

# Hospital

Annual Medicaid Conference  
October 2012

**Presented by:**  
Coleen Lawrence  
DHCFP  
and  
Donna Perkins/Jennifer Shaffer  
HPES

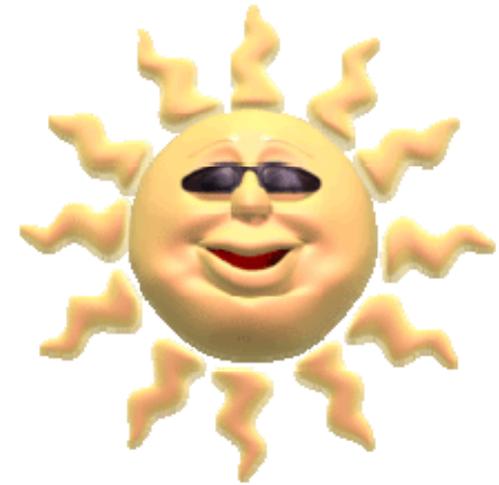
# Upcoming Changes

- Health care reform
  - New eligibles (ER room)
- Provider preventable conditions
- ICD-10
- C-sections reimbursement policy
- TeleHealth
- CBT course for UB04
- Therapy limits
- Registered dietician
- Transplant Centers of Excellence



# Hot Billing Topics

- National Drug Codes (NDCs)
- Roll up of Prior Authorization (PA) lines
- Retro Eligibility with PA Roll up
- PA denials
- Helpful hints on the Provider Web Portal related to entering PAs, attachments, symbols, etc.



# Top Denial Reasons and Edits

- Admit Date – locator 6 and 12
- Adjustments – entering the wrong bill type
- Edits 0313 and 0316 – TPL
- Edits 0208 and 0308 – Timely Filing
- Edit 0453 – Enrolled in MCO
- Edit 0318 – Recipient not covered on DOS
- Edit 0155 – No PA on file
- Edit 0450 – Emergency Service Only
- Edits 0301 and 0302 – Duplicate



# Edits 0313 and 0316

Bill any other available insurance (0313)

Medicaid has more TPL policies than claim documentation shows (0316)

- Verify the recipient's other insurance(s)
- Bill the recipient's other insurance(s) first
- Send the claim with the primary EOB(s) attached
- Bill only for the recipient's legal obligation to pay
- If the primary insurance denied the claim, applied payment to the co-insurance and/or deductible, or if primary insurance was terminated or exhausted, send claim to Customer Service for special batching



# Edits 0208 and 0308

Date of service exceeds claim filing limit

- 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 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 payer exists, the timely filing period is 365 days from date of service.  
*MSM Chapter 100, Section 105.2B*



# Edit 0453

Recipient enrolled in HMO

- Always verify recipient's eligibility through Electronic Verification System (EVS), Audio Response System (ARS) or a swipe card system prior to rendering services
- Send your claim to the appropriate Managed Care Organization (MCO) in which the recipient is enrolled for the date(s) of service(s)
- Remember to obtain your prior authorization from the correct entity



# Edit 0318

Recipient not authorized on Date(s) of Service billed

- Always verify recipient eligibility through EVS, ARS or a swipe card system, prior to rendering services
- If the recipient receives retroactive eligibility, first refund any monies collected from the recipient then submit the claim to the appropriate Medicaid program, i.e., Medicaid FFS, HPN or Amerigroup



# Edit 0155

Procedure requires authorization

- Ensure a valid, **approved** prior authorization number is listed on claim in field 23, unless using an inpatient facility's prior authorization, then only bill with the correct place of service
- Ensure prior authorization was issued to the servicing NPI billed on the claim
- Prior authorization dates must be within the dates of service on claim

**APPROVED**



# Edit 0450

Non-emergency service not authorized for non-citizens

- Refer to the Emergency Diagnosis Codes for Non-Citizen Coverage Only list, which can be found at [www.medicaid.nv.gov](http://www.medicaid.nv.gov)
- Make sure medical documentation is submitted with the claim



# Edits 0301 and 0302

Duplicate payment request – Same provider, same dates of service

- Review your remittance advice to determine if the service has already been paid. In most cases, the service being submitted has already been paid (including a zero payment) to the provider



# Helpful Billing Tips

- NDC is required for drugs on outpatient claims (provider type 12). Do not include the J-code.
- Adjustments – use the appropriate bill type
- Revenue code without CPT/HCPCS code
- Review balance due amounts to ensure accuracy



# Contact information

## **Customer Service Center**

Claim inquiries and general information

Phone: (877) 638-3472

## **Automated Response System (ARS)**

Phone: (800) 942-6511

## **Assistance with Prior Authorizations**

Phone: (800) 525-2395

## **Requests for Provider Training**

Email: [NevadaProviderTraining@hp.com](mailto:NevadaProviderTraining@hp.com)



# Questions?



Thank you for your attention

Please complete the course evaluation  
before leaving

Enjoy the remainder of your day

