# Nevada Medicaid and Nevada Check Up News

Division of Health Care Financing and Policy (DHCFP)

HP Enterprise Services (HPES)

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First Quarter 2013

***Inside This Issue:***



## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $487,670,479.29 in claims during the three-month period of October, November and December 2012. Nearly 100 percent of current claims continue to be adjudicated within 30 days. DHCFP and HPES thank you for participating in Nevada Medicaid and Nevada Check Up.

# Provider Enrollment Applications Being Updated per ACA Regulations

To improve the program integrity of the Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) programs, the Patient Protection and Affordable Care Act (ACA) requires these programs to screen and enroll all providers associated with the program. These new requirements are more extensive than the previous screening procedures and include capturing the social security numbers, date of birth, and address for all owners, managing employees, and anyone with a controlling interest of 5 percent or more.

Specific federal requirements and definitions can be found in 42 Code of Federal Regulations Parts 455.100 - 455.470. The changes will allow Medicaid programs to more effectively monitor and restrict those individuals or entities who purposely defraud and abuse the Medicaid system. The Nevada Medicaid/ Nevada Check Up Provider Enrollment and Re-Enrollment Applications are currently being updated to capture the additional information.

## *Use Email to Submit Your Enrollment Application*

Effective immediately, providers may submit their initial and re-enrollment Provider Enrollment Applications through email instead of mailing the paper forms through the U.S. Postal Service. The email address is: nv.providerapps@hp.com.

Please scan the Application, Provider Contract and all supporting documentation, including all of the documents required per the Enrollment Checklists, and attach all items to one email.

**Please note:**

- Applications received by HP Enterprise Services (HPES) before 11 a.m. Pacific Time Monday through Friday will be considered received the same day. Any received after 11 a.m. will be logged as received the next business day. Please allow processing time before inquiring on the status of your enrollment request. Any questions can be directed to the Provider Enrollment Unit at (877) 638-3472 (select option 2, option 0, and then option 5).
- If you send your Application via email, do not mail the paper copy.
- Email box nv.providerapps@hp.com is intended for Provider Enrollment Applications only. Provider Information Change forms (FA-33) can be faxed to (775) 335-8502. General inquiries need to be made by calling the Provider Enrollment Unit.

# Update from the Provider Training Team

The HP Enterprise Services (HPES) training team is inviting providers to let us know the topics you would like covered at the Annual Medicaid Conference. The Conference is held each October in Reno and in Las Vegas.

Please send the topics you would like covered to the training team at nevadaprovidertraining@hp.com.

The HPES training team has listened to your feedback and in 2013 the team is providing enhanced services to Nevada Medicaid providers. Two of the enhanced services are:

1. The presentations from the monthly workshops and the Annual Medicaid Conference are posted on the Provider Training webpage at www.medicaid.nv.gov for providers to review.
2. Provider Representatives are available in your area to provide one-on-one assistance when you have questions or concerns.

You may contact your Provider Representative team with your questions:

***Provider Services Manager***

Jennifer Shaffer

Office: (775) 335-8585 Cell: (775) 313-2811

***Northern Nevada***

Kim Teixeira – Provider Representative

Office: (775) 335-8569 Cell: (775) 323-9667

Shanna Lira – Provider Representative

Office: (775) 335-8566 Cell: (775) 343-9929

Nedra Daugherty – Provider Representative

Office: (775) 335-8568 Cell: (775) 233-1226

***Southern Nevada***

Tiffani Hart – Provider Representative

Cell: (702) 266-6923

Two additional Provider Representatives will be added in the Southern Nevada area in 2013. Please watch web announcements at www.medicaid.nv.gov for their contact information.

## *Useful Tools for Providers: Automated Response System and Electronic Verification System*

The Automated Response System (ARS) and the online Electronic Verification System (EVS) are convenient, useful tools in obtaining recipient eligibility, recent payment details, claim status and prior authorization information.

Six years of claim status information is available to providers through both ARS and EVS.

- ARS is accessed by telephone by calling (800) 942-6511.
- EVS is accessed through the Nevada Medicaid website at www.medicaid.nv.gov. Select the "EVS" tab to review the User Manual and to register or login to EVS.

If you have any questions regarding how a claim was adjudicated, please contact an agent in the Customer Service Center at (877) 638-3472. Select option 2 for provider, then option 0, then option 2. Please have your servicing NPI, or API, recipient's Medicaid ID and date of service for the claim available.

