Welcome

Annual Medicaid Conference
October 2012

Introductions:
Coleen Lawrence, DHCFP

Opening Remarks:
Coleen Lawrence, DHCFP
Connie Anderson, DHCFP
Donna Perkins, HPES

©2011 Hewlett-Packard Development Company, L.P.
The information contained herein is subject to change without notice.

Welcome

- Welcome — Coleen Lawrence, CPM, MSSL
  DHCFP, Chief, Program Services

  Connie Anderson, BA, MRA
  DHCFP, Chief, Continuum of Care

- Housekeeping And Evaluations — Donna Perkins
  HPES, Account Operations Manager

Conference Agenda - Morning

Registration	7:30 – 8:15	
General Session	8:30 – 8:40	Welcome
General Session	8:40 – 9:00	What's New
General Session	9:00 – 9:15	Provider Re-Enrollment Review
General Session	9:15 – 9:25	EPSDT
General Session	9:25 – 9:35	Appeals and Hearings
General Session	9:35 – 10:00	SUR, RAC, Medicaid Fraud
Break	10:00 – 10:15	
Breakout Session	10:15 – 12:00	Personal Care Services
Breakout Session	10:15 – 12:00	Skilled Nursing
Breakout Session	10:15 – 12:00	Behavioral Health
Breakout Session	10:15 – 12:00	Physician
Breakout Session	10:15 – 12:00	Hospital
Breakout Session	10:15 – 12:00	Dental

Conference Agenda - Afternoon

Registration	12:30 – 1:15	
General Session	1:30 – 1:40	Welcome
General Session	1:40 – 2:00	What's New
General Session	2:00 – 2:15	Provider Re-Enrollment Review
General Session	2:15 – 2:25	EPSDT
General Session	2:25 – 2:35	Appeals and Hearings
General Session	2:35 – 3:00	SUR, RAC, Medicaid Fraud
Break	3:00 – 3:15	
Breakout Session	3:15 – 5:00	Personal Care Services
Breakout Session	3:15 – 5:00	Skilled Nursing
Breakout Session	3:15 – 5:00	Behavioral Health
Breakout Session	3:15 – 5:00	Physician
Breakout Session	3:15 – 5:00	Hospital
Breakout Session	3:15 – 5:00	Dental

What's New?

- Division of Health Care Financing and Policy Administrator
- Health Care Reform
- ICD-10
  http://www.cms.gov/Medicare/Coding/ICD10
- National Correct Coding Initiative (NCCI)
  http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/

Guest Vendors

Third Party Liability (TPL) Identification and Recovery
Emdeon/Envoy
(855) 528-2596

Pharmacy
Catamaran
Prior Authorization: (855) 455-3311
Technical/General Inquiries: (866) 244-8554

Electronic Health Records (EHR) Incentive Program
CGI Business Services
(888) 639-3452

Recovery Audit Contractors (RAC)
Health Management Systems (HMS)
(877) 248-8523

Electronic Claims Submission Provider
Allscripts/Payerpath
(877) 638-3472

Thank you for your attendance!

The conference evaluation is electronic this year. Please use the link below to access the evaluation. After the conference, you will receive an email containing this link.

https://www.surveymonkey.com/s/PP82286

The evaluation will be open until November 16.

Provider Re-enrollment

Annual Medicaid Conference
October 2012

Presented by: Jennifer Frischmann
DHCFP
and
Jo Mallard
HPES

©2012 Hewlett-Packard Development Company, L.P.
The information contained herein is subject to change without notice

Benefits of Re-enrollment

- Speeds payment to providers
- Ensures provider contact information is current
- Tracks if provider is accepting new Medicaid recipients
- Obtains new signature on Provider Contract

Provider Re-enrollment Process

- Provider identified from oldest enrollment to newest (most recent)
- 1/36 of providers will be contacted each month
- 60-day letter
- 20-day letter
- Validation and entry of re-enrollment information into Medicaid Management Information System (MMIS)

Why Does Enrollment Matter?

