

Nevada Medicaid News

Third Quarter 2010

Volume 7, Issue 3



Nevada Medicaid and Nevada Check Up
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Read Nevada Medicaid News Online; Newsletter Is No Longer Mailed

Effective with this issue of Nevada Medicaid News, this newsletter is no longer mailed to providers. To save on printing and mailing costs and paper use, the Division of Health Care Financing and Policy (DHCFP) has discontinued the printed version and encourages providers to read Nevada Medicaid News online.

An online-only version of the newsletter allows more articles to be included in each issue for even more details about policy changes, provider responsibilities, billing and claims payment, training, contact information, etc. Unlike a printed newsletter, the online version provides convenient links to additional sources of information.

The newsletter will continue to be posted on Magellan Medicaid Administration, Inc.'s Nevada Medicaid website on a quarterly basis on the "[Announcements/Newsletters](#)" webpage under the "Providers" menu.

Attention Behavioral Health Providers: Basic Skills Training (BST) Notification Process and Service Limits

Effective October 11, 2010, providers must include BST services (units not to exceed the daily limits) in Sections VIII and XI of form FA-11A for notification purposes only. Once the notification is received, the BST will be assigned an authorization number that must be included on claim submissions.

If other services are requested in combination with BST, clinical reviews will be conducted on these services taking into consideration BST as a part of the overall treatment plan. It is imperative that providers include on the notification and render only those services which are medically necessary for each individual recipient.

BST is limited to a maximum of 2 hours per day through this notification process regardless of the recipient's level of needs determination score. For a 90-day authorization period, the maximum allowable number of units is 720. This includes any combination of procedure code H2014 with no modifier and procedure code H2014 with modifier HQ.

Providers must adhere to all documentation and supervision requirements as outlined in Chapter 400 of the Medicaid Services Manual.

Annual Medicaid Conference Is Just Around The Corner

Act now so you do not miss the 2010 Annual Medicaid Conference in Reno on Oct. 13 and in Las Vegas on Oct. 20.

Please note: Due to the continuing State of Nevada budgetary constraints, Division of Health Care Financing and Policy (DHCFP) representatives will not attend this year's conference. Two State staff members will attend to collect your policy questions. Questions of concern to many providers will be addressed in future provider trainings, web announcements and/or provider newsletters, as appropriate.

Magellan Medicaid Administration staff will conduct the conference, which will address recipient eligibility, prior authorization, clinical claim editor, Third Party Liability (TPL), claim status, Electronic Data Interchange (EDI), claim form tips and instructions, timely filing, appeals and many more topics.

Providers may choose to attend a morning or an afternoon conference in either Reno or Las Vegas on the scheduled days. The main presentation in each conference provides information pertinent to all providers.

Following the main presentation, "break-out" sessions provide program-specific information for certain provider types. The [2010 Training Registration Form](#) lists each break-out session. When registering, please select only



one break-out session and verify that the break-out session you choose has your provider type indicated next to it.

One of the break-out sessions providers may select is an introduction to electronic claims submission. The Payer-path presentation is open to any provider type and is offered in lecture format; hands-on computer training is not available during the conference.

To register for the conference, complete the [2010 Training Registration Form](#). Submit your registration using the fax number or mailing address indicated at the top of the form.

If you have registered to attend the conference and need to cancel, please notify the training unit as soon as possible at nvtraining@magellanhealth.com.

Having TPL Or Eligibility Discrepancies? – Here's Who To Contact!

The Provider Support Unit at DHCFP has created a new email account for Medicare-related Third Party Liability (TPL) issues. For any issues or concerns you have regarding *Medicare Prime TPL*, send an email to TPL@dhcfp.nv.gov. Below are some additional contacts that may be helpful.

If you are having a problem with *Private/Commercial TPL*, including *Medicare Replacement/HMO plans*, contact HMS at renotpl@hms.com or call (775) 335-1040 in the Reno area or toll-free (800) 873-5875.

If you are having a problem with *eligibility that is not reflecting in the Electronic Verification System (EVS)* but you have verified the recipient is eligible, contact Magellan Medicaid Administration at (877) 638-3472 and a customer service representative will be able to direct the information accordingly for corrections.

New Enrollment Requirements Being Implemented For Behavioral Health Providers (PTs 14 And 82)

As providers were notified in [Web Announcement 350](#), Nevada Medicaid is implementing new enrollment requirements for Behavioral Health providers to facilitate the prior authorization, billing and claim adjudication processes for these providers.

