2. Provider Network

2.1. Service Termination and Provider Closure

Anticipated changes in the MCO provider network shall be reported to the Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD) Contract Managers in writing within 30 calendar days prior to the change, or as soon as the MCO knows of the anticipated change, whichever comes earlier. Unexpected changes shall be reported within five calendar days of the MCO's knowledge about the change.

Anticipated Changes	
Notification	30 Calendar Days minimum
Narrative	10 Calendar Days from date of Notification
Transition Plan A (Overall)	15 Calendar Days from date of Notification (if change is significant)
Transition Plan B (Member Specific)	15 Calendar Days from date of Notification (if change is significant)
Unanticipated Changes	
Notification	5 Calendar Days maximum
Narrative	10 Calendar Days from date of Notification
Transition Plan A (Overall)	15 Calendar Days from date of Notification (if change is significant)
Transition Plan B (~~MemberSpecific~~Member Specific)	15 Calendar Days from date of Notification (if change is significant)

The MCO is required to submit a Notification, Narrative, Transition Plan A, and Transition Plan B as appropriate, to its Contract Manager on anticipated changes to the network. Refer to the appendices included in this section for HCA~~HSD~~ templates. The Manager for either the Behavioral Health (BH) Unit or the Long Term Services and Supports (LTSS) Unit shall be copied on any network change related to either BH or LTSS. Notification is expected whenever a provider informs the MCO, or when the MCO learns through means other than provider notification, of its intent to change or terminate a service(s). Notification is also expected if a service provider becomes incapable of performing a contracted service. In all instances, the MCO is expected to report how the changes will affect the service delivery system, which may result in the need for members to transition from one service provider to another.

In both expected and unexpected changes in the network, the MCO shall assess the significance of the change or closure within 10 calendar days of confirmation by the provider. If the MCO determines the change will not have a significant impact on the system, the Narrative template must be submitted within 10 calendar days from the date of notification of change or closure to the Contract Manager. In the Narrative, the MCO must explain all factors considered in making a determination that the change will not significantly impact the system and provide assurances that all members will be transitioned to new providers (if applicable). If the MCO determines the change or closure will significantly impact the delivery system, the MCO is required to submit Transition Plan A (Overall) and Transition Plan B (Client-Specific) to the Contract Manager within 15 calendar days of the official Notification and Narrative to HCA~~HSD~~. In the event HCA~~HSD~~ determines a network change is significant, the MCO will be required to submit all transition information as requested.

Transition information will be submitted on the templates provided by HCA~~HSD~~ with all columns completed. The Narrative will be submitted in text format. Updates will be submitted every other week after the initial submission. A final update will be submitted when all members are transitioned. The Notification, Narrative, and Transition Plan A will be submitted via email to the HCA~~HSD~~ Contract Manager. Transition Plan B will be submitted by fax or via a secure website as determined by the MCO and HCA~~HSD~~. The HCA~~HSD~~ Contract Manager will review and approve the official Notification, Narrative, and Transition Plan A and will monitor and provide feedback on Transition Plan B.
If the submitted transition plan documents are incomplete, with the exception of Plan B, HCA~~HSD~~ will reject the reporting and monetary penalties may apply per Section 7.3.3.6.5 of the Medicaid Managed Care Services Agreement.

2.2. MCO Initiated Provider Network Closures and Reductions

The MCOs will submit a written request to HCA~~HSD~~ regarding a significant change in the MCO's provider network to include either closure or reduction of providers. A significant change is defined as:

- Affecting more than 100 members statewide;
- Affecting more than 100 members in urban area;
- Affecting more than 50 members in rural area;
- Affecting more than 25 members in frontier area; and/or

- Limits or removes members' choice of providers, (e.g., closure of BH network, in rural and frontier areas).

The request must be submitted at least 60 calendar days prior to the MCO's intended action.

- The request must include a completed Notification form and provide justification for the closure or reduction of the specific provider network.
- The MCO must submit a current Geographical Access (Geo/Access) report demonstrating ~~member~~Member access and include the accessibility overview, map, and analysis of the provider network.
- HCA~~HSD~~ will review and provide the MCO with a written approval or denial within 10 business days.
- At HCA~~HSD~~'s discretion, the MCOs may be required to submit all transition plan documents.

2.3. Provider Monitoring

HCA~~HSD~~/MAD monitors provider access and network adequacy in a variety of ways and through various reports. The following methods are utilized to monitor MCO provider access and network adequacy:

- Provider Satisfaction Survey;
- Member Satisfaction Survey;
- Secret Shopper Survey;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results;
- External Quality Review Organization (EQRO) Reviews;
- MCO Call Center Reports;
- Member Grievances & Appeals Report;
- Primary Care Physician/ Primary Care Provider (PCP) Report;
- Geo/Access Report;
- Network Adequacy Report; and
- Ad Hoc Reports.

2.4. Requirements for Provider Enrollment

In considering provider enrollment, it is important for the MCO to understand there are many instances when claims cannot be paid, if the billing provider, rendering, referring, ordering, or attending physician or other practitioner is not enrolled and active with a status of 60 or 70. All managed care network

providers, including network providers of an MCO subcontractor, must be enrolled through a Provider Participation Agreement (PPA) with the State Medicaid Agency. MAD may require that some "non-network" providers enroll based on the number of services rendered to New Mexico Medicaid recipients or other criteria.

