

# Reconsideration, Adjustment and Void Workshop

# Resources

When online use:

[HIPAA.desknm@state.nm.us](mailto:HIPAA.desknm@state.nm.us)

[NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us)

Call Center 800-299-7304

## New Mexico Web Portal

- Provider Information section
- Links and FAQ section
- Provider Login section

# Web Portal

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Providers will have the ability to verify and perform eligibilities inquires by Date Ranges. Visit <https://nmmedicaid.portal.conduent.com/static/index.htm> to utilize this new feature.

You may need to re-bookmark the New Mexico Medicaid Web Portal address to:

<https://nmmedicaid.portal.conduent.com/static/index.htm>

# New Mexico Medicaid Portal



**New Mexico Medicaid Portal**

**Recipient/Recipiente**      **Providers**

**Recipients**

**I AM ALREADY ENROLLED IN THE NEW MEXICO MEDICAID PROGRAM**

Log in to:

- Check your eligibility.
- Enroll in or change your managed care plan.
- Request a replacement Medicaid ID card.
- Ask a question about your coverage.

**YA ESTOY REGISTRADO/A EN EL PROGRAMA DE MEDICAID DE NUEVO MEXICO**

Entre a:

- Chequear su elegibilidad.
- Registrarse o cambiar su plan de cuidado administrativo.
- Solicitar una Tarjeta de Identificación de reemplazo.
- Hacer una pregunta sobre su cobertura.

**I AM NOT ENROLLED BUT WOULD LIKE MORE INFORMATION ABOUT THE NEW MEXICO MEDICAID PROGRAM**

- [Click here for information about the program](#)
- [Click here to see if you might be eligible](#)

**NO ESTOY REGISTRADO/A, PERO QUISIERA SABER MAS INFORMACIÓN SOBRE EL PROGRAMA DE MEDICAID DE NUEVO MEXICO**

- Haga "click" aquí para información sobre el programa
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**Providers**

**SECURE INFORMATION**

Log in to:

- Submit claims online.
- Inquire on recipient eligibility, claims, payments, and prior authorizations.
- View or print remittance advices and other reports.
- MORE

**PUBLIC INFORMATION**

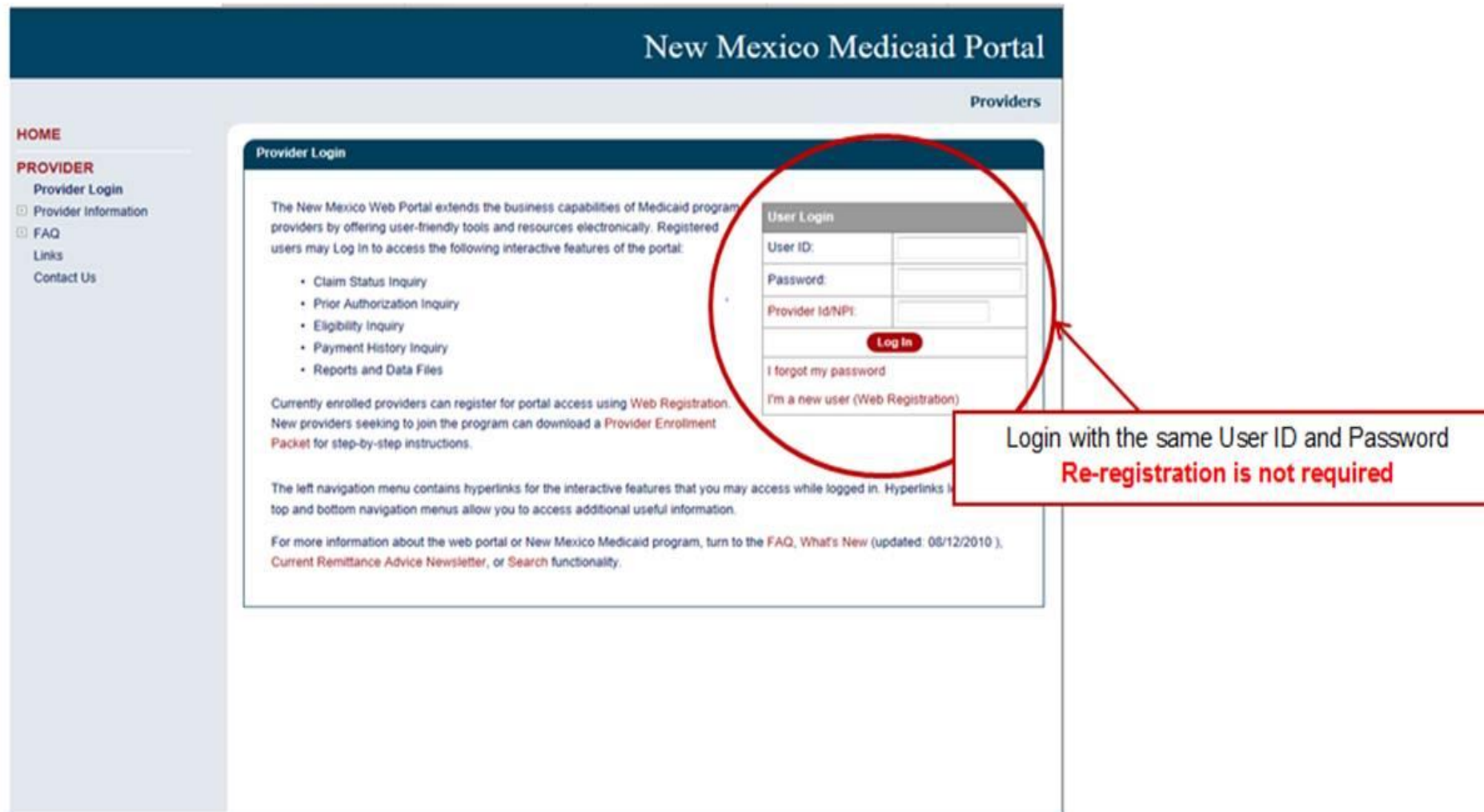
View valuable information about the New Mexico Medicaid program, including:

