Nevada Medicaid and Nevada Check Up News

Division of Health Care Financing and Policy (DHCFP)

HP Enterprise Services (HPES)

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Inside This Issue:

Provider Re-Enrollment Process Is Under Way

As directed by the Division of Health Care Financing and Policy (DHCFP), HP Enterprise Services (HPES) will perform provider re-enrollment for Nevada Medicaid and Nevada Check Up providers on a recurring basis to ensure that every provider is re-enrolled at least every 36 months.

The re-enrollment process, which began June 1, 2012, is being performed in phases so that not all providers have to re-enroll at the same time. A re-enrollment letter will be sent to providers 60 days prior to the provider's enrollment end date. The letter will include the Provider Web Portal location of the Provider Enrollment Application and Contract and the Enrollment Checklist for each provider type. The re-enrollment packet must be submitted within the requested time frames or the provider's contract will be terminated.

Providers who have been enrolled the longest length of time will be notified and re-enrolled first. For example, providers who have recently completed re-enrollment activities, such as Durable Medical Equipment (DME) and Behavioral Health providers, will be notified to re-enroll toward the end of the 36-month period that started June 1, 2012.

Please review the Provider Re-Enrollment Frequently Asked Questions (FAQs) on the Provider Enrollment webpage for additional information. Call (877) 638-3472 (select option 2 for providers and then option 6 for provider enrollment) to discuss any further questions you may have.

Only ASC X12 Version 5010 Format Accepted Effective July 1, 2012

In December 2011, the Division of Health Care Financing and Policy (DHCFP) announced that, effective January 1, 2012, Nevada would accept both Accredited Standards Committee (ASC) X12 Version 5010 **and** Version 4010 transactions. Nevada announced that it would support Dual Use of these transactions at a minimum for the duration of the Discretion Period announced by the Centers for Medicare & Medicaid Services (CMS), which began January 1, 2012, and continued through March 31, 2012.

DHCFP announced that effective April 1, 2012, it would continue to accept X12 transactions in both the 4010 and 5010 versions until June 30, 2012.

Effective July 1, 2012, only the Version 5010 format is accepted.

Nevada Medicaid and Nevada Check Up providers and trading partners (aka service centers) who wish to continue to conduct business with Nevada using electronic transactions must transition to ASC X12 Version 5010. Testing is supported by EDIFECS Inc. through the EDIFECS Ramp Management Testing Solution. Contact the help desk via email at nvmmis.edirampsupport@hp.com to request access to the testing tool and instructions.

Screening for Provider Preventable Conditions

Beginning with claims with July 1, 2012, dates of service, HP Enterprise Services (HPES) will screen all prior authorization requests for Provider Preventable Conditions (PPCs). This is part of Nevada Medicaid's implementation of Section 2702 of the Patient Protection and Affordable Care Act, which prohibits payment for conditions caused by providers. It is similar to the treatment of hospital-acquired conditions (HACs) by the Medicare program.

For information on the final rule, visit Medicaid.gov at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Provider-Preventable-Conditions.html.

The conditions targeted for non-payment, established by the Centers for Medicare & Medicaid Services (CMS), are either high cost or high volume or both, and could reasonably have been prevented through the application of evidence-based guidelines.

If it is determined that a prior authorization request includes treatment for a PPC, the portion of the request attributable to the PPC will be denied. Note that the denial is for payment only and that any medically-necessary treatment is to be delivered to recipients. The existing appeals process is available for determinations of a PPC.

The second part of implementation will be a retrospective review of hospital claims. Claims fitting the criteria for a PPC will be identified and providers will be supplied information identifying the potential PPCs using the same process and timing for identifying and reviewing Medicare HACs. Providers will have 30 days to review and respond to any discrepancies, and provider-confirmed PPCs will be subject to payment reduction.

Changes to the Medicaid Services Manual (MSM) Section 105.2A and the State Plan sections 4.19a, 4.19b and 4.19d were made after input from providers at two public workshops.

Preventive Medical Services Covered by Nevada Medicaid

Nevada Medicaid reimburses for preventive services for women, children, men and family planning as recommended by the United States Preventive Services Task Force (USPSTF) A and B Recommendations.