Each MCO must submit a monthly listing of its network providers including the network providers of its subcontractors. This list is due by the tenth day of each month, reflecting the network providers for the previous month, and must include the following:

- Provider Name;
- Provider National Provider Identifier (NPI);
- Provider Taxpayer Identification Number (Social Security Number [SSN] or Federal Employer Identification Number);
- Provider Location Address; and
- If provider receives direct reimbursement from MCO or is employed by a provider receiving the payment.

The Patient Protection and Affordable Care Act (PPACA) Title 42, Part 455 of the Code of Federal Regulations requires attending, ordering, referring, rendering, and prescribing providers to be enrolled in the Medicaid program in order to meet PPACA program integrity requirements designed to ensure all attended, prescribed, ordered, referred, or rendered services, items, and admissions for Medicaid beneficiaries originate from properly-licensed providers who have not been excluded from Medicare or Medicaid. A provider who is enrolled through a PPA with MAD only as a fee-for-service (FFS) provider, only as a managed care provider, or who is enrolled as both FFS and managed care is considered to be "enrolled with Medicaid" for these purposes.

Therefore, the expectation is that most services and items will only be paid by the Medicaid program if the individual provider who attends, prescribes, orders, refers, or renders a service or item is identified on the claim and is enrolled in the Medicaid program. Otherwise, the claim will be denied in accordance with Federal requirements.

This requirement now applies to both the Medicaid FFS program and to the Medicaid MCOs. Even with the implementation of these requirements, FFS and the MCOs will still be required to continue implementing more changes in the near future, such as:

- Including prescribing providers on pharmacy claims.

- Ensuring we are meeting Centers for Medicare & Medicaid Services (CMS) expectations for ~~Indian Health Services~~Indian Health Service (IHS) and Federally Qualified Health Centers (FQHCs), which may have changed since the previous CMS review.
- Working towards including rendering providers on more BH services and home and community-based services (HCBS) developmentally disabled (DD) waiver services. (We may also begin enrolling opticians, hearing aid testers, and other individuals who provide services within a health care business entity. We are expanding our type and specialty listings to accommodate this action.
- The MCOs should allow certified-nurse practitioners, clinical nurse specialists and certified nurse-midwives who have been granted parity with physician privileges at health facilities to admit, discharge, and authorize continued patient care.

  Under these requirements, it is possible that some practitioners will need to enroll in the Medicaid program; otherwise, the recipient may have to change individual providers in order for their services to be ordered, referred, prescribed, or attended by a Medicaid enrolled provider.

  There are also some providers who are members of groups, agencies, and other facilities who have not enrolled individually as a ~~member~~Member of the group, agency, or facility. To a lesser extent, there may be some individual providers who have not enrolled in the Medicaid program because they do not bill Medicaid, but who, never-the-less, order or prescribe services for the recipient that will be billed to Medicaid by other providers as a result of the order or prescription.
- MAD has developed and made available on the Conduent New Mexico Medicaid Web Portal at https://nmmedicaid.portal.conduent.com/webportal/providerSearch a lookup tool to help providers obtain the NPI of a rendering, prescribing, ordering, referring, or attending provider. The instructions for using this web portal tool and contact information for the Conduent Provider Relations staff, are included in this document.

  Providers should use this tool to determine if any services they are providing to Medicaid recipients are based on prescriptions, orders, or referrals from a provider who is not enrolled in the Medicaid or managed care program.

  Providers should also use this tool to determine if any provider or practitioner on their staff needs to be enrolled and to immediately begin the enrollment process if necessary.
- MAD allows provider enrollment as a Medicaid provider solely for the purpose of establishing appropriate enrollment for the services they order, refer, or prescribe without having to commit to seeing all Medicaid patients or even any Medicaid patients.

While discriminatory practices towards recipients are not allowed by State and Federal rules, a provider can still choose to limit his or her practice and participation in the Medicaid program in ways that are not discriminatory. Such limitations could include treating emergency situations only, only seeing recipients who are dually eligible for Medicare, limiting the number of patients or recipients seen, or to only see existing recipients without taking new patients.

This information may be useful to a provider who is hesitant to enroll in the Medicaid program.

Hospital, Residential, Nursing Facility (NF), HH, and Hospice Claims

The essential requirements are:

- The attending provider must be reported on the Universal Billing (UB) format claim for the following:
  - Inpatient hospital claims;
  - Hospice claims; and
  - Home health agency (HHA) claims (referring or ordering provider in the attending field).
- NF and intermediate care facilities for individuals with intellectual disabilities (ICF-IID) claims (referring or ordering provider in attending field;
- Residential facility claims (adult accredited residential treatment center [AARTC], accredited residential treatment centers for youth (ARTC for youth), non-accredited residential treatment centers (RTC) and Group Homes) (referring or ordering provider in the attending field);
- The rendering provider must be reported at the claim header level or on all lines on an outpatient hospital claim;
- A referring or ordering provider must be reported on an outpatient hospital claim when the service is the result of a referral; and/or
- If any of these providers submit claims on the CMS 1500 format, such as the physician component that corresponds to an inpatient or outpatient hospital claim, the requirements for rendering provider on the CMS 1500 format must be followed.

Referring or Ordering Providers on Claims

The essential requirements are:

- When the service provided is the result of a referral from another practitioner, that provider should be reported as the Referring or Ordering provider.
- In most instances, the MCO will not know if the service was based on a referral or not; therefore, in most instances, a referral cannot be required. ~~Instead~~Instead, the provider must be relied upon to follow the instructions. However, there are certain types of providers whose services are performed only upon an order or referral from another provider such as independent laboratories, radiology facilities, suppliers of medical equipment, medical supplies, and oxygen. ~~So~~So, it is possible to make the Referring or Ordering provider mandatory under these circumstances as indicated in this document.

