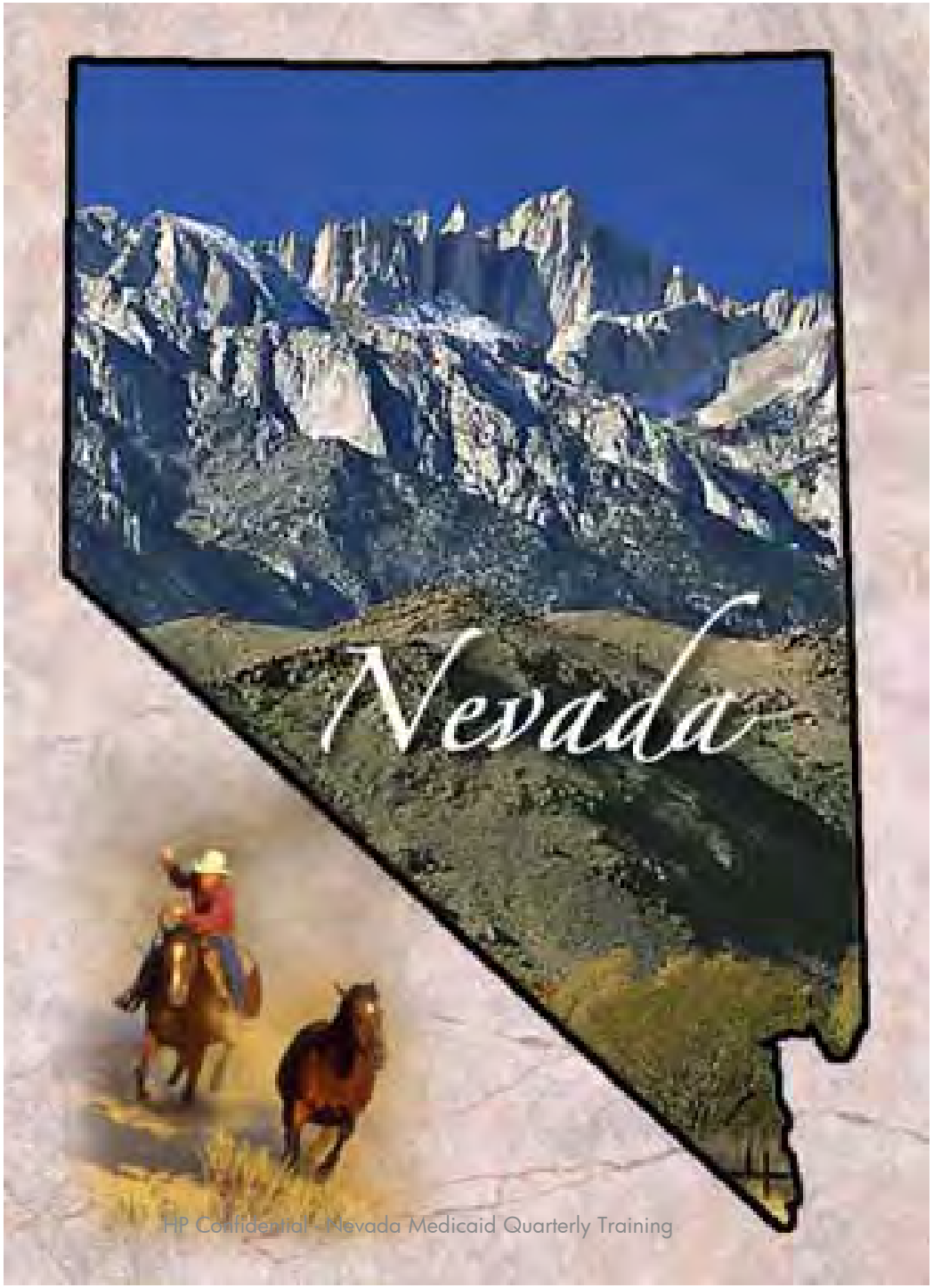
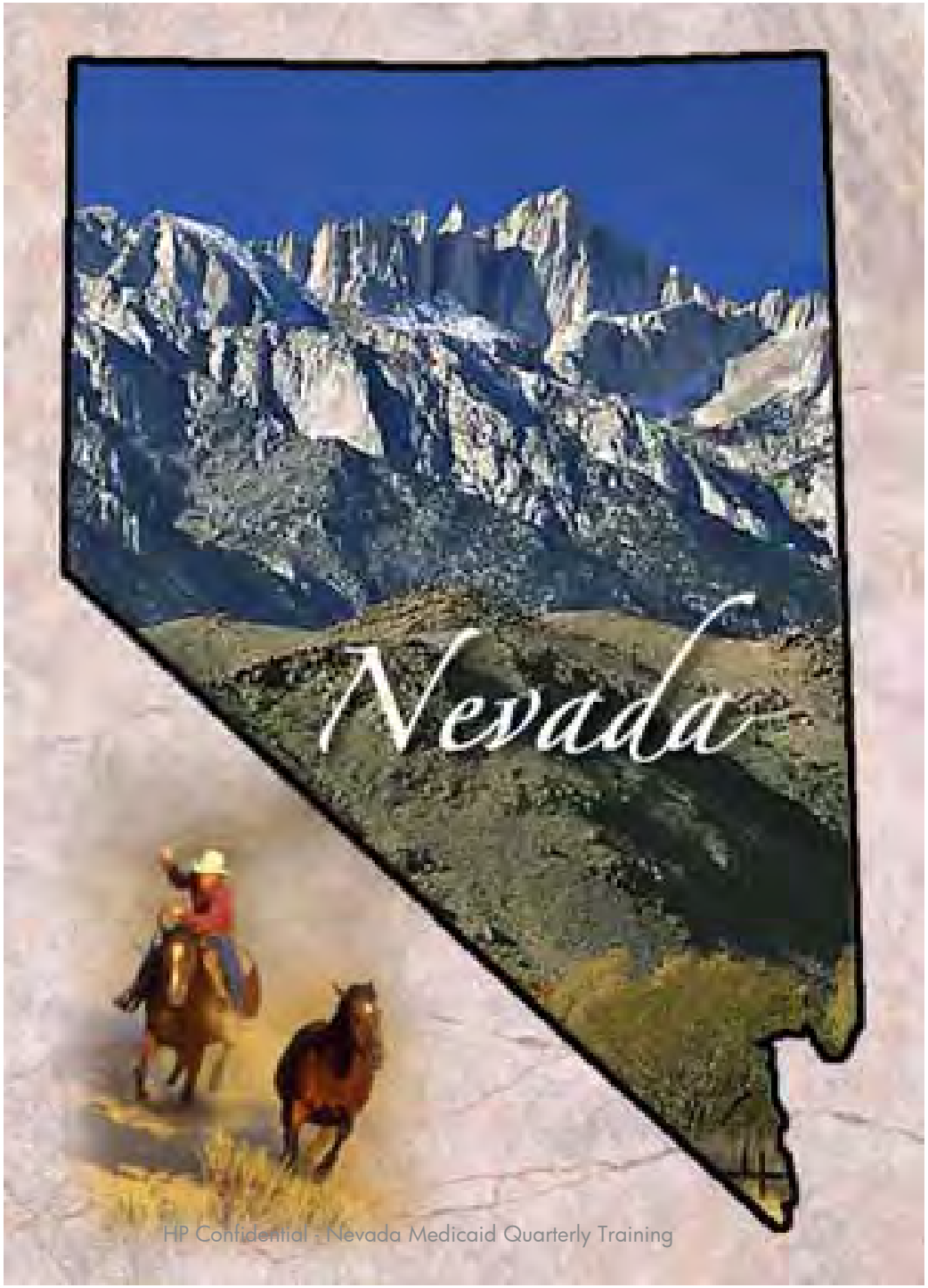


Quarterly Training for Medicaid Providers January 2013

Presented by: HPES Training Department

Agenda

- New training model for 2013
- Provider Re-enrollment
- EHR – Electronic Health Records
- RAC – Recovery Audit Contractor
- ICD-10
- NCCI: Medically Unlikely Edits
- DHCFP Public Notices/Hearings
- TPL – Third Party Liability
- Web Announcements



New Training Model for 2013

HP Enterprise Services Training - 2013

We have listened to your feedback and in 2013 the HP Enterprise Services (HPES) training team will provide enhanced services to Nevada Medicaid providers. Provider Representatives will be available in your area to provide one-on-one assistance when you have questions or concerns.