- First step in preventing fraud, waste and abuse
- Helps ensure qualified and trusted individuals are providing services
- Prevents access to care issues

Impact from Patient Protection and Affordable Care Act (PPACA)

- Enhanced screening
- Unscheduled or unannounced site visits
- Fingerprint-based criminal background checks
- National Provider Identifier (NPI)
- Temporary Moratoria
- Revalidation

Screening

- **Limited** - License verification, database checks
- **Moderate** - Unannounced site visits
- **High** - Criminal background check, fingerprinting

Frequently Asked Questions

Nevada Medicaid and Nevada Check Up Provider Enrollment - Windows Internet Explorer

File Edit View Favorites Tools Help

http://www.medicaid.nv.gov/providers/enroll.aspx

Favorites Web Slice Gallery

athp - Home | Nevada Medicaid and ...

Page Safety Tools

Nevada Department of Health and Human Services

Division of Health Care Financing and Policy Provider Portal

Wednesday 06/20/2012 01:23 PM PST

Transition Info | Site Map

Home | Providers | EVS | Pharmacy | Prior Authorization | Quick Links | Contact Us

Notification

Enhancements were implemented in the online prior authorization and electronic verification systems on February 20, 2012. For more information, see Web Announcement 451.

Provider Enrollment

- Provider Re-Enrollment Frequently Asked Questions (FAQs) (Updated April 11, 2012)
- Behavioral Health Provider Enrollment Frequently Asked Questions (FAQs) (Updated April 15, 20
- Prior Authorization Information Sheet For Behavioral Health Provider Types 14 And 82 (Updated Feb. 21, 2011)
- QMHA Education and Professional Work Experience Requirements

http://www.medicaid.nv.gov/providers/enroll.aspx

For More Information

Homepage of Provider Web Portal:

- www.medicaid.nv.gov

Under "Providers" tab select "Announcements/Newsletters":

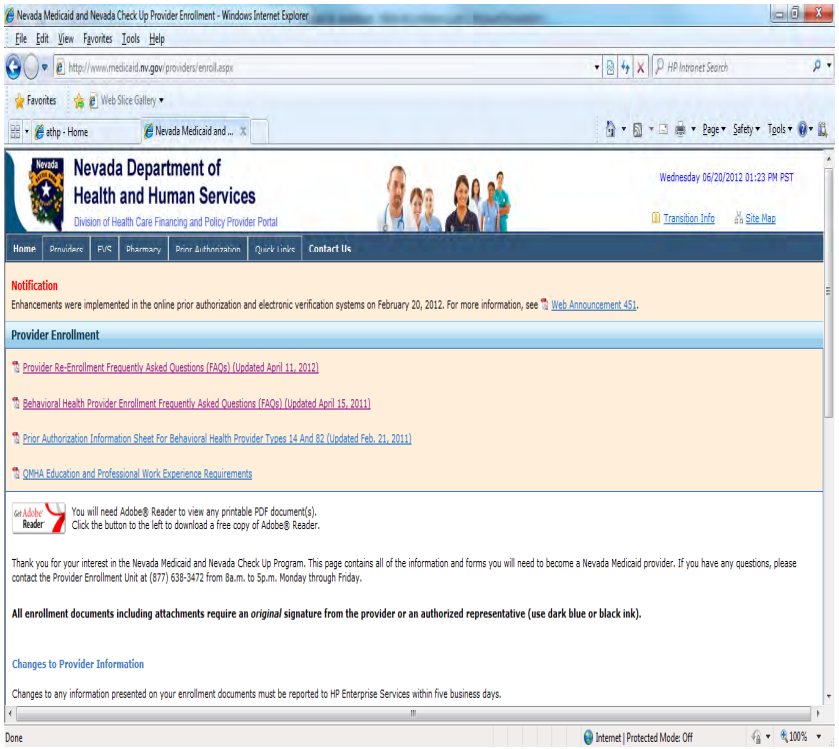
- Web Announcement #450
- Quarterly Provider Newsletters

Under "Providers" tab, select "Provider Enrollment":

