

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:

- 2 [Nevada Division of Health Care Financing and Policy Awarded \\$2 Million for State Innovative Model Grant](#)
- 2 [Attention All Providers: Payment Integrity Reviews Are in Progress](#)
- 3 [Provider Web Portal Enhancements Include Ability to Search PA Criteria, Fee Schedules and Medicaid Providers](#)
- 3 [CAQH CORE 350: Health Care Claim Payment/Advice \(835\) Infrastructure Rule](#)
- 4 [Nevada Medicaid Health Care Guidance Program Partners with Providers to Improve Patient Health](#)
- 5 [Billing and Pharmacy Override Instructions for Hospice Drugs](#)
- 5 [ICD-10 Compliance Date Scheduled for October 1, 2015](#)
- 5 [Health Care Guidance Program Contact Information](#)
- 5 [Contact Information](#)

Services for Children with Autism Spectrum Disorder

On July 7, 2014, the Center for Medicare & Medicaid Services (CMS) released guidance (CIB 07-07-2014) on approaches available under the federal Medicaid program for providing medically necessary diagnostic and treatment services to children with Autism Spectrum Disorder (ASD). CMS is not singling out Applied Behavior Analysis (ABA) or any other specific treatment in its directive to states, but is indicating the services must be comprehensive and include behavioral intervention.

The Nevada Division of Health Care Financing and Policy (DHCFP) is proposing coverage for ABA services for categorically needy individuals under age 21, identifying Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as the coverage authority.

The DHCFP is taking the following steps:

- A series of workshops were held to gain stakeholder input on ABA policy development of medical coverage policy, reimbursement, and provider qualifications. The workshop agendas and associated materials can be found on the DHCFP website at: <http://dhcftp.nv.gov/publicnotices.htm>
- Ongoing information regarding the medical coverage policy development for ABA services can be found on the DHCFP ABA webpage at: <https://dhcftp.nv.gov/ABA.htm>
- A Public Hearing will be held on the State Plan Amendment (SPA) and medical coverage policy with an anticipated effective date for the first quarter of Calendar Year 2016.
- Policy and Rates SPA's will be submitted for CMS approval. CMS has 90 days for comment.

Currently, Nevada Medicaid covers screenings under EPSDT. See [Web Announcement 892](#) for details.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$753,128,056.08 in claims during the three-month period of October, November and December 2014.

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

Nevada Division of Health Care Financing and Policy Awarded \$2 Million for State Innovative Model Grant

In July 2014, the Nevada Division of Health Care Financing and Policy (DHCFP), working closely with the Nevada Governor's office, submitted an application for the State Innovation Models (SIM) grant from the Centers for Medicare & Medicaid Services (CMS). In December 2014, Nevada was awarded a SIM grant in the amount of \$2 million beginning February 1, 2015, and ending January 31, 2016. It is anticipated that future funding will be available in subsequent years to test the design model that will be developed during the first year.

The intent of the grant is to develop innovative plans that will achieve the following:

- Improve access to care for Nevadans
- Improve the health status of Nevadans
- Reform the healthcare delivery and payment system in Nevada
- Contain healthcare costs while increasing healthcare value

The plans will integrate the strategies of Governor Brian Sandoval's core health priorities:

- Access to affordable and high quality health care
- Prevention strategies that increase awareness
- Wellness initiatives that educate, encourage and empower
- Chronic disease
- Quality of health services
- Improve pre-natal care
- Provide accessible and affordable mental health services

Baseline measures will be established for population conditions, such as behavioral health, tobacco use, obesity and diabetes.

The experience and knowledge that Nevada Stakeholders have to offer is an integral part of the success of developing a design. DHCFP will be meeting with Stakeholders to design innovative, healthcare payment and service delivery models that will achieve the vision of the SIM grant resulting in better health, better care and lower costs for Nevada's population.

The Nevada SIM website <https://dhcfnv.gov/SIM.htm> is a great resource for learning more about the SIM grant.

Because Stakeholders' opinions and thoughts on Nevada healthcare are valuable, please participate in the survey located at https://www.surveymonkey.com/s/NV_SIM. DHCFP will consider all ideas during the development of the Model Design.

To be included in future meetings, or receive updates and newsletters, please send a request in an email to NVSIM@mslc.com. Please share this information with anyone who may be interested.

Attention All Providers: Payment Integrity Reviews Are in Progress

The Nevada Division of Health Care Financing and Policy (DHCFP) has contracted with Health Management Systems, Inc. (HMS) to be the Recovery Audit Contractor (RAC) for Nevada Medicaid. In accordance with this contract, the DHCFP has tasked HMS to conduct Payment Integrity reviews, wherein HMS will review the patient accounts of certain providers to identify credit balances that may result in overpayments or underpayments. HMS' activity began April 1, 2015.

