State of New Mexico
Medical Assistance Program Manual

Supplement

DATE: MAY 13, 2015   **NUMBER: 15-03**

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS:

I.   ICD 10 IMPLEMENTATION

Providers are reminded that, effective October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA).

Providers are encouraged to learn about and stay up to date with ICD-10 by visiting the CMS ICD-10 website at http://www.cms.gov/Medicare/Coding/ICD10/Index.html Resources specific to providers can be found at the CMS website at: http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

Providers may also want to sign up to receive industry emails related to ICD 10 implementation at: http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html

For claims billed with dates of service (DOS) prior to October 1, 2015, providers should use the ICD-9 code set. For claims billed with DOS occurring October 1, 2015 and forward, providers should use the ICD-10 code set. The claim forms have indicators or qualifiers for the provider to indicate whether the diagnosis codes on the claim are ICD 9 or 10. However, for Medicaid claims the use of ICD 9 or 10 must correspond to the date requirements stated above.

It is important that providers coordinate and work with their trading partners and vendors to ensure they can meet these transition dates.

If you are a provider who does not usually diagnose, but uses medical records or another provider's order for diagnoses, and those records or orders contain diagnoses that were made prior to October 1, 2015 you must be prepared in advance to translate those codes into ICD 10 codes.

There are new documents related to ICD-10, including FAQs and information on testing, on the NM Medicaid Portal, available at this link: https://nmmedicaid.acs-inc.com/static/ProviderInformation.htm#ICD_10Testing The documents may also be accessed by going to the main portal page https://nmmedicaid.acs-inc.com/static/index.htm and then clicking, in the lower right corner, the link that is titled "ICD-10 Testing"

Providers should also review the E-News for details regarding upcoming ICD training and compliance. Archived editions of the E News are available on the portal at: https://nmmedicaid.acs-inc.com/static/E-News_and_Notices.htm

If you would like to receive the E-News by email, send a request to NMProviderSUPPORT at NMProviderSUPPORT@xerox.com and we will add you to the list.
If you need further information about the ICD-10 Transition, please contact the New Mexico HIPAA Helpdesk at (800) 299 – 7304 option 6 and then option 4 or (505) 246 – 0710 option 4 or via email at HIPAA.Desk.NM@xerox.com.

II. BILLING USING PAPER CLAIMS

Some New Mexico Medicaid providers continue to submit claims using paper forms instead of using electronic claims submission. NM Medicaid has now discontinued the process of allowing providers to bill on paper. Effective July 31, 2015, NM Medicaid will begin the process of purging provider IDs from the exception roster, which will cause claims to deny if billed on paper. This action is being taken to reduce administrative expense, reduce processing errors and improve processing times.

Providers will be able to continue to bill on paper when they are submitting a claim with a proper attachment. We encourage providers to review the approved attachment codes posted on the Medicaid web portal at: https://nmmedicaid.acs-inc.com/static/index.htm Once a provider has been purged from the exception roster, paper claims submitted with invalid attachment codes will automatically be denied.

In an effort to lessen the impact to providers Xerox, the NM Medicaid fiscal agent, has outreached providers with the highest volume of paper claim submissions in 2014 which includes; Physicians, Dentists, Medical Supply Companies, Behavioral Health Agencies, Clinic Federally Qualified Health Centers (FQHC), Ground Ambulance, Physical Therapists, Ambulatory Surgical Centers (ASC), Rehabilitation Centers, Nurse Practitioners, Residential Treatment Centers (RTC), License Professional Clinic Counselor (LPCC) and Non-Profit Clinics. Xerox has received positive feedback as many of the providers are considering using the Medicaid web-portal.

The advantages of submitting electronically include: 1) a hard-copy (paper) claim goes through many clerical channels before it is entered into the MMIS for payment. This is a very time-consuming process. In the case of a pended claim, the time between receipt of the original claim and payment can increase by weeks, and 2) electronic claims are pre-edited for errors and have a much higher payment-to-denial ratio.

