

Nevada Medicaid News

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First Health
Services Corporation®

Nevada Medicaid and Nevada Check Up
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Nevada MMIS Receives Federal Certification

In June 2005, the Centers for Medicare & Medicaid Services (CMS) officially certified the Nevada Medicaid Management Information System (MMIS). The certification is acknowledgement that the Nevada Division of Health Care Financing and Policy (DHCFP) and First Health Services have successfully customized the MMIS to meet the needs of the State of Nevada and requirements set forth by CMS.

Medicaid is a jointly funded cooperative venture between federal and state governments to provide medical and health-related services to eligible needy persons. The Nevada MMIS met all federal requirements to receive CMS certification, which means that Nevada Medicaid qualifies for additional Federal Financial Participation (FFP).

Quarterly Update on Claims Paid

The Nevada Medicaid program paid out to providers more than \$303,923,425.57 in claims during the three-month period of April, May and June 2005. Nearly 100 percent of current Nevada Medicaid and Nevada Check Up claims continue to be adjudicated within 30 days due in part to the efforts of all providers.

The Nevada Division of Health Care Financing and Policy and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

Does First Health Services Have Your Correct Address?

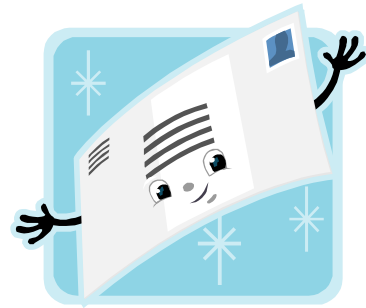
Nevada Medicaid and Nevada Check Up require that all providers submit a Provider Information Change Form (FH-33) within five business days of any change to their provider information on file with First Health Services. The requirement applies to changes to addresses,

as well as licenses and certifications, Medicare billing numbers, IRS information, and adding or excluding providers to a Provider Group.

Entering a new address on your claim form does not change your file in the Medicaid Management Information System (MMIS). Remittances will be mailed to the address shown in your file, and not the one shown on your claim.

To check your addresses on file, please call First Health Services' Provider Enrollment Unit at (877) 638-3472 (press 2, then press 4). The CSR will access your provider information and verify the addresses. Ask the CSR to check the information for each of the Provider Medicaid Numbers under which you file claims. Please ensure that the correct contact person is also recorded.

The CSR cannot alter the files. If any of the information is incorrect or you want to add or delete an address, please complete and submit form FH-33. List all Provider Medicaid Numbers affected by the change. Use additional forms if you need to correct more than one of your addresses on file.



Below are explanations of the four addresses First Health Services can have recorded for you:

Servicing Address: The physical location of your practice, business or facility.

Mail-To Address: The address used for correspondence other than Remittance Advices (RAs) and Medicaid checks. This does not have to be a physical location.

Pay-To Address: The address to which your Medicaid check is sent.

Remittance Advice Address: If applicable, the address to which your hard copy (paper) Remittance Advice (RA) is mailed. If this address is not provided, your RA is mailed to the Servicing Address.

FH-33 can be downloaded from <https://medicaid.nv.gov> from three locations on the website: select "Forms" from the "Providers" drop-down menu; or select "Change My Provider Information" or "Provider Enrollment" from the "Quick Links" drop-down menu.

FH-33 is an active form, which means you can complete the form on your computer, print it, sign it (the provider's signature is required), then mail it to: First Health Services, Provider Enrollment, P.O. Box 30047, Reno, NV 89520-3047.

Verify Recipient Eligibility and Benefit Plans on a Monthly Basis

An essential step in rendering services to Nevada Medicaid and Nevada Check Up recipients is to verify eligibility and benefit plans each time before providing services. If a recipient is not eligible for Nevada Medicaid/Nevada Check Up benefits, the claim will deny.

A recipient's eligibility may change on the first day of any given month. For example, a provider may verify a recipient's eligibility for two or more calendar months at one time, but on the first day of the second month the eligibility may change and the recipient may not be covered

starting that second month. By the same token, a prior authorization for one month may not continue into the next month if the recipient loses eligibility. **The only way a provider will know about the change is to continue to verify the recipient’s eligibility every month.**

Three easy methods to check recipient eligibility and service limits, and to determine if a recipient is currently enrolled in a Health Maintenance Organization (HMO), also referred to as a Managed Care Organization (MCO), are:

- ◆ Log on to the Electronic Verification System (EVS) at <https://medicaid.nv.gov>. From the “Providers” drop-down menu select “EVS Logon” or for information about the system select “EVS User Manual.”
- ◆ Call the Nevada Medicaid Audio Response System (ARS) at (800) 942-6511.
- ◆ Utilize the swipe card system. Contact your swipe card vendor to help you set up your system.

