

Nevada Medicaid and Nevada Check Up News



Division of Health Care Financing and
Policy (DHCFP)

HP Enterprise Services
(HPES)



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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$447,995,123.64 in claims during the three-month period of July, August and September 2012. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

DHCFP and HP Enterprise Services thank you for participating in Nevada Medicaid and Nevada Check Up.

Provider Re-Enrollment Reminders

Beginning June 1, 2012, providers are required to re-enroll in Nevada Medicaid and Nevada Check Up once every 36 months. Providers will receive a re-enrollment letter 60 days prior to their enrollment end date and a reminder letter 20 days before the enrollment deadline.

When providers receive their re-enrollment letter, they must submit a Provider Enrollment Application and Contract and each document listed on the Enrollment Checklist for their provider type. Submission of a re-enrollment application does not guarantee ongoing participation in the program. If it is found that providers no longer meet conditions of participation, their current enrollment may be terminated and their contract may not be renewed.

Re-enrollment reminders:

- Each section of the application must be completed, even if the information has not changed.
- Please verify that each address is entered correctly and the Electronic Funds Transfer Authorization section is complete.
- **Use the new Individual or Group Re-Enrollment Applications available on the [Provider Enrollment](#) webpage.**
- Be sure to include all documents listed on the Enrollment Checklist. Submit the Enrollment Checklist along with the documents if required for your provider type. The first line of the Checklist will indicate this requirement.
- Be sure to sign and date (current date) the Re-Enrollment Application and the Contract.
- The individual person/provider of service who is enrolling must sign the Application.
- Providers who do not re-enroll within 60 days of the date on their re-enrollment letter may have their provider contract terminated.

Prevention Reminder from DHCFP

The Division of Health Care Financing and Policy (DHCFP) would like to invite you to join with us as we strive to heighten the awareness of prevention and encourage early detection and treatment of disease in the Nevada Medicaid population.

As a reminder, Medicaid provides coverage of certain HCPCS codes for screenings and behavioral counseling; specifically codes G0442-G0447.

Medicaid also provides reimbursement for a full range of preventive lab/diagnostic screening services specific for preventive health that aim to prevent disease from developing or prevent serious complications of disease.

ICD-10 Compliance Date Set for October 1, 2014

On February 16, 2012, Health and Human Services (HHS) Secretary Kathleen G. Sebelius announced that HHS would initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes. The final rule adopting ICD-10 as a standard, published in January 2009, set a compliance date of October 1, 2013.

On April 9, 2012, Secretary Sebelius announced a proposed rule that, if approved, would postpone the compliance date until October 1, 2014.

On August 24, 2012, the HHS announced the proposed rule was approved and the compliance date has been delayed until October 1, 2014.

Nevada's Division of Health Care Financing and Policy (DHCFP) and its trading partners are moving forward to be ready for the compliance date.

- ICD-10 will affect diagnosis and procedure coding for all entities covered by the Health Insurance Portability and Accountability Act (HIPAA), not only those entities who submit Medicare or Medicaid claims. The change to ICD-10 does not affect Current Procedural Terminology (CPT) coding for outpatient procedures.
- DHCFP is currently working to identify where ICD codes are used within DHCFP's policies, processes and systems. DHCFP and HP Enterprise Services (HPES) are identifying the tasks necessary to remediate the Medicaid Management Information System (MMIS).
- ICD-9 codes must be used for all procedures and diagnoses dates of service before October 1, 2014. Claims with ICD-10 codes dates of service before October 1, 2014, will be denied.
- ICD-10 codes must be used for all procedures and diagnoses dates of service on and after October 1, 2014. Claims with ICD-9 codes dates of service on or after October 1, 2014, will be denied.

Providers are advised to talk with your software vendor to ensure your system will be upgraded to support ICD-10 by October 1, 2014.

Keep Up to Date on ICD-10: Visit the [CMS ICD-10 website](#) for the latest news and resources to help you prepare.

New Fax Numbers for ADHC, LOC, PASRR, PCS and Dental Forms

Fax numbers providers use to submit some prior authorization forms to HP Enterprise Services (HPES) were changed on November 5, 2012, in order to enhance the authorization process. The process enhancement allows documents to go directly to the staff responsible for authorizing the services.

Fax numbers have changed only for the forms listed below. Continue to fax prior authorization forms not listed to 866-480-9903.

Dental services: The fax number for form FA-26A Dental History Request has been changed to 855-709-6848. Dental prior authorization requests that do not require x-rays (submit with the ADA claim form marked prior authorization) may be faxed to 855-709-6848.