Meet Your Provider Representative Team

Provider Services Manager

- Jennifer Shaffer
  - Office: (775) 335-8585 Cell: (775) 313-2811

Northern Nevada

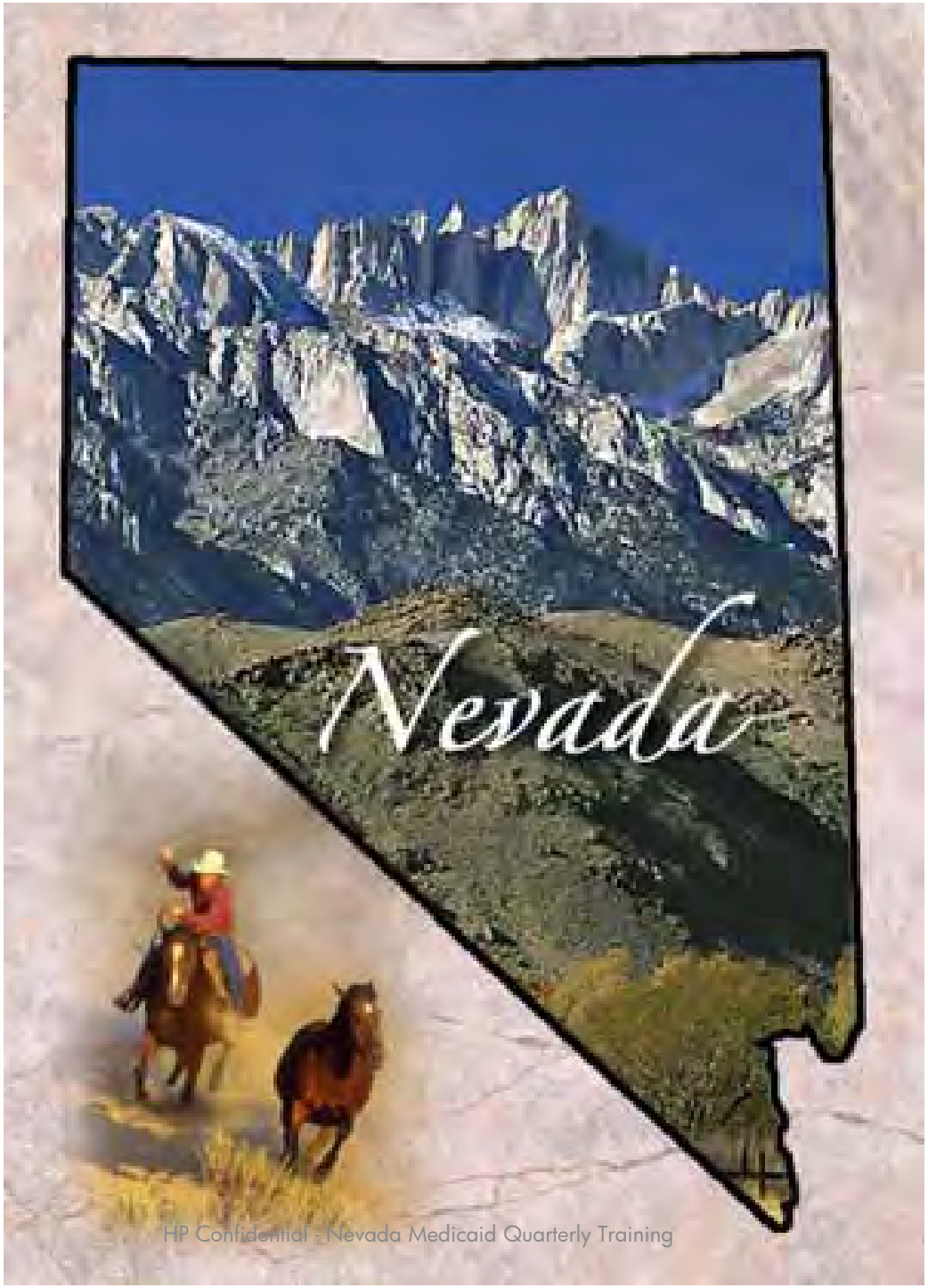
- Kim Teixeira – Provider Representative
  - Office: (775) 335-8569 Cell: (775) 323-9667
- Shanna Lira – Provider Representative
  - Office: (775) 335-8566 Cell: (775) 343-9929
- Nedra Daugherty – Provider Representative
  - Office: (775) 335-8568

Southern Nevada

- Tiffani Hart – Provider Representative
  - Cell: (702) 266-6923

Contact the Provider Training Team

- By phone – (877) 638-3472
  - Options 2, then 0, then 4
- By email – nevadaprovidertraining@hp.com
- By fax – (775) 624-5979



Provider Re-enrollment

Provider Re-enrollment

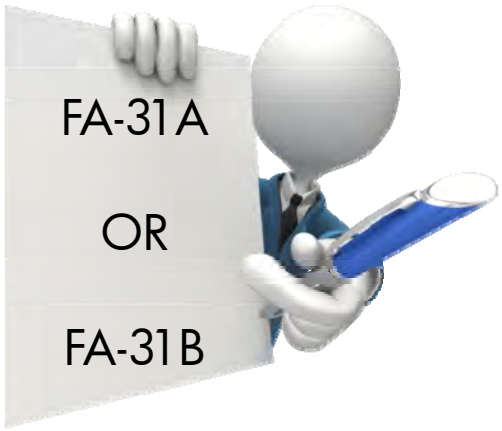
As directed by the Nevada Division of Health Care Financing and Policy (DHCFP), HPES will perform provider re-enrollment for Nevada Medicaid and Nevada Check Up providers on a recurring basis to ensure that every provider is re-enrolled at least every 36 months.

Provider Re-enrollment

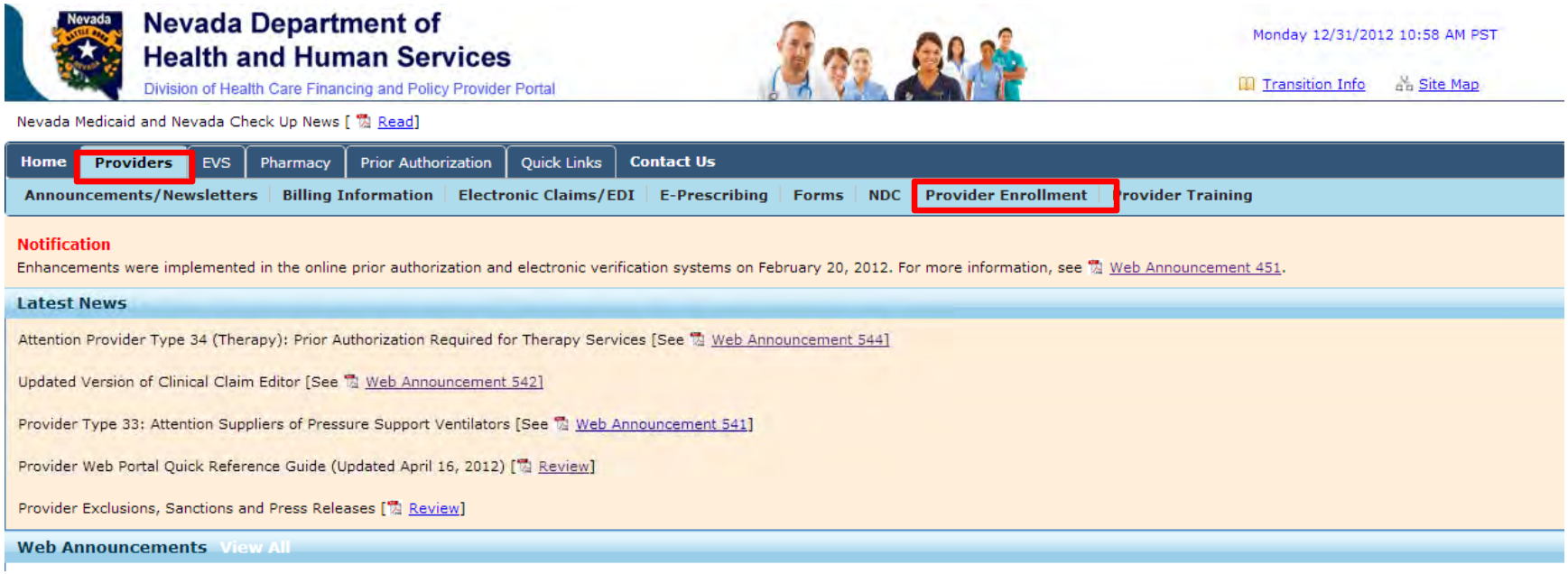
- Providers are identified from oldest enrollment to newest (most recent)
- 1/36 of providers will be notified each month
- 60-day letter
- 20-day letter
- Validation and entry of re-enrollment information into Medicaid Management Information System (MMIS)

New Re-enrollment Applications

- There are now two new re-enrollment applications:
  - FA-31A – Provider re-enrollment application for individuals
  - FA-31B – Provider re-enrollment application for groups/facilities
- Do not re-enroll until you receive your letter
- Use the correct re-enrollment application
- Applications are PDF formats



Location of Re-enrollment Applications



www.medicaid.nv.gov

Re-enrollment Applications

Mailing Address

Mail completed enrollment forms and required documentation to HP Enterprise Services, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042

Required Enrollment Documents

- Provider Enrollment Instructions: You will need these instructions to complete Questions 1-4 in the Provider Enrollment Packet. The instructions include common enrollment questions and information about out-of-state providers and provider groups.
- Provider Enrollment Packet: Complete and submit the forms in this packet to enroll as a Nevada Medicaid and Nevada Check Up provider. This Packet contains the Provider Enrollment Application (form FA-31) and the Division of Health Care Financing and Policy (DHCFP) Provider Contract.
- Enrollment Checklists: Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.

