

Nevada Medicaid and Nevada Check Up News



Division of Health Care Financing and
Policy (DHCFP)

HP Enterprise Services
(HPES)



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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$458,508,847.51 in claims during the three-month period of July, August and September 2013.

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.

Attention Currently Enrolled Nevada Medicaid Providers:

Ordering, Prescribing or Referring (OPR) Provider Enrollment Requirement Will Impact Claims Processing

With the implementation of the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) requires all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). Traditionally, most providers have enrolled in the Nevada Medicaid program to furnish covered services to Medicaid recipients and to submit claims for such services. However, the Affordable Care Act now requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid.

The Division of Health Care Financing and Policy (DHCFP) is actively working on the implementation of this new requirement and announcements regarding the effective date and enrollment process will be posted on this website. Implementation is anticipated for the second quarter of 2014.

Nevada Medicaid-enrolled billing providers please note the following:

- If you provide services to a Nevada Medicaid recipient from an ordering, prescribing or referring provider, you will be required to enter that OPR provider's name and National Provider Identifier (NPI) on the claim form.
- **Your claims may deny if the ordering, prescribing or referring provider entered on the claim is not enrolled as a Nevada Medicaid OPR provider.**
- The OPR provider must have an NPI and must be of a provider/specialty type that is eligible to order and refer. These providers include, but are not limited to, provider type (PT) 14 specialty 305, PT 20, PT 24, PT 25, PT 26 specialty 162, PT 74 and PT 77.
- An enrollment application exclusively for OPR providers will be posted on the Provider Enrollment webpage at www.medicaid.nv.gov in early 2014. Providers will be notified when the application is available.
- Interns, residents and fellows must have an NPI and submit an OPR Application to be able to order, prescribe and refer for Nevada Medicaid recipients.
- Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid

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Upcoming Payment Error Rate Measurement (PERM) Review by Federal Contractors

The Centers for Medicare & Medicaid Services (CMS) will measure the accuracy of Medicaid and Children's Health Insurance Program (CHIP) payments made by each state for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS will use national contractors to measure improper payments in Medicaid and CHIP. The statistical contractor will provide statistical support to the program by producing the claims to be reviewed and by calculating Nevada's error rate. A+ Government Solutions, Inc. will provide the documentation/database support by collecting medical policies from the State and by collecting medical records from providers. A+ Government Solutions, Inc. will also conduct the medical and processing reviews for sampled claims following guidance provided by CMS. The PERM review for Nevada will be conducted on claims paid during the period October 1, 2013, through September 30, 2014.

Medical records are needed to support the medical reviews conducted by A+ Government Solutions, Inc. to determine if the service provided was medically necessary and correctly paid in accordance with established policy. In order to obtain the appropriate medical record documentation for the claims selected in the PERM sampling process, A+ Government Solutions, Inc. will contact you, the provider, to verify your name and address and to determine how you want to receive the medical record request(s) (via facsimile, U.S. mail). Once the provider receives the request for medical records, the

provider must submit the information electronically or in hard copy within 75 days. A+ Government Solutions, Inc. will follow up to ensure that providers submit the documentation before the 75-day time frame has expired. It is very important that providers cooperate by sending in all requested documentation. If the provider fails to submit appropriate and sufficient documentation to support the claim billed to and paid by the DHCFP within the allotted time frame, the payment will be considered an error and will be recovered from the provider. Past studies indicate the largest cause of errors occur in the medical review area and are due to the provider sending either no documentation or insufficient documentation. CMS will host a series of interactive PERM Provider Education Webinars. Providers may access more valuable PERM information at www.cms.gov/PERM.

Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a) (27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services. The furnishing of information includes medical records. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

Implementation of Medicare Ordering and Referring Denial Edits January 6, 2014

The Centers for Medicare & Medicaid Services (CMS) has announced the implementation of ordering and referring denial edits for Medicare claims with dates of service on or after January 6, 2014. These edits will check the following claims for a valid individual National Provider Identifier (NPI) and deny or zero pay the claim when the NPI is invalid:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;

- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); and
- Claims from Part A Home Health Agencies.

