Nevada Medicaid News

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Nevada Medicaid and Nevada Check Up
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Submit Updated License(s) To First Health Services

On a monthly basis, the Division of Health Care Financing and Policy (DHCFP) will be mailing letters to providers who have a license(s) expiring within 30 days from the date of the letter. Providers who receive these letters are required to submit a copy of their updated license(s) to First Health Services by the due date noted. Failure to submit the updated license by the due date may result in the termination of their Medicaid contract.

A copy of the license must be mailed to: First Health Services, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042. Please write your NPI/API on the license.

Please note: **any** provider who has renewed a license within the last 12 months is asked to ensure that a copy has been submitted to First Health Services.

PCS Agency Enrollment Moratorium In The Greater Las Vegas Area

A moratorium is in effect on new enrollments for Personal Care Services (PCS) **Provider Type (PT) 30** agencies in the greater Las Vegas area. This area includes North Las Vegas, Las Vegas, Henderson and Boulder City.

This moratorium has been enacted because, at this time, there are sufficient PCS agencies in this area to meet the needs of Medicaid recipients.

Magellan Acquires First Health Services From Coventry

Magellan Health Services, Inc. (Nasdaq:MGLN) has acquired First Health Services Corporation from Coventry Health Care, Inc. (NYSE:CVH) effective Aug. 1, 2009.

Magellan Health Services, Inc. is the country's leading diversified specialty health care management organization. Magellan operates in the behavioral health, radiology, and specialty pharmacy and oncology management arenas. Its customers include health plans, corporations and government agencies.

Magellan's corporate goals include empowering health plans, employers, governments and providers to efficiently improve the health, welfare and productivity of the people they serve.

While the change in ownership of First Health Services will be seamless for Nevada Medicaid/Nevada Check Up providers, Magellan's experience in the health care management field and expertise in customer service, claims payment, clinical management, and information technology tools and connectivity should be beneficial for Nevada's providers.

For more information on Magellan Health Services, visit their website at http://www.magellanhealth.com.

Providers, Billing Staff And Front Office Staff Invited To Attend Annual Medicaid Conference

The Annual Medicaid Conference will be held Oct. 14, 2009, at the Reno/Sparks Convention Center in Reno and Oct. 21, 2009, at the Cashman Center in Las Vegas.

The Division of Health Care Financing and Policy (DHCFP) and First Health Services encourage providers, clinicians, billing staff and front office staff to attend the Conference, which presents current and upcoming policy information for all providers followed by "break-out sessions" where provider type specific instruction is provided in individual conference rooms.

Providers themselves are encouraged to attend the Conference to learn about new Medicaid policy, prior authorization procedures, and Medicaid coverage changes

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Reminders To Request Ongoing Services Are Discontinued For Provider Types 30 And 83

Effective for Personal Care Functional Assessments with expiration dates of Sept. 30, 2009, or after, First Health Services will no longer send reminders to provider agencies to request ongoing services. Providers were originally notified of this change on July 17, 2009, through web announcement 275, which is online at https://medicaid.nv.gov. Web announcement 275 was also faxed to all Personal Care Service agencies.

Per Medicaid Services Manual (MSM) section 3503.1D.1 .b, requests for ongoing services must be submitted to First Health Services at least 30 days prior to the expiration of the current authorization.

Requests should be submitted with the most current demographic information. Authorizations that expire will not be adjusted or eligible for reimbursement until a new Functional Assessment and Service Plan are completed and a new authorization can be issued.

Agencies must ensure that care is continued and the recipient is not placed at risk if an authorization is allowed to expire.

CMS Program Requires States To Post A List Of Medicaid Dental Providers

Effective Aug. 4, 2009, the Centers for Medicare & Medicaid Services (CMS) is requiring each state to post online a list of all dentists (provider type 22) who are actively enrolled in the Medicaid program.

The list will be updated quarterly and must contain the provider's physical address, phone number, specialty, and indicators if he/she is accepting new patients and can accommodate special needs.

