State Level Registry
Procedure Manual

New Mexico Medicaid Program

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Introduction

New Mexico Medial Assistance Division (MAD) (referred to as "MAD" throughout the document) is participating in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) incentive payment program for Medicaid Eligible Professionals (EPs) and Eligible Hospitals (EHs). The EHR program provides an incentive payment to MAD providers that adopt, implement, or upgrade (AIU) EHR technology and subsequently meets the meaningful use (MU) criteria. The incentive payments are part of the American Recovery and Reinvestment Act (ARRA) health care initiative to promote the use of Health Information Technology (HIT) to improve the health care outcomes and provide cost saving efficiencies in the health care system.

The Conduent National State Level Registry Service Delivery Team is responsible for the client facing support of the Medicaid EHR incentive program. The team is responsible for the implementation, maintenance and new product releases relating to the State Level Registry website and dashboard.

Conduent ABQ staff are responsible for Tier 1 and Tier II calls, provider relations with those seeking enrollment in the SLR as well as those needing to enroll as Medicaid providers, pre-payment verification.

Providers can enroll in the MAD EHR program as early as July 2011 or as late as 2016 in order to receive the maximum incentive payments allowed, per the CMS final rule.

EHR program operations are divided among four functional areas for the EHR incentive program:

- Determining eligibility
- Registration and attestation
- Processing payments
- Auditing processes

Conduent State Level Registry staff support providers in the EHR program enrollment and attestation processes, process documentation received from enrolling providers and offer those providers timely and professional correspondence.

This document describes detailed processes for each functional area and how the SLR is used in these areas.

EHR Program Overview

Determining Provider Eligibility

Prior to enrollment in the EHR program, both Eligible Professionals (EP) and Eligible Hospitals (EH) must meet eligibility requirements for participation in the New Mexico Medicaid EHR program. Eligibility requirements for EP and EH are based on provider type and patient volume thresholds.

Eligible Professionals (EPs) Eligible for EHR Enrollment	
Provider	**Provider Type**
Physician, Non-Pediatrician	• 301 – Specialty Type 301
Physician, Pediatrician	• 301 – Specialty Type 337
Physician, Doctor of Osteopathy	• 302 – Specialty Type 301
Physician Assistant (Practicing in an FQHC or RHC that is "so led" by a Physician Assistant)	• 305 – Specialty Type 305
Certified Nurse Practitioner	• 316 – Specialty Type 316
Certified Nurse Midwife	• 322 – Specialty Type 322
Dentist	• 421 – Specialty Type 421
Patient Volume	
• ≥ 30% Medicaid patient volume ≥ 20% for pediatricians only or • Practice predominantly in an Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with ≥30% needy individual patient volume	
Additional Requirements	
• Not hospital based	
• Enrolled as a fee-for-service provider	
• Follow all MAD provider participation processes	
• NM licensed (except IHS providers who can be licensed in any state)	
• Credentialed where necessary, not sanctioned, and living	
• Association with a tax identification number (TIN)	
Group Practice Requirements	
• The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP	

• There is an auditable data source to support the clinic's or group practice's patient volume determination
• All EPs in the group practice or clinic must use the same methodology for the payment year
• The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way
• If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated

Eligible Hospitals (EHs) Eligible for EHR Enrollment	
Provider	**Provider Type**
• Acute Care Hospital	• 201 • 221
• Children's Hospital	• There are currently no separately certified children's hospitals in New Mexico
Patient Volume	
• Meet a 10% patient volume threshold • The exception to hospital patient volume is for children's hospitals, as they have no patient volume requirement	
MAD Requirements	
• Enrolled as a MAD fee for service provider	
• Follow all MAD provider participation agreement processes	

Additional EHR program participation requirements are summarized in the Appendices.

Registration and Attestation

http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

https://ehrincentives.cms.gov/hitech/login.action

During registration at the CMS Registration and Attestation System, providers need their National Provider Identification (NPI) number and a Federal Tax Identification number (TIN) for the payee to whom the incentive payment should be made. Incentive payments can be made to the individual eligible provider (EP) or an eligible provider (EP) may choose to reassign payment to a TIN associated with his or her employer or the facility in which she or he works. Prior to registration at the CMS Registration System, it is critical that EPs review their business arrangements and make a decision on payment designation. New Mexico Medicaid does not make this decision for EHR Incentive Program .

The tax identification number (TIN) of the individual or entity receiving the incentive payment must be associated with the individual provider in the Medicaid Management Information System (MMIS) system.

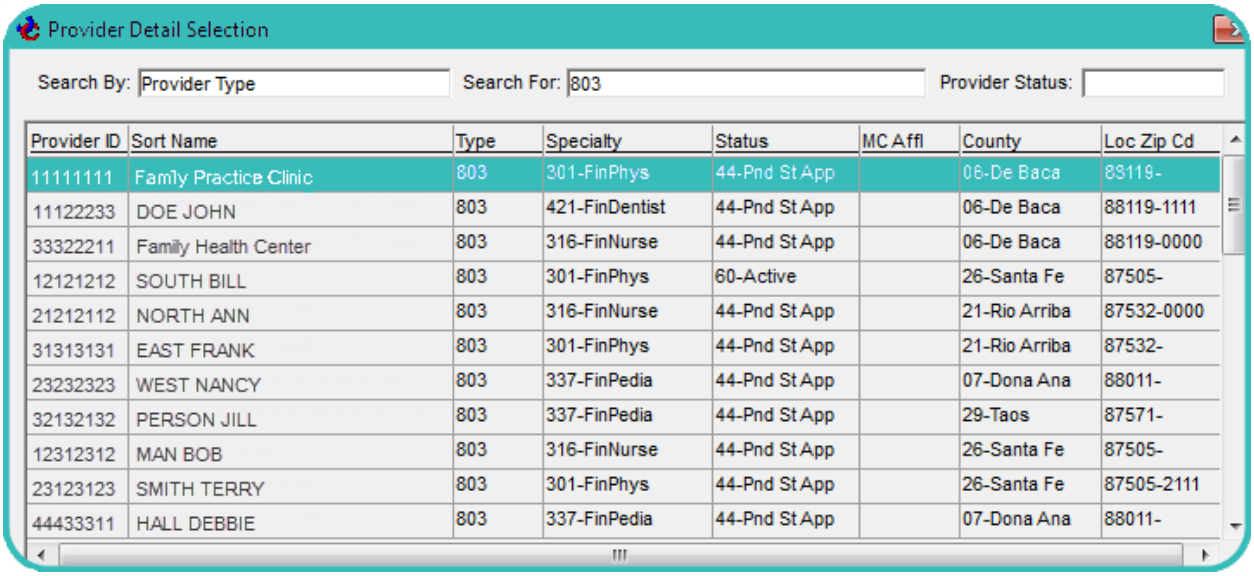
An EP who is a servicing-only provider as part of a group practice, FQHC, RHC, Public Health Office meeting EHR program requirements may assign his/her payments to the entity as part of the EP's business arrangement or may assign payment to an organization recognized by MAD as a qualified organization promoting the use of EHR technology. Currently MAD recognizes both New Mexico Health Information Collaborative and New Mexico HIT Regional Extension Center as entities promoting the use of EHR technology. EPs and EHs who plan to assign incentive payments are required to identify a TIN for the assignee. The assigned entity must also register with the National Level Registry (NLR). A servicing provider operating in a group practice who wishes to receive EHR payments in his/her own name must be listed as a fee-for-service (FFS) provider, enroll as a billing or unrestricted provider, and demonstrate AIU or meaningful use.

The NLR issues a registration/tracking number to the provider for future correspondence and tracking enrollment progress, and sends a daily batch file to the SLR with provider enrollment updates. Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. The SLR also accepts routine updates from the NLR containing CMS attestation detail relating to Medicare eligible hospitals. EHs seeking payment from both Medicare and Medicaid are required to visit the NLR annually to attest to meaningful use before returning to the SLR system to attest for NM Medicaid EHR Incentive Program.

Once NLR data files are sent to the SLR, Conduent SLR staff validates information providers entered in the NLR. Conduent validates the NPI in the NLR transaction is on file in the MMIS system, and validates the provider is an active MAD fee for service provider. If either of these conditions is not met, a message is automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Detailed SLR module training is provided by the Conduent /SLR team. Conduent SLR staff along with the State's Electronic Health Records (EHR) staff successfully automates key functions in the enrollment process including:

- Verifying an enrollee's active Medicaid provider status
- Verifying an enrollee's Medicaid patient volume
- Notifying providers of eligibility determinations
- Producing a file of EPs and EHs, and forwarding to the fiscal agent (FA) for updating the provider master file
- Notifying providers of eligibility and anticipated payment schedule
- Notifying NLR of authorized EHR incentive payments via file exchange



All providers must attest to adopt, implement or upgrade a certified EHR system and provide a CMS certification number of that technology for first participation year. All providers are required to attest to meeting meaningful use to receive incentive payments after the first participation year.

Verification of Attestations

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided in the SLR, Conduent staff conducts a review of attested elements and includes verifying supporting documentation and checking provider exclusion lists. Providers must print and sign an attestation document in addition to electronic signature in the SLR. Incentive payments cannot be released until signed attestation is received at Conduent.

During SLR registration, providers are asked to input information that confirms their eligibility, such as patient volume numerator and denominator. MAD and Conduent uses a “state dashboard” in the SLR to validate provider eligibility requirements via desktop audit/reports from MMIS. In this case, the verification of patient volume numerator a provider states in SLR can be compared to Medicaid claims data for that provider. Data that is not stored in MMIS are requested from providers, such as reports of provider total patient volume (denominator). These documents are uploaded into SLR during EP/EH attestation as evidence of eligibility. If any attestation data does not validate eligibility, then the EP/EH moves to a hold status until the issue is resolved.

Processing Payments

Providers can enroll in the MAD EHR program as early as July 2011 or as late as 2016 in order to receive the maximum incentive payments allowed. The maximum incentive payment an EP could receive from MAD equals $63,750, over a period of six years, or $42,500 for pediatricians with a 20 percent or greater Medicaid patient volume. EPs may receive payments on an annual, non-consecutive basis for up to six years between 2011 and 2021. Providers receiving payment in calendar years beyond 2016 must have received payment in the previous payment year. To receive an incentive payment in the

second, third, fourth, fifth and sixth payment year, the EP must demonstrate that it is a meaningful user of EHR technology, as described in the Final Rule (which is revised periodically by the Centers for Medicare and Medicaid Services (CMS)).

The table below summarizes EP maximum payments over six participation years.

Provider	EP	EP Pediatrician
Patient Volume	**30 %**	**20-29%**
Year 1	$21,250	$14,167
Year 2	$8,500	$5,667
Year 3	$8,500	$5,667
Year 4	$8,500	$5,667
Year 5	$8,500	$5,667
Total Incentive Payment	$63,750	$42,500

EH payment methodology is more complex and actual payments for EH vary based on hospital cost report data. EHs have a base amount of $2,000,000 for each of four years, plus a discharge-related amount, times the Medicaid share of the total. EH payments are an aggregate amount paid over 3 or 4 years (conditional upon EH participation in HIE). MAD accepts the most recent submitted Medicare Cost Reports as the basis for the calculation of EHR Incentive Program payment at the time of enrollment. MAD uses the (MMIS) data as the basis for validating hospital Medicaid patient volume.

MAD uses the Hospital Audit Agent to support calculation of each EH's incentive payment and reaches agreement with the EHs and their representative, the NM Hospital Association, on the accuracy of each EH calculation before submitting the results for payment. EHs do not have to upload the cost report in the SLR, as MAD already has access to cost reports.

Hospitals may not request a re-calculation of the EHR payment once the parties have agreed to the base year for the Medicare cost report.

Upon successful completion of provider registration, attestation and verification by EHR program team (Conduent), requests for provider incentive payments are either approved, denied, or pending further review. The SLR automatically calculates EP/EH incentive payment based on payment methodologies set by CMS Final Rule.

MAD uses its Accounting Transaction Request (ATR) process to make all EHR incentive payments. The SLR enrollment module is anticipated to automate the interface of approved providers and hospitals to both the Fiscal Agent (FA) (to update the provider file) and to the Program Administration Bureau (to initiate the ATRs). The ATR is designed to authorize non-client based payments, such as cost settlements, but can be used for any non-client transaction. Presently a manual process, the ATR request is approved by Program Administration Bureau (PAB) staff and forwarded to the FA for data entry and processing. Conduent processes the EHR payments within 30 days

following the approval for program participation and makes the payments as part of the weekly payment cycle.

Audits and Appeals

MAD expects to verify most aspects of EHR eligibility as part of its pre-payment screening including:

- Active Medicaid provider participation for both EPs and EHs
- Medicaid patient volume for EPs in independent practice (broken out by FFS, MCO by each contracted MCO, and out-of-state Medicaid payer)
- Participation in the group practices identified by EP as meeting the threshold for Medicaid patient volume
- Total Medicaid patients for group practices
- All members of a group use the same methodology for assigning patients to participating EP
- Not a hospital based provider for EPs
- Adopting, Implementing or Upgrading (AIU) certified EHR software for EPs
- Hospital patient volume from audit reports
- Hospital incentive payment calculation (one time process)

MAD is using the attestation statement to collect assurances for AIU, not hospital based (for EPs except those practicing primarily in FQHCs or RHCs) and provider generated statements for patient volume. The SLR enrollment module allows EPs and EHs to upload documentation supporting AIU and other program requirements to submit with the attestation. The SLR supports automated interfaces to the provider master file to verify active Medicaid status; to the Data Warehouse (DW) for Medicaid patient volume in routine situations, and place of service for EPs.

Change History

Revision	Date	Page	Section or Step	Description
001	07/27/13	• All	• All	• Made minor grammar/ punctuation corrections.
002		• l	•	•

Conduent SLR Overview

Security and Confidentiality

Unit Access

Conduent SLR staff is located within the Conduent Albuquerque operational site. Two doors offer access to the area. These doors are protected by a security badge access system at all times.

Visitors must sign in and obtain a security badge at the Conduent reception area on the first floor. The receptionist notifies the unit's designated representative of the visitor's arrival. All visitors are subject to Conduent Security Visitor Policy. Personal visitors are not allowed beyond the reception area.

Provider File Update Access

Over the past decade, Conduent has demonstrated our commitment to a secure, accurate provider data maintenance function. Most, if not all, OmniCaid users are allowed to view provider data via the OmniCaid provider windows (inquiry access). However, OmniCaid allows only those system users with appropriate security authorizations to add, change, or delete provider data.

We work with MAD to develop a list of individuals at Conduent and MAD that are allowed to update the provider database. We ensure that this list is kept up to date and that the actual security authorizations within OmniCaid match those approved by MAD. Furthermore, Conduent ensures that system users at MAD and at Conduent who are authorized to update the provider database are prohibited from resolving pended claims and vice versa, with the exception of individuals designated as 'super users.' Conduent includes this security measure in our Security Plan.

Record Maintenance

Most documents are scanned into Workflow before EHR staff sees them. If a paper document reached EHR staff, they would take it to the Mailroom for scanning into Workflow.

