Clinical Claim Editor Will Analyze Claims for Professional and Outpatient Services

In the first quarter of 2009, clinical claim editor will begin reviewing and adjudicating claims for professional and outpatient services in conjunction with the Medicaid Management Information System (MMIS). Prior to this implementation, the Division of Health Care Financing and Policy (DHCFP) and First Health Services have been implementing a clinical claim editor to ensure nationally recognized billing guidelines are met and claims are paid. Coder analysis is derived from the most clinically likely scenario based on American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS) and specialty society guidelines, industry standards and Nevada Medicaid/Nevada Check Up policy.

For complete instructions and a checklist of items that must be included with an appeal, see the "How to File an Appeal" section of the Billing Information from the "Providers" menu. The Billin g Man ual provides instruction on resubmitting a denied claim or submitting an adjustment or void. You cannot appeal a claim because it was paid incorrectly; you must handle incorrect payments by submitting an adjustment.

CONTENTs:
Electronic Prescribing Page 2
Pharmacy Lock-In Program Page 2
Provider Training Expands in 2009 to Include OPAS and Behavioral Health Sessions

First Health Services and the Division of Health Care Financing and Policy offer free, comprehensive training throughout the year for newly enrolled providers as well as established providers and staff. The schedule for 2009 includes Claim Type Training, Provider Type Training and Nevada Medicaid Policy.

The free Annual Medicaid Conference covers general information for all providers, as well as individualized training focused on the following topics:

- New comprehensive training begins in January. Registration is required for all classes and conferences.
- The 2009 Nevada Medicaid and Nevada Check Up Provider Training Catalog contains class schedules and descriptions, training locations and registration links. The "Providers" menu at https://medicaid.nv.gov contains class schedules and descriptions.

Preliminary Agenda:
- General information for all providers (March 10-11, Las Vegas)
- Preventive Services (April 7-8, Las Vegas)
- Electronic Prescribing (April 14-15, Las Vegas)
- Electronic Health Records (April 21-22, Las Vegas)
- Preventive Services (May 12-13, Las Vegas)

Additional information can be accessed at http://nevada.fhsc.com (select "Billing Information" from the "Providers" menu).
E-Prescribing: The Division of Health Care Financing and Policy (DHCFP) and First Health Services have incorporated an enhancement that impacts those prescribers who use, or are looking to use, electronic prescribing technology.

Eligibility, recipient pharmacy claims history, Nevada Medicaid drug cog eration data and the indication of the need for prior authorization for N evada Medicaid/Nevada Check Up Fee For Service recipients are now available to prescribers who use electronic prescribing systems.

Access to this data can build the efficiency of a practice by helping to decrease the num ber of callbacks and questions th at arise when prescriptions are not prepared in line with the required coverage eligibility requirements.

This data is only available to providers who transmit prescriptions electroni cally to a pharmacy co mputer, not to fax machines. Prescribers can utilize e-prescribing to its fullest by recognizing the capabilities of their systems, working with their vendors to enable their systems for computer-to-computer connectivity with pharmacies, and understanding if their systems can receive and work with Nevada Medicaid supplied data.

For further details, select the new “E-Prescribing” tab from the “Providers” menu at https://medicaid.nv.gov.

Tamper-Resistant Prescription Pads: Effective Oct. 1, 2008, all written, non-electronic prescriptions for Medicaid Fee For Service outpatient drugs must contain at least one feature from each of three categories of tamper resistance specified by the Centers for Medicare & Medicaid Services (CMS). See Web Announcement 215 at https://medicaid.nv.gov for the categories as well as situations when the requirement does not apply.

PDL Changes Effective Dec. 17, 2008: In Se ptember 2008, the Pharmacy and Therapeutics (P&T) Co-committee of DHCFP co-mpleted the annual review of the Preferred Drug List (PDL). The actions tak en by the committee are listed in the web announcement titled “Preferred Drug List (PDL) Changes Effective December 17, 2008.” The web announcement and complete PDL are posted on the “Preferred Drug List” page under “Pharmacy” at https://medicaid.nv.gov.