Rendering Providers on Claims

The essential requirements are:

- The rendering provider must be identified for most services.
- Exceptions and special circumstances are described in this document.

2.5. Institutional Type Providers

Specific Provider Reporting Requirements

- **HHA Claims; NF Claims**: the ordering provider's NPI must be indicated in the attending provider NPI field.
- **Hospice Claims, Residential Provider claims** (ARTC, RTC, and Group Homes): the attending provider's NPI is required.
- **Hospital Inpatient Claims** (including specialty hospitals): the attending provider's NPI is required. See below for requirements for outpatient hospital claims.
- **Hospital Outpatient claims** (Including specialty hospitals): the rendering provider's NPI must be reported on hospital outpatient claims. It may either be reported at the header level (if a single provider is the rendering provider) or at the line level (if there are different rendering providers for each service or line). Or they may always choose to report at the line level.

  In many hospitals, the rendering provider may be a resident, an intern, or a supervised nurse, technician, or other individual who cannot enroll as a provider in their own right. In these situations,

the provider overseeing the services for the recipient may be considered the rendering provider and reported as such.

Even though one may think of a lab code or radiology code, or some other service codes on the claim as not being performed by the provider, but rather by a lab or radiology technician, the provider overseeing the service for the recipient is still to be reported as the rendering provider ~~on that~~on that line.

Correct Placement of Information on Claims

Attending Physicians for Inpatient Hospitals, Hospice Providers, Ordering Physicians or HHAs NFs, ICF-IID, and Residential Facilities

Paper UB format claim:	Report the names and NPI in form locator 76 (Attending Provider Name and Identifiers)
Electronic 837 I claim:	Report the names and NPI in loop 2310A
Data Element NM 101	Attending Provider = “71”
Data Element NM 103	Attending Provider Last Name
Data Element NM 104	Attending Provider First Name
Data Element NM 108	Identification Code Qualifier “XX”
Data Element NM 109	Attending Physician Primary Identifier NPI

Referring or Ordering Physicians (or other Providers), Reported when Applicable

Paper UB format:	Report the NPI and name of the referring or other provider in Field Locator 78 (Other Physician’s Name and Identifier)

The following loop, segment, and element places are used to report the referring provider’s NPI and name, depending on whether reporting is being done at the header or line level

Referring Provider – 2310F (Header)/2420D (Line), Data Element NM101 = “DN”

Referring Provider Last Name – 2310F (Header)/2420D (Line), Data Element NM103

Referring Provider First Name – 2310F (Header)/2420D (Line), NM104

Referring Provider’s NPI – 2310F (Header)/2420D (Line), NM108 = “XX”

Referring Provider’s NPI – 2310F (Header)/2420D (Line), NM109

Referring or ordering providers are to be reported on claims when the service or item is the result of a referral or an order.

Rendering providers must be reported on claims for professional services such as reading or interpreting the results of an anatomical laboratory service or radiological images. Rendering providers may either be reported at the header level (if a single provider is the rendering provider) or at the line level.

The rendering, referring, or ordering provider may be a resident, intern, supervised nurse, technician, or other individual not typically enrolled as a provider in their own right. In these situations, the supervising provider may be considered the rendering provider, referring, or ordering provider, as appropriate, and reported as such.

2.6. Providers Whose Services are Based on Orders and Referrals

Specific Provider Reporting Requirements

For the Medicaid program, MAD does not distinguish between an ordering and referring provider; information may be placed in either the ordering or referring provider fields.

The following providers should always have an ordering or referring provider for their services or items:

- Clinical diagnostic laboratories including clinical labs, diagnostic labs for physical tests and measurements, clinical labs with radiology, and other diagnostic laboratories.
- Hearing aid dealers, IV infusion services, opticians and other eyeglass dispensers, and medical supply and durable medical equipment (DME) companies.
- Occupational therapists, orthotists, physical therapists, prosthetists, speech and language pathologists, and rehabilitation centers.
- Radiology and radiation treatment facilities.

  MAD recognizes that some therapists can self-refer; that is, upon seeing and evaluating a recipient, they may refer the recipient to themselves for treatment. When this occurs, the therapist must report himself or herself as the referring provider, as well as the rendering provider.

  Sometimes the referring, ordering, or prescribing provider may be a resident, intern, or supervised nurse, technician, or other qualified individual who cannot enroll as a provider in their own right. In these situations, the supervising provider may be considered the rendering provider and reported as such.

  When a laboratory, radiology, or diagnostic test is for or includes a professional component for reading or interpretation of the results, the rendering provider must be provided in addition to the referring or ordering provider.

