Nevada Medicaid News

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Recent Changes to Chapters in the Medicaid Services Manual

The following chapters in the Medicaid Services Manual (MSM) were revised between June 29, 2007, and Nov. 13, 2007, due to changes in Nevada Medicaid policy. Please review the MSM at http://www.dhcfp.nv.gov or by using the Medicaid Services Manual link posted at https://medicaid.nv.gov. The changes to the chapters are indicated by red lettering.

Chapter 100 - Medicaid Program
Chapter 200 - Hospital Services Program
Chapter 500 - Nursing Facilities
Chapter 600 - Physicians Services
Chapter 900 - Private Duty Nursing
Chapter 1000 - Dental Services
Chapter 1200 - Pharmacy Services
Chapter 1300 - Durable Medical Equipment (DME)
Chapter 1500 - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Chapter 3300 - Surveillance and Utilization Review (SURS)

The following MSM chapters are in draft stages and will be added to the MSM once approved in public hearing:

Chapter 2000 - Audiology
Chapter 3000 - Disability
Chapter 3800 - Subrogation
Chapter 3900 - Assisted Living Waiver

Watch for updates to Chapter 800 – Nevada HIFAESI Subsidy Program in the Nevada Medicaid Operations Manual (MOM). The chapter has been revised and the changes will be posted soon.

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Physician/Outpatient Administered Drug Claims to Require NDC & NDC Quantities

The Deficit Reduction Act of 2005 requires fee-for-service State Medicaid programs to capture and report National Drug Codes (NDC) for physician/outpatient-facility administered drugs beginning Jan. 1, 2008, in order for the State to receive federal financial participation.

To facilitate this federal mandate, Nevada Medicaid will require NDC and NDC quantity be entered for physician/outpatient-facility administered drugs on claims **received** at First Health Services on and after Jan. 1, 2008. This requirement applies to paper claim forms CMS-1500 and UB-04 and electronic transactions 837P and 837I. Provider types affected by this change are: 12, 14, 17, 20, 21, 22, 24, 25, 27, 29, 36, 45, 64, 72, 74 and 77.

Claims received at First Health Services on and after Jan. 1, 2008, for physician/outpatient-facility administered drugs without corresponding NDCs and NDC quantities will be denied.

Details, billing instructions and training information providers may access are posted on the First Health Services website at https://medicaid.nv.gov.

2008 Will Bring Regulation Changes for PCA Agencies

In early 2008, regulatory changes will be adopted that will require agencies that provide personal care services in the home (Personal Care Aide – Provider Agencies) to apply for a license through the Nevada Health Division of the Nevada Department of Health and Human Services and pay newly established fees.

The purpose of the regulation change will be to protect vulnerable elderly and disabled recipients from caregivers who have no oversight from any regulatory agency.

An immediate effect on PCA agencies is that they will be required to become licensed and pay associated fees. A long-term effect on agencies will be that they may be reviewed for compliance with regulations every three years.

For additional information, visit the Bureau of Licensure and Certification webpage on the Health Division's website at http://health.nv.gov.

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Updates on Major Issues

NPI/API:

Until further notice, providers may continue to enter their Provider Medicaid Number or thier National Provider Identifier/Atypical Provider Identifier (NPI/API) in the appropriate fields on claims received at First Health Services. These instructions apply to both paper and electronic claims. Providers will be notified of the effective date when only NPI/API will be accepted.

The claim form instructions and EDI Companion Guides at https://medicaid.nv.gov provide details on billing with NPI/-API.

NPI Registry:

The Centers for Medicare & Medicaid Services (CMS) has made available National Plan and Provider Enumeration System (NPPES) health care provider data via the internet.

The NPI Registry can be found at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. A Downloadable File is available at http://nppesdata.cms.hhs.gov/cms_NPI_files.html (an underscore precedes and follows "NPI").

