

Waiver Nursing & Waiver Nursing Delegation Billing Process

- 1) Make sure the service is outlined in the service plan.
- 2) Verify in CPT the service is authorized. County places in CPT and the information translates over to the PNM/MITS system so claims can be applied against the approval.
- 3) The CPT approval looks like pictured below. Without this approval the PNM/MITS claims will not go through.

Site Name: 10L		Effective Date: 8/1/2016	End Date: 12/31/9999
Manage: Site Home View Manage Versions Manage Notes View Non Waiver Spans			
Christopher	Change	DODD #:	Medicaid #:
Waiver: 8/4/2021 - 8/3/2022	Change	Type: I/O	Status: ENRL Budget Summary
Manage Waiver Nursing Delegation:			
<input checked="" type="checkbox"/> Aug <input checked="" type="checkbox"/> Sep <input checked="" type="checkbox"/> Oct <input checked="" type="checkbox"/> Nov <input checked="" type="checkbox"/> Dec <input checked="" type="checkbox"/> Jan <input checked="" type="checkbox"/> Feb <input checked="" type="checkbox"/> Mar <input checked="" type="checkbox"/> Apr <input checked="" type="checkbox"/> May <input checked="" type="checkbox"/> Jun <input checked="" type="checkbox"/> Jul <input checked="" type="checkbox"/> Aug			
	Start Date	End Date	Provider Name
	08/04/2021	08/03/2022	, LLC

- 4) When billing for a month, gather all the data required for a billing claim. If a new person with a new claim, you will also need, diagnosis code & referring physician.
- 5) Log into PNM and navigate to Provider Management Home, go to "self-service", click on the + sign and go to "claims".

Manage Application	
Enrollment Actions	+ Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	- Self Service Selections:
	View Provider File
	Provider Correspondence
	Remittance Advice
	Recipient Eligibility
	Claims
	Prior Authorization
	Hospice
	Payment Innovation Reports

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- 6) To process a New Claim
- 7) From the menu, choose, CLAIMS, then PROFESSIONAL.
- 8) You only have certain boxes that are required. See below for highlighted ones.

This is where you will need, name, birthday, Medicaid number, diagnosis code (which relates to why the person needs waiver delegated nursing). You will also need ordering physician and their NPI number. (for additional provider information)

TOTAL CHARGES	
Total Charges	\$88.44
Medicaid Allowed Amount	\$88.44
TPL Paid Amount	\$0.00
Total Medicaid Paid Amount	\$88.44
Medicaid CoPay Amount	\$0.00

Medicaid # & DOB – When starting a new claim, this is all you need to enter in the first section. The name of the self-advocate will populate.

Sequence	Diagnosis Code	Description
01	E46	UNSPECIFIED PROTEIN-CALORIE MALNUTRITION

For the diagnosis section, all you need to do is “add” the diagnosis code related to the reason for the nursing service. (you wouldn’t add the DD diagnosis here). Typically see one diagnosis here. You can get the specific diagnosis related to the nursing routine from the nurse or the physician who ordered the routine.

There is nothing to enter under “Header – Other Payer”.

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Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	04/28/2022	12.00	\$88.44	\$88.44	PAID	12	G0494					

Select row above to update -or- click add an item button below.

delete **add an item** copy

Item 1

*From DOS 04/28/2022

To DOS 04/28/2022

*Units 12.00

*Charges \$88.44

Medicaid Allowed Amount \$88.44

Rendering Provider 2743151

Submitted EAPG

Initial EAPG

Status PAID

Visit Start Time

Visit End Time

Service Duration less than 90 days

*Place Of Service 12 [Search]

*Procedure Code G0494 [Search]

Emergency

Referred EPSDT Service/ Family Planning

*Diagnosis Code Pointer 01 01 01 01

Modifiers [Search] [Search] [Search] [Search]

Final EAPG

Pay Action

*note: when rates changed 7.1.22, screenshot example above not updated.