- Provider Re-enrollment FAQs
- Provider Enrollment Application and Contract (*Provider Enrollment Packet*)
- Enrollment Checklists

Customer Service Center:

- Phone: (877) 638-3472
  - Option 2, then Option 6 for Provider Enrollment



Reminders

- Watch for re-enrollment notification
- Download the Enrollment Application and Contract (Provider Enrollment Packet)
- Download the appropriate Checklist for your provider type and specialty
- Submit the enrollment packet within the requested time frame

EPSDT

Annual Medicaid Conference
October 2012

Presented by: Marti Cote
DHCFP

©2012 Hewlett-Packard Development Company, L.P.
The information contained herein is subject to change without notice

See Separate Handout

Appeals and Fair Hearings

Annual Medicaid Conference
October 2012

Presented by: DHCFP and HPES

©2012 Hewlett-Packard Development Company, L.P.
The information contained herein is subject to change without notice

Difference between Appeal and Fair Hearing

- An **Appeal** is the process available through HP Enterprise Services (HPES) to allow a provider an opportunity to dispute a denied claim

- A **Fair Hearing** is the process available through the Division of Health Care Financing and Policy (DHCFP) and is available only *after* the Appeal process has been exhausted

What is an Appeal?

- An Appeal is a request for a denied claim to be reconsidered
- Appeals must be postmarked within 30 days from the date of the remittance advice (RA) showing the denied claim
- Always refer to the Provider Billing Manual for the most accurate up-to-date information regarding Appeals

HPES reviews appeals

- After an Appeal has been filed, you may receive the following letters:

  1. Received
  2. Rejected
  3. Approved
  4. Denied

Appeal received

- Upon receipt of the Appeal, HPES will send a notice of receipt

Notice of Receipt: Appeal Received

Notice Date: 5/29/2012

, NV

Attention:
Provider NPI/API:
Appeal Number:

Appeal Received

We have received your appeal for the claim with Internal Control Number(s) for recipient on dates of service:

-

Your appeal was received on . We will review and respond to your appeal within 30 days from the date received.

If you have questions, please call our Customer Service Center at (877) 638-3472

Thank you,

HP Enterprise Services
Appeals Unit

Appeal rejected

- This example is for an Appeal that has been rejected. The rejection reason would be stated in the letter.

Notice: Appeal Rejected

Notice Date: 5/29/2012

, NV

Attention:
Provider NPI/API:
Appeal Number:

Appeal Rejected

Your request for appeal has been rejected for the reasons specified below. Appeal procedures are discussed in the Provider Billing Manual at http://medicaid.nv.gov (select *Billing Information* from the Provider's menu) and in the Medicaid Services Manual, Chapter 100. If you have any questions, please call (877) 638-3472.

Appeal approved

- This Notice of Decision (NOD) shows that the Appeal has been approved. The appealed edit will be reprocessed.

- IMPORTANT: Payment is not guaranteed, because other edits could prevent payment.

Notice of Decision: Appeal Approved

Notice Date: 5/29/2012

, NV
Attention:
Provider NPI/API:
Appeal Number:

Appeal Approved

HP Enterprise Services has approved your appeal for the claim with Internal Control Number for recipient on date(s) of service:
-

We will reprocess this claim and the results will be shown on a future remittance advice.

If you have any questions, please call the Customer Service Center at (877) 638-3472.

Thank you,
HP Enterprise Services
Provider Appeals Unit

Appeal denied

- This NOD shows that the Appeal has been denied and explains why it was denied
- The second page contains Frequently Asked Questions about Hearing Preparation Meetings and Fair Hearings

Notice of Decision: Appeal Denied

Notice Date:
5/29/2012

, NV

Attention:
Provider NPI/API:
Appeal Number:

Appeal Denied

After a thorough review, HP Enterprise Services has denied your appeal for the claim with Internal Control Number for recipient on dates of service:

Your appeal was denied for the following reasons:

If you do not agree with this decision, you may request a Fair Hearing by submitting:
(1) copy of this letter with the bottom portion completed,
(2) a copy of the remittance advice pages showing the denial,
(3) a copy of the original signed claim and
(4) supporting documentation (such as prior authorization, physician's notes, ER reports).