The new fax numbers are indicated at the top of each form and are listed in the following table.

| Form Number | Form Name | New Fax Number |
|-------------|--|----------------|
| FA-17 | Adult Day Health Care (ADHC) | 855-709-6846 |
| FA-18 | Level 1 Identification Screening for PASRR | 855-709-6847 |
| FA-19 | Level of Care Assessment for Nursing Facilities | 855-709-6847 |
| FA-20 | PASRR and LOC Copy Request | 855-709-6847 |
| FA-21 | PASRR and LOC Data Correction Form | 855-709-6847 |
| FA-22 | Screening Request for Pediatric Specialty Care Services | 855-709-6847 |
| FA-24 | Personal Care Services (PCS) Prior Authorization | 855-709-6846 |
| FA-24A | Coordination of Hospice and Waiver or Personal Care Services (PCS) | 855-709-6847 |
| FA-24B | Legally Responsible Relative Waiver For the Personal Care Services Program | 855-709-6846 |
| FA-26A D | ental History Request | 855-709-6848 |

Updated Version of Clinical Claim Editor Implemented

The Division of Health Care Financing and Policy (DHCFP) and HP Enterprise Services (HPES) have incorporated an updated version of the clinical claim editor into the Medicaid Management Information System (MMIS). The clinical claim editor criteria used to audit professional and outpatient services claims now includes the National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUE). Claims are now subject to MUE.

MUE are units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services and durable medical equipment. This component defines, for each HCPCS/CPT code, the number of units of service that is unlikely to be correct, e.g., claims for excision of more than one appendix or more than one hysterectomy.

More information about the NCCI mandate can be found on the Centers for Medicare & Medicaid Services (CMS) website located at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>

Important Billing Information:

- Many codes will no longer have cutback logic in the MMIS. If your claim has units billed over the MUE limit, then all units will be denied. Units will not be cutback to the allowed amount and paid.
- Do not use modifiers that are not necessary, because they could cause your claim to deny.

The following is an example of a new MUE:

| Edit | Description | ADJ/ RSN | Remarks/NCPDP/ Status | Description |
|------|---|-------------|--------------------------|---|
| 4730 | NCCI: UNITS OF SERVICE EXCEED MUE LIMIT | 151 | N362 | The number of Days or Units of Service exceeds our acceptable maximum |

NCCI Denial is a Provider Liability

NCCI denied services SHOULD NOT be billed to the recipient. The denied service is a provider liability. Providers cannot use an “Advanced Beneficiary Notice” or waiver of liability to obtain payment from recipients.

Paper Remittance Advices (RAs) will contain the following statement when the RA contains an NCCI edit:

- NCCI denials should not be billed to the beneficiary MA13

Electronic 835s will contain the following additional Remark code when the 835 contains an NCCI edit:

- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code

Provider Type 33: Billing Change for Suppliers of Pressure Support Ventilators

As a result of the implementation of a new version of the clinical claim editor to include Medically Unlikely Edits (MUE), providers who deliver a ventilator and a back-up ventilator HCPCS code E0463 (Pressure support ventilator with volume control mode) will need to change the way they currently bill for the back-up ventilator.

Previously, providers were instructed to bill the number of units provided on one claim line using the usual and customary rate. With the addition of MUE editing in the Medicaid Management Information System (MMIS), claims for the back-up ventilator must be submitted on a separate line appending a TW modifier to indicate back-up equipment. Two units for E0463 on a single claim line will be denied with an NCCI MUE edit.

Billing Example:

| | DOS | HCPCS/CPT | Mod 1 | Mod 2 | Units |
|---------|----------|-----------|-------|-------|-------|
| Line 1: | 12/10/12 | E0463 | RR | | 1 |
| Line 2: | 12/10/12 | E0463 | RR | TW | 1 |

Prior Authorization: Providers who deliver a ventilator and/or back-up ventilator will still need to obtain a prior authorization for 1 or 2 units (1 unit for each ventilator).

What is the Nevada Incentive Payment Program for Electronic Health Records?

As part of the American Recovery and Reinvestment Act of 2009, federal incentive payments are available to eligible doctors and hospitals when they adopt certified Electronic Health Records (EHRs) and demonstrate meaningful use.

The many benefits of EHRs include efficiency, effectiveness and financial incentive.