Correct Placement of Information

Referring or Ordering Physicians (or other Provider), Reported when Applicable

Paper CMS 1500 format: Report the NPI of the referring or ordering provider in Field Locator 17b (Other Physician's Name and Identifier)

Electronic 837P: The following loop, segment, and element places are used to report the referring provider's NPI and name, depending on whether reporting is being done at the header or line level

Referring Provider – 2310A (Header)/2420F (Line), Data Element NM101 = "DN"

Referring Provider Last Name – 2310A (Header)/2420F (Line), Data Element NM103

Referring Provider First Name – 2310A (Header)/2420F (Line), NM104

Referring Provider's NPI – 2310A (Header)/2420F (Line), NM108 = "XX"

Referring Provider's NPI – 2310A (Header)/2420F (Line), NM109

Rendering Physician or Other Provider - Report on all Professional Services

Paper CMS 1500: Report the NPI of the rendering provider in Field Locator 24 J lower line Rendering Provider ID number

Electronic 837P: The following loop, segment and element places are used to report the rendering provider's NPI and name, depending on whether reporting is being done at the header or line level

Rendering Provider – 2310B (Header)/2420A (Line), Data Element NM101 = "82"

Rendering Provider Last Name - 2310B (Header)/2420A (Line), Data Element M103

Rendering Provider First Name – 2310B (Header)/2420A (Line), NM104

Rendering Provider's NPI – 2310B (Header)/2420A (Line), NM108 = "XX"

Rendering Provider's NPI – 2310B (Header)/2420A (Line), NM109

2.7. Rendering Providers

Rendering providers must be reported on professional services. There is a new requirement for rendering providers that they must also be reported on laboratory, radiology, injections, supplies, items, and all other services reported on a CMS 1500 format claim.

Even though one may think of a lab code, a radiology code, or other service codes on the claim as not being performed by the physician or physician extender, but rather by a lab or radiology technician, or an injection or other treatment as being performed by a nurse or other staff, the provider overseeing

the primary service for the recipient is still to be reported as the rendering provider for these types of services.

Rendering providers may either be reported at the header level (if a single provider is the rendering provider) or at the line level.

In many hospitals, the rendering provider may be a resident, an intern, or a supervised nurse, technician, or other individual not typically enrolled as a provider in their own right. In these situations, the supervising provider may be considered the rendering provider and reported as such.

Referring or ordering providers are to be reported when the service is a result of a referral or an order. It may also be reported at the header level on a claim or at the line lever.

Specific Provider Reporting Requirements

Multidisciplinary Team Services

MAD is still working on issues with BH Agencies, Certified Mental Health (MH) Centers, BH Core Service Agencies, Opioid Treatment Centers, Health Homes, and Case Management Agencies, regarding reporting rendering providers on any service which is rendered by a multidisciplinary team. For these providers, for services that are not provided by a multidisciplinary team, the provider must report rendering providers and proceed with enrolling all practitioners on their staffs.

If the rendering provider is a resident, intern, supervised nurse, technician, or other qualified individual who cannot enroll as a provider in their own right, the supervising provider may be considered the rendering provider and reported as such.

Referring and Ordering Providers:

In addition to a rendering provider, the referring or ordering provider may also be reported. For the Medicaid program, MAD does not distinguish between an ordering and referring provide and the information may be placed in either the ordering or referring provider fields. These instructions are for using the referring provider fields.

If the referring, ordering, or prescribing provider is a resident, an intern, a supervised nurse, technician, or other qualified individual who cannot enroll as a provider in their own right, the supervising provider may be considered the rendering provider and reported as such.

Correct Placement of Information

Rendering Physician or Other Provider - Report on all Professional Services

Paper CMS 1500: Report the NPI of the rendering provider in Field Locator 24 J lower line Rendering Provider ID number.

Electronic 837P: The following loop, segment, and element places are used to report the rendering provider's NPI and name, depending on whether reporting is being done at the header or line level.

Rendering Provider – 2310B (Header)/2420A (Line), Data Element NM101 = "82"

Rendering Provider Last Name 2310B (Header)/2420A (Line), Data Element NM103

Rendering Provider First Name – 2310B (Header)/2420A (Line), NM104

Rendering Provider's NPI – 2310B (Header)/2420A (Line), NM108 = "XX"

Rendering Provider's NPI – 2310B (Header)/2420A (Line), NM109

Rendering Dentist or Other Provider, Report on Dental Services

Paper ADA form: Report the NPI of the rendering provider in Block 54.

Electronic 837D: The following loop, segment and element places are used to report the rendering provider's NPI and name, depending on whether reporting is being done at the header or line level.

Rendering Provider – 2310B (Header)/2420A (Line), Data Element NM101 = "82"

Rendering Provider Last Name - 2310B (Header)/2420A (Line), Data Element NM103

Rendering Provider First Name – 2310B (Header)/2420A (Line), NM104

Rendering Provider's NPI – 2310B (Header)/2420A (Line), NM108 = "XX"

Rendering Provider's NPI – 2310B (Header)/2420A (Line), NM109

Referring or Ordering Physicians or Other Provider) - Reported When Applicable

Paper CMS 1500 format: Report the NPI of the referring or ordering provider in Field Locator 17b (Other Physician's Name and Identifier).

Electronic 837P: The following loop, segment and element places are used to report the referring provider's NPI and name, depending on whether reporting is being done at the header or line level.

Referring Provider – 2310A (Header)/2420F (Line), Data Element NM101 = "DN"

Referring Provider Last Name – 2310A (Header)/2420F (Line), Data Element NM103

Referring Provider First Name – 2310A (Header)/2420F (Line), NM104

Referring Provider's NPI – 2310A (Header)/2420F (Line), NM108 = "XX"

Referring Provider's NPI – 2310A (Header)/2420F (Line), NM109

Referring or Ordering Dentist On Dental Claims - Reported When Applicable

Paper ADA: Form does not have this field. Cannot be reported.

Electronic 837: The following loop, segment and element places are used to report the referring provider's NPI and name, depending on whether reporting is being done at the header or line level.

