Nevada Medicaid News

First Quarter 2011
Volume 8, Issue 1

Nevada Medicaid and Nevada Check Up
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Is Your Renewed License In Your Provider Enrollment File?

Providers are responsible for ensuring that all professional licenses relevant to their Medicaid enrollment on file with Magellan Medicaid Administration, Inc. are current. As providers may be aware, the Division of Health Care Financing and Policy (DHCFP) and Magellan Medicaid Administration have been sending letters to providers regarding expired licenses.

If you receive a letter requesting a copy of a renewed license, please respond on or before the date indicated on the letter. Failure to respond to the request by the date indicated on the letter may result in the termination of the Medicaid contract. Please fax or mail a copy of the letter with your license. If you do not have the letter, please indicate your NPI on your cover sheet.

Don't wait for your letter to arrive. Please fax or mail a copy of your renewed license to Magellan Medicaid Administration. Indicate your NPI on your cover sheet.

Attention Nursing Facilities: Billed Admit Date Must Identify Most Recent Episode Of Care

Nursing Facility claims must reflect the recipient's *most recent* admission date in UB-04 Field 12 (Admission/Start of Care Date). For example, if a recipient is admitted on Jan. 1, discharged on Jan. 15 and then re-admitted on Jan. 18, the admission date in Field 12 for the *first* episode of care must be Jan. 1 and the admission date in Field 12 for the *second* episode of care must be Jan. 18.

Entering an admission date in Field 12 for a previous episode of care wrongfully signifies that the recipient has been in the Nursing Facility the entire date span with no discharge days (e.g., using the Jan. 1 admission date for services rendered on the episode of care beginning Jan. 18). Entering the wrong date causes payment delays for hospitals and other acute care facilities that provided service on the days the recipient was not in the Nursing Facility. Errors of this type may result in a review by the Surveillance and Utilization Review unit and recoupment of the incorrectly billed claim.

A Message From DHCFP Regarding Prevention: *Family Planning Services*

State and federal regulations grant the right for eligible Medicaid recipients of either sex and of child-bearing age to receive family planning services provided by any participating clinic, physician, physician's assistant, nurse practitioner, certified nurse midwife or pharmacy.

Family planning services and supplies are for the primary purpose of preventing and/or spacing pregnancies. Family planning education is also for the purpose of encouraging children and youth to become comfortable with discussing issues such as sexuality, birth control, prevention of sexually transmitted diseases and early intervention of teen pregnancies.

When discussing and educating your recipients, ensure you bill the counseling session appropriately using CPT code 99401 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes).

When discussing birth control options with your Medicaid recipients, please also inform them that depending on which form of birth control they use, if it is long term, i.e., intrauterine contraceptive device (IUD) or implanted contraception capsules/devices, that they will be financially responsible for the removal of it if they are no longer Medicaid eligible.

For more information, see Medicaid Services Manual, Chapter 600, Physician Services, Section 603.3 Family Planning Services as well as the Billing Information on Magellan Medicaid Administration's Nevada Medicaid website.

You may also contact the DHCFP Program Specialist with questions by sending an email to Alexis Ulrich at Alexis.Ulrich@dhcfp.nv.gov.

Re-Enrollment Is Under Way For Behavioral Health Provider Types 14 And 82

The re-enrollment process for Behavioral Health provider types (PTs) 14 (Behavioral Health Outpatient Treatment) and 82 (Behavioral Health Rehabilitative Treatment) is under way. By Oct. 31, 2011, each group and all individual service providers linked to each group must submit a new Provider Enrollment Application and Contract and the appropriate documents required per the Enrollment Checklists. Please submit the group and individual Provider Enrollment Packets together.

PTs 14 and 82 must have a group National Provider Identifier (NPI) to enroll/re-enroll in Nevada Medicaid. Atypical Provider Identifiers (APIs) are no longer assigned to PTs 14 and 82 and APIs for these providers will terminate in the Medicaid Management Information System (MMIS) effective Oct. 31, 2011.

PTs 14 and 82 may not request prior authorizations (PAs) using an API on and after Aug. 1, 2011. Requests for PA with an API will be returned to the provider beginning Aug. 1.

