Nevada Medicaid and Nevada Check Up News

Division of Health Care Financing and Policy (DHCFP)

Hewlett Packard Enterprise

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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $815,839,174.52 in claims during the three-month period of July, August and September 2015. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

DHCFP and Hewlett Packard Enterprise thank you for participating in Nevada Medicaid and Nevada Check Up.

Applied Behavior Analysis (ABA) Services Coverage Implemented January 1, 2016

The Nevada Division of Health Care Financing and Policy (DHCFP) has implemented coverage for Applied Behavior Analysis (ABA) services for categorically needy individuals under age 21, identifying Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as the coverage authority.

ABA services are effective January 1, 2016.

For providers who have not yet enrolled, provider enrollment checklists are online on the Provider Type 85 Applied Behavior Analysis (ABA) Enrollment Checklist webpage. See Web Announcements 940 and 951 for enrollment instructions.

Many ABA services require prior authorization (PA). Use form FA-11E to request authorization for services. Form FA-11F must be submitted with initial requests for ABA services along with FA-11E. PA forms are available on the Provider Forms webpage. The Provider Web Portal prior authorization system has been updated to add the Applied Behavior Analysis (ABA) authorization type to the "Authorization Type" drop-down list. See Web Announcement 1024 for screenshots of the authorization pages.

Provider type (PT) 85 may bill for ABA services with dates of service on or after January 1, 2016. The PT 85 Billing Guideline is posted under Billing Guidelines (by Provider Type) on the Billing Information webpage.

The medical coverage policy for ABA can be found in Medicaid Services Manual Chapter 1500 Healthy Kids Program, located on the DHCFP website at: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/ Ongoing information regarding ABA services can be found on the DHCFP ABA webpage at: http://dhcfp.nv.gov/Pgms/CPT/ABA/.

Recent Web Portal Enhancements Improve Prior Authorization Application

In addition to the implementation of the Online Provider Enrollment Portal and the addition of the ABA prior authorization type mentioned in other articles in this newsletter, the Provider Web Portal has been modified with the following updates that are assisting providers who use the prior authorization application.

Prior Authorization Attachments: An enhancement has been made to the Provider Web Portal prior authorization application to display attachment information on the "View Provider Request" page for all prior authorizations submitted with attachments. The "View Provider Request" page displays the transmission method, file name and attachment type in the attachment section. See Web Announcement 1028 for a screenshot showing an example of the Attachments section.

Multiple Medical Citation Reasons: Enhancements were made to the Provider Web Portal prior authorization application to allow multiple medical citation reasons on a Notice of Decision (NOD). The Prior Authorization "View Authorization Response," "View Authorization Print" and "View Denial Information" pages can now display up to five medical citation reasons per service line for a more detailed reason of decision. See Web Announcement 1013 for examples of the three pages.

Aim for High-Quality Health Care Service Delivery

When you enroll to become a Nevada Medicaid/ Nevada Check Up provider, please select the provider type(s) (and specialty(ies) if applicable) that will allow you to provide health care services you are qualified to provide and that will be in the best interest of the recipients who seek your services. Work within your scope of practice to adhere to policy, provide the care recipients truly need and, most importantly, focus on ethical provision of services, putting recipients' best interests first.

Before you begin providing services, review the Medicaid Services Manual (MSM) chapter that pertains to your services. The MSM specifies the policies you will be required to follow.

Please review the Nevada Medicaid and Nevada Check Up Provider Contract you signed with the Division of Health Care Financing and Policy (DHCFP) and ensure you are providing access to high-quality health care for Nevada's recipients.

Three sections of the Contract that capture your responsibilities toward Nevada's recipients are:

1.1 To adhere to standards of practice, professional standards and levels of Service as set forth in all applicable local, state and federal laws, statues, rules and regulations as well as administrative policies and procedures set forth by the Division relating to the Provider's performance under this Contract and to hold harmless, indemnify and defend the Division from all negligent or intentionally detrimental acts of the Provider, its agents and employees.

