Annual New Code Update Process

This is an annual process that most commonly affects Hospitals, Physicians, Mid Level providers, DME and Pharmacy. The process is started as soon the Division of Healthcare Finance & Policy (DHCFP) receives verification from CMS that the code list and assigned values are accurate and available. We cannot begin the process without the full file from CMS or the most recent Optum coding books.

The New Code Upload process involves staff from multiple units. The Rates Unit staff downloads the data from the CMS website then formats in and builds it into the template that is used. The data is then sent to the Clinical Policy Team. They must review each new code and definition using the most recent Optum books, to determine which codes are covered/eligible under NV Medicaid policy. Not all of the codes released by CMS are used. The Program Services Unit determines which codes will be covered, what the service limitations are, and which provider types will be eligible for the codes. The information then is returned to the Rates Unit. The QA process begins and rate methodology is set for each code using CMS information as a baseline and then finalizing rates based on the methodology outlined in the State Plan. Each codes rate is set individually and the rate varies by provider type. One code could have 10 or more different rates assigned to it. Upon completion the data is sent to the IS Unit to coordinate with the Fiscal Agent's programming unit to update the billing system. At this time the codes and rates are uploaded into a test environment so that it can be tested and quality checked to ensure accuracy. Once all of this has been completed, the data is pushed into production, the codes become payable, and the claims recycle occurs.

The current process is necessary to ensure quality and avoid system errors, take backs and multiple remittance advice reconciliations. It is a priority for DHCFP to get the new codes updated as quickly as possible and to verify accuracy in order to ensure that claims only have to be processed once.

This is a similar process to that utilized by other payers of medical claims.