Nevada Medicaid and Nevada Check Up News

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Nevada Medicaid Provider Web Portal (PWP) Upgrade to be Implemented on July 24, 2017

The Nevada Medicaid Provider Web Portal (PWP) upgrade from version 4.0 to version 5.0 has been postponed and will be implemented on July 24, 2017. Upgrades to the Nevada Medicaid Provider Web Portal that benefit all providers will include:

- increased role-based security features
- simplified, one-page Create Prior Authorization process
- ability to upload and submit Prior Authorization Reconsiderations

All chapters of the Electronic Verification System (EVS) User Manual will be updated to reflect the changes to the Provider Web Portal. For assistance with using the new features on the PWP, providers are encouraged to refer to Chapter 1: Getting Started, Chapter 4: Prior Authorization and Chapter 8: Upload Files.

Currently, most provider types can generate a prior authorization request via the Provider Web Portal. With this upgrade implementation, **Dental/Orthodontia, Adult Day Health Care (ADHC)** and **Personal Care Services (PCS)** providers will also be able to generate a prior authorization request via the Provider Web Portal.

The upgrade will enhance prior authorization processes to allow PCS providers to upload and submit requests for Update Visit (annual), Significant Change in Condition, Temporary Service Authorization, Cancel Authorization, One-Time Service, Information Only, Self-Directed Skilled Services and Transfers. PCS providers are encouraged to use the PWP, as the new functionality will assist them in improving their authorization and tracking processes.

For further details regarding the PWP upgrades, please review the PCS, Prior Authorization and Web Portal Upgrade Frequently Asked Questions. If you missed the Provider Web Portal 5.0 provider training sessions in June and would like assistance using the PWP, please contact the Provider Training Field Representative staff by sending an email to NevadaProviderTraining@dxc.com.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $939,379,179.13 in claims during the three-month period of January, February and March 2017. Nearly 100 percent of current claims continue to be adjudicated within 30 days. Thank you for participating in Nevada Medicaid and Nevada Check Up.

Attention All Nevada Medicaid Providers:

Managed Care Organization (MCO) Changes Effective 2017

Effective July 1, 2017, the Division of Health Care Financing and Policy (DHCFP) offers four (4) Managed Care Organizations (MCOs) for Medicaid Managed Care recipients, which include the following vendors: Aetna Better Health of Nevada (AET), Amerigroup Community Care (AGP), Health Plan of Nevada (HPN) and SilverSummit Healthplan (SSH).

Beginning this year (2017) and going forward, Open Enrollment will run from April 1 through June 30. Any household may make one final change to another MCO within 90 days from July 1. The DHCFP's goal for Open Enrollment is to fulfill requirements outlined in the Code of Federal Regulations (CFR) 42 CFR 438.56(c). Open Enrollment is the process which allows recipients to change their MCO choice once per year without having to show good cause for changing.

One Open Enrollment letter is mailed per managed care household for recipients currently enrolled in an MCO. Any recipient requesting to change their MCO choice after the close of Open Enrollment must contact their current MCO to request a "Good Cause" for disenrollment. Any household may make one final change to another MCO within 90 days from July 1. A letter has been mailed to recipients notifying them of the option to change MCOs.

Reminder:

Important Changes to Medicaid Managed Care Dental Services

Effective **July 1, 2017**, the dental services currently provided to Medicaid Managed Care recipients in urban Clark and urban Washoe counties are no longer managed by the current Managed Care Organizations (MCO). As of **July 1, 2017**, dental services and claims are being administered through Fee for Service (FFS) until a Dental Benefits Administrator (DBA) can be selected to manage dental services. The Division of Health Care Financing and Policy (DHCFP) is currently in the process of selecting a DBA to serve eligible recipients in the mandatory MCO coverage areas of urban Washoe and urban Clark counties. The DHCFP will notify providers of the name and contact information once a DBA is selected.

- All dental claims with **dates of service on or before June 30, 2017**, should be sent to the patients' current MCOs: **Amerigroup Community Care** or **Health Plan of Nevada**.
- All dental claims with **dates of service on or after July 1, 2017**, should be sent to **FFS Nevada Medicaid (the Nevada Medicaid fiscal agent DXC Technology)** until further notice.

Please note there will be NO changes to current dental benefits. If you have any provider enrollment or billing questions, please contact Nevada Medicaid at the following telephone number (877) 638-3472, option 2.

For recipients that require Hospital or Ambulatory Surgical Center (ASC) Dental Services, please refer to Medicaid Services Manual Chapter 1000, Section 1003.17. Providers will continue to submit a prior authorization request for the Hospital or ASC to the patients' current MCOs. All professional dental services claims will be submitted utilizing the American Dental Association (ADA) form.

Resources:

Nevada Medicaid Information: www.medicaid.nv.gov
Provider Billing Information: www.medicaid.nv.gov, click on the "Providers" and "Billing Information" tabs

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact Nevada Medicaid Provider Customer Service Center 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. Select "Resources" and then select "Telephone Directory" for the telephone number of the Administration Office you would like to contact.

Notification of Impending Payment Error Rate Measurement (PERM) Review by Federal Contractors

The Centers for Medicare & Medicaid Services (CMS) measures the accuracy of Medicaid and state Children's Health Insurance Program (CHIP) payments made by each state for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. CMS has contracted with Chickasaw Nation Industries (CNI) to conduct the medical record and data processing reviews. The PERM review for Nevada will be conducted on a sample of claims paid during the period October 1, 2016 through September 30, 2017.