Some of this information may not be readily available to Medicaid; therefore, dentists may receive a phone call from First Health Services and/or State Medicaid staff asking for this information in the near future.

A Message From DHCFP Regarding Prevention: Breast Cancer Awareness

For over 20 years, October has been designated as National Breast Cancer Awareness Month in order to educate women about early breast cancer detection, diagnosis and treatment. Nevada Medicaid invites providers to join the effort to heighten the awareness of breast cancer prevention.

Mammography screenings are a woman's best chance for detecting breast cancer early. Medicaid provides coverage for mammography screenings, along with yearly gynecologic exams, including breast examinations.

Medicaid encourages women to practice regular self-breast exams. One of Medicaid's main goals is to prevent the disease from developing or prevent serious complications of the disease.

Early detection is the key.

Preferred Drug List (PDL) Changes Effective Sept. 29, 2009

The Pharmacy and Therapeutics (P&T) Committee of the Nevada Department of Health and Human Services' Division of Health Care Financing and Policy met for the annual review of the Nevada Medicaid Preferred Drug List (PDL) on June 25, 2009.

All actions taken by the Committee are effective Sept. 29, 2009.

The changes regarding the PDL are indicated in the web announcement titled "Preferred Drug List (PDL) Changes Effective Sept. 29, 2009," which is online at https://medicaid.nv.gov (select "Announcements/Training" or "Preferred Drug List" from the "Pharmacy" menu). The complete PDL is also posted on the "Preferred Drug List" webpage.

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.

If you have questions 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 "Policy and Rate Staff contacts." Follow the instructions 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 $326,612,281.05 in claims during the three-month period of April, May and June 2009. 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.

Medicaid Manual Changes

The following Medicaid Manual chapters were revised in July and August 2009.

Please review the current Medicaid Manuals at http://dhcfp.nv.gov.

MSM 100 – Medicaid Program
MSM 600 – Physician Services
MSM 700 – Rates and Cost Containment
MSM 1000 – Dental
MSM 1100 – Ocular Services
MSM 3200 – Hospice
MSM 3600 – Managed Care Organization
Nevada Check Up Program Manual

HMS Contracted To Conduct Medicaid Integrity Program Provider Audits For Nevada

All DHCFP Nevada Medicaid/Nevada Check Up fee-for-service providers, institutional and non-institutional providers and managed care providers are subject to audit under the federal Medicaid Integrity Program (MIP). The MIP audits are not to be confused with the Payment Error Rate Measurement (PERM) audits.

The MIP was created by the Deficit Reduction Act of 2005 and Section 1936 of the Social § Security Act (42 U.S.C. § 1396u-6) and directed the Centers for Medicare & Medicaid Services (CMS) to enter in to contracts to: review Medicaid provider actions; audit provider claims; identify overpayments; and educate providers and others on Medicaid program integrity issues.

The MIP federal contractor for provider audits in Nevada is HMS. ***Providers are urged to be prepared for HMS to contact them at any time***.

The primary objectives of the MIP provider audits are to ensure: claims are paid for services provided and properly documented; services are billed using the appropriate procedure codes; services are covered under the Medicaid program; and claims are paid in accordance with all state and federal laws, regulations and policies.

Most audits under MIP will be desk audits; however, on some occasions HMS will conduct field audits at the provider's location. Generally, a notification letter will be sent to the provider two weeks before the beginning of the audit. Providers are required by Section 4.2 of the DHCFP provider contract and the Medicaid Services Manual Chapter 3303.2B to cooperate and provide any and all documentation requested by federal officials or their authorized agents.

Disclosure of protected health information to HMS is permitted under the Health Insurance Portability and Accountability Act (HIPAA), reference 45 CFR 164.512 (d) (1) (iii). Requested documentation must be provided within the time frames specified by HMS. For desk audits, providers will be given at least a two-week notice to provide the necessary documentation. For field audits, the provider must have the records available in time for the auditor's arrival at the provider's office.

