Nevada Medicaid News

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UAC: The New Way to Register for Online Products

The User Administration Console (UAC) is the new way Nevada Medicaid/Nevada Check Up providers register for access to the Electronic Verification System (EVS), the Online Prior Authorization System (OPAS) and Pharmacy Web PA (online now for providers who submit prior authorization requests for prescription drugs).

The UAC application puts the control and maintenance of user access in the hands of the organization (provider). Instead of requesting access for each staff member through First Health Services, providers will choose a Delegated Administrator who will register through UAC to create users, grant users appropriate access to EVS, OPAS and/or Pharmacy Web PA, and create secondary administrators for large organizations.

Existing EVS/OPAS users may log in with their existing user ID(s) to access EVS/OPAS. Once any of the following situations occur for existing users, providers will need to choose a Delegated Administrator to access UAC to accomplish the task: reset a password, change an access level or add/delete a user.

UAC registration is completed by:

1. Requesting a Personal Identification Number (PIN);
2. Registering with the PIN; and
3. Activating your account.

Click on "User Administration" in the top right corner of the https://mediciad.nv.gov website to access UAC or click on "Reference" for guides and tutorials.

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Updates on Major Issues

NPI/API: If you have not already done so, please provide First Health Services with your National Provider Identifier (NPI) by completing and mailing the Provider Information Change Form (FH-33). Enter your NPI in Field 4.a. and your Taxonomy Code(s) in Field 4.b. FH-33 is posted at https://medicaid.nv.gov (select "Forms" from the "Providers" menu).

Until further notice, providers may enter their Provider Medicaid Number or their NPI or their Atypical Provider Identifier (API) in the appropriate fields on claims received at First Health Services. These instructions apply to both paper and electronic claims. Providers will be notified of the effective date when only NPI/API will be accepted.

Reminder: If NPI/API is used on the claim, then the entire claim must be NPI/API compliant. For example, if you enter NPI for "Rendering/Servicing Provider ID" please enter NPI for "Billing Provider."

CMS-1500 (version 08/05) Billers: When using your NPI in the bottom, white half of Field 24J and in Field 33A, you must use qualifier ZZ in Field 24I. Qualifier 1D is not valid on claims showing NPI in these fields.

When using your API in Fields 24J and 33A, please enter qualifier N5 in Field 24I.

National Drug Codes (NDC): The federal Deficit Reduction Act (DRA) of 2005 requires State Medicaid programs to collect National Drug Code (NDC) information on claims for physician-administered drugs, i.e., drugs administered in an outpatient setting. This mandate requires Nevada Medicaid's compliance with federal regulations regarding recovery of drug manufacturer rebates.

NDC and NDC billing units will be required on CMS-1500 (version 08/05) and UB-04 claims beginning Jan. 1, 2008. Please visit https://medicaid.nv.gov for claim form instructions and web announcements concerning this requirement.

Prescriber NPI on Pharmacy Claims: When entering the prescriber's ID on claims, pharmacy providers are encouraged to use the prescriber's NPI immediately instead of the prescriber's Provider Medicaid Number. Providers will be notified of the effective date when the prescriber's NPI will be mandatory.

Tamper-Resistant Prescription Pads Due in October 2007: Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007 requires that all written, non-electronic prescriptions for Medicaid outpatient drugs be executed on tamper-resistant pads in order for the drugs to be reimbursable by the federal government. Please see Web Announcement 157 at https://medicaid.nv.gov for details and links to Chapter 1200 of the Medicaid Services Manual and the Centers for Medicare & Medicaid Services (CMS) website.

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OIG's Authorities Regarding Exclusion from Participation in Federal Programs

September 1999 – The Office of Inspector General (OIG) was established in the U.S. Department of Health and Human Services to identify and eliminate fraud, waste and abuse in the Department's programs and to promote efficiency and economy in Departmental operations. The OIG carries out this mission through a nationwide program of audits, inspections and investigations.

In addition, the OIG has been given the authority to exclude from participation in Medicare, Medicaid and other Federal health care programs individuals and entities who have engaged in fraud or abuse, and to impose civil money penalties (CMPs) for certain misconduct related to Federal health care programs (sections 1128 and 1128A of the Social Security Act).

To enhance the OIG's ability to protect the Medicare and Medicaid programs and recipients, the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93, expanded and revised the OIG's administrative sanction authorities by, among other things, establishing certain mandatory and discretionary exclusions for various types of misconduct.