- Training presentations
- FAQs
- 5010 testing
- Fee schedules
- Enrollment forms
- Helpful links
- MORE

Terms of Usage   Privacy Policy   Browser Compatibility   Help

Select "Log in to"

# Web Portal- Login



**New Mexico Medicaid Portal**

Providers

**HOME**

**PROVIDER**

- Provider Login
- Provider Information
- FAQ
- Links
- Contact Us

**Provider Login**

The New Mexico Web Portal extends the business capabilities of Medicaid program providers by offering user-friendly tools and resources electronically. Registered users may Log in to access the following interactive features of the portal:

- Claim Status Inquiry
- Prior Authorization Inquiry
- Eligibility Inquiry
- Payment History Inquiry
- Reports and Data Files

Currently enrolled providers can register for portal access using [Web Registration](#). New providers seeking to join the program can download a [Provider Enrollment Packet](#) for step-by-step instructions.

The left navigation menu contains hyperlinks for the interactive features that you may access while logged in. Hyperlinks in the top and bottom navigation menus allow you to access additional useful information.

For more information about the web portal or New Mexico Medicaid program, turn to the [FAQ](#), [What's New](#) (updated: 08/12/2010 ), [Current Remittance Advice Newsletter](#), or [Search](#) functionality.

**User Login**

User ID:

Password:

Provider ID/NPI:

**Log In**

[I forgot my password](#)

[I'm a new user \(Web Registration\)](#)

**Login with the same User ID and Password**  
**Re-registration is not required**

# Important State Websites

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## STATE WEBSITE:

### PROGRAM POLICY MANUAL

- <http://www.hsd.state.nm.us/mad/policymanual.html>

## BILLING INSTRUCTIONS

- <http://www.hsd.state.nm.us/mad/billinginstructions.html>

## REGISTERS AND SUPPLEMENTS:

- <http://www.hsd.state.nm.us/mad/registers/2012.html>

# Transaction Control Number

# What is a Transaction Control Number (TCN)?

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- The TCN is a unique number assigned to each and every claim
- This number contains information about the claim and can be used to identify your claim when calling provider services

**91325900085000001**



# What is a Transaction Control Number (TCN)?

9 1 6 0 4 9 0 0 0 8 5 0 0 0 0 0 1

The first digit indicates what the claim “media” is:

- 2 = electronic crossover
- 3 = other electronic claim
- 4 = system generated claim or adjustment
- 8 = paper claim
- 9 = Web portal claim entry

The last two digits of the year the claim was received

The numeric day of the year.