Mail this information to: Hearings Supervisor, Nevada Medicaid, 1100 E. Williams St. Ste. 102, Carson City, NV 89701. Fair Hearing requests must be received within 90 days of this notice. The day after the Notice Date shown above is the first day of the 90-day period. At the Fair Hearing, you will be represented by yourself or by legal counsel.

I hereby request a Fair Hearing in regards to the denial of the claim listed above.
Name: _____
Contact Phone: _____
Provider's Legal Counsel (if applicable):
_____
Legal Counsel's mailing address:
_____
Legal counsel's phone:
_____
Signature_____
Date: _____

Next Steps for a Denied Appeal

- If the Appeal is denied, the NOD explains how the provider can request a Fair Hearing
- A NOD will give the provider a list of the required documents and the address at the DHCFP to send the request for a Fair Hearing
- If the provider requests a Fair Hearing, the request must be received by DHCFP within 90 days from the date of the NOD

Request for a Fair Hearing

A Fair Hearing request to DHCFP must include:

- NOD, with the bottom portion completed
- Copy of the denied claim
- Copy of the RA from which the denied claim is included
- Any supporting documentation you want to be considered

Reference Medicaid Services Manual (MSM) Chapter 3100

Other Fair Hearing Subjects

- Fair Hearings can also be requested for the following issues (not all inclusive):
  - Provider Contract Termination
  - Overpayment Amount/Recoupment
    - *Surveillance and Utilization Review (SUR)*
    - *Recovery Audit Contractor (RAC)*
    - *Payment Error Rate Measurement (PERM)*

- Notification letter will not look like an Appeal NOD, but rather a letter from the DCHFP or other Auditing Contractor. Information on how to request a Fair Hearing is provided within the documentation.

Hearing Preparation Meeting (HPM)

- When a request for a Fair Hearing is received by DHCFP, a Hearing Preparation Meeting (HPM) is scheduled
- The HPM will take place telephonically
- The HPM is an informal discussion to allow a provider an opportunity to explain why they believe their claim should not have been denied

Fair Hearing

- A Fair Hearing is a formal proceeding before an Administrative Hearing Officer
- A Fair Hearing is available only when the Appeal process through HPES has been exhausted
- DHCFP has an inter-local contract with the Department of Administration to conduct the Fair Hearings
- Reference Medicaid Services Manual (MSM) Chapter 3100 Hearings

Fair Hearing, continued

At a Fair Hearing, providers may:

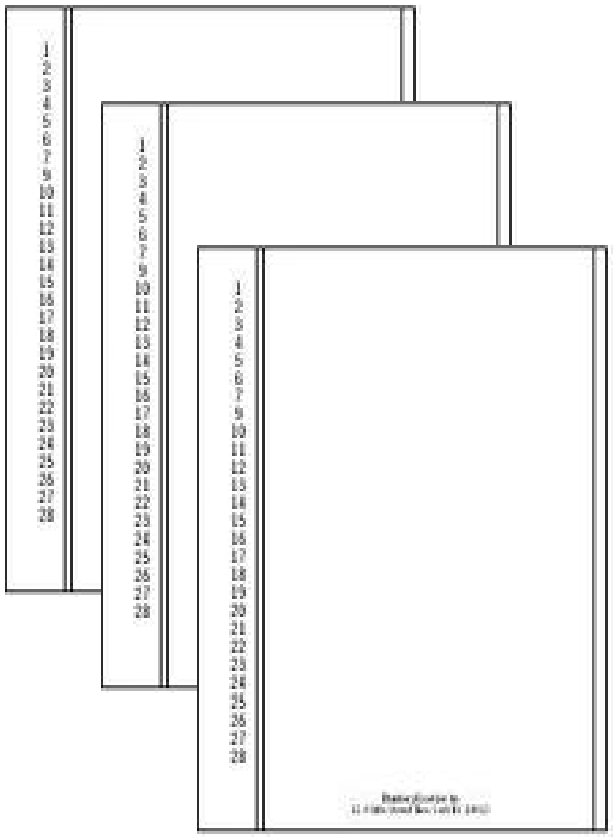
- represent themselves, or
- designate someone to represent them, or
- have an attorney represent them