Note: Your Third Party Liability (TPL) claims may be affected. Claims denied by Medicare because a provider did not follow Medicare procedures will not cross over to Medicaid.

For more information regarding this regulation, please visit: [MLN Matters® Article #SE1305](#).

OPR Provider Enrollment Requirement - Continued from page 1

- are not required to enroll separately as OPR providers.
- Please note that this extends to pharmacy Point of Sale (POS) systems as well. The POS system will deny, at the time of the pharmacy transaction, any claims submitted for a Medicaid recipient with a prescriber who is not enrolled as a

Medicaid provider.

- This new requirement does not apply to orders, prescriptions or referrals for individuals enrolled in a Medicaid Managed Care Organization (MCO). It is applicable only to the Nevada Fee for Service (FFS) Medicaid program.

Training Presentations May Have the Answers to Your Questions

The PowerPoint® presentations used in monthly provider training workshops are available online to answer many questions providers might have. The presentations are located on the [Provider Training](#) webpage at www.medicaid.nv.gov under the heading “Workshop Materials.”

Presentation topics include:

- New Level Of Care (LOC) Screening Tool for PASRR Users
- Billing for Outpatient Administered Drugs (National Drug Code Billing)
- Allscripts-Payerpath Institutional Claim Form UB-04
- Allscripts-Payerpath Institutional Claim Form CMS-1500
- CMS-1500 Claim Form Instructions
- UB-04 Claim Form Instructions
- Verifying Eligibility
- ICD-10 Overview
- Prior Authorization Submission
- Program Integrity – Be Aware of Medicaid Fraud
- Introduction to Becoming a Nevada Medicaid Provider
- Medicaid Services Manual
- Introduction to Nevada Medicaid and Nevada Check Up

If your questions are not answered by viewing the presentations, please contact your [Provider Services Field Representative](#). Refer to the attached [document](#) to determine which Field Representative is assigned to assist you with inquiries.

Reminders for Submitting Paper Claim Forms

Please review the following reminders for submitting paper claim forms to HP Enterprise Services to help ensure your claim is processed quickly and correctly:

- Effective January 2, 2014, Nevada Medicaid began accepting the new CMS-1500 (02-12) claim form and the new 2012 American Dental Association (ADA) claim form. A three-month dual-use period of the current forms and the new forms will be in effect January 2 through March 31, 2014. The CMS-1500 (version 08/05) and the 2006 ADA will both continue to be accepted for claims received at HP Enterprise Services before April 1, 2014. **Beginning April 1, 2014, the new CMS-1500 (02-12) and 2012 ADA forms must be used.** Effective April 1, 2014, the CMS-1500 (version 08/05) and the 2006 ADA will be returned to providers.
- Any correspondence must be sent along with the related claims submission or claim appeals requests. If you send only the supporting documents, such as your letter and EOB, the documents will be returned to you.
- Be sure your billing address and phone number are entered and accurate on your claim form.
- Copies of paper claim forms may be submitted, but please ensure that the copy you submit is legible. Reasons why a paper claim form will be returned to you to resubmit may include but are not limited to:
 - ✓ The font is too light or too small to be legible.
 - ✓ The type is smudged and is not legible.
 - ✓ The background is dark and cannot be read by the scanner.
 - ✓ The claim is printed at a reduced size and appears smaller than CMS-approved forms.
- The Explanation of Benefits (EOB), just like the claim form, must be suitable for scanning so that data can be accurately captured. If the data is printed too light or is smudged, the claim will be returned to you.