The DHCFP's objective is to identify and recover overpayments determined to be refundable to the Medicaid program. The Payment Integrity reviews will include either on-site or remote reviews, as well as provider self-disclosure reviews. Providers will be notified via mail if their practice or facility has been selected for a review. Providers are required to respond to these notices and return the requested documentation to HMS within 30 calendar days of receiving the notice.

Questions about the Medicaid Payment Integrity reviews may be directed to Bob Lander, DHCFP RAC Special Projects Coordinator, at (775) 687-8404.

Provider Web Portal Enhancements Include Ability to Search PA Criteria, Fee Schedules and Medicaid Providers

Enhancements are continuing to be made to the Provider Web Portal to improve the user's experience by providing additional tools to assist with billing and prior authorizations. Recent enhancements are listed below.

- Effective January 26, 2015, providers and their delegates have the ability to search criteria for prior authorization requirements for a procedure or revenue code based on provider type and specialty. The "Authorization Criteria" search can be accessed through the unsecured and secured areas of the Provider Web Portal. See [Web Announcement 867](#) for details.
- Effective January 26, 2015, enhancements were made to the "View Authorization Response" page in the Provider Web Portal so that users may see additional prior authorization denial information, the dates and units requested by the provider, as well as all of the diagnosis, service lines and attachments added since the prior authorization was initially submitted. See [Web Announcement 868](#) for details.
- Effective February 16, 2015, the Pharmacy prior authorization link on the Provider Web Portal displays only for providers that have at least one of the following prescriber provider types associated with their National Provider Identifier (NPI): 12, 17, 20, 21, 22, 24, 25, 27, 42, 45, 55, 64, 72, 74 or 77.
- Effective February 23, 2015, an update was made to the "Search Fee Schedule" application. When search results are returned, the default sort is now based on the "Effective Date" column. See [Web Announcement 887](#) for details on this update and [Web Announcement 854](#) for the original notification that the "Search Fee Schedule" can be accessed through the unsecured and secured areas of the Provider Web Portal.
- Effective February 23, 2015, providers and their delegates have the ability to perform provider searches on the Provider Web Portal. The "Search Providers" feature gives users the ability to find other Nevada Medicaid participating providers. The search results will show active providers only, and will indicate if the provider is an Ordering, Prescribing or Referring (OPR) Specialty 400 provider only. Please see the full [Web Announcement 905](#) for details and screenshots explaining how to access and use this tool.

CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule

Effective February 8, 2015, the Nevada Medicaid program implemented the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules CAQH CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

This CAQH CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule supports the CORE "Safe Harbor" connectivity requirement.

By requiring the delivery and use of these CORE infrastructure requirements when conducting the v5010 X12 835, the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule helps provide the information that is necessary to electronically process a claim payment and corresponding remittance details and thus reduce the current cost of today's paper-based transaction process.

The solution will not require trading partners to remove existing connections that do not match the rule, nor will it require that all covered entities use only this method for all new connections. A trading partner may decide to continue to use the current connection or use the new "Safe Harbor" connectivity method at their discretion.

If you are interested in using this method, please contact HP Enterprise Services (HPES) at (877) 638-3472 (select options 2, 0 then 3) or send an email to nvmmis.edisupport@hp.com.

Nevada Medicaid Health Care Guidance Program Partners with Providers to Improve Patient Health

The Nevada Medicaid Health Care Guidance Program partners with local providers to help certain fee-for-service (FFS) Nevada Medicaid recipients better manage their health. This care management program, which launched June 1, 2014, is conducted by McKesson Care Management under contract to the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP), and has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with a section 1115 waiver of the Social Security Act as a possible five-year program through June 30, 2018.

Serving up to 41,500 individuals, the Health Care Guidance Program was developed to provide innovative solutions for Nevada Medicaid recipients who are facing one or more chronic medical conditions, have a persistent mental health or substance use disorder, or demonstrate high service need.

The goals of the program are to assist providers coordinate care for their highest risk, most chronically ill patients that qualify, and to establish reforms that sustain the improvements in the quality of health and wellness for FFS Nevada Medicaid recipients and provide care in a more cost-efficient manner. The Health Care Guidance program is an additional medical benefit, and participation is mandatory for all eligible Nevada Medicaid recipients. Using predictive modeling, eligible patients are identified by cost, risk level, and the presence of any combination of approximately 50 chronic physical and mental health conditions. Providers are also able to make real-time referrals of eligible patients into the program. Once identified, the recipients are assigned to one of eight care management programs based on their qualifying condition(s) and needs, and then receive one-on-one care management services that promote self-management skills for their health care.