# Increased Payment for Certain Primary Care Physicians *for Calendar Years 2013 and 2014 as Part of the Affordable Care Act*

As part of the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) has implemented a rate increase for certain Primary Care Physicians (PCPs) and their associated subspecialties. This increased rate is effective for calendar years 2013 and 2014. The increased rate only applies to services rendered to Medicaid recipients. Per CMS, stand-alone Children's Health Insurance Program (CHIP) programs are not eligible. Nevada Check Up is a stand-alone CHIP program.

***Specialties That Qualify for the Enhanced PCP Rate***

The final rule applies to services furnished by a physician or "under the personal supervision of a physician who self-attests to a specialty designation of:

- family medicine,
- general internal medicine, or
- pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA)."

The subspecialties within the three specialties that are included can be found on the American Board of Medical Specialties website at http://www.abms.org/who_we_help/physicians/specialties.aspx.

A physician must self-attest that he or she:

1. is board certified with such a specialty or subspecialty; OR
2. has furnished evaluation and management (E&M) services and vaccine administration services under specific HCPCS codes (described below) that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

The increased payment is *not* available to physicians who are reimbursed through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or health department encounter or visit rate or as part of a nursing facility per diem payment rate. Additionally, increased payment is not available for OB/GYN providers per CMS.

***Codes/services that qualify for the enhanced rate***

Those services (as designated in HCPCS) are:

1. Evaluation and management (E&M) codes 99201 through 99499.
2. Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor code.

***How will Nevada Medicaid implement the PCP rate increase?***

**Please note:** Information regarding the Nevada Medicaid State Plan Amendment (SPA) change, eligibility requirements and reimbursement methodologies are being proposed to CMS and will only be implemented upon CMS approval. Changes will be effective January 1, 2013.

Nevada Medicaid is actively working to implement the required changes. A SPA is being drafted to update the State Plan to reflect the new reimbursement methodology for the affected providers and HCPCS codes for Fee for Service providers. Nevada Medicaid Fee for Service providers who are identified as eligible for the increased rate will receive a supplemental payment monthly for the difference between the current reimbursement rate for the affected codes and the new rate. These payments will begin in April 2013 for claims with service dates January 1, 2013, forward, to allow for the 120 days timely filing rule.

The CMS final rule states that Medicaid programs should use either the rate under the Medicare Physician Fee Schedule (MPFS) for calendar years 2013 and 2014 or, if greater, the payment rate that would be applicable if the 2009 Conversion Factor were used to calculate the MPFS. At this time, Nevada Medicaid intends to use the 2009 Conversion Factor to calculate the new rates. These rates are only in effect for service dates from January 1, 2013, to December 31, 2014. Rates will automatically default back to the previous rate on January 1, 2015.

A list of eligible codes and their corresponding reimbursement will be published on the Division of Health Care Financing and Policy (DHCFP) Rates and Cost Containment website. The information will be available after further clarification from CMS is received. For questions or concerns regarding the eligible codes and rates, please contact the

## *Primary Care Physicians (PCPs)*

Rates and Cost Containment Unit at (775) 684-3689.

Providers who self attest to being board certified in one of the eligible specialties/subspecialties or are furnishing the required threshold of E&M services and vaccine administration services are subject to internal DHCFP review. If it is determined by DHCFP that the provider has not met the threshold for the claims requirement or is not board certified, the provider will be removed from the eligible list and any enhanced payments will be recouped.

In addition, increased payment is available for services provided under the personal supervision of eligible physicians. This means that the physician accepts professional responsibility (and legal liability) for the services provided.

The eligibility of services provided by nurse practitioners and physician's assistants is dependent on 1) the eligibility of the physician and 2) whether or not the physician accepts professional responsibility for the services provided by the nurse practitioner or physician's assistant.

For the nurse practitioners and physician's assistants billing under his or her own provider number, we/DHCFP require the following documentation:

1. A signed letter from the physician accepting professional responsibility for services provided under their personal supervision. The letter should include those provider's names and National Provider Identifier (NPI) numbers for which the physician is accepting responsibility.
2. A completed self-attestation form from the physician that is accepting professional responsibility including the eligibility requirements.
3. A completed self-attestation form from the nurse practitioner or physician's assistant including the name of the physician that is accepting professional responsibility for his/her services.

