

# Nevada Medicaid News

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Nevada Medicaid and Nevada Check Up  
Fiscal Agent  
P.O. Box 30042  
Reno, NV 89520-3042

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## **ALERT:**

## Register Now To Attend The Annual Medicaid Conference

Providers still have time to register to attend the free Annual Medicaid Conference presented by the Division of Health Care Financing and Policy (DHCFP) and Magellan Medicaid Administration, Inc. Direct practitioners/health care providers are encouraged to attend along with billing staff, office managers, admitting and front-desk staff and billing agencies.

The annual policy and billing information portion of this year's conference will be replaced by a presentation by Hewlett-Packard (HP), the company that will become the new fiscal agent. Details regarding HP's presentation will be posted on the Transition webpage on this website.

After the main presentation, break-out sessions will provide program-specific information for certain provider types (check the current [2011 Training Registration Form](#) to see if a break-out session is offered for your provider type).

The conference will be held in Reno on Oct. 12 at the Reno/Sparks Convention Center at 4590 S. Virginia St. and in Las Vegas on Oct. 19 at the Cashman Center located at 850 Las Vegas Boulevard N.

Providers may choose to attend a morning or an afternoon conference in either Reno or Las Vegas on the scheduled days. The same information will be presented at all conferences. To register for the conference, complete and fax the [2011 Training Registration Form](#) as soon as possible to Magellan Medicaid Administration. If you have registered and have determined you will not be able to attend, please call (877) 638-3472.

## Quarterly Update On Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers **\$394,968,222.63** in claims during the three-month period of April, May and June 2011. Nearly 100 percent of current claims continue to be adjudicated within 30 days. The DHCFP and Magellan Medicaid Administration thank you for participating in Nevada Medicaid and Nevada Check Up.

## URGENT: Behavioral Health Providers Must Be Re-Enrolled By Oct. 31, 2011

**B**ehavioral Health provider types 14 (Behavioral Health Outpatient Treatment) and 82 (Behavioral Health Rehabilitative Treatment) must re-enroll in Nevada Medicaid by Oct. 31, 2011.

Providers who do not re-enroll will have their provider contract terminated effective Oct. 31, 2011. 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.

Submission of a re-enrollment application does not guarantee the provider's current enrollment will continue. If it is found that providers/groups do not meet the criteria for their provider type and/or specialty, their re-enrollment will be denied and their current enrollment will be terminated.

Enrollment/re-enrollment reminders, tips and information can be found in articles in previous newsletters, multiple web announcements on this website, remittance advice messages and letters. Online resources available to providers are the [Behavioral Health Provider Enrollment Frequently Asked Questions \(FAQs\)](#), [Prior Authorization Information Sheet For Behavioral Health Provider Types 14 And 82, QMHA Education and Professional Work Experience Requirements](#) and User Administration Console (UAC) Information Sheet

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For further information, contact the Provider Enrollment Unit at (877) 638-3472.

## *APIs Can No Longer Be Used On Prior Authorization Requests For Behavioral Health Services*

**P**rior authorization (PA) requests for all behavioral health services submitted by provider types 14 and 82 (new initial requests or additional/subsequent requests) with a beginning date of service on/after Aug. 1, 2011, are not authorized if an Atypical Provider Identifier (API) is used. The group/billing National Provider Identifier (NPI) must be used on these PA requests.

If an API is used for either the requestor or the servicing provider on PA requests with a beginning date of service on/after Aug. 1, 2011, the request will be technically denied. Once the technical denial is received, providers must change their request date and the start date of services when they resubmit the request to be in compliance with the current submission guidelines, which can be found in the [Billing Manual](#) and the PT 14, 26 and 82 [Billing Guides](#).

### **Updated Version Of Clinical Claim Editor Complies With National Correct Coding Initiative**

**T**he Division of Health Care Financing and Policy (DHCFP) has incorporated an updated version of clinical claim editor into the Medicaid Management Information System (MMIS). The update affects Nevada Medicaid/Nevada Check Up claims processed on/after Sept. 19, 2011, regardless of the date of service.

The new clinical claim editor version complies with the requirements of the Patient Protection and Affordable

Care Act, which mandates the use of National Correct Coding Initiative (NCCI) claims processing methodologies effective for claims filed on/after Oct. 1, 2010.