Year 1 of Nevada Medicaid EHR Incentives

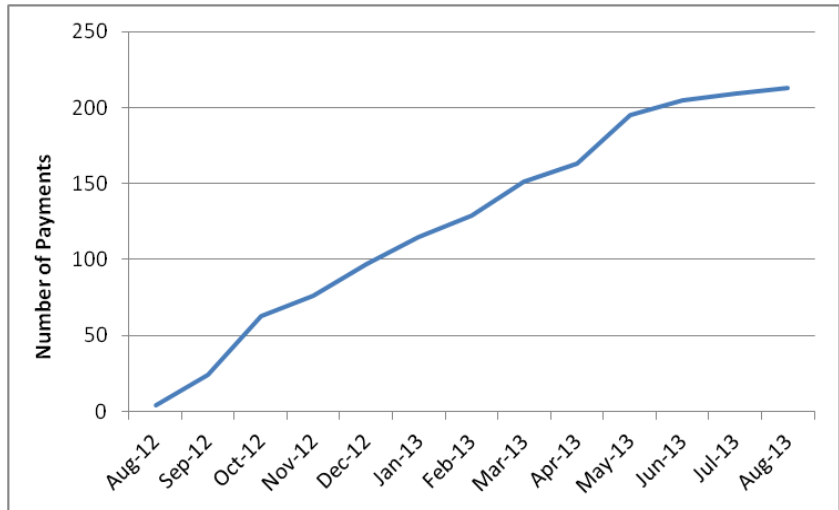
A great deal of progress has been made since launching the Nevada Medicaid Electronic Health Records (EHR) Incentive Program with significant potential opportunity remaining for the providers and hospitals in Nevada.

The Nevada Medicaid EHR Incentive Program launched in August 2012 for Eligible Professionals (EPs) and Eligible Hospitals (EHs). The program allows attestation for the Adopt, Implement or Upgrade (AIU) provision of the Medicaid EHR Incentive Program. First payments were made within weeks of the program launch and participation by Nevada EPs and EHs has been steadily increasing since that time.

With 213 payments to EPs and EHs through the first year of operation, the Nevada Medicaid EHR Incentive Program resulted in more than \$20 million in incentives to hospitals and eligible providers throughout the state. While EHs have received the largest percentage of these payments overall, the Pediatric and Physician groups have seen the highest number of incentives.

Among the 135 Pediatric and Physician payments, 87% of those payments have gone to EPs practicing in solo or small group practices with less than five total physicians. While a number of large group practices will be attesting their Medicaid eligible providers in the coming months, small physician offices are expected to continue to make up the majority of the Medicaid EHR Incentive Program participation.

With Medicaid Expansion pending in the State of Nevada, it is expected that Year 2 and beyond for the Nevada Medicaid EHR Incentive program will see increased participation from the EP population throughout Nevada.



Nevada providers who have not yet begun participating in the Nevada Medicaid EHR Incentive Program still have time to do so. First year AIU attestation is available through 2016 and Nevada Medicaid is now accepting attestations for years 1 through 3. Beginning in January 2014, Nevada Medicaid will also begin accepting registrations for Stage 2 Meaningful Use.

To see more information and keep up to date on important announcements, please visit <http://dhcftp.nv.gov/EHRIncentives.htm> or call (888) 639-3452 or send an email to NEIPS.us.ipod@cgi.com.

TOTAL PROGRAM PAYMENTS		
	Amount Paid	# of Payments
Hospitals	\$ 15,713,589.52	25
Midwives	\$ 21,250.00	1
Nurse Practitioners	\$ 646,000.00	25
Pediatrics	\$ 1,722,672.00	67
Physician's Assistants	\$ 191,250.00	7
Dentists	\$ 433,500.00	20
Physicians	\$ 1,610,752.00	68
Grand Total	\$ 20,339,013.52	213

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 DHC FP website at <http://dhcftp.nv.gov>. Under the "DHC FP 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.

Implementation nears for CAQH CORE®

Eligibility and Claim Status Operating Rules

The Operating Rules for the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE®) Phase I and II is scheduled to be implemented for Nevada Medicaid/Nevada Check Up in early 2014. The Patient Protection and Affordable Care Act (ACA) requires implementation of CAQH CORE Operating Rules. Web announcements on this website (www.medicaid.nv.gov) will notify providers of the implementation date.