Batch number

The claim number within the batch.

The twelfth digit in an adjustment/void TCN will either be:

- 1= Debit
- 2= Credit

This is the Julian Date - this represents the date the claim was received by Conduent: this claim was received the 49<sup>th</sup> day of 2016, or February 18, 2016

# Completing a Reconsideration Form

# When to Complete a Reconsideration Request

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- Proof of timely filing for repeated untimely filing denials with extenuating circumstances
- Proof of non-duplicate service for an initial duplicate denial
- Response to the fiscal agent's requests for additional information regarding a previously denied claim (only when instructed by the fiscal agent)

# Reconsideration Request Form

**RECONSIDERATION REQUEST**  
NEW MEXICO MEDICAID

**Only** use this form to submit additional information for a previously **denied** claim for reprocessing.

- Use this form to submit proof of timely filing for repeated untimely filing denials with extenuating circumstances (Note: Do not use the reconsideration form for normal timely filing denials, resubmit claims with proof of timely filing).
- This form must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back.
- Reconsideration requests cannot be completed via the web portal.
- For reconsideration request exceeding 5 claims or more, please contact New Mexico Medicaid Provider Relations at [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us).

**MAIL TO:**  
CONDUENT  
P.O. BOX 26500  
ALBUQUERQUE, NM 87125

**ALL FIELDS BELOW  
(SECTIONS A,B,C,D)  
ARE REQUIRED TO BE COMPLETED IN ORDER TO PROCESS THIS REQUEST**

**INCOMPLETE FORMS WILL BE RETURNED**

<b>SECTION A: Provider Information</b>		<b>SECTION B: Claim Information</b>	
Billing NPI (Must be 10 digits) <input type="text"/>		Client ID# <input type="text"/>	
OR Billing NM Provider ID <input type="text"/>		TCN (Must be 17 digits) <input type="text"/>	
<b>SECTION C: Detailed Reason for Request</b>     			
<b>SECTION D: Authorization</b>			
Requestor Name <input type="text"/>		Requestor Email <input type="text"/>	
Requestor Signature <input type="text"/>		Requestor Phone <input type="text"/>	
By signing below, I hereby certify that I am authorized to make the above request		Date <input type="text"/>	

# Reconsideration Request Form

## RECONSIDERATION REQUEST NEW MEXICO MEDICAID

When the form should be used

**Only** use this form to submit additional information for a previously **denied** claim for reprocessing.

- Use this form to submit proof of timely filing for repeated untimely filing denials with extenuating circumstances (Note: Do not use the reconsideration form for normal timely filing denials, resubmit claims with proof of timely filing).
- This form must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back.
- Reconsideration requests cannot be completed via the web portal.
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Mailing Address

**MAIL TO:**  
CONDUENT  
P.O. BOX 26500  
ALBUQUERQUE, NM 87125

# Reconsideration Request Form

Fill in the following:  
NPI  
Or  
NM  
Provider ID

All fields are required!

SECTION A: Provider Information		SECTION B: Claim Information	
NPI (Must be 10 digits) <input type="text"/>		Client ID# <input type="text"/>	
OR NM Provider ID <input type="text"/>		TCN (Must be 17 digits) <input type="text"/>	
SECTION C: Detailed Reason for Request			
<p><b>Required</b></p> <p>Provide information regarding why this request needs to be reconsidered</p>			
SECTION D: Authorization			
Requestor Name <input type="text"/>		Requestor Email <input type="text"/>	
Requestor Signature <input type="text"/>		Date <input type="text"/>	
Requestor Phone <input type="text"/>		Requestor Phone <input type="text"/>	

# Which Scenarios Would be Considered Reconsiderations?

## Scenario #1

Medicaid denied the claim for Exception code 0101- Service dates within Centennial Care Enrollment Period. The patient was admitted on 09/03/17 and has not been discharged. The patient became eligible with Presbyterian Healthcare Services Centennial Care after the admission date.

