

# Nevada Medicaid and Nevada Check Up News



Division of Health Care Financing and  
Policy (DHCFP)

HP Enterprise Services  
(HPES)



## Dual-Use Periods Are Ending for ADA and CMS-1500 Claim Forms; New Forms Must Be Used

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### ***2012 ADA Claim Form Must Be Used Effective May 1, 2014; Fields 29a, 34a and 38 Are Required***

Effective with claims received at HP Enterprise Services (HPES) on or after May 1, 2014, the new 2012 American Dental Association (ADA) claim form must be used. The dual-use period of the 2006 version and the 2012 version ends on April 30, 2014. Effective May 1, 2014, claims submitted with the 2006 ADA claim form will be returned to providers.

- **Please note:** For dates of service on or after May 1, 2014, claims on the 2012 ADA form will deny if **valid diagnosis codes and diagnosis pointers** (Fields 29a and 34a) and **place of treatment codes** (Field 38) are not included on the claim. Please review the [2012 ADA Claim Form Instructions](#).
- Electronic billers: Please refer to the Transaction 837D – Dental Health Care Claim and Encounter Companion Guide for billing instructions. The Companion Guides are available on the [Electronic Claims/EDI](#) webpage.

### ***New CMS-1500 (02-12) Claim Form Must Be Used Effective May 3, 2014***

Effective with claims received at HP Enterprise Services (HPES) on or after May 3, 2014, the new CMS-1500 (02-12) claim form must be used. The dual-use period of version 02-12 and version 08/05 ends on May 2, 2014. Effective May 3, 2014, claims submitted with the CMS-1500 (version 08/05) claim form will be returned to providers.

Due to updates to field instructions, providers are encouraged to review the [CMS-1500 \(02-12\) Claim Form Instructions](#). For example:

- In Field 21, enter up to twelve (12) ICD-9 codes in the spaces indicated A through L. Please enter the codes **across each line**, not down.
- In Field 24E, the Diagnosis pointers must be alpha characters. They are no longer numeric values. If you enter multiple codes in Field 21, then in Field 24E use a dash between the first and last letters, i.e., A-D, instead of ABCD. Please note: This is a claim form field in which dashes are acceptable.
- In Field 30, the space is labeled as reserved for NUCC use, but the **Balance Due is required**. If Medicaid is primary coverage, enter the amount shown in Field 28. If the recipient has Third Party Liability (TPL) (including Medicare), enter the recipient's legal obligation to pay. Do not include write-off, contractual adjustment or behavioral health reduction amounts.
- Electronic billers: Please refer to the Transaction 837P – Professional Health Care Claim and Encounter Companion Guide for billing instructions. The Companion Guides are available on the [Electronic Claims/EDI](#) webpage.

## PERM Cycle 3 Provider Education Webinar/Conference Calls

The Centers for Medicare & Medicaid Services (CMS) will host four Payment Error Rate Measurement (PERM) provider education webinar/conference calls during Cycle 3 (2014). The purpose is to provide opportunities for the providers of the Medicaid and Children's Health Insurance Program (CHIP) communities to enhance their understanding of specific provider responsibilities during the PERM.

The PERM program is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 or IPERIA).

Webinar/conference call participants will learn from presentations that feature:

- The PERM process and provider responsibilities during a PERM review
- Recent trends, frequent mistakes and best practices
- The Electronic Submission of Medical Documentation "esMD" program

The presentations will be repeated for each session. Providers will have the opportunity to ask questions live through the conference lines, via the webinar, and through the dedicated PERM Provider email address at [PERMProviders@cms.hhs.gov](mailto:PERMProviders@cms.hhs.gov).

**Presentation materials and participant call-in information will be posted as downloads on the "Providers" tab of the PERM website at:** <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/PERM/Providers.html>

The webinars are being presented on the Adobe Connect Pro platform. To test your connection in advance, launch: [https://webinar.cms.hhs.gov/common/help/en/support/meeting\\_test.htm](https://webinar.cms.hhs.gov/common/help/en/support/meeting_test.htm)

### **Tuesday, June 10, 2014 noon-1 p.m. Pacific Time**

The two-step audio/webinar process is:

1. **Audio:** Login to <https://cms.webex.com/cms/j.php?J=992454311>. The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.