Conduent Mail room retains paper files in a folder by tax ID number. Conduent maintains hard copy files with all documentation including original provider signatures and lists of individuals with ownership for seven years after termination or disenrollment.

Record Retention Requirements

Conduent maintains a file for each enrolled and terminated provider. This file contains all provider participation agreements with original signatures, copies of licenses and other documents supplied by the provider, written requests from the provider or MAD to update a provider's information in the system, and other provider enrollment-related documents. In addition, we optically scan and store the electronic images of all new hardcopy provider participation agreements and related documentation once we approve a provider to participate in the program. We index the images by provider ID number for storage and retrieval purposes. As provider enrollment staff updates each provider record via the re-verification process, we scan and image the provider's existing hardcopy file. In addition, we have worked to scan and store images of any existing hardcopy provider files.

We comply with RFP requirements to maintain all hardcopy provider enrollment application material and related documentation for as long as the provider remains enrolled in the New Mexico Medicaid Program and for seven years after enrollment has been terminated. Conduent also maintains images of all provider EHR documentation on the Electronic Document Management system (EDMS) via Intraviewer, where it is available for retrieval online. Depending on MAD's needs and New Mexico court requirements, MAD may elect to reduce the hard copy document retention requirement once our imaging solution has proven be reliable and secure.

Confidentiality

Security and confidentiality (privacy) are addressed in Health Insurance Portability and Accountability Act (HIPAA) legislation. HIPAA rules and regulations are followed to ensure the privacy of sensitive health data. Every effort is made to guarantee that protected data is kept confidential and is not available for staff, vendors, or other persons who do not have a "need to know". This includes efforts such as ensuring that claims and other sensitive documents are not displayed on copiers, fax machines, unattended desks or other work areas as well as clearing work areas prior to departure.

Staffing

Conduent supports the New Mexico Medicaid EHR Incentive Program as operated by Medical Assistance Division. To meet the needs of the EHR Incentive Program, MAD has outlined the functional program areas and descriptions of Conduent vs. MAD roles in the EHR Program.

EHR Functional Area	Description	Lead Role	Example of Duties	Inbound and Outbound Communi-	Comments

				cation	
EHR Program Policy	Defines program rules and operations based on federal and state statutes.	MAD	Interprets guidelines established by federal agencies. Troubleshoots program issues	Refer to MAD	Conduent will become more familiar over time
EHR Program Eligibility Requirements	Determination of Eligible Professionals (EP) and Eligible Hospitals (EH) per program rules.	Conduent	Includes solid understanding of EP types, EH types, patient volume requirements,	Yes	Should be able to respond to "am I eligible" inquiries
EHR Enrollment Workflow	Total workflow for EP/EH and groups requesting incentive payment	Conduent	Understanding of national and state registration interfaces	Yes	Should be able to respond to "how do I enroll" inquiries
EHR SLR Product Function	Registration, attestation payment, and appeals functions of SLR	Conduent	Based on workflow above, understand how a "claim" moves through the SLR	Yes	Like OmniCaid, payment request can be held for review, suspended, approved.
EHR Program Payment Processing	Reviews and validates attestations	Conduent	"works" the incentive payment request through the state dashboard Includes validating	Yes	Use of OmniCaid as validation of eligibility

			requirements such as patient volume calculations		
EHR Program Communications	Disseminate EHR program details to provider community	MAD	Program launch timeline, documentation required to register, etc.	N/A	
EHR Program oversight	Post-payment audits	MAD	Based on existing MAD audit procedures	N/A	Conduent can perform prepayment audits via DW desktop audits
EHR Meaningful Use		MAD		Refer to MAD	Conduent is up to speed on MU since initial program launch

Change History

Revision	Date	Page	Section or Step	Description
001	07/29/13	• All	• All	• Made minor grammar/ punctuation/formatting corrections.
002	11/14/17	• All	• All	• Conduent Rebranding
003		•	•	•

Service Level Agreements (SLAs)

Service Level Agreements for State Level Registry (SLR) have more than one source.

1. Exhibit A – Scope of Work, specifies in "M, Deliverable Number 13: State Level Registry (SLR) – Ongoing Operation and Maintenance" at Section 13.2.5:

   - Provide the help desk service for all initial "Tier I" contacts by telephone, email or web regarding the SLR.

2. For the State Level Registry there are no other written Service Level Agreements (SLAs) as are outlined in the contract with the State for other aspects and services.

   However, there are some unwritten arrangements whereby SLR mirrors Provider Enrollment SLAs for the State Level Registry Help Desk and application processing.

   Exhibit A – Scope of Work in "R, Deliverable Number 18: Ongoing Provider Management Services" at Section 18, regarding Provider Enrollment:

   - Hold times shall not exceed, on average, more than two (2) minutes prior to reaching a SLR staff member.
   - The Help Desk call abandonment rate must not exceed five percent (5%), as measured on a monthly basis.
   - Track and respond to all written provider inquiries within ten (10) business days of the receipt of the query.
   - MAD 220 Applications are to go through the indexing and review process within 10 business days of receipt. Thereafter they are sent to Quality for review. Within five business (5) days of the completion of Quality review, they go to the State for review. If the State approves the MAD 220 Application, any new providers are to be activated within 5 bus days.
   - Attestations are to go through the indexing process within 10 business days of receipt.

Computer Applications

There are many tools available to assist SLR staff with EHR enrollment functions. All SLR personnel use the following computer applications:

- New Mexico Medicaid Management Information System (MMIS)
- Conduent Intranet
- Optical Imaging Technology (OIT)
- Reports Online
- Trading Partner Management System (TPMS)
- Contact management system
- SharePoint
- IntraViewer SLR Dashboard
- Certified Health IT Product List

Staff receives intensive education about all the program applications during training sessions. A brief description of these applications is outlined in the sections that follow.

There is also a MAD system available to assist SLR staffs:

- Data Tool

Provider Subsystem

The New Mexico OmniCaid provider subsystem maintains comprehensive current and historical information about all medical and non-medical providers who are eligible to participate in Medicaid as administered by the New Mexico Human Services Department, MAD. This subsystem facilitates provider participation and retention, and maintains security and control over all provider-related data. Maintenance and access of critical provider information is achieved through extensive online, real-time inquiry and update capabilities along with a number of automated interfaces.

Online Search

Online, real-time inquiry and update access to provider information is available to authorized users. The provider selection window is used to search the database for a provider or a list of providers who meet specified selection criteria. The user can select a provider by any of the following criteria:

- Medicaid provider ID
- Medicare provider ID
- National provider ID (NPI)

- Full or partial provider sort name
- Provider doing business as (DBA) name
- License number
- Social security number (SSN)
- Federal employer identification number (FEIN)
- National association board of pharmacists ID (NABP ID)

The user may restrict the search to providers in active status only if desired. With the exception of provider name, only those provider records that match the entered key field criteria are displayed on the provider selection window. For the provider name key field, the first provider that has a name the same as or alphabetically following the entered key field is the first provider displayed on the selection window. All succeeding providers are displayed in alphabetic order. In this way, all provider records are accessible using the provider name key field. Please note that the sort name is used in the search rather than the provider name or the DBA name.

Regardless of the key field used, the user may scroll forward or backward within the list of providers until the desired provider is located. A number of provider fields are displayed for each provider on the provider selection window. The current status is shown for each provider. If a provider has more than one specialty, each specialty is displayed on a different row.

The user may find the desired information displayed on the selection screen. If not, the user may select a provider for detailed viewing by highlighting the row and clicking the select push button. The name/address window is displayed, and the user may use the tabs at the top of the window to navigate to any of the other windows for which tabs are displayed. The Go To menu selection navigates to reference rates and claims financial windows.

If a single provider record matches the key field criteria entered on the provider selection window, the provider selection window is not displayed. Instead, the provider name/address window for the matched provider record is displayed. The tabs displayed at the top of the window allow the user to move to the other provider windows for that provider.

If no provider records match the criteria entered by the user, an appropriate message is displayed on the provider selection window.

Maintain Current and Historical Provider Information

The provider subsystem maintains a repository of current and historical provider information for use by the State and its fiscal agent, other subsystems, and by external applications. This information is not purged. Critical data maintained by the provider subsystem includes:

Data Element	Description
Provider identification	• System assigns unique provider identification number

numbers	when new providers are added • When available, other ID numbers maintained are: – Enterprise ID (used to associate providers) – Medicare provider numbers and affiliated carrier/intermediary IDs – Universal physician ID (UPIN) – National association of boards of pharmacy (NABP) ID – National provider ID (NPI)
Provider name and address	• Three provider names maintained are: – Legal name – Sort name – Doing business as (DBA) name • Addresses for billing, mailing, and practice location are captured. • For each address, a phone and FAX number may be entered.
Enrollment status codes	• Status codes keeps track of whether a provider's application is: – Pending – Approved – Denied – Terminated
Provider type codes	• Designate the State's classification of providers
Authorized specialty codes	• Providers may have multiple specialties for which they authorized to provide services
Major programs	• Authorized users may enter multiple programs in which the provider participates • Date spans specify the beginning and ending date for the provider's participation in the program • Date spans within a major program may not overlap
Billing information	• Billing codes indicate: – If a provider can provide services – If a provider can bill and get paid – The type of claims a provider is authorized to submit • Multiple electronic media claims (EMC) media codes are maintained to indicate how claims are submitted
Licensing and certification data and effective dates	• This data includes: – Laboratory certification CLIA numbers – Certificate type and effective dates – Licensing and certification spans – License number – Licensing/certifying agency ID and state code – Expiration date – Restriction indicator – Effective dates
Group affiliation data	• This data enables identification of: – All members of a group – All groups with which an individual provider is

	affiliated – Effective dates of each affiliation • Affiliation types include: – Group – Billing agent – Association – Denied – New owner
Remittance and payment information	• This information includes: – EFT (Electronic Funds Transfer) indicator – EFT account number – Bank ID number – Remittance media – Sort sequence of remittance advices • Encounter only and service only providers are not allowed to enter EFT information
Provider restriction and on-review codes and effective dates	• This data indicates: – Restriction origination – Date spans for the review – Type of restriction – Reason for the restriction – Restricted claim types and programs – Ranges of codes indicating: o Procedure codes o Diagnosis codes o DRG codes o Revenue codes – Where the restricted claims are sent – How restricted claims are handled
Managed care provider cross-reference data	• The network affiliation interface file is received from the managed care organizations (MCOs) • Processing of this data includes: – Adding new providers – Assigning Medicaid provider IDs – Updating existing providers • Each MCO and a list of their providers may be accessed on the MC provider affiliation window for display purposes only

Cross-reference Information

National Provider Identifier (NPI) Information

The provider subsystem contains a module that cross-matches NPIs to proprietary provider numbers.

This cross-match module allows the MMIS to accept NPIs on various transactions, and determine the internal New Mexico provider ID associated with that NPI. This allowed

the basic internal functionality of the MMIS to remain intact while providing the capability of accepting NPI.

Individuals and Groups

Often relationships exist between providers on the provider table. The Provider Affiliations window allows the user to document and maintain these relationships. Providers that represent a group or a member of a group must have their own provider ID. The user can enter four types of affiliations for a provider, while a fifth type is created automatically by MMIS. The user may inquire on affiliations by choosing an affiliation type from the drop down data window and by designating an affiliation direction of either list members or list groups. The affiliation types that can be added by the user are billing agent affiliation (one or more providers billed by one agent), group practice affiliation (one or more providers in one group practice), or association affiliation (one or more individual nurse practitioner to one doctor). The user can also add a duplicate affiliation (one or more denied provider IDs to one provider ID that is kept). A duplicate affiliation would be created manually when the user found two or more provider IDs for the same provider. The user would deny all of the providers except one go to the affiliation tab of the provider ID that is kept and enter the provider IDs of the denied providers as members. The provider ID that is kept would be considered the group and the denied providers would be the members. The last type of affiliation is new owner and is set up by the MMIS system automatically when a change of ownership is initiated on the name and address tab. The new owner is considered the group, and the old is the member.

To enter affiliation information the user searches for the provider ID of the group, billing agent, association or the duplicate that was kept, then goes to the Provider Affiliations window and adds members. Members are always added to groups; groups are not added to members. When inquiring, if the user sets the affiliation direction to “List Group”, this window lists the groups of which a provider is a member. Conversely, when the user sets the affiliation direction to “List Member”, this window lists the members of the group provider. It should be noted that a provider may be a member of more than one group and may have one or more affiliation types. A provider may also be a member of a group and themselves is defined as a group for members under them. For example, a doctor may be a member of a group practice. The same doctor can have an affiliation type of association with nurse practitioners as members.

Financial Information

Financial data for each provider is kept in the claims subsystem. The provider subsystem has a GO TO function that allows the user to click on claims financial to view provider credit balances and accounts receivable, claim summary, financial summary and prior year summary data.

Provider Rates

The reference subsystem contains rates that allow unique prices to be established for specific providers. The provider subsystem has a GO TO function that enables inquiry to the reference rates procedure matrix screen and the reference rates institutional screen to access pricing information. If the user has the authority to update the reference data displayed, they are able to do so at this time.

Electronic Funds Transfer (EFT) Information

Encounter only and service only providers are not allowed to request EFT processing.

Other providers may submit a request for EFT processing. The approval process begins with transmitting the pre-note file to Wells Fargo. This is done every Friday evening at 8:00 PM Eastern time (6:00 PM Mountain). That file includes every provider that has entered a request on the EFT screen (which sets their EFT Status initially as "T"). After transmittal of the pre-note file, the Provider EFT status is changed to "S", which locks out further updates to that row.

The RC105 report is produced every morning at 8:00 AM. If a provider has been rejected or returned by Wells Fargo, it is detailed on the report and their EFT Status is updated to "F" (for failed). After processing all the reject or return records, the program then finds all the EFT records with an "S" status that is over 13 days old and sets those statuses to "P" (for production).

Therefore, if a provider has entered his information by close of business (COB) on Friday, it is sent for verification that evening. If there are no problems reported back to us by Wells Fargo, they are approved (and eligible for EFT) by 8:00 AM two weeks later.

- An example (in Mountain Time):
  - Provider A enters their EFT information at 3:45 PM on Friday, August 7, 2013.
  - Provider B enters their EFT information at 6:27 PM the same day (after the pre-note file has been pulled).
  - Assuming no problems, Provider A gets EFT payments during the payment cycle on August 21 (payment date of 8/24, EFT release date of 8/25).
  - Assuming no problems, Provider B gets EFT payments one week after Provider A

Check Hold Processing

For a variety of reasons, the State occasionally requests that checks be held for a particular provider. System List #4951 has been created to track all providers that are in "check hold" status.

Based on a memo from the State, Conduent Operations creates an entry with the provider ID in both the starting and ending values, the appropriate effective start date, and an effective end date of '12/31/9999'. When a provider is removed from the check hold list (again based on a memo from the State), the effective end date is updated to reflect the date the provider is removed from check hold status.

