

Nevada Medicaid and Nevada Check Up News



Division of Health Care Financing and
Policy (DHCFP)

HP Enterprise Services
(HPES)



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Inside This Issue:

- 2 [Medicaid EHR Incentive Payment Program Update](#)
- 3 [Tips and Reminders for Submitting Claim Forms](#)
- 4 [Make Preparations Now for ICD-10 Implementation on October 1, 2014](#)
- 4 [Provider Type 39 \(ADHC\): Use HCPCS Code S5102 for All-day Services](#)
- 5 [Prevention Reminder from DHCFP: Adolescent Health](#)
- 5 [Attention Provider Types 11, 13, 56, 63 and 75](#)
- 5 [Recipients to Receive Notices of Decision Regarding Technical Denials](#)
- 5 [Contact Information](#)

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$432,840,358.92 in claims during the three-month period of January, February and March 2013. 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.

Ordering, Prescribing or Referring (OPR) Providers Required to Enroll in Medicaid

With the implementation of the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) requires all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (\$455.410 Enrollment and Screening of Providers). Traditionally, most providers have enrolled in the Nevada Medicaid program to furnish covered services to Medicaid recipients and to submit claims for such services. However, the Affordable Care Act (ACA) now requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid.

Ordering, prescribing or referring (OPR) providers do not bill Nevada Medicaid for services rendered, but may order, prescribe or refer services/supplies for Medicaid recipients. For Medicaid to reimburse for services or medical supplies resulting from a practitioner's order, prescription or referral, the OPR provider must be enrolled in Medicaid. Enrolling as an OPR provider is appropriate for practitioners who:

- May occasionally see an individual who is a Medicaid recipient who needs additional services or supplies that will be covered by the Medicaid program
- Do not want to be enrolled as another Nevada Medicaid provider type
- Do not plan to submit claims for payment of services rendered

This new requirement does not apply to orders, prescriptions or referrals for individuals enrolled in a Medicaid Managed Care Organization (MCO). It is applicable only to the Nevada Fee for Service (FFS) Medicaid program. Furthermore, the CMS Final Rule mandates that if items or services are ordered, prescribed or referred by a resident or intern, the claim must identify the teaching physician as the ordering or referring supplier and the teaching physician must be identified on the claim by his or her legal name and National Provider Identifier (NPI), and he or she must be an enrolled provider.

Continued on page 2

The Medicaid EHR Incentive Payment Program Update

The Electronic Health Record (EHR) Incentive Payment Program provides incentive payments for eligible health care providers to use EHR technology in ways that can positively impact patient care. Incentive payments are available to eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. This program is supported through the Centers for Medicare & Medicaid Services (CMS) as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Eligible Professional/Eligible Hospital payments for adopting, implementing and upgrading (AIU): As of July 3, 2013, a total of 222 providers and 24 hospitals have received more than \$20,180,354.87 in payments from the Nevada Medicaid EHR Incentive payment program.

Second year Meaningful Use (MU) payments: As of June 21, 2013, six providers have been paid a total of \$51,000.

Providers that have received their incentive payment are invited to visit <http://www.surveymonkey.com/s/TD2W5DW> to take a short survey regarding their experience with the incentive program. Participation is encouraged as it is Nevada Medicaid's goal to use provider comments and suggestions to maintain and improve the program.

In order to meet the MU Public Health Objectives, providers need to have interoperability with state public health registries. Registry contact information is listed below.

Cancer Registry – Donnamarie Milazzo

(775) 684-3221

Syndromic Surveillance – Lacy Matsler

(775) 684-5984

Electronic Laboratory Reporting – Rick Sowadsky

(775) 684-5941

Immunization Registry – Amanda Harris

(775) 684-4258

To see more information and keep up to date on important announcements, please visit <http://dhcfp.nv.gov/EHRIncentives.htm>.

The Division of Health Care Financing and Policy (DHCFP) has contracted with a vendor, CGI, for the incentive program to assist providers through their attestation and eligibility verification. Once registered, providers can contact the CGI Business Service Center at (888) 639-3452 or send an email to them at NEIPS.us.ipod@cgi.com for questions regarding the program.