2. **Webinar:** In a separate window, login to <https://webinar.cms.hhs.gov/perm2014cycle3web/> to access the webinar.

### **Thursday June 26, 2014 noon-1 p.m. Pacific Time**

The two-step audio/webinar process is:

1. **Audio:** Login to <https://cms.webex.com/cms/j.php?J=998353879>. The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to <https://webinar.cms.hhs.gov/perm2014cycle3web/> to access the webinar.

### **Wednesday, July 16, 2014 noon-1 p.m. Pacific Time**

The two-step audio/webinar process is:

1. **Audio:** Login to <https://cms.webex.com/cms/j.php?J=997166126>. The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to <https://webinar.cms.hhs.gov/perm2014cycle3web/> to access the webinar.

### **Wednesday, July 30, 2014 noon-1 p.m. Pacific Time**

The two-step audio/webinar process is:

1. **Audio:** Login to <https://cms.webex.com/cms/j.php?J=991531095>. The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to <https://webinar.cms.hhs.gov/perm2014cycle3web/> to access the webinar.

CMS encourages all participants to submit questions not addressed in the session to the dedicated PERM Provider email address at [PERMProviders@cms.hhs.gov](mailto:PERMProviders@cms.hhs.gov) or you may also contact your State PERM representatives with any questions and for information about education and training.

Please check the CMS Website and PERM Provider's page regularly for helpful education materials, FAQs and updates at <http://www.cms.gov/PERM>.

## *Implementation of the Use of ICD-10 Codes Delayed*

Congress has implemented a bill to delay the implementation of ICD-10 code sets, which were scheduled to be implemented on October 1, 2014. Nevada Medicaid/Nevada Check Up providers must continue to bill using ICD-9 codes until further notice. Web announcements at [www.medicaid.nv.gov](http://www.medicaid.nv.gov) will provide information regarding the implementation of ICD-10 codes.

## Verify Recipient Eligibility, Benefits and MCO or Fee-for-Service Enrollment Prior to Rendering Service

Each provider is responsible for verifying recipient eligibility prior to rendering service each time a service is provided. The Automated Response System (ARS) and the online Electronic Verification System (EVS) are useful tools in obtaining recipient eligibility, as well as recent payment details, claim status and prior authorization information. ARS and EVS are updated daily to reflect the most current information. A third option, a Swipe Card System, provides real-time access to verify recipient eligibility using the recipient's Medicaid ID card.

**Reminder:** EVS is useful in identifying if a recipient has dual Medicaid and Medicare benefits or if a recipient is enrolled in Fee-for-Service or a Managed Care Organization (MCO).

- **EVS:** To access EVS, visit the Nevada Medicaid website at [www.medicaid.nv.gov](http://www.medicaid.nv.gov). Select the "EVS" tab to review the User Manual and to register or login to EVS. EVS is available 24 hours a day, 7 days a week, except during maintenance periods. For assistance with obtaining a secured login, contact the HP Enterprise Services Field Representatives at [NevadaProviderTraining@hp.com](mailto:NevadaProviderTraining@hp.com) or by calling (877) 638-3472. Select option 2 for provider, then option 0, then option 4 for Provider Training.
- **ARS:** To access ARS, call (800) 942-6511. The ARS provides the same information as EVS, only via the phone. Your NPI/API is required to log on.
- **Swipe Card System:** To implement a swipe card system, please contact a swipe card vendor directly. Vendors that are certified to provide this service are listed in the Service Center Directory located on the Electronic Claims/EDI webpage.

During periods when the above tools are not functioning, providers may contact the Customer Service Center by calling (877) 638-3472. Select option 2 for provider, then option 0, then option 2. Please have your servicing NPI, or API, recipient's Medicaid ID and date of service for the claim available.