The new enrollment requirements are in effect for providers who enrolled beginning Sept. 1, 2010, as provider types 14 (Behavioral Health Outpatient Treatment) or 82 (Behavioral Health Rehabilitative Treatment). The new conditions of enrollment effective Sept. 1, 2010, include:

- Behavioral Health providers are now required to enroll with a National Provider Identifier (NPI). Atypical Provider Identifiers (APIs) will no longer be assigned to these providers. NPIs must be used in the prior authorization and billing processes. NPIs are obtained through the National Plan and Provider Enumeration System (NPPES) online (at <https://nppes.cms.hhs.gov> click on “National Provider Identifier (NPI)” and follow the instructions) or call (800) 465-3203.
- Individual providers (servicing/rendering providers) are now required to enroll independently with the appropriate

specialty (QMHP, QMHA, QBA) and must be linked to a group/billing NPI. A potential taxonomy code for individual QMHA and QBA providers to use when applying for their NPI is 225400000X for rehabilitation practitioner (practitioner who trains or re-trains individuals disabled by disease or injury to help them attain their maximum functional capacity).

- Groups/businesses must enroll under a single group/billing NPI with a “000” specialty and have individual servicing providers linked to them. Direct servicing providers must be linked to the group’s NPI. Potential taxonomy codes for groups are: 193200000X for multi specialty (a business group of one or more providers who practice with different areas of specialization) and 193400000X for single specialty (a business group of one or more providers, all of whom practice with the same area of specialization).

Behavioral Health providers who enrolled prior to Sept. 1, 2010, will be required to re-enroll under the new guidelines beginning Jan. 1, 2011, but may begin the re-enrollment process any time after Oct. 1, 2010. Please monitor the Magellan Medicaid Administration Nevada Medicaid website for additional details regarding the re-enrollment process.

Report Changes To Provider Addresses

Changes to your address information must be reported to Magellan Medicaid Administration using the [Provider Information Change Form \(FA-33\)](#).

Medicaid providers are required to report, in writing within five working days, any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may

result in termination of your Nevada Medicaid and Nevada Check Up Provider Contract at the time of discovery (*per Medicaid Services Manual, Chapter 100, section 103.3, December 2008*).

All four addresses, i.e., Service, Mail-To, Remittance Advice and Pay-To, on file must be current and correct at all times. If you have changes to more than one of these four addresses, be sure to complete a separate FA-33 for each address.

Provider Specialty Codes

In an effort for the Division of Health Care Financing and Policy (DHCFP) and Magellan Medicaid Administration to collect accurate statistical information, all providers are strongly encouraged to list a specialty code at the time of enrollment.

If you have not declared a specialty and would like to do so, please complete a [Provider Information Change Form \(FA-33\)](#). This form is available on this website (at

<https://medicaid.nv.gov> select “Forms” or “Provider Enrollment” from the “Providers” menu). The completed form should be mailed to Magellan Medicaid Administration, Provider Enrollment, P.O. Box 30042, Reno, NV 89520-3042 or faxed to Provider Enrollment at (775) 784-7932.

A listing of Nevada Medicaid specialty codes by provider types is located in Table E-1 of the [Provider Enrollment Instructions](#).

How HHS-Proposed HIPAA Changes May Affect Providers

If proposed changes to the Health Insurance Portability and Accountability Act (HIPAA) are adopted, Covered Entities would be required to revise their Business Associate Agreements, their HIPAA Notice of Privacy Practices, and their policies for responding to access requests.

On July 8, 2010, the U.S. Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking (NPRM) that would both implement many of the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009, and modify other HIPAA requirements.

One major development is that the proposed regulations would extend HIPAA's reach to subcontractors of Business Associates, making them liable for privacy and security violations to the same extent as Business Associates.

A new right afforded to individuals by the proposed rule is

that Covered Entities honor an individual's request not to share information with their health plan if the individual is paying the full cost of the service to which the information relates. Covered Entities would have to permit individuals to determine which health care items or services this restriction applies to.

In accordance with HITECH, the NPRM requires Covered Entities to give individuals electronic copies of any Protected Health Information (PHI) maintained in electronic form. Covered Entities would have to provide an electronic copy to an individual's designee, if requested. Other proposed changes include establishing new limitations on the use and disclosure of PHI for marketing and fundraising, prohibitions on the sale of PHI, and changes to implement civil monetary penalties.