The NPI Registry and the Downloadable File are tools Nevada Medicaid pharmacy providers may use to obtain a physician's NPI when entering the prescriber's ID on claims. Pharmacy providers are encouraged to use the prescriber's NPI immediately instead of the prescriber's Provider Medicaid Number. Providers will be notified of the effective date when the prescriber's NPI will be mandatory.

Tamper-Resistant Prescription Pads:

The implementation date for the requirement that all written prescriptions for fee-for-service Medicaid recipients be written on tamper-resistant prescription pads has been delayed to April 1, 2008. The provision of Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007 was originally scheduled to be implemented on Oct. 1, 2007. See Web Announcement 160 at https://medicaid.nv.gov for details.

Effective Date for PDL Changes was Nov. 15, 2007

The effective date for changes to the Preferred Drug List (PDL) made by the Pharmacy and Therapeutics (P&T) Committee of the Nevada Department of Health and Human Services' Division of Health Care Financing and Policy was Nov. 15, 2007.

The changes reflected in the PDL were made by the P&T Committee during its annual review of the PDL on June 21, 2007. For the list of drugs added, drugs removed and drugs reviewed but not added, please see the PDL posted at https://medicaid.nv.gov (select "Preferred Drug List" from the "Pharmacy" menu).

If you have questions regarding the PDL, please contact the First Health Services Clinical Call Center at (800) 505-9185.

CONTACT INFORMATION

If you have a question concerning the manner in which a claim was adjudicated, please contact First Health Services by calling (877) 638-3472 or e-mailing nevadamedicaid@fhsc.com.

If you have questions about Medicaid Service Policy or Rates, you can go to the Division of Health Care Financing and Policy (DHCFP) website: http://www.dhcfp.nv.gov. Under the DHCFP Index box, move your cursor over "Contact Us" and select "Policy and Rate Staff contacts." Follow the directions to find the person at DHCFP who can answer your question. You can either phone the contact person or send an e-mail.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $289,370,542.49 in claims during the three-month period of July, August and September 2007. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

The DHCFP and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

Billing Tips and Reminders

Electronic Billing:

Did you know that billing claims electronically speeds your reimbursement and reduces errors? For information, call (877) 638-3472.

Paper Claim Forms:

Do not write any unnecessary comments (i.e. "EOB attached") or descriptions anywhere on your claim.

Print all information clearly. Ensure letters and numbers can be distinguished (i.e., the letter S and the number 5 or the letter O and the number zero 0. You may use Ø for zero.).

Check Recipient Eligibility:

Remember to check recipient eligibility before rendering services. Eligibility may be checke online through the Electronic Verification System (EVS) (at https://medicaid.nv.gov from the EVS menu) or by calling the Nevada Medicaid Audio Response System (ARS) at (800) 942-6511.

Visit https://medicaid.nv.gov weekly for important updates and information.

Payment Error Rate Measurement (PERM) Update

The Centers for Medicare & Medicaid Services (CMS) will measure the accuracy of Medicaid and State Children's Health Insurance Program (SCHIP/Nevada Check Up) payments made by each state for services rendered to recipients through the Payment Error Rate Measurement (PERM) program.

The PERM review for Nevada Medicaid and Nevada Check Up will be conducted on claims paid during federal fiscal year 2008 (October 2007 through September 2008).

Medical records are needed to support the medical review portion of PERM conducted by HealthDataInsights, who is the federal contractor reviewing medical records. HealthDataInsights must determine if the service selected for review was medically necessary and correctly paid in accordance with established policy. If a claim in which your provider number was identified to receive reimbursement is selected for review, the federal contractor requesting the medical record documentation, Livanta LLC, will contact you for a copy of ALL the medical records needed to support that claim.

Once you receive the initial request for the medical record documentation, you must submit the information electronically or in hard copy to Livanta LLC within 60 days. Please note that it will be the responsibility of the provider receiving payment to ensure that any and all supporting medical records, from any and all provider(s) who rendered a service on the claim under review, are submitted within the timeframes specified in this article.

IMPORTANT CHANGE

Please note that the timeframes for submittal of medical record documentation changed with the final PERM regulations issued by CMS on Aug. 31, 2007. Information about the new timeline is contained in this newsletter article.