When you have completed the enrollment/re-enrollment process (all individual service providers' NPIs have been linked to the group/billing NPI), you are ready to obtain prior authorization (PA) with your group/billing NPI regardless of the service being requested. Once you have re-enrolled, if your active PA was authorized with a group API, then bill the claim with that group API. If your active PA was authorized with an NPI, then bill the claim with the NPI of the rendering and billing providers. Please review the CMS-1500 Claim Form Instructions for proper use of NPIs/APIs on claims.

NPIs of providers who do not re-enroll will terminate in the MMIS effective Oct. 31, 2011, and providers will receive a letter indicating the termination.

Submission of a re-enrollment application does not guarantee the provider's current enrollment will continue. If it is found that providers/groups do not meet the criteria for their provider type and/or specialty, their re-enrollment will be denied and their current enrollment will be terminated.

Note: Provider qualifications required for services provided remain unchanged and are specified in the Medicaid Services Manual (MSM) Chapter 400. For example, code H2017 for psychosocial rehabilitation services must still be provided by either a QMHP or QMHA.

Electronic Health Record (EHR) Incentive Program

Are you unsure which Electronic Health Record (EHR) Incentive Program is right for you? The Centers for Medicare & Medicaid Services (CMS) has resources to help you make this important decision. Learning more about the Medicare and Medicaid EHR Incentive Programs and how they differ can help you make an informed decision.

Here are a few key differences between the Medicare and Medicaid EHR Incentive Programs.

For Eligible Professionals:

- The maximum payment for Eligible Professionals (EPs) registering for the **Medicare** program is $44,000, with a possible 10% increase for EPs in a health professional shortage area.
- The maximum payment for EPs registering for the **Medicaid** EHR Incentive Program is $63,750.
- EPs must demonstrate meaningful use for each year of participation in the Medicare program to receive payments.
- The Medicaid program begins providing payments in the first year after EPs adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.
- For the second through the sixth years of participation in the Medicaid program, EPs must demonstrate meaningful use to receive payments.

For Eligible Hospitals and Critical Access Hospitals:

- Under the Medicare EHR Incentive Program, eligible hospitals (EHs) and critical access hospitals (CAHs) can begin receiving incentive payments in any year from FY 2011 to FY 2015, but payments decrease for hospitals beginning to receive payments in 2014 or later.
- With the Medicaid EHR Incentive Program, EHs and CAHs can begin receiving incentive payments in any year from FY 2011 to FY 2016.
- Children's hospitals, cancer hospitals or acute care hospitals in the U.S. territories are only eligible for the Medicaid EHR Incentive Program.

More information for all Eligible Participants:

To see more differences between these two programs, check out the EHR Incentive Programs Comparison Chart on the CMS EHR Incentive Programs website. We encourage you to review the comparison chart to find the right EHR Incentive Program for you, and to use the Eligibility Wizard to determine which program you are eligible for.

Some states launched their Medicaid EHR Incentive Programs beginning Jan. 3, 2011, but most states will launch their programs during the spring and summer. 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. To join the email distribution list or to get more information about Nevada's Health Information Technology (HIT) planning efforts, please send an email to NevadaHIT@dhcfp.nv.gov or visit https://dhcfp.nv.gov/EHRIncentives.htm.

Provider assistance through the Regional Extension Center:

The HealthInsight Regional Extension Center (REC) is pleased to support providers engaging in the Medicare and Medicaid EHR Incentive Programs. HealthInsight can provide direct, subsidized assistance to providers' offices to help them meet the requirements.

HealthInsight REC services include:

- Providers' needs and goals assessment;
- EHR vendor selection assistance: Needs analysis, evaluation guidance, vendor relationship management;
- Workflow analysis: Map out and improve current work processes through the use of EHR;
- Project management and implementation: Planning resources;
- Plan development: Address deficiencies and reach meaningful use requirements;
- Privacy and security best practice: Policy and procedures templates; and
- Health information exchange: Connection assistance.