1.2 To provide Services to Recipients without regard to age, sex, race, color, religion, national origin, disability or type of illness or condition. This includes providing Services in accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794). To provide Services in accordance with the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and regulations adopted hereunder contained in 28 C.F.R §§ 36.101 through 36.999, inclusive.

1.3 To provide Services in accordance with the terms, conditions and requirements of the Health Insurance Portability and Accountability Act of 1996 as amended and the HITECH Act (HIPAA) and related regulations at 45 CFR 160, 162 and 164.

Provider Services Field Representatives are available to assist providers in understanding billing policy and claim submission. Refer to the Provider Services Field Representative Team Territories document for the Representative who can assist you. Please review web announcements at www.medicaid.nv.gov for helpful provider training sessions you can attend.

Use ICD-10 Codes on Claims with Dates of Service on or after October 1, 2015

ICD-10 code sets were implemented on October 1, 2015. Be sure you and your clearinghouse are billing with ICD-10 codes on claims with dates of service on or after October 1, 2015. ICD-9 codes can only be used on claims with a date of service prior to October 1, 2015. If ICD-9 codes are used with a date of service on or after October 1, 2015, the claims will be denied.

Reminders:

- Claims billed with dates of service through September 30, 2015, must use ICD-9 codes.
- Claims with dates of service on or after October 1, 2015, must use ICD-10 codes.
- Claims submitted with dates of service that span one month to the next must be separated into two claim lines (split billed) as shown below:

  Dates of service September 15 through October 1:
  One claim for dates of service through September 30
  One claim with date of service October 1

- **Please note:** For inpatient hospital claims (provider types 11, 13, 19, 44, 56, 63 and 75) with dates of service that span from a previous month through October 2015 with the discharge date on or after October 1, 2015, the entire claim should be billed using ICD-10 codes. Inpatient hospital providers are not required to split bill these claims.

Use Online Provider Enrollment Portal for New Enrollment, Re-Enrollment, Revalidation and Provider Changes

Effective December 1, 2015, the web-based Online Provider Enrollment Portal is available for providers to complete new enrollment, re-enrollment, revalidation and provider changes. The new portal is accessed from the Provider Enrollment webpage by clicking on the "Online Provider Enrollment" link at the top of the page. For revalidation and provider changes, you can log into the Provider Web Portal through the EVS HPE Login link and click on the new "Revalidate-Update Provider" link on the My Home page. A list of all of the provider types associated with the National Provider Identifier (NPI) will be displayed and you can choose to revalidate or update. This will take you to the Online Provider Enrollment site where existing provider information will be populated.

The following helpful tips will assist providers when using the new Online Provider Enrollment Portal:

1. Prior to starting the application, review the provider enrollment checklist for your provider type and gather all pertinent information, including applicable ownership, agent and managing employee information. Review the Provider Enrollment Information Booklet for additional information.
2. The Online Provider Enrollment Portal will timeout after 20 minutes of inactivity on any screen. After 15 minutes of inactivity, a pop-up box will display asking you if you wish to extend the session. A second pop-up will display at 20 minutes notifying you that your session has expired.
3. You will need to create a password to continue your application at a later date. Make sure that you remember your password; if your password is forgotten it cannot be reset and your application information will be lost. You will need to begin a new application.
4. To resume a revalidation or change application, you must log in to the secure web portal and reselect the same provider type you were working on. You cannot resume a revalidation or change application using the "Resume Enrollment" panel within the Online Provider Enrollment application.
5. The Online Provider Enrollment application fields that are displayed throughout the enrollment process are contingent on the enrollment type and provider type values you select.
6. Please reference the Online Provider Enrollment User Manual on the Provider Enrollment webpage for step-by-step instructions on using the portal.
7. The Online Provider Enrollment application is to be used with Internet Explorer 7.0 or higher, or Firefox 3.0 or higher. Use of another browser, i.e., Google Chrome or Safari, or using the browser's forward or backward navigation buttons to navigate through the application may cause unpredictable results within the Provider Enrollment application.