The enactment of HIPAA in 1996 and the Balanced Budget Act (BBA) of 1997, Public Law 105-33, further expanded the OIG's sanction authorities beyond programs funded by the Department to all "Federal health care programs." BBA also authorized a new CMP authority to be imposed against health care providers or entities that employ or enter into contracts with excluded individuals for the provision of services or items to Federal program recipients. This prohibition of employing or contracting with an excluded individual or entity applies whether the Federal reimbursement is based on itemized claims, cost reports, fee schedules or the Health Care Financing Administration's Prospective Payment System (PPS).

Under the CMP authority, providers such as hospitals, nursing homes, hospices and group medical practices may face CMP exposure if they submit claims to a Federal health care program for health care items or services provided, directly or indirectly, by excluded individuals or entities.

The OIG urges health care providers to check the OIG List of Excluded Individuals/Entities on the OIG website prior to hiring or contracting with individuals or entities. Providers should also periodically check the OIG website for determining the participation/exclusion status of current employees and contractors.

This article has been compiled from a Special Advisory Bulletin, the full content of which is posted on the OIG website (see Web Announcement 156 at https://medicaid.nv.gov for a link to the OIG website and Exclusion Program webpage).

Billing Tips and Reminders

Paper Claim Forms – Before sending your paper claim forms to First Health Services:

► Enter all Provider Medicaid Numbers and/or National Provider Identifiers (NPI) in the correct fields on claim forms. Please review current claim form instructions at https://medicaid.nv.gov.

► Enter claim form information, especially digits, so the data is centered in the form fields. Data that overlaps lines (top, bottom or sides) may not be entered correctly into the system for processing.

► Be sure to sign the CMS-1500 (version 08-05) and ADA 2006 claim forms. Unsigned claims will be returned as incomplete. Do not sign the UB-04.

Checking Recipient Eligibility – Prior authorizations do not confirm recipient eligibility. Remember to verify recipient eligibility before rendering services. Eligibility may be checked online through the Electronic Verification System (EVS) (at https://medicaid.nv.gov from the EVS menu) or by calling the Nevada Medicaid Audio Response System (ARS) at (800) 942-6511.

CONTACT INFORMATION

If you have a question concerning the manner in which a claim was adjudicated, please contact First Health Services by calling (877) 638-3472 or e-mailing: nevadamedicaid@fhsc.com.

If you have questions about Medicaid Service Policy or Rates, you can go to the Division of Health Care Financing and Policy (DHCFP) website: www.dhcfp.state.nv.us and look for the item labeled: Contact Information. Move your cursor to that item and follow the directions to find the person at DHCFP who can answer your question. You can either phone the contact person or send an e-mail.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $264,090,917.50 in claims during the three-month period of April, May and June 2007. Nearly 100 percent of current claims continue to be adjudicated within 30 days. The DHCFP and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

New Fax and Phone Numbers for Adult Day Health Care, Pre-Admission Screening Resident Review and Level of Care

Effective July 30, 2007, new fax and telephone numbers must now be used by Provider Types 11 (Hospital, Inpatient), 19 (Nursing Facility) and 39 (Adult Day Health Care) when submitting Pre-Admission Screening Resident Review (PASRR) and Level of Care (LOC) screening requests or when requesting an authorization for Adult Day Health Care. The process providers use to submit a request has not changed.

The new toll-free fax number is **(800) 846-7971**. The new toll-free customer service telephone number to call regarding these requests is **(800) 648-7593**.

Payment Error Rate Measurement (PERM) Update on Federal Contractors and Medical Record Requests

The Centers for Medicare & Medicaid Services (CMS) will measure the accuracy of Medicaid and State Children's Health Insurance Program (SCHIP) 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 Medicaid and SCHIP (Nevada Check Up) payments. The Lewin Group will provide statistical support to the program by producing the claims to be reviewed and by calculating Nevada's error rate. Livanta LLC will provide the documentation/database support by collecting medical policies from the State and by collecting medical records from providers. HealthDataInsights Inc. will conduct the medical and processing reviews for sampled claims following CMS guidance.

The PERM review for Nevada will be conducted on claims paid Oct. 1, 2007, through Sept. 30, 2008.