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a recipient's current or possible future health care risks through assessments, lab work and other diagnostic studies.

Medicaid Services Manual (MSM) Chapter 600, Physician Services, Attachment A, was updated effective April 11, 2012. Review pages 18-25 of Attachment A for the topics and descriptions of the preventive health services covered by Nevada Medicaid.

Nevada Incentive Payment Program News

The Division of Health Care Financing and Policy (DHCFP) has announced the Nevada Incentive Payment Program for Electronic Health Records (EHR) will begin to accept provider registrations from the Centers for Medicare & Medicaid Services (CMS) in late summer 2012. This means that Nevada providers will be able to register for the program with CMS, and then access the Nevada Electronic Health Record Incentive system to complete their Medicaid EHR Incentive Attestation and receive their incentive payment.

Additional Nevada Medicaid EHR Incentive Program news, updates and program information can be found on the DHCFP website (https://dhcfp.nv.gov/EHRIncentives.htm). Check the site often for additional details, including dates when Nevada Registrations can be completed on the CMS Registration website.

Fingerprint-based Criminal History and Child Abuse and Neglect Screening (CANS) Requirements

The following announcement applies to all Nevada Medicaid and Nevada Check Up providers:

In order to comply with the Adam Walsh Child Protection Act of 2006, a full, fingerprint-based criminal history and Child Abuse and Neglect Screening (CANS) must be conducted for all prospective foster/adoptive parent(s) and household members over the age of eighteen (18) prior to the placement of children in foster/adoptive homes. This requirement also extends to employees or volunteers **and *any* persons providing care to foster children**.

Additional background investigations must be conducted every five (5) years thereafter. More information can be found at the Division of Child and Family Services website at www.dcfs.state.nv.us.

Quarterly Provider Training Update

The HP Enterprise Services (HPES) training team will conduct provider training workshops in July, August and September, leading up to the Annual Medicaid Conference in October. If you have registered for a workshop, you will receive a reminder notice of the workshop date, time and location approximately two weeks prior to the workshop. Descriptions of the upcoming workshops are below.

JULY: The July workshops will focus on Adjustments and Voids, Submitting a Special Batch request, and Appeals. The workshop content includes:

- When and how to Adjust or Void a claim; claim form instructions
- When and how to submit an Appeal; appeal scenarios; the workflow process
- When and how to submit a Special Batch claim; the workflow process

AUGUST: A virtual classroom in August will provide an Introduction to Nevada Medicaid and Nevada Check Up. The workshop content will include:

- The benefits to providers of enrolling in Nevada Medicaid and Nevada Check Up
- The benefits to their recipients
- The role of Nevada's Medicaid Managed Care Organizations (MCO)

SEPTEMBER: The September workshops will give providers an overview of the Medicaid Services Manual (MSM). The workshop content will include:

- The significance of the MSM
- How to find policy information that applies to all providers
- How to find policy information that applies to their provider type

New Provider Training: This workshop will give providers new to Nevada Medicaid an overview of how the program works including what is expected of each provider. The content of the workshop includes:

- Expectations of the provider
- How to "connect" with HPES
  - The Electronic Verification System and the online prior authorization system, including registration, navigation, claims review, PA review and recipient eligibility
- An overview of billing for Medicaid

The full 2012 workshop schedule is published in the 2012 Provider Training Catalog and in the automated Provider Training Registration Form (FA-41).

Annual Medicaid Conference in October

The Annual Medicaid Conference will be held in Reno October 17, 2012, and in Las Vegas October 24, 2012. The breakout sessions for the Conference have been announced. Providers may register for the Conference now by using FA-41. The session locations, dates and times are listed below.

Note: All General and Breakout Session content is the same in both morning and afternoon sessions, and content is the same in both Reno and Las Vegas, which allows providers to select the most convenient destination.

Each Conference will begin with a General Session, followed by a break, then the Breakout Sessions. When you register, you will choose from the following Breakout Sessions.