The provider would like us to override the 0101 denial and reprocess the claim for payment.

## **Reconsideration?**

**NO** – On the CMS-1500 if Box 18 is completed (Hospitalization Dates Related to Current Services), the system will bypass this edit. No Reconsideration is required.

# Which Scenarios Would be Considered Reconsiderations?

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## Scenario # 2:

A Third Party Liability (TPL)\SALUD retracted their payment on 03/27/2017. Per the Medicaid Web Portal, the patient is Medicaid eligible on DOS. The provider attached the claim form and the TPL\CCO retraction EOB for proof of timely filing.

The provider would like the 2 year timely filing limit overridden.

## **Reconsideration?**

**YES** – Since the payment to primary payer was recently retracted and provider is submitting within 90 days from the date on the Retraction EOB, this can be reconsidered for timely filing.



# Which Scenarios Would be Considered Reconsiderations?

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## Scenario # 3:

The provider submitted a claim (DOS 08/30/16) on 09/12/2016, the claim denied on 10/19/2016 for missing Prior Authorization number. The provider resubmitted the claim with Prior Authorization number and a Reconsideration form on 3/15/17, asking for timely filing to be overridden.

The provider would like timely filing to be overridden.

## **Reconsideration?**

**NO** – The provider did not re-submit the corrected claim within the (one time) 90 day timely filing grace period .

# Which Scenarios Would be Considered Reconsiderations?

## Scenario # 4:

The provider submitted a claim with dates of service 12/24/2016 and attached an EOB payment from the primary payer dated 3/14/2017.

The provider is requesting to override timely filing.

## **Reconsideration?**

**YES** – The provider can submit a reconsideration due to receiving the EOB with a payment from primary payer and submitting to NM Medicaid within 90 days of the payment date of that primary payer EOB.

# Remittance Advice EOB Code

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The following EOB code will be on Providers Remittance Advices if any reconsideration has denied.

**0879** (Reconsideration Request) - Your request for reconsideration has been reviewed and denied.

If a submitted Reconsideration processes and pays, the claim will have a “Paid” status reflected on their Remittance Advice.

# When is it Necessary to Fill Out an Adjustment Form for a Claim

# Adjustments

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- Claims paid incorrectly must be adjusted
- DO NOT resubmit a denied claim with an adjustment sheet attached

# Adjustments

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Adjustments will not be considered unless submitted on the adjustment request form with the below included.

- Corrected claim
  
- TCN indicated on claim form for timely filing review
  - ❑ CMS 1500 form: Put the TCN in block 22 on the paper form. Leave the “Code” blank, and put the TCN in the “Original Reference No.” field
  
  - ❑ UB Form: Put the TCN in Form Locator 64 “Document Control Number” (DCN) matching the appropriate payer line, using a paper form
  
  - ❑ Dental Claim Form: Enter the TCN number in Box 35 beginning on the left side

# Adjustments

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- Requests to adjust a claim must be submitted within 90 days from the date on the RA for the paid claim
- Always fill out the corrected claim (replacement claim) exactly as the claim was originally filed with the exception of the information being changed

# Completing an Adjustment Form



# Adjustment Request Form

## ADJUSTMENT / VOID REQUEST NEW MEXICO MEDICAID

Must select one of the options below

**ADJUSTMENT**

Use this selection:

To make any changes to a claim that was paid incorrectly.

- Must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back.
- Always fill out the corrected claim (replacement claim) exactly as the claim was originally filed, with the exception of the information being changed.
- Adjustment requests must be submitted within 90 days from the date of the Remit Advice (RA) form the original paid claim.
- Submitting Adjustments via the web portal can only be done for claims submitted online. *i.e. Claims that were originally submitted through the web portal (these claims are indicated by TCNs that begin with a 9), can be adjusted via the web portal*
- For adjustment requests exceeding 5 claims or more, send your request via email to [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us).

**VOID**

Use this selection:

For any paid claim that needs to be fully recouped.

- Only entire claims can be voided
- Paid claims that need lines or a line voided are to be considered as an adjustment, not a void.
- There is no time limit when a claim can be voided.
- Voids via web portal can only be done for online submitted claims. *i.e. Claims that were originally submitted through the web portal (these claims are indicated by TCNs that begin with a 9) can be voided via the web portal.*
- A claim form is not needed for a Void request
- For void requests exceeding 5 claims or more, send your request via email to [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us).