These are just highlights of the voluminous NPRM. More information and the complete proposed rule can be found on the HHS website at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechnprm.html>

Payment Error Rate Measurement (PERM)

The Improper Payments Information Act of 2002 (IPIA) requires the Centers for Medicare & Medicaid Services (CMS) to estimate improper payments in all state Medicaid and State Children's Health Insurance Programs (Nevada Check Up). CMS must annually calculate and report to Congress the national error rates in each of these programs and the actions it is taking to reduce improper payments in these health care programs.

To meet the requirements of the federal mandate, CMS requires each state to undergo a Payment Error Rate Measurement (PERM) review once every three years. The next PERM review for Nevada will be conducted on claims paid during the period Oct. 1, 2010, through Sept. 30, 2011. PERM reviews consist of a thorough analysis of recipient eligibility, claims processing and medical record or service documentation. Recipient eligibility reviews will be conducted by the Division of Welfare and Supportive Services (DWSS). The claims processing and medical record or service documentation reviews for the mandated PERM program will be conducted by federal contractors.

As noted in the [Billing Manual for Nevada Medicaid and Nevada Check Up](#) and the [Medicaid Services Manual \(MSM\)](#) Chapter 100, Section 105.1.11, a provider's medical records must contain all information necessary to disclose the full extent of services (i.e., financial and clinical data). Nevada Medicaid requires providers to retain medi-

cal records for at least six years per MSM Chapter 3300, Section 3303.2B.11: "Providers must retain patient records in accordance with state and or federal statutes and regulations or at a minimum for six years from the date of payment for the specified service." Upon request, records must be provided free of charge to a designated Medicaid agency, the Secretary of Health and Human Services or Nevada's Medicaid Fraud Control Unit. Records in electronic format must be readily accessible.

Additional information regarding providers' responsibilities in respect to mandated PERM audits can be found in MSM Chapter 3300, Section 3303.2B. Please also note that it is the provider's responsibility to consult with each MSM chapter for provider type specific information and documentation requirements.

Report Medicaid Fraud!

Reporting Medicaid fraud and abuse is a responsibility every one shares. If you suspect Medicaid fraud or abuse, please contact the Surveillance and Utilization Review Subsystem (SURS) of DHCFP.

To submit a report or to simply ask a question, click on the "Report Medicaid Fraud!" link on the [DHCFP Home](#) webpage. All information will be held in strict confidence.

Online Prior Authorization System Tip Sheet For Behavioral Health Services

Prior authorization requests (PARs) for all behavioral health services may be submitted online using the First-HCM web-based application called the Online Prior Authorization System (OPAS). Online PARs can be submitted for:

- *Acute Inpatient Psychiatric Hospitals*
- *Residential Treatment Centers*
- *Outpatient Mental Health Services*
- *Psychological Testing*
- *Rehabilitative Mental Health Services*

The following tips were developed from questions providers and new users asked during instructor-led trainings.

- ✓ Access to OPAS is requested using the User Administration Console (UAC).
 - UAC is available at <https://medicaid.nv.gov> (click on the “User Administration” link in the top right corner of the webpage).
- ✓ Monitor the “Status” of a PAR and proceed accordingly.
 - “New” status means the PAR has not yet been submitted by the provider:
 - *Check your queue for “new” status on a daily basis, complete the request and hit the “submit” button. Please click only once.*
 - *If you are entering information and saving the request without submitting, remember to “save” and then “cancel” to check the request in for another user (like a library book).*
 - “Pending Information” means the review requires additional information to proceed:
 - Open the message tab and provide the requested information on the appropriate provider page.
- ✓ “Request” types not to be confused with “Status” are found in the Access Control List.
 - When submitting a reconsideration request on a **partial** authorization, remember to request only for the number of units/hours from the original request that were denied.
 - A partial approval of services means only those units/hours denied may be reconsidered.
- ✓ For technical support, call the Web Support Call Center at (800) 241-8726, option 4.
- ✓ For training support, call (775) 784-3935.

Reminder: *Review Billing Manual*

Each provider is reminded to periodically review the [Billing Manual for Nevada Medicaid and Nevada Check Up](#), which is updated on an ongoing basis to reflect policy changes, revised instructions or current contact information.

The Billing Manual contains valuable information that applies to all provider types regarding Third Party Liability (TPL), timely filing, recipient eligibility, the Electronic Verification

System (EVS), the Automated Response System (ARS), Electronic Data Interchange (EDI), prior and retrospective authorizations, claim adjustments, appeals and claim attachment requirements.