Letters – 803 Welcome and Return to Provider (RTPs)

Description and Purpose

SLR staff are responsible for the two SLR letters. EHR letters are not automatically generated; rather SLR staff produces them. Letters are printed in a format suitable for folding and inserting into window envelopes for mailing.

- The 803 Welcome Letter

  The 803 Welcome Letter is sent after a MAD 220 Application is approved by the State.

- The Return to Provider Letter

During processing, some EHR documents are determined to be incomplete or containing obvious errors. Once a document is determined incomplete or contains errors, EHR specialists attach a Return to Provider (RTP) letter or, in the case of applications, a MAD 220 RTP letter. The RTP letter indicates the specific problems which the provider must correct before the documents can be resubmitted.

There are many reasons documents are returned to providers. Documents which cannot be processed because of errors or omissions must be returned to the provider with clearly filled out MAD 220/RTP letters in a timely manner.

Processing Steps – RTP MAD 220

1. Obtain a blank MAD 220
2. Enter the provider number issued above the Name box
3. Enter the provider name
4. Check all boxes applicable to the errors
   - If more detail is needed to describe the missing item or errors, write it in the 'Other Required Information' space
   - If more space is needed, continue writing on the back

Change History

Revision	Date	Page	Section or Step	Description
001	08/03/11	• All	• All	• Initial Publication
002	08/07/11	• All	• All	• Procedures reviewed by PE staff – updates and formatting completed (TLB)
003	07/29/13	• All	• All	• Made minor grammar/ punctuation corrections.

Reports

Requesting Reports

Reports can be viewed and downloaded from the Dashboard. There are also some reports in Share Point.

Analyzing Data

The following reports are used by the State, fiscal agents, and federal government to analyze provider data. The asterisks (*) indicate the reports that are produced by the data warehouse. Data warehouse reports can change, based on need and requests.

- Provider daily activity report
- Provider information sheet
- Address labels list
- License renewal/recertification list
- Re-verification list
- Pending application reminder listing
- Provider turnaround document
- Provider duplicate SSN report
- Provider duplicate name report
- Provider duplicate license report by board type
- CLIA certification update report
- Numeric provider listing*
- Alphabetic provider listing*
- Provider listing by provider type*
- Provider listing by practice specialty*
- Provider listing by group affiliation*
- Terminated provider list*
- Provider listing by county*
- Out-of-state alphabetic listing*
- Medicare/Medicaid cross reference*
- Providers by FEIN number report*
- Active provider count report*
- Alphabetic restricted providers list*

Audit Trails

When provider data is added or updated, the user ID, date and time are stored in three columns in the row of the table that was processed. This information provides a history by recording when and who modified this row last. The audit fields can be accessed online. A nightly report is generated to show the daily activity.

Change History

Revision	Date	Page	Section or Step	Description
001	07/29/13	• All	• All	• Made minor grammar/ punctuation/formatting corrections.
002		• l	•	•
003		•	•	•

EHR Processing Procedures

Processing EHR Documents

Receipt of EHR Documents, Indexing, Scanning and Return Mail

The Claims Department Mailroom staff opens and scans documents received via mail. The Mailroom also handles all return mail. Once opened, the Claims Department Mailroom also indexes the mailed documents and files them for retention purposes by received date. Conduent also maintains images of all provider EHR documentation on the Electronic Document Management system (EDMS) via Intraviewer, where it is available for retrieval online.

Required Information

MAD will not approve MAD 220s if the required information items listed below are not completed by the provider and/or reviewed by Conduent:

Provider	Conduent
• Complete Section 1, Box 1-5, 8-12	• Complete Box 6-7
• Complete Section 1, Box 12	• Complete Box 18-19, 23
• Complete Section 2, Box 13-17, 20-23	• "FOR STATE PURPOSES" Section, indicate if a new Medicaid ID was assigned, and enter newly assigned Medicaid ID numbers for EP and payment recipient, if necessary.
• Sign MAD 220 Form in blue ink	•
• Sign MAD 220 form on Page 2 in two places	
• Attach W9 (one W9 can be submitted by provider for a Payee, but each payee provider type should have a copy of the W9 attached to the MAD 220)	
• Bottom of Page One must be initialed by provider	

Change History

Revision	Date	Page	Section or Step	Description
001	07/29/13	• All	• All	• Made minor grammar/ punctuation/formatting corrections.
002	11/14/17	• All	• All	• Conduent Rebranding
003		•	•	•

EHR Incentive Payment Provider Attestation Form

Indexing an Attestation – Using IntraViewer and OmniCaid

Description and Purpose

The purpose of this section is to outline the proper procedures for working an Attestation in Workflow.

Performance Standard

All Attestations will go through the Indexing and Review processing steps. Several questions will need to be answered in each step. And the entire process needs to be completed within 10 business days of the received date.

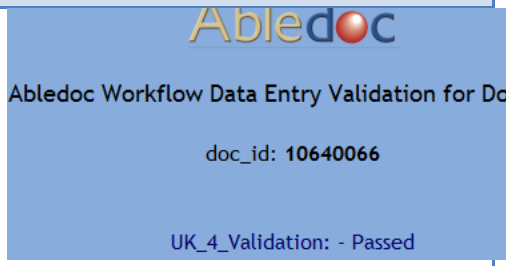
Processing Steps

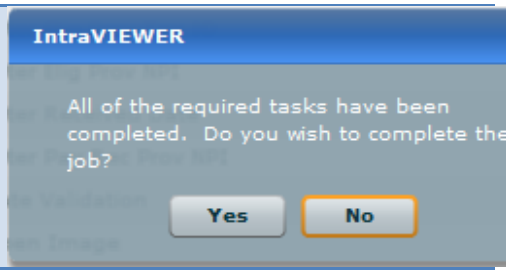
Processing Steps for Indexing an Attestation– using IntraViewer Image & OmniCaid

First:

- **Open the image in Workflow**
- **Using both NPI's on the Attestation image open in OmniCaid**

Then complete the Indexing in Workflow as follows:

WF Tasks	WF Question	Details for WF Questions	Instructions for WF Questions
1.	Is Doc Type Correct? Is this a XXX or something else?	Drop down has the following choices: MAD 220, Attestation or Miscellaneous. QA – verify you are looking at the correct document.	• Open the document image and verify if it was scanned into the correct flow. If so continue to step 2. • If image shows the document in the wrong flow, choose the correct one and move on to step 2 – you will still need to answer the rest of the questions. However the document will re-enter the flow to be indexed again in the correct flow.
2.	Enter Elig Prov Tax ID	Enter Provider Tax ID	• Locate and enter Provider Tax ID/Social Security number listed under provider name on page 3 of Attestation. • Select ok.
3.	Enter Elig Prov NPI	Enter Provider NPI	• Locate and enter Provider NPI listed under provider name on page 3 of Attestation. • Select ok.
4.	Enter Received Date	Enter date Attestation received at Conduent.	• Enter date document received at Conduent (yyyy, mm, dd), select ok.
5.	Enter pay Rec Provider NPI	Payee Provider information listed on page 1 of Attestation.	• Locate and enter Payee Provider NPI located on page 1 of Attestation, select ok.
6.	Date Validation	Validation is automatic and Workflow should show the following: UK_4_Validation: - Passed If not, go back and correct the date format to yyyy-mm-dd under Step 4 and enter the received date.	• 

	Save	Use the save button. Then answer yes to the pop up question.	• 

Processing an Attestation – Using IntraViewer and OmniCaid

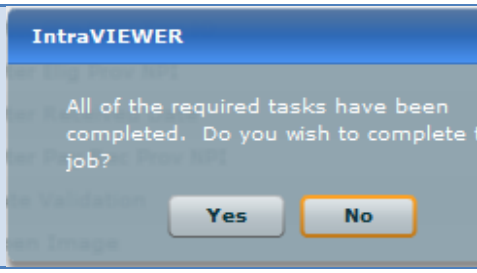
First:

Review Steps for Processing an Attestation – using IntraViewer Image & OmniCaid

- **Open the image in Workflow**
- **Using both NPI's on the Attestation open in OmniCaid**

Then complete the Processing in Workflow as follows:

WF Tasks	WF Question	Details for WF Questions	Instructions for WF Questions
1.	What is the Document status?	Choose one of the drop down answers: Process, Duplicate, RTP. QA – if it is being processed continue. For Duplicates & RTP's continue checking to ensure all information is entered in WF correctly.	• Duplicate • Process – continue to step 5. • RTP – continue to step 2.
2.	Was a MAD-220 required?	Select yes or no from drop down.	• Select yes or no from drop down. • Select ok.
3.	Confirm Eligible Provider's Volume.	Select yes or no from drop down.	• Select yes or no from drop down. • Select ok.

4.	Confirm Group Provider's Volume.	Select yes or no from drop down.	• Select yes or no from drop down. • Select ok.
5.	Save	Use the save button. Then answer yes to the pop up question.	

EHR Incentive Payment Provider Participation Agreement Form - MAD 220

The New Mexico EHR Incentive Payment Program is committed to a smooth program registration and attestation process and timely distribution of incentive payments to designated payees.

The EHR Incentive Payment Provider Participation Agreement—Form MAD 220 has been created to aid in the successful completion of the registration and attestation process of EHR Incentive payment in a manner not currently captured in the New Mexico Medicaid Computer Payment System.

Description and Purpose

The purpose of this section is to outline the proper procedures for working MAD 220 applications. Each of these applications has various parts that must be reviewed and researched prior to adding eligibility for the eligible professional provider (EP) or the incentive payment recipient (IPR). When information on a MAD 220 is correctly completed and information from the OmniCaid system has been verified, each of the applications must be entered following the steps below to create an 803 provider type for payment.

Completion of the Provider Participation Agreement – Form MAD 220 must be done if any of the following apply (not inclusive of all instances in which Form MAD 220 may be required):

The Eligible Professional Provider is enrolled in the Medicaid Fee-for-Service program and the eligible professional provider wants to assign the incentive payment to a group, clinic or other entity, and that group, clinic or other entity is not the same provider type as the eligible provider. The Provider Participation Agreement – Form MAD 220 must be completed if any of the following apply (not inclusive of all instances in which Form MAD 220 may be required):

Examples:

- A certified nurse midwife or a certified nurse practitioner assigns payment to a physician group
- A pediatrician assigns payment to a non-pediatrician group
- A physician assigns payment to anyone other than a physician group
- A dentist assigns payment to anyone other than a dental group
- Any eligible professional provider assigns payment to a hospital, federally qualified health clinic (FQHC) or rural health clinic (RHC)

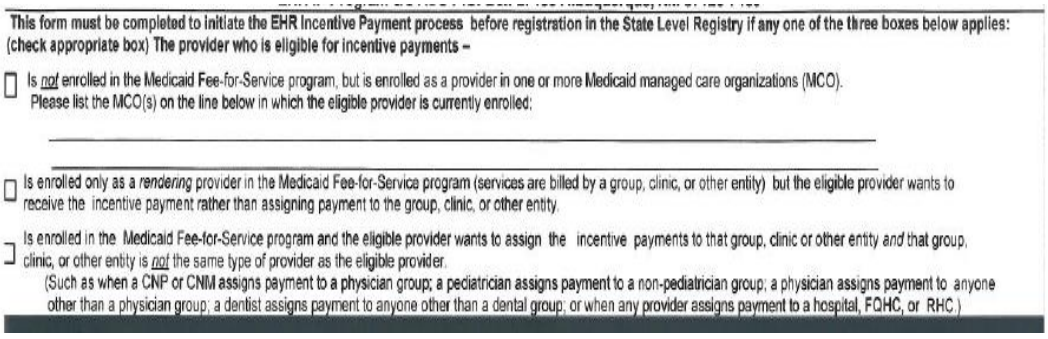
Performance Standard

All MAD 220 applications must be reported on the tracking log and date stamped when Stamp dated as received. Applications must be processed and worked within 10 business days of the received date. The MAD 220 Application is sent to Conduent's Quality Assurance for review and then to the State for approval.

Processing Steps

1. **Screening and Verification**

   Eligible Professionals choose one of the following options.



This form must be completed to initiate the EHR Incentive Payment process before registration in the State Level Registry if any one of the three boxes below applies: (check appropriate box) The provider who is eligible for incentive payments –

☐ Is *not* enrolled in the Medicaid Fee-for-Service program, but is enrolled as a provider in one or more Medicaid managed care organizations (MCO). Please list the MCO(s) on the line below in which the eligible provider is currently enrolled:

_____

☐ Is enrolled only as a *rendering* provider in the Medicaid Fee-for-Service program (services are billed by a group, clinic, or other entity) but the eligible provider wants to receive the incentive payment rather than assigning payment to the group, clinic, or other entity.

☐ Is enrolled in the Medicaid Fee-for-Service program and the eligible provider wants to assign the incentive payments to that group, clinic or other entity *and* that group, clinic, or other entity is *not* the same type of provider as the eligible provider.
(Such as when a CNP or CNM assigns payment to a physician group; a pediatrician assigns payment to a non-pediatrician group; a physician assigns payment to anyone other than a physician group; a dentist assigns payment to anyone other than a dental group; or when any provider assigns payment to a hospital, FQHC, or RHC.)

   Determine if the MAD 220 is needed based on the information supplied.

Field Number	Field Name	Required?	Instructions

1.	Name of Provider	Yes	• Return application to the provider if left blank or incomplete
2.	National Provider ID	Yes	• Return application to the provider if left blank
3.	State License Information	Conditional	• Return application to the provider if left blank or if cannot obtain information from OmniCaid
4.	Location Address	Conditional	• Mailing Address information can be used in lieu of location information or “same” can be written in for either • PO Boxes are not acceptable • Return to provide (RTP) if blank or PO Box indicated
5.	Mailing Address Billing Address	Conditional	• Location Address information can be used in lieu of mailing information • Add both in Mail/Bill tabs • Return form if both are blank
6.	Eligible Provider Type Box Checked	Conditional	• Conduent can verity the 803 provider type need in MMIS if left blank by provider
7.	New Mexico Medicaid Number (if previously assigned)	No	• Conduent can obtain this information from OmniCaid if needed
8.	Email Address	No	• Conduent can obtain this information from either the Dashboard or SLR for the point of contact
9.	Phone Number	No	• Conduent can obtain this information from the provider via email or from the SLR report
10.	Social Security	Yes	• If not included, return the

	Number		application to the provider
11.	Date of Birth	Yes	• RTP if left blank
12.	Exclusions or Suspensions Information	Yes	• If provider response is "Yes", a signed and dated statement of explanation must be attached for review by MAD • If statement is not attached, RTP • If checked answers are not initialed, RTP
--	Contact Person Name	Conditional	• Conduent can obtain this information from the provider or from the SLR report
--	Contact Person Email / Phone #	Conditional	• Use this email/phone on location address field if left blank • Obtain this information from either the Dashboard or SLR for the point of contact

Page 1, Section 2 (MAD 220)
Enter fields 13-17, 19-23, and 25 into OmniCaid.