Providers may submit electronic claims either singly or as a batch:
Single claim submission (less than 30 claim a month): Providers have the ability to utilize the Online Claims Entry feature on the New Mexico Medicaid Web Portal at https://nmmedicaid.acs-inc.com/static/index.htm . This new feature will allow Providers to create timesaving templates that allow you to save repeatable claims information. All submissions will have real-time claims adjudication with instant claim status response. This feature also allows the submission of adjustments or voids of claims that were previously submitted through the web using the new Online Claims Entry feature. Providers have the ability to attach required documents electronically. Providers may review training presentations on the topic of online claims entry on the web portal at: https://nmmedicaid.acs-inc.com/static/ProviderInformation.htm#TrainingPresentations

Batch submission: Providers can take advantage of electronic transactions by sending claims directly to an approved NM clearinghouse or billing agent. Providers are also encouraged to review EDI information posted on the Medicaid Web portal: https://nmmedicaid.acs-inc.com/static/ProviderInformation.htm

If you have any questions on the above information please call the New Mexico Medicaid Call Center at 1-800-299-7304 or HIPAA.Desk.NM@xerox.com

III. COUGH AND COLD COVERAGE

Effective August 1, 2015, pharmacy claims for cough and cold products will be denied if the eligible recipient is under the age of four.

The U.S. Food and Drug Administration's (FDA) Nonprescription Drug Advisory Committee has reviewed the safety and efficacy of over the counter (OTC) cough and cold products in children and made recommendations for their use in young children. The FDA issued a public health advisory recommending parents not use these products in children younger than two years of age. After continued meetings with the FDA, the Consumer Healthcare Products Association (CHPA), who represent the OTC cough and cold product manufacturers, announced that its members would voluntarily revise the labels of children's cough and cold medicines to indicate that the products should not be used in children younger than four (4) years of age.

More information on this change can be found at the FDA's website: http://www.fda.gov/drugs/resourcesforyou/specialfeatures/ucm263948

New Mexico Medical Assistance Division (MAD) lists cough and cold preparations for an eligible recipient under the age of four to the pharmacy as a non-covered service. See 8.324.4.14 NMAC, Noncovered Services or Service Restrictions, available on the HSD/MAD website at: http://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx .

IV. THREE DIMENSIONAL SCREENING AND DIAGNOSTIC MAMMOGRAPHIES

Breast tomosynthesis (threedimensional (3D) mammography) produces direct digital images and is appropriately reported using one of the three existing HCPCS codes that describe digital mammography services. When using these codes to bill a 3D image, the two-dimensional image is included. Breast tomosynthesis, and all other types of digital mammography, are described using the following codes:

G0202 Screening mammography, producing direct digital image, bilateral, all views
G0204 Diagnostic mammography, direct digital image, bilateral, all views
 G0206 Diagnostic mammography, producing direct digital image, unilateral, all views

Effective January 1, 2015, by following Medicare's billing procedures, Medicaid providers may bill mammography codes with add-on codes in order to be reimbursed for 3D

screening and diagnostic mammographies. Screening and diagnostic mammographies may both be billed on the same day, however, modifiers must be used to bypass the National Correct Coding Initiative (NCCI) edits if appropriate.

Providers may refer to the Medicare MLN Matters information sheet Number: MM8874 available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf for more information on the Medicare policy.

G0202   (existing 2D mammography screening code) SCREENING MAMMOGRAPHY, PRODUCING DIRECT DIGITAL IMAGE, BILATERAL, ALL VIEWS

Global rate:	$113.68
Technical (TC) rate:	$81.18
Professional rate (26):	$32.51
OPPS:	$81.18 OPPS JA

77063   (add-on to G0202) SCREENING DIGITAL TOMOGRAPHY OF BOTH BREASTS

Global rate:	$53.67
Technical (TC) rate:	$37.92
Professional rate (26):	$15.10
OPPS:	$23.74 OPPS JA