Recommended Enrollment Documents

- Electronic Transaction Agreement for Service Centers (FA-35): This form must be submitted if you wish to send electronic claims directly from your practice or if you are a Service Center (clearinghouse). Click here for further instructions.
- Service Center Operational Information (FA-36): This form must be submitted by all Service Centers (clearinghouses) and by all providers who wish to send electronic claims directly from their practice. Click here for further instructions.
- Service Center Authorization Form for Providers (FA-37): This form must be submitted by all providers who wish to send electronic claims. Click here for further instructions.
- Payerpath Enrollment Form (FA-39): This form must be submitted by all providers who wish to use Payerpath. Claim submission through Payerpath is free to all Nevada Medicaid providers. Click here for further instructions.

Re-Enrollment Documents

- Provider Re-Enrollment Application (Individuals) (FA-31A): This application must be submitted by active individual providers who have received a re-enrollment letter.
- Provider Re-Enrollment Application (Groups/Facilities) (FA-31B): This application must be submitted by active group/facility providers who have received a re-enrollment letter.

Re-enrollment Contact Information*

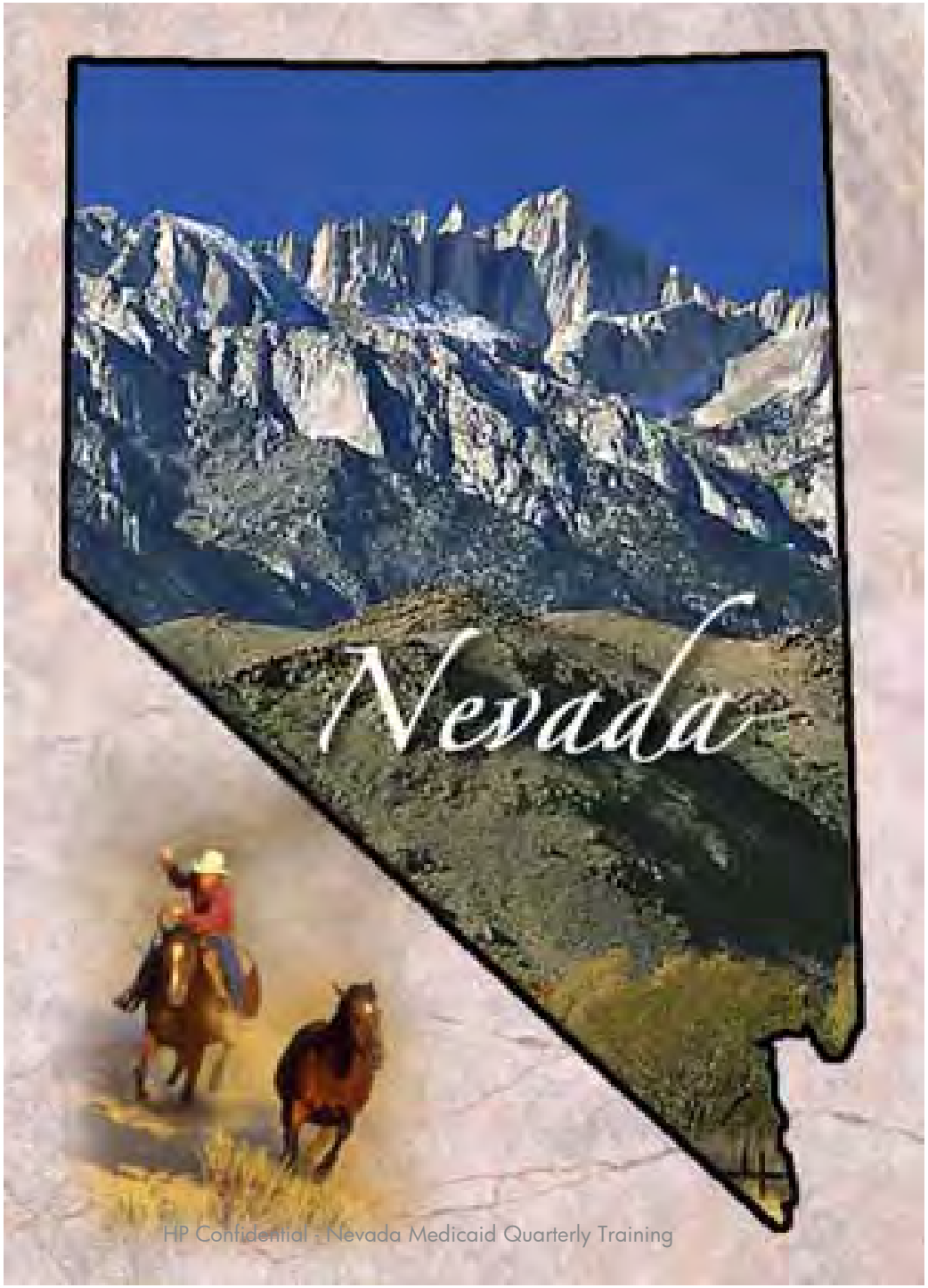
- Mail your completed re-enrollment application to:

  Provider Enrollment
  PO Box 30042
  Reno, NV 89520-3042

- To speak with a Provider Enrollment representative:

  (877) 638-3472
  Options 2, then 0, then 5

** Please allow sufficient time for your application to be processed*



Electronic Health Records (EHR) Incentive Program

Electronic Health Records (EHR)

What is the Nevada Incentive Payment Program for Electronic Records?

The Nevada Incentive Payment Program for Electronic Records is part of the Centers for Medicare & Medicaid Services (CMS) Electronic Health Records (EHR) Incentive Program. The Medicaid EHR Incentive Program provides incentive payments to eligible professionals, hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

What is an EHR?

An electronic health record (EHR)—sometimes called an electronic medical record (EMR)—allows healthcare providers to record patient information electronically instead of using paper records. However, EHRs are often capable of doing much more than just recording information. The EHR Incentive Program asks providers to use the capabilities of their EHRs to achieve benchmarks that can lead to improved patient care.

EHR – Incentive Payments

How much can I receive?

Eligible Professionals (EPs) who meet eligibility criteria can receive a maximum of $63,750 in incentive payments from Medicaid over a 6-year period. If participation criteria are met, the first year payment is $21,250; years two through six payments are $8,500 each.

Pediatricians have a different set of requirements and incentive payments. Pediatricians with a Medicaid patient volume threshold between 20% and 29% will receive a maximum of $42,500; however, pediatricians with 30% or more Medicaid patient volume can still receive up to $63,750.

EHR – Qualification

Do I qualify for the Program?