Limited-time offer for free REC services:

To encourage participation in the REC program, HealthInsight will be waiving fees for priority primary care providers to work with the REC to achieve the first year meaningful use criteria. Fees for specialists are still in effect and fees will be reinstated for primary care providers for meaningful use stages 2 and 3.

Contact the REC team at (800) 483-0932 or REC@HealthInsight.org, or for more information visit the HealthInsight REC website.

Tips To Assist In Submitting Clean Claims

The following tips for paper claim forms will assist providers in avoiding common errors that may delay claim adjudication or cause claims to deny:

- National Provider Identifiers/ Atypical Provider Identifiers (NPIs/APIs) must be on the claim form and must be entered correctly in ADA Fields 49 and 54, CMS-1500 Fields 24J and 33a/33b and UB-04 Fields 56 and 76/77.
- The 9-digit zip code must be listed in the provider address field.
- Adjustments and voids cannot be submitted for denied claims. You can adjust/void previously paid claims (including zero paid claims), not denied or pended claims.
- Notes must not be entered in fields on the claim forms. All notes are to be on a separate 8½-by-11-inch sheet of paper attached to the claim.
- Multiple lines cannot be billed on the ADA and CMS-1500 claim forms when there is other insurance or Medicare (Third Party Liability – TPL) available. Use only one line per claim.
- 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.
- The total billed (balance due field) after TPL cannot be more than the recipient's legal obligation to pay. Do not include write-off, contractual adjustment or behavioral health reduction amounts.
- CMS-1500 Field 24I is a required field. Providers billing with an NPI must enter the "ZZ" ID qualifier and providers billing with an API must enter the "N5" qualifier.
- "From" and "To/Through" dates must be entered in CMS-1500 Field 24A or UB-04 Field 6 even if they are the same date.
- Multiple lines cannot be billed for an adjustment/void on the ADA and CMS-1500. Use only one line per claim.
- When adjusting a claim, do not put the Medicaid payment in the Amount Paid (CMS-1500 Field 29), Remarks (ADA Field 35) or Prior Payments (UB-04 Field 54) fields.
- The billing provider or authorized representative must sign and date CMS-1500 Field 31 or ADA Field 53. Original, rubber stamp and electronic signatures are accepted.
- Occurrence codes must be used correctly in UB-04 Field(s) 31-36.
- Code "0099" must be used on UB-04 Field 42, Line 23 on multiple-page claims. "0099" signifies that there is another page to the claim. Use code "0001" on UB-04 Field 42, Line 23 to indicate the last page of a multiple-page claim.

Reminders:

- Recipient eligibility can change from month to month. Always check eligibility before rendering service.
- Claim Form Instructions and Billing Guides for each provider type are online at https://medicaid.nv.gov to assist providers and billing staff.

Updated Version Of Clinical Claim Editor Incorporated Into MMIS

The Division of Health Care Financing and Policy (DHCFP) and Magellan Medicaid Administration 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 has been updated to include the 2011 Common Procedural Terminology (CPT) standard billing and coding practices. Previous to the update, the criteria was based on 2009 and 2010 CPT billing and coding guidelines.

The current update affects any claims processed on and after March 21, 2011, regardless of date of submission or date of service.

CMS Proposed Rule For Medicaid Payment Adjustment For Provider-Preventable Conditions

The Division of Health Care Financing and Policy (DHCFP) has begun work to implement a Proposed Rule prohibiting Medicaid from paying for care associated with provider-preventable conditions (PPCs). The final rule, mandated by the Affordable Care Act, will be effective as of July 1, 2011. The new regulation follows a concept similar to reduced payments for hospital-acquired conditions (HACs) by the Medicare program.

Although cost savings is a driver, nonpayment policies are directed toward improving recipient safety through eliminating payment for poor quality care that harms recipients. The concept behind the provision is that public programs should not pay for treating a health problem arising from a recipient's care at a facility if the secondary problem could reasonably have been avoided.

For this regulation, the Centers for Medicare & Medicaid Services (CMS) coined the umbrella term PPC to include hospital and non-hospital acquired conditions. The term HAC is very narrowly defined in statute as conditions identified for Medicare within inpatient hospital settings. The new rule for Medicaid broadens application of the regulation to other types of providers.