G0204   (existing 2D mammography bilateral diagnostic code) DIAGNOSTIC MAMMOGRAPHY, PRODUCING DIRECT 2D DIGITAL IMAGE, BILATERAL ALL VIEWS

Global rate:	$120.25
Technical (TC) rate:	$79.94
Professional rate (26):	$40.30
OPPS:	$110.16 OPPS JA

G0206   (existing 2D mammography unilateral diagnostic code) DIAGNOSTIC MAMMOGRAPHY, PRODUCING DIRECT 2D DIGITAL IMAGE, UNILATERAL, ALL VIEWS

Global rate:	$97.26
Technical (TC) rate:	$64.76
Professional rate (26):	$32.51
OPPS:	$86.50 OPPS JA

G0279	(add on to G0204 or G0206) DIAGNOSTIC DIGITAL BREAST TOMOSYNTHESIS, UNILATERAL OR BILATERAL (LIST SEPARATELY IN ADDITION TO G0204 OR G0206)	
Global rate:	$54.09	
Technical (TC) rate:	$23.78	
Professional rate (26):	$30.38	
OPPS:	$23.78	OPPS JA

V. REPORTING RENDERING, ORDERING, REFERRING, PRESCRIBING AND ADMITTING PROVIDERS

Providers submitting claims to the Medicaid program must identify the referring, prescribing, ordering, and admitting providers on most claim forms.

The Centers for Medicare and Medicaid Services (CMS) require that rendering, ordering, referring, prescribing and admitting providers generally be identified on claims in order for Medicaid to make payment on the claims.

Existing requirements for reporting rendering, ordering, referring, prescribing and admitting providers:

- In May 2012, the Medical Assistance Division (MAD) issued supplement 12-05 that contained information on the requirement that providers must begin reporting the prescribing, referring, or ordering provider on claims submitted for payment to the New Mexico Medicaid Fee-for-Service (FFS) program. This requirement became effective July 1, 2012, with the following instructions:

  - Providers of services that are ordered or prescribed (such as a laboratory or radiology facility, a pharmacy or medical supply company) will always need the NPI of an ordering or prescribing practitioner in order to submit their own claims for payment to the New Mexico Medicaid program. We strongly urge providers to share their NPIs with these other entities. When ordering, referring or prescribing items or services, please make your NPI available to the providers who will be billing for those services.

  - The NPI is reported in the following ways:
    CMS-1500: Report the NPI of the referring /ordering / prescribing provider in Field Locator 17b

    UB-04: Report the NPI of the referring /ordering provider in Field Locator 78

Pharmacy: Mandatory for NCPDP (pharmacy transactions) Report the NPI of the prescribing provider in segment 411-DB

Electronic: When billing electronically, corresponding fields on the 837 electronic transactions must contain the information. The following loop, segment and element places may be used in order to report the referring or ordering provider's NPI and name:
Referring Provider Last Name – 2310A, NM1/DN, 03
Referring Provider First Name – 2310A, NM1/DN, 04
Referring Provider's NPI – 2310A, NM1/DN, 09
Ordering Provider's Last Name – 2420E, NM1/DK, 03
Ordering Provider's First Name – 2420E, NM1/DK, 04
Ordering Provider's NPI – 2420E, NM1/DK, 09

- Referring provider requirements:
  There will not always be a referring provider for many services. However, for some provider claims, there must always be a referring provider NPI in the appropriate field:
  IV Infusion Services
  Lab, Clinical Free Standing
  Lab, Clinical With Radiology
  Laboratory, Diagnostic
  Medical Supply Companies
  Occupational Therapists
  Orthotists
  Physical Therapists
  Prosthetists
  Radiology Facility
  Rehabilitation Centers

- Specific Provider Instructions:
  o Dental claim, rendering practitioner: report the NPI of the treating dentist in field 54
  o Lab and radiology claims: the ordering practitioner must be identified. Report the NPI of the referring/ordering / prescribing provider in Field Locator 17b (Referring Physician NPI)
  o Medical supply claim: the ordering practitioner NPI must be indicated. Report the NPI of the referring /ordering / prescribing provider in Field Locator 17b (Referring Physician NPI)