Each location will follow this schedule:

General Morning Session	8:30-10:00 a.m.	**General Afternoon Session**	1:30 – 3 p.m.
Break	10:00-10:15 a.m.	Break	3-3:15 p.m.
Breakout Sessions		**Breakout Sessions**	
Personal Care Services	10:15-noon	Personal Care Services	3:15 – 5:00 p.m.
Skilled Nursing Facilities	10:15-noon	Skilled Nursing Facilities	3:15 – 5:00 p.m.
Behavioral Health	10:15-noon	Behavioral Health	3:15 – 5:00 p.m.
Physician	10:15-noon	Physician	3:15 – 5:00 p.m.
Hospital	10:15-noon	Hospital	3:15 – 5:00 p.m.
Dental	10:15-noon	Dental	3:15 – 5:00 p.m.

Behavioral Health Provider Types 14 and 82:

Tips to Avoid the Top Errors That May Affect Your Claims Payment

Most providers are busy seeing patients while also trying to run a business; however, close attention also needs to be given to filing clear and accurate Nevada Medicaid and Nevada Check Up claims that are in compliance with policies and procedures. Failure to do so can expose your practice/business to compliance violations. Errors that are not self-corrected can lead to various administrative actions, including recoupment of overpayments, provider suspensions, terminations and other actions as detailed Medicaid Services Manual (MSM) Chapter 3300, Program Integrity.

Ensure that claims submitted by your practice/business are accurate. Your Medicaid claims compliance plan should provide special attention to the following list of errors most commonly made by Behavioral Health provider types 14 and 82. These errors can affect claims payment.

Error #1: Inadequate or no documentation to support the claim (see MSM 403.2A6). Specifically, records must include AT LEAST:

- Recipient's name,
- Progress notes with specific contents, including acknowledgement of recipient's/guardian's choice in selecting providers,
- Indications of the recipient's and family's/guardian's involvement in care planning,
- Indications of recipient's and family's/guardian's awareness of scope, goals and objectives of services available, and
- Recipient's and family's/guardian's acknowledgement that services are designed to reduce the intensity/duration of care to the least intensive level possible while maintaining overall health (MSM 403.6B1 and 3303.2B).

Common errors include documentation that only contains part of the required information and records that are not maintained to current date.

TIP: You may want to create a checklist for you and your staff to be sure all of the required documents are in the file. Remember, you bear the ultimate responsibility for the contents of case files.

Error #2: Progress notes not documented on the date of service (MSM 403.6B1b).

Common errors include progress notes for a range of service dates, repetitive progress notes (cut and paste), missing notes for each date of service, and untimely preparation of progress notes.

TIP: You should create a procedure to periodically review a batch of random case files, so your staff will know you expect them to be up-to-date at all times. Reviewing them all at one time will also make you aware of providers who "cut and paste" repetitive case notes.

Error #3: Billing individual services instead of group therapy services (MSM 403.4c2 and 403.4c3).

- Individual Services are one-to-one interventions.

Common errors include a single servicing provider claiming individual services/sessions during the same day and time for more than one recipient.

TIP: When you periodically review files, have a schedule of group therapy sessions handy so you can crosscheck times and dates. Verify that dates and times of individual services for each recipient do not conflict or overlap with other recipients

Error #4: Providers practicing outside of their scope of service (MSM 403.2A3 and 403.2B2).

- Remember, you are responsible for knowing what your staff is qualified to do.

Common errors include replacing planned providers with those that are not qualified to perform the service when logistical issues arise.

TIP: Have a contingency plan for employee absences such as sick days or vacation. Your back-up staff should be qualified to handle all types of services you provide.

Error #5: Day Treatment services provided in the recipient's home or home-like setting (MSM 403.6E1).

- Day Treatment must be facility based and out of the home.

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TIP:

Have a contingency plan for employee absences such as sick days or vacation. Your back-up staff should be qualified to handle all types of services you provide.

Behavioral Health Provider Types 14 and 82: Tips to Avoid the Top Errors That May Affect Your Claims Payment

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- Day Treatment does NOT include routine supervision and monitoring.
- You may NOT bill separately for Basic Skills Training (BST), Psychosocial Rehabilitation (PSR), Peer-to-Peer Support and Crisis Intervention (CI) services on the same day and time you bill for Day Treatment.