On the "Detail" section:

- 1) Add an item
- 2) Put in your DOS (you can only do one day at a time)
- 3) # of units
- 4) Total charges
- 5) Agency NPI if it doesn't auto populate for you.
- 6) Place of service: 12 is "home" or you can search to find appropriate code
- 7) Procedure code:
 - G0494 – Waiver Nursing Delegation/Consultation by LPN (Agency \$7.81 – 15 min)
 - G0493 – Waiver Nursing Delegation/Consultation by RN (Agency \$9.24 – 15 min)
 - G0493 – With U9 "modifier" (see red circle above for where to enter) (Agency \$39.26 – per assessment)
 - Waiver Nursing – (Agency – RN: T1002; 1st 35-60 mins-\$50.29, then \$9.25 T1002 thereafter)-see rule*
 - Waiver Nursing – (Agency – LPN: T1003; 1st 35-60 mins - \$43.13, then \$7.82 T1003 thereafter)-see rule*
- 8) Diagnosis code pointer is "1"
- 9) Additional Provider Information – this is where you will add the ordering physician name and NPI number.

Additional Provider Information				
Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
1	Ordering Provider	1538360912	Fieler	Lisha

Type changes below.

delete **add an item**

Detail Item 1

Type of Provider Ordering Provider

*Provider # 1538360912

*Last Name FIELER

*First Name, MI LISHA

Add an Item, Detail 1, Ordering Provider, NPI, Last and First name of Physician.

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NPI #'s are public information and can be searched at the link below:

<https://www.npinumberlookup.org/>

Then you "Submit" claim

Attachments

*** No rows found ***

Select row above to update -or- click add an item button below.

delete add an item

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN Reason

Claim Status Information

Claim Status Not Submitted yet

submit cancel

Payment or Denial details will follow:

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN Reason

Claim Status Information

Claim Status PAID

Claim ICN 2222126001938

Paid Date 05/12/2022

Paid Amount \$88.44

cancel adjust void copy claim

If you need to enter another claim for a person, simply click on "copy claim" (see above)

Once you copy the claim, you simply go in and edit the date of service, units, charge, place of service and procedure code (if procedure code differs from previous claim), then submit.

When billing for the first time, follow the "new claim" steps for each self-advocate you need to enter billing for.

THE NEXT MONTH -

If you are in a new month and need to enter claims, follow steps 1 -13, then:

- 1) Go to "claims" and then "search". (if you have a previous paid claim)
- 2) Enter in the Medicaid number, PAID status and DATE RANGE so you can find, copy and edit previous claims for new submission.

Welcome, KRISTI BLACK Sunday 02/13/2022 5:28:12 PM

Providers CPC Performance Account **Claims** Episode Claims Eligibility Reports Publications

search search detail dental institutional professional

Claim Search: 274 LLC

ICN/TCN Claim Type

Medicaid Billing Number 000000000000 Status P - PAID

Rendering Provider ID [Search] RA Date

Amount Billed Date of Service Date Range

Prescription Number From/Thru DOS 10/01/2021 10/31/2021

Limited to 12 month range

Records 20

search clear

When you see the person you associated with the Medicaid number you entered, **IMMEDIATELY** scroll the bottom and click on **"copy claim"**. Don't start editing or you will write over a previously paid claim. Once you scroll down to the bottom and "copy claim", you can then edit. 😊

Select row above to update -or- click add an item button below.

delete add an item

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN Reason

Claim Status Information

Claim Status PAID

Claim ICN 22210

Paid Date 03/25/2021

Paid Amount \$58.96

cancel adjust void **copy claim**

3) Next, go to middle of page click on date of service, not the words, but the actual date.

Header - Other Payer Amounts and Adjustment Reason Codes

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	10/26/2021	10.00	\$73.70	\$73.70	PAID	12	G0494					

Select row above to update -or- click add an item button below.

delete add an item copy

4) bill for. Edit the **date of service, units, place of service, procedure code** (if applicable).

5) Special NOTE: If the code is G0494 it was, the service was performed by an LPN under the direction of a nurse. The rates are different for G0494 and G0493. (as of 7/1/22)

6) G0494: \$7.81 per unit (LPN)

7) G0493: \$9.24 per unit (RN)

8) G0493: \$39.26 (assessment) U9 Modifier

**note: when rates changed 7.1.22, screenshot example above not updated.*

Header - Other Payer Amounts and Adjustment Reason Codes

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	10/26/2021	10.00	\$73.70	\$73.70	PAID	12	G0494					

Select row above to update -or- click add an item button below.