- Pharmacy claim: the prescriber NPI must be indicated. Mandatory for NCPDP (pharmacy transactions) – report the NPI of the prescribing provider in segment 411-DB
- Practitioner claims (CMS 1500 format): The rendering NPI must be provided, and if there is a referring provider, that must be indicated also. Report the NPI of the referring /ordering / prescribing provider in Field Locator 17b (Referring Physician NPI)

The final implementation of CMS requirements to enforce standards that are already applicable to Medicare claims are as follows:

- Home Health Agency claims: the ordering practitioner NPI must be indicated in the attending provider field in form locator 76 (Attending Provider Name and Identifiers)
- Hospice claim: the attending NPI is required. Report the NPI in form locator 76 (Attending Provider Name and Identifiers)
- Hospital Inpatient claim: the attending practitioner must be identified in form locator 76 (Attending Provider Name and Identifiers)
- Hospital Outpatient UB claims: Report the NPI of the referring /ordering provider in Field Locator 78 (Other Physician's Name and Identifier)
- Nursing facility claims: the ordering provider goes in the attending field. Report the NPI in form locator 76 (Attending Provider Name and Identifiers)
- Transportation claims: Report the NPI of the referring /ordering / prescribing provider in Field Locator 17b (Referring Physician NPI)

Beginning August 1, 2015, any claim submitted to the Medicaid program's fiscal agent for the Fee for Service program that does not have NPI information as required will be denied. This is necessary to comply with federal requirements.

VI. REQUIREMENT FOR PRESCRIBING, REFERRING, ORDERING, PROVIDERS TO BE ENROLLED WITH THE MEDICAL ASSISTANCE DIVISION

Effective July 1, 2015, in order for MAD to reimburse claims for services or items that result from a practitioner's referral, order or prescription, the prescribing, referring, or ordering provider must be actively enrolled with MAD either as a FFS provider, a managed care organization (MCO) provider, or as both.

This requirement is a provision of the Patient Protection and Affordable Care Act (PPACA). All claims submitted for the New Mexico Medicaid FFS program to Xerox company (or, for pharmacy claims, to the Xerox PDCS system) for payment for ordered, prescribed or referred items or services must include the NPI of the prescribing, referring

or ordering-only practitioner and that prescribing, referring or ordering-only practitioner must be actively enrolled with MAD.

- When a provider does not have an individual NPI, but is permitted under State law to order, prescribe or refer services for Medicaid eligible recipients, a provider may use the NPI of the facility or hospital out of which they practice. Common examples are interns, and possibly residents, practicing at the University of New Mexico Hospital; practitioners practicing at Indian Health Services (IHS) clinics; or, practitioners working at a comprehensive outpatient rehabilitation facility (CORF). In these cases, a provider may use the NPI of the facility as the referring, ordering or prescribing NPI. All other providers should report the referring, ordering, or prescribing NPI as applicable.

- Prior to July 1, 2015, MAD also intends to make a change to the Xerox/MAD web portal such that an MCO or a provider may enter an NPI number for a provider and see the status of enrollment of that provider, if any, from the OmniCaid provider file. A reverse search by name will also be possible. MAD anticipates this will help providers determine if other providers are already enrolled in Medicaid as well as check on the status of their own enrollment.

- MAD is also adding several new provider specialties and some provider types to assure that all non-independent practice behavioral health providers, physical and occupational therapy assistants, pharmacists with prescribing authority and other individuals will be able to be enrolled as rendering or prescribing providers in the Medicaid program. Providers will be informed when this change is made.
  Currently, some but not all, non-independent practice behavioral health providers are able to enroll as a Medicaid provider. The upcoming changes should allow all non-independent practice behavioral health providers to enroll.

