

SUMMER
2011



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

MedNotesSM

FOR MANAGED CARE MEDICAID AND NEVADA CHECK UP PROVIDERS

Focus

Open Enrollment Deadline is September 12

Medicaid and Nevada Check Up members have until September 12, 2011, to switch health plans. If your patients are satisfied with their health plan, no further action is required. To switch, enrollees must complete the form sent by Nevada Medicaid and return it in the self-addressed, postage-paid envelope. All eligible household members must be enrolled in the same plan unless they provide good cause for splitting. Each household must remain enrolled in their health plan for the remainder of the enrollment year, which runs through September 30, 2012. The purpose of this "lock in" period is to promote continuity of care for enrollees with their providers and health plan.

If you're asked why choose Health Plan of Nevada, please remember that we offer unlimited visits to the doctor as well as unlimited prescription drugs and over-the-counter medications.

We provide:

- Health education classes
- Health management programs
- 24-hour telephone advice nurse service
- Nursing and social service care management

If you or your patients have questions, please call our Member Services Department at (702) 242-7317 or (800) 962-8074. We're available Monday through Friday from 8 a.m. to 5 p.m.



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Fraud and Abuse Roadmap

Most physicians strive to work ethically, render high-quality medical care to their patients, and submit proper claims for payment. Society places enormous trust in physicians, and rightly so.

The Federal Government also places enormous trust in physicians. Medicare, Medicaid, and other federal health care programs rely on physicians' medical judgment to treat beneficiaries with appropriate services. When reimbursing physicians and hospitals for services provided to program beneficiaries, the Federal Government relies on physicians to submit accurate and truthful claims information.

It's important that physicians understand how to comply with federal laws by identifying "red flags" that could lead to potential liability in law enforcement and administrative actions. The five most important federal fraud and abuse laws that apply to physicians are the:

- False Claims Act (FCA),
- Anti-Kickback Statute (AKS),
- Physician Self-Referral Law (Stark law),
- Exclusion Authorities, and
- Civil Monetary Penalties Law (CMPL).

In this issue, we'll cover the False Claims Act [31 U.S.C. §§ 3729–3733]. The civil FCA protects the government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus \$11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly.

Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or ex-business partners, hospital or office staff, patients, or competitors.

There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims. The government also

may impose administrative civil monetary penalties for false or fraudulent claims.

The Department of Health & Human Services Office of the Inspector General (OIG) has published the free information guide *Fraud and Abuse Roadmap* to help physicians. Download a copy at <http://oig.hhs.gov/fraud/PhysicianEducation>.

Important Tips on Claims Submissions

Before you submit an electronic claim, make sure to check the correct spelling of your patient's name and validate the date of birth. This will reduce the number of claims sent back to you. Electronic claim submissions are convenient, but they only work when all data matches our processing system.

Please use standard CMS 1500 and UB04 forms. Make sure the claim form is correctly aligned and the font is at least 10 point. Please DO NOT use colored highlighter on the claim. Be sure the attachments match the claim and, if it's a multi-page claim, the patient's documents are in sequential order.

You can help us process your claims in a timely manner by accessing HPN@YourService. Please call our Provider Services Department at **702-242-7088** if you need help with our website or don't have access to the provider portal.

Attention: HPN Medicaid Dental Providers

On June 1, 2011, we initiated several new administrative guidelines and claims payment requirements. Please make sure your office is in compliance.

- A copy of a predetermination or duplicate radiographs must be submitted with all restorative, prosthodontic or oral surgery claims for all ages. All X-rays are appropriately discarded and are not retained for future review.



- Providers are required to bill 0150 for an initial comprehensive exam and 0120 for following periodic exams. There is a provision for an additional 0150 billing from a different office.
- A narrative is required when submitting claims with Code 0140.
- Code 9310 no longer is allowed when billed by a general dentist and requires a narrative from a dental specialist. HPN no longer covers this code when billed by a dentist in the same practice association or group as the referring dentist.
- HPN no longer reimburses for the routine extraction of deciduous teeth that are ready to exfoliate.
- HPN no longer reimburses for the routine extraction of asymptomatic 3rd molars.
- All reconsiderations require a copy of the EOP denial with notations or attached duplicate X-rays. Please do not submit additional copies of claims unless changes have been made to the original billing.
- Please do not submit duplicates unless you have checked HPN@YourService, the claim has not been received, and it has been 30 days since your original submission.
- Prior notification still applies for recipients 21 and older.
- If you have any questions regarding these changes, please call our Dental Provider Services Department at (702) 242-7086 or (866) 253-8378.

New Mental Health and Substance Abuse Provider

Starting June 1, 2011, HPN Medicaid and Nevada Check Up members in northern and southern Nevada will access Human Behavior Institute (HBI) for mental health services, substance abuse treatment and utilization management. Behavioral Healthcare Options (BHO) will be assisting HPN with HBI oversight, transition of care and day-to-day operations.

If you have a Medicaid member currently in treatment, contact HBI for authorization and a plan of transition at the telephone numbers listed below. All new Medicaid members should be directed to HBI for treatment.

Human Behavior Institute (HBI) is a full-service behavioral health organization that develops and implements managed behavioral health services and employee assistance programs to self-funded employers, insurance carriers, union trusts and third party administrators. HBI has an extensive delivery

system provided by network practitioners and staff-model specialty clinics. HBI is devoted to excellence in clinical care and customer service.

HBI is located at 2740 S. Jones in Las Vegas, NV. The phone number is (702) 248-8866 or (800) 441-4483.

If you have any questions regarding these changes, please contact Behavioral Healthcare Options Administration at (702) 240-8733.

Lead Screening Rates Improve

Over the past two years, Health Plan of Nevada (HPN) has implemented multifaceted member and provider-level strategies to improve lead screening rates for two-year-old children – a key priority for the state of Nevada. Thanks to your efforts, the most recent Healthcare Effectiveness Data and Information Set (HEDIS) 2010 lead screening rates were 24.82% and 40.80% for the SmartChoice and Nevada Check Up Medicaid populations. Statistically significant improvements and ongoing positive trends were shown for both populations from the 2008 baseline period to the second re-measurement period in 2010.

We Need Your Help

Although the lead screening rates have improved in the past two years, rates are still in the 10th national percentile as compared to other plans across the country.

We need help from all of our providers to continue this positive trend. Please educate and encourage parents of one-year-old children to have lead screening done prior to the child's second birthday. It does not count if the lead screening is done after the second birthday, even if it is just one or two days late.

Free Program For Your Office

We want your office to participate in our Pediatric Education and Rewards Program. Through this program, we make available free patient education resources including Lead Screening Risk Factor Checklists. Your office also can receive rewards for your patients. We ask that you provide these rewards when patients get recommended care, such as well child care, lead screening and/or timely immunizations. Please call our Quality Improvement Department at (702) 242-7064 if you want to participate.

How To Contact Us

Member Services Department

HPN Medicaid/Nevada Check Up..... **800-962-8074**

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m.

Provider Services

Toll-Free **800-745-7065**

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m.

Pharmacy Services

Pharmacy **800-925-7455**

Fax Toll-Free **800-997-9672**

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m.

Prior Authorization

Toll-Free **800-288-2264**

Fax Toll-Free **800-282-8845**

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m.



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