

Nevada Medicaid News

SPRING 2004

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* Reminder *

Check Recipient Eligibility Every Time

By Internet:
Use the Electronic Verification System (EVS) at the <https://medicaid.nv.gov> website. Select "Providers," then pull down to EVS Logon.

By Telephone:
Call the Automated Response System (ARS) at 1-800-942-6511.

Remember to put in the date ranges for the period you are checking from the first of the month to the last day of the same month.



**First Health
Services Corporation®**

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Welcome:

The State of Nevada's Division of Health Care Financing and Policy (DHCFP) and First Health Services Corporation welcome all providers to your first newsletter, which is filled with articles and tips that will keep you informed about Nevada Medicaid happenings.

As you are well aware, since Oct. 1, 2003, the Nevada Medicaid and Nevada Check Up programs have been undergoing significant changes, including a new fiscal agent contractor, a new system, new policies and billing procedures, new reimbursement rates, and the implementation of Federal requirements for the Health Insurance Portability and Accountability Act (HIPAA).

We would like to extend our thanks to all providers and staff for your patience and cooperation in this process, and assure you that we are continuing to work very hard to make the Nevada Medicaid program one of the best in the nation.

As we move through 2004, you will continue to see improvements in the Nevada Medicaid and Nevada Check Up programs. We will keep you updated on these improvements through letters, remittance advice messages, and e-mail when applicable. We also recommend that you visit the First Health Services website weekly to keep up-to-date on the latest news and policy: <https://medicaid.nv.gov>. Weekly Web Announcements are posted on the home page and all past announcements can be reviewed by selecting "Newsletters/Announcements" from the "Providers" drop-down menu. Many documents and forms have been updated since Oct. 1, 2003. Please verify that you are using the correct version of all forms. Again, we thank you all for your continued diligence and dedication to the Nevada Medicaid and Nevada Check Up recipients as we move forward. If you have any questions or suggestions, please do not hesitate to contact our Customer Service Center at (877) NEV-FHSC (877-638-3472) or e-mail nevadamedicaid@fhsc.com.

First Health Services Corporation

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Website Updated Weekly

The First Health Services website provides you with access to important information regarding the Nevada Medicaid and Nevada Check Up programs. We update the website regularly and recommend that you visit it weekly to keep up-to-date on the most current Medicaid news and policy.

To go to the First Health Services website, open your web browser. The website is best viewed with Internet Explorer, version 6.0 or higher. Type “<https://medicaid.nv.gov>” (without the quotation marks) into the Address Bar, and then click the Go button on the right side of your screen.

The website will open to the Home page. Here you will find the most current web announcement(s) and across the top the Navigation Bar will list the web pages you may open. The choices on the Navigation Bar are: Providers, Pharmacy, Quick Links, Search and Contact Us. Hold your mouse pointer over any of these items, and a drop-down menu appears. Then, move your mouse pointer over the drop-down menu item you wish to select, and click to go to that web page.

The “**Providers**” drop-down menu will provide you with access to current and archived web announcements; billing manuals, appendices and manual revision histories; information regarding electronic billing; electronic verification system to check recipient eligibility; forms you need to interface with First Health Services; documents for requesting prior, retrospective or concurrent authorization; training seminars and contact information; and a list of types of claims that are being or will be recycled.

The “**Pharmacy**” drop-down menu will provide access to the claims processing manual for pharmacy providers; the list of drug classes scheduled for review; Maximum Allowable Cost document requests; Maximum Allowable Cost list; and an introduction to the Preferred Drug List program.

The “**Quick Links**” drop-down menu will provide access to the form used to change provider, business or facility information; links for local and national codes to comply with the Health Insurance Portability and Accountability Act (HIPAA); link to the State of Nevada’s Division of Health Care Financing and Policy (Nevada Medicaid) website; frequently asked questions regarding Nevada Medicaid; and application forms needed for provider enrollment in the Nevada Medicaid program.

The “**Search**” drop-down menu will help you find specific documents on the website.

The “**Contact Us**” drop-down menu is the place on the website to find contact names, mailing addresses, telephone numbers and e-mail addresses for the various First Health Services departments. Just click on the department you want to contact.

Training for Providers and Billing Staff

First Health Services provides training seminars and one-on-one training sessions for providers and billing staff to explain Nevada Medicaid and Nevada Check Up billing procedures.

Upcoming seminar schedules are posted on the First Health Services website and are included in your Remittance