- A provider may enroll by accessing the New Mexico Medicaid web portal at https://nmmedicaid.acs-inc.com/static/index.htm or by contacting Xerox's Provider Relations Help Desk at 800-299-7304 or 505-246-0710.

  A provider can choose to participate only in managed care if the provider does not wish to participate in the fee-for-service Medicaid program. When a provider is enrolled through the Medicaid program, information is given to the MCOs.

  The PPACA requires prescribing, referring or ordering-only providers to enroll only to meet new PPACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

Enrolling in NM Medicaid as a prescribing, referring or ordering-only provider:
  • Does not obligate you to see Medicaid patients;
  • Does not require an annual renewal; and,
  • Helps ensure that your prescriptions, referrals and orders for Medicaid patients are accepted and processed appropriately.

All claims submitted for the New Mexico Medicaid FFS program to Xerox (or, for pharmacy claims, to the Xerox PDCS system) for payment for ordered, prescribed or referred items or services must now include the NPI of the prescribing, referring or ordering-only practitioner and that prescribing, referring or ordering-only practitioner must be actively enrolled with MAD and/or a NM Medicaid Centennial Care MCO.

It is ultimately the responsibility of the Medicaid provider rendering the service to obtain the NPI of the prescribing, referring or ordering-only provider and confirm that the prescribing, referring or ordering-only is enrolled in the NM 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 claims being denied.
MAD suggests that pharmacies and other providers require any prescribing, referring or ordering-only provider to include their NPI on any prescription/order/referral he or she writes. This will allow the provider filling the prescription or performing the ordered service to verify the provider's Medicaid enrollment, before preparing the claim.
For retail pharmacies filling a prescription for medication, simply bill the claim using your point-of-sale (POS) system with the NPI of the prescriber. If the prescriber is not enrolled with Medicaid, you will receive a claim rejection that informs you of the prescriber's status.

Information specifically for managed care organizations: Effective July 1, 2015 Billing and rendering providers must be enrolled in the Medicaid program either as a managed care provider (status 70) or as a fee for service (FFS) & managed care provider (status 60).
The purpose of the requirement is to assure that billing providers and rendering providers can always be identified by having their NPI numbers registered in the Omnicaid provider file. It will also assure that encounter data can be submitted by the MCO and accepted by MAD.

Beginning with dates of service on July 1, 2015, an MCO may suspend or deny claims for which the rendering or billing provider is identified with an NPI that is not associated with an active FFS or managed care provider record (status 60 or 70), except as follows:

VII.   SERVICES PROVIDED IN SCHOOLS

A service that is in the Individual Education Plan (I.E.P.) or Individual Family Education Plan (I.F.S.P.) can only be billed by a school. Even if you currently have a contract with a school for which you provide services as part of an I.E.P or I.F.S.P., that service must be billed to the Medicaid program by the school and it is the school that will be paid by Medicaid.

If a service is provided in a school, and the service is in the I.E.P. or I.F.S.P. the place of service on the claim must be reported as 03 – school.

Each provider with a contract with a school must make certain that the contract requires the school to bill for services in the I.E.P. or I.F.S.P. The school then pays the provider according to their contract for services and payment rate.

A MAD school-based service that is in the eligible recipient's ITP and IEP or IFSP must only be billed by the provider, not its employees. When the provider utilizes a contracted practitioner to render the service, the provider must submit the claim, not the contracted practitioner. It is the responsibility of the provider to reimburse the contracted practitioner.

It is possible that not all services rendered by the provider to students at a school will be billable by the school to the Medicaid program, such as coordinating the services with the school or consultation with principals, school counselors, or teachers. The school's payment to the provider may include some of those services that cannot be billed by the school to Medicaid. This is a contract issue between the school and the provider.

School districts are able to bill and be reimbursed for certain Medicaid-related administrative activities, such as conducting Medicaid-related outreach; facilitating Medicaid eligibility determinations; coordinating transportation to Medicaid-covered services; making referrals; coordinating and monitoring Medicaid services; and engaging in medical service program planning, policy development and interagency coordination. But these services are paid to the schools as an administrative payment, not by individually billed claims.

