Nevada Medicaid News

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First Health Services Corporation®
A Coventry Health Care Company
Nevada Medicaid and Nevada Check Up
Fiscal Agent
P.O. Box 30042
Reno, NV 89520-3042
(877) 638-3472

Provider Training Expands in 2009 to Include OPAS and Behavioral Health Sessions

First Health Services and the Division of Health Care Financing and Policy offer free, comprehensive training throughout the year for newly enrolled providers as well as established providers and staff.

The schedule for 2009 includes Claim Type Training, Provider Type Training and Nevada Medicaid Policy.

In order to meet the needs of providers, the training program has been expanded for 2009 to include sessions focusing on the Online Prior Authorization System (OPAS) for provider types 11 and 56 and Behavioral Health billing and policy for provider types 14 and 82.

The free Annual Medicaid Conference covers general information for all providers, as well as individualized instruction according to provider type.

New comprehensive training begins in January. Registration is required for all classes and the Conference.

The 2009 Nevada Medicaid and Nevada Check Up Provider Training Catalog contains class schedules and descriptions, training locations and registration details (select "Provider Training" from the "Providers" menu at https://medicaid.nv.gov).

MCO Update: DHCFP Contracts with AMERIGROUP; No Change to Health Plan of Nevada Contract

The Division of Health Care Financing and Policy (DHCFP) has announced that AMERIGROUP will assume the remaining term of the Medicaid Managed Care Organization (MCO) contract currently held by Anthem BCBS PP (Partnership Plan) effective Feb. 1, 2009. No change has been made to the contract with Health Plan of Nevada.

AMERIGROUP will provide, and Health Plan of Nevada will continue to provide, all regular managed care services, including dental, to Medicaid TANF/CHAP and Nevada Check Up recipients in urban Washoe and urban Clark counties beginning Feb. 1, 2009. Anthem BCBS PP (Partnership Plan)'s contract ends on Jan. 31, 2009.

First Health Services continues to administer prior authorizations and provider reimbursements for Fee For Service (FFS) claims.

Anthem BCBS PP providers are advised to submit their claims for services to Anthem in a timely manner before Feb. 1, 2009, to assist in a smooth transition.

Providers who have questions regarding the MCOs may call the DHCFP Business Lines Unit at (775) 684-3692.

Details Regarding Prior Authorization Denials

Providers who receive a denial (non-certification decision) in response to a prior authorization (PA) request may call to request the clinical basis for the decision. A First Health Services representative will provide the principal reason for the denial and specific reasons why medical necessity criteria were not met.

Upon the provider's request, a written statement specifying the clinical rationale used in making the non-certification decision will be provided.

The numbers to call are (800) 648-7593 for adult day health care and dental PAs and (800) 525-2395 for all other service types (except pharmacy).

CONTENTS:

News for Prescribers & Pharmacies

E-Prescribing:

The Division of Health Care Financing and Policy (DHCFP) and First Health Services have incorporated an enhancement that impacts those prescribers who use, or are looking to use, electronic prescribing technology.

Eligibility, recipient pharmacy claims history, Nevada Medicaid drug coverage data and the indication of the need for prior authorization for Nevada Medicaid/Nevada Check Up Fee For Service recipients are now available to prescribers who use electronic prescribing systems.

Access to this data can build the efficiency of a practice by helping to decrease the number of callbacks and questions that arise when prescriptions are not prepared in line with drug coverage/eligibility requirements.

This data is only available to providers who transmit prescriptions electronically to pharmacy computers, not to fax machines. Prescribers can utilize e-prescribing to its fullest by recognizing the capabilities of their systems, working with their vendors to enable their systems for computer-to-computer connectivity with pharmacies, and understanding if their systems can receive and work with Nevada Medicaid-supplied data.

For further details, select the new "E-Prescribing" tab from the "Providers" menu at https://medicaid.nv.gov.

Tamper-Resistant Prescription Pads:

Effective Oct. 1, 2008, all written, non-electronic prescriptions for Medicaid Fee For Service outpatient drugs must contain at least one feature from each of three categories of tamper resistance specified by the Centers for Medicare & Medicaid Services (CMS). See Web Announcement 215 at https://medicaid.nv.gov for the categories as well as situations when the requirement does not apply.