Serving as an extension of the provider's practice and the medical home, the Health Care Guidance Program will be delivered by regional care teams. By design, care team members will be situated geographically within their clients' communities, and reflect the diversity of Nevada. Care teams include community-based primary nurses, care team supervisors, social workers, community health workers/peer support, and complex case managers. The care teams are led by a full-time, in-state Medical Director who oversees and provides guidance for the program and its delivery.

Using evidence-based clinical guidelines, the care teams coordinate with the patient's providers and treatment team to work with the patient on implementing personalized care plans and managing follow-up appointments and services. Patients receive targeted one-on-one support that may include coaching on their conditions and

treatment plans conducted face to face or telephonically, assistance with selection of a primary care provider, identification of both medical and non-medical barriers that impact their health, access to 24/7 nurse advice services, links to community resources and health education materials, help obtaining equipment and medications, coordinating transportation, and support for care transitions between settings and providers.

Providers can access patients' care plans, receive clinical alerts, obtain monthly reports regarding gaps in patient care, and provide online feedback to the care team. By providing ancillary staff, the Health Care Guidance Program supports the provider-patient relationship and contributes to improved outcomes, reduced no-shows, increased medication adherence, and better well-being for patients.

Care management programs like the Nevada Medicaid Health Care Guidance Program have been shown to improve the health and quality of life of participants with chronic illnesses, while also reducing health care costs. Amy J. Khan, MD, MPH, Medical Director for the Nevada Health Care Guidance Program, said, "When a patient and their family understand how to better manage chronic diseases on a daily basis, the patients often need fewer extended hospital stays, ED visits, or other costly medical interventions. We work closely with local providers to break down barriers to care and help improve the health outcomes of their patients."

Nevada Medicaid Health Care Guidance Program Contact Information:

- Providers who have questions about the Nevada Medicaid Health Care Guidance Program may contact Dr. Amy J. Khan at amy.khan@mckesson.com or 775-232-9558.
- Providers may validate the enrollment of recipients and refer FFS Nevada Medicaid recipients into the program by faxing a referral to 1-800-542-8074 or by calling the program directly at 1-855-606-7875 and selecting prompt "2."
- Providers may also download a referral form or validate recipient enrollment by visiting the Nevada Medicaid Health Care Guidance Program website at <http://www.nvguidance.vitalplatform.com/providerportal/nev>.

Billing and Pharmacy Override Instructions for Hospice Drugs

Medicaid Services Manual (MSM) Chapter 3200 - Hospice states that drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid Hospice Program and are to be billed in accordance with the appropriate MSM chapter for those services.

Hospice recipients can be identified by:

- Information on the recipient’s Medicaid enrollment file, or
- The PATIENT LOCATION code (Field 307-C7) on the inbound claim contains a code “11” (Hospice)

Specifically for pharmacy claims, if a recipient is on hospice with Nevada Medicaid as the secondary but is filling a medication that is not related to their hospice diagnosis, that medication should be billed to Medicaid. The pharmacy must enter an override code of “08” in Field 461-EU (Payer Defined Exception). Please work closely with the hospice agency to verify which medications are covered by hospice.

ICD-10 Compliance Date Scheduled for October 1, 2015

The ICD-9 code sets used to report medical diagnosis and inpatient procedures will be replaced by ICD-10 code sets on **October 1, 2015**. Congress delayed the implementation of ICD-10 code sets from October 1, 2014, to October 1, 2015.

ICD-9 codes must continue to be used for all procedures and diagnoses dates of service (outpatient services) or dates of discharge (inpatient services) before October 1, 2015. **Claims with ICD-10 codes dates of service or discharge before October 1, 2015, will be rejected.**

According to the CMS ICD-10 Introduction fact sheet, the transition to ICD-10 is occurring because ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

Providers are advised to talk with your software vendor to ensure your system will be upgraded to support ICD-10 by October 1, 2015. Resources and additional information are available on the [CMS ICD-10 website](#).

Nevada Medicaid Health Care Guidance Program Contact Information				
	Phone	Email	Fax	Online (as of September 2014)
Questions about the program	775-232-9558	amy.khan@mckesson.com		
To refer or validate enrollment of patients	1-855-606-7875, select prompt “2”		1-800-542-8074	http://www.nvguidance.vitalplatform.com/providerportal/nev

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, then option 0, then option 2 for claim status.

If you have a question about Medicaid Service Policy or Rates, you can go to the DHCfp website at <http://dhcftp.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.