Common errors include overlapping Day Treatment and other services, and claiming in-home therapy as Day Treatment.

TIP: Make sure your staff understands this important distinction, and review case notes for inaccuracies or scheduling conflicts.

Error #6: Enticement, kickbacks or stipends by/from providers (MSM 3302.5 and 3303.1A2h).

- It may seem like Medicaid 101, but a surprising number of providers still fall for this trap.

TIP: Watch for unusual influxes of recipients or recipients all coming from similar sources. Someone may be soliciting them.

Error#7: Billing for services not provided to maximize authorized units (MSM 3303.1A2w and 3303.1.A2x2).

TIP: If your authorized units ALWAYS match treatment billings, there is probably an issue. Keep track of missed recipient appointments or sick days, so you can reconcile them with claims.

More tips for establishing an in-house Medicaid compliance program can be found on the U.S. Department of Health & Human Services Office of Inspector (OIG) Compliance page: http://oig.hhs.gov/compliance/compliance-guidance/index.asp

Please keep in mind that the Nevada Medicaid and Nevada Check Up provider contract requires:

- 1.6 To comply with protocols set forth in the Nevada Medicaid Services Manual, the Nevada Check Up Manual and Medicaid Operations Manual, including but not limited to, verifying recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the recipient retains freedom of choice of provider.

Your State of Nevada Medicaid program specialist can answer claims and claims management questions. For the telephone number to contact your program specialist, log on to 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 wish to contact.

Occupational/Physical Therapy Providers Needed for PCS Program in Northern and Rural Nevada

In March 2010, DHCFP modified the Nevada Medicaid Personal Care Services (PCS) program to require the completion of the initial functional assessment for PCS by an Occupational or Physical Therapist (OT/PT). Currently, there is a special need for OT/PT providers to serve the northern and rural areas of Nevada.

By participating in the program and assisting with "hands on" assessments in the recipient's home, OTs/PTs are providing Medicaid recipients with an accurate functional assessment.

This is not an employment position with the State, but is done by Nevada-licensed OTs/PTs or eligible hospitals, clinics or agencies enrolled as Medicaid providers. If you are an OT/PT provider interested in assisting the Nevada Medicaid PCS program and completing these functional assessments, you will need to be a Nevada Medicaid provider and attend a training session on PCS policies and functional assessment tools.

OT/PTs who are interested in completing these assessments should verify their enrollment or begin the enrollment process. To enroll as a Nevada Medicaid provider, see the instructions and forms on the "Provider Enrollment" webpage.

Trainings on the assessment process are scheduled periodically. To place your name on the list for a training session or to obtain more information about this program, please contact
Pam Loomis at pamela.j.loomis@hp.com or
Tammy Moffitt at TammyMoffitt@dhcfp.nv.gov.

Tips When Submitting Paper Claims

To help ensure your paper claim is processed quickly and correctly, please remember the following instructions.

- When printing the form, use the appropriate full-size format of the claim form. The image must be full page; do not reduce the size of the image on the 8 ½ by 11 inch page. Copies must be of the original claim and must have a light background. Dark images are not acceptable and will be returned.
- Recipient data on the claim form needs to be within the appropriate claim field and below the "field description." Data should not be shifted up, down or sideways. Data that is typed over the claim "line" is not acceptable, because scanning becomes unreadable, and the claim will be returned to you.
- The Explanation of Benefits (EOB), just like the claim form, must be suitable for scanning so that data can be accurately captured. If the data is printed too light or is smudged, the claim will be returned to you.
- When you would like to request a claim be reprocessed, be sure to send the original claim with the supporting documents. If you send only the supporting documents, such as your letter and EOB, the documents will be returned to you.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact HPES by calling (877) 638-3472, press option 2 for providers and then option 3 for claim status.

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 would like to contact.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers **$411,411,968.66** in claims during the three-month period of January, February and March 2012. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

DHCFP and HP Enterprise Services thank you for participating in Nevada Medicaid and Nevada Check Up.