PDL Changes Effective Dec. 17, 2008:

In September 2008, the Pharmacy and Therapeutics (P &T) Committee of DHCFP completed the annual review of the Preferred Drug List (PDL). The actions taken by the committee are listed in the web announcement titled "Preferred Drug List (PDL) Changes Effective December 17, 2008." The web announcement and complete PDL are posted on the "Preferred Drug List" page under "Pharmacy" at https://medicaid.nv.gov.

Pharmacy Lock-In Program:

Nevada Medicaid has implemented a pharmacy lock-in program for Nevada Medicaid/Nevada Check Up recipients who receive nine or more controlled substance prescriptions within a 60-day period. The goals of the lock-in program are to provide continuity of care, avoid over utilization of prescription drugs, and ensure that only the most medically necessary care and services are provided.

Recipients will be locked-in for controlled substances only. Once the DHCFP makes the decision to lock in a recipient to a pharmacy, First Health Services will send a notification to the recipient, the recipient's most utilized (locked-in) pharmacy and the recipient's physician(s). Recipients may change their lock-in pharmacy through their local Medicaid District Office.

If a lock-in recipient attempts to get a controlled substance from another pharmacy, the claim will deny with a "50" rejection code, which is "Non Matched Pharmacy ID Number." The pharmacy may receive a transaction message that states "Non Matched Pharmacy ID - Check NPI/Locked In - Call 1-800-505-9185."

Pharmacies may call (800) 505-9185 to determine the lock-in pharmacy or request an override to the denial. Overrides will be considered if the lock-in pharmacy is out of stock; the lock-in pharmacy is closed; or the recipient is out of town and cannot access the lock-in pharmacy.

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 sending an e-mail to 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 at http://dhcfp.nv.gov. Under the "DHCFP Index" box, move your cursor over "Contact Us" and select "Policy and Rate Staff contacts." 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 $314,942,245.54 in claims during the three-month period of July, August and September 2008. 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.

Medicaid Manual Changes

The following Medicaid Manual chapters were revised in August or September 2008.

MOM Chapter 200 – Boards, Committees and Advisory Committees
NCU Chapter 1000 – Nevada Check Up
MSM Chapter 400 – Treatment Home Services
MSM Chapter 900 – Private Duty Nursing
MSM Chapter 1000 – Dental Services
MSM Chapter 1100 – Ocular Services
MSM Chapter 1200 – Prescribed Drugs
MSM Chapter 1300 – DME
MSM Chapter 1500 – Healthy Kids
MSM Chapter 1900 – Transportation
MSM Chapter 2200 – Aging Services
MSM Chapter 2800 – School Based Child Health Services
MSM Chapter 3500 – Personal Care Services Program

HIPP Benefits the State, Medicaid Recipients and Taxpayers

The Health Insurance Premium Payment (HIPP) program is a cost-savings program that identifies Medicaid recipients who have access to private health insurance through an employer. Medicaid pays the medical premiums, co-insurance and deductibles for eligible recipients when it is determined to be cost-effective.

Taxpayer dollars are saved by purchasing health insurance available to Medicaid recipients, because high costs are deferred to the private insurance. The program assists recipients in paying employer premiums they otherwise may not be able to afford.

If a provider has a recipient who may benefit from the program, Nevada Medicaid asks that the recipient be referred to the contact information at the end of this article.

To be eligible for the program, recipients:

- Must be eligible for full Nevada Medicaid, and
- Must be eligible for, and have access to, private health insurance through their employer, and
- Cannot be eligible for Medicare.

Important details regarding HIPP include:

- Changes to employer health premiums may result in disenrollment from the HIPP program if the insurance is no longer cost-effective.
- Recipients who have a catastrophic illness, condition or are pregnant are eligible to participate in HIPP if it is determined to be cost-effective.
- If it is determined that paying the group health insurance is cost-effective, then Medicaid recipients are expected to enroll in the HIPP program. Non-cooperation may result in disenrollment from the Medicaid program.
- Nevada Check Up recipients are not eligible for HIPP.