If a service is not included in the I.E.P. or I.F.S.P. because it is being performed at the school for the convenience of the student, the provider of the service may bill the services to the Medicaid program or to the managed care organization if the child is enrolled in a managed care organization. For a service taking place in the school, billing of the Medicaid program or managed care organization directly by the provider is only allowed when the service is not in the I.E.P. or I.F.S.P. but is medically necessary and is not primarily educational in nature.

Even when services not in the I.E.P or I.F.S.P. are billable to Medicaid or a managed care organization, additional activities such as coordinating the student's treatment or services with the school, school counselors, principals, or teachers are not billable to the Medicaid

program, either as a consultation or evaluation and management code. The school may be able to pay the provider for such, but the provider cannot bill the Medicaid program for the coordinating and consultation services.

A practitioner's coordination with the eligible recipient's school or contractor, or his or her consultation with principals, school counselors, or teachers is not billable as a service by the practitioner. The practitioner must consult with the provider to determine if it will include such activities in its contract with the practitioner. The provider may not bill MAD separately for these services but can include them as administrative costs.

VIII. REQUIREMENT TO USE CURRENT ADA DENTAL CLAIM FORM

On May 1st, 2015, NM Medicaid will no longer accept the American Dental Association (ADA) 2006 paper claim form. ADA 2006 paper claim forms received on or after May 1st, 2015 will not be processed and will be returned to the provider.

Prior to May 1, 2015, providers are encouraged to:
- Submit claims electronically using your electronic billing services or through the NM Medicaid Portal (https://nmmedicaid.acs-inc.com/static/index.htm)
- Obtain and start using the ADA 2012 paper claim form (for more information, see the ADA website: http://www.ada.org/en/publications/cdt/ada-dental-claim-form)
- Providers are reminded it the provider's responsibility to submit claims correctly and within the timely filing guidelines.

If you have any questions please call the Xerox New Mexico Medicaid Call Center at 1-800-299-7304, option 6.

IX. NEW MEXICO ALTERNATIVE BENEFIT PLAN – A REMINDER

Provisions in the federal Patient Protections & Affordable Care Act (PPACA), effective January 1, 2014, created a new group of eligible individuals that are covered for many Medicaid services. These recipients have been referred to as the "Other Adult Group" or the "Expansion Population".

Because their benefits under Medicaid are a little different from the standard Medicaid covered services, to distinguish them from other Medicaid recipients, this particular Medicaid program is known as the "Alterative Benefit Plan (ABP) and the recipients are commonly known as "Alternative Benefit Plan recipients" or just "ABP recipients". Providers should refer to Medical Assistance Division (MAD) supplement 14-02, containing detailed information on the ABP, available at the MAD website under "Providers", "New Mexico Administrative Code Program Rules and Billing", "Supplements to NMAC Program Rules" or at http://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx It is important to note that the information contained specifically in Item VII of supplement 14-02 (Cost

Sharing – Copayments) is no longer valid. Updated copayment information for ABP recipients can be found in the charts described below:

Providers may access a table providing a comparison of the ABP services package to the Standard Medicaid services package. Since individuals who have ABP coverage will always be ages 19-64, the comparison to Standard Medicaid coverage is for the same age range (ages 19 and above). This table is available on the MAD website under "Looking for Information", "Information for Recipients", "Alternative Benefit Plan vs. State Plan Comparison Chart" or at http://www.hsd.state.nm.us/LookingForInformation/client-co-payments.aspx

A chart containing detailed information related to cost sharing provisions, including co-pays, is also available on the MAD website under "Looking for Information", "Information for Recipients", "Cost Sharing Chart" or at http://www.hsd.state.nm.us/LookingForInformation/cost-sharing-chart.aspx

Providers may also inquire about a recipient's eligibility and benefits by logging in to the New Mexico Medicaid Portal at https://nmmedicaid.acs-inc.com/static/providerlogin.htm or by calling the New Mexico Medicaid fiscal agent, Xerox. The Xerox Eligibility Help Desk can be reached at 505-246-2056 or 800-705-4452, and the Automated Voice Response System (AVRS) at 800-820-6901.