### *Tips for Completing and Submitting Paper Claim Forms*

Please review the following reminders for submitting paper claim forms to HP Enterprise Services to help ensure your claim is processed quickly and correctly:

- Reasons why a paper claim form will be returned to you to resubmit may include but are not limited to:
  - ✓ Missing signature on the ADA or CMS-1500 claim forms.
  - ✓ Claim is not legible, i.e., the type is smudged and is not legible.
  - ✓ Data on the claim has shifted and is not aligned within the fields.
  - ✓ The provider's National Provider Identifier (NPI) is missing.
  - ✓ The balance due, total fee or amount due is missing on the claim form.
- The Explanation of Benefits (EOB), just like the claim form, must be suitable for scanning so that data can be accurately captured. If the data is printed too light or is smudged, the claim will be returned to you.
- Any correspondence must be sent along with the related claims submission or claim appeals requests. If you send only the supporting documents, such as your letter and EOB, the documents will be returned to you.
- Be sure that your billing address and phone number are entered and accurate on your claim form.

### Providers are Required to Report Contact and Address Changes within 5 Days

Providers are required to ensure that their current contact information and physical address are on file with HP Enterprise Services (HPES). Changes to enrollment information after you enroll (except changes in business ownership) must be updated via form FA-33 within five (5) business days of the change. Business ownership changes must be reported within five (5) business days by resubmitting a complete, new set of enrollment documents and a copy of the purchase agreement.

[FA-33 – Provider Information Change Form](#) – is available on the [Provider Enrollment](#) webpage and the [Provider Forms](#) webpage at [www.medicaid.nv.gov](http://www.medicaid.nv.gov). The form can be faxed to (775) 335-8593 or mailed to HP Enterprise Services, Provider Enrollment, P.O. Box 30042, Reno NV 89520-3042.

# CAQH CORE® Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rules Implemented

The Operating Rules for the Council of Affordable Quality Healthcare (CAQH) Committee on Operating Rules for the Information Exchange (CORE®) Phase III has been implemented for Nevada Medicaid/Nevada Check Up. The Patient Protection and Affordable Care Act (ACA) require implementation of CAQH CORE Operating Rules. The original implementation date of January 2014 was delayed until March 2014.

CAQH CORE Phase III Operating Rules support Electronic Funds Transfer (EFT) and health care payment and Electronic Remittance Advice (ERA) transactions. The Rules encourage entities to use the infrastructure they have for eligibility and claim status and apply it to the health care claim payment/advice. In order to electronically process an 835, health plans and providers need to have a detailed 835 record.

## CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule:

Due to the Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Nevada must comply with the Healthcare EFT Standards:

- No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date
- AND
- No later than three business days after the CCD+ Effective Entry Date

**With the implementation of CAQH CORE III, trading partners and providers no longer have their 835 transactions available on the Monday prior to their EFT Effective Date.** The Electronic Remittance Advice is now available on the Wednesday, at 12:01 a.m. Pacific Time, prior to the EFT Effective date. This change is mandatory to keep Nevada Medicaid/Nevada Check Up compliant.

## CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule:

The Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advise Remark Codes (RARCs) Rule establishes data content rule requirements for conducting the v5010 X12 835 transaction (ERA). The v5010 X12 835 provides data to the provider regarding the payment of a claim including why the total charges originally submitted on a claim have not been paid in full or a claim has been denied. The denial or adjustment of a claim is identified by the health plan using combinations of four claim denial/adjustment code sets that, when used in combination,

should supply the provider with necessary detail regarding the payment of the claim. These code sets are Claim Adjustment Reason Codes (CARCs), Remittance Advise Remark Codes (RARCs), Claim Adjustment Group Codes (CAGCs) and NCPDP External Code List Reject Codes (NCPDP Reject Codes).