Referring Provider – 2310A (Header)/2420F (Line), Data Element NM101 = "DN"

Referring Provider Last Name – 2310A (Header)/2420F (Line), Data Element NM103

Referring Provider First Name – 2310A (Header)/2420F (Line), NM104

Referring Provider's NPI – 2310A (Header)/2420F (Line), NM108 = "XX"

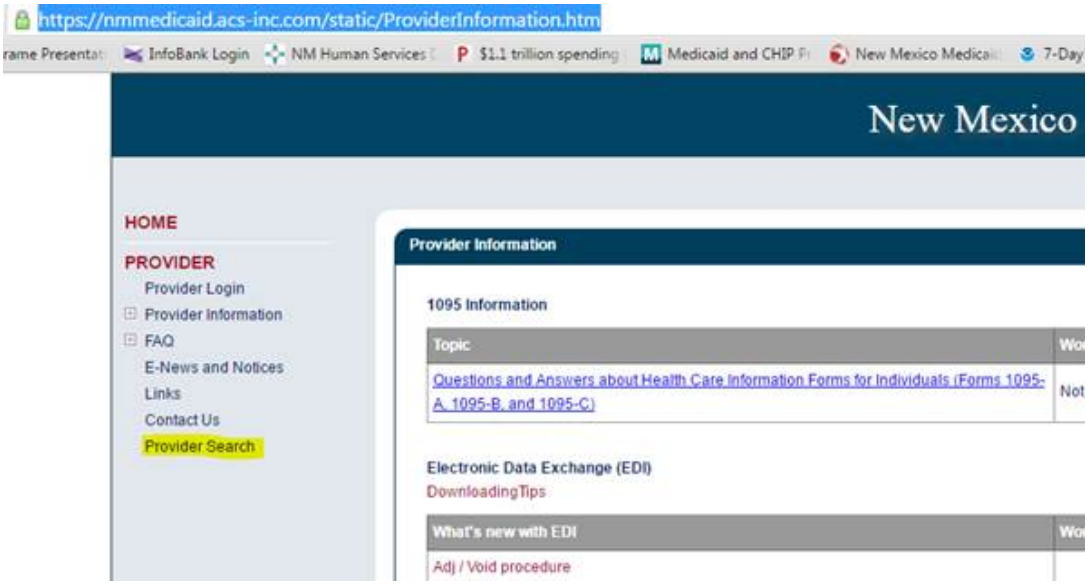
Referring Provider's NPI – 2310A (Header)/2420F (Line), NM109

2.8. Using the Web to Verify Attending, Ordering, Referring, Rendering or Prescribing Providers

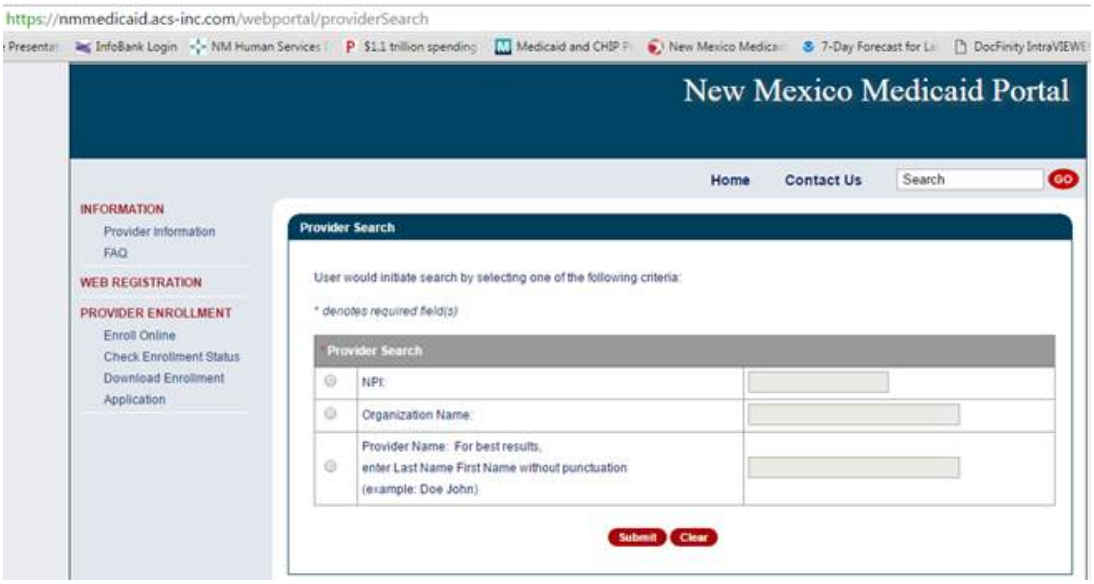
It is ultimately the responsibility of the Medicaid provider billing the service to obtain the NPI of the prescribing, referring, ordering, attending, or rendering provider and to confirm the provider's active enrollment in the Medicaid program. Each Medicaid provider will need to develop its own internal processes to ensure the enrollment requirement is met or the provider risks the claim being denied.

A provider may look up the NPI of a provider participating in the Medicaid program on the Conduent New Mexico Medicaid web portal and may also determine if the attending, ordering, referring, rendering, or prescribing provider is enrolled in the Medicaid FFS or managed care program as required.