- *Efficiency:* EHRs give providers the ability to share patient data with colleagues and patients; to retrieve old data effortlessly; to view test results prescribed by other doctors; and to access patient records remotely to answer patient questions intelligently from outside the medical office.
- *Effectiveness:* EHRs can compute information such as drug interactions or allergies and provide “decision support” for clinicians. They reduce costs through reduced paperwork, improved safety, reduced duplication of testing, and, most importantly, improved health through the delivery of more effective health care.
- *Financial Incentive:* Currently, the federal government is encouraging physicians to transition to a certified EHR system by providing financial incentives of up to \$44,000 for Medicare providers, or \$63,750 for Medicaid providers. Physicians have the opportunity to receive financial and technical help being offered through the Medicaid and Medicare programs and Regional Extension Centers (RECs). Financial incentives are also available for some hospitals.

The Division of Health Care Financing and Policy (DHCFP) launched the Nevada EHR program on August 6, 2012, and as of January 4, 2013, a total of 116 providers and 13 hospitals have received over **\$11,006,355.82** in payments from the Nevada Medicaid EHR Incentive payment program.

Medicaid providers can receive their first year’s incentive payment for adopting, implementing or upgrading certified EHR technology.

- Adopting – Purchasing a certified EHR system,
- Implementing – Beginning implementation of a previously purchased certified EHR system, or
- Upgrading – Purchasing or implementing an upgraded version of a certified system.

However, Medicaid providers must demonstrate meaningful use in subsequent years in order to qualify for additional payments.

What defines Meaningful Use for the Medicaid EHR Incentive Program?

To receive more than one year of Medicaid incentives, providers must go beyond purchasing and installing a system. They must demonstrate that they are “meaningfully using” that system by satisfying the three stages of meaningful use criteria. The table on page 5 outlines the three stages as they are currently known.

The Centers for Medicare & Medicaid Services (CMS) website has a broad range of information available, including federal eligibility requirements, meaningful use definitions, and the payment process. Please go to: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms>. To learn more about the Nevada Medicaid EHR Incentive Program, please visit <https://dhcfp.nv.gov/EHRIncentives.htm>.

Nevada EHR Incentive Payment System (NEIPS) Updates coming in January 2013!

Eligible Professional Changes for Program Year 2013

Payment Year 1 Option – AIU or MU

Beginning in January 2013, Eligible Professionals (EP) attesting for their first payment year in program year 2013 will have the option to attest to Adopt/Implement/Upgrade (AIU) or to Meaningful Use (MU). Upon initiation of the payment year 1 enrollment, the EP will be presented with a question to determine the appropriate attestation path for the EP (AIU or MU). The EP may choose either path as part of the Medicaid Program.

The change is being made to allow EPs who can participate in either the Medicare or the Medicaid EHR incentive programs to avoid Medicare payment adjustments as a result of not attesting to being a Meaningful User by program year 2014, with adjustments to be enforced in program year 2015. Please refer to the [Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals](#) for further information on the proposed payment adjustments.

Definition of Hospital Based Eligible Professionals

CMS added a new section to the EHR Incentive Program Final Rule, §495.5, to allow EPs who are hospital based to participate in the program if the EP can demonstrate that the EP funds the acquisition, implementation and maintenance of Certified EHR Technology (CEHRT), including supporting hardware and any interfaces necessary to meet meaningful use, without reimbursement from an eligible hospital (EH) or critical access hospital (CAH); and uses

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such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital’s CEHRT).

An EP who is designated as hospital based, but wishes to be determined non-hospital based will utilize an administrative process throughout the incentive payment year to provide documentation and seek a non-hospital based determination. The EP must have funded the acquisition, implementation and maintenance of the CEHRT, including supporting hardware and use the CEHRT at a hospital in lieu of the CEHRT of the hospital.

Following a successful non-hospital based determination, the EP must attest each subsequent year that they continue to be in the same situation of funding of the acquisition, implementation and maintenance of CEHRT, including supporting hardware, and use the CEHRT at a hospital without reimbursement from an eligible hospital or CAH, in lieu of using the CEHRT of such hospital, but would not have to provide the supporting documentation again.

If and when a non-hospital based determination has been made, the EP would then have to meet the same requirements of the EHR incentive program as any other EP including being subject to payment adjustments if applicable with a sole exception: The EP would include in their attestation to meaningfully use all encounters at all loca-

tions, including those in the inpatient and emergency departments of the hospital, rather than just outpatient locations (other than the emergency department) as is the case for all other EPs.

Adopt-Implement-Upgrade Requirements: CMS requires that at least one of the clinical locations used for the calculation of an EP’s patient volume have CEHRT during the payment year for which the EP is attesting to AIU or MU.

