Nevada Medicaid and Nevada Check Up News

Division of Health Care Financing and Policy (DHCFP)

HP Enterprise Services (HPES)

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Third Quarter 2012

Inside This Issue:

Quarterly Update on Claims Paid

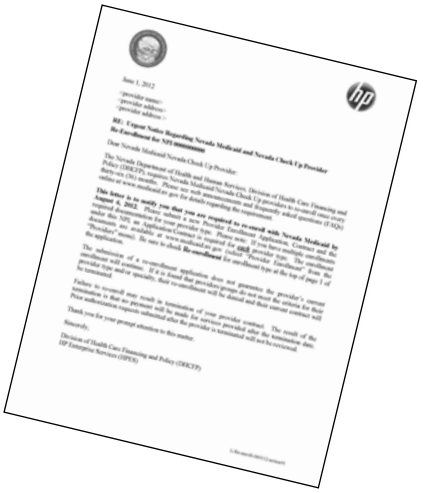
Nevada Medicaid and Nevada Check Up paid out to providers $455,148,795.39 in claims during the three-month period of January, February and March 2012. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

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

Act Now if You Have Received Your Provider Re-Enrollment Letter

Have you received your letter requesting that you re-enroll in Nevada Medicaid and Nevada Check Up? **If you have, then be sure to re-enroll now!**

Beginning June 1, 2012, providers are required to re-enroll in Nevada Medicaid and Nevada Check Up once every 36 months. Providers will receive a re-enrollment letter 60 days prior to their enrollment end date and a reminder letter 20 days before the enrollment deadline.



The subject line on the 60-day letter is: "Urgent Notice Regarding Nevada Medicaid and Nevada Check Up Provider Re-Enrollment for NPI <your 10-digit npi>." **Watch for your letter and do not discard it.**

Providers who do not re-enroll within 60 days of the date on their re-enrollment letter will have their provider contract terminated. The result of the termination is that no payment will be made to the provider for dates of service after the effective date of the termination.

When you receive the letter, you must re-enroll by completing the Provider Enrollment Application and Contract and submitting it along with the documents listed on the Enrollment Checklist for your provider type. Be sure to check the "Re-enrollment" checkbox at the top of the application.

Please wait until you receive your notification before you submit your re-enrollment packet. Other tips are available in the Provider Re-Enrollment Frequently Asked Questions (FAQs) on the Provider Enrollment webpage.

Annual Medicaid Conference

The Annual Medicaid Conference is this month. The date for the Reno session is October 17 and the Las Vegas session is October 24. If you have not yet signed up, please visit the registration page to sign up for the morning or afternoon General Session, as well as for the breakout session you wish to attend.

The automated 2012 Training Registration Form (FA-41) is also located on the provider training webpage. Within the online registration tool, select the "Register Here" link. Once you have registered for the city and sessions, a confirmation page will be sent to you by email.

Provider Audits/Reviews

Providers who bill the fiscal agent for services provided to Nevada Medicaid or Nevada Check Up recipients are subject to audits and/or reviews of their claims and the documentation supporting these claims. Providers are selected for audits and/or review for various reasons, including random selection, complaints received, data mining, schemes taking place in other states and many other reasons.

All providers are subject to audits and/or reviews. It is extremely important to provide all information requested by any of these entities so everything pertinent can be considered in the audit/review. The Division of Health Care Financing and Policy (DHCFP) has taken considerable steps in coordinating the reviews to ensure that providers are not contacted by multiple auditing entities regarding the same issue(s).

Below are brief descriptions of the various entities that perform these audits and/or reviews:

Surveillance and Utilization Review (DHCFP)

The program within the State Medicaid agency that protects the integrity of the program from fraud, waste and abuse by providers is known as the Surveillance and Utilization Review (SUR) Unit. SUR identifies aberrant billing practices, sanctions those who have abused the Medicaid program, recovers overpayments, and assists in criminal investigations when appropriate. Audits/reviews may consist of desk audits or field audits.

Recovery Audit Contractor (RAC)

The Patient Protection and Affordable Care Act (PPACA), calls for expansion of the Recovery Audit Contractor (RAC) Program to the Medicaid program. The contractor is tasked with identification of underpayments and the identification and recovery of overpayments. Nevada has contracted with Health Management Systems (HMS) to perform this service and their reviews are in progress now (as of September 2012). Claims with underpayments will be reprocessed in order to reimburse the provider properly for their services.

The Medicaid RAC program will not replace the State's other Program Integrity initiatives. In accordance with the statute, States must coordinate the RAC's efforts with those of existing State entities and law enforcement authorities, as well as with federal authorities. This will ensure that cases of fraud, waste and abuse are processed through the appropriate channels. HMS will be communicating with provider associations and provider education will be offered as this project continues.