1. From the main 'Provider Information' section of the portal https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm
2. Click on the 'Provider Search' link on the left side of the screen (highlighted in yellow below.) It can also be accessed directly by going to the URL: https://nmmedicaid.portal.conduent.com/webportal/providerSearch



3. Then search by NPI, organization name, or provider name.



4. You will get results such as those below.

5. To be considered to meet the Medicaid FFS or managed care enrollment requirements, a provider must either be “active” as a status 60 or “MCO” as a status 70 on the date of service on the claim.
6. If you do not get any results, re-check the information entered.
7. If you do not find the ordering, referring, or prescribing provider listed, and the individual provider works for the ~~Indian Health Services~~Indian Health Service or a tribal health care facility, an FQHC, or is a resident at University of New Mexico Hospital (UNMH), you can look up the organization using the provider name search field and use the NPI of that entity on the claim.

   You can search for an organization by putting part of the organization’s name in the search field. The NPI of an organization such as those listed above may be entered as the prescriber or referring provider.

2.9. Exclusions

At this time, reporting the rendering, referring, ordering, or attending providers on a claim are not required for the following provider types. However, to the extent that an MCO may already be requiring such information, there is no need for the MCO to discontinue the requirement.

Provider Type	Description
221	~~Indian Health Services~~Indian Health Service Hospital or Tribal Comp facility –
313	Clinic FQHC, Medical
314	Clinic, Rural Health Medical, freestanding
315	Clinic, Rural Health Medical, hospital-based
343	Methadone Clinic
346	Lodging, Meals
363	Community Benefit Provider (enrolled for MCOs only)
401	Ambulance, Air
402	Ambulance, Ground
403	Handivan
404	Taxi, or MCO General Transportation Contractor (Non-Capitated)
462	Case Management Agency (specialty required)

This may change in the future as we work with CMS and providers.

~~HSD~~HCA is not addressing value added services (VAS) at this time. If an MCO feels it is appropriate to notify providers of VAS that a rendering or referring provider or ordering provider is required, an MCO may do so. For example, a physician applying a dental fluoride varnish would reasonably be expected to be identified as a rendering provider; however, this is not stated on any FFS list.

When Medicare or a Medicare Advantage program has paid the claim, and the claim is being evaluated for co-insurance, deductible or co-payment, rendering, referring, ordering, or attending providers on a claim are not required. However, for any other claim with a prior payment, such as from an insurance company or a health maintenance organization plan, there is no exemption. The provider must add the information to the claim.

If MAD does not enroll certain providers of services that are in managed care, such as Support Brokers, there is no requirement for them to be actively enrolled in Medicaid. If a provider is enrolled or identified with a provider type in the 900 series of provider types, which are only applicable to managed care (such as a traditional healer), there is no current requirement that rendering, referring, ordering, attending providers be reported.

Medicaid is not requiring changes for pharmacy claims at this time. MAD is working on system changes within the State system to meet the Federal requirements for prescriber, but more work is needed. MCOs do not need to remove any requirements on pharmacy claims they may already have in place. School-based health clinics are not exempt from the requirements. Neither are out of state, out-of-network providers, or single case agreement providers exempt from the rule.

2.10. General Information on the Requirements based on Procedure Codes

Each procedure code in the Omnicaid System has an indicator on it that indicates if a rendering provider is required (with an S), a referring provider is required (with an R), or whether both are required (with a B) or if nothing is required (with an N).

A list of codes with the indicators is periodically provided to each MCO which includes most codes on the Rendering Provider Required by Procedure Code List.

However, there are some important considerations in using that list:

1. **Referring Requirements for Laboratories, Radiology Facilities, Suppliers of Prosthetics and Orthotics, Oxygen, DME, and Medical Supplies**

   The indicator on the procedure code list is not applicable to services billed by laboratories, radiology facilities, prosthesis and orthosis suppliers, oxygen suppliers, durable medical equipment and medical supply suppliers.

   For these providers there is always an expectation that the services were ordered and therefore the ordering provider must be indicated.

   Therefore, for example, the indicator on a lab code that says a rendering provider is required does not apply to these providers, not even the free-standing laboratory. Rather, the requirement that there should always be a referring provider is applicable.

   For a laboratory or radiology facility, a rendering provider would only be required when a professional interpretation billed (typically using modifier 26).

For claim processing and encounter purposes MAD does not make a distinction between referring or ordering providers. Either will meet the requirements when a referring provider is required.

2. Rendering Provider Requirements

The Rendering Provider Required by Procedure Code List described above may be used to determine when a rendering provider is required. However, there are other aspects to be considered, such as the billing provider type.

The following provider types are always exempt from reporting a rendering provider. This may change in the future, but until individuals working within these providers are always enrolled, we cannot enforce a rendering provider requirements:

Provider Type	Description
218	Treatment Foster Care Services
221	~~Indian Health Services~~Indian Health Service Hospital or Triba
324	Nursing, Private Duty
334	Optician
336	Orthotist
337	Prosthetist
338	Prosthetist & Orthotist
343	Methadone Clinic
344	HCBS or Mi Via Self-Directed Waivers
346	Lodging, Meals
363	Community Benefit Provider
405	Birthing Centers
412	Hearing Aid Supplier
414	Medical Supply Company
415	IV Infusion Services
416	Pharmacy
417	Pharmacy, Rural Health Clinic (RHC)
441	Developmental Delay Services
447	Renal Dialysis Facility
462	Case Management Agency

For clarity, MAD has prepared a list of all FFS provider types for which a rendering provider may be required (Rendering Provider Required by Provider Type List). If the provider is on this list, and the procedure code is on the Rendering Provider Required by Procedure Code List, a rendering provider should be reported.