Field Number	Field Name	Required?	Instructions
13.	Check Applicable box	• Conditional	• If not checked, use Attestation to verify who the payment is assigned to
14.	Name of Incentive Payment Recipient	• Yes	• If not included, RTP
15.	Phone number	• No	• Obtain this information from the provider via email or from the SLR report

16.	Mailing Address Billing Address	• Conditional	• Location Address information can be used in lieu of mailing information • Add both in Mail/Bill tabs • Return form if both are blank
17.	Location Address	• Conditional	• Mailing Address information can be used in lieu of location information or “same” can be written in for either • PO Boxes are not acceptable • RTP if blank or PO Box indicated
18.	Check the appropriate box	• No	• Verity the 803 provider type need in MMIS if left blank by provider
19	New Mexico Medicaid Number (if previously assigned)	• Conditional	• Conduent can check the appropriate box if left blank by provider • Box must be checked prior to forwarding to the State for approval
20.	National Provider ID	• Yes	• RTP if left blank
21.	Federal Tax Number or Social Security Number	• Yes	• RTP if left blank
22.	Business Name	• Conditional	• Information can be obtained or verified on W-9 • If no W-9 is attached or as miscellaneous file in Interviewer and field is left blank, RTP • If IPR and EP are the same, the name can be individual’s name
23.	Federal Legal Name	• Conditional	• Information can be obtained or verified on W-9 • If no W-9 is attached or as miscellaneous file in Interviewer and field is left blank, RTP

			• If IPR and EP are the same the name can be individual's name
24.	Profit Indicator	• Yes	• If non-profit is checked, a 501C3 needs to be attached or as miscellaneous file in Interviewer we no longer need a 503c3 • A 501C3 is not needed for IHS • If the "for profit" is checked, check the Profit Indicator on the Enrollment tab
25.	Tax Payments	• Yes	• Leave this section blank in OmniCaid; an attachment is not needed if "Yes" is indicated on application • If "No" is indicated, an explanation must be attached. • Contact provider if it is determined that an explanation is needed
26.	Email Address	• No	• Obtain this information from either the Dashboard or SLR for the point of contact
27.	W-9 Attached Applicant Initials Certifying information is true and correct on page one	• Yes	• Needs to be dated within the last year from the date the application was initially received. • If the application is received before the W-9 date expires continue with the application as is. • Workflow indicates if W-9 is attached to application or as Miscellaneous file • Intraviewer Provider File can be used to obtain a current W-9, if needed • Contact provider if it is determined that a current W-9

			is needed, but not attached to application or available in Intraviewer • If not initialed by EP/IPR representative, RTP

Page 2, Section 2 (MAD 220)

Field Number	Field Name	Required?	Instructions
--	Printed Name of individual provider (listed in box 1 on page 1)	Yes	• RTP if name is omitted
--	Signature of individual provider and date	Yes	• Must be an original signature in BLUE ink • RTP if not signed in BLUE ink or is not an original signature
28.	Exclusions or Suspensions Information for Incentive Payment Recipient	Yes	• If provider response is "Yes", descriptions must be given in the boxes provided. • RTP if either "Yes" or "No" are not indicated.
--	Printed Name of authorized legal representative and Title	Yes	• RTP if name is omitted. • Title is not a required field.
--	Signature of authorized legal representative and date	Yes	• Must be an original signature in BLUE ink. • Must have date of signature • RTP if not signed in BLUE ink or is not an original signature or if not dated.

Enrollment Review and OmniCaid Entry

1. Open OmniCaid to the Provider Detail section
2. Conduct a search for both the EP and the IPR using the following search elements:

Search by Field	Search for Field
NPI Number boxes 2 and 20	Enter the NPI numbers submitted on the MAD 220 application
Federal Employer Tax ID/Social Security Number boxes 10 and 21	Enter the NPI numbers submitted on the MAD 220 application
Name Search	Enter the EP's or the IPR's name

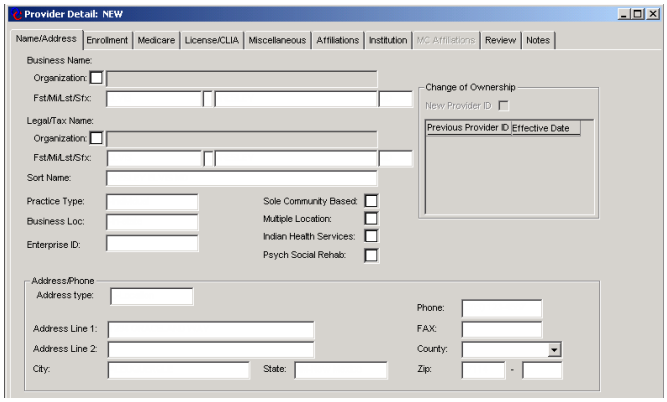
a. Verify whether or not the NPIs are active and that the specialties correspond with the specialties of the EP who is assigning payment and the IPR that is receiving the payment. If not, an 803 provider type needs to be created for either the EP or IPR.

b. If they are the same specialty but one of them does not have an active 60 status, an 803 needs to be created for the payment to be assigned or issued for the same specialty.

c. If they are both active and have the same specialty, there is no need to create another 803 record to be created

d. If an 803 type needs to be created for either EP or IPR, proceed to the next steps.

3. Select New



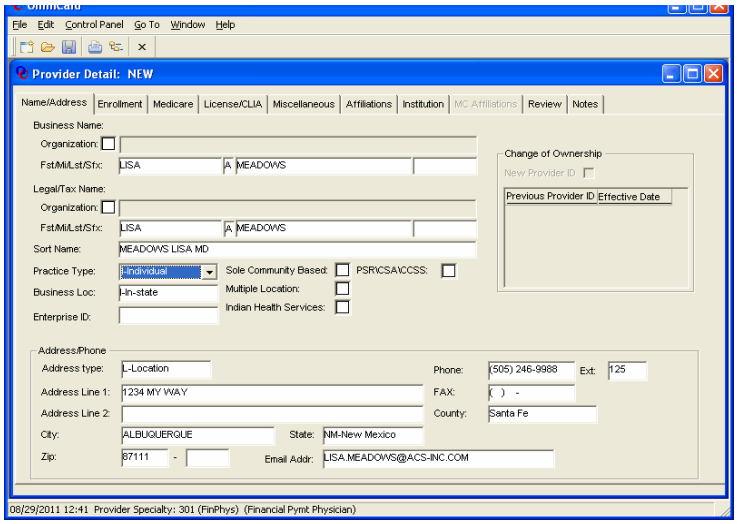
OmniCaid will open to a blank Name/Address screen.

Name/Address Tab

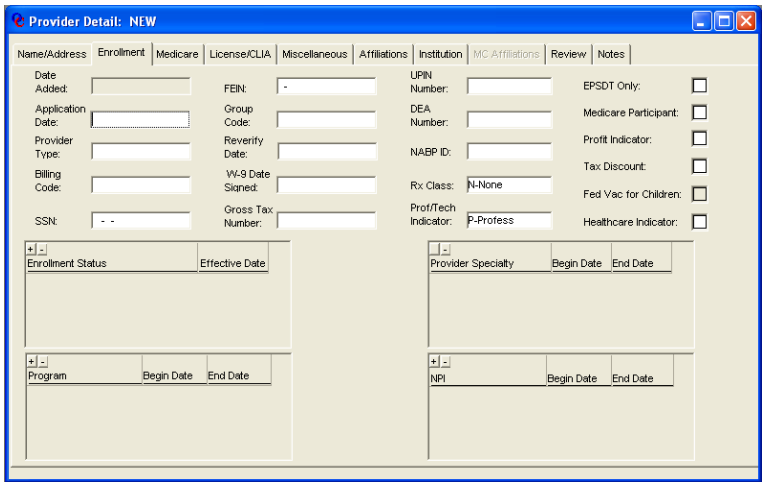
Step	Field Name in OmniCaid	Enrolling the 803 for EP	Enrolling the 803 for IPR
1.	Business Name Organization	Enter name from box 1	• Unrestricted payee/rendering combo -

	Fst/Mi/Lst/Sfx		enter from box 22 of the application or W-9 • Note: The organization is only checked if the W-9 or box 22 indicates this is a Doing Business As name.
2.	Legal/Tax Name Organization Fst/Mi/Lst/Sfx	Enter name from box 1	• Enter from box 23 of the application or from the W-9
3.	Sort Name	Using name in box 1 in format, Last name first-first name 2nd – Middle Initial or Middle Name 3rd – Suffix last	• Enter from box 22 of the application
4.	Practice Type	Use Individual	• Enter based on W-9 classification, i.e., individual, corporation, partnership, or trust
5.	Business Location	Choose In-State	• Choose In-State, Border, or Out of State • Note: Border is within 100 miles of New Mexico. Consult border list for cities outside, but contiguous to New Mexico.
6	Enterprise ID	Auto populated by OmniCaid after the record is saved. This is also the new Medicaid ID for the new record	• Auto populated by OmniCaid after the record is saved. This is also the new Medicaid ID for the new record
7.	Check Boxes	Leave unchecked	• Leave unchecked unless it is an IHS facility
8.	Location Address	Enter from item 4 of the application PO Boxes are not acceptable	• Enter from item 17 of the application • PO Boxes are not acceptable
9.	Location Phone Number	Enter phone number from contact info in box 12 or if no phone	• Enter phone number from contact info in box 12 or if no phone number in box 12,

		number in box 12, enter phone number from box 9 of the application	enter phone number from box 15 of the application
10.	Mailing & Billing Address	Enter from box 5 of the application	• Enter from box 16 of the application billing phone # and email is NOT required
11.	County Code	Use drop down to enter the appropriate county code in box 5	• Use drop down to enter the appropriate county code in box 17
12.	Zip Code + 4 digits	Enter the Zip Code plus 4 digits (Use 1111, 2222, etc. if entering multiple 803 provider types for the same NPI #. This prevents a duplicate NPI error from occurring. Only enter the plus 4 digits if entering multiple 803 providers	• Enter the Zip Code plus 4 digits (Use 1111, 2222, etc. if entering multiple 803 provider types for the same NPI #. This prevents a duplicate NPI error from occurring.
13	Email address	Enter from item POC in box 12 of the application. If not in box 12, use email address in box 8 or leave blank	• Enter from item POC in box 12 of the application. If not in box 12, use email address in box 26 or leave blank



4. Click on the Enrollment Tab



Step	Field Name	Enrolling the 803 for EP	Enrolling the 803 for IPR
1.	Application Date	• Enter the signature date of the Individual Provider as the application date (top page 2)	• Enter the signature date of the Individual Provider as the application date (top page 2)
2.	Provider Type	• Enter Provider Type 803	• Enter Provider Type 803
3.	Billing Code	• Should auto-populate to “F” • Enter “F” only	• Should auto-populate to “F” • Enter “F” only
4.	Social Security Number	• Enter from either box 10 or W-9	• Enter from either box 21 or W-9
5.	FEIN	• Enter from box 10 or W-9	• Enter from box 21 or W-9
6.	Group Code	• Should always be “I” for individual	• Should always be “I” for individual
7.	Re-verify Date	• Enter the scanned Julian date	• Enter the scanned Julian date
8.	W-9 Date Signed	• Enter the signed date from the attached W-9 form • Needs to be dated with in the last year from the date the application was	• Enter the signed date from the attached W-9 form • Needs to be dated with in the last year from the date the application was initially received.

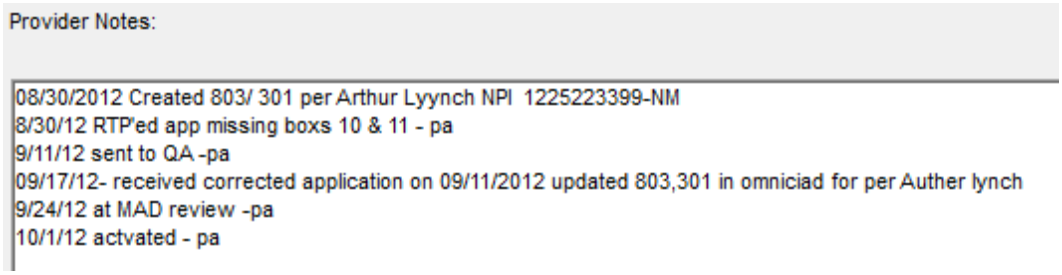
		initially received. • If the application is received before the W-9 date expires, continue with the application as is. • If one is on file, reference it under the notes	• If the App is rcvd before the W-9 date expires, continue with the application as is. • If one is on file, reference it under the notes
9.	Gross Tax Number	NA	NA
	Date of Birth	• When 803 created for EP enter from box 11	NA
10.	UPIN Number	NA	NA
11.	DEA Number	NA	NA
12.	NABP ID	NA	NA
13.	Prof/Tech Indicator	NA	NA
14.	EPSDT Only	NA	NA
15.	Medicare Participant	NA	NA
16.	Profit Indicator	• Check Yes for a person	• Should always be checked unless the applicant indicates he or she is tax exempt in box 24 • A tax exempt 501c3 letter has to be attached addressed to the business's legal name • IHS facilities are always exempt
17.	Tax Discount	NA	NA
18.	Fed Vac for Children	NA	NA
20.	Healthcare Indicator	NA	NA

21.	Enrollment Status	• Always set to 44-Pending Status approval. Will be changed to 60-Active when form is reviewed, approved and signed by State • Effective date will be the EP signature date. Will change to the approval date if different from the State after Conduent receives it back.	• Always set to 44-Pending Status approval. Will be changed to 60-Active when form is reviewed, approved and signed by State • Effective date will be the EP signature date. Will change to the approval date if different from the State after Conduent receives it back.
22.	Program	• Always select M-MAD • Effective date will be the EP signature date. Will change to the approval date if different from the State after Conduent receives it back	• Always select M-MAD • Effective date will be the EP signature date. Will change to the approval date if different from the State after Conduent receives it back.
23.	Provider Specialty	• Utilize the drop down to associate the appropriate Provider Specialty with item 6 of the application. See chart below. • Effective date will be the EP signature date. Will change to the approval date if different from the State after Conduent receives it back.	• Utilize the drop down to associate the appropriate Provider Specialty with item 6 of the application. See chart below. • Effective date will be the EP signature date. Will change to the approval date if different from the State after Conduent receives it back.
24.	NPI	• Enter from box 2 of the application • -Note: Begin date is always 01/01/1964	• Enter from box 20 of the application • -Note: Begin date is always 01/01/1964

Provider Type	803 Provider Specialty
301-Physician, Non-Pediatrician	301-FinPhys
301-Physician, Pediatrician	337-FinPedia

302-Physician, Doctor of Osteopathy	301-FinPhys
305-Physician Assistant in an FQHC or RHC	305-FinPhyAsst
316-Certified Nurse Practitioner	316-FinNurse
322-Certified Nurse Midwife	322-FinMidwife
421-Dentist	421-FinDentist
201-Hospital	201-FinHosp

5. Click on the Notes Tab and enter notes regarding the set-up of the 803 account.
6. Examples of notes below use similar set-up.



7. Click the Save icon.

   The assigned Medicaid ID is found in the Enterprise ID field in OmniCaid and is added to Workflow questions EP-803 Provider ID & IPR-803 Provider ID.