The Centers for Medicare & Medicaid Services (CMS) originally developed the NCCI to prevent improper payments when incorrect code combinations are reported. If you have questions regarding NCCI, please visit the CMS website at <http://www.cms.gov/nationalcorrectcoding/>.

## Current Medicaid Providers

### **ATTENTION Occupational and Physical Therapists: Your Services are Needed to Complete Functional Assessments for Medicaid Recipients**

**D**ue to the success of the pilot project of all initial functional assessments for Personal Care Services (PCS) being completed by occupational and physical therapists (OTs/PTs), the DHCFP has decided that effective Dec. 5, 2011, all functional reassessments will also be completed by OTs/PTs.

A PCS program goal is to enable all Medicaid recipients to go to any Nevada Medicaid provider of physical or occupational therapy for their functional assessment. In order to accomplish this goal, additional OTs/PTs are needed to expand the existing pool of therapists serving all areas of the state.

A one-time training session on how to perform an effective functional assessment will be available. Additionally, be-

ginning Dec. 5, 2011, all OTs/PTs who perform functional assessments will no longer be required to create a service plan. This will reduce the amount of time spent documenting results of the visit.

OTs/PTs will be reimbursed \$150.62 per assessment performed in the recipient's home and \$75.31 for assessments performed in a clinical setting. Therapists may be reimbursed for mileage to and from the recipient's home at a rate of .28 per mile.

To place your name on the list for a training session or to obtain more information about this exciting opportunity, please contact Tammy Moffitt at (775) 684-3670 or [tammy.moffitt@dhcfp.nv.gov](mailto:tammy.moffitt@dhcfp.nv.gov) or Paula Schneider at (775) 684-3667 or [paula.schneider@dhcfp.nv.gov](mailto:paula.schneider@dhcfp.nv.gov).



### **Newborns And Other Recipients Incorrectly Enrolled In A Managed Care Plan**

**A**s of April 8, 2011, certain Medicaid recipients who should have been enrolled into Medicaid Fee For Service (FFS) were incorrectly enrolled into a managed care plan (Health Plan of Nevada or Amerigroup Community Care).

The majority of cases occurred with newborns whose mothers are not enrolled in managed care. In some instances, entire families were assigned to managed care incorrectly. Although the majority of Medicaid recipients are enrolled correctly, there is a significant volume of FFS recipients who were retro-enrolled into managed care.

The Division of Health Care Financing and Policy (DHCFP) and Magellan Medicaid Administration, Inc. are working together to correct this enrollment issue as quickly as possible and expect this issue to be resolved by mid-October.

DHCFP has authorized the following temporary meas-

ures. The normal processes will resume once this issue has been resolved.

- Magellan Medicaid Administration will process all related prior authorization (PA) requests outside of the normal process and time frame. This authorization will include concurrent and retrospective requests. Please note on your PA request for services that incorrect enrollment is the reason for the late submission.
- Services provided to a Medicaid recipient that would normally not be covered under Medicaid FFS will be covered due to incorrect enrollment; for example, circumcision for newborn males is a covered service under an MCO plan, but is not covered under Medicaid FFS.

Any claims denied inappropriately due to this enrollment issue will be automatically reprocessed without the need for providers to resubmit the claims. The adjudication of any reprocessed claims will be reported on a future remittance advice.

## Providers Must Repay Medicaid Overpayments Within 60 Days Of Identification

The Patient Protection and Affordable Care Act (PPACA), which was signed into law in 2010, imposes new federal requirements on Medicaid providers to have a more proficient and time-sensitive process for identifying errors and overpayments received under the Medicaid program, and disclosing and repaying the Medicaid program for amounts that providers received in error.

Under changes set forth in the PPACA, providers are obligated to report, explain and repay overpayments within sixty (60) calendar days of identification. Those providers who fail to disclose, explain and repay the overpayment in a timely manner may be subject to administrative action taken by the Division of Health Care Financing and Policy (DHCFP), up to and including termination of the provider contract.

The DHCFP recognizes that many improper payments are

discovered during the course of a provider's internal review process. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both Nevada and the provider involved.

In order to encourage self-disclosure, the DHCFP is willing to set up payment arrangements and work with individual providers. This joint effort will assist the State in combating fraud, waste, abuse or inappropriate payment of funds, whether intentional or unintentional, under the State's Medicaid program.

Providers should use the following link to report overpayments: <https://dhcfnv.gov/ContactSURS.asp>. The DHCFP's Surveillance and Utilization Review Section (SURS) unit will contact the provider upon receipt of the information.