The rendering provider cannot be the same as the billing provider if the billing provider is a group.

- A billing group provider number cannot be used as the rendering provider on the claim. There may be various ways of enforcing this.

  However, MAD has always designated whether a provider is a group practice or an individual. Most individual health professionals can belong to a group practice or practice individually. When it is possible for a provider ID to be either a "group" (G) or an "individual" (I), MAD is careful when processing an application to designate the provider as either G or I.

  This information is used when validating a rendering provider entered on a claim. Assume there is a professional group such as Scrooge and Marley Pediatricians with a G indicator and there is an individual within the group "Dr. Jacob Marley" with an I indicator.

  If the billing provider Scrooge and Marley Pediatricians also enters their group NPI number in the rendering provider field, the Medicaid Management Information Systems (MMIS) will detect the rendering provider is the same as the billing group and deny the claim.

  If the billing provider is an individual, Dr. Bob Cratchit, for example, and the NPI appears as both the billing provider and the rendering provider, the MMIS will recognize that the billing provider is an individual and therefore may certainly use the individual NPI in the rendering provider field. (This is done by using by-pass logic in the edit.)

  In the MMIS, the billing provider is propagated to the lines of the claim.

- This principle remains exactly the same for dental individual providers and dental group practices.

  Not all providers can be designated as a G and having many employees does not make a provider a group. The G distinction is largely for professional providers and the groups they form. Institutional providers such as hospitals are considered I, not as group, as is a hospice or an HHA – that is, they only function as individual entities.

  The only exception is the FQHC because it is a clinic and a clinic is considered a group practice.

  Depending on how the MCO processes Comprehensive Outpatient Rehabilitation Facility claims, such as if they use the UB format, there is a requirement for rendering providers to be identified for them.

- One of the major new requirements for Medicaid is the rendering provider must be reported for outpatient hospital services billed on the outpatient hospital claim.
- ~~Behavioral Health Codes Exempted from Reporting Rendering Provider~~

  ~~It is anticipated that many of the BH codes listed below will, at some point, require a rendering provider. Until there has been further communications with the providers, MAD will not require a rendering provider for the following. A chart showing the rendering provider requirements for BH services will be periodically updated and sent to the MCOs.~~

Note that for clarity, MAD will periodically send the MCOs lists of all codes that do and do not require a rendering provider. Also, a transportation provider never has to identify a rendering provider.

Note that if a MCO is already requiring rendering providers for these codes, there is no need for a MCO to stop doing so.

Also, please do not use this list to try to determine which codes are a benefit of the program. That is a different issue. We do not necessarily cover all the codes described above.

3. Attending Provider Requirements by Provider Type

The following providers require an attending provider. A rendering provider is never required unless the provider is not the facility, but rather a practitioner billing on the CMS 1500 form such as for skilled nursing facility (SNF) rehabilitation services, for example.

Provider Type	Description
201	Hospital, General Acute Inpatient
202	Hospital, Rehabilitation Unit in a General Acute Hospital Inpatient
203	Hospital, Rehabilitation or Other Specialty Hospitals- such as LTAC hospitals - Inpatient
204	Hospital, Psychiatric Unit in a General Acute Hospital Inpatient
205	Hospital, Psychiatric Free-Standing Inpatient
211	NF, Private for NF Stays
212	NF, State for NF Stays
213	Hospital, Swing-Bed for NF Stays
216	ARTC, Joint Commission accredited for Residential Facility Stays
217	RTC, not Joint Commission accredited for Residential Facility Stays
219	RTC Group Home, not Joint Commission accredited for Residential Facility Stays

The attending provider cannot be the same as the billing provider and must be an individual provider. The MMIS has edits that enforce this requirement.

4. The Referring Provider by Provider Type

The requirements for referring providers on some claims is covered in number 1, above. A referring provider is required from the following unless otherwise exempted in this document (such as when we say that Medicare cross overs are exempt from the requirement).

Provider Type	Description
351	Lab, Clinical Freestanding
352	Radiology Facility
353	Laboratory, Clinical with Radiology
354	Diagnostic Laboratory (physical measurements)
414	Medical Supply Company
415	IV Infusion Services
416	Pharmacy when billing on a CMS 1500 format
417	Pharmacy, RHC when billing on a CMS 1500 format
451	Occupational Therapy (OT) (may self-refer)
452	Occupational Therapist Licensed, not certified (may self-refer)
453	Physical Therapy (PT) (may self-refer)
454	Physical Therapist, Licensed, not certified (may self-refer)

Additional circumstances for which a referring provider is required are as follows:

Provider Type	Description
324	Nursing, Private Duty - referring is required when not being billed by an HHA
334	Optician - a referring provider must be indicated for glasses but not for repairs

Other providers are to report a referring provider when there is one, but generally unless the MCO specifically requires a referring provider for a service, it is not known whether the service was due to a referral.

However, the following procedure codes would seem to logically have a referring provider so it must be reported for them:

Description	Procedure Code	Requirement
Office Consultation	99241	R-Referring
Office Consultation	99242	R-Referring
Office Consultation	99243	R-Referring
Office Consultation	99244	R-Referring
Office Consultation	99245	R-Referring

At this time, CMS rules allow Medicaid to accept the referring provider can be an institution and not necessarily an individual. This is generally allowed when the referring provider is with a type of institution such as UNMH, an IHS facility, or tribal facility where interns, residents, and non-enrolled staff might be practicing. MCOs must also allow for this.

