MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 27, 2018

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 change the retroactive enrollment date (backdate) to 90 days for all in-state provider contracts. Out-of-state providers are not impacted and may continue to request up to 365 days of retroactive enrollment. The retroactive enrollment date is based upon the date a complete application and provider contract are received.

Revisions to MSM Chapter 100 are also proposed to change the in-state provider billing time frame (stale date) to 90 days for all provider types. To be considered timely, claims must be received by the fiscal agent within 90 days from the date of service or the date of eligibility decision, whichever is later. Out-of-state providers and Third-Party Liability (TPL) will not be affected.

Entities Financially Affected: All provider types.

Financial Impact on Local Government: Unknown at this time.

These changes are effective October 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL N/A MSM Ch 100 – MEDICAID PROGRAM	MTL 14/17, 19/15 MSM Ch 100 – MEDICAID PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.1	**Request for Enrollment, Re-Enrollment and Revalidation**	Changed “six months” to “90 days” and added “Out-of-state providers may request up to 365 days of retroactive enrollment.”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
105.2B	**Billing Time Frames (Stale Dates)**	Changed “180” to “90.”

A moratorium may be implemented at the discretion of the federal DHHS or the DHCFP. A new enrollment application is required for enrollment after it is lifted.

102.1 REQUEST FOR ENROLLMENT, RE-ENROLLMENT AND REVALIDATION

A request for enrollment means an applicant, who has never been a Nevada Medicaid provider, submits an initial enrollment application; re-enrollment means a former Nevada Medicaid provider, whose contract was terminated or deactivated and who is now eligible to "re-enroll," submits an initial enrollment application; and, revalidation means an active Nevada Medicaid provider, who must validate their current enrollment to extend their agreement with Nevada Medicaid, submits a revalidation application.

A provider may request enrollment, including re-enrollment and revalidation, in the Nevada Medicaid Program by completing the Enrollment Application and providing the required verifications for their requested provider type. However, the DHCFP is not obligated to enroll all eligible providers, and all types of enrollment are at the discretion of the DHCFP. For additional information regarding enrollment, the provider may contact the Provider Enrollment Unit of the Fiscal Agent. Refer to Section 108 for contact information.

The effective date of the provider contract is the date received. Exceptions may be allowed for up to ~~six months~~90 days of retroactive enrollment to encompass dates on which the otherwise eligible provider furnished services to a Medicaid recipient. Out-of-state providers may request up to 365 days of retroactive enrollment. All approved Provider Contracts, unless otherwise withdrawn or terminated, shall expire 60 months from enrollment date, with the exception of Durable Medical Equipment (DME) Contracts which shall expire 36 months from enrollment date, unless withdrawn or terminated.

If the provider does not meet all State and Federal requirements at the time of the initial request for participation, the effective date of the provider contract will be the date all requirements are met. If the Provider is serving a sanction period, they are not eligible for enrollment.

A. If discrepancies are found to exist during the pre-enrollment period, the DHCFP and/or the Fiscal Agent may conduct additional inspections prior to enrollment. Failure to provide complete and accurate information, or to resolve discrepancies as prescribed by the DHCFP and/or the Fiscal Agent, may result in denial of the application.

   The Fiscal Agent may complete additional screenings on applicants for the purpose of verifying the accuracy of information provided in the application and in order to prevent fraud and abuse.

   The screening may include, but is not limited to, the following:

   1. on-site inspection prior to enrollment;

l. Vascular catheter-associated infection.

m. Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery other than in pediatric and/or obstetric patients.

If a PPC is caused by one provider or facility (primary) and is then treated by a different facility or provider (secondary), payment will not be denied to the secondary provider. The DHCFP will make appropriate payments to the secondary provider and may pursue recovery of all money in full, including legal expenses and other recovery costs from the primary provider. This recoupment may be recovered directly from the primary provider, or through subrogation of the injured recipient's settlement. The anticipated costs of long-term health care consequences to the recipient may also be considered in all recoveries.

Providers can request an appeal via the fiscal agent if they disagree with an adverse determination related to a PPC. The fiscal agent's appeal process must be exhausted before pursuing a Fair Hearing with the DHCFP. Refer to MSM Chapter 3100, Section 3105 for additional information on Fair Hearings.

Individual agreements between managed care organizations and their providers may vary from fee for service limitations.

105.2B BILLING TIME FRAMES (STALE DATES)

Providers must bill Medicaid for all claims within the specific time frame set by Medicaid. To be considered timely, claims must be received by the fiscal agent within ~~180~~ 90 days from the date of service or the date of eligibility decision, whichever is later. For out-of-state providers or when a third-party resource exists, the timely filing period is 365 days.

Stale date criteria are strictly adhered to whether the claim is initially received or being appealed for a stale date override.

In order to submit claims for which eligibility was determined after the date of service within the required time frame, providers should query the EVS every 30 days until the determination of eligibility is obtained.

105.2C DISPUTED PAYMENT

The Fiscal Agent is responsible for research and adjudication of all disputed payments. This includes claims for which the provider is requesting an override even though the claim has not been previously submitted and denied.