Two categories of PPCs are proposed: HACs and Other Provider-Preventable Conditions (OPPCs), which are conditions that states identify and have approved through their Medicaid State Plans. CMS has suggested states choose OPPCs based on these guidelines: Conditions and events should be discrete, auditable, quantifiable and clearly defined; the condition or event must be clearly adverse; and the condition or event must be reasonably preventable.

Medicare HACs will be included in the regulation and include:

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- State III and IV pressure ulcers.
- Falls and trauma manifestations of poor glycemic control.
- Catheter-associated urinary tract infection.
- Surgical site infection following certain procedures.
- Deep vein thrombosis/pulmonary embolism following certain procedures.

The proposed rule requires that providers report conditions identified for non-payment when they occur, regardless of a provider's intention to bill. It also proposes that existing claims systems be used as a platform for provider self-reporting.

CMS recognized that some states may need to isolate the increased cost of the services (possibly through a utilization review) and reduce the per diem rate accordingly.

Look for upcoming Public Workshops to provide your input.

Provider Training Benefits New And Experienced Staff

Magellan Medicaid Administration's free, year-round provider training benefits new staff and is a useful refresher course for staff members who have billing experience.

Office managers, billing staff, billing agencies, direct practitioners/health care providers, admitting and front-desk staff are all encouraged to attend the training.

Sessions provide information that will assist providers in avoiding simple errors on prior authorization requests, claims and appeals. For example, the training sessions will provide direction on the appropriate National Provider Identifier/Atypical Provider Identifier (NPI/API) to use on prior authorization requests. If the wrong NPI/API is used on a prior authorization request, the provider must submit a data correction, which may take 30 days or longer to process. The provider cannot bill the claim until the data correction is processed, which ultimately delays the claim adjudication.

Other valuable topics included in each training session are timely filing, recipient eligibility, remittance advices, adjustments/voids, Third Party Liability (TPL) and much more.

Review the 2011 Provider Training Catalog for course schedule, training locations and registration instructions.

Registration is required. Please complete and submit the 2011 Training Registration Form to register for the courses you would like to attend.

Reminder To All Providers Regarding Social Security Act Violations

Under section 1128A(a)(5) of the Social Security Act (the Act), enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a person who offers or transfers to a Medicare or Medicaid beneficiary/recipient any remuneration that the person knows or should know is likely to influence the beneficiary's/recipient's selection of a particular provider, practitioner or supplier of Medicare or Medicaid payable items or services, may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act.

All Nevada Medicaid providers are subject to audits and reviews conducted by various state and federal agencies. Should a violation of 1128A(a)(5) of the Act be identified during an audit or review, the provider may be referred to the federal Department of Health and Human Services' Office of Inspector General (OIG) for prosecution and/or exclusion from participating in any federal healthcare programs.

Report Your Change Of Address

Please ensure that all provider address information on file with Magellan Medicaid Administration is current. Mail is not forwarded to a provider's new address.

In accordance with Medicaid Services Manual (MSM) Chapter 100, Section 103.3, providers are required to report in writing within five (5) working days any change in ownership, address, addition or removal of a practitioner or any other information pertinent to the receipt of Medicaid funds.

Use form FA-33 to report provider changes. When reporting a change of address, be sure to indicate which address you are updating. Magellan Medicaid Administration can record a service address, mail-to address, remittance advice address and pay-to address for each provider.

Failure to report provider changes and/or provider mail returned to Nevada Medicaid or Magellan Medicaid Administration due to change of address may result in the termination of the Medicaid contract.

ARS: A Useful Tool To Answer Your Claims Status Questions

The Automated Response System (ARS) is Magellan Medicaid Administration's automated system that provides access to claim status, recipient eligibility, provider payments, prior authorization status, service limits and prescriber IDs via the telephone.

To access ARS, call (800) 942-6511.

Quarterly Update On Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers **$401,978,628.07** in claims during the three-month period of October, November and December 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 "Main Phone Numbers." Call the Administration Office of the area you want to contact.