**ALL FIELDS BELOW  
(SECTIONS A,B,C,D)  
ARE REQUIRED TO BE COMPLETED IN ORDER TO PROCESS THIS REQUEST**

**INCOMPLETE FORMS WILL BE RETURNED**

SECTION A: Provider Information		SECTION B: Claim Information	
Billing NPI (Must be 10 digits)		Client ID#	
<input type="text"/>		<input type="text"/>	
OR			
Billing NM Provider ID		TCN (Must be 17 digits)	
<input type="text"/>		<input type="text"/>	
SECTION C: Detailed Reason for Request			
<input type="text"/>			
SECTION D: Authorization			
Requestor Name		Requestor Email	
<input type="text"/>		<input type="text"/>	
Requestor Signature		Requestor Phone	
<input type="text"/>		<input type="text"/>	
		Date	
		<input type="text"/>	

By signing below, I hereby certify that I am authorized to make the above request

# ADJUSTMENT REQUEST

New Mexico Medicaid



- This form is to be used ONLY for:**
- ✓ Correcting a billing error on a previously paid claim
  - ✓ Responding to the fiscal agent regarding requests for additional information regarding a previously paid claim (Note: Only when specifically instructed by the fiscal agent, otherwise attach any required documentation and resubmit claim through the normal process.)

**MAIL TO:**  
**CONDUENT**  
**P.O. BOX 26500**  
**ALBUQUERQUE, NM 87125**

**All fields on form must be completed**

**Fill in the following:  
 NPI  
 Or  
 NM Provider ID**

**All fields are required in order to process this request. Incomplete forms will be returned.**

Section A: Provider Information		Section B: Claim Information	
NPI: <input style="width: 80%;" type="text"/>	Client ID: <input style="width: 80%;" type="text"/>	Required	
Or NM Provider ID: <input style="width: 80%;" type="text"/>	TCN: <input style="width: 80%;" type="text"/>	Required	
Section C: Reason for Request			
<p style="color: red; font-weight: bold;">Required</p> <p style="color: red;">WHY DO YOU Need TO ADJUST THIS CLAIM? Modify DATE OF SERVICE, change # of units, Update PROC CODE, add or revise MODIFIER.....</p>			
Section D: Authorization			
Requestor Name: <input style="width: 80%;" type="text"/>	Requestor Email: <input style="width: 80%;" type="text"/>	Required	
<small>By signing below, I hereby certify that I am authorized to make the above request.</small>		Requestor Phone: <input style="width: 80%;" type="text"/>	Required
Signature: <input style="width: 80%;" type="text"/>	Date: <input style="width: 80%;" type="text"/>	Required	
Section E: Fiscal Agent/MAD Use Only			

03/19/2013

ADJUSTMENT

# Adjustments – Filing Guidelines Recap

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- Complete Adjustment form
- Fill out corrected claim (CMS1500, UB04, or ADA 2006)
- Complete all information as it was on the claim previously submitted, with the exception of the changes being made
- Mail to Conduent PO Box 27460 Albuquerque, NM 87125-7460, Attn: Claims Adjustment (keep a copy for your files)

# Completing a Void Form

**VOID REQUEST**  
New Mexico Medicaid



This form is to be used **ONLY** for:  
✓ Complete reversal of a previously paid claim  
(Note: This form is not to be used to void only a line.)

**MAIL TO:**  
CONDUENT  
P.O. BOX 26500  
ALBUQUERQUE, NM 87125

All fields on form must be completed

Fill in the following:  
NPI  
Or  
NM Provider ID

All fields are required in order to process this request. Incomplete forms will be returned.