CORE determined that the healthcare industry requires operating rules establishing data content requirements for the consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes when transmitting the v5010 X12 835. Consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes for electronic reporting of claims adjustment and denials will help to mitigate:

- Unnecessary manual provider follow-up
- Faulty electronic secondary billing
- Inappropriate write-offs of billable charges
- Incorrect billing of patients for co-pays and deductibles
- Posting delays

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans and/or patients
- More accurate and efficient payment of claims

Achieving a consistent and uniform approach in such a complex area requires using a multi-step process that is focused on actively enabling the industry to reach its long-term goal of a maximum set of CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC combinations. This initial rule provides a clear set of reasonable and well-researched requirements and a process to create future requirements that are based upon real-world results. Trading partners and providers will begin to see updated CARC/RARC code combinations on their 835 transactions as a result of the implementation of Rule 360.

## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$474,371,510.80 in claims during the three-month period of October, November and December 2013. Nearly 100 percent of current claims continue to be adjudicated within 30 days. DHCFP and HPES thank you for participating in Nevada Medicaid and Nevada Check Up.

## Reminder for Current Providers: Ordering, Prescribing or Referring Providers Will Need to Enroll in Nevada Medicaid/Nevada Check Up

The Division of Health Care Financing and Policy (DHCFP) is actively working on the implementation of the new requirement for all ordering, prescribing and referring physicians to be enrolled in Nevada Medicaid/Nevada Check Up to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. This requirement is part of the Patient Protection and Affordable Care Act (§455.410 Enrollment and Screening of Providers).

**Web announcements regarding the effective date will be published at [www.medicaid.nv.gov](http://www.medicaid.nv.gov).**

Physicians or other eligible professionals who are already fully enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as ordering, prescribing or referring (OPR) providers.

OPR providers do not bill Nevada Medicaid for services rendered, but may order, prescribe or refer services/supplies for Medicaid recipients.

Enrolling as an OPR provider is appropriate for practitioners who:

- May occasionally see an individual who is a Medicaid recipient who needs additional services or supplies that will be covered by the Medicaid program
- Do not want to be enrolled as another Nevada Medicaid provider type
- Do not plan to submit claims for payment of services rendered

Physicians, other practitioners and facilities who actually render services to Medicaid recipients based on an order, prescription or referral, will not be paid for such items or services unless the OPR provider is enrolled in Medicaid and the OPR's NPI is included on the claim submitted to Medicaid by the rendering provider (42 CFR 455.440).

Please note that this ACA requirement extends to pharmacy Point of Sale (POS) systems as well. The POS system will deny, at the time of the pharmacy transaction, any claims submitted for a Medicaid recipient with a prescriber who is not enrolled either as a fully participating or OPR Medicaid provider.

### *Fax Prior Authorization Requests on Clean Forms*

Providers who fax prior authorization requests are reminded to use fresh, clean forms and to write legibly. Pre-filled, hand-written forms that are used multiple times may become illegible. Most forms on the website are active, which means you can type the information into the form and print the form for faxing.

Prior authorization forms are available on the Providers Forms webpage at <https://www.medicaid.nv.gov/providers/forms/forms.aspx>

Providers are encouraged to register to use the online prior authorization system. Visit [www.medicaid.nv.gov](http://www.medicaid.nv.gov) and from the "Prior Authorization" tab, select "PA

Login." Quick reference guides are available on the "PA Login" webpage and a tutorial is available by selecting "PA Tutorials" from the "Prior Authorization" tab. For assistance registering, contact the HPES Provider Services Field Representative team at [NevadaProviderTraining@hp.com](mailto:NevadaProviderTraining@hp.com). The Provider Services Field Representatives conduct workshops that include prior authorization submission training. Please review [Web Announcement 714](#) for times, dates and locations for the next training sessions.

Please note: Provider types 22, 30, 39 and 83 should continue to fax prior authorizations as usual.

### Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact HPES by calling (877) 638-3472, press option 2 for providers, then option 0, then option 2 for claim status.

If you have a question about Medicaid Service Policy or Rates, you can go to the DHCFP website at <http://dhcfp.nv.gov>. Under the "DHCFP Index" box, move your cursor over "Contact Us" and select "[Main Phone Numbers](#)." Call the Administration Office of the area you would like to contact.