Medical or service documentation records are needed to support the medical record reviews and 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, CNI 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 or U.S. mail). The medical record request letters will come on CMS letterhead. Once you have received the request for medical records, you must submit the documentation requested within 75 days. 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. Past studies indicate the largest cause of errors occurs in the medical record review area and are due to the provider sending either no documentation or insufficient documentation. Medical records request letters may be sent out as early as mid-summer 2017.

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 or service documentation records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR Part 160 and 164).

Please visit the CMS website for more provider information about PERM at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/

Attention All Providers:

Update Regarding Nevada Medicaid Fiscal Agent

Effective April 3, 2017, Hewlett Packard Enterprise merged with Computer Sciences Corporation (CSC) to form a brand new company named "DXC Technology." The merger created an independent, end-to-end IT services company that strives to lead clients and customers through their digital transformations by acting as the multiplier of change. The new company is the culmination of 60 years of IT experience along with talent in the world of digital transformations.

DXC Technology will continue acting as the fiscal agent for Nevada Medicaid, and all services currently provided will continue without interruption, including the provider call centers, provider communication, billing instructions and reference documents through the www.medicaid.nv.gov website, provider enrollment, prior authorizations, provider training, etc.

As of June 26, 2017, communication with Nevada Medicaid providers and recipients is being altered to refer to DXC Technology as Nevada Medicaid. Providers and recipients may continue to see and hear references to DXC Technology where applicable, but the call center staff and documents will begin referring to "Nevada Medicaid" instead of DXC Technology. As part of this transition, documents will display the Nevada State Seal instead of the DXC Technology company logo.

The provider call center contact information for Nevada Medicaid for billing, provider enrollment, prior authorization, etc., will remain the same. Email addresses to contact the fiscal agent will be changing to reflect DXC instead of HPE. Please note the new email addresses that will be posted on the www.medicaid.nv.gov website and on return emails when you are contacted by DXC Technology staff.

If you have any questions regarding this transition, please reach out to the Nevada Medicaid Provider Customer Service Call Center at (877) 638-3472.

Fingerprint-based Criminal Background Checks (FCBC) for "High" Risk Providers

Effective July 1, 2017, the Division of Health Care Financing and Policy (DHCFP) implemented a mandatory fingerprint-based criminal background check (FCBC) for certain providers as part of the Nevada Medicaid provider enrollment process. This change is in response to the enhanced enrollment screening provisions contained in the Affordable Care Act (ACA) and the DHCFP's compliance with these requirements.

As defined in 42 CFR 455.434, the FCBC will be applied to providers and suppliers in the "high" risk category as defined by DHCFP. This includes newly enrolling and re-enrolling Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) suppliers and Home Health Agency (HHA) providers, in addition to providers who have been elevated to the "high" risk category in accordance with enrollment screening regulations. The requirement is applicable to any "high" risk provider who enrolled August 1, 2015, and forward.

For DMEPOS suppliers and HHA providers, the FCBC will be completed on all individuals with a 5 percent or greater ownership interest in the provider; this includes any individual that has any partnership (general or limited) in a DMEPOS supplier or HHA.

FCBCs are also required for any provider that has been elevated to the "high" risk category for any of the following reasons:

- A payment suspension has been imposed on a provider based on credible allegation of fraud, waste or abuse. The provider's risk level remains "high" for 10 years beyond the date of the payment suspension.
- Providers who have an existing overpayment of $1500* or greater and the overpayment is **all** of the following:
  - ◊ more than 30 days old
  - ◊ has not been repaid at the time the application was filed
  - ◊ not currently being appealed
  - ◊ not part of a DHCFP-approved extended repayment scheduled for the entire outstanding overpayment

  *Note: The $1500 threshold is an aggregate of all outstanding debts and interest, to include the principal overpayment balance amount and the accrued interest amount for a given provider.
- The provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid Program within the previous 10 years.

A notification letter will be sent to providers that have been determined to be in the "high" risk category or whose risk level has been adjusted to "high." The notification will include instructions and information regarding where to obtain fingerprints, associated costs, how to submit fingerprints and the time frame for response. If the provider is an organization or group, information will also be provided regarding which associated individuals are required to submit fingerprints.

Failure to comply with any portion of the FCBC requirements shall result in provider (individual/entity) termination.

Attention All Providers: Reminder to Enter Ordering, Prescribing or Referring Provider's National Provider Identifier on Claims

As providers were reminded in Web Announcement 1372: If the service you are billing was ordered, prescribed or referred by another physician or other eligible professional, you must enter that Ordering, Prescribing or Referring (OPR) provider's National Provider Identifier (NPI) on the claim form. The following provider types are always required to include the NPI of the OPR provider on their claim: 16, 17 (specialties 167, 169, 196 and 215), 19 (specialties 184 and 186), 23, 27, 28, 29, 33, 34, 37, 43, 45, 46, 55, 63, 64, 68 and 85. Electronic Verification System (EVS) User Manual Chapter 7 (Search Provider) provides instructions on how to search the Provider Web Portal for OPR providers.

It is the responsibility of the billing provider to ensure that the NPI which they enter on a claim belongs to an individual provider (not an organization or group): who ordered, prescribed or referred the service being billed; is authorized to do so; and is an active Nevada Medicaid provider on the date of service. **Any claims which do not conform to these requirements may be denied, and if the claims are paid in error, they are subject to recoupment.**

If an OPR provider's NPI is submitted on the claim when it is not mandatory, the NPI will still be validated by the system and the claim will deny if the OPR provider's NPI is not valid or the OPR provider is not enrolled in Nevada Medicaid.