Nevada Medicaid News

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Nevada Medicaid and Nevada Check Up
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Inside This Issue

Re-Enrollment Begins For Behavioral Health Provider Types 14 And 82

Effective Sept. 1, 2010, Nevada Medicaid implemented new enrollment procedures for Behavioral Health provider types (PTs) 14 (Behavioral Health Outpatient Treatment) and 82 (Behavioral Health Rehabilitative Treatment) in an effort to facilitate the prior authorization, billing and claim adjudication processes for these providers.

This project continues with mandatory re-enrollment beginning Jan. 1, 2011, for providers who enrolled prior to Sept. 1, 2010. PTs 14 and 82 must submit a new Provider Enrollment Application, Provider Contract and the documents required for each specialty per the Enrollment Checklists.

Providers are encouraged to review the following key dates:

- **Sept. 1, 2010:** New enrollment procedures were implemented for providers who enrolled on and after this date. Voluntary re-enrollment began.
- **Jan. 1, 2011:** Mandatory re-enrollment begins for providers who enrolled prior to Sept. 1, 2010.
- **Aug. 1, 2011:** Prior authorizations (PAs) may not be requested using an Atypical Provider Identifier (API) on and after this date.
- **Oct. 31, 2011:** Providers must be re-enrolled (does not apply to providers who enrolled on or after Sept. 1, 2010). **APIs will be terminated.**

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Revised Enrollment Application Must Be Used Effective Jan. 1, 2011

A revised Provider Enrollment Application (dated 12/02/10 in the bottom left corner) has been posted to this website and is available for immediate use. Any previous versions of the Application received by Magellan Medicaid Administration on or after Jan. 1, 2011, will be returned to the provider.

NEW: If reporting a change in business ownership, please be sure to check the "Ownership Change" box at the top of page 1 of the Application.

A Message From DHCFP Regarding Prevention: *Childhood Obesity*

The Surgeon General estimates that more than 17 percent of children in the United States (roughly 12.5 million) are overweight. This puts today's kids at a greater risk for serious health problems. Providers should encourage the importance of healthy eating and physical activity at a young age in order to assist in preventing childhood obesity.

The American Academy of Pediatrics (AAP) strives to improve the health of children who are overweight or obese. Nevada Medicaid reimburses for office visits or screenings in order to prevent or treat childhood obesity.

These visits should include at least the following:

1. Conducting a thorough history including family history, eating and physical activity with all of the recipient's behaviors (including TV/computer/video screen time, sweetened beverages, eating out and quantity of fruits and vegetables).

2. Considering a recipient's risk according to family history, height and weight gain pattern, socioeconomic, ethnic and cultural considerations, and presence of comorbidities and/or environmental factors.

3. Calculating and plotting body mass index (BMI) for all recipients on a yearly basis beginning at age 2.

Childhood obesity prevention should include promotion and support for breastfeeding, family meals, limited screen time, regular physical activity and yearly BMI monitoring.

For more detailed information regarding how to conduct these office visits, go to the Clinical Resources section of http://www.aap.org/obesity/health_professionals.html?technology=0 on the AAP website.

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- **Nov. 15, 2011:** Providers who did not re-enroll by Oct. 31, 2011, will start receiving letters terminating their National Provider Identifiers (NPIs) in the Medicaid Management Information System (MMIS).

Enrollment Tips:

- Please submit your group enrollment application along with your Qualified Behavioral Aides (QBA) and Qualified Mental Health Associates (QMHA) applications.
- In order for your group enrollment to be approved, the clinical and direct supervisors are required to be Nevada Medicaid providers.
- In the event that the group application does not meet State of Nevada Medicaid Services Manual Chapter 400 policy requirements, it will be returned. When the group application is returned, the QBA and QMHA applications will also be returned.
- An individual NPI must be linked to a group NPI per the new enrollment process; therefore, you must resubmit your QBA or QMHA applications when the group application is resubmitted.

Resources:

- Behavioral Health Provider Enrollment Frequently Asked Questions (FAQs) are online to assist providers in the enrollment and re-enrollment process. Please refer to the FAQs periodically as the document will be updated on an ongoing basis. To review the FAQs, select "Provider Enrollment" from the "Providers" menu on this website.
- The attached Prior Authorization Information Sheet offers useful tips regarding PAs submitted by provider types 14 and 82 who have enrolled on or after Sept. 1, 2010.
- The attached User Administration Console Information Sheet will assist newly enrolled and current providers who are interested in registering to use the FirstHCM/Online Prior Authorization System (OPAS) and the Electronic Verification System (EVS).

EHR Incentives – Get The Facts From CMS

There's a lot of talk right now about electronic health records and how health care professionals and hospitals are going to pay for them. Incentive payments totaling as much as **$27 billion** may be made under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs beginning in 2011.

So you probably have a lot of questions about them as well: Am I eligible to receive incentive payments? When do the programs begin? How much are the incentive payments? What do I need to participate? What are the key dates for these programs?

