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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 18-009

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 24, 2018

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 18-009. The SPA updates language related to payment of claims to be consistent with current methodology for cost avoidance and cost savings programs. The SPA was submitted to my office on July 27, 2018.

This SPA is approved effective July 27, 2018. Attached is a copy of the following pages to be incorporated into your State Plan:

- Section 4, Pages 69-69a
- Attachment 4.22-B, Pages 1-2

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Marta Jensen: Acting Administrator, DHCFP

Encls: Approval Package

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **18-009**

2. STATE: **NEVADA**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 27, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 433. 137-139, CFR 447.20, 1902(a)(25) and (I) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $0
b. FFY 2019 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Third Party Liability Attachment 4.22, Pages 69 and 69a~~
~~Attachment 4.22-B, Pages 1 and 2~~ PB
Section 4, Pages 69 and 69a
Attachment 4.22-B, Pages 1 and 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Third Party Liability Attachment 4.22, Pages 69 and 69a~~
~~Attachment 4.22-B, Pages 1 and 2~~ PB
Section 4, Pages 69 and 69a
Attachment 4.22-B, Pages 1 and 2

10. SUBJECT OF AMENDMENT:

Updating Attachments 4.22 and 4.22-B Third Party Liability State Plan language related to payment of claims consistent with current methodology for cost avoidance and cost savings.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Marta Jensen

13. TYPED NAME:
Marta Jensen

14. TITLE:
Administrator, Division of Health Care Finance and Policy

15. DATE SUBMITTED: 7/27/18

16. RETURN TO:
Lynne Foster, Chief of Division Compliance
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 7/27/18

18. DATE APPROVED: 8/24/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/27/18

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Hye Sun Lee

22. TITLE: Acting, Associate Regional Administrator

23. REMARKS: Pen and Ink: Box 8 - Update to read "Section 4, Pages 69 and 69a / Attachment 4.22-B, Pages 1 and 2". Box 9: Update to read "Section 4, Pages 69 and 69a / Attachment 4.22-B, Pages 1 and 2".

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: NEVADA

REQUIREMENTS FOR THIRD PARTY LIABILITY

Citation:

4.22 Third Party Liability

(a) The Medicaid agency meets all requirements of:

42 CFR 433.137

1902(a)(25)(H) and

(I) of the Act

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A: IDENTIFING LIABLE RESOURCES

(1) Specifies the frequency with which the data exchanges required in 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in 433.138(e) are conducted;

42 CFR 433.138 (g)(1)(ii)

and (2) (ii)

(2) Describes the methods the agency uses for meeting the follow-up requirements contained in 433.138 (g)(1)(i) and (g)(2)(i);

42 CFR 433.138 (g)(3)(i)

and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under 433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third-party data base and third-party recovery unit of all information obtained through the follow-up that identifies legally liable third-party resources; and

42 CFR 433.138 (g)(4)(i)

through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under 433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
JUNE 2018

State/Territory: NEVADA

42 CFR 433.139(b)(3)(ii)(A)	X	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22B – PAYMENT OF CLAIMS:
CFR 433.139(b)(3)(ii)(C)		(1)	The method used in determining a provider's compliance with the third-party billing requirements at 433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

THIRD PARTY LIABILITY – PAYMENT OF CLAIMS

The Nevada Medicaid program is designed to function primarily as a cost avoidance system, with cost savings. This method was chosen as the most efficient and least costly due to the multitude of insurance companies utilized by Nevada residents. Also, insurance data is fed through a secured transmittal bill paying system on an individual basis. Direct contact is made by the fiscal agent TPL unit directly with insurance carriers and all available information is collected.

The Nevada bill paying system has a direct connection to the Center for Medicare and Medicaid Services' system. Cost savings occur when post-payment recovery is also incorporated. Criteria have therefore been established for both systems with emphasis on cost effectiveness and FFP compliance.

42 CFR 433.139(b)(3)(ii)(C)

1. Cost Avoidance Method

    a. Claims with Medicaid paid amounts greater than zero are rejected on the remittance advice with insurance billing instructions and carrier information.

    b. Services identified by individual policies as non-covered are not subject to cost avoidance or recovery.

42 CFR 433.139(f)(2&3), 42 CFR 447.20 and 7 CFR 273.18(e)(8)(ii)

2. Post-Payment Recovery

    a. Recovery - Provider

        1. States only pursue recoveries from providers whenever Medicare is the primary source.

        2. Claims which were unidentified or missed in cost avoidance are subject to claims with Medicaid outlined in 1.a above. Recovery is made by computer history adjustments.

        3. Due to Medicare timely filing, recovery efforts are not attempted when more than 12 months have elapsed from date of service to the projected adjustment date.

    b. Recovery – Insurance Carrier

        1. When necessary, direct recovery is attempted through individual insurance carriers. This can occur when providers are unsuccessful with billing attempts, but the fiscal agent (FA) has sufficient information to pursue collection. Claims with Medicaid paid amounts of less than $25 are not pursued.

            A. Claims with Medicaid paid amounts of less than $25 are not pursued.

        2. Claims with Medicaid paid amounts of $25 or greater are pursued by the FA through the individual insurance company.

3. Casualty - Subrogation

42 CFR 433.139(f)(e)

a. Claims which edit for trauma codes are processed through the regular processing cycle. If the billed amount is $125 or greater and no insurance has paid on the claim, the claim is referred to the fiscal agent for subrogation follow-up.

b. If the billed amount is less than $125, no investigation is initiated unless large quantities of claims exist for this diagnosis or service date.

c. Claims with billed amounts of $125 or more are investigated and followed through the legal process until settlements are reached or a determination made to drop the case.