The DHCFP does not oversee these audits. The audits will be conducted independently by HMS. The DHCFP's role in the MIP provider audit process is to: ensure the MIP audits do not conflict with other state audits; review draft reports produced by HMS; ensure HMS reached findings in accordance with state and federal laws, regulations and policies; collect overpayments from providers; and adjudicate provider appeals.

Additional information on the Medicaid Integrity Program provider audits can be found at:

http://www.cms.hhs.gov/MedicaidIntegrityProgram

NPIs/APIs Impact The Prior Authorization Process

First Health Services is committed to working with providers to ensure timely prior authorization (PA) for services rendered to recipients and timely payment for services.

A common error in the PA process occurs when the National Provider Identifier/Atypical Provider Identifier (NPI/API) indicated on the request for PA does not match the NPI/API on the claim. First Health Services' prior authorization department will authorize services under the NPI/API shown on the request for PA. If the claim is billed under a different NPI/API than was indicated on the PA, the claim will deny due to no prior authorization for the billed claim.

For example, a physician's office requests a PA under the physician's individual NPI. He performs surgery at an ambulatory care facility with general anesthesia. The claim is billed under the NPI for the facility; but, because the office obtained the PA under the physician's individual NPI, the claim is denied.

In all cases when an authorization is approved under one NPI/API, and then billed under another, the remedy is for the provider to submit an FH-29 Prior Authorization Data Correction Form. First Health Services receives the data correction and must cancel the original request under the incorrect NPI/API, and re-key the request under the "corrected" NPI/API as indicated by the provider. This process often results in a delay in payment.

First Health Services receives and processes hundreds of data corrections per month and processes these after initial and concurrent authorizations are processed. Data corrections are done as quickly as possible, and are not required by the Division of Health Care Financing and Policy (DHCFP) to be completed within a specific time frame.

Providers are urged to take the following steps to help in reducing data correction requests and, therefore, reduce payment delays:

- Double check the NPI/API and ensure the appropriate provider of services is indicated on the prior authorization request.
- Ensure that the NPI/API on the PA matches the NPI/API on the claim.
- If the data correction is not completed within one week, ***do not re-submit another data correction request.*** An additional request results in a further backlog of data corrections and staff time to eliminate duplicate requests.
- Call (800) 525-2395 to ask about the staus of your request.

It is the provider's responsibility to ensure that information on the prior authorization request is accurate and complete. Please take the time to review the request for accuracy to help First Health Services pay you in a timely manner.

Annual Medicaid Conference ... *Continued from page 1*

specific to their provider types. The Conference gives providers the opportunity to familiarize themselves with the Medicaid billing process their staff must follow to ensure that claims are submitted accurately and are paid in a timely manner.

The three-hour morning and afternoon Conferences are identical. If you have not yet registered for the Conference, you still can by completing and faxing the **2009 Provider Training Registration Form**, which is online at https://medicaid.nv.gov (select "Provider Training" from the "Providers" menu).

First Health Services and DHCFP also present claim type training sessions throughout the year. The next sessions are scheduled for December 2009. Claim type training for UB, CMS-1500 and ADA submitters covers billing instructions for the specified claim form, as well as current and upcoming policy. The sessions include helpful everyday biling tips, an overview of available resources and tools, and much more.

The claim type classes are recommended for new and established billing personnel as well as front office staff. Staff members that are new to Medicaid billing will learn Medicaid program guidelines and proper billing guidelines. The classes are a useful refresher for the seasoned billing person to keep updated with recent changes to billing guidelines. Front office staff attendance is also recommended to ensure a seamless process in each office from intake through billing.

Register for the claim type classes using the Provider Training Registration Form. Please ensure that all information is entered correctly and legibly on the Registration Form, including your e-mail address. Course/Conference confirmations will be returned via e-mail.

All training is free of charge
to Nevada Medicaid/Nevada Check Up providers and staff.

Watch the website for the 2010 Provider Training Catalog, which will be online before the end of this year. Providers may register at any time for any course offered throughout the year. Early registration is encouraged.

New for 2010: Look for an easier way to submit the Training Registration Form.