Final Review

1. When the application is received back in workflow, review the status.
2. If it is approved, change the OmniCaid file to active status using dates of Agreement set by the State.
3. If it is not approved, review the reason given by the State and contact the provider for additional attachments and information.
4. Update the Notes tab to show what happened to the record
5. Send out a 803 welcome letter(s) to the appropriate provider

Indexing a MAD 220 – Using IntraViewer and OmniCaid

Description and Purpose

The purpose of this document is to outline the proper procedures for working a MAD 220 application in workflow. Each 220 application has various sections that must be reviewed and researched prior to adding eligibility into OmniCaid. Each application must be entered into OmniCaid following the steps below to create an 803 provider type for payment.

All MAD 220 applications go through the indexing and review processing steps. Several questions need to be answered in each step. Applications must be processed and worked within 10 business days of the received date. The MAD 220 Application is sent to Conduent's Quality Assurance for review and then to the State for approval.

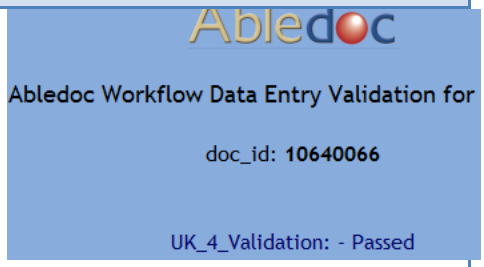
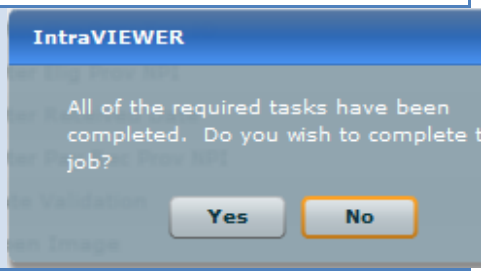
Processing Steps

1. Open the image in Workflow (WF)

2. Using both NPI's on the 220 image (boxes 2 and 20) open in OmniCaid

WF Tasks	WF Question	Details for WF Questions	Instructions for WF Questions
1.	Is Doc Type Correct? Is this a XXX or something else?	Drop down has the following choices: MAD 220, Attestation or Miscellaneous. QA – verify you are looking at the correct document.	• Open the document image and verify if it was scanned into the correct flow. If so continue to step 2. • If image shows the document in the wrong flow, choose the correct one and move on to step 2 – you will still need to answer the rest of the questions. However, the

			document will re-enter the flow to be indexed again in the correct flow.
2.	Enter EP Tax ID	Verify Tax ID (EIN) and/or SSN in OmniCaid and on the 220. QA – check WF to see that the SSN or Tax ID (EIN) has been entered correctly and matches box 10 and OC or, alternatively, that the 803 that was created matches box 10.	• Box 10 for EP – If EP has an active OC account, verify it is the same. • If EP does not have an active OC account, an 803 will be created using the number in box 10 on the application.
3.	Enter EP NPI	Verify NPI in OC and on the 220. QA - check WF to see that the NPI has been entered correctly and matches box 2 and OC or the 803 that was created.	• Box 2 for EP – If EP has an active 60 OC account, verify that the NPI is the same. • If EP does not have an active OC account, an 803 will be created using the number in box 2 on application.
4.	Enter received date Yyyy-mm-dd	TCN – Re-Verify & Received date. QA – check WF to see that the TCN date has been entered correctly. The date the Provider signed the 220 application is to be used.,	• Enter date using the following format: year-month-day. • Use the TCN stamped on the document during scanning.
5.	Enter IPR's NPI	IPR's NPI QA - check WF to see that the NPI has been entered correctly and matches box 20 and OC or,	• Box 20 for IPR – If IPR has an active 60 OmniCaid account, verify it is the same. • If IPR does not have an active 60 OC account, we will be creating an 803 using the number in box 20 on

		alternatively, if an 803 was created.	application.
6.	Date Validation	Validation is automatic and workflow should show following: UK_4_Validation: - Passed If not, go back and correct the date format to yyyy-mm-dd under Step 4 and enter the received date.	
	Save	Use the save button. Then answer Yes to the pop up question.	

Review Steps

1. Open the image in Workflow (WF)
2. Using both NPI's on the 220 image (boxes 2 and 20) open in OmniCaid
3. If *03 accounts were created – use 803 types under the NPI above

WF Tasks	WF Question	Details for WF Questions	Instructions for WF Questions
1.	What is the Document status?	Choose one of the drop down answers: Process, Duplicate, and RTP. QA – if it is being processed continue. For Duplicates & RTP's continue checking to	• Duplicate – Verify that we currently have a 220 in the correct flow process by reviewing the documents in IntraViewer under "flow status" tab. • Process – continue to

		ensure all information is entered in WF correctly.	step 5. • RTP – continue to step 2.
2.	RTP Reason.	Select one of the reasons from drop down. QA – verify the reason for RTP is correct and that a RTP letter was created.	• Choose the reason. If "other" is chosen, enter the reason in SLR Notes below (step 4). • Create an RTP letter for the IPR & EP. Template is located in the share drive under SLR-EHR – RTP letters.
3.	Enter related CRM #, if one was opened.	Use CRM if needed or if SLR notes (step 4) does not have enough room. QA – CRM is not necessary for processing; SLR notes line is used. if one is created, reviewer asks SLR team if questions arise.	• Using Microsoft Dynamics CRM, follow steps to create a CRM.
4.	SLR Notes.	Notes are not required. Use this for supporting reasons for processing or to explain why we did what we did. QA – review if questions arise, ask SLR team.	• For example, use for: RTP "other" reason; if a W-9 or a 501C3 is not attached; or to explain anything else needed to process the application.
5.	EP Status - What is the status of the provider matching the NPI found in box 2?	For EP Status use WF drop down. 60-Active, 70-MCO, Denied, No Match Found, Pending, Terminated. May be in box 7 of 220. Research in OC to find current status of EP. QA - check in WF to make sure status has been entered correctly and matches OmniCaid status.	• Use NPI in box 2 to search in OC for which one of the drop down answers apply – 60 active, 70 MCO, 44 pending, Denied, Termed, No Match. • If the only profile available is 803, be sure to add SLR notes.

6.	EP NM Provider ID - Enter EP's current active NM Provider ID?	For EP – NM Provider ID. Use what is in OmniCaid. If no match or not in OmniCaid enter eight zeros - we will be creating an 803 using the NPI in box 2 and SSN or Tax ID in box 10 on application. QA – In WF check the entry was correctly added and matches the OC status for the EP ID entered in box 6.	• Enter ID shown on top left of OmniCaid screen or Enterprise ID located in the Name/Address tab. • If ID status found in OmniCaid is one of the following: MCO, Pending, Termed, or Denied use the corresponding New Mexico Provider ID for this question. • Do not use 803 IDs.
7.	EP Type/Specialty - Enter EP's T/S for their current active NM Provider ID?	EP T/S – Type & Specialty, Use the following correct format: 000/000 If provider has no specialty use three zeros after the provider type. QA – In WF check the entry was correctly added and matches the Type and specialty in OmniCaid for the EP ID entered in box 6.	• This information is in Provider Detail under the Enrollment tab. • Use provider type. • Use provider specialty.
8.	EP Billing Code – Billing code for their current active NM Provider ID?	EP Billing code. Select the drop down answer that matches what is in OmniCaid. QA – verify in OmniCaid – the Provider ID entered for question # 6 above matches the billing code entered here.	• In OmniCaid bring up the provider ID for answer (6) see above. In Provider Detail under the enrollment tab, verify the Billing Code. • Billing, Carrier, Financial, HIPP, PE Determiner, Servicing, Unrestricted or Crossover.
9.	EP Sanction Check - Was there a match when sanction checking the EP?	EP Sanction Check. Use the Office of Inspector General web site to check the name or SSN http://exclusions.oig.hhs.gov/ QA – Verify the same way.	• Type in provider's name using format given on Website and run the check if it comes back with results check the provider SSN.

10.	EP 803 Provider ID - What is the NM Provider ID of the 803 Provider created for the EP?	EP 803 Provider ID created. The field is auto populated with “none created”. Leave as is if you don’t create one. If you do create a new profile for the EP , enter it at this step. QA – If the WF answer has a provider ID, use that to verify the EP’s information on the top part of the 220 application.	• Only create a new provider file if, the provider does not have an active 60 status in OmniCaid or, the same provider/ type as the IPR. • Leave the answer as is if, the provider does not need an 803 created for them.
11.	EP 803 Specialty – Enter EP’s Specialty for their 803 NM Provider ID.	EP 803 Specialty created. Specialty is determined by what is already established in OmniCaid. If provider is not in OmniCaid or box 6 is left blank, research specialty by contacting the POC. QA – Check the provider’s OmniCaid file to see if the specialty currently on file matches what was entered for the new 803 created.	• Use one of the specialties listed in box 6 and research the provider’s OmniCaid file for the specialty we have on file to the one checked. Then enter in OmniCaid under the Enrollment tab. • 301-FinPhys, 337-FinPedia, 305-FinHPhyAsst, 316-FinNurse, 322-FinMidwife, 421-FinDentist.
12.	Affiliated? - Is the EP currently affiliated with the IPR?	If affiliated, use OmniCaid to look up NPI’s in boxes 2 & 20. Check that the names of the EP and IPR are on the Affiliated tab. If not affiliated, contact POC for proof of employment during the attestation dates. QA – Check OmniCaid affiliation tabs or the SLR notes.	• Check that the EP listed in section 1 is listed under the IPR’s affiliation tab. • Check that the IPR listed in section 2 is listed under the EP’s Affiliations tab. • If provider is a self-payer, answer Yes to this
13.	IPR Status – What is the Status of the provider	IPR Status. Research in OmniCaid to find current status. Then use WF drop down to choose the	• Use NPI in box 20 or Tax ID in box 21 to search in OmniCaid to determine which one of the WF

	Matching the NPI found in box 20?	correct status. QA - check WF has been entered correctly and matches OmniCaid status.	answers applies – • 60 active, 70 MCO, 44 pending, Denied, Termed, No Match. • Multiple answers may apply use the order above.
14.	IPR NM Provider ID - Enter IPR Provider's current active NM Provider ID.	IPR NM provider ID. Use what is in OmniCaid - it may be in box 19 of 220. If no match or not in OmniCaid, enter eight zeros - we will be creating an 803 using the NPI in box 20 and SSN or Tax ID number in box 21 on application. QA – check WF entered correctly and matches OC entry for status.	• Enter ID shown on top left of OmniCaid screen or Enterprise ID located in the Name/Address tab. • If ID status found in OmniCaid is MCO, Pending, Termed, or Denied, use that NM Provider ID for this question. • Do not use 803 IDs.
15.	IPR Type/Specialty –Enter IPR Provider's T/S for their current active NM provider ID.	IPR – Type and Specialty use correct format 000/000. If provider has no specialty, use three zeros after the provider type. QA – Check WF entered correctly and matches OC T/S.	• Find in Provider Detail under Enrollment tab. • Use provider type. • Use provider specialty.
16.	IPR Billing Code - Enter IPR provider's billing code for their current active NM provider ID.	IPR Billing code, research in OmniCaid to find the current billing code for IPR. Select the drop down answer that matches what is in OmniCaid. QA – verify in OmniCaid that the Provider ID entered for question 14 above matches the billing code entered here.	• In OC use the provider ID for answer (14) above in Provider Detail under the Enrollment tab to verify the Billing Code. • Billing, Carrier, Financial, HIPP, PE Determiner, Servicing, Unrestricted or Crossover.
17.	IPR Sanction Check - Was there a match when sanction checking the IPR provider?	IPR Sanction Check, Use the Office of Inspector General Website to check the name or SSN http://exclusions.oig.hhs.gov/	• Type in provider's name using format given on Website and run the check if it comes back with results check the

		QA Verify the same way.	provider SSN.
18.	IPR 803 Provider ID – What is the New Mexico Provider ID of the 803 provider created for the IPR provider?	IPR 803 Provider ID created. The field is auto populated with "none created". Leave it as is if you don't create a new profile. If you do create a new profile for the IPR, enter it at this step. QA – If WF answer has a provider ID, use that to verify the IPR's information on the bottom part of the 220 application.	• Only create a new provider profile if the provider does not have an active 60 status in OmniCaid or the same provider/ type as the EP. • Leave the answer as is if the IPR does not need an 803 created for them.
19.	IPR 803 Specialty – Enter IPR providers Specialty for their NM provider ID	IPR 803 Specialty created. Specialty is determined by the information in box 18 or, if box 18 is left blank, research what specialty is showing in OmniCaid. QA – Check the provider's OmniCaid file to see if the specialty we currently have on file matches what was entered for the new 803 created.	• Use one of the specialties listed in box 18 and research the active 60 provider file for the specialty we have on file against the one checked in box 18. Then enter it in OmniCaid under the enrollment tab. • 301-FinPhys, 337-FinPedia, 305-FinHPhyAsst, 316-FinNurse, 322-FinMidwife, 421-FinDentist.
20.	W-9 Attached? Is there a W-9 attached for the IPR?	Use the drop down and add notes to SLR notes. QA – Check WF answers and 803 created to verify the date on the W-9 form matches what was entered in OmniCaid.	• If attached, be sure it is signed and dated. Add date to OmniCaid for the 803 created in Provider File under the Enrollment tab. • If W-9 is not attached, answer one of the following: Found in Provider File, No W-9 Found, Not Required. • Add note in SLR Notes question or create a CRM and explain the

			situation. • Once the W-9 is received and scanned into Miscellaneous documents in WF, be aware that an EP attesting to EHR, and assigning the Group as the "payee" will require a Group W-9. If the EP is paying him or herself, an individual W-9 is required.
21.	501C3 Attached? – If applicable, is a Non Profit Tax Exempt 501C3 letter attached?	Use the drop down and add notes to SLR notes. ALL IHS facilities are tax exempt. ALWAYS use the answer "Not Required" QA – Check WF answers and 803 created to see if the profit indicator is checked or not. If not checked, look for 501C3 letter..	• If letter is attached, be sure it is from the IRS with all correct information on the letter. • If a 501C3 is not attached, answer one of the following questions in the drop down: Found in Provider File; No 501C3 Found; or Not Required. • Add note in SLR Notes "question" or create a CRM and explain the situation. • Once 501c3 received and scanned into Miscellaneous documents in WF, reference where document can be located.
22.	Were any of the Disclosure Questions answered Yes?	These questions are on page 2 of the application. QA – Check WF questions against the application. Check WF notes if needed.	• If any of these questions (12-A, 12-B, 12-C, 28 or multiple) are answered 'Yes' add notes in CRM and make sure all the proper attachments are included. If proper documents are not with the image, make notes in

			SLR as to where they are located. • If “No” is the answer, continue processing the application.
23.	Review all questions and OC 803 files created	Be sure all required questions are check marked as done. QA – all questions are answered with the correct information and 803 files are complete.	• All 803 Provider Files created need to be reviewed. • Add notes where applicable and in OmniCaid.