The program has many resources to assist providers in determining if they might be eligible to participate as well as identify the participation requirements. Eligible provider types include:

- Acute Care / Critical Access / Cancer / Children's Hospitals
- Physician
- Nurse Practitioner
- Certified Nurse Mid-Wife
- Dentist
- Physician Assistants who practice in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Indian Health Program (IHP) that includes Indian Health Service/Tribal Organization/Urban Indian Organization (I/T/U) that is so led by a Physician Assistant

Find out if you might be eligible to participate in the EHR Incentive Program and what you need to start participating by visiting the CMS hosted site to test potential eligibility at: http://www.browserspring.com/widgets/cms/test.html

EHR – More Information

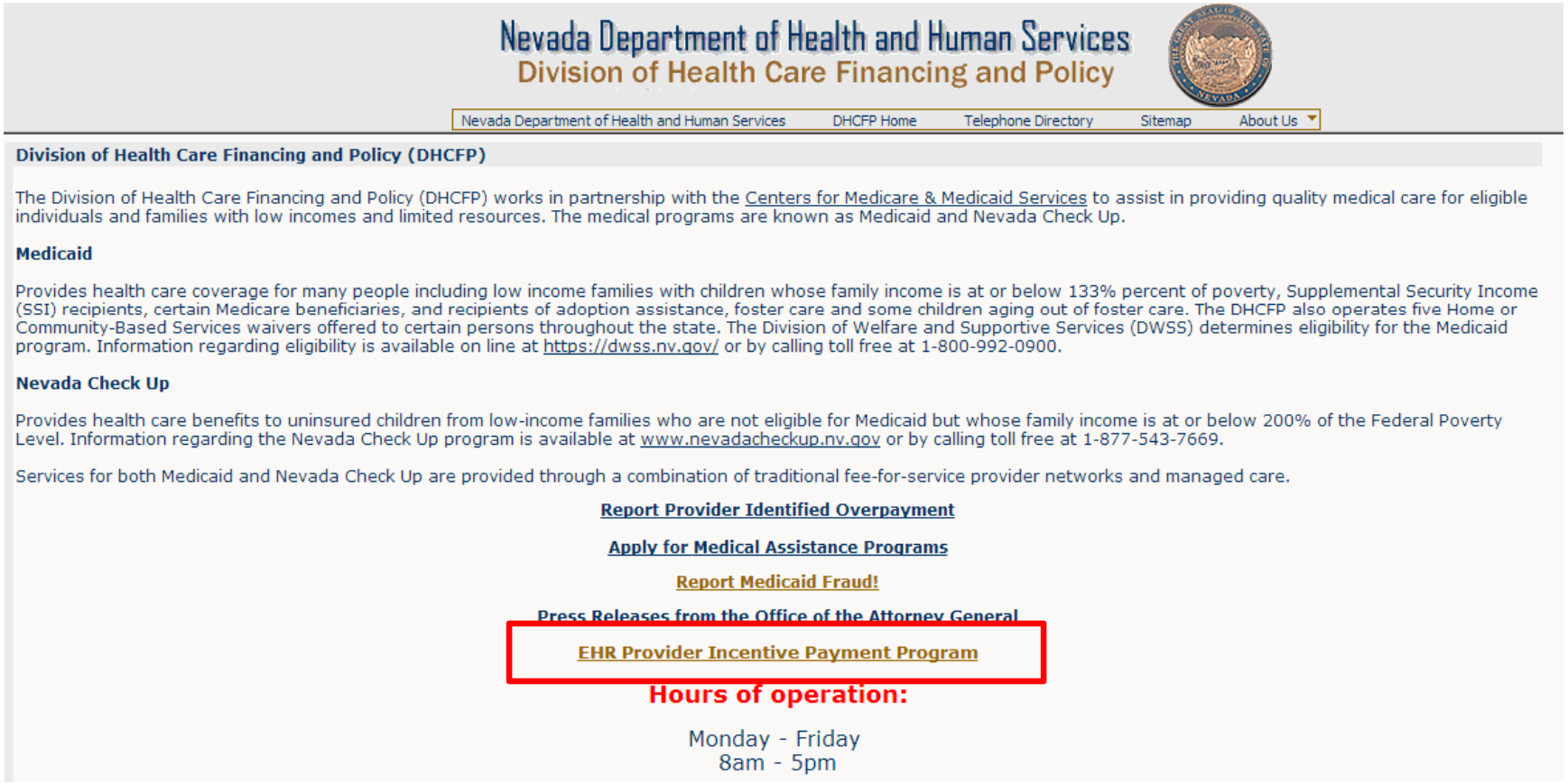
Where can I learn more about the program?

The Division of Health Care Financing and Policy has developed an EHR information webpage to help Nevada Medicaid providers better understand the Medicaid EHR Incentive Program: http://dhcfp.nv.gov/EHRIncentives.htm

Also, Nevada Medicaid providers may contact the CGI Business Service Center for additional information and assistance at:

- (888) 639-3452 or NEIPS.us.ipod@cgi.com

EHR Provider Incentive Payment Program



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

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Division of Health Care Financing and Policy (DHCFP)

The Division of Health Care Financing and Policy (DHCFP) works in partnership with the Centers for Medicare & Medicaid Services to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up.

Medicaid

Provides health care coverage for many people including low income families with children whose family income is at or below 133% percent of poverty, Supplemental Security Income (SSI) recipients, certain Medicare beneficiaries, and recipients of adoption assistance, foster care and some children aging out of foster care. The DHCFP also operates five Home or Community-Based Services waivers offered to certain persons throughout the state. The Division of Welfare and Supportive Services (DWSS) determines eligibility for the Medicaid program. Information regarding eligibility is available on line at https://dwss.nv.gov/ or by calling toll free at 1-800-992-0900.

Nevada Check Up

Provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid but whose family income is at or below 200% of the Federal Poverty Level. Information regarding the Nevada Check Up program is available at www.nevadacheckup.nv.gov or by calling toll free at 1-877-543-7669.

Services for both Medicaid and Nevada Check Up are provided through a combination of traditional fee-for-service provider networks and managed care.

Report Provider Identified Overpayment

Apply for Medical Assistance Programs

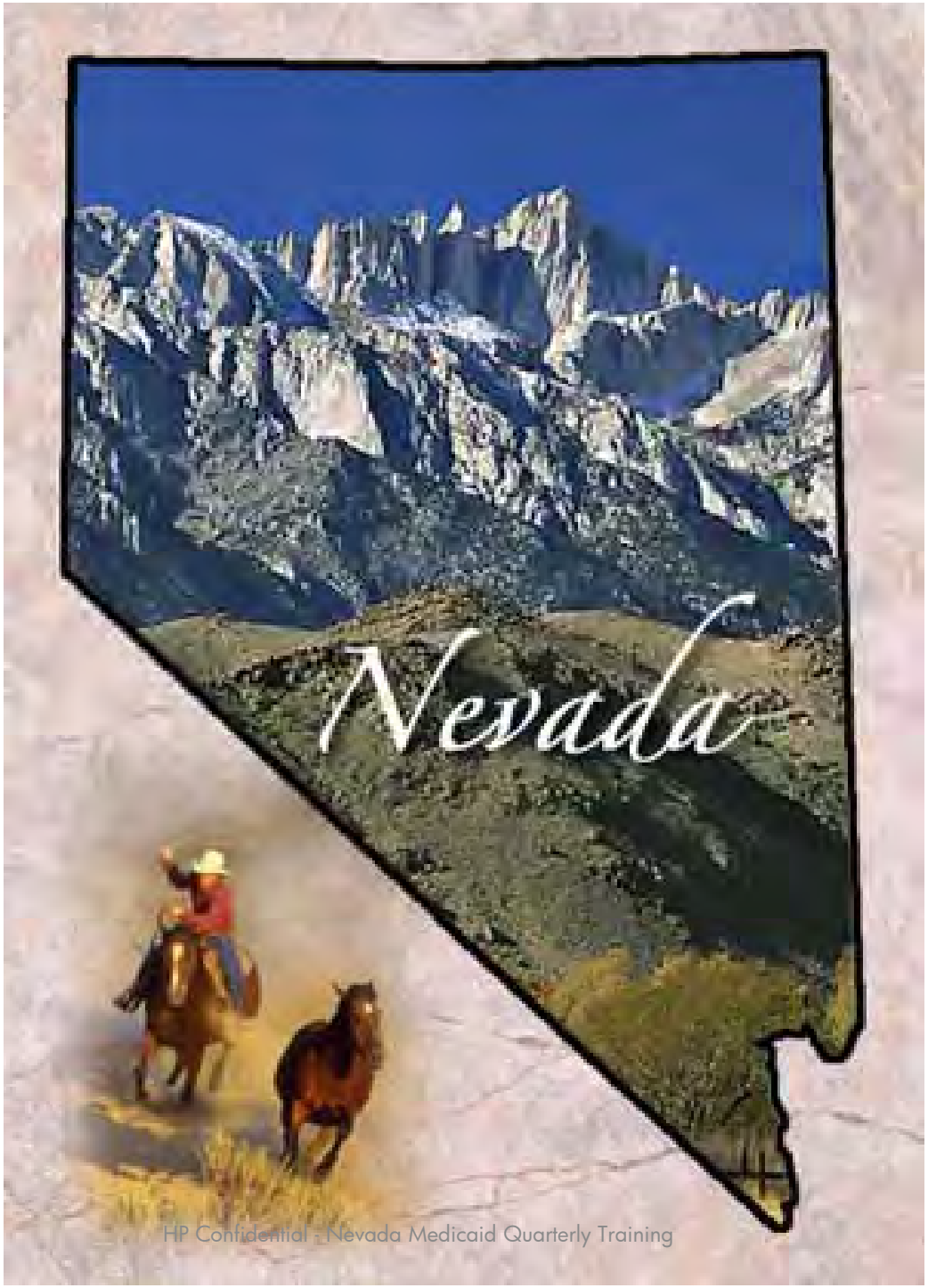
Report Medicaid Fraud!