Figure A - EVS Eligibility Screen Print shows a portion of an eligibility response screen you will see when you access EVS for eligibility information. The left-most column (Benefit Plan field) indicates in which benefit plan(s) the recipient is enrolled. If EVS displays “MEDICAID FFS” only in the Benefit Plan field, the recipient was eligible to receive full Medicaid benefits during the time period specified.

Figure A shows that the recipient is enrolled in one of the two HMOs in Nevada. The bolded box under “Eligibility Information” will say **either** Health Plan of Nevada, Inc. or NevadaCare Inc. when the recipient is enrolled in one or the other. The bolded box under “MEDICAID FFS” in Figure A reads “XIX MAN NNEV,” which also indicates that this recipient was enrolled in Title XIX Managed Care Northern Nevada during the time period specified.

If the recipient is a Qualified Medicare Beneficiary (QMB), EVS will display “MED CO & DED” only in the Benefit Plan field.

Eligibility Information					
Provider Name Last/Org Name (Current MCO):			HEALTH PLAN OF NEVADA, INC		DOD: 05/12/2004
Provider Name Last/Org Name (Previous MCO):					DOD:
Benefit Plan (Plan Coverage Desc)	Begin-End (Date Time Period)	Eligibility or Benefit Info	Patient Pay (Benefit Amt)	Provider ID (Benefit Related Entity ID)	Phone Number Communication Number
MEDICAID FFS	08/07/2004-08/31/2004	1	0.00		
XIX MAN NNEV	08/07/2004-08/31/2004	1	0.00		

Figure A - EVS Eligibility Screen Print

Reminders:

- ◆ Look at all lines when viewing eligibility information on EVS; scroll down to view the entire screen and all benefit plans listed.
- ◆ Verify recipient eligibility on a monthly basis.
- ◆ When a recipient is enrolled in an HMO, submit any claim(s) to the recipient’s HMO.

General Reminders for All Providers

Medicare Benefit-Exhausted Services

Recipients who are eligible for both Medicaid and Medicare benefits are referred to as having dual eligibility. Dual eligibility creates some situations that require special instructions for providers to follow in order to be paid appropriately by Medicaid, such as when the recipient's Medicare benefits have been exhausted.

When a recipient's Medicare benefits have been exhausted, Medicare will send to the provider an Explanation of Medicare Benefits (EOMB). Upon receiving the EOMB, the provider must obtain a Medicare Catastrophic Coverage Act (MECCA or MCCA) form and attach a copy of the MECCA to the Medicaid claim that is submitted to First Health Services.

If First Health Services is unaware that Medicare benefits have been exhausted, Medicaid claims will be denied. Medicaid is the payer of last resort after all other Third Party Liability (TPL) health care coverage (including Medicare) has paid a recipient's medical expenses.

If you have any questions regarding Medicare crossover claims, please call a First Health Services Customer Service Representative at (877) 638-3472.

Prior Authorization Requests

The preferred way for Nevada Medicaid and Nevada Check Up providers to submit Prior Authorization (PA) requests to First Health Services is by using the Online Prior Authorization System. For information on the system, visit <https://medicaid.nv.gov> (select "Prior Authorization" from the "Providers" drop-down menu).

If you mail or fax PA requests instead of submitting them online, please complete all required fields on the forms clearly and legibly, and include all necessary clinical documentation. Prior Authorizations may be delayed if all forms are not completed and/or supplementary information is not provided.

PA forms are available online at <https://medicaid.nv.gov> by selecting "Prior Authorization" or "Forms" from the "Providers" drop-down menu. Many of the forms are active, which means you can complete them on your computer, print them, sign if applicable, and then fax or mail the forms to First Health Services.

Services that require Prior Authorization are listed in the Provider Billing Manuals under "Chapter E – Prior Authorization" and under each provider type. The Manuals are posted online under the "Providers" drop-down menu at <https://medicaid.nv.gov>.