Final Review

- Update the notes tab for the 803 Provider files created in OmniCaid.
- See examples below:

Change History

Revision	Date	Page	Step or Section	Description
001	10/27/11	• All	• All	• Initial Publication (TLB)
002	10/18/12	• All	• All	• Created MAD 220 workflow procedures
003	12/10/12	• All	• All	• Added more detailed instructions for EP and IPR under the enrollment review & OmniCaid Entry section.
004	03/13/13	• All	• All	• Revised MAD 220 instructions (PA)
005	04/08/13	• All	• All	• Added Microsoft Dynamics step 3, Added Abledoc & IntraViewer step 6, updated 803 instructions for both EP/IPR and added 501C3 IHS answer step 21
006	06/27/13	• All	• All	• Added revised MAD 220 instructions to SLR manual.
007	07/28/13	• All	• All	• Changed ACS to Xerox and made minor grammar/ • punctuation/formatting corrections.
008	11/14/17	All	All	• Conduent Rebranding
				•

Indian Health Services (IHS)

Indian Health Services are always exempt from taxes.

SLR Processes Different than Provider Enrollment Processes

1. Items Scanned into Workflow

    a. If a MAD 220 is received with a W-9 or 501C3 but the MAD 220 must be returned to the provider for some reason (correction, additional information, approval sheet, etc.), SLR Staff scan the W-9 or 501C3 or other related document into Workflow to retain and preserve the document before the correct MAD 220 is received; and,
    b. Information in the scanned W-9 or 501C3 or other related document received with the returned MAD 220 may be used, at SLR Staff discretion, when the correct MAD 220 is received.
    c. If a SLR/EHR related document must be sent to the State or returned to the State for some reason (correction, additional information, approval sheet, etc.), SLR Staff scan the requested document into Workflow to send or return the requested document(s) to the State.

2. Use of “Reasonable Information”

    a. To complete a MAD 220 and/or Attestation form, SLR Staff use “reasonable information” from the already existing information on file (OmniCaid or

Dashboard or State Data Tool, etc.) and/or from other resources which would have the accurate information (the CMS Registration and Attestation System and State Data Tool) and which will allow accurate completion of the document.

3. If a caller is known to the SLR Staff person, and there are ongoing telephone calls back and forth with a caller known to the SLR Staff person throughout the same day and regarding the same issue(s), a simplified identification of the caller is allowed. That simplified identification includes:

    a. Recognition of the caller's voice from prior contacts; and
    b. Caller and SLR Staff call each other by their name; and,
    c. Calls are back and forth throughout the same day in succession; and,
    d. Content of calls relate to the same issue(s).

4. If a caller is from the State (MAD, EHR, etc.) and known to the SLR Staff person, and there are ongoing telephone calls back and forth with a caller known to the SLR Staff person throughout the same day, a simplified identification of the caller is allowed. That simplified identification includes:

    a. Recognition of the caller's voice from prior contacts; and
    b. Caller and SLR Staff call each other by their name; and,
    c. Calls are back and forth throughout the same day in succession; and,
    d. Content of calls relate to the same issue(s) i.e., SLR/EHR.

    In addition, understanding that the State is Conduent's client, and knowing it is desirable to have a good working relationship with State staff, the following apply:

    a. Banter and exchange of personal information is acceptable in the appropriate manner; and,
    b. The full Conduent greetings at the beginning and end of a telephone call with an unknown caller are not always necessary and/or appropriate (for example, if State staff by word, tone or action makes it clear they want to get to the purpose and content of the call and/or are ready to end the call).

5. SLR Staff do not enter and/or update information not related to SLR.

    a. SLR Staff are responsible to enter and/or update information required for the SLR; and,
    b. SLR Staff do not interfere with Provider Enrollment. SLR staff do not enter and/or update Provider Enrollment information used by and for Provider Enrollment

Appendix A – Definitions

Term	Definition
Acute care hospital	• An acute care hospital is defined as a health care facility where the average length of patient stay is 25 days or fewer and a Medicare CCN number (i.e. provider number) whose last four digits in the series run from 0001 through 0879 and 1300 through 1399
Adopt, Implement, Upgrade	• Demonstrate meaningful use of certified EHR technology
Eligible Professional Encounter	• For purposes of calculating EP patient volume, a Medicaid encounter is defined as services rendered on any one day to an individual where MAD or another State's Medicaid program paid for: – Part or all of the service; or – Part or all of their premiums, co-payments, and/or cost-sharing
Hospital-based EP	• An EP is considered hospital based if 90% or more of their covered professional services in either an inpatient (place of service 21) or emergency room (place of service 23) of a hospital
Medicaid Encounter	• Services rendered on any one day to an individual where MAD or another State's Medicaid program paid for: – Part or all of the service; or – Part or all of their premiums, co-payments, and/or cost-sharing
MMIS	• Medicaid Management Information System is the system the state of New Mexico uses to process Medicaid claims
Needy Individual Encounter	• For purposes of calculating patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were: – Paid for by Medicaid or Children's Health Insurance Program funding including MAD, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act; – Furnished by the provider as uncompensated care, or – Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's

	ability to pay.
'So led'	• The PA is the primary provider in a clinic • The PA is a clinical or medical director at the practice • The PA is an owner of the FQHC or RHC

Appendix B - EHR Important Acronyms

Acronym	Description
AAC	Average Allowable Cost(of certified E.H.R technology)
AIU	Adopt, Implement, or Upgrade
ARRA	American Recovery and Reinvestment Act
CAH	Critical Access Hospital
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHPL	Certified Health Information Technology Product List
CMS	Children's Medical Service
CMS	Centers for Medicare and Medicaid
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality System
CR	Contact Record
CRM	Customer Relationship Management
CY	Calendar Year
EHR	Electronic Health Records
EH	Eligible Hospital
EIN	Tax Identification
EP	Eligible Professional

EPO	Exclusive Provider Organization
FACA	Federal Advisory Committee Act
FFP	Federal Financial Participation
FFS	Fee For Service
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
FY	Fiscal Year
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HIC	New Mexico Health Information Collaborative
HIE	Health Information Exchange
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HITREC	New Mexico HIT Regional Extension Center
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
HPSA	Health Professional Shortage Area
HRSA	Health Resource and Services Administration
IAPD	Implementation Advance Planning Document
IPR	Incentive Payment Recipient
ICR	Information Collection Requirement
ID	Identification Number
IHS	Indian Health Service
IPA	Independent Practice Association

IRS	Internal Revenue Service
IT	Information Technology
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAD	Medical Assistance Division, State of New Mexico
MAO	Medicare Advantage Organization
MCO	Managed Care Organization
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information Systems
MSA	Medical Savings Account
NAAC	Net Average Allowable Cost (of certified E.H.R technology)
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NHIN	National Health Information Network
NPI	National Provider Identifier
NPRM	Notice of Proposed Rulemaking
OC	OmniCaid
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PAHP	Prepaid Ambulatory Health Plan
PAPD	Planning Advance Planning Document
PDCS	Prescription Drugs Claim System
PE	Provider Enrollment
PECOS	Provider Enrollment Chain and Ownership System
PFFS	Private Fee-For-Service

PHO	Physician Hospital Organization
PHS	Public Health Service
PHSA	Public Health Service Act
PIHP	Prepaid Inpatient Health Plan
POC	Point of Contact
POS	Place of Service
PPO	Preferred Provider Organization
PQRI	Physician Quality Reporting Initiative
PSO	Provider Sponsored Organization
PV	Patient Volume
QA	Quality Assurance
RTP	Return to Provider
RHC	Rural Health Clinic
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
RPPO	Regional Preferred Provider Organization
SLR	State Level Registry
SMHP	State Medicaid Health Information Technology Plan
SSN	Social Security Number
T/S	Type/Specialty
TCN	Transaction Control Number
TIN	Tax Identification Number
WF	Workflow
W-9	Tax Form from Internal Revenue Service
803	EHR Financial Payment Type

Appendix C – EHR Provider Participation Requirements

Entity – Eligible Professional (EP) or Eligible Hospital (EH)		Definition	Qualifying Patient Volume Threshold	Patient Volume Verification Method
Physician	• Physician, including Pediatrician and Psychiatrist • Can practice in any setting other than hospital based, including public health office	• Non-hospital based – cannot have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting	• 30% Medicaid	• Medicaid patient encounters in any 90 day reporting period in the preceding calendar year divided by total patient encounters in same 90 day period Or • [Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period] + [Unduplicated Medicaid encounters in that same 90-day period] *100 [Total patients assigned to the provider in the same 90-day with at least one encounter in the year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day

				period]
	• Pediatrician w/reduced incentive	• Non-hospital based – cannot have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting	• 20%	• Can use either option
	• EP's, including physicians, dentists ,N-M and NP predominately practicing in FQHC/RHC	• Over 50% of total patient encounters over 6 mos. occur at FQHC or RHC. • Not subject to hospital-based exclusion.	• 30% patient volume attributed to needy individuals • Medicaid or CHIP • Uncompensated care or • Services at no cost or sliding scale	• Can use either option above but with needy individuals used in numerator and denominator
Dentist	• May practice in any setting	• Non-hospital based – cannot have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	• 30%	• Can use either option
Certified Nurse Midwives	• May practice in any setting	• Non-hospital based – cannot have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	• 30%	• Can use either option

PA @ FQHC/RHC led by PA	• Practice limited to FQHC or RHC	• Not subject to hospital-based exclusion	• 30% Needy individuals	• Can use either option
Nurse Practitioner	• May practice in any setting	• Non-hospital based – cannot have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	• 30%	• Can use either option
Eligible Hospitals	• Acute Care Hospitals and Critical Access Hospitals	• CCN range • Avg. patient stay <25 days.	• 10%	• Must use patient encounters, but encounters for hospitals are inpatient discharges and ER visits
	• Children's Hospital	• CCN range	• No requirement	• N/A
IHS & 638 Hospitals	• All IHS acute care hospitals	• CCN range • Avg. patient stay <25 days.	• 10%	• Must use patient encounters, but encounters for hospitals are inpatient discharges and ER visits. Verification from RPMS data runs.

Appendix D - EHR Operations Questions

1. Will providers have an escalation process in the event they do not receive payments or if the payment is denied and they don't agree with the denial reason?
   - Yes there will be an informal appeals process in place (MAD).
2. Will we be able to see the documents that are uploaded by the provider in the SLR or will they need to mail them in?
   - Once they are uploaded, we are able to view the documents (Validation process). Certain documents still need to be mailed in per state regulations.
3. How will the payment reports look? Will they come from Conduent to the State and then to CMS, or will we be able to upload the information to CMS directly?
   - Once a provider has passed all eligibility and validation checks, the SLR passes payment information to the CMS for duplication and exclusion checks. The SLR application packages all eligible providers and sends to NLR.
4. In the event a provider receives duplicate payments, can we recoup payment and if so what will be the process?
   - Yes, the recoupment can be done against certain codes (131 = pay and 141 = recoup)
5. How will the certification ID be verified with the ONC? At this time it can be searched by product, name, or vendor.
   - There is an interface between the SLR and ONC. The certification ID has to be validated before the provider can complete registration.
6. With regards to the eligibility formula, will the formula stay the same or will New Mexico utilize their own formula or will we allow EPs to formulate their own?
   - New Mexico does not deviate from the eligibility formula that is in place.
7. Although an EP cannot receive dual payments under Medicare/Medicaid, can they receive payments under the CMS Electronic (ERX) incentive and Medicaid incentive?
   - Yes
8. Under Non-Hospital-Based Eligible Professionals, it lists physicians as either MD or DO. What about OD (Ophthalmologist Doctors)?
   - If the physician is not listed as an MD or DO, such as an OD, they are handled by the State. Providers of neighboring states and FQHC by a PA are other examples of instances that the State handles.
9. By what date will we establish the mechanism and process by which we verify and audit an eligible professional's attestation?
   - After attestations are submitted, there is a 30 day window to process payment. The 30 day period is when all verifications and audits are carried out.
10. What are some examples of "auditable" data sources?

- Provider type, attestation status, attestations with exceptions, Eligible Professional patient volumes, groups that have more than {XX} providers, Eligible hospital Medicaid Volumes and Length of Stay, and Eligible Hospitals with Medicaid Managed Care Inpatient Bed Days.

Appendix E - EHR Frequently Asked Questions

1. If an EP can use a group's PV (patient volume), can this include the PV of ancillary providers within that group?
   - Yes, but only qualifying eligible professionals receive the incentive payment, e.g. a RN is not eligible for the program but their encounters are included.
2. What data sources will New Mexico use to support demographic data that is reported?
   - MMIS provides validation for MAD FFS status, provider NPI, type, place of service for claims (not hospital based), number of Medicaid claims (Medicaid patient volume)
3. What defines a "needy" individual?
   - A needy individual encounter is defined as services rendered on any one day to an individual where medical services were:
     - Paid for by Medicaid or Children's Health Insurance Program funding including MAD, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
     - Furnished by the provider as uncompensated care; or
     - Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.
4. Can an EP or group count patients seen from other states in their encounters?
   - Yes
5. How long after registration will an EP receive payment?
   - 30-days or less, following Conduent existing Medicaid claims processing schedule.
6. If the incentives are based on the individual and not the practice, how do we determine what amount is reported for the equipment? For example, in a group practice setting: Does each provider in the practice report the total amount or is the total amount for the equipment divided by the total number of providers and that number is reported by the individual providers?
   - EPs no longer have to show evidence of their share of average allowable costs, e.g. purchasing EHR technology.
7. Will New Mexico require separate contracts to be signed indicating AIU or future AIU?
   - No. Evidence of AIU is only valid for a provider's first participation payment year. After Year One, providers must demonstrate evidence of meaningful use, not AIU.

8. If services are rendered in a nursing home, can it count as an encounter?
   - Technically, Yes, if it is a Medicaid encounter for a qualifying EP but only the EP can count the encounter, not the nursing home itself since it is ineligible for the program.
9. Will NM preselect 90 day periods for EP to choose from to help streamline the prepayment verification for the first year?
   - No. Providers choose their reporting period.
10. Can information be used from an old group that has changed ownership and is no longer current in regards to patient volume?

- Patient volume must be associated with the EP that is participating in EHR program.

11. Will there be a mechanism in OmniCaid which allows us to track providers who have EHR in place?
    - No. The SLR keeps AIU attestation evidence for EP participation year.
12. How will we store information that is uploaded from the providers during registration and for how long?
    - The SLR receives and stores uploaded documents for the life of the program (10 years).
13. Will the provider request actual payment through the SLR or through a CMS-1500 which can be manually uploaded along with other documents during registration?
    - EHR incentive payments are requested via attestation and processed via SLR only.
14. Will the SLR automatically compute the allowed incentive amount for the EP and EH or will this be manually done by the payment coordinator?
    - SLR automatically calculates the incentive payments for both EP and EH. MMIS issues the payment once approved by MAD/ Conduent.
15. Will NM adopt additional requirements for "Meaningful Use" since individual states are allowed to?
    - No, states only flexibility regarding meaningful use measures is limited to requiring any of the four public health measures to be included as part of the core set of measures. At this time, New Mexico MAD has elected not to include public health measures as core set. We expect to update our State Medicaid Health Information Technology plan with required public health measures.