Some additional benefits to enrolling in the program include:

- Other medical services may be included if covered through the employer health insurance.
- Non-Medicaid household members do not qualify for HIPP; although, if medical coverage cannot be separated by family member, and does not increase the premium amounts, then other household members may be eligible for insurance services.
- Once recipients are no longer utilizing the Medicaid program, individuals can take over their premium payments without waiting for the next open enrollment period.

Providers who have questions about the program may contact the Division of Health Care Financing and Policy's Provider Support Unit at (775) 687-8413 or e- mail HIPP@dhcfp.nv.gov.

Recipients who are interested in HIPP may call Health Management Systems (HMS) at (775) 335-1040 or 1-800-856-8839 or e-mail nevadahipp@hms.com. HMS administers HIPP for Nevada Medicaid.

Clarification of Medicaid and Check Up Preventive Health Services

Nevada Medicaid Preventive Health Services

Preventive Health Services is a benefit for children enrolled in Nevada Medicaid. The goal of this program is to keep children healthy and regular checkups help to keep children healthy.

Preventive Health Services include (but are not limited to):

- EPSDT screening, including vision, dental and hearing screens;
- Immunizations;
- Lead testing and other laboratory tests.

Nevada Check Up Preventive Health Services

Preventive Health Services is a benefit for children enrolled in Nevada Check Up. The goal of this program is to keep children healthy and regular checkups help to keep children healthy. Some problems start before a child looks or feels sick. As the child's health care provider, you can find and treat these problems early, before they lead to a serious problem.

Preventive Health Services include (but are not limited to):

- *Well baby/Well child exams by the child's doctor;
- Shots (immunizations) to keep the child healthy;
- Lead testing and other laboratory tests;
- Annual eye exam (CPT 92002, 92 004, 9 2012, 92014).

*NOTE: EPSDT screens (for Nevada Medicaid recipients) and Well baby/Well child screens (for Nevada Check Up recipients) are basically one and the same and are billed using the same codes with the same reimbursement. Because Nevada Check Up can no longer reimburse for any treatments outside of the state plan (as EPSDT allows), their screenings cannot be called "EPSDT" and thus the term Well baby/Well child is used.

Clinical Claim Editor Will Analyze Claims for Professional and Outpatient Services

In the first quarter of 2009, clinical claim editor will begin reviewing and adjudicating claims for professional and outpatient services in conjunction with the Medicaid Management Information System (MMIS). Previous communications reported a December 2008 implementation.

The Division of Health Care Financing and Policy (DHCFP) and First Health Services are implementing a clinical claim editor to ensure nationally recognized billing guidelines will be followed. Claim analysis is derived from the most clinically likely scenarios based on American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS) and specialty society guidelines, industry standards and **Nevada Medicaid/Nevada Check Up policy**.

Providers who use correct coding may not see any changes on their remittance advices (RAs); however, providers who are not following standard billing and coding practices will see changes. Affected claims may be denied and then adjudicated with the most appropriate coding for the service being billed. The denied claim and the corresponding adjudicated claim will be shown on the same RA.

Providers are encouraged to monitor web announcements at https://medicaid.nv.com for updates and additional information. Useful Frequently Asked Questions (FAQs) regarding edit categories, edit definitions, modifiers and RA changes will soon be posted on the website (select "Announcements/Newsletters" from the "Providers" menu).

Please be sure your billing service is aware that RAs will reflect changes due to this MMIS enhancement.

Filing an Appeal on a Denied Claim

If you do not agree with a claim denial, please contact the First Health Services Customer Service Center at (877) 638-3472. Certain denials can be resolved by phone. If this is not the case for your claim, the representative may be able to advise you how to resubmit your claim so it can be paid.

If you do submit an appeal, be sure to postmark it no later than 30 calendar days from the date on the remittance advice listing the claim as denied. Be sure to mail appeals separately from other claims.

For complete instructions and a checklist of items that must be included with an appeal, see the "How to File an Appeal" section of the Billing Manual, which is online at https://medicaid.nv.gov (select "Billing Information" from the "Providers" menu).

The Billing Manual also provides instruction on resubmitting a denied claim or submitting an adjustment or void. You cannot appeal a claim because it was paid incorrectly; you must handle incorrect payments by submitting an adjustment.