EP Volume Attestation and Volume Time Frame:

Nevada will allow their providers the option to calculate total Medicaid encounters, panel counts, or total needy individual patient encounters in any representative, continuous 90-day period in the 12 months preceding the EP’s attestation. This option will be in addition to the current regulatory language that bases patient volume on the prior calendar year.

EP Encounters Count:

CMS expanded the definition of “encounter” to include any service rendered on any one day to an individual enrolled in a Medicaid program. Such a definition will ensure that patients enrolled in a Medicaid program are counted, even if the Medicaid program did not pay for the service (because, for example, a third party payer paid for

| Stage | Focus | Meaningful Use Objectives | Clinical Quality Measures | Reporting Mechanism |
|-----------------------|--|---|--|---|
| Stage 1 (2012) | <ul style="list-style-type: none"> Electronically capturing health information in a coded format Using that information to track key clinical conditions Communicating that information for care coordination purposes Initiating the reporting of clinical quality measures and public health information | <ul style="list-style-type: none"> EPs: 20 objectives (15 core and 5 others from a set of options) EHRs: 19 objectives (14 core and 5 others from a set of options) | <p><u>Eligible Professionals (EPs):</u></p> <ul style="list-style-type: none"> Providers must report on 3 clinical quality measures (alternate core measures if one or more of the core measures don’t apply) Providers must also choose 3 other measures from a list of 38 <p><u>Eligible Hospitals (EHRs):</u></p> <ul style="list-style-type: none"> Hospitals must report on 15 clinical quality measures | <ul style="list-style-type: none"> Reported to the state via attestation |
| Stage 2 (2013) | CMS Stage 2 Information Stage 2 Meaningful Use Final Rule | | | |
| Stage 3 (2015) | <ul style="list-style-type: none"> Achieving improvements in quality, safety and efficiency Decision support for national high priority conditions Patient access to self-management tools Access to comprehensive patient data Improving population health outcomes | <p><i>To be defined by future rulemaking by CMS</i></p> | | <p><i>TBD</i></p> |

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the item or service, or the service is not covered under Medicaid). This expanded encounter definition also includes “denied” claims based on reason. If a Medicaid claim was denied due to the patient being ineligible for Medicaid at the time of service, then it would not be appropriate to count them.

Practicing Predominately in an FQHC/RHC/IHP Facility:

CMS revised the definition of “practices predominantly” in order to provide more flexibility for eligible professionals. An EP attesting for program year 2013 may use either: (1) the most recent calendar year; or (2) the most recent 12 months prior to attestation to determine if they practice predominantly in an FQHC/RHC/IHP facility. These changes are not retroactive to program year 2012.

Eligible Hospital Changes for Program Year 2013

Hospital Volume Attestation and Volume Time Frame:

Nevada will allow their providers the option to calculate total Medicaid encounters in any representative, continuous 90-day period in the 12 months preceding the eligible hospital’s attestation. This option will be in addition to the current regulatory language that bases patient volume on the prior federal fiscal year.

Hospital Encounters Count:

CMS expanded the definition of “encounter” to include any service rendered on any one day to an individual enrolled in a Medicaid program. Such a definition will ensure that patients enrolled in a Medicaid program are counted, even if the Medicaid program did not pay for the service (because, for example, a third party payer paid for the item or service, or the service is not covered under Medicaid). This expanded encounter definition also includes “denied” claims based on reason. If a Medicaid claim was denied due to the patient being ineligible for Medicaid at the time of service, then it would not be appropriate to count them.

Payment Calculation

Acute Care Inpatient Bed Days and Discharges for the Medicaid Share and Discharge-Related Amount: CMS amended the hospital payment regulations to recognize that only acute-care discharges and bed-days are included in the hospital payment calculations. CMS has added this language to clarify that all bed days and discharges used in the calculation are strictly limited to the acute-inpatient portion of the hospital. All hospitals will continue to exclude non-acute bed days and discharges (i.e., nursery discharges and bed days). CMS recognizes that neonatal intensive care days are considered acute inpatient services that should be included in the hospital incentive calculation.

Increased Payment for certain Primary Care Physicians for Calendar Years 2013 and 2014 as part of the Affordable Care Act

As part of the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) has implemented a rate increase for certain Primary Care Physicians (PCPs) and their associated subspecialties. This increased rate is effective for calendar years 2013 and 2014.

The increased rate only applies to services rendered to Medicaid recipients. Per CMS, stand-alone Children’s Health Insurance Program (CHIP) programs are not eligible. Nevada Check Up is a stand-alone CHIP program.