**Please note: Providers who do not self attest will not be eligible for the increased reimbursement.** ***Self attestation forms must be received no later than March 15, 2013, in order to be considered eligible for reimbursement. Providers who submit self attestation after March 15, 2013, will be eligible for payments starting the month the self attestation was submitted.***

To claim self attestation, the provider must complete the self attestation form, which will be available on the DHCFP website or through the HP Enterprise Services Provider Web Portal. Completed self attestation forms must be submitted to DHCFP Provider Support via fax at (775) 684-3720. For questions regarding the self attestation, please contact Provider Support at (775) 684-3700.

***Who to contact?***

For questions regarding eligible codes, reimbursement or specialties, please contact the DHCFP Rates and Cost Containment Unit at (775) 684-3621.

***Please note: Information regarding the Nevada Medicaid SPA change, eligibility requirements and reimbursement methodologies are being proposed to CMS and will only be implemented upon CMS approval. Changes will be effective January 1, 2013. Further, the codes and provider specialties affected are subject to change if CMS issues further instruction. Additionally, CMS has ruled that if the service/code is not currently covered by Medicaid, that Medicaid is not required to now cover the service.***

## Prevention Reminder from DHCFP: *Annual Wellness Visit (AWV)*

The Patient Protection and Affordable Care Act (ACA) added a new benefit for Medicare recipients in 2010 called the Annual Wellness Visit (AWV). Similar to Medicare, Nevada Medicaid will now reimburse for the Annual Wellness Visit for recipients over the age of 21, with dates of service on or after January 1, 2013.

Included in the AWV are such services as taking medical history, a health risk assessment, an evaluation of the recipient's physical condition, and a screening for such things as depression. The AWV also includes a personalized prevention plan, which the provider uses to develop a strategy with the recipient to manage their own health, including planning the preventive services and screenings that may be needed over the next 5 to 10 years.

The AWV is not a routine physical exam, but provides the recipient and provider with an opportunity to review health concerns and preventive measures.

The following codes may be used for the AWV:

- **G0438:** Annual Wellness Visit; including a personalized prevention plan of service; initial visit
- **G0439:** Annual Wellness Visit; including a personalized prevention plan of service; subsequent visit

# Prior Authorization Reminders for All Providers and Tips for Behavioral Health Providers

The following reminders will assist providers in submitting and managing their prior authorization requests.

***Attention all providers:***

1. Review submission guidelines for required timelines specific to the services you are requesting. The Billing Manual and the Billing Guide for your provider type provide timeline information. Not submitting within the guidelines may result in a technical denial.
2. When a service is denied you cannot request an unscheduled revision. Providers may request an appeal for denied services. Please refer to the Billing Manual for information on the peer-to-peer and reconsideration process and timelines.
3. Submit requests using the correct forms; please review the Billing Manual and Billing Guides for this information.
4. Up-to-date information to justify the need for service(s) is required in order for HP Enterprise Services (HPES) to be able to authorize the services.
5. Please update the Not Otherwise Specified (NOS) diagnosis.
6. Keep attachments to a minimum. Be concise. The form has fields for all pertinent information.

***Attention behavioral health services providers:***

When requesting add-on code 90785, please follow the criteria as outlined in the Common Procedural Terminology (CPT) manual.

*Submitting an unscheduled revision:*

Unscheduled revision is to request additional units within the 90-day authorization period due to a change in the recipient's clinical presentation and not for administrative solutions for the provider (i.e., ran out of units). The earliest start date may be the date you submit the request for review for the unscheduled revision and the end date must remain the same as the original end date.

Additional clinical information must be submitted to support the request or demonstrate medical necessity for the additional services. The request for an unscheduled revision should only include the additional units/services that are being requested.

Unscheduled revision is NOT submitted when a denial is issued for a service. For denied services, please follow these guidelines:

1. Request a peer-to-peer review within 10 business days of the original date of denial.
2. Request a reconsideration within 30 business days of the original date of denial.

When submitting prior authorization requests, please use the appropriate forms as approved by Nevada Medicaid:

- FA-10A for psychological testing
- FA-10B for neuropsychological testing
- FA-10C for developmental testing
- FA-10D for neurobehavioral status exam
- FA-11 for outpatient mental health services - initial services
- FA-11A for a combination of outpatient mental health and rehabilitation mental health (RMH) services or RMH only
- FA-11C for retrospective authorization for crisis interventions

## Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact HPES by calling (877) 638-3472, press option 2 for providers, then option 0, then option 2 for claim status.

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://dhcfp.nv.gov. Under the "DHCFP Index" box, move your cursor over "Contact Us" and select "Main Phone Numbers." Call the Administration Office of the area you would like to contact.