Appendix F – Quick Tips for Eligible Hospitals

The current Quick Tips for Eligible Hospitals can be found at:

http://nm.arraincentive.com/docs/NM-EH-QuickTips.pdf

New Mexico Medicaid Electronic Health Records (EHR) Incentive Payment Program

Register Today!

Medicaid EHR Incentive Payments for Eligible Hospitals

- The aggregate incentive amount to be paid over a three-year period is a one-time upfront calculation based on the CMS Final Program Rule.
- Payments will be distributed over a three-year period:
  - 50% of the aggregate incentive amount will be paid in participation year 1 for AIU
  - 40% of the aggregate incentive amount will be paid in participation year 2 for Meaningful Use
  - 10% of the aggregate incentive amount will be paid in participation year 3 for Meaningful Use
- Program spans 2011-2021, but hospitals must initiate payment by 2016
- Participation years can be on a non-consecutive, annual basis prior to 2016
- Payments can be expected within 30 days of successful registration and EHR unit receipt of signed and mailed attestation document

Eligible Hospitals Payment Calculation

- The aggregate incentive amount is the total amount that the hospital could receive in Medicaid payments over a theoretical four years of the program. It is the product of two factors: 1) the overall Electronic Health Records (EHR) program amount multiplied by 2) the Medicaid share of discharges.
- Please visit the CMS website for details on how the hospital incentive payment is calculated: http://www.cms.gov/MLNProducts/downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf

Eligible Hospitals

- Acute Care, including Critical Access, and Cancer Hospitals – Medicaid Provider Type 201
  - Average patient stay 25 days or less
  - Claim Control Number (CCN) falls between 0001-0879 or between 1300-1399
  - Must meet 10% Medicaid patient volume
  - Must attest to AIU in program year 1, except for dually eligible hospitals who meet Medicare Meaningful Use
- Separately Certified Children's Hospitals – None exist in New Mexico

Adopt, Implement, Upgrade (AIU)

Hospitals must attest to adoption, implementation or upgrade of a certified EHR system, provide a CMS certification number of that technology for the first participation year, and provide one of the following documents:

- EHR Vendor letter
- EHR Vendor invoice
- EHR Sales contract
- EHR Service/training contract

Defining Program Patient Volume

10% Medicaid patient volume for all patient encounters over a continuous 90-day period in the preceding fiscal year

Medicaid Encounters

- Services rendered on any one day to an individual
- Services paid or partially paid by Medicaid
- Includes premiums, co-pays, or other cost sharing
- Claims paid amount must be greater than zero
- Must exclude CHIP recipients from Medicaid encounters

Registration

Eligible Hospitals will need:

- National Provider Identification Number (NPI)
- Tax Identification Number (TIN)
- Provider Enrollment, Chain and Ownership System Number (PECOS)
- Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select **"Both Medicare and Medicaid"** during registration at CMS Registration and Attestation system.
  - Dually-eligible hospitals should register and attest to AIU for Medicaid first, then attest to Medicare Meaningful use
  - Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid" or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment

Important Links

Determine if you meet the eligibility requirements. Visit the **CMS** website at http://www.cms.gov/EHRIncentivePrograms/

To register or get a jump start on registration, visit the New Mexico Provider Outreach Page at http://nm.arraincentive.com/default.aspx

Get information on certified EHR systems by visiting http://onc-chpl.force.com/ehrcert

For complete program information and to view the Final Rule, visit http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

Additional Resources

For questions on the registration process, please call 1-800-299-7304 or email to EHRPROGRAMNM@acs-inc.com

Quick Tips for Eligible Hospitals version 1.0

Appendix G – Quick Tips for Eligible Professionals

The current Quick Tips for Eligible Professionals can be found at:

http://nm.arraincentive.com/docs/NM-EP-QuickTips.pdf

New Mexico Medicaid Electronic Health Record Incentive Payment Program

Register Today!

Incentive Payments

- Program spans 2011-2021
- Pays up to $63,750 over 6 years or $42,500 for pediatricians with 20-29% patient volume
- Eligible Professionals must begin receiving incentive payments no later than CY 2016 in order to receive maximum incentive payments allowed
- Payments can be expected within 30 days of successful registration and EHR unit receipt of signed and mailed attestation documents
- Participation years can be non-consecutive

Eligible Professional Provider Types

- Physicians = Medicaid Provider Types 301 and 302
- Pediatrician = Medicaid Provider Type 301/ specialty type 037
- Nurse Practitioner = Medicaid Provider Type 316
- Certified Nurse Midwife = Medicaid Provider Type 322
- Dentist = Medicaid Provider Type 421
- Physician Assistant = Medicaid Provider Type 305 (working in either a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is led by a PA. PAs working in a physician led clinic are NOT eligible.)

Adopt, Implement, Upgrade (AIU)

Providers must attest to adopt, implement or upgrade a certified EHR system, provide a CMS certification number of that technology for the first participation year, and provide one of the following documents:

- EHR Vendor letter
- EHR Vendor invoice
- EHR Sales contract
- EHR Service/training contract

Program Patient Volume Requirements

EPs are required to have a minimum of 30% Medicaid patient volume for all patient encounters over a continuous 90-day period within the most recent calendar year prior to registering. There are three exceptions:

1. Pediatricians not working in a FQHC or RHC qualify if they have at least 20% Medicaid patient volume, but payment will be reduced to 2/3 of the total incentive.
2. EPs practicing predominantly in an FQHC or RHC may use "needy individuals" to meet 30% patient volume.
3. CHIP (Children's Health Insurance Program) encounters must be excluded from Medicaid patient volume but may be used in calculating "needy individuals" for FQHCs and RHCs only.

Defining Program Patient Volume

Medicaid Encounters

- Services rendered on any one day to an individual
- Services paid or partially paid by Medicaid
- Includes premiums, co-pays, or other cost sharing
- Claims paid amount must be greater than zero
- Must exclude CHIP (Children's Health Insurance Program) recipients from Medicaid encounters

Needy Individuals

- Receiving medical assistance from Medicaid or CHIP (Children's Health Insurance Program)
- Uncompensated care furnished by the provider
- An individual who pays on a sliding scale

Group Volume

Clinics or group practices may elect to use group calculation if:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- As long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data); and
- There is an auditable data source to support the clinic's patient volume determination.

Important Links

Determine if you meet the eligibility requirements. Visit the **CMS** website at http://www.cms.gov/EHRIncentivePrograms/

To get a jump start on registration, visit the New Mexico Provider Outreach Page at http://nm.arraincentive.com/default.aspx

Get information on certified EHR systems by visiting http://onc-chpl.force.com/ehrcert

For complete program information and to view the Final Rule, visit http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

Additional Resources

For additional questions, please contact the State Level Registry department by calling 1-800-299-7304 or via email at mailto:EHRPROGRAMNM@acs-inc.com

Quick Tips for Eligible Professionals version 1.0

Appendix H - EHR Program Attestation Elements

The table below organizes attestation elements which must be collected to support EHR program implementation.

Provider Type	EHR Year 1 Reporting Period	EHR Years 2 – 6 Reporting Period	Attestation		Data Source Used to Validate
			Yes No	Data Provided	
All	• Define the 90 day period used for meeting patient volume requirements	• Define the 90 day period used for meeting patient volume requirements		✓	• SLR entry by provider
EPs	• Identify the method by which they meet patient volume (panel vs. encounter)	• Identify the method by which they meet patient volume (panel vs. encounter)		✓	• SLR entry by provider
All	• Provide the number of Medicaid patients, by payment source • Medicaid payers include: NM FFS, MCO payers and out-of-state Medicaid.	• Provide the number of Medicaid patients, by payment source • Medicaid payers include NM FFS, MCO payers and out-of-state Medicaid		✓	• MMIS/DW desktop query – # of claims, category of eligibility codes (excludes CHIP

					071/1)
All	• Provide the total number of patients	• Provide the total number of patients		✓	• Provider uploads practice management reports
Select EPs	• EPs predominantly practicing in an FQHC or RHC must provide the total number of needy individuals as defined by the rule.	• EPs predominantly practicing in an FQHC or RHC must provide the total number of needy individuals as defined by the rule.		✓	• MMIS/DW desktop query – # of claims, category of eligibility codes (includes CHIP 071/1)
Physician Assistant	• Attest that he/she is working in an FQHC or RHC so led by a PA	• Attest that he/she is working in an FQHC or RHC so led by a PA	✓		• PA list from NM PCA
EPs	• Attests that he/she practices predominantly in an FQHC or RHC, if applicable	• Attests that he/she practices predominantly in an FQHC or RHC, if applicable	✓		• PA list from NM PCA
EPs	• Non-hospital based professional as defined by the rule, except those EPs practicing predominantly in FQHC or RHC	• Non-hospital based professional as defined by the rule, except those EPs practicing predominantly in FQHC or RHC	✓		• MMIS/DW desktop query – place of service codes
EPs	• Not concurrently receiving an incentive payment from another State, Medicare or under another New Mexico TIN	• Not concurrently receiving an incentive payment under another State, Medicare or another New Mexico TIN	✓		• NLR
EHs	• Not concurrently receiving an incentive payment from another State, or under another New Mexico TIN	• Not concurrently receiving an incentive payment from another State, or under another New Mexico TIN	✓		• NLR

All	• Adopted, implemented or upgraded (A/I/U) certified EHR	• Used certified EHR technology	✓		• Vendor letter, invoice, service contract
All	• The EHR product used is certified and provide the product certification number	• The EHR product used is certified and provide the product certification number		✓	• SLR validates
EPs	• Confirmed assignment of payment to TIN	• Confirmed assignment of payment to TIN	✓		• SLR validates
All	•	• Specified the meaningful use reporting period (90 days for first year of MU reporting, then full year thereafter) • Provided the result of each applicable measure for all patients seen during the EHR reporting period for which a selected meaningful use measure is applicable		✓	• TBD
All	•	• Satisfied the required objectives and associated measures as defined under §495.6 and as applicable to the stage per the rule	✓		•
All	•	• Satisfied the State required Public Health objectives and associated measures	✓		TBD
All	•	• Attests that the clinical quality measures not reported do not apply to any patients treated by the provider	✓		TBD

All	• Attests that all information is true and accurate per wording in the rule	• Attests that all information is true and accurate per wording in the rule			Signed attestation mailed to Conduent
EHs and CAHs	• The official submitting on behalf of an EH or CAH, to the best of their knowledge attests to the accuracy of the information being submitted as being accurate and true	• The official submitting on behalf of an EH or CAH, to the best of their knowledge attests to the accuracy of the information being submitted is accurate and true			Signed attestation mailed to Conduent

Appendix I – Form MAD 220

STATE OF NEW MEXICO - MEDICAL ASSISTANCE DIVISION
ELECTRONIC HEALTH RECORD INCENTIVE PAYMENT
PROVIDER PARTICIPATION AGREEMENT TYPE 803

Page 1

Mail Completed Application to:
EHR IP Program c/o ACS P.O. Box 27460 Albuquerque, NM 87125-7460

This form must be completed to initiate the EHR Incentive Payment process before registration in the State Level Registry if any one of the three boxes below applies: (check appropriate box) The provider who is eligible for incentive payments –

☐ Is *not* enrolled in the Medicaid Fee-for-Service program, but is enrolled as a provider in one or more Medicaid managed care organizations (MCO). Please list the MCO(s) on the line below in which the eligible provider is currently enrolled:

_____

☐ Is enrolled only as a *rendering* provider in the Medicaid Fee-for-Service program (services are billed by a group, clinic, or other entity) but the eligible provider wants to receive the incentive payment rather than assigning payment to the group, clinic, or other entity.

☐ Is enrolled in the Medicaid Fee-for-Service program and the eligible provider wants to assign the incentive payments to that group, clinic or other entity *and* that group, clinic, or other entity is *not* the same type of provider as the eligible provider.
(Such as when a CNP or CNM assigns payment to a physician group; a pediatrician assigns payment to a non-pediatrician group; a physician assigns payment to anyone other than a physician group; a dentist assigns payment to anyone other than a dental group; or when any provider assigns payment to a hospital, FQHC, or RHC.)

SECTION I: IDENTIFY THE ELIGIBLE PROVIDER

(1) Name	(2) National Provider Identifier (NPI)	(3) License Information Number / State / Expiration Date

(4) Location Address	City	County	State	Zip Code

(5) Mailing address for correspondence	City	County	State	Zip Code

(6) Check the appropriate box. The eligible provider is a:

☐ Physician, Non-Pediatrician ☐ Certified Nurse Practitioner ☐ Certified Nurse Midwife
☐ Physician Assistant in an FQHC or RHC ☐ Pediatrician ☐ Dentist

(7) If currently enrolled as a Medicaid provider, please indicate the current Medicaid ID number(s).

(8) Email Address	(9) Social Security Number	(10) Date of Birth

(11)
A) Have you ever had a license revoked, suspended or denied in any state? ☐ YES ☐ NO Initial_____
B) Have you ever been convicted of any criminal offense? ☐ YES ☐ NO Initial_____
C) Have you ever been excluded or suspended from participation in Title XVIII (Medicare), Title XIX (Medicaid), Title XX (Block Grants to States for Social Services), Title XXI (SCHIPS) or any other health care program? ☐ YES ☐ NO Initial_____

If YES to any of the above three questions, attach a brief statement of situation; date; city, county and professional association or court which handled the matter; any precinct case identification, and the adjudication or other result. If deemed appropriate, Medical Assistance Division (MAD) may undertake its own investigation. Depending on the issue, and/or MAD investigation, if deemed appropriate, MAD may exclude the applicant from participation in Electronic Health Records Incentive Program.

SECTION II: IDENTIFY THE RECIPIENT OF THE INCENTIVE PAYMENT

Complete the information below for the individual, group, clinic or other entity who will receive the incentive payment.

(12) Check applicable box:

☐ The eligible provider identified in Section I will receive the incentive payment.

☐ The eligible provider identified in Section I will assign the payment to an affiliated group, clinic or other entity.