Medical records are needed to support the reviews conducted by HealthDataInsights to determine if the service provided was medically necessary and correctly paid in accordance with established policy. For claims selected in the PERM sampling process, Livanta LLC will contact the provider for a copy of the medical records to support the claim billed to and paid by the Division of Health Care Financing and Policy (DHCFP). To obtain the appropriate medical record documentation, Livanta LLC will contact the provider to verify name and address and to determine how the provider wants to receive the medical record request(s) (via facsimile or U.S. mail).

The initial provider contacts will occur in the first few months of 2008. Once the provider receives the request for medical records, the provider must submit the information electronically or in hard copy within 90 days. Livanta LLC and, if necessary, State PERM staff will follow up to ensure that providers submit the documentation before the 90-day timeframe 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 90-day timeframe, 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.

Understandably, providers are concerned with maintaining the privacy of recipient 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.

A Message from DHCFP Regarding Prevention

Lead Screening: Nevada Medicaid reminds all Early Periodic Screening Diagnosis & Treatment (EPSDT) providers performing Healthy Kids exams that blood lead testing is federally mandated for all 12 and 24 month olds as part of the Healthy Kids exam, without exception. The EPSDT section of the Centers for Medicare & Medicaid Services' (CMS) State Medicaid Manual states the following:

"**Lead Toxicity Screening** – All children are considered at risk and must be screened for lead poisoning. HCFA (CMS) requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample."

"**Diagnosis, Treatment and Follow-up** – If a child is found to have blood lead levels equal to or greater than 10 ug/dL, providers are to use their professional judgment with reference to Centers for Disease Control and Prevention (CDC) guidelines covering patient management and treatment including follow-up blood tests and initiating investigations to determine the source of lead, where indicated."

Immunizations: Nevada Medicaid also encourages providers to become Vaccines for Children (VFC) providers in order to receive free vaccines for Medicaid children. The vaccine is made available to providers free of charge by the Nevada State Health Division. Providers may bill for the administration fee for the vaccine. For program and enrollment information, go to http://health.nv.gov/index.php?option=com_content&task=view&id=506&Itemid=1037

Vaccinations and Lead Testing in the Medical Provider's Office: It is highly recommended that EPSDT recipients be vaccinated at the time of the Healthy Kids exam, if possible, rather than being referred to a local health department for immunizations. Many Medicaid recipients/families have difficulty with transportation or getting time off work, so vaccinating at the time of the Healthy Kids exam is desirable and will increase the chance of the child receiving the necessary immunizations. The same holds true for the lead test.

A Message from DHCFP: Periodontal Coverage for Pregnant Adult Women

The Division of Health Care Financing and Policy (DHCFP) has recently received legislative approval to provide periodontal coverage for pregnant adult women. Effective Oct. 1, 2007, any adult recipient will now qualify for certain periodontal services during her pregnancy.

Studies have linked periodontal disease during pregnancy to both premature births and low-birth-weight babies. DHCFP feels it would be both beneficial to our recipients and cost-saving for the State if we introduced certain key benefits which were previously not covered for pregnant Medicaid recipients over the age of 21 (such as periodontal exams/screenings and scaling/root planing procedures).

The DHCFP will be distributing flyers, sharing the news at various coalition meetings, and doing outreach to targeted groups (such as OBGYN providers) regarding these changes. Our hope is that we can reach as many pregnant adult recipients with periodontal disease or gingivitis as possible.

By introducing periodontal benefits to the pregnant adult Medicaid population, we hope to reduce future expenditures on expensive hospital care for premature births and low-birth-weight babies. In addition, these newly expanded benefits will help to provide access to services for pregnant women (and their unborn babies) whose health and quality of life are at risk if the disease is left untreated.

We would like to request our providers' support in this endeavor. You can help by sharing the news with your colleagues, patients and staff members. This endeavor is based upon the principle that the more women we reach, the more premature births we can prevent, which will be a benefit for everyone – Nevada Medicaid, our providers, our taxpayers and, most certainly, the recipients – in the long run.

The Medicaid Fee Schedule will be revised showing the periodontal benefits that will be available to pregnant females over the age of 21.

Changes to covered benefits in the Medicaid Services Manual (MSM) – Chapter 1000 – Dental Services (the Medicaid dental policy) must go to Public Hearing for final approval and adoption. For the official list of these covered periodontal benefits, please refer to MSM Chapter 1000 on or after Oct. 1, 2007, at www.dhcfp.state.nv.us.

Visit **https://medicaid.nv.gov** weekly for important updates & information