A Fair Hearing:

- is a formal legal proceeding
- includes documents submitted into a public record
- includes sworn testimony by witnesses from both parties

Hearing Officer's Decision

- At the conclusion of the Fair Hearing, the Hearings Officer will close the record and render a final decision within 30 days
- A copy of the Hearing Officer's Decision is provided to both parties
- An unfavorable decision may be petitioned for Judicial Review by either party
- Reference Nevada Revised Statute (NRS) 422.306



Summary of processes

Step 1: Appeal

MSM – 105.2c.1a
Letter addressing specific reason for the appeal, including:

- Name and NPI/API, ICN of the claim, the recipient's name and Medicaid ID; and
- Number, the date of service and the name and phone number of the person to be contacted regarding the appeal; and
- Documentation to thoroughly support the appeal request; and
- A copy of the Remittance Advice showing the denied claim; and
- An original signed paper claim that may be used for processing should the appeal be approved.

Step 2: Fair Hearing

- Available to any provider who wants to dispute a denied Appeal
- Request for a Fair Hearing is made to the DHCFP
- Providers **must** exhaust the fiscal agent's appeal process prior to pursuing a Fair Hearing

Step 3: Judicial Review

- Process available to either party dissatisfied with the outcome of the Fair Hearing

Reminders:

For the most up-to-date information regarding provider Appeals and Fair Hearings, always refer to:

- Provider Billing Manual on the HPES website (www.medicaid.nv.gov)
- Medicaid Services Manual Chapter 100 Medicaid Program and Chapter 3100 Provider Hearings section on the DHCFP website (https://dhcfp.nv.gov)

Questions?

Contact information

Customer Service Center

Claim inquiries and general information

Phone: (877) 638-3472

Automated Response System (ARS)

Phone: (800) 942-6511

Requests for Provider Training

Email: NevadaProviderTraining@hp.com

Program Integrity within the Medicaid Program

Be Aware of Medicaid Fraud

Presented by DHCFP and HPES

©2011 Hewlett-Packard Development Company, L.P.
The information contained herein is subject to change without notice.

Program Integrity

- The proper management of Medicaid funding to ensure correct payments are made to legitimate providers for appropriate and reasonable services for eligible recipients

- Strong program integrity helps assure that Medicaid funds are channeled appropriately to those who need and are eligible for the services

Definition of Fraud

- Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

  (42 CFR 455.2)

Definition of Abuse

Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices and result in:

- An unnecessary cost to the Nevada Medicaid or Nevada Check Up programs, or
- Reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care

It also includes recipient practices that result in unnecessary cost to the Medicaid or Nevada Check Up programs. Recipient cases are referred to the Division of Welfare and Supportive Services Investigations and Recovery unit.

Definition of Improper Payment

An improper payment is any payment that is billed to or paid by the Division of Health Care Financing and Policy (DHCFP) that is not in accordance with:

- *Nevada Medicaid or Nevada Check Up policy governing the service provided*
- *Fiscal agent billing manuals*
- *Contractual requirements*
- *Standard record keeping requirements of the provider discipline*
- *Federal law or state statutes*

An improper payment can be an overpayment or an underpayment

Examples of Fraud and Abuse (not all inclusive)

- Billing for services that were not provided or received
- Billing for a higher level of service than was actually performed (up-coding)
- Payments for unbundled services when an all-inclusive bundled code should have been billed
- Payments not in accordance with applicable pricing or rates
- Data entry errors resulting in incorrect payments
- Duplicate payments
- Payments for non-medically necessary services
- Payments for an incorrect number of units billed
- Payments that cannot be substantiated by appropriate or sufficient medical or service record documentation

Program Integrity Programs

The DHCFP has several programs in place to protect the fiscal integrity of the Nevada Medicaid program from fraud and abuse.