## Medical Record Request Reminder – Federal Payment Error Rate Measurement (PERM)

This is a reminder that sometime this fall providers will begin receiving medical record requests for claims under review for the federal Payment Error Rate Measurement (PERM) program. The requests will be sent on Centers for Medicare & Medicaid Services (CMS) letterhead. Once you receive the request for medical records, you must submit the information electronically or in hard copy within 75 days.

A+ Government Solutions, Inc., the CMS federal contractor performing the medical record reviews, will follow up to ensure that providers submit the documentation before

the 75-day time frame has expired. It is very important that you cooperate by sending in all requested documentation.

If you fail to submit **appropriate and sufficient** documentation to support the claim billed to and paid by the DHCFP within the 75-day time frame, the payment will be considered an error and will be recovered from the provider. Past studies indicate most errors discovered through the PERM program occur in the medical review area and are due to the provider sending either no documentation or insufficient documentation.

## Use 2011 HIPAA-Compliant CPT, HCPCS And ADA Codes On Prior Authorization Requests

All prior authorization (PA) requests must be submitted with HIPAA-compliant 2011 codes. Magellan Medicaid Administration, Inc.'s prior authorization system has been updated with the 2011 procedure codes. For the list of 2011 codes available for billing, see [Web Announcement 407](#).

Through Nov. 15, 2011, providers may submit a retrospective authorization request for any previously submitted PA code request that was not processed due to the 2011 codes not being updated in the system. Please note on the request: "Request delayed due to a 2011 code." Providers will not be penalized for retrospective requests due to the 2011 codes.

## Implementation Plans Under Way For Provider-Preventable Conditions Program

Nevada Medicaid is moving forward with implementation plans for prohibiting payment for “provider-preventable conditions,” a newly coined term for health care-acquired conditions, which can span a variety of provider types and causes.

On June 1, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a [final rule](#) prohibiting Medicaid payments to providers for conditions that are reasonably preventable, implementing Section 2702 of the Patient Protection and Affordable Care Act. Although cost savings is a driver, non-payment policies are directed toward improving patient safety through eliminating payment for poor quality care that harms patients.

Although the rule allows for states to identify additional conditions for non-payment, Nevada Medicaid’s initial plans are to prohibit payment for

only those conditions for which it is required.

They are:

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- Stage III and IV pressure ulcers.
- Falls and trauma.
- Manifestations of poor glycemic control.
- Catheter-associated urinary tract infection.
- Vascular catheter-associated infection.
- Surgical site infection following various specified procedures.
- Deep vein thrombosis/pulmonary embolism following total knee or

hip replacement, except in pediatric and obstetric patients.

- Surgery on the wrong patient.
- Wrong surgery on a patient.
- Wrong site surgery.

Although the rule requires providers to self-report provider-preventable conditions, Nevada Medicaid is also looking at reviewing prior authorizations and a retrospective review of claims data submitted by providers to the University of Nevada, Las Vegas Center for Health Information Analysis.

Implementation is required by July 1, 2012; however, plans are to have systems in place on Jan. 1, 2012.

Participation and input are welcome at upcoming Public Workshops and Nevada Medicaid will gather input from the Nevada Hospital Association and the DHCFP’s [Medical Care Advisory Committee \(MCAC\)](#).

### *Instructions On Billing Claims With OHC/TPL*

Per [Medicaid Services Manual \(MSM\), Chapter 100](#), Section 104.1: “It is not necessary to bill Other Health Care Coverage (OHC) if it is known the service provided is not a covered benefit under the OHC policy.”

Please follow these instructions when submitting OHC/Third Party Liability (TPL) denied claims:

- Submit a paper claim form.
- Follow the Nevada Medicaid/ Nevada Check Up [claim form instructions](#).
- Attach a cover letter (8 1/2 x 11 sheet of paper) to each claim stat-

ing “Please review for processing for OHC or TPL”; the denial reason; and the date, phone number and the name of the person from whom the coverage information on the insurance was obtained.

- Send the claim to the attention of Customer Service.

If an audit or review finds that the OHC/TPL payer truly did cover a service and the notes on the cover letter are incorrect, the provider will be referred to the Surveillance and Utilization Review Section (SURS) unit and administrative actions, including recovery of monies paid and termination of the provider contract, may occur.

### Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact Magellan Medicaid Administration by calling (877) 638-3472.

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://dhcftp.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 want to contact.