Nevada Medicaid News

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Diabetic Supply Program Implemented March 1, 2009

Nevada Medicaid Fee For Service and Nevada Check Up Fee For Service implemented a new Diabetic Supply Program on March 1, 2009.

Through this new program, two manufacturers (Abbott Diabetes Care , Inc. and Life Scan, Inc., a Johnson & Johnson company) provide the State with rebates for preferred blood-glucose monitors and test strips. The savings is allowing the State to lower diabetic supply expenditures without reducing rates or affecting quality and access to care.

The new program allows for a one-time replacement of a recipient's current monitor for a new one from a preferred list of products. Prescribers, pharmacies and affected recipients have been notified of this by mail.

A new webpage devoted to the Diabetic Supply Program has been created at https://medicaid.nv.gov (select "Diabetic Supplies" from the "Pharmacy" menu).

For complete coverage and limitations, see Medicaid Services Manual, Chapter 1200-Prescription Services online at http://dhcfp.nv.gov.

Clinical Claim Editor Begins Reviewing and Adjudicating Professional/Outpatient Claims

Effective March 16, 2009, professional and outpatient claims are being reviewed and adjudicated by the clinical claim editor. The first remittance advices to reflect clinical claim editor adjudication are dated March 27.

The new claim editing software reviews and adjudicates claims in conjunction with the Medicaid Management Information System (MMIS) to ensure nationally recognized billing guidelines and Nevada Medicaid policies are followed.

Frequently Asked Questions (FAQs) have been created to assist providers (see Web Announcement 241 at https://medicaid.nv.gov). FAQ topics include edit categories, edit definitions and modifiers.

The following questions/answers are four of the FAQs posted online:

Q Will there be new billing instructions to follow?
A No. If you are using correct coding currently, nothing will change for you; however, if you are not following standard billing and coding practices, your claims will be affected. 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 remittance advice.

Q Will the clinical claim editor compare current claims to previously submitted claims?
A Yes. Clinical claim editor compares the current claim/claim line(s) with a claim/claim line(s) that has been previously paid. Previously adjudicated claims are stored in the MMIS and referenced when needed by the clinical claim editor.

Q Will the claim editor incorporate pre- and post-operative edits?
A Yes. Pre- and post-operative auditing automatically denies Evaluation & Management (E&M) services rendered within the pre- and post-operative timeframe as defined by CMS.

Q Can unnecessary modifiers cause clinical claim editor to deny the claim?
A Yes. Please ensure that national coding guidelines are followed.
(**Note:** The clinical claim editor will deny claims submitted with *unnecessary* modifiers. For example, the use of the modifier NU (New Equipment) on a claim for disposables will cause the claim to deny.)

CONTENTS:

Options for Children Under the PCS Program

Under provisions of Early and Periodic Screening, Diagnostic and Treatment services (EPSDT, known in Nevada as Healthy Kids), children under age 21 whose needs cannot be met through the social model of the Personal Care Services (PCS) program may qualify for additional personal care services under the medical model of the PCS program. To request the medical model, a doctor's order is required.

If the medical model is chosen, a new doctor's order is required each time an assessment is performed. If a physician's order is not received, only benefits under the social model will be considered. Whether services are under the social or medical model, they must be medically necessary and directly related to the specific needs of the individual recipient.

The following personal care services are not covered under either the social model or the medical model: non-age appropriate services, companion care, respite care, chore services, babysitting and transportation.

For additional information see Medicaid Services Manual (MSM) Chapter 1500-Healthy Kids (EPSDT) and Chapter 3500-Personal Care Services (PCS) Program. The MSM is online at http://dhcfp.nv.gov.

PASRR and LOC Policy Changes Implemented

A Public Hearing held Feb. 10, 2009, resulted in the implementation of the following policy changes effective immediately for any provider who completes Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) screening forms:

- PASRR and LOC screening forms must be completed and signed by a licensed health care provider. For providers utilizing the On line Prior Authorization System (OPAS), tab 4 contains a field to identify the licensed person who completed the form.
- First Health Services will return screening forms not completed by licensed persons.
- Criteria for Pediatric Level of Care I and II and ventilator dependence have been revised.

Please refer to Chapter 500-Nursing Facilities of the Medicaid Services Manual (MSM) for all policy changes. The MSM is online at http://dhcfp.nv.gov.

Providers who do not use OPAS can register for access at https://medicaid.nv.gov (select "OPAS Login" from the "Prior Authorization" menu and click on the "Need to register?" option).

Are You E-Prescribing for Your Recipients?

Are you using your e-prescribing software to place prescriptions for Nevada Medicaid/Nevada Check Up Fee For Service recipients?

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 available to prescribers who transmit prescriptions electronically to pharmacy computers, not fax machines.

Prescribers can utilize electronic prescribing to its fullest by working with their vendors to enable their systems for computer-to-computer connectivity with pharmacies. View information and resources at https://medicaid.nv.gov (select the "E-Prescribing" tab from the "Providers" menu).

PDL Changes Effective March 12, 2009

The Pharmacy and Therapeutics (P&T) Committee of the Division of Health Care Financing and Policy (DHCFP) met on Dec. 11, 2008, to review the Preferred Drug List (PDL). The actions taken by the committee are listed in the web announcement titled "Preferred Drug List (PDL) Changes Effective March 12, 2009." The web announcement and complete PDL are posted on the "Preferred Drug List" page under "Pharmacy" at https://medicaid.nv.gov.