- *Surveillance and Utilization Review (DHCFP)*
- *Recovery Audit Contractors (contracted with DHCFP)*
- *Medicaid Integrity Contractors (contracted with CMS)*
- *Payment Error Rate Measurement (PERM)*
- *Financial Compliance Audit (DHCFP)*
- *Medicaid Fraud Control Unit (The Office of the Attorney General)*

Surveillance and Utilization Review (SUR)

- Statewide program to safeguard against unnecessary or inappropriate use of services
- Prevent, detect and recover provider overpayments in the Nevada Medicaid and Nevada Check Up programs
- Develop statistical provider profiles
- Analyze claims data to identify potential fraud, waste, over-utilization and abuse
- Collect provider overpayments or improper billing
- Refer appropriate cases to Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution

Fraud and Abuse Referrals/Complaints

Conduct reviews of potential fraud and abuse based on complaints, referrals and data mining

- Referrals/complaints are received from various sources
  - **Medicaid patients**
  - **Medicaid provider employees**
  - **Other governmental entities**
    - *Medicaid District Offices*
    - *Medicaid Central Office*
    - *Fiscal Agent (HP)*
    - *Medicaid Fraud Control Unit (MFCU)*
    - *Office of Inspector General*
- Referrals/complaints are received via phone, email, fax or letter

Data Mining Software

- The DHCFP is in the process of implementing data mining software that will show outliers from their peers
- This software, among other things, will show high utilization, procedures that should be bundled, high modifier usage and other areas of possible fraudulent billings

Review Process

- Reviews include:
  - Policy review
  - Claim payment review
  - Review of outliers
    - » Spikes in payment for certain provider types
    - » High use of specific codes
    - » Review of high-risk claims (provider types known for fraudulent practices)
    - » Review of procedures/codes paid at a percentage of billed charges

Recovery Audit Contractors (RAC)

- A mandate issued by the Affordable Care Act effective January 1, 2012, requires states to contract with one or more RACs to reduce improper Medicaid payments through the efficient detection and collection of overpayments and the detection of underpayments
- States must establish these programs in a manner consistent with state law, and generally in the same manner as the Medicare RAC program
- DHCFP has contracted with Health Management Systems (HMS)
- Audit results are sent to the affected providers for review and comment
- If an overpayment is discovered, HMS will send a recoupment letter to the provider and will collect the overpayment

Medicaid Integrity Contractors (MIC)

- The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP)
  - *A major function of the MIP is creation of the contracts with the Medicaid Integrity Contractors (MICs)*
- MICs are contracted directly with the Centers for Medicare & Medicaid Services (CMS) to conduct data mining activities and provider audits
- Audit results are sent to the affected providers, CMS and to the DHCFP SUR unit for review and comment
- If an overpayment is discovered, the SUR unit will send a recoupment letter to the provider and will pursue collection of the overpayment.

Payment Error Rate Measurement (PERM)

- The Improper Payments Information Act of 2002 (IPIA) requires the CMS to estimate improper payments in all state Medicaid and state Children's Health Insurance Programs (Nevada Check Up)
- PERM reviews consist of a thorough analysis of recipient eligibility, claims processing and medical record or service documentation
- CMS requires each state to undergo a PERM review once every three years
  - *Nevada was reviewed in federal fiscal year 2011 and will be reviewed every third year thereafter*

Financial and Policy Compliance

- DHCFP staff will conduct regular financial and policy compliance reviews/audits of programs and services provided under the Medicaid and Nevada Check Up programs
- These audits consist of a thorough review of program policy, claims processing and/or medical or service record documentation

Recoupment and Corrective Actions

The DHCFP may take one or a combination of the following actions:

- *Full or partial suspension of payment until the review/audit/investigation is complete*
- *Educational contact*
- *Warning letters*
- *Special requirements imposed as a condition of participation*
- *Recoupment*
  - Recoupments can go back **6 years** from the date the claim was adjudicated.
- *Termination of the Medicaid Provider Contract*