Section A: Provider Information		Section B: Claim Information	
NPI: <input type="text"/>	Or	Client ID: <input type="text"/> Required	
NM Provider ID: <input type="text"/>		TCN: <input type="text"/> Required	
Section C: Reason for Request			
<input type="text"/>			
Section D: Authorization			
Requestor Name: <input type="text"/> Required		Requestor Email: <input type="text"/> Required	
By signing below, I hereby certify that I am authorized to make the above request.		Requestor Phone: <input type="text"/> Required	
Signature: <input type="text"/> Required		Date: <input type="text"/> Required	
Section E: Fiscal Agent/MAD Use Only			
<input type="text"/>			

Voids are not used to void a line

# Voids

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- There is no time limit on when a claim can be voided
- If the intent is to have a previously paid claim adjusted, you will have to adhere to the claim adjustment timely filing guidelines

# Request Form Instructions

# Request Form Instructions

**REQUEST FORM INSTRUCTIONS**

**New Mexico Medicaid**



**HUMAN SERVICES DEPARTMENT**

**When to use each form:**

**Reconsideration Request Form**

- ✓ Proof of timely filing for repeated untimely filing denials with extenuating circumstances. (Note: Do not use reconsideration form for normal timely filing denials, resubmit claims with proof of timely filing)
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**Adjustment Request Form**

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**Void Request Form**

- ✓ Complete reversal of a previously paid claim (Note: This form is not to be used to void only a line.)

**How to complete each form:**

**Section A: Provider Information**

- NPI: Enter the billing provider's 10 digit National Provider Identifier.
- NM Provider ID: Enter the billing provider's 8 digit New Mexico Provider Identifier.

**Section B: Claim Information**

- Client ID: Enter the client's New Mexico Medicaid identification number up to 14 digits.
- TCN: Enter the 17 digit Transaction Control Number of the previously submitted claim you are referencing.

**Section C: Reason for Request**

- Provide details regarding the request. If you received a call reference number regarding this issue please include it here.

**Section D: Authorization**

- Requestor Name: The name of the person submitting this request.
- Requestor Email: The email address that we could contact you at during normal business hours if we have questions regarding this request.
- Requestor Phone: the phone number that we could contact you at during normal business hours if we have questions regarding this request.
- Signature: Signature authorizing us to process this request. If a claim is attached it must also be signed.
- Date: The date the request is being made.

**Section E: Fiscal Agent/MAD Use Only**

- This section is reserved for use by the Medicaid Fiscal Agent and/or Medical Assistance Division

**Attachments**

- When requesting a reconsideration or adjustment, a completed red claim form and any addition documentation required must be attached. (Note: A copy of a claim is not acceptable.)


03/19/2013 REQUEST FORM INSTRUCTIONS



# Request Form Instructions

## REQUEST FORM INSTRUCTIONS

### New Mexico Medicaid



HUMAN SERVICES  
DEPARTMENT

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03/19/2013

REQUEST FORM INSTRUCTIONS

# Forms on the Web Portal

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**Recipient/Recipiente**



**Providers**



**Recipients**

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**Entre a:**

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- Hacer una pregunta sobre su cobertura.

**Providers**

**I AM NOT ENROLLED BUT WOULD LIKE MORE INFORMATION ABOUT THE NEW MEXICO MEDICAID PROGRAM**

- [Click here for information about the program](#)
- [Click here to see if you might be eligible](#)