Press Releases from the Office of the Attorney General

EHR Provider Incentive Payment Program

Hours of operation:

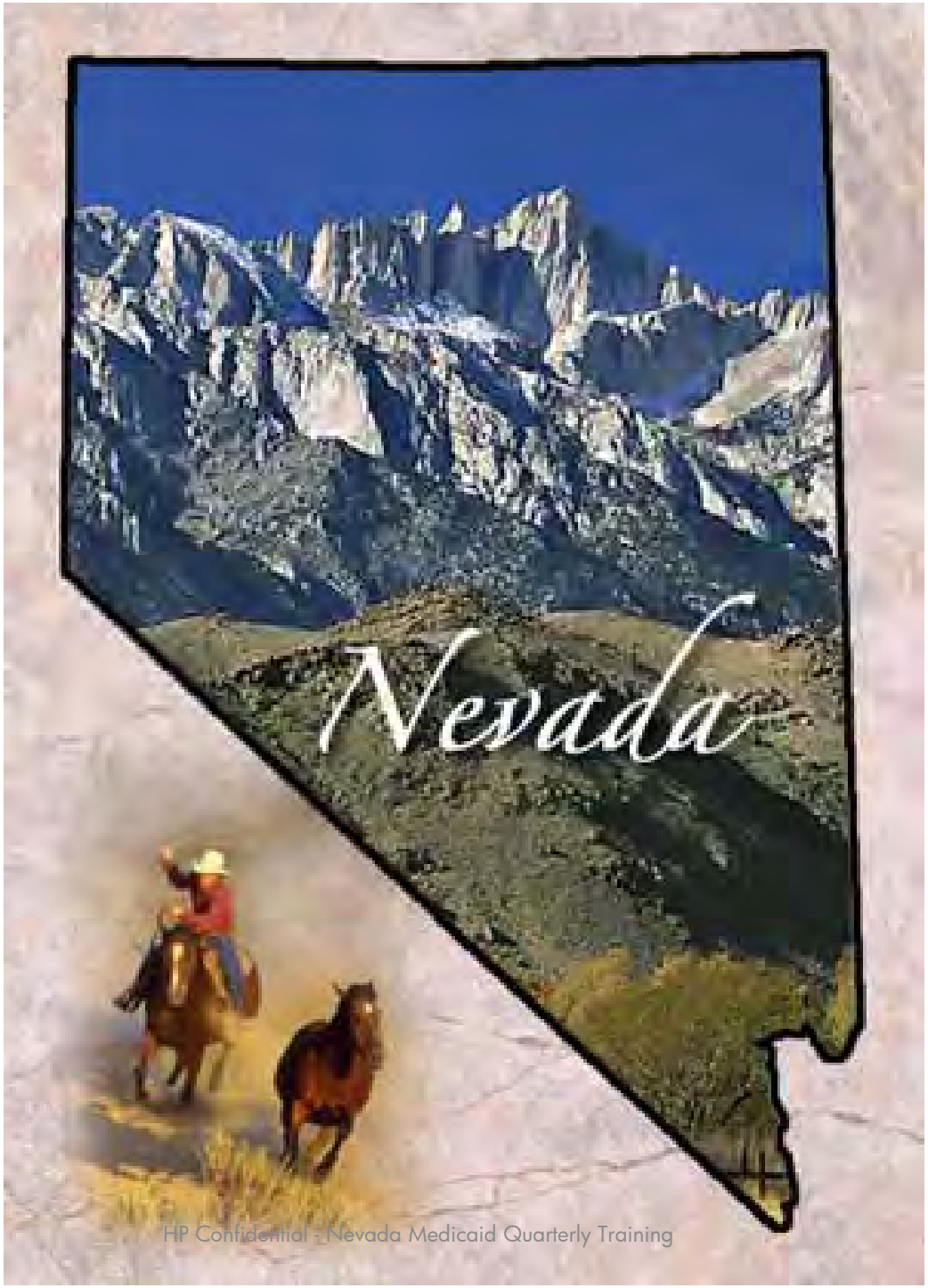
Monday - Friday
8am - 5pm



Recovery Audit Contractor (RAC)

Recovery Audit Contractor – RAC

- A mandate issued by the Affordable Care Act effective January 1, 2012, requires states to contract with one or more RAC(s) 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.



ICD-10

ICD-10 Compliance Date Set for October 1, 2014

On February 16, 2012, Health and Human Services (HHS) Secretary Kathleen G. Sebelius announced that HHS would initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes. The final rule adopting ICD-10 as a standard, published in January 2009, set a compliance date of October 1, 2013.

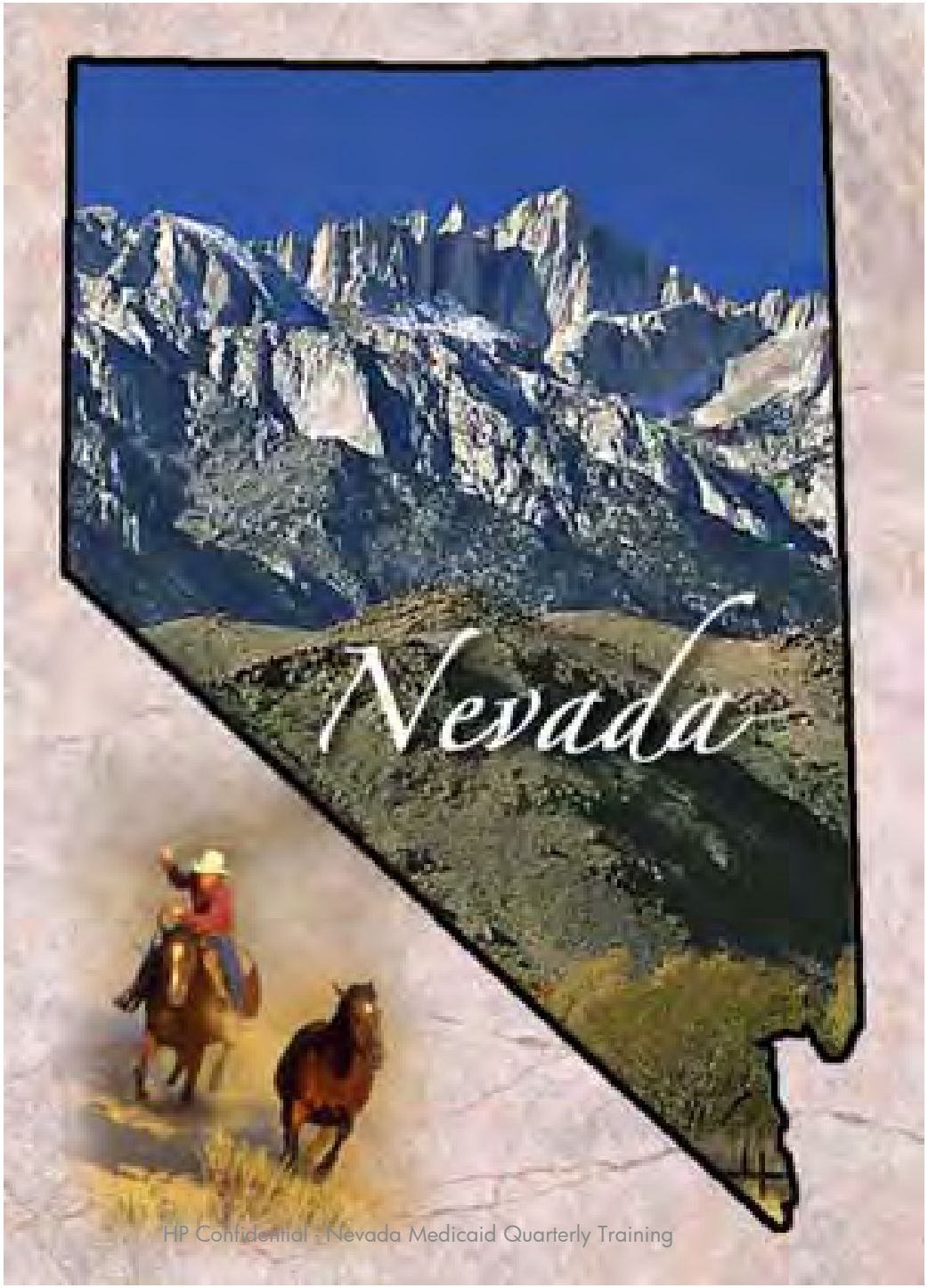
On April 9, 2012, Secretary Sebelius announced a proposed rule that, if approved, would postpone the compliance date until October 1, 2014.