Specialties That Qualify for the Enhanced PCP Rate

The final rule applies to services furnished by a physician or “under the personal supervision of a physician who self-attests to a specialty designation of:

- Family medicine,
- General internal medicine, or
- Pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Spe-

cialties (ABPS) or the American Osteopathic Association (AOA).”

The subspecialties within the three specialties that are included can be found on the American Board of Medical Specialties website at http://www.abms.org/who_we_help/physicians/specialties.aspx.

A physician must self-attest that he or she:

- is board certified with such a specialty or subspecialty; OR
- has furnished evaluation and management services and vaccine administration services under specific HCPCS codes (described below) that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

The increased payment is *not* available to physicians who are reimbursed through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or health depart-

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ment encounter or visit rate or as part of a nursing facility per diem payment rate. Additionally, increased payment is not available for OB/GYN providers per CMS.

Codes/services that qualify for the enhanced rate

Those services (as designated in HCPCS) are:

- Evaluation and Management (E&M) codes 99201 through 99499.
- Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor code.

How will Nevada Medicaid implement the PCP rate increase?

Nevada Medicaid is actively working to implement the required changes. A Nevada Medicaid State Plan Amendment (SPA) is being drafted to reflect the new reimbursement methodology for the affected providers and HCPCS codes for Fee for Service providers. Nevada Medicaid Fee for Service providers who are identified as eligible for the increased rate will receive a supplemental payment monthly for the difference between the current reimbursement rate for the affected codes and the new rate. These payments will begin in April 2013 for claims with service dates January 1, 2013, forward, to allow for the 120 days timely filing rule.

The CMS final rule states that Medicaid programs should use either the rate under the Medicare Physician Fee Schedule (MPFS) for calendar years 2013 and 2014 or, if greater, the payment rate that would be applicable if the 2009 Conversion Factor were used to calculate the MPFS. At this time, Nevada Medicaid intends to use the 2009 Conversion Factor to calculate the new rates. These rates are only in effect for service dates from January 1, 2013, to December 31, 2014. Rates will automatically default back to the previous rate on January 1, 2015.

A list of eligible codes and their corresponding reimbursement will be published on the Division of Health Care Financing and Policy (DHCFP) Rates and Cost Containment website. The information will be available after further clarification from CMS is received. For questions or concerns regarding the eligible codes and rates, please contact the Rates and Cost Containment Unit at (775) 684-3689.

Providers who would like to be considered for the increased rate **must** self attest that he or she:

- is board certified with such a specialty or subspecialty; OR
- has furnished E&M services and vaccine administration services under specific HCPCS codes that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

Providers who self attest to being board certified in one of the eligible specialties/subspecialties or are furnishing the required threshold of E&M services and vaccine administration services are subject to internal DHCFP review. If it is determined by DHCFP that the provider has not met the threshold for the claims requirement or is not board certified, the provider will be removed from the eligible list and any enhanced payments will be recouped.

Please note: Providers who do not self attest will not be eligible for the increased reimbursement.

To claim self attestation, the provider must complete the self attestation form, which will be available on the DHCFP website or through the HP Enterprise Services Provider Web Portal (see [Web Announcement 552](#)). Completed self attestation forms must be submitted to DHCFP Provider Support via fax at (775) 684-3720. Providers must submit the self attestation form to DHCFP by March 15, 2013, in order to be considered eligible for any retroactive rate increase. Providers submitting their forms after that date will only be eligible for the increased rate going forward. For questions regarding the self attestation, please contact Provider Support at (775) 684-3700.

Who to contact? For questions regarding eligible codes, reimbursement or specialties, please contact the DHCFP Rates and Cost Containment Unit at (775) 684-3689.

Please note: Information regarding the Nevada Medicaid SPA change, eligibility requirements and reimbursement methodologies are being proposed to CMS and will only be implemented upon CMS approval. Changes will be effective January 1, 2013. Further, the codes and provider specialties affected are subject to change if CMS issues further instruction. Additionally, CMS has ruled that if the service/code is not currently covered by Medicaid, that Medicaid is not required to now cover the service.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact HPES by calling (877) 638-3472, press option 2 for providers, then option 0, then option 2 for claim status.

If you have a question about Medicaid Service Policy or Rates, you can go to the Division of Health Care Financing and Policy (DHCFP) website at <http://dhcfp.nv.gov>. Under the "DHCFP Index" box, move your cursor over "Contact Us" and select "[Main Phone Numbers](#)." Call the Administration Office of the area you would like to contact.