Save Time and Money by Using Electronic Claim Submission

Providers who use electronic billing (also called Electronic Data Interchange or "EDI") instead of paper claim submission experience the following benefits:

Faster reimbursement ***Claim error detection*** ***Money savings on postage and claim purchase costs***

Time savings by not having to prepare paper documents ***Claims submission 24 hours a day, 7 days a week***

Providers can submit electronic claims through a clearinghouse or through their existing, HIPAA-compliant business management software. If you have not yet enrolled to bill electronically, you can do so by completing forms located on the Provider Forms or Electronic Claims/EDI webpages. A list of HIPAA-certified service centers/clearinghouses that submit claims for providers appears on the EDI webpage.

The Payerpath service center is a free service for all Nevada Medicaid providers. The Hewlett Packard Enterprise Electronic Data Interchange (EDI) department has scheduled virtual room training sessions for providers who have recently signed up to use Payerpath for their Nevada Medicaid claim submissions. The training covers claim set up, submission, reviewing your claims, reporting and remittance advice review. See monthly web announcements posted at www.medicaid.nv.gov for the dates and times of the training and registration instructions.

Companion Guides containing technical specifications for each electronic transaction have been published to assist providers and clearinghouses in submitting claims. The EDI Companion Guides are available on the Electronic Claims/EDI webpage at https://www.medicaid.nv.gov/providers/edi.aspx

For assistance with enrolling or questions regarding the EDI enrollment forms, please contact the EDI department by calling (877) 638-3472, option 2, then option 0, then option 3.

Claim Appeal Request Process

Providers have the right to appeal a claim that has been denied. Appeals must be postmarked no later than 30 calendar days from the date on the remittance advice listing the claim as denied. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days. Per MSM Chapter 100, Section 105.2C titled *Disputed Payment*, appeal requests for subsequent same service claim submissions will not be considered. That is, if a provider resubmits a claim that has already been denied and another denial is received, the provider does not have another 30-day window in which to submit an appeal. Such appeal requests will be rejected.

How to file a claim appeal:

To submit a claim appeal, include *each* component listed below:

- A completed form FA-90 (Formal Claim Appeal Request) or a cover letter that contains *all* of the following:
  - ◊ Reason for the appeal.
  - ◊ Provider name and NPI/API.
  - ◊ The claim's ICN (claim number).
  - ◊ Name and phone number of the person Hewlett Packard Enterprise can contact regarding the appeal.
- Documentation to support the issue, when applicable, e.g., physician's notes, ER reports.
- A completed, original signed paper claim that may be used for processing should the appeal be approved. The billing provider or authorized representative must sign and date the claim. Original, rubber stamp and electronic signatures are accepted.

Claim appeals (FA-90 or cover letter, documentation and original signed paper claim) may be submitted:

Via mail to:

Hewlett Packard Enterprise
Attention: Claim Appeals
P.O. Box 30042
Reno NV 89520-3042

Via email:

The claim appeal may be submitted via email to ProviderClaimAppeals@hpe.com. To submit via email, scan the cover letter or the completed form FA-90 and all supporting documents, including the original signed claim, and attach all items to one email. Please send the documents using secure email and write "Claim Appeal" in the subject line. Please note: If the claim appeal is submitted via email, all future correspondence regarding the appeal will be done via email.

Mail claim appeals (and appeal documentation cited above) separately from other claims, e.g., adjustments, voids, original submissions and resubmissions.

After you file an appeal, Hewlett Packard Enterprise researches the appeal and retains a copy of all documentation used in the determination process. Hewlett Packard Enterprise sends a Notice of Decision letter when a determination has been reached.

If your appeal is denied, you can request a fair hearing. When applicable, instructions for requesting a fair hearing are included with your Notice of Decision.

A fair hearing request must be received no later than *90 days* from the notice date on the Notice of Decision letter. The day after the notice date is considered the first day of the 90-day period. For additional information on Fair Hearings, please refer to the Medicaid Services Manual (MSM) Chapter 3100.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact Hewlett Packard Enterprise by calling (877) 638-3472, press option 2 for providers, then option 0 and then option 2 for claim status.

If you have a question about Medicaid Service Policy, you can go to the DHCFP website at http://dhcfp.nv.gov. From the "Resources" tab select "Telephone Directory" and call the Administration Office of the area you would like to contact.