It's important that you have a reliable resource to turn to for accurate information. The Centers for Medicare & Medicaid Services (CMS) is the federal agency establishing these incentive programs. The CMS website is the official federal source for facts about the Medicare and Medicaid EHR Incentive Programs.

The website contains up-to-date resources that will give you the insight you need to make educated decisions.

- Use flowchart tip sheets to help determine eligibility for the incentive programs.
- Learn about the opportunities available to Medicare Eligible Professionals to receive incentive payments for participating in important Medicare initiatives, such as the Medicare EHR Incentive Program, the Physician Quality Reporting Initiative (PQRI) and E-Prescribing.
- Learn about Medicaid recipient volume requirements, payment amounts, and the time frames for the Medicaid EHR Incentive Program.
- Learn which hospitals are eligible for incentive payments, along with user-friendly information about the factors that impact incentive payment amounts and sample payment calculations.

Avoid reading false or misleading information. Get the facts from the federal source – the CMS Medicare and Medicaid EHR Incentive Programs website. Visit http://www.cms.gov/EHRIncentivePrograms today.

The Division of Health Care Financing and Policy (DHCFP) is working with CMS during planning efforts for the development of the Nevada Medicaid EHR Incentive Program. The program will provide incentives to eligible Medicaid providers who demonstrate meaningful use of certified EHR technology.

To join the Health Information Technology (HIT) email distribution list or to get more information about Nevada's HIT planning efforts, please send an email to NevadaHIT@dhcfp.nv.gov or visit https://dhcfp.nv.gov/EHRIncentives.htm.

Attention Pharmacy Providers:

CMS Changes Coverage For Compounding Ingredients

Effective Jan. 1, 2011, Nevada Medicaid will no longer cover certain compounding ingredients listed by the Centers for Medicare & Medicaid Services (CMS) as excluded from the Medicaid Drug Rebate Program.

On Aug. 11, 2010, CMS published a memo on their website announcing the removal of Active Pharmaceutical Ingredients (APIs) and Excipients as covered outpatient drugs. APIs are products commonly included in extemporaneously compounded prescriptions as the active drug component (i.e., bulk powdered drugs). The Excipients category includes many compounding bases (i.e., aquaphor).

The CMS memo may be accessed at http://www.cms.gov MedicaidDrugRebateProgram/02_State_Releases.asp and then select Downloads for Calendar Year 2010. The memo is release 155 (rel 155.pdf).

The list of newly excluded APIs and Excipients is extensive and revisions are expected to the list as CMS identifies additional products in the marketplace that meet their criteria. You may access the listing at: http://www.cms.gov/reimbursement/02_Spotlight.asp. Select the zipped file under Downloads named "API and Excipient NDCs to be Removed...," which contains two listings, one for APIs and one for Excipients.

If you frequently compound prescriptions for Medicaid recipients, you will want to review the CMS list. You should expect that claims for certain types of compounded prescriptions that have been paid in the past will now reject.

Initial Notification Of Impending Payment Error Rate Measurement (PERM) Review By Federal Contractors For FFY 2011

The Payment Error Rate Measurement (PERM) audit is a federally mandated program that measures the accuracy of Medicaid and Children's Health Insurance Program (CHIP) claims payments and managed care capitation payments. The federal oversight agency, the Centers for Medicare & Medicaid Services (CMS), uses national contractors to measure improper payments in the Medicaid and CHIP (Nevada Check Up) programs. The federal contractor, A+ Government Solutions, Inc., will request medical records from providers and conduct the claims processing and medical record review portions of the PERM audit following guidance provided by CMS.

The PERM review for Nevada will be conducted on claims paid during the period Oct. 1, 2010, through Sept. 30, 2011.

Medical records are needed to support the medical reviews conducted by A+ Government Solutions, Inc. to determine if the service provided was medically necessary and correctly paid in accordance with established policy. In order to obtain the appropriate medical record documentation for the claims selected in the PERM sampling process, A+ Government Solutions, Inc. will contact you, the provider, to verify your name and address and to determine how you want to receive the medical record request(s) (via facsimile or USPS mail). Once the provider receives the request for medical records, the provider must submit the information electronically or in hard copy within 75 days. A+ Government Solutions, Inc. will follow up to ensure that providers submit the documentation before the 75-day time frame has expired.

It is very important that providers cooperate by sending in all requested documentation. If the provider fails to submit **appropriate and sufficient** documentation to support the claim billed to and paid by the DHCFP within the 75-day time frame, the payment will be considered an error and will be recovered from the provider. Past studies indicate the largest cause of errors occurs in the medical review area and the errors are due to the provider sending either no documentation or insufficient documentation.

It is understood that providers are concerned with maintaining the privacy of recipient 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.