Providers are also reminded to review the [Claim Form Instructions](#) (ADA, CMS-1500 and UB), the [Pharmacy Billing Manual](#) and the [Billing Guidelines](#) for their provider types for updated information.

A Message From DHCFP Regarding Prevention: EPSDT Healthy Kids Screenings

Did you know that you can obtain separate reimbursement for EPSDT Healthy Kids screenings by including age-appropriate developmental screening, family planning, fluoride varnish and/or immunizations?

Effective with dates of service on or after July 14, 2010, Nevada Medicaid will now reimburse separately for developmental screenings, provided that a valid, standardized screening tool (i.e., PEDS, Ages and Stages, etc.) is utilized and entered into the child's health care record.

Although the American Academy of Pediatrics recommends the use of a standardized screening tool at ages 9, 18 and 30 months and 3 and 4 years of age, the exact frequency of standardized testing depends on the clinical setting and provider's judgment as to medical necessity.

Asking questions about development as part of the general informal developmental survey or history is not a



“standardized screening” and is not separately reportable. Providers may be subject to a random audit of records to assure the use of the screening tool. For billing instructions, see the [Billing Manual for Nevada Medicaid and Nevada Check Up](#) and [Billing Guidelines](#).

As has always been the case, providers may also bill separately for age-appropriate family planning counseling, fluoride varnish application and vaccine administration. Lead testing, which is also required at certain ages, is included in the Healthy Kids exam, unless the testing is done at a separate laboratory.

Remember to include all federally required components of the Healthy Kids exam, which can be found in [Medicaid Services Manual \(MSM\) Chapter 1500](#). If all components are not documented in the child's health care record, a recoupment may occur.

For more information, please contact Marti Coté, R.N., at (775) 684-3748 or mcote@dhcfp.nv.gov.

Occupational/Physical Therapy PCS Assessment Program Update

The Division of Health Care Financing and Policy (DHCFP) modified the Nevada Medicaid Personal Care Services (PCS) program on March 1, 2010, to require the completion of the initial functional assessment for PCS by an Occupational or Physical Therapist (OT/PT).

The changes to the program have been very successful and DHCFP is anticipating the need for additional providers to complete functional assessments.

By participating in the program and assisting with “hands-on” assessments, OTs/PTs are providing Medicaid recipients with an accurate functional assessment.

This is not an employment position with the State, but is done by Nevada-licensed OTs/PTs or eligible hospitals, clinics or agencies enrolled as Medicaid providers. If you are an OT/PT provider interested in assisting the Nevada

Medicaid PCS program and completing these functional assessments, you will need to be a Nevada Medicaid provider and attend a training session on PCS policies and functional assessment tools.

OT/PTs who are interested in completing these assessments should verify their enrollment or begin the enrollment process. To enroll as a Nevada Medicaid provider, see the instructions and forms on the “[Provider Enrollment](#)” webpage.

Trainings on the assessment process will be scheduled shortly. To place your name on the list for a training session or to obtain more information about this program, please contact Pam Loomis at pjloomis@magellanhealth.com or Jack Zenteno at jack.zenteno@dhcfp.nv.gov.

The DHCFP reports a special need for OT/PT providers to serve the northern and rural areas of Nevada.

Results Are In From E-Health Study

The Division of Health Care Financing and Policy (DHCFP) is working with the Centers for Medicare & Medicaid Services (CMS) during planning efforts for the development of the Nevada Medicaid Electronic Health Record (EHR) Incentive Program.

The program will provide incentives to eligible Medicaid providers that demonstrate meaningful use of certified EHR technology. An important part of the planning process is to obtain feedback from health care providers within the State about their current uses of health information technology (HIT).

The E-Health Study report detailing the results of this effort was recently finalized and provides a baseline of overall statewide readiness for HIT in Nevada's health care community. Feedback was gathered from providers in several ways. There were approximately 80 stakeholders, primarily consisting of physicians, nurses and hospital representatives, who participated in 15 scheduled focus groups. A total of 32 one-on-one and group interviews were conducted and there were just over 400 total responses to an online e-health survey.

As a result of the assessment activities, it is clear that Nevada's provider community and other health care stakeholders generally support both the concept and value of EHRs and the exchange of health information. Nearly half of all survey respondents have an EHR (46%) and another 32% of the non-EHR users plan to implement a system within the next five years.