(13) Name of Incentive Payment Recipient

(14) Mailing address for correspondence	City	County	State	Zip Code

(15) Location Address	City	County	State	Zip Code

(16) Check the appropriate box. The incentive payment recipient is a:

☐ Physician, Non-Pediatrician ☐ Certified Nurse Practitioner ☐ Certified Nurse Midwife
☐ Physician Assistant in an FQHC or RHC ☐ Pediatrician ☐ Dentist

(17) Indicate the Medicaid ID Number of the incentive payment recipient, if currently enrolled as a Medicaid Fee-for-Service provider:

(18) National Provider Identifier (NPI) of the incentive payment recipient:	(19) Federal Tax Number or Social Security Number of incentive payment recipient: *(Payments will be reported on 1099 form using this number.)*

(20) Business Name (DBA) of the incentive payment recipient:	(21) Federal Tax (legal) name of the incentive payment recipient: (must match IRS letter)

(22) Select one: ☐ for profit ☐ non-profit [attach 501(c)3]	(23) Are federal tax payments current? If not, attach an explanation. ☐ YES ☐ NO	(24) Email Address

(25) A fully executed W-9 is required to be attached. Please check here to affirm that you have attached a fully executed W-9 (available at: www.irs.gov).
☐ YES ☐ NO

APPLICANT INITIAL HERE_____ CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

STATE OF NEW MEXICO - MEDICAL ASSISTANCE DIVISION
ELECTRONIC HEALTH RECORD INCENTIVE PAYMENT
PROVIDER PARTICIPATION AGREEMENT TYPE 803

FOR STATE PURPOSES ONLY

EHR MEDICAID ID created in MMIS? ☐ Yes ☐ No MEDICAID ID/SPECIALTY CODE: _____ ☐ Bill Code "F" ☐ Status Code 60 ☐ Already Exists

Medicaid ID Number Assigned: _____

All EHR Incentive Payment applicants must complete the following:

Has the eligible provider, group, clinic or other entity to whom the incentive payment is being assigned, or any person who has ownership or control interest in the provider, group, clinic, or entity to whom the incentive payment is being assigned, or any person who is an agent, service provider or managing employee of the provider, group, clinic, or other entity to whom the incentive payment is being assigned, been convicted of a criminal offense related to that person's involvement in any program under Title XVIII (Medicare), Title XIX (Medicaid), or the Title XX (Block Grants to States for Social Services), or Title XXI (SCHIPS) services program since the inception of those programs? If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary:

☐ YES ☐ NO

FOR STATE PURPOSES ONLY

NAME	SOCIAL SECURITY NUMBER	DESCRIPTION	
			Sanction Verified?: ☐ Yes ☐ No Match Found?: ☐ Yes ☐ No
			Sanction Verified?: ☐ Yes ☐ No Match Found?: ☐ Yes ☐ No
			Sanction Verified?: ☐ Yes ☐ No Match Found?: ☐ Yes ☐ No

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list a contact person, active e-mail address (as this is the likeliest means by which you will be contacted), and telephone number.

Contact Person: _____

Active e-mail Address: _____

Telephone Number: _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Original signature required. Please use blue ink only.

By signature, I agree to abide by and be held to all federal, state, and local laws, rules, and regulations, including, but not limited to, NMAC 8.300.22 and related instructions.

I am attesting that I understand that payment will be from federal and/or state funds and that any falsification or concealment of a material fact may be prosecuted under federal and/or state law.

INDIVIDUAL PROVIDER:

Printed Name of Individual Practitioner (*listed in box #1 on page 1*): _____

Signature of Individual Practitioner: _____ Date: _____

The eligible provider and, if different, the incentive payment recipient will be notified of the provider number of the incentive payment recipient, at which time the incentive payment recipient must register for electronic funds transfer (EFT) in order to receive payments electronically. Registration for EFT can be done through the New Mexico Medicaid web portal at https://nmmedicaid.acs-inc.com/nm/general/home.do

FOR STATE PURPOSES ONLY:

HUMAN SERVICES DEPARTMENT APPROVAL

☐ APPROVED ☐ NOT APPROVED

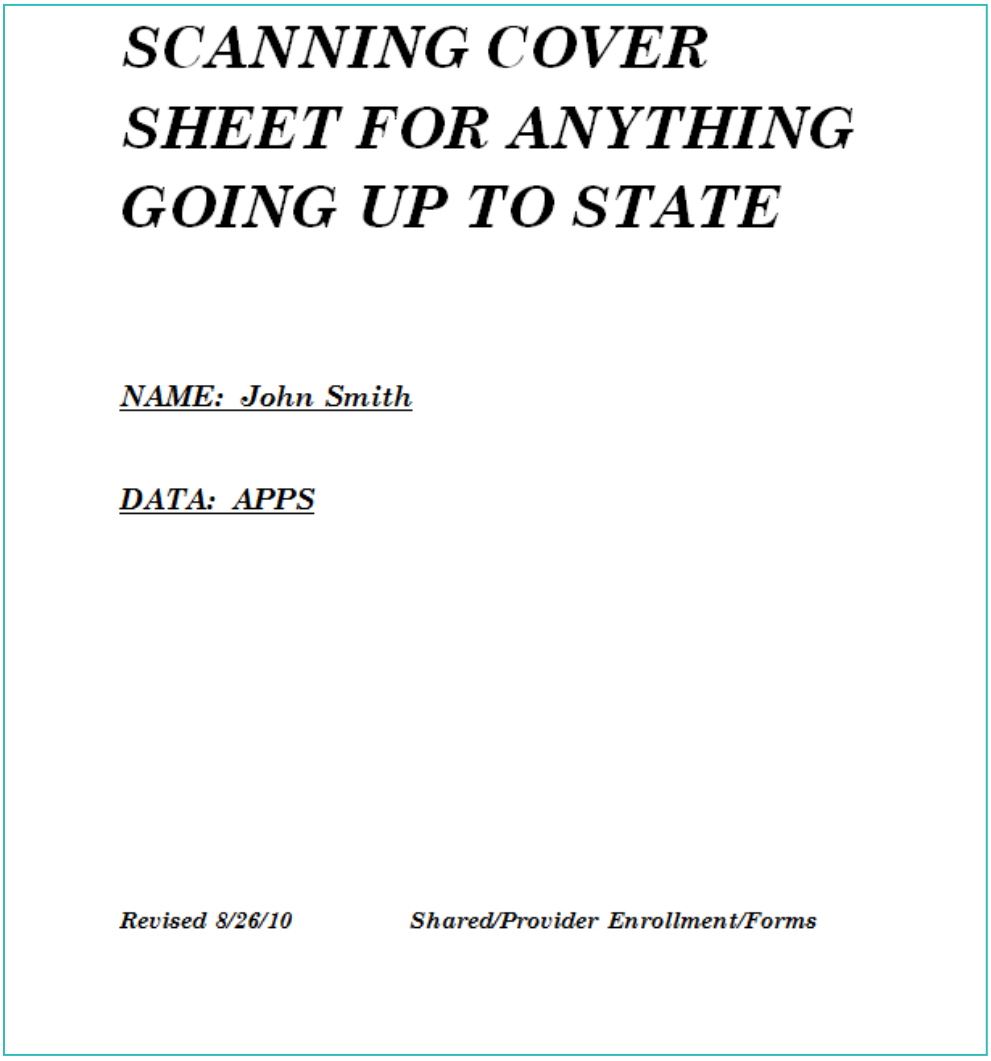
Reasons Not Approved:

Dates of Agreement: From: _____

Authorized Signature	Date

EHR Incentive Payment Program - Provider Participation Agreement Type 803

Appendix J - Scanning Cover Sheet



SCANNING COVER SHEET FOR ANYTHING GOING UP TO STATE

NAME: John Smith

DATA: APPS

Revised 8/26/10 ***Shared/Provider Enrollment/Forms***

Appendix K - Return to Provider Letter

Please see attached current version of the letter.

Appendix L - Return to Provider (RTP) Reasons

Type of Document	Omission Errors	Use of White Out	Missing Items	Counterfeit	Faxes or Copies	Not Legible	Not Applicable
Applications	• MAD 220 boxes: 1, 2, 3, 10, 11, 12, , 14, 20, 21, 24, 25, 27, 28 • Signature	✔	• Documents required per the provider type and specialty list, if not received after waiting period	• Overly exaggerated check box sizes • Check boxes missing • Numbers replaced with letters • Not the original size (smaller on page or only half of a page size) • Page cut off and completed on another paper	• Signature – Traced – Photocopy – Fax	• Signature	• MAD 220 boxes 4 and 5 cannot say ‘same’ • MAD220, someone other than individual signed the app

Type of Document	Omission Errors	Use of White Out	Missing Items	Counterfeit	Faxes or Copies	Not Legible	Not Applicable
Turn Around Documents	• Response to questions on last page (currently there are 3) • Initial next to questions • Ownership info (sections A & B) if required – Name – Address – Phone – Social security #	✔	• Signatures • Pay to number – Requesting a location address change without proper attachments	• Not the original size (smaller on page or only half of a page size) • Page cut off and completed on another paper	• Faxed TAD. • Signatures that are: – Traced – Photocopy –		• Signatures
Licenses	•					✔	• Not for provider listed
DEA Number	•					✔	• Not for provider listed
Medicare	•					✔	• Not for provider listed

Type of Document	Omission Errors	Use of White Out	Missing Items	Counterfeit	Faxes or Copies	Not Legible	Not Applicable
Cross-reference requests	• Signatures						
Address changes	• Signatures						
Name changes	• Signatures						
Terminations	• Signatures						
Retro requests	• Signatures						
Disaffiliations	• Signatures						
CHOWs	• Signatures		• Board members • Dates • Tax change info				

Appendix M - Specialties for SLR Providers

Provider Type	803 Provider Specialty
301-Physician, Non-Pediatrician	301-FinPhys
301-Physician, Pediatrician	337-FinPedia
302-Physician, Doctor of Osteopathy	301-FinPhys
305-Physician Assistant in an FQHC or RHC	305-FinPhyAsst
316-Certified Nurse Practitioner	316-FinNurse
322-Certified Nurse Midwife	322-FinMidwife
421-Dentist	421-FinDentist
201-Hospital	201-FinHosp

Appendix N - Licensing Board Contact Information

States	Websites	Phone Numbers
Texas	http://reg.tmb.state.tx.us/OnLineVerif/Phys_SearchVerif.asp	(800) 248-4062 (512) 305-7030
Oklahoma Medical	http://www.okmedicalboard.org/search	(405) 962-1400
Oklahoma Osteopath	http://www.docboard.org/ok/df/oksearch.htm	(405) 528-8625
Colorado	https://www.colorado.gov/dora/licensing/	(303) 894-7800
Utah	https://secure.utah.gov/llv/search/index.html;jsessionid=d309c881c2b405412b768b7845b5	(801) 530-6628
Arizona Medical	http://azmd.gov/GLSPages/DoctorSearch.aspx	480-551-2700 877-255-2212
Arizona Osteopath	http://www.azdo.gov/GLSPages/DoctorSearch.aspx	480-657-7703

Appendix O - OmniCaid System Changes

OmniCaid system changes implemented for SLR are outlined below:

1. Created new reason codes for financial payouts/receivables/receipt and receipt disposition for the Health Incentive payments.
    a. Reason Code 131 for Payout codes (Cost Center 86712 Cost Code 58); and,
    a. Reason Code 141 for Receivable codes (Cost Center 86712 Cost Code 58)): and,
    b. Reason Code 151 for Receipt codes; and
    c. Reason Code 152 for Receipt disposition codes (HIT Receipt applied to HIT Receivable); and,
    d. Reason Code 155 for Refund codes.
2. Assigned cost center 86712 is 100% FFP and is assigned only for the health incentive payouts; defined by reason code 131 or 141 coming in on the financial transaction (this cost center code was already established as 100% FFP). Cost center 86712 is also assigned to the health incentive refund; defined by reason code 155.
3. Develop an automated interface from the State Level Registry (SLR) to OmniCaid that would generate the creation of a financial payout via entry to the OmniCaid Financial subsystem as a financial payout or recoupment. Given the tight timeframe, this file could initially be used to do manual entry into the financial subsystem like is done with the ATR process today. The SLR estimates are approximately 1400 providers participating, so we do want this file automated as soon as possible. This payment file would be sent daily or weekly. It is in the same ASCII, pipe delimited format The elements on the SLR to OmniCaid Payment file are the following:

Field	Description
SLR Transaction Num	Defined by the SLR; they are indicating that they will use a sequential number so that the SLR can identify for which practitioner the payment was made (Payment may be made to a payee on behalf of an affiliated provider, so the file may have multiple records for one payee, depending on how many practitioners' payments are being made to that payee). Since this number needs to be returned to the SLR when the payment confirmation interface is returned from the MMIS, OmniCaid needs to be able to capture this number; not on the window, but somewhere so that it can be reported back. The SLR Transaction Num is stored on the Financial Header Table.

Date of Transmission	CCYYMMDD
Medicaid Provider ID	They will send the Medicaid provider id; not the NPI, submitted as an alphanumeric 10 digit field
Reason Code	Two codes for HIT; 131 if transaction is a payout or 141 if transaction is a recoupment
Amount	Amount of Payment Authorized
Settled Thru Date	CCYYMMDD; And instructed to fill in the last day of the month for the year in which the payment was being made (Reason: SLR/EHR certification years don't necessarily match other OmniCaid fiscal years)
Number of Records Total	T' followed by number of records total. 'Tnnnnnn'.

4. Generate in OmniCaid either a payout or receivable based on the incoming file. All fields on the incoming file are required. Payments can only be made to Active Medicaid FFS providers with Provider Billing Code = 'B' or 'U' or 'F'. The incoming payment file must be processed within 24 hours of its receipt. Fill in the cost center 86712 for any acceptable record on this file.
5. There is an interface from OmniCaid to SLR that reports the status of any transactions on that week's automated feed. The file format for this file is as follows:

Field	Description
SLR Transaction Num	SLR Transaction Num on the file from the SLR
Payment Confirmation	X (1); Since there's not a Header Status code on the financial table; an indicator would be created here to indicate Paid or Rejected. If the transaction record was rejected, we would need to have only the detail below filled in as was submitted on the incoming file with a reject reason code that identifies the problem:
Reject Reason Code	A code that identifies why the transaction failed. Possible reasons are: R1 - Invalid Payee Provider ID R2 - Duplicate SLR Transaction Num R3 - Invalid Reason Code R4 - Invalid Settled Date R5 - Invalid Date of Transmission R6 - Invalid Amount R7 - Invalid Number of Records Total

Date of Transmission	CCYYMMDD; Date of the Payment Confirmation file
FCN	FCN if the financial transaction was paid
Reason Code	Either 131 or 141
Cost Center	86712
Date Paid	CCYYMMDD: Date Financial payment made
Reimb Amount	S9(9)V99
EFT Number (c_eft_trc_id)	15 byte, alphanumeric
Warrant Number (c_hdr_warr_num)	11 byte, alphanumeric
Trailer Number of Records Total	T' followed by number of records total. 'Tnnnnnn'.

6. Make any changes necessary to ensure these transactions report correctly on SHARE
7. Make any changes necessary to ensure these transactions report on the provider 1099
8. CMS64 Admin report is a quarterly federal report that reports the amount of payments each quarter. Based on the Omnicaid System Changes write-up, it was modified to include SLR payments.

Once payment is disbursed to the eligible TIN, NLR is notified by MAD via SLR that a payment has been made. SLR uses file exchange from MMIS that contains active FFS provider data.

Appendix P – Registration User Guides

Below find links to CMS EHR Website where Registration User Guides can be accessed:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/EducationalMaterials.html

For EHR Registration, Attestation and PECOS Checklist:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Registration_Attestation_PECOChecklist_09_25_12.pdf

For Medicaid Registration User Guide for Eligible Professionals:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EHRMedicaidEP_RegistrationUserGuide.pdf

For Medicare and Medicaid Registration User Guide for Hospitals:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EHRHospital_RegistrationUserGuide.pdf