Pharmacy Lock-In Program: Nevada Medicaid has developed a pharmacy lock-in program for Nevada Medicaid/Nevada Check Up recipients who receive nine or more controlled substance prescriptions within a 60-day period. The goals of the lock-in program are to provide continuity of care, avoid over utilization of prescription drugs, and ensure that only the most medically necessary care and services are provided.

Recipients will be locked-in for controlled substances only. Once the DHCFP makes the decision to lock in a recipient to a pharmacy, First Health Services will send a notification to the recipient, the recipient’s most utilized (locked-in) pharmacy and the recipient’s prescribers. Recipients may change their lock-in pharmacy through their local Medicaid District Office.

If a lock-in recipient attempts to get a controlled substance from another pharmacy, the claim will deny with the “50” rejection code, which is “Non Matched Pharmacy ID Number.” The pharmacy may receive a transaction message that states “Non Matched Pharmacy ID - Check NPI/Locked In - Call 1-800-505-9185.”

Pharmacies may call (800) 505-9185 to determine the lock-in pharmacy or request an override to the denial. Overrides will be considered if the lock-in pharmacy is out of stock; the lock-in pharmacy is closed; or the recipient is out of town and cannot access the lock-in pharmacy.

Quarterly Update on Claims Paid Nevada M edicaid and N evada Check Up paid out to providers $314,942,245.54 in claims during the three-month period of July, August and September 2008. Nearly 100 percent of current claims continue to be adjudicated within 30 days. The DHCFP and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

Medicaid Manual Changes The following Medicaid Manual chapters were revised in August or September 2008:

- MMM Chapter 200 – Boards, Committees and Advisory Committees
- NCU Chapter 1000 – Nevada Check Up
- MSM Chapter 400 – Treatment Home Services
- MSM Chapter 900 – Private Duty Nursing
- MSM Chapter 1000 – Dental Services
- MSM Chapter 1100 – Ocular Services
- MSM Chapter 1200 – Prescribed Drugs
- MSM Chapter 1300 – DM
- MSM Chapter 1500 – Healthy Kids
- MSM Chapter 1900 – Transportation
- MSM Chapter 2200 – Aging Services
- MSM Chapter 2800 – School Based Child Health Services
- MSM Chapter 3500 – Personal Care Services Program

HIPP Benefits the State, Medicaid Recipients and Taxpayers The Health Insurance Premium Payment (HIPP) program is a cost-savings program that identifies Medicaid recipients who have access to private health insurance through an em ployer. Medicaid pays the m edical prem ium, co-insurance and deductibles for eligible recipients when it is determined to be cost-effective.

Taxpayer dollars are save d by purchasing health insurance available to Medicaid recipients, because high costs a re de-f erred to the private insurance. The program assists recipients in paying employer premiums they otherwise may not be able to afford.

If a provi der has a recipient who may benefit from the program, Nevada Medicaid asks that the recipient be referred to the contact information at the end of this article.

To be eligible for the program, recipients:

- Must be eligible for full Nevada Medicaid, and
- Must be eligible for, own the premium payments, and
- Cannot be eligible for Medicare.

Important details regarding HIPP include:

- Changes to employer health premiums may result in disenrollment from the HIPP program if the insurance is no longer cost-effective.
- Recipients who have a catastrophic illness, condition or are pregnant are eligible to participate in HIP P if it is determined to be cost-effective.

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Nevada Medicaid Preventive Health Services

Preventive Health Services is a benefit for children enrolled in Nevada Medicaid. The goal of this program is to keep children healthy and reduce the number of preventable illnesses.

Preventive Health Services include (but are not limited to):
- EPSDT screening, including vision, dental and hearing exams;
- Immunizations;
- Lead testing and other laboratory tests.