Referrals to the Medicaid Fraud Control Unit (MFCU)

If evidence of criminal intent is found in any of the reviews, the case is referred to the MFCU for investigation

Examples:

- Falsification of provider timesheets
- Providers billing for an improbably high number of services or recipients per day

  Example: Billing for services that were demonstrably not provided to the recipient

- Forgery of documents by providers

Other PI Actions

Program Integrity also encompasses a variety of other functions, such as:

- *Detecting areas where Medicaid regulations can be improved*
- *Finding contradictions in policy*
- *Administering the provisions of the Federal and Nevada False Claims Acts*
- *Participate in provider training to discuss fraud and abuse prevention*

SUR Contact Information

If you suspect that a provider is receiving improper payments, please contact the SUR unit. SUR will investigate and, if appropriate, refer the information to the appropriate office.

Phone: (775) 687-8405

https://dhcfp.nv.gov/NPIContactUs.asp

Additionally, you can find press releases pertaining to Medicaid fraud at the following link:

https://dhcfp.nv.gov/pressreleases.htm

OFFICE · OF · THE
THE GREAT SEAL OF THE STATE OF
ALL FOR OUR COUNTRY
NEVADA
ATTORNEY · GENERAL

MEDICAID FRAUD CONTROL UNIT

Medicaid Fraud Prevention Training

Medicaid Fraud Control Unit (MFCU)

- MFCUs created by Congress in 1977
- Law enforcement entities made up of sworn officers, prosecutors and support staff
- Funded jointly by federal/state government
- Currently 50 MFCUs nationwide (49 States + D.C.)
- Investigate and prosecute provider fraud and violations of state law pertaining to fraud in the Medicaid program
- Investigate and prosecute complaints of resident abuse, neglect or misappropriation of resident funds in board and care

Medicaid Fraud Control Unit (MFCU)

Cases in Nevada have involved issues such as:

- Billing for services not rendered or medically unnecessary
- Upcoding or unbundling
- Whistleblower lawsuits
- Product tampering
- Elder abuse/neglect
- Elder exploitation

Medicaid Fraud Control Unit (MFCU)

What happens to those who commit Medicaid Fraud?

Direct consequences

- Criminal charges
- Incarceration/house arrest/probation/community service
- Fines/penalties/restitution/costs
- Other court ordered punishments/rehabilitation
- Civil suits

Indirect or Collateral Consequences

- Loss of provider contract
- HHS-OIG Exclusion List
- License sanction or revocation
- Negative press

Medicaid Fraud Control Unit (MFCU)

Case Example: Behavioral Health 123

- Created Mental Health Group Homes
- Hired House Staff
  - No Training / Only Monitored Clients
- Company submitted prior authorization requests (PARs) for Clients
- Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR) services were authorized but not provided
  - Clients unavailable to receive services
- Company still billed for BST and PSR services

AUTHORIZED vs PROVIDED

Medicaid Fraud Control Unit (MFCU)

Case Example: Physician 123

- Physician Created Pain Management Clinic
  - Split Time Between Pain Management Clinic and Local Hospitals
- Physician Hired Licensed Professionals for Clinic
- Licensed Professionals Provided Services at Clinic
- Physician Billed as if He/She Personally Provided Service, not the Licensed Professionals
  - Even billed for times when the physician was working at the hospital
- Physician Billed for Covered Services when Non-Covered Services were Actually Provided
  - Non-Covered: Classes, Books, Videotapes, and Telephone Calls
  - Covered: Office Visits

Medicaid Fraud Control Unit (MFCU)

Five ways to report an allegation of Medicaid Fraud:

1. Email — aginfo@ag.nv.gov
2. Mail — Attn: MFCU
   Nevada Attorney General's Office
   100 N. Carson Street
   Carson City, NV 89701
3. Call — 775-684-1191 or 702-486-3187
4. Fax — 775-684-1192
5. Website — http://ag.state.nv.us/
   (File a Complaint tab)

Thank you for your time.

Questions?