X.   NATIONAL CORRECT CODING INITIATIVE UPDATES

The Centers for Medicare and Medicaid Services (CMS) required states to implement a new group of Procedure to Procedure (PTP) edits relating to durable medical equipment (DME).

These new National Correct Coding Initiative (NCCI) PTP DME edits are used to process Medicaid claims effective January 1, 2015. These edits are associated with exception code 6506.

This is in addition to the previous two groups of NCCI edits already in place which are: (1) PTP edits for practitioner and ambulatory surgical center (ASC) services; and (2) PTP edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services).

NCCI PTP edits define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Providers are reminded to keep up to date with the policy manual, code sets, FAQs and other documents related to the NCCI program that are frequently released or updated by the Centers for Medicare and Medicaid Services (CMS) on their NCCI website at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

Providers are also encouraged to read the notice on multiple topics, including new NCCI edits and modifiers, available on the NM Medicaid Portal at:
 https://nmmedicaid.acs-inc.com/static/PDFs/NCCI_And_Other_Topics.pdf

XI.   MEDICATION ASSISTED TREATMENT SERVICES FOR OPIOID ADDICTION –REMINDER

The New Mexico Medicaid program covers Opiate Treatment Program (OTP) services. These are "medication assisted treatment" (MAT) services for opioid addiction. These programs are often called "methadone clinics".

The New Mexico Medicaid program will pay for MAT services when provided by an opiate treatment center that is enrolled with the NM Medicaid program and when provided to eligible Medicaid recipients who have full NM Medicaid benefits.

Methadone for treatment of opioid addiction can only be provided by a federally certified OTP. Methadone cannot be prescribed in an office-based setting to treat opioid addiction. We encourage providers who treat clients that could benefit from MAT services to refer those clients to an OTP for further treatment of their opioid addiction.

The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a website with helpful information, news and resources for providers, available at:
http://dpt.samhsa.gov/

XII.   NM HSD FRAUD, WASTE AND ABUSE REORGANIZATION

On January 19, 2015 the Human Services Department placed all Fraud, Waste and Abuse actions under the authority of the Office of the Inspector General. This now includes all Medicaid provider cases. The Office of the Inspector General is mandated to conduct audits and reviews of all HSD administered services and looks forward to working with all providers in the future. If you have specific questions please contact the Investigations Bureau Chief, Mr. David Gonsalez at 505-222-9368 or by email DavidR.Gonsalez@state.nm.us.

Prevention and detection of fraud, waste, and abuse is not solely the government's responsibility. Providers play an important role as well. Legitimate providers and the government share the same goal: provision of quality medical care appropriately documented and billed. If a provider learns something that indicates another provider may be engaging in suspect practices, there are several options available for reporting. Suspect provider practices shall be reported to:

- NM Human Services Department Office of Inspector General email HSDOIGFraud@state.nm.us or call 1-800-228-4802

- NM Attorney General's Office Medicaid Fraud and Elder Abuse Division : Call 1-800-525-6519

A Medicaid provider is responsible for assuring that his or her staff is educated on false claims. Providers should refer to Article IX (*Employee Education Regarding False Claims)* of the Provider Participation Agreement for more information.

CMS' Center for Program Integrity provides educational resources to educate providers, beneficiaries and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse.
There are several available resources including print and electronic media, toolkits, train-the-trainer guides, webinars, videos, and other innovative strategies for those in the Medicaid community.   Topics covered include beneficiary card sharing, compliance for the dental professional, drug diversion, personal care services, and more.
These resources are available on the CMS website at: http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html

If you have questions regarding the information in this Supplement, you may contact the Medicaid Program Policy Bureau at (505) 827-3171.

We appreciate your participation in the Medicaid program.