On August 24, 2012, the HHS announced the proposed rule was approved and the compliance date has been delayed until October 1, 2014.

Nevada's Division of Health Care Financing and Policy (DHCFP) and its trading partners are moving forward to be ready for the compliance date.

- ICD-10 will affect diagnosis and procedure coding for all entities covered by the Health Insurance Portability and Accountability Act (HIPAA), not only those entities who submit Medicare or Medicaid claims. The change to ICD-10 does not affect Current Procedural Terminology (CPT) coding for outpatient procedures.
- DHCFP is currently working to identify where ICD codes are used within DHCFP's policies, processes and systems. DHCFP and HP Enterprise Services (HPES) are identifying the tasks necessary to remediate the Medicaid Management Information System (MMIS).
- ICD-9 codes must be used for all procedures and diagnoses dates of service before October 1, 2014. Claims with ICD-10 codes dates of service before October 1, 2014, will be denied.
- ICD-10 codes must be used for all procedures and diagnoses dates of service on and after October 1, 2014. Claims with ICD-9 codes dates of service on or after October 1, 2014, will be denied.

Providers are advised to talk with your software vendor to ensure your system will be upgraded to support ICD-10 by October 1, 2014.



National Correct Coding Initiative Medically Unlikely Edits

(NCCI – MUE)

NCCI – MUE Web Announcement 542

December 10, 2012
Announcement 542

Updated Version of Clinical Claim Editor Implemented

The Division of Health Care Financing and Policy (DHCFP) and HP Enterprise Services 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 now includes the National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUE). Claims are now subject to MUE.

MUE are units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct, e.g., claims for excision of more than one appendix or more than one hysterectomy.

More information about the NCCI mandate can be found on the Centers for Medicare & Medicaid Services (CMS) website. At www.medicaid.gov select "By Topic" from the "Medicaid" tab, select "Data & Systems" from the left-side menu, click on "Coding and Classification," then click on "The National Correct Coding Initiative (NCCI) in Medicaid."

Important Billing Information:

- Many codes will no longer have cutback logic in the MMIS. If your claim has units billed over the MUE limit, then all units will be denied. Units will not be cutback to the allowed amount and paid.
- Do not use modifiers that are not necessary, because they could cause your claim to deny.

The following is an example of a new MUE:

Edit	Description	ADJ/RSN	Remarks/NCPDP/Status	Description
4730	NCCI: UNITS OF SERVICE EXCEED MUE LIMIT	151	N362	The number of Days or Units of Service exceeds our acceptable maximum

NCCI Denial is a Provider Liability:

NCCI denied services SHOULD NOT be billed to the recipient. The denied service is a provider liability. Providers cannot use an "Advanced Beneficiary Notice" or waiver of liability to obtain payment from recipients.

Paper Remittance Advices (RAs) will now contain the following statement when the RA contains an NCCI edit:

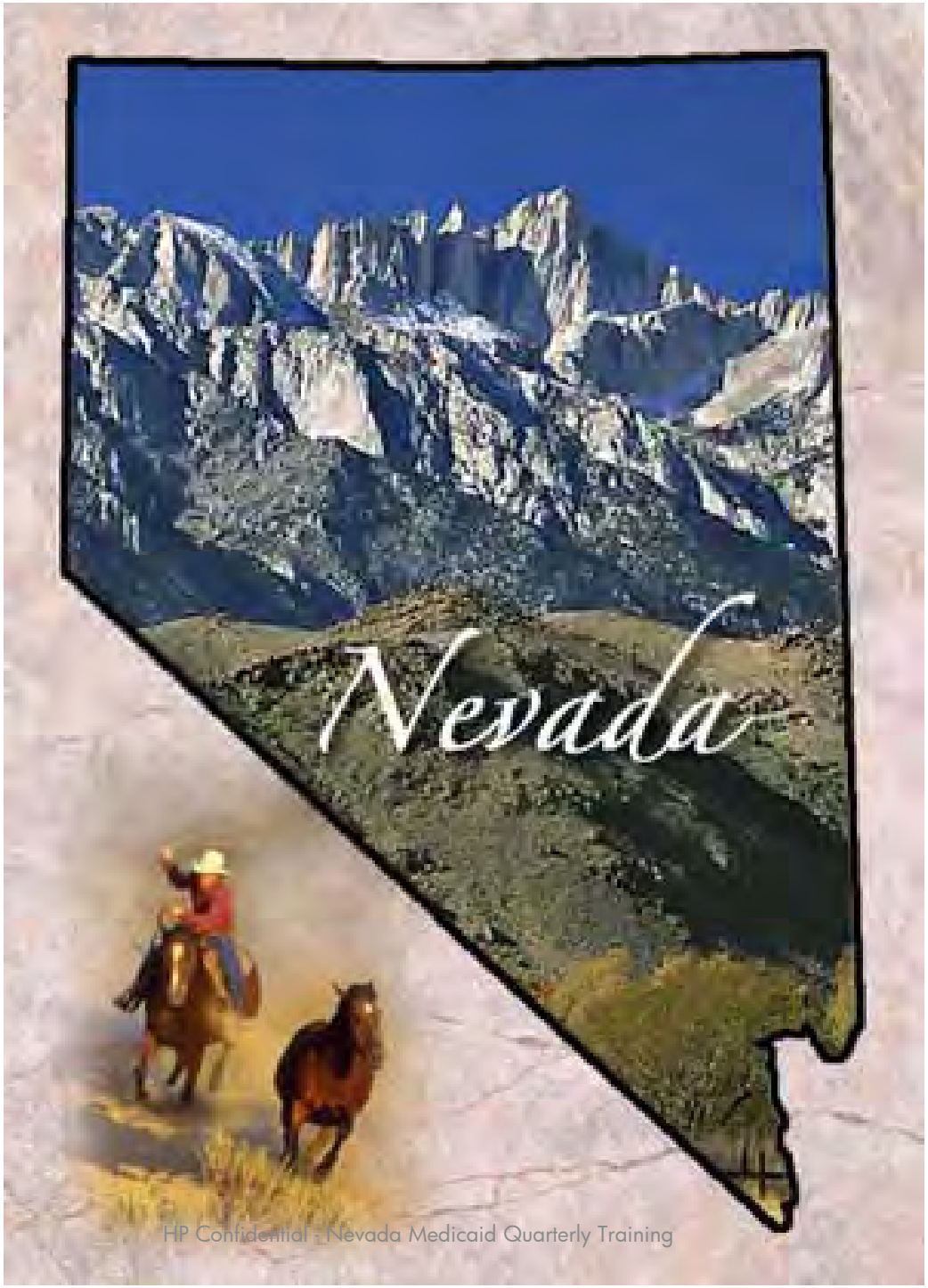
- NCCI denials should not be billed to the recipient MA13

Electronic 835s will now contain the following additional Remark code when the 835 contains an NCCI edit:

- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code

NCCI – MUE Information

- The clinical claim editor criteria used to audit professional and outpatient services claims has been updated to include the National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUE).
- MUE are units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services and durable medical equipment.
- This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct, e.g., claims for excision of more than one appendix or more than one hysterectomy.
- More information about the NCCI mandate can be found on the Centers for Medicare & Medicaid Services (CMS) website located at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html