Billing Tips For TPL And Paper Claim Forms

The following four tips will assist providers when billing claims with Third Party Liability (TPL) using CMS-1500 and ADA claim forms:

1. Claims with two or more payors in addition to Medicaid must be billed on a paper claim form.
2. When billing claims with TPL, bill only one claim line per paper form.
3. If a recipient has TPL, the other carrier's Explanation of Benefits (EOB) showing reason codes and definitions must be attached to each paper claim.
4. If you are billing multiple claims, a copy of the EOB must be attached to each of the claims.
   a. For example, to bill four procedures when there is a primary carrier and Medicaid coverage, submit four claim forms – each with one claim line completed. Attach the primary carrier's EOB to each claim form. In this example, you would need four copies of the EOB.
   b. If four claims are submitted and an EOB is attached to only one of the claims, then the three claims without an EOB will be adjudicated without an EOB attachment.

Refer to the CMS-1500, UB and ADA claim form instructions for additional information when submitting claims with TPL.

Reminders for paper claim forms:

- Place the claim form on top of its attachment.
- Do not fold, staple or crease claims. You may use paper clips, binder clips or rubber bands to group claims and/or attachments.

2011 Provider Training Catalog And Registration Form

The 2011 Provider Training Catalog provides details about the free training offered throughout the year to Nevada Medicaid/Nevada Check Up providers and staff.

Catalog contents include the course schedule, training locations, Annual Medicaid Conference details and registration instructions.

Magellan Medicaid Administration extends a sincere thank you to those providers and staff who attended the 2010 Medicaid Conferences in Reno and Las Vegas. Magellan Medicaid Administration staff appreciates the opportunity to meet providers at the Conference and at training sessions held throughout the year.

Providers are invited to complete and submit the 2011 Training Registration Form now for any course scheduled for 2011.


2011 Training Registration Form

Attention Dental Providers (PT 22): Prior Authorization Determinations For Dental Services Are No Longer Faxed

Effective Dec. 1, 2010, determination results from prior authorization requests for dental services are no longer faxed to providers.

All determinations are mailed to the address on file and can be obtained in real time by utilizing the Electronic Verification System (EVS) via the internet or Automated Response System (ARS) via telephone. Providers who call the Magellan Medicaid Administration Dental Prior Authorization Department for their authorization determination will be referred to EVS or ARS.

You may access EVS from the menu bar that appears at the top of each page of this website (http://medicaid.nv.gov).

You may access ARS by calling (800) 942-6511.

Please do not request authorizations for services that do not require a prior authorization. Refer to the Dental Fee Schedule to determine if prior authorization is required. If a prior authorization request contains multiple service codes, Magellan Medicaid Administration will address only those codes that require prior authorization.

To avoid duplication of services, use the Dental History Request form to request a recipient's dental history.

User Administration Console: *Management Tool For Web-Based Products*

The User Administration Console (UAC) is the free, web-based registration, security and user management tool for providers who use Magellan Medicaid Administration's web-based products: the FirstHCM/ Online Prior Authorization System (OPAS), Electronic Verification System (EVS) and Pharmacy Web PA.

To get started in using the web-based products, providers or provider groups select a staff member to be their Delegated Administrator.

The Delegated Administrator will be responsible for maintaining the organization's user base, i.e., requesting access, assigning/removing user access and assigning passwords, etc. For the Delegated Administrator's roles and responsibilities and instructions on how to request access as a Delegated Administrator, review the attached UAC Information Sheet·

Access to UAC is easy. Select the "User Administration" link that is located at the top of every webpage of this website.

Additional resources are available in the UAC Reference Collection which contains an application product sheet and guides to registering, upgrading or acquiring users, and organizing users. Select "Reference" from the top of any page of the website to view the documents in the Reference Collection.

For any questions regarding UAC, call the Magellan Medicaid Administration Web Support Call Center at (800) 241-8726.

Medicaid Manual Changes

The following Medicaid Manual chapters were approved for revision and/or revised during the period September through December 2010. Please review the current Medicaid Manuals on the DHCFP website.

September 2010:
MSM 1000 - Dental
MSM 1300 - DME, Disposable Supplies and Supplements
MSM 2300 - Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities

October 2010:
MOM 1000 - Medicaid Operations Manual - Disability Determination Program

November 2010:
NA

December 2010:
MSM 100 - Medicaid Program
MSM 1200 - Prescribed Drugs
MSM 1900 - Transportation
MSM 2100 - Home and Community Based Waiver (HCBW) for Persons with Mental Retardation and Related Conditions

Quarterly Update On Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers **$382,899,280.69** in claims during the three-month period of July, August and September 2010.

Nearly 100 percent of current claims continue to be adjudicated within 30 days. The DHCFP and Magellan Medicaid Administration thank you for participating in Nevada Medicaid and Nevada Check Up.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact Magellan Medicaid Administration by calling (877) 638-3472.

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 "Policy and Rate Staff contacts." Follow the instructions to find the person at DHCFP who can answer your question. You can either call the contact person or send an email.