




State of New Mexico
Medical Assistance Program Manual
Supplement



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TO: ACUTE CARE, SKILLED NURSING, LONG-TERM CARE, AND HOME HEALTH FACILITIES/AGENCIES

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SUBJECT: SUSPENSION OF PRIOR AUTHORIZATION REQUIREMENTS FOR SKILLED NURSING, LONG-TERM CARE, AND HOME HEALTH FACILITIES/AGENCIES

This Supplement replaces Supplement 22-12. The New Mexico Human Services Department, Medical Assistance Division (HSD/MAD) is issuing this Supplement to inform providers of a change in program requirements related to the Public Health Emergency Order declared by the New Mexico Department of Health (DOH) on December 5, 2022.

Increased demand for in-patient care resulting from Respiratory Syncytial Virus (RSV), Influenza-Like Illness (ILI) and COVID-19 has caused acute care facilities (ACF) in New Mexico to expand their inpatient and intensive care units beyond normal capacity. As an individual who receives treatment in an ACF stabilizes, a skilled nursing, long-term care, or home health facility/agency may be able to provide necessary ongoing care. When medically appropriate, transferring a patient from an ACF to one of these alternative settings frees capacity in the ACF.

Therefore, HSD is suspending all prior authorization requirements relating to the discharge and transfer of any patient from an ACF to a skilled nursing, long-term care, or home health facility/agency for the duration of this public health emergency (PHE).

ELIGIBILITY VERIFICATION

- a. Providers must always verify an individual's eligibility for Medicaid. A provider must confirm client eligibility using one of the following tools:
NM Web Portal: <https://nmmedicaid.portal.conduent.com/static/index.htm>
Medicaid Eligibility Verification System (MEVS) at 1-800-299-7304 or 1-505-246-0710 option 4, then option 1
Automated Voice Response System (AVRS) at 1-800-820-6901, available 24 hours a day, 7 days a week for checking eligibility.

CLAIM SUBMISSION GUIDANCE

1. **Skilled Nursing/Long-Term Care Facilities:** Providers who receive a Medicaid eligible client as a transfer from an ACF will not have to go through Comagine for a level of care review. These “short term” admissions will still require a level of care segment be added to the client file. “Short term” for a nursing facility stay is defined as those stays that are less than 90 days. The following steps must be followed to ensure that this information is in place prior to submitting a claim. If the client file does not reflect a level of care for the specific dates of service, the claim will be denied. Stays beyond 90 days must go through the regular process required for level of care review.
 - a. Submitting for a Level of Care (LOC): Providers must follow this instruction to request a level of care for clients they receive as an ACF transfer. The following required information must be sent via email to the Consolidated Customer Service Center (CCSC), Help Desk at NM.Providers@hsd.nm.gov, with the subject line “Acute Care Facility Transfer to Nursing Facility”. The information will be used to load a level of care segment for the client. A level of care must be on file to process the claim.
 - i. Client Name
 - ii. Client Medicaid ID
 - iii. Date of Birth
 - iv. Provider Name
 - v. Provider Number
 - vi. Date of Admission
 - b. Required Claim Information: Providers will continue to submit on the UB claim format. In addition to the information providers currently enter on the claim, the claim will require the following:
 - i. Verify that the LOC is in place via the NM Web portal.
 - ii. Use only Revenue Code 0190 (Long Term Care/Residential Room and Board) to bill room and board for these transfers. The room and board service will be reimbursed at the “Low Nursing Facility” per diem rate reflected on the provider’s Institutional Rate File for the date of service.
 - iii. Enter a Condition Code of DR (Disaster Relief) in a box between 18-28 of the UB04 or loop 2300 and segment HI where HI01 – 1 = BG and HI01 – 2 = DR for Electronic Data Interchange (EDI). This will be used for tracking purposes and will not have an impact on reimbursement.
2. **Home Health Agencies:** A Medicaid eligible client who is discharged from an ACF that requires “short term” continued care at home can be referred for care through an enrolled Medicaid Home Health provider without a prior authorization review by Comagine. “Short term” for home health care is defined as care provided for a period of no more than 60 days. If care is required beyond the 60 day period, the provider must go through the regular process for approval.
 - a. Before a claim is submitted to the MAD Fiscal Agent, Conduent, and to avoid a claim denial, the following required information must be sent via email to the Consolidated Customer Service Center (CCSC), Help Desk at NM.Providers@hsd.nm.gov, with the subject line “Acute Care Facility to Home Health”. The information will be used to load required information to bypass the prior authorization requirement.
 - i. Client Name
 - ii. Client Medicaid ID
 - iii. Date of Birth
 - iv. Provider Name
 - v. Provider Number
 - vi. Date of Admission
 - vii. Revenue Codes
 - viii. Units of service for each revenue code

b. Required Claim information:

- i. Verify that the Prior Authorization (PA) is in place via the NM Web portal.
- ii. A claim should not be submitted until the above information has been provided.
- iii. Claim submission requirements and reimbursement do not change.
- iv. Enter a Condition Code of DR (Disaster Relief) in a box between 18-28 of the UB04 or loop 2300 and segment HI where HI01 – 1 = BG and HI01 – 2 = DR for Electronic Data Interchange (EDI). This will be used for tracking purposes and will not have an impact on reimbursement.

This Supplement will sunset upon the end of the DOH declared public health emergency.

Please contact the [Conduent](#) Consolidated Customer Service Center (CCSC) Provider Help Desk at 1-800-299-7304 if you have any questions regarding this Supplement.