For questions regarding prior authorization forms and procedures for Personal Care Aide and Dental services call (800) 648-7593; for Pharmacy services call (800) 505-9185; and for all other services call (800) 525-2395.

Online Resources

Visit <https://medicaid.nv.gov> on a weekly basis to keep up to date on:

Billing Manual revisions – select "Billing Manuals" from the "Providers" drop-down menu.

State Medicaid Policy Updates – select "DHCFP Web Site," then click on "Medicaid Service Manuals."

Provider Training sessions – select "Provider Training" from the "Providers" drop-down menu.

Web Announcements – from the homepage click on "View all web announcements."

Notifications for Pharmacy Providers

Revision to Prospective Drug Utilization Review (ProDUR) Denials:

Since June 15, 2005, certain ProDUR conflict messages have required the pharmacist to enter appropriate Intervention and Outcome Codes to override the denial (refer to the ProDUR Denial Memorandum dated May 18, 2005). Based on feedback received from practicing pharmacists as well as the Drug Use Review Board of the Nevada Division of Health Care Financing and Policy, therapeutic duplicate and ingredient duplicate edits were inactivated. More revisions are anticipated and will be announced soon.

Antidepressant Grandfathering to Expire:

On September 22, 2004, recipients receiving non-preferred antidepressant medications were allowed to continue receiving the medications for up to one year without the need for prior authorization. This policy was followed to ensure continuity of care. The expiration date for the one-year grandfathering period has been extended to coincide with the implementation of an update to the Preferred Drug List (PDL). In order to ensure continuity of care and minimize recipient confusion and frustration, prescribers must contact the First Health Services Clinical Call Center if they wish to have these recipients continue on a non-preferred antidepressant. The phone number is 1-800-505-9185.

Note: This message does not apply to recipients who started on a non-preferred antidepressant after September 22, 2004, since prior authorization would have been required at the time therapy was initiated.

Pharmacy Provider Forums:

In order to provide an opportunity for pharmacy providers to ask questions and provide feedback on pharmacy billing issues and changes, provider forums are held on a quarterly basis. The first sessions were held in July; the next forums will be scheduled for September and October. Refer to <https://medicaid.nv.gov> for dates and locations. Select “Announcements/Meetings” from the “Pharmacy” drop-down menu.

Preferred Drug List Reminder:

The current version of the Nevada Medicaid Preferred Drug List (PDL) is posted online at <https://medicaid.nv.gov> (select “Preferred Drug List” from the “Pharmacy” drop-down menu).

Update on Stale-Dated Claims Policy

First Health Services Corporation is authorized by the Division of Health Care Financing and Policy (DHCFP) to process for adjudication the stale-dated claims that were submitted by Medicaid providers from September 1, 2003, to the present as long as the requests meet either one (1) of the following criteria:

- ◆ The provider submits documentation that demonstrates they had delayed submitting the claim for payment because they were pursuing payment from another source (third party liability resource).

- ♦ The provider submits documentation that demonstrates the delay in submitting the claim was the result of erroneous information (faulty edits, missing codes, etc.) provided by the State's Welfare or Medicaid agencies or First Health Services.

In both instances, the provider must submit the stale-dated Medicaid claims with an attachment (e.g., copy of Explanation of Benefit (EOB)) validating that they meet at least one of the criteria listed above. Stale-dated Medicaid claims without such validation would be denied for timely filing limits.

DHCFP believes ongoing claims are paying accurately and there is no reason to give more time to providers to file clean claims. However, if stale-date issues still exist, DHCFP gives First Health Services the authority to override the stale date when providers can document their actions did not cause the filing delay.

Reminder for Physicians Billing Non-Oral Drug Codes

Nevada Medicaid would like to remind providers who bill "J" and "Q" Healthcare Common Procedure Coding System (HCPCS) codes that Chapter 600, Section 605 of the Division of Health Care Financing and Policy's Medicaid Services Manual (MSM) refers providers to other chapters that should be referenced and cross referenced. Among those chapters included on the References and Cross References list in Section 605 is Chapter 1200 – Prescribed Drugs.

Chapter 1200, Section 1207.B.3 states the following:

3. Physician Office/Clinic:

Pharmacy charges are billed separately, using the appropriate CPT code for administration of the drug. The drug is to be billed per HCPCS J-Code at Redbook AWP (Average Wholesale Price). The provider is to enter the Redbook AWP under billed charges on the CMS 1500 and will be reimbursed at billed charges (Redbook AWP) minus fifteen percent (15%). Reference Chapter 1300 for billing of associated supplies.