Ordering, Prescribing or Referring Providers

Continued from page 1

Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

It is important for OPR providers to understand the implications of failing to enroll in Medicaid. If you are an OPR provider, the physicians, other practitioners and facilities who actually render services to Medicaid recipients based on your order, prescription or referral will not be paid for such items or services unless you enroll in Medicaid and your NPI is included on the claim submitted to Medicaid by the rendering provider (42 CFR 455.440).


Please note that this extends to pharmacy Point of Sale (POS) systems as well. The POS system will deny, at the time of the pharmacy transaction, any claims submitted for a Medicaid recipient with a prescriber who is not enrolled as a Medicaid provider.

The Division of Health Care Financing and Policy (DHCFP) is actively working on the implementation of this new requirement and announcements regarding the effective date and enrollment process will be forthcoming.

Tips and Reminders for Submitting Claim Forms

Please review the following tips and reminders for submitting claim forms to HP Enterprise Services (HPES):

- Any correspondence must be sent along with the related claims submission or claim appeals requests. If you send only the supporting documents, such as your letter and EOB, the documents will be returned to you.
- The UB Claim Form Instructions and CMS-1500 Claim Form Instructions have been updated. Please review and use the documents that are currently online with an updated date of 05/14/2013. (The date is shown in the bottom left corner of each page.) Previous versions are no longer accepted. In addition to general information, updates have been made to the field instructions.

Paper Claim Form Instructions	
The following instructions are for paper claims. For electronic claim requirements, technical professionals can refer to Companion Guides for transactions 837D , 837I and 837P .	
Title	Last Update
 ADA Claim Form Instructions	12/05/11
 CMS-1500 Claim Form Instructions	05/14/13
 UB Claim Form Instructions	05/14/13
Title	Last Update

- The claim form instructions are on the [Billing Information](#) webpage of this website, along with the general Billing Manual for all provider types and the Billing Guides for each provider type.
- To help ensure your paper claim is processed quickly and correctly, please remember the following instructions.
 - When submitting a CMS-1500 claim form, field 31 must be signed. When submitting a Dental claim form, field 53 must be signed.
 - When printing the form, use the appropriate full-size format of the claim form. The image must be full page; do not reduce the size of the image on the 8 ½ by 11 inch page.
 - Recipient data on the claim form needs to be within the appropriate claim field and below the “field description.” Data should not be shifted up, down or sideways. Data that is typed over the claim “line” is not acceptable and the claim will be returned to you.
 - The Explanation of Benefits (EOB), just like the claim form, must be suitable for imaging so that data can be accurately captured. If the data is printed too light or is smudged, the claim will be returned to you. All pages, front and back, of the EOB must be copied and submitted.
- Copies of paper claim forms may be submitted, but please ensure that the copy you submit is legible. Reasons why a paper claim form will be returned to you to resubmit may include but are not limited to:
 - The font is too light or too small to be legible.
 - The type is smudged and is not legible.
 - The background is dark and cannot be read by the scanner.
 - The claim is printed at a reduced size and appears smaller than CMS-approved forms.

Note: Per Medicaid Services Manual (MSM) Chapter 100 Section 105.1H, it is the provider’s responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid time frames. All claims must be of sufficient quality to allow electronic imaging and OCR, therefore, corrections are not allowed. All paper claims must be submitted on the original applicable CMS-1500 or UB04 claim forms. Facsimiles, photocopies, or laser-printed claim forms may not be scanned and are unacceptable. Those claims not meeting this criterion will be returned from the fiscal agent to the provider.

Make Preparations Now for ICD-10 Implementation on October 1, 2014

On **October 1, 2014**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

Implementation

Implementation planning for ICD-10-CM should begin immediately if it is not already under way, regardless of the size or function of your practice. ICD-10-CM implementation is not just a billing or information systems project. The organizational effect of the transition will be broad and deep. Industry experts recommend that by the end of first-quarter 2013, providers should have finalized their ICD-10 training plans, established ICD workgroups, and determined who in their organization will lead the ICD-10 charge. In fact, timelines developed by the Centers for Medicare & Medicaid Services (CMS) suggest that high-level training for ICD-10 testing teams begin in March 2013 and extend through December of this year.

The table shown above displays the high-level differences between ICD-9 and ICD-10, and Procedure Coding System (PCS) codes.