You will have a maximum of 60 days to submit ALL the required documentation. Please be sure to send all information at the same time, as the 60-day clock stops when Livanta LLC receives your initial documentation packet.

If the federal contractor determines the claim under review needs additional supporting documentation, you, the provider, will be contacted again by Livanta LLC. You will only have 15 days to respond to their request for additional information.

It is important that you, the provider, cooperate by submitting <u>all requested documentation in a timely and complete manner.</u>

No response from you or submittal of insufficient documentation within the stated timeframes will result in the claim being counted as an error and the Division of Health Care Financing and Policy (DHCFP) will initiate recovery of the claim payment. Past studies indicate that most errors occur in the medical review area and are due to the provider sending either no documentation or insufficient documentation within the specified timeframes.

Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services. The furnishing of information includes medical records.

In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

A Message from DHCFP Regarding Prevention: Diabetes Awareness

Nearly 21 million children and adults in the United States are living with diabetes, and another 54 million people are at-risk. It is possible to delay or even prevent type 2 diabetes from developing. There is a lot you can do yourself to know your risks for pre-diabetes and to take action to prevent diabetes if you have, or are at risk for, pre-diabetes.

Pre-diabetes

Before people develop type 2 diabetes, they almost always have pre-diabetes, which is blood glucose levels that are higher than normal but not yet high enough to be diagnosed as diabetes. There are 54 million people in the United States who have pre-diabetes. Diabetes is more common in African Americans, Latinos, Native Americans, Asian Americans and Pacific Islanders. If you are a member of one of these ethnic groups, you need to pay special attention and speak with your health care provider.

How to prevent or delay diabetes

Pre-diabetes is a serious medical condition that can be treated. The good news is that a recently completed study conclusively showed that people with pre-diabetes can prevent the development of type 2 diabetes by making changes in their diet and increasing their level of physical activity. – *American Diabetes Association – http://www.diabetes.org/diabetes-prevention.jsp*

Diabetic supplies

Nevada Medicaid reimburses for office visits and testing for diabetes. Diabetic supplies are reimbursed through the Pharmacy Program – Chapter 1200 of the Medicaid Services Manual (MSM) and includes glucometers, test strips, lancet devices and insulin syringes.

External ambulatory infusion insulin pumps are also a covered benefit for Medicaid recipients who meet the criteria. See Chapter 1300 of the MSM – Durable Medical Equipment. The MSM is posted at http://www.dhcfp.nv.gov.

Nevada Medicaid/Nevada Check Up and MCOs Work to Reduce Racial and Ethnic Disparity in Health Care

Nevada Medicaid and Nevada Check Up provide medical care services to most of their recipients through two managed care organizations (MCOs): Health Plan of Nevada and Anthem Blue Cross Blue Shield. The Division of Health Care Financing and Policy (DHCFP) and the MCOs collaborate yearly on quality improvement projects in an effort to improve the recipients' access to and receipt of quality health care services in this State.

DHCFP and the MCOs established the MCO Racial and Ethnic Disparities Work Group (Work Group) tasked with the development of action steps to implement and ensure that race, ethnicity and the primary languages spoken by recipients are collected through an improved process. These improvements will lead to the delivery of services in a culturally competent manner. The Work Group held the first of its monthly meetings in July 2007 to begin developing ways to leverage data to reduce racial and ethnic health care disparities.

Another important task of the Work Group is to look at cultural issues within different ethnic communities that might cause health care disparities. The Work Group will take steps toward making providers aware of the disparities and conduct ongoing provider training, thereby significantly reducing health care disparities for all recipients in the State of Nevada.

DHCFP is also reviewing its Fee-For-Service (FFS) claims data to evaluate how Nevada's FFS recipients' access to and receipt of quality health care compare to that of the MCO recipients as well as the national trends. Future newsletter articles will address the progress DHCFP has made in these important research projects.

Visit **https://medicaid.nv.gov** weekly for important updates & information