To review the MSM, visit <https://medicaid.nv.gov>; select "DHCFP Web Site" from the "Quick Links" drop-down menu, then click on "Medicaid Service Manuals."

The Centers for Medicare & Medicaid Services Announces Proposed Changes to the Payment Error Rate Measurement Program

On July 22, 2005, the Centers for Medicare & Medicaid Services (CMS) published a notice in the Federal Register announcing *proposed* changes to the Payment Error Rate Measurement (PERM) program that was set to start on October 2, 2005. The PERM program was a result of the Improper Payments Information Act of 2002 (Public Law No. 107-300), enacted in

November 2002, requiring federal agencies to annually review and identify programs and activities that may be susceptible to significant erroneous payments.

The proposed change announced on July 22, 2005, indicates CMS will hire a federal contractor to conduct the medical and processing reviews, and only a sample of states will be reviewed each year. A total of 18 states will be chosen for review each year, for each program (Medicaid and State Children's Health Insurance Program (SCHIP), known as Check Up in Nevada). The proposed change was made as a result of public comments to the August 27, 2004, proposed PERM rule.

The effect of this proposed change on Medicaid and Check Up providers in Nevada will be minimal if Nevada is chosen as a sample state for each program. All providers will still be included in the sample pool and may be subject to a medical records request. The medical records request will come from the federal contractor for CMS and if the provider does not submit sufficient documentation to support the medical necessity of the service or the documentation is not submitted timely, the federal contractor will record the claim as an error and the Nevada Division of Health Care Financing and Policy (DHCFP) will be required to recover the payment from the provider.

Since CMS is the designated health oversight agency for both the Medicaid and SCHIP programs, the medical records request is a permitted disclosure under the Health Insurance Portability and Accountability Act (HIPAA), privacy regulations 164.512 (d). In addition, DHCFP provider contracts contain language requiring providers to furnish medical record documentation to federal employees or authorized representatives to perform audits and other activities, as requested. Information collected for this program will be held in strict confidence in compliance with all applicable policies, requirements, regulations and statutes.

The DHCFP will notify Medicaid and Check Up providers if any additional changes to the PERM program are announced.

Transportation Option for Recipients in Need

Transportation to covered, medically necessary, non-emergency services is available for Medicaid recipients and Nevada Check Up participants who have no other means to travel to appointments.

The Division of Health Care Financing and Policy, which administers Medicaid and Nevada Check Up, contracts with a non-emergency transportation broker named LogistiCare. LogistiCare is a nationwide company now with offices in Las Vegas. The company has developed a network of transportation providers ranging from individual volunteers who use private vehicles to paratransit services with the capability to simultaneously transport multiple passengers with mobility issues. LogistiCare's call center operates 24 hours a day, seven days a week and staff members are always ready to arrange the most economical form of transportation that is appropriate for each individual's medical condition. The statewide access number is 1-888-737-0833.

Normally, a recipient, or a provider on behalf of a recipient, contacts LogistiCare at least 48 hours prior to the scheduled appointment. LogistiCare verifies the recipient's eligibility for services, contacts the Medicaid provider to verify the appointment, and schedules the ride.

Transportation to medical services that require prior authorization cannot be confirmed until LogistiCare is able to verify that prior authorization has been issued by the appropriate entity. This includes travel to all out-of-state appointments regardless of the medical specialty or service to be accessed.

In addition to scheduling transportation, LogistiCare has the capability of reimbursing Medicaid recipients and Nevada Check Up participants who use their own vehicles to travel to appointments. Reimbursement is on a per-mile basis.

When using LogistiCare's services, it is important to remember that the company is contractually obligated to use the most economical means of transportation that is appropriate for the individual's medical condition. Additionally, the company must consider whether the individual's appointment is with the nearest appropriate provider. One escort may travel with an individual who needs ambulatory assistance during transit and at the location of the medical appointment. Except in limited circumstances, an escort is required for an individual who is under the age of 18.

Chapter 1900 of the Medicaid Services Manual sets forth policy for both emergency and non-emergency transportation. The chapter is undergoing extensive revisions and it is anticipated that the new document will be presented for public hearing in September 2005. To monitor when the proposed chapter is posted for public review, visit <http://dhcfp.state.nv.us> and choose "Public Notices" from the left-hand menu.