Please Note: While the new ICD-10 codes will provide greater specificity through the expansion of the overall code set, providers will need to adopt only those codes

Code	ICD-9	ICD-10
Diagnosis (Clinical Modification - CM)	3,000 codes	68,000 codes
	3-5 digits (alpha/numeric)	3-7 digits (alpha/numeric)
Inpatient Procedure Coding System (PCS)	13,000 codes	72,081 codes
	3-4 digits (numeric)	7 digits (alpha/numeric)

that are relevant to their day-to-day operations.

Submission of Claims

On March 27, 2012, the National Uniform Claim Committee (NUCC) announced the release of a revised version of the 1500 Health Insurance Claim Form (version 02/12). This revised version will update the current 1500 Claim Form (version 08/05), often referred to as the “HCFA 1500” or “CMS-1500.” This revision is not fully

approved and is not currently accepted for claim submissions. You will be notified when it is approved and available for use.

The CMS-1500 form revision includes changes to accommodate ICD-10 code changes, but does not rely on the implementation of ICD-10 to become active. More information is available from the NUCC website at: www.nucc.org.

More Information

Providers are encouraged to check the CMS website for the most up-to-date information and timelines. The following webpages contain useful information and resources:

<http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10>

<http://www.cms.gov/Medicare/Coding/ICD10/ICD-10ImplementationTimelines.html>

Provider Type 39 (ADHC): Use HCPCS Code S5102 for All-day Services

Effective March 1, 2013, provider type 39 (Adult Day Health Care) must bill using HCPCS code S5102 (Day care services, adult; per diem) if services are authorized and provided for six hours or more per day. Please be advised:

- All new initial prior authorization (PA) requests for ADHC and annual updates submitted on or after March 1, 2013, will be authorized as code S5102.
- PAs that were entered previously to March 1, 2013, will remain under code S5100 and should continue to be billed using HCPCS code S5100 until their annual update has been requested and a new PA utilizing

HCPCS code S5102 has been issued.

- Bill with code S5100 (Day care services, adult; per 15 minutes) if services are authorized and provided for less than 6 hours per day. Bill one unit for each 15 minutes.
- Bill code S5102 at one unit per day; one unit is a per diem rate for 6 hours or more.
- Providers cannot bill codes S5100 and S5102 for the same recipient on the same date of service.
- The procedure code on the prior authorization must match the procedure code on the claim.

Prevention Reminder from DHCFP: *Adolescent Health*

Nevada Medicaid covers preventive health services for adolescents. In 2009, a study from the University of California, San Francisco stated that “Most American teens don't receive the appropriate amount of preventive health services, even though this type of care can establish good health behaviors and discourage damaging behaviors that can affect teens for the rest of their life.” (The study was published online March 30, 2009, in the journal *Pediatrics*).

The [Guidelines for Adolescent Preventive Services \(GAPS\)](#) is a complete set of recommendations for adolescent preventive health services. Fourteen separate topics or health conditions are broken down into four types of services:

- Three recommendations pertain to the delivery of health care services.

- Seven recommendations pertain to the use of health guidance to promote the health and well-being of adolescents and their parents or guardians.
- Thirteen recommendations describe the need to screen for specific conditions that are relatively common to adolescents and that cause significant suffering either during adolescence or later in life.
- One recommendation pertains to the use of immunizations for the primary prevention of selected infectious diseases.

For more information on preventive services for adolescents and children of all ages, please refer to Medicaid Services Manual (MSM) [Chapter 600](#), Attachment A, Policy #6-14.

Attention Provider Types 11, 13, 56, 63 and 75: Instruction for Concurrent Review PAs That Are Greater Than 18 Lines

Regarding prior authorization (PA) requests for hospital inpatient concurrent reviews that are greater than 18 lines: If a concurrent review PA requires more than 18 lines, beginning at what would be line 19, please start a new PA with the next day's date **following** the “through” date from line 18.

For example:

Line 18:	1/1 to 1/4
Line 1 of new PA:	1/5

This change is **only** for PAs more than 18 lines, and for the first line of the new PA.

Please remember that only one (1) PA is allowed per claim.

Recipients to Receive Notices of Decision Regarding Technical Denials

A new process has been implemented related to prior authorization requests that receive a technical denial. Effective May 27, 2013, when a provider fails to submit the necessary information with a prior authorization request and a technical denial is issued, both the provider and the recipient will receive a Notice of Decision (NOD).

Prior to this change, only providers received the NOD when a technical denial was issued. Providers are advised to be prepared for calls from recipients regarding these NODs.

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://dhcftp.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.