MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 26, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 – MEDICAID PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program are being proposed to remove the specificity associated with National Correct Coding Initiative (NCCI) edits and simply cite the rule. Revisions are also being proposed to further clarify instances of fraudulent billing.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective April 27. 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 30823 MEDICAID PROGRAM	MTL 19/15 MEDICAID PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
105.1(2)	**Medicaid Payments to Providers**	Removed specific types of NCCI edits and added the rule associated with edits for clarification.
106.3(2)(a)	**Tier 2 – Seven Year Sanction**	Removed comma and added “and/or” for clarification.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
106.3(3)(b)	**Tier 3 – 12 Month Sanction**	Removed comma and added “and/or” for clarification.

105 MEDICAID BILLING AND PAYMENT

Medicaid payment must be made directly to the contracted person, entity or institution providing the care or service unless conditions under #2 below are met. Federal regulations prohibit factoring or reassignment of payment.

1. A provider may use a billing agent to complete Medicaid billing only if the compensation for this service is:

   a. related to the actual cost of processing the billing;

   b. not related on a percentage or other basis to the amount that is billed or collected; and

   c. not dependent on the collection of the payment.

2. Medicaid payment for an individual practitioner may be made to:

   a. the employer of a practitioner if the practitioner is required, as a condition of employment, to turn over his fees to his employer;

   b. the group if the practitioner and the group have a contract in place under which the group submits the claims;

   c. the facility in which the services are provided, if the practitioner has a contract under which the facility submits the claims; or

   d. a foundation, plan or similar organization operating an organized health care delivery system if the practitioner has a contract under which the organization submits the claims. An "organized health care delivery system" may be a public or private Health Maintenance Organization (HMO).

105.1 MEDICAID PAYMENTS TO PROVIDERS

1. As specified in federal regulations and the terms of all provider agreements, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. This includes, but is not limited to, situations where the provider's claim is denied by Medicaid for failure to bill timely, accurately or when Medicaid payment equates to zero because a third party's payment exceeds Medicaid's allowable amount.

2. Medicaid utilizes the Centers for Medicare and Medicaid Services (CMS) developed National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate payments. The NCCI edits are defined as edits applied to services performed

by the same provider for the same beneficiary on the same date of service. ~~They consist of two types of edits:~~ Section 6507 of the Affordable Care Act requires each State Medicaid program to implement compatible methodologies of the NCCI, to promote correct coding and to control improper coding leading to inappropriate payment.

~~1. NCCI edits, or procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and~~

~~2. Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.~~

3. Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims editor program employs a nationally recognized standardized method of processing claims for professional services using clinical logic based on the most current CPT, Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD), American Medical Association (AMA), CMS and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.

4. If an individual is pending Medicaid, it is requested the provider await an eligibility decision before billing for the service. If the provider decides not to wait for the decision, he or she may request payment from the recipient while the decision is pending. Once the recipient is found eligible for Medicaid, and the date of service for which payment was collected is covered, the provider must return the entire amount collected to the recipient before billing Medicaid. The payment subsequently received from Medicaid is payment in full and no additional payment may be requested from the recipient, and no part of the payment made by the recipient may be retained by the provider.

5. Providers are to bill their usual and customary fees unless otherwise specified in Medicaid policy. For exceptions, refer to individual chapters. Billings are submitted according to established Medicaid policies.

6. Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.

106.3 SANCTION PERIODS

Providers who are terminated or denied from Nevada Medicaid for cause will serve a sanction period that begins with the effective date of the termination or denial. Sanctioned providers will not be reimbursed for any services provided on or after the date of termination. Providers who have not been permanently sanctioned from the Nevada Medicaid program may resubmit a new Provider Enrollment Application at the end of the sanction.

Sanctions may be applied to any person who has ownership or controlling interest in the provider or who is an agent or managing employee of the provider.

1. Tier 1 - Permanent Sanction

   a. Provider is on the OIG exclusion list.

   b. Provider has been convicted of a criminal felony offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (CHIP) (NCU), or the Title XX services program.

   c. Provider has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU), or the Title XX services program.

   d. Provider has been convicted of any offense listed below:

      1. Murder, voluntary manslaughter, mayhem or kidnapping;

      2. Sexual assault, sexual seduction or any sexually related crime;

      3. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission;

      4. False imprisonment or involuntary servitude;

      5. Criminal neglect of patients per the NRS 200.495;

      6. Abuse or neglect of children per NRS 200.508 through 200.5085;

      7. Abuse, neglect, exploitation or isolation of older persons;

      8. Any offense against a minor under NRS 200.700 through 200.760;

9. Any offense against public decency and good morals under a provision NRS 201.015 through NRS 201.56.

The DHCFP may choose to allow re-enrollment if the United States Department of Health and Human Services (DHHS) or Medicare notifies the DHCFP that the provider may be reinstated.

2. Tier 2 – Seven Year Sanction

a. Provider has been terminated due to quality of care issues or inappropriate~~,~~ and/or fraudulent billing practices as identified as a result of an investigation, audit, review or survey.

b. Provider has been convicted of any offense listed below:

1. Assault or battery;

2. Any offense involving arson, fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;

3. Harassment or stalking;

4. Any offense against the executive power of the State in violation of NRS 197;

5. Any offense against the legislative power of the State in violation of NRS 198;

6. Any offense against public justice in violation of NRS 199;

7. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or

8. Any other felony involving the use of a firearm or other deadly weapon within the immediately preceding seven years.

3. Tier 3 – Twelve Month Sanction

a. Provider was denied enrollment due to omitting information regarding criminal background or ownership and/or supplying false information on the Provider Enrollment Application;

b. Provider was terminated as a result of an investigation, audit, review, or survey not related to quality of care or inappropriate~~,~~ and/or fraudulent billing practices;

c. Provider was terminated due to not meeting the conditions of participation as stated in Chapter 100 all-inclusive of the Nevada MSM or other conditions of participation as required by the Nevada MSM for the specified provider type;

d. Provider was terminated due to being under investigation by a law enforcement or state agency for conduct that it is deemed incompatible with the mission of the DHCFP;

e. Provider was terminated due to conviction of a misdemeanor, gross misdemeanor or felony, not listed in Tier 1 or Tier 2, which is incompatible with the mission of the DHCFP;

f. Provider has failed to follow through with their DHCFP approved corrective action plan; or

g. Provider has a restricted professional license.

4. Immediate Re-Application

Providers whose contracts have been terminated for the following reasons may reapply at any time:

a. Loss of contact;

b. No payments made to provider within the prior 24 months;

c. When the sole issue is a change in federal law and the law has been repealed; or

d. Provider failed to provide requested information.

106.4 PROCEDURES FOR TERMINATION AND NON-RENEWAL

If the DHCFP decides to terminate or not renew a provider contract in the Nevada Medicaid Program:

1. A Notice of Intent to Terminate or Non-renew will be sent to the provider at the last known mailing address via U.S. mail. The notice will include:

a. a description of proposed action;