DHCFP Public Notices/Hearings

Public Hearing Web Announcement

November 5, 2012
Announcement 531

Medicaid Services Manual Updates

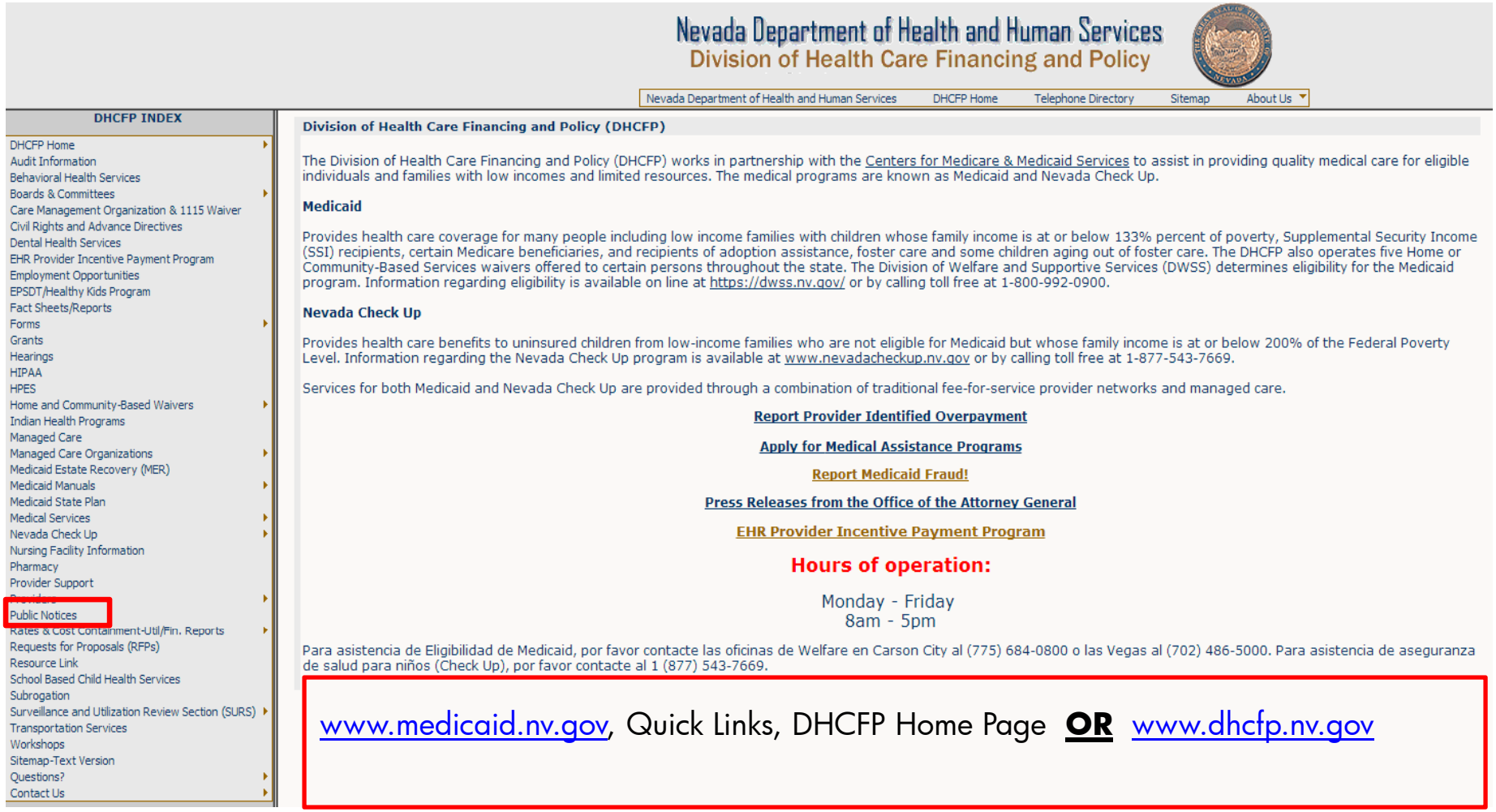
The following Medicaid Services Manual (MSM) chapter changes were approved at a recent Division of Health Care Financing and Policy (DHCFP) Public Hearing. Changes were approved with effective dates as noted. Please review the updated MSM chapters on the DHCFP website. The schedule and agendas for future hearings are on the DHCFP's Public Notices webpage.

The following sections were revised:

- 200 – Hospital Services (effective 10-10-2012)
- 2200 – Home and Community Based Waiver (HCBW) for the Frail Elderly (effective 9-12-2012)
- 3400 – Telehealth Services (effective 9-12-2012)
- 3500 – Personal Care Services Program (effective 9-12-2012)
- 3600 – Managed Care Organization (effective 10-12-2012)

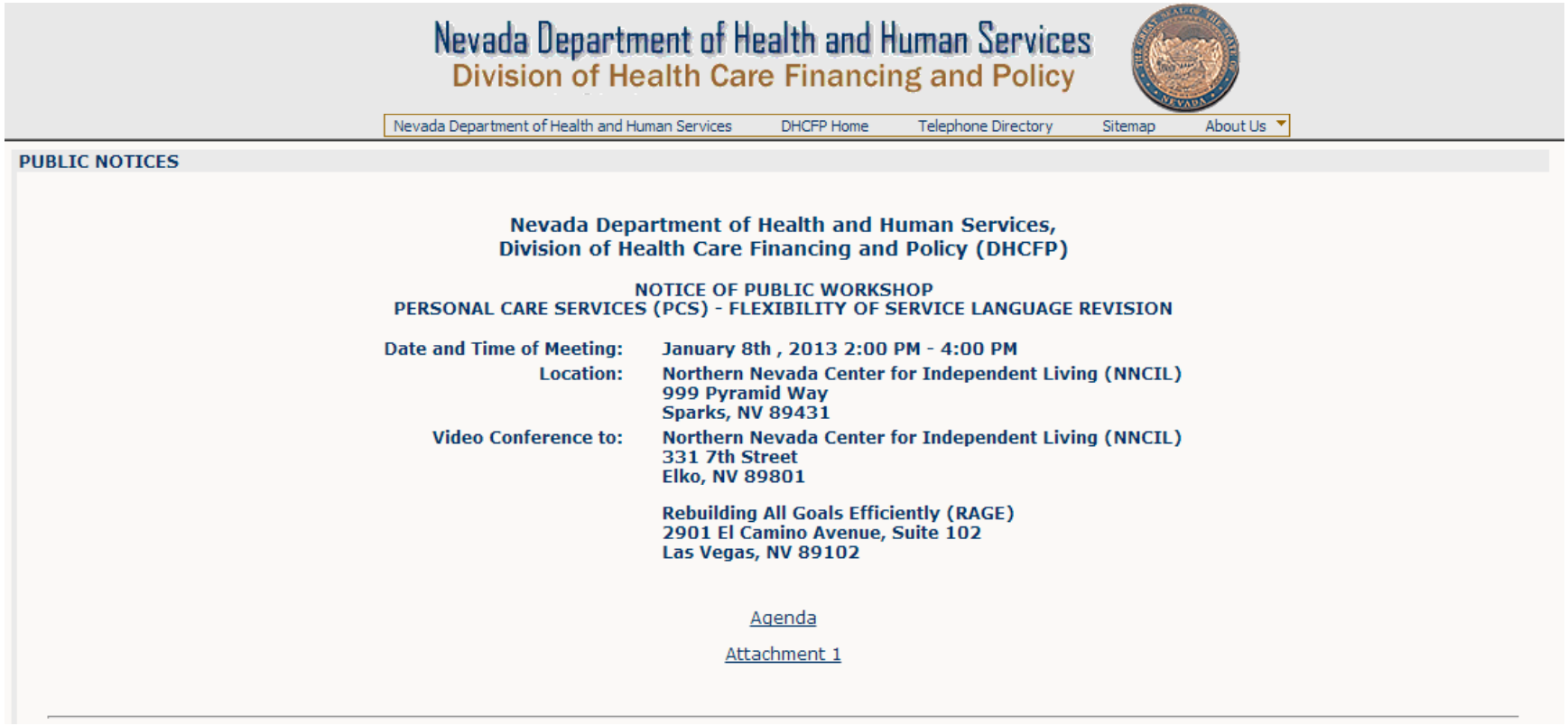
The complete manual is linked at the top of the MSM page.

Locating Public Notices



www.medicaid.nv.gov, Quick Links, DHCFP Home Page **OR** www.dhcfp.nv.gov

Public Notice Agenda



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Division of Health Care Financing and Policy