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.

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 instructions 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 $288,261,534.62 in claims during the three-month period of October, November and December 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 during the period October 2008 through February 2009. Please review the current Medicaid Manuals at http://dhcfp.nv.gov.

MOM Chapter 600 – Katie Beckett
MSM Chapter 100 – Medicaid Program
MSM Chapter 500 – Nursing Facilities
MSM Chapter 1200 – Prescribed Drugs
MSM Chapter 1300 – DME
MSM Chapter 1600 – Intermediate Care for the Mentally Retarded
MSM Chapter 1900 – Transportation
MSM Chapter 2500 – Targeted Case Management
MSM Chapter 3200 – Hospice Services
MSM Chapter 3500 – Personal Care Services Program
MSM Chapter 3600 – Managed Care Program

Medicaid Reimbursements Will Be Suspended for Providers Who Fail to Report Changes

The Division of Health Care Financing and Policy (Nevada Medicaid) plans to institute a payment suspension process for Nevada Medicaid/Nevada Check Up providers who have not reported changes within the required time period as noted in the provider contract and Chapter 100-Eligibility Coverage and Limitations of the Medicaid Services Manual.

Providers are required to notify Nevada Medicaid within five working days of a change in professional licensure, facility/business/practice address, provider group membership or business ownership.

When it is discovered that the information on file with Nevada Medicaid is incorrect, First Health Services will suspend all payments to a provider until the corrected information and associated verifications are received. The provider will be notified in writing, at the last known address, of the suspension and the information that is required for the suspension to be lifted.

Information that will be required from the provider:

- If the provider has completed an enrollment application within the previous 12 months, then the Provider Information Change Form (FH-33) and applicable verifications to support the change will be required.

- If the provider's enrollment application is older than one year, then the provider will be required to complete a new Provider Enrollment Application (FH-31), and submit the applicable verifications.

The application/contract and change form are online at https://medicaid.nv.gov (select "Provider Enrollment" from the "Providers" menu). The Medicaid Services Manual is online at http://dhcfp.nv.gov.

Once the provider has submitted the required information and First Health Services has updated their records, the suspension will be lifted and any checks/EFT transfers that were held will be sent to the provider. If the provider fails to submit the required information within the designated time period, his/her contract will be terminated.

In order to avoid payment suspensions, providers may call First Health Services' Provider Enrollment Unit at (877) 638-3472 to verify their addresses on file and submit FH-33, if necessary, as soon as possible.

Providers Are Urged to Watch for These Billing Errors

The First Health Services training staff has identified a number of repetitive errors on claims. These errors can ultimately cause claims to be delayed or to deny.

The repetitive billing errors include but are not limited to:

- TPL claims are being submitted without the primary insurance EOB page attached showing the message for denial codes.
- In the required Field 24I on the CMS-1500 Claim Form, the "ZZ" qualifier is either missing or incorrectly entered.
- The 9-digit zip code is not listed in the provider address field.
- The total billed (balance due field) after TPL is more than the co-insurance and/or deductible showing on the primary EOB.
- Occurrence codes are missing or are used incorrectly in UB-04 Claim Form field(s) 31-36.
- NPI/API is missing from the claim form or the old 9-digit legacy provider number is still on the claim. (NPI/API is required as of May 23, 2008.)
- "From" and "To" dates are missing on the CMS-1500. (The dates must be used even if they are the same date.)
- Multiple lines are billed on the ADA and CMS-1500 when there is other insurance or Medicare (TPL) available. (Use only one line per claim.)
- Multiple lines are billed for an adjustment/void on the ADA and CMS-1500. (Use only one line per claim.)
- Adjustments and voids are being submitted for denied claims. (Remember you can adjust/void a previously paid claim, not a denied or pended claim.)
- Notes are used in fields on the claim forms. (All claim form fields are live and all notes are to be on a separate 8½-by-11-inch letter attached to the claim.)
- Code "0099" is not used on the UB-04 Claim Form, Field 42, Line 23 on multiple-page claims. ("0099" must be used in this field to signify that there is another page to the claim.)

Please work with your billing staff or billing agencies to ensure that claims are being submitted correctly and that billing guidelines are followed. Claim Form Instructions and Billing Guidelines are online at https://medicaid.nv.gov (select "Billing Information" from the "Providers" menu).

First Health Services and the Division of Health Care Financing and Policy (DHCFP) offer **free,** ongoing training to all providers. Review the Provider Training Catalog (select "Provider Training" from the "Providers" menu) and register for the class best suited to your provider type.

Free Online Training with Well-Child Curriculum for Pediatric Providers

Nevada Medicaid (Title XIX) and Maternal Child Health (Title V) are partnering with the University of Nevada, Reno (UNR) and Georgetown University to offer online training for pediatric providers.

This is a Well-Child Curriculum about comprehensive primary care visits for either private pay or Medicaid/SCHIP children. Nevada Medicaid is especially in terested in engaging rural primary care providers to take the free course.

Instructions to register and further information are available at http://www.brightfutures.org/wellchildnevada. The course is available until June 30, 2009.

Instructions to receive CMEs or CEUs:

The program offers a total of 5 CMEs or CEUs. At the end of the course, you will see instructions to receive the CME. If you have difficulty, please contact John Richards at richarjt@georgetown.edu or Marti Coté at Nevada Medicaid mcote@dhcfp.nv.gov.