delete add an item copy

Item 1

*From DOS 10/26/2021

To DOS 10/26/2021

*Units 10.00

*Charges \$73.70

Medicaid Allowed Amount \$73.70

Rendering Provider 27

Submitted EAPG

Initial EAPG

Status PAID

Visit Start Time

Visit End Time

Service Duration less than 90 days

*Place Of Service 12

*Procedure Code G0494

Emergency

Referred EPSDT Service/ Family Planning

*Diagnosis Code Pointer

Modifiers

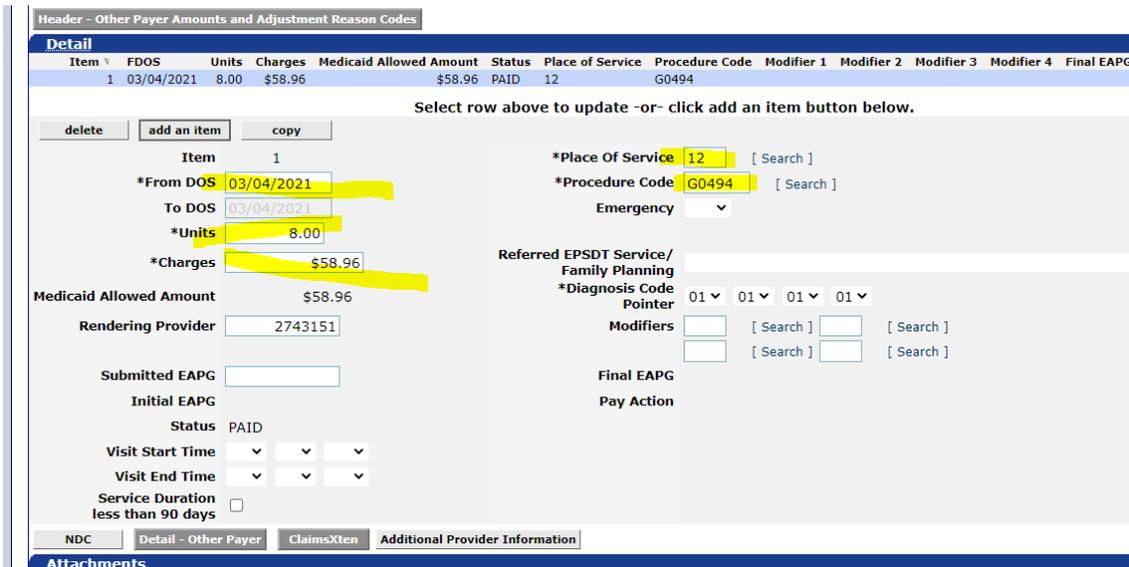
Final EAPG

Pay Action

**note: when rates changed 7.1.22, screenshot example above not updated.*

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Once you have edited the boxes as applicable, click on submit at the bottom and verify PAID
 9) Continue this process for each person until you have submitted all the claims.



Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	03/04/2021	8.00	\$58.96	\$58.96	PAID	12	G0494					

Select row above to update -or- click add an item button below.

Item: 1
 *From DOS: 03/04/2021
 To DOS: 03/04/2021
 *Units: 8.00
 *Charges: \$58.96
 Medicaid Allowed Amount: \$58.96
 Rendering Provider: 2743151
 Submitted EAPG:
 Initial EAPG:
 Status: PAID
 Visit Start Time:
 Visit End Time:
 Service Duration less than 90 days:

*Place Of Service: 12 [Search]
 *Procedure Code: G0494 [Search]
 Emergency:
 Referred EPSDT Service/ Family Planning
 *Diagnosis Code Pointer: 01 01 01 01
 Modifiers: [Search] [Search]
 [Search] [Search]
 Final EAPG:
 Pay Action:

**note: when rates changed 7.1.22, screenshot example above not updated.*

Notes: Claims are due by Friday at 5pm to be paid out the following week. The Monday following claims entry, the remittance advice report will be available in the reports section of the MITS menu.

The following Monday, you can navigate to the reports section to view the "remittance advice" to confirm billed, paid and denied.

Manage Application

Enrollment Actions + Enrollment Action Selections:

Programs - Program Selections:

Self Service - Self Service Selections:

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- [Provider Correspondence](#)
- [Remittance Advice](#)
- [Recipient Eligibility](#)
- [Claims](#)
- [Prior Authorization](#)
- [Hospice](#)
- [Payment Innovation Reports](#)