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PUBLIC NOTICES

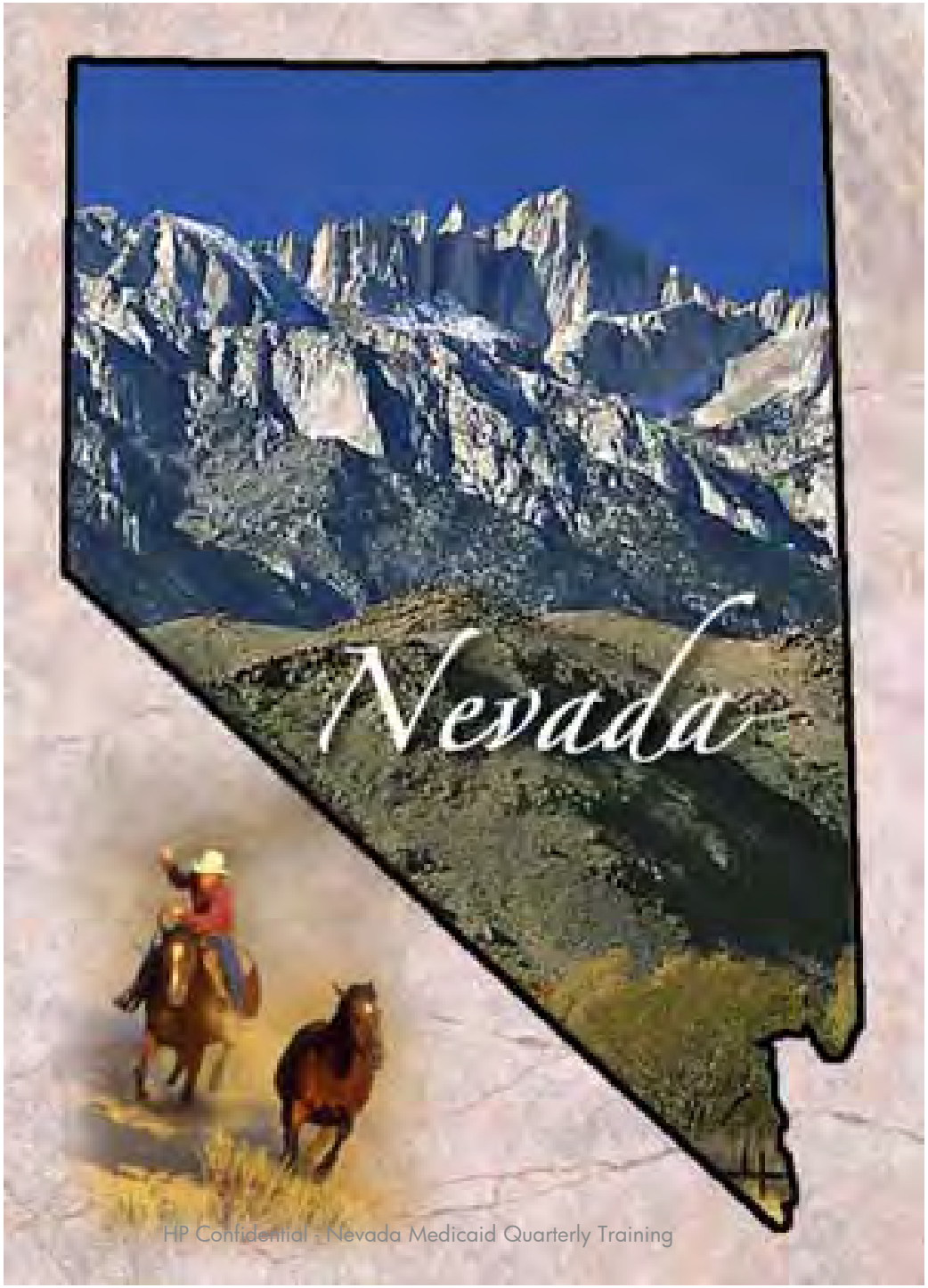
Nevada Department of Health and Human Services,
Division of Health Care Financing and Policy (DHCFP)

NOTICE OF PUBLIC WORKSHOP
PERSONAL CARE SERVICES (PCS) - FLEXIBILITY OF SERVICE LANGUAGE REVISION

Date and Time of Meeting:	**January 8th , 2013 2:00 PM - 4:00 PM**
Location:	**Northern Nevada Center for Independent Living (NNCIL)** **999 Pyramid Way** **Sparks, NV 89431**
Video Conference to:	**Northern Nevada Center for Independent Living (NNCIL)** **331 7th Street** **Elko, NV 89801**
	Rebuilding All Goals Efficiently (RAGE) **2901 El Camino Avenue, Suite 102** **Las Vegas, NV 89102**

Agenda

Attachment 1



Third Party Liability (TPL)

Third Party Liability – TPL

TPL or Third Party Liability insurance providers carry some of the expense for recipients. Always check for TPL.

- Private Insurance
  - Emdeon is the company that partners with HPES to perform TPL identification and recovery.

- If you believe a recipient's private insurance records are incorrect, please contact Emdeon at:
  - Phone: (855) 528-2596
  - Email: TPL-NV@emdeon.com

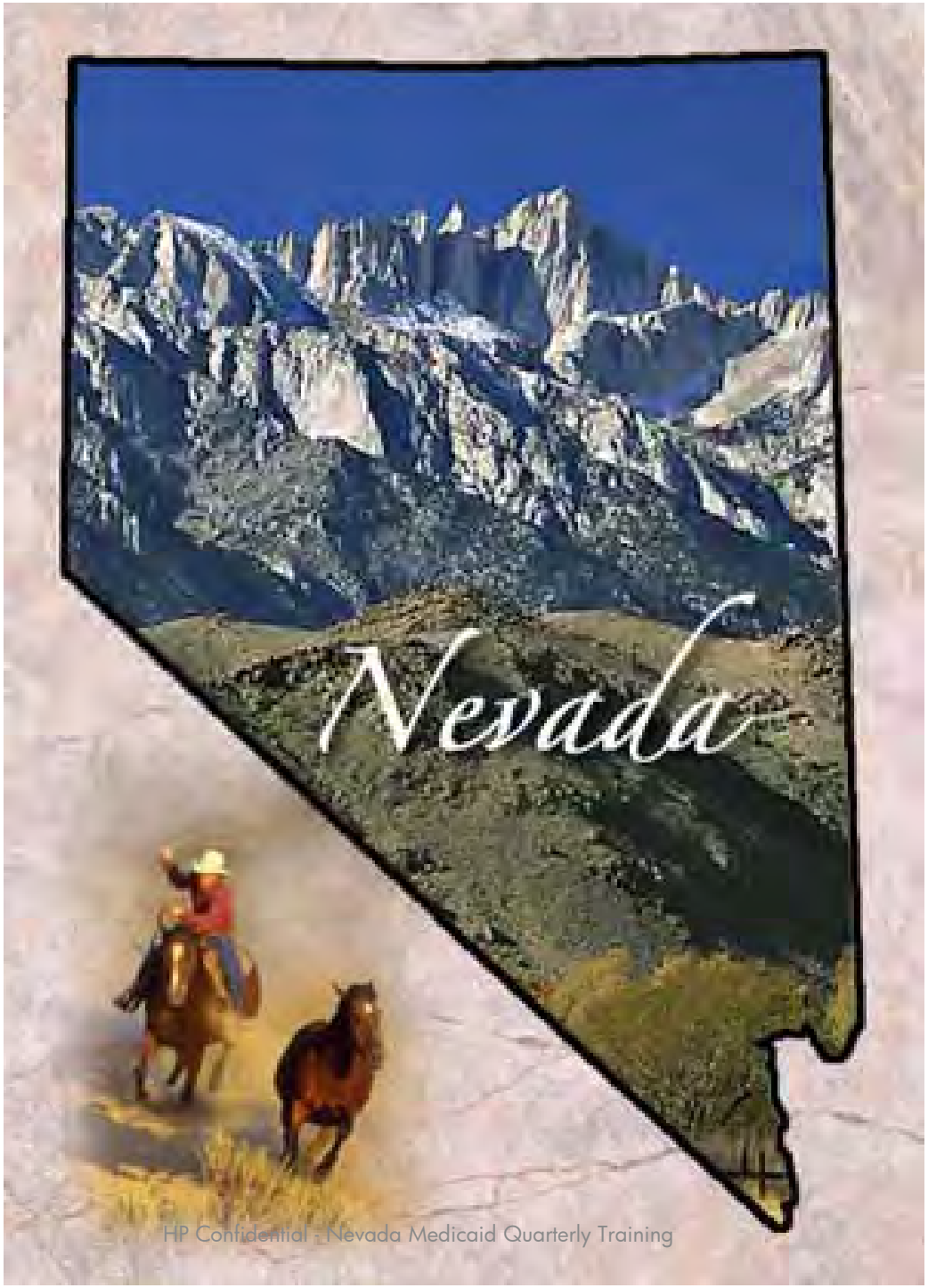
TPL

Medicare

- If you believe a recipient's Medicare record is incorrect, please contact the DHCFP at:
  - Email: tpl@dhcfp.nv.gov

TPL Tips

- Verify the recipient's other insurance(s).
- Bill the recipient's other insurance(s) first.
- Send the claim with the primary EOB(s) attached.
- Bill only one line per claim with the primary EOB(s) attached to each claim.
- Bill only for the recipient's legal obligation to pay.
- If the primary insurance denied the claim or applied payment to the co-insurance and/or deductible, or if primary insurance was terminated or exhausted, send the claim to HPES Customer Service for special batching.



Web Announcements

Web Announcements

- Provider communications are posted as web announcements with updates, changes and new information.
- Announcements may contain special billing instructions and links.
- Remember to check web announcements frequently at www.medicaid.nv.gov.

Locating Web Announcements

Q
&
A

Thank you for attending today!

Please complete your evaluation.
We appreciate the feedback!

Thank you!