2.11. Appendices

2.11.1 Notification of Change in Services – Notification of Transition

2.11.2 MCO Notification to ~~HSD~~HCA of Change or Closure- Narrative for Provider/Facility

2.11.3 Transition Plan A- Overall Transition Plan Information- MCO Transition Plan for Provider/Facility

2.11.4 Transition Plan B- Member Specific Information for Provider

2.11.5 Definitions

2.11.1. Notification of Change in Services – Notification of Transition

MCO NOTIFICATION TO ~~HSD~~ HCA NOTICE OF CHANGE IN SERVICES ☐

MCO NOTIFICATION TO ~~HSD~~HCA- NOTICE OF TRANSITION ☐

*Expected Change ☐ *Unexpected Change ☐

Date:

Date MCO Notified of Closure:

Anticipated Date of Closure:

Name of Provider or Facility:

Type of Provider Individual:
☐Group:
☐Agency: ☐
Facility: ☐

Full contract termination? Yes ☐ No ☐

Addresses of all locations (include county and region type):

Type(s) of Service(s):

Satellite location terminating? Yes ☐ No ☐

Address of location terming (include county and region type):
Type(s) of Service(s) at location:

Terminating Services only? Yes ☐ No ☐

Type(s) of Service(s):

Total Number of Members Affected: <21 >21

Transition Plans Required? Yes ☐ No ☐

Narrative Due Date: (Due 10 calendar days after Notification):

The below items should be filled in only if transition plans are required.

Transition Plans A & B Due Date:
(Due 15 calendar days after Notification)

Name of MCO Staff and/or Care Coordinator Responsible for Transition:

*Notification of unexpected change is due within five business days of confirmed change. Notification of expected change is due 30 days prior to the confirmed change.

2.11.2. Transition Plans Narrative

MCO Notification to ~~HSD~~HCA of Change or Closure

Narrative For

(Provider/Facility Name)

Date:

MCO Staff and/or Care Coordinator:

Describe the reason(s) and/or circumstances and any contributing factors to the change or closure:

How the change affects delivery of, or access to, covered services (describe how the change impacts the system as whole and at the community level):

The MCO's plan for maintaining access and the quality of Member care:

Please explain all factors considered in making the determination that the change will not significantly impact the system and provide assurances that all Members will be transitioned to new providers (if applicable).

Transition issues identified

2.11.3. Transition Plan A

Overall Transition Plan Information

MCO Transition Plan For

(Provider Name) (Date)

	MCO task assignment	Comments	Begin Date	End Date
1. Preplanning				
MCO receives communication of contract, location, service closure.				
Closing program sends a formal letter to MCO advising of closing.				
List of affected members sent to MCO.				
List of special problems expected or associated with transition.				
MCO letter to affected members offering assistance (as needed).				
2. Network Operations				
Contracting department to complete Table A Provider Information.				
3. Transition planning				
Meeting with program or director.				
Complete plan to ensure program is appropriately referring and transitioning affected members.				
Progress updates of transition program.				
Template for Records Retention Completed and attached.				
4. Communication to ~~HSD~~HCA				
Submit notification.				

	MCO task assignment	Comments	Begin Date	End Date
Submit narrative.				
Submit Transition Plan A.				
Submit Transition Plan B.				
Bi-weekly updates of transition plans and narrative from MCO to state agency contact person.				
5. Care Coordination				
Identify Care Coordinators to be contact point for members seeking assistance.				
Care Coordinator review of community resources.				
Care coordination and MCO Clinical/UM Department tasks.				
Compile weekly report of care coordination.				
Meeting with MCO and program transition team to coordinate efforts, if applicable.				
Other requirements as needed depending on circumstances of closing.				
Transition plan finalized.				

MCO certifies the transition of all members has taken place and is finalized.

Signature:

_____**Date:** _____

2.11.4. Transition Plan B

TRANSITION PLAN B
Member Specific Information
(Provider Name)
(Date)

Member Name	Social Security Number	Medicaid ID	Member Date of Birth	Guardian (if applicable)	Services currently receiving (therapy, med monitoring, PCO, etc.)	Current Provider, address, phone number, county	County in which member recieves services

HUMAN SERVICES DEPARTMENT

TRANSITION PLAN B
Member Specific Information
(Provider Name)
(Date)

Service County Status: Rural, Urban or Frontier	Date of discharge	New Provider	Date of Transition or anticipated date	Appointment Date (for outpatient Services)	Care Coordinator and phone number (if applicable)	Special Conditions/Arrangements (Housing issues, social issues, etc.)	Special Condition/Arrangment Behavioral Health Code(s) - See Special Conditions Legend	MCO notified? (Y, N, NA)

2.11.5. Definitions

- **Certified Nurse Midwife (CNM)** means a registered nurse pursuant to the Nursing Practice Act who is licensed by the board of nursing for advanced practice and licensed by the Department of Health as a nurse-midwife.
- **Certified Nurse Practitioner (CNP)** means a registered nurse who is licensed by the board for advanced practice as a certified nurse practitioner and whose name and pertinent information are entered on the list of certified nurse practitioners maintained by the board.
- **Clinical Nurse Specialist (CNS)** means a registered nurse who is licensed by the board for advanced practice as a clinical nurse specialist and whose name and pertinent information are entered on the list of clinical nurse specialists maintained by the board.