Medicaid Integrity Contractors (MIC)

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP). A major function of the MIP is contracts with the Medicaid Integrity Contractors or (MIC). MICs are contracted directly with the Centers for Medicare & Medicaid Services (CMS) to conduct data mining activities and provider audits. Audit results are sent to the affected providers, CMS and to the SUR Unit for review and comment. If an overpayment is discovered, the SUR Unit will send a recoupment letter to the provider and will collect the overpayment from the provider. The MIC is contracted directly with CMS and is also reimbursed by CMS.

Payment Error Rate Measurement (PERM)

CMS implemented the Payment Error Rate Measurement (PERM) program to meet the requirements of the Improper Payments Information Act (IPIA) of 2002. Under the PERM program, every three years, each state undergoes eligibility, data processing and medical record reviews of a random sample of fee-for-service and managed care payments from the Medicaid program and the Children's Health Insurance Program (CHIP) (Nevada Check Up). The data processing and medical record reviews are performed by a CMS contractor. The current CMS contractor is A+ Government Solutions. PERM reviews for Nevada are currently underway and the next PERM review for Nevada will occur for claims paid between October 1, 2013, and September 30, 2014. Improper payments identified during the PERM audits are recovered from the provider.

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 Provider Training Update

Workshop Presentations

PowerPoint presentations that are given at the monthly provider training workshops are now posted on the Provider Training webpage. The presentations are placed under "Workshop Materials" after the sessions have completed.

Providers can use the documents as reference material, but are encouraged to attend future training sessions and review the Billing Manual and Billing Guidelines for current information.

Upcoming Training Topics

The training topics for November and December have been revised. Please note that "Money Follows the Person" in November has been cancelled. In its place, the workshops most often requested by providers have been added. The Training Registration Form reflects the schedule below.

November

Reno

November 6 – Eligibility on the Provider Web Portal

November 6 – Appeals, Voids and Special Batching

November 7 – CMS-1500 Claim Form Billing

November 8 – Allscripts/Payerpath for CMS-1500

November 8 – Provider Web Portal

Las Vegas

November 13 – Eligibility on the Provider Web Portal

November 13 – Appeals, Voids and Special Batching

November 14 – CMS-1500 Claim Form Billing

November 16 – Allscripts/Payerpath for CMS-1500

November 16 – Provider Web Portal

December

Virtual Room

December 11 – Prior Authorization on the Provider Web Portal

Payment Suspensions Required Upon a Receipt of a Credible Allegation of Fraud

On February 2, 2011, in the Federal Register Volume 76, Number 22, the Centers for Medicare & Medicaid Services (CMS) clarified new requirements under the Patient Protection and Affordable Care Act (PPACA) regarding Medicaid Program Integrity efforts to combat fraud and abuse. The Social Security Act was amended with requirements that the State Medicaid agency:

- MUST suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity.
- MUST make a fraud referral to the Medicaid Fraud Control Unit (MFCU) whenever the State Medicaid agency investigation leads to the initiation of a payment suspension in whole or part.
- MUST send notice of its suspension of program payments within the following time frames:
    - Five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.
    - Thirty days if requested by law enforcement in writing to delay sending such notice; such request for delay may be renewed in writing up to twice and in no event may exceed 90 days.
- MUST grant, upon provider request, administrative review in accordance with the appropriate State statutes.

The Social Security Act was also amended to include a definition of credible allegation of fraud. A credible allegation of fraud may be an allegation that has been verified by the State, from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases and law enforcement investigations

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

These new provisions in the Social Security Act are effective March 25, 2011.

Updated Version of Clinical Claim Editor

The Division of Health Care Financing and Policy (DHCFP) and HP Enterprise Services will incorporate an updated version of the clinical claim editor into the Medicaid Management Information System (MMIS). Please monitor this website for the implementation date.

The clinical claim editor criteria used to audit professional and outpatient services claims will be 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.

Please monitor this website for the implementation date.

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

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 contain the following statement when the RA contains an NCCI edit:

- NCCI denials should not be billed to the beneficiary MA13

Electronic 835s will 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

The following is an example of an 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

Provider Type 33: Attention Suppliers of Pressure Support Ventilators

When the new version of the clinical claim editor is implemented, providers who deliver a ventilator and a back-up ventilator HCPCS code E0463 (Pressure support ventilator with volume control mode) will need to change the way they bill for the back-up ventilator.

Currently, providers are instructed to bill the number of units provided on one claim line using the usual and customary rate. With the addition of MUE editing in MMIS, claims for the back-up ventilator will need to be submitted on a separate line appending a TW modifier to indicate back-up equipment. Two units for E0463 on a single claim line will be denied with an NCCI MUE.

Billing Example:

	DOS	HCPC/CPT	Mod 1	Mod 2	Units
Line 1:	xx/xx/xx	EO463	RR		1
Line 2:	xx/xx/xx	E0463	RR	TW	1

Prior Authorization: Providers who deliver a ventilator and/or back-up ventilator will still need to obtain a prior authorization for 1 or 2 units (1 unit for each ventilator).