee Schedule effective July 1, 2006 is located under the heading WAIVER SERVICES at http://www.state.nm.us/hsd/mad/FeeSchedule_070106.htm

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Guide for Waiver Services Transferring to Medicaid Fee-for-Service

General Requirements:

- **Except for behavioral health, these changes apply to children under age 21 only.** The recipient's ISP and budget must be revised at least 2 weeks prior to the recipient's 21st birthday. For example, when a recipient turns 21, private duty nursing must be included in the ISP and budget to be covered by the waiver rather than under the Medicaid Fee-for-Service Program or SALUD! Managed Care Program.

- **These changes apply only to budgets and ISP's with a start date on or after July 1, 2006**. Otherwise, continue to bill the waiver program until a new budget and ISP is in place.

- **This information on coding and prior authorization requirements are only applicable for fee-for-service Medicaid**, that is, recipients not enrolled in a SALUD! managed care organization. Information on billing managed care organizations and their prior authorization requirements are determined by each managed care organization.

- **Prior authorizations for services for fee-for-service recipients are given by Blue Cross Blue Shield of New Mexico,** the utilization review contractor for the Medicaid fee-for-service program. The expiration of the prior authorization must be before the recipient's 21st birthday.

For Medicaid fee-for-service recipients, requests for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (SP) are submitted on a MAD 303 Form and submitted to BCBSNM Medicaid Utilization Review. Requests can be made for up to 12 months of service for Children with Special Health Needs (CSHCN). It would be beneficial to have the ISP and the FFS PA coincide with the same 12 month period. In order for therapies to be approved by BCBSNM, services need doctor's orders that justify the medical necessity. Contact BCBSNM at 800-392-9019 for instructions as necessary.

- **When requesting in-home or client location services on the authorization request, therapists must justify the necessity of the in-home/client location.**

- **Providers cannot bill the Fee-for-Service Medicaid Program for (1) attending Individual Service Plan (ISP) waiver meetings; (2) services for community integration/socialization; (3) services provided by assistant therapists; (4) report writing; or (5) respite care.** Waiver providers may continue to bill as a waiver provider for some of these services, according to the rules and instructions of each specific waiver.

Client's Waiver Program	**Codes and Services for the Fee-for-Service Medicaid Program (for recipients in HCBS waivers but not enrolled in SALUD! Managed Care)**
DD **MF** **D&E**	**Speech Therapy Center Based:** codes 92506, 92507, and 92508, all per visit. Most services rendered directly to the recipient and also when working with the recipient's care-giver when the recipient is present. This may include participation of new staff (e.g. respite worker) or the family in therapeutic techniques as long as the child is present and the therapist is showing the staff/family member individualized hands on strategies they can implement between therapy appointments - for example, a speech therapist involves the parent and/or respite worker while teaching the child to use a communication device. **Speech Therapy Client Location:** code G0153, unit per 15 minutes Speech therapy to support effective communication will generally be supported under the state plan. If a child is non-verbal and the speech therapist is developing and teaching the child to use a communication device the service can be covered under the state plan because the ability to communicate is necessary in all settings.
DD **MF** **D&E**	**Physical Therapy Center Based:** codes 97001, 97002, 95831 to 95904, 97010 to 97028, and 97597 to 97606, all per visit except for ; codes 97032 to 97542, and 97750 to 97762, all per 15 min (except for 97537 which is not covered). **Codes not covered** 97005, 97006, 97537, 97545, and 97546 Most services rendered directly to the recipient and to the recipient's care-giver when the recipient is present. Physical therapy to support or enhance mobility will generally be supported under the state plan because mobility is necessary in all settings. **Physical Therapy Client Location:** code G0151, use 1 unit per each 15 min. **Participation of new staff (e.g. respite worker) or the family in therapeutic techniques** is billable to FFS as long as the child is present and the therapist is showing the staff/family member individualized hands on strategies they can implement between therapy appointments. For example, a physical therapist involves the parent and/or respite worker to safely position a child for bathing or how to carry out range of motion exercises to be done daily.

DD **MF** **D&E**	**Occupational Therapy Center Based:** codes 97003, 97004, 95831 to 95904, 97010 to 97028, and 97597 to 97606, all per visit; codes 97032 to 97542, and 97750 to 97762, all per 15 min (except for 97537 which is not covered). **Codes not covered** 97005, 97006, 97537, 97545, and 97546 Most services rendered directly to the recipient and to the recipient's care-giver when the recipient is present. Occupational therapy to support or enhance mobility will generally be supported under the state plan because mobility is necessary in all settings. **Occupational Therapy Client Location:** code G0151, use 1 unit per each 15 min. **Participation of new staff (e.g. respite worker) or the family in therapeutic techniques** is billable to FFS as long as the child is present and the therapist is showing the staff/family member individualized hands on strategies they can implement between therapy appointments.
DD **MF** **D&E** **AIDS**	**Private Duty Nursing, (RN or LPN):** For RN use code T1000 modifier TD for each 15 min (Use the modifier for billing but not when requesting prior authorization) For LPN use code T1000 modifier TE for each 15 min (Use the modifier for billing but not when requesting prior authorization)
DD, MF **D&E** **AIDS**	**Personal Care:** code S5125, 1 unit for each 15 minutes For coverage, refer to Medicaid program regulations. These are services overseen by an RN and must include periodic visits from the RN.
D&E	**Bowel and Bladder:** Refer to Medicaid program regulations. If billed by a home health agency, the appropriate HHA revenue code is used. If billed as private duty nursing, the code for private duty nursing is used.
DD **MF** **D&E**	**Consultations:** code G9001, 1 unit for each 15 minutes (generally not expected to exceed 3 units at most) This code can ONLY be used for complex clinical issues that must be coordinated with other providers. For example, the physical therapist consults with the speech therapist about posturing for a client at risk of aspiration. Phone calls are not covered by FFS unless the calls qualify as consultations. For example, when a therapist is contacted by the waiver case manager, such as the waiver case manager contacting the EPSDT therapist by phone to collect information and request a copy of progress notes for the (ISP), the therapist CANNOT bill code G9001.
MF	**Home Health Aide:** When provided by a home health agency, use revenue code 0571.
DD	**Behavior Therapy:** Contact Value Options for the specific procedure codes.