CAQH CORE® Phase I and II Operating Rules support electronic eligibility and claim status inquiries. The Rules streamline and bring uniformity to essential administrative transactions between health care providers and health plans. In addition, the Rules simplify interoperability for all trading partners.

The implementation of the CAQH CORE Eligibility and Claim Status Operating Rules will allow Nevada Medicaid/Nevada Check Up providers to:

- Receive eligibility responses that include the required CAQH CORE service type codes covered by the recipient's Medicaid plan. These service type codes will be returned on the EDI 5010 270/271 transaction and the Provider Web Portal eligibility responses.
- Inquire on eligibility using a generic or explicit inquiry request. A generic inquiry response will include all 12 CAQH CORE service type codes. An explicit inquiry response will only include the CAQH CORE service type codes that were used on the explicit eligibility request.
- Submit real time and batch 5010 270/271 Eligibility and 276/277 Claim Status transactions. There will be a future web announcement with more information for trading partners regarding how to be set up and how to test this new service.

Please review the following frequently asked questions for further details regarding the CAQH CORE Phase I and II Operating Rules.

1. What is CAQH CORE?

CAQH: Council for Affordable Quality Healthcare

CORE: Committee on Operating Rules for Information Exchange

The CAQH CORE is a multi-stakeholder industry collaboration developing operating rules that streamline administrative transactions. Over the past eight years, CAQH CORE participation has grown to more than 140 organizations. CAQH CORE has a proven track record of delivering a strong return on investment that is driven by widespread adoption and voluntary certification of operating rules. CAQH CORE was designated by the Department of Health and Human Services to author three sets of federally mandated operating rules under ACA. To learn more about CAQH CORE, visit www.caqh.org/benefits.php.

2. What are operating rules?

Section 1104(1) of the Patient Protection and Affordable Care Act (ACA) defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”

The CORE operating rules build on existing standards to make electronic transactions more predictable and consistent, regardless of the technology. They address gaps in standards, help refine the infrastructure that supports electronic data exchange, and recognize interdependencies among transactions.

3. How do the Phase I and Phase II CAQH CORE Eligibility and Claim Status Operating Rules affect providers?

The CAQH CORE Eligibility and Claim Status Operating Rules will allow providers to do the following:

- Receive eligibility responses that include the required CAQH CORE service type codes covered by the recipient's Medicaid plan. These service type codes will be returned on the EDI 5010 270/271 transaction and the Provider Web Portal eligibility responses.

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CAQH CORE®

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- Inquire on eligibility using a generic or explicit inquiry request. A generic inquiry response will include all 12 CAQH CORE service type codes. An explicit inquiry response will only include the CAQH CORE service type codes that were used on the explicit eligibility request.

4. What is a generic 5010 270 eligibility inquiry?

A generic 5010 270 eligibility inquiry is a request that only contains service type code “30” for Health Benefit Plan coverage in the EQ01 segment of the transaction.

5. What service type codes are returned on a generic 5010 271 eligibility response?

A generic 5010 271 eligibility response will contain the following 12 service type codes:

- 1 Medical Care
- 33 Chiropractic
- 35 Dental Care
- 47 Hospital
- 48 Hospital - Inpatient
- 50 Hospital - Outpatient
- 86 Emergency Services
- 88 Pharmacy
- 98 Professional (Physician) Visit - Office
- AL Vision (Optometry)
- MH Mental Health
- UC Urgent Care

6. What is an explicit eligibility inquiry?

An explicit 5010 270 inquiry is a request that contains a service type code other than and not including “30” for Health Benefit Plan coverage in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific type of benefit, for example, “48” (Hospital - Inpatient).

7. Is there a limit on the number of service type codes that can be used on an explicit eligibility inquiry?

An explicit 5010 270/271 eligibility inquiry can contain up to 10 service type codes. If an explicit 5010 270/271 eligibility inquiry contains more than 10 service type codes, the 271 response will return the equivalent of a Generic Inquiry.

The Provider Web Portal will allow only one service type code for an explicit eligibility inquiry request.