**NO ESTOY REGISTRADO/A, PERO QUISIERA SABER MAS INFORMACIÓN SOBRE EL PROGRAMA DE MEDICAID DE NUEVO MEXICO**

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**Providers**

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- MORE

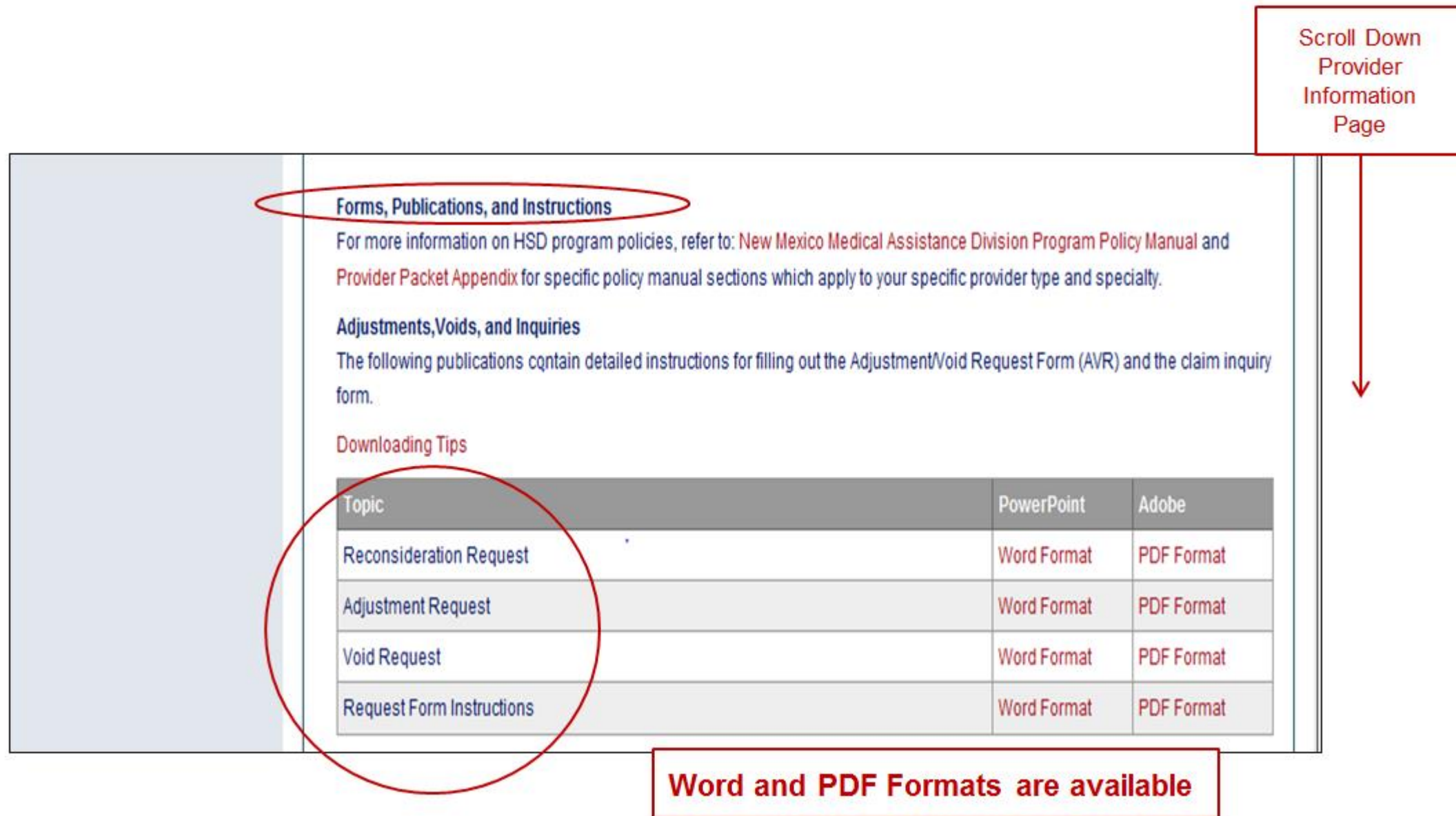
**PUBLIC INFORMATION**

[View valuable information about the New Mexico Medicaid program, including:](#)

- Training presentations
- FAQs
- 5010 testing
- Fee schedules
- Enrollment forms
- Helpful links
- MORE

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# Forms on the Web Portal



**Forms, Publications, and Instructions**

For more information on HSD program policies, refer to: [New Mexico Medical Assistance Division Program Policy Manual](#) and [Provider Packet Appendix](#) for specific policy manual sections which apply to your specific provider type and specialty.

**Adjustments, Voids, and Inquiries**

The following publications contain detailed instructions for filling out the Adjustment/Void Request Form (AVR) and the claim inquiry form.

**Downloading Tips**

Topic	PowerPoint	Adobe
Reconsideration Request	Word Format	PDF Format
Adjustment Request	Word Format	PDF Format
Void Request	Word Format	PDF Format
Request Form Instructions	Word Format	PDF Format

**Word and PDF Formats are available**

Scroll Down Provider Information Page

# Resources

When online use: **Ask Service Representative**

[hipaa.desknm@state.nm.us](mailto:hipaa.desknm@state.nm.us)

[NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us)

Call Center 800-299-7304

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**CONDUENT**