Levels of EHR adoption and utilization vary greatly across the provider community. Providers use a broad range of EHR functionality to provide and track clinical care and to support operations, but more sophisticated functions of EHRs are not consistently being used. In addition, little exchange of health information is occurring outside of a provider's or stakeholder's network.

The complete landscape assessment report along with additional information about Nevada's HIT planning efforts is available online at <http://dhhs.nv.gov/HIT.htm>.

In addition, CMS published the final rule for the Medicare and Medicaid EHR Incentive Programs on July 28, 2010. This rule provides many of the parameters and requirements for the incentive programs.

A copy of the final rule and related documents is accessible through the CMS website at <http://www.cms.gov/EHRIncentivePrograms>. This official website provides up-to-date, detailed information about the incentive programs, including eligibility, certification, meaningful use and registration.

DHCFP will soon begin development of Nevada's State Medicaid HIT Plan and will be seeking input and cooperation from a variety of providers in the health care community to assist with the development process, primarily through outreach campaigns, visioning sessions, and possibly any systems testing that may be necessary.

Please send an email to NevadaHIT@dhcfp.nv.gov with any questions regarding the Nevada HIT planning efforts.

Enjoy The Convenience Of Pharmacy Web PA For Prescription Drug Authorizations

Did you know that you can use Magellan Medicaid Administration's web-based prior authorization process to request an authorization for a prescription drug at any time 24/7, at your convenience, without talking with a Clinical Call Center customer service representative?

By using Pharmacy Web PA, authorized users can obtain an immediate approval online, when appropriate, by answering a few simple questions. For more details about Pharmacy Web PA, see [Web Announcement 158](#) and the Pharmacy Web PA Product Sheet. The Product Sheet provides an overview of the application with easy steps for

submitting requests and additional advantages to using the system.

Providers may register to use Pharmacy Web PA through the User Administration Console (UAC). On this website (<https://medicaid.nv.gov>), click on the "User Administration" link in the top right corner of the webpage. Once you have a user ID and password through UAC, you can access the "Pharmacy Web PA Login" from the "Pharmacy" menu.

For registration assistance, call the Web Support Call Center at (800) 241-8726.

Prior Authorization Requirements For Obstetrical Hospital Admissions

The [Provider Type 11 \(Hospital, Inpatient\) Billing Guide](#) has been updated with a grid showing Prior Authorization Requirements for Obstetrical Hospital Admissions.

This convenient tool provides the prior authorization re-

quirements for labor, the day prior to and the day of delivery, and for each post partum day for vaginal and Cesarean deliveries with or without complications.

The grid also includes the correct telephone number and when to call for authorization for certain deliveries.

Public Hearings

Providers are encouraged to attend public hearings and voice their opinions on policy changes. Hearings are scheduled for the second Tuesday of each month.

Public hearing announcements are posted on the "[Public Notices](#)" webpage on the DHCFP website as they become available (at dhcftp.nv.gov select "Public Notices" from the

"DHCFP Index" list). The "Public Notices" webpage contains meeting agendas with dates, times and locations of each meeting or hearing, any pertinent documents, the public hearings schedule, past agendas and past meeting minutes.

To request email notices for scheduled public hearings, send an email to Rita Mackie at rmackie@dhcftp.nv.gov.

Medicaid Manual Changes

The following Medicaid Manual chapters were approved for revision and/or revised during the period June through August 2010. Please review the current [Medicaid Manuals](#) on the DHCFP website.

June 2010:

- MSM 1600 – Intermediate Care for the Mentally Retarded
- MSM 1900 – Transportation
- MSM 2800 – School Based Child Health Services

July 2010:

- MSM 500 – Nursing Facilities
- MSM 600 – Physician Services
- MSM 1500 – Healthy Kids Program
- MSM 2700 – Home and Community-Based Waiver (HCBW) for the Elderly in Adult Residential Care

August 2010:

- MSM 800 – Laboratory Services
- MSM 2200 – Home and Community-Based Waiver (HCBW) for the Frail Elderly
- MSM 2600 – Intermediary Service Organization

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact Magellan Medicaid Administration by calling (877) 638-3472.

If you have a question about Medicaid Service Policy or Rates, you can go to the Division of Health Care Financing and Policy (DHCFP) website at <http://dhcftp.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 call the contact person or send an email.

Quarterly Update On Claims Paid

Nevada Medicaid and Nevada Check Up paid to providers \$370,956,859.37 in claims during the three-month period of April, May and June 2010. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

The DHCFP and Magellan Medicaid Administration thank you for participating in Nevada Medicaid and Nevada Check Up.