Preventive Health Services is available to children enrolled in Nevada Medicaid. The goal of this program is to keep children healthy and reduce the number of preventable illnesses.

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Providers who use correct coding may not see any changes on their remittance advice (RA); however, providers who are not following standard billing and coding practices will see changes. Affected claims may be denied and then adjudicated by the most appropriate coding for the service being billed. The denied claim and the corresponding adjudicated claim will be shown on the same RA.

Providers are encouraged to monitor web announcements at [https://medicaid.nv.gov](https://medicaid.nv.gov) for updates and additional information. Useful Frequently Asked Questions (FAQs) regarding edit categories, edit definitions, modifiers and RAs changes will soon be posted on the website (select “Announcements/Newsletters” from the “Providers” menu).

Providers should be aware that RA changes due to the MMIS enhancement.

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**Filing an Appeal on a Denied Claim**

If you do not agree with a claim denial, please contact the First Health Services Customer Service Center at (877) 638-3472. Certain denials can be resolved by phone. If this is not the case for your claim, the representative may be able to advise you how to resubmit your claim so it can be paid.

If you do submit an appeal, be sure to postmark it no later than 30 calendar days from the date on the remittance advice listing the claim as denied. Be sure to mail appeals separately from other claims.

For complete instructions and a checklist of items that must be included with an appeal, see the “How to File an Appeal” section of the Billing Manual (select “Billing Information” from the “Providers” menu). The Billing Manual also provides instruction on resubmitting a denied claim or submitting an adjustment or void. You cannot appeal a claim because it was paid incorrectly; you must handle in correct payments by submitting an adjustment.

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**Provider Training Expands in 2009 to Include OPAS and Behavioral Health Sessions**

First Health Services and the Division of Health Care Financing and Policy offer free, comprehensive training through the Medicaid Management Information (MMIS) system is implemented.

In order to meet the needs of providers, the training program has been expanded for 2009 to include sessions focusing on the Online Prior Authorization System (OPAS) for provider types A, B, and M. The training program will cover billing and policy for provider types 14 and 82.

The free Annual Medicaid Conference will provide general and individualized training sessions for all providers, as well as webinars for individual providers.

The 2009 Nevada Medicaid Check Up Provider Training Catalog contains class schedules and descriptions, training locations and registration details. Please visit [https://medicaid.nv.gov](https://medicaid.nv.gov).

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**MCO Update: DHCFP Contracts with AMERIGROUP; No Change to Health Plan of Nevada Contract**

The Division of Health Care Financing and Policy (DHCFP) has announced that AMERIGROUP will assume the remaining term of the Medicaid Managed Care Organization (MCO) contract currently held by Anthem BCBS PP (Partnership Plan) effective Feb. 1, 2009. No change has been made to the contract with Health Plan of Nevada.

AMERIGROUP will provide, and Health Plan of Nevada will continue to provide, all regular managed care services, including dental, to Medicaid TANF/CHAP and Nevada Check Up recipients in urban Washoe and urban Clark counties beginning Feb. 1, 2009. Anthem BCBS PP (Partnership Plan)’s contract ends on Jan. 31, 2009.

First Health Services continues to administer prior authorizations and provider reimbursements for fee-for-service (FFS) claims.

Anthem BCBS PP providers are advised to submit their claims for services to Anthem in a timely manner before Feb. 1, 2009, to assist in a smooth transition.

Providers who have questions regarding the MCOs may call the DHCFP Business Lines Unit at (775) 684-3692.

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**Details Regarding Prior Authorization Denials**

Providers who receive a denial (non-certification decision) in response to a prior authorization (PA) request may call to request the clinical basis for the decision. A First Health Services representative will provide the principal reason for the denial and specific reasons why medical necessity criteria were not met.

Upon the provider’s request, a written statement specifying the clinical rationale used in making the non-certification decision will be provided.

The numbers to call are (800) 648-7593 for adult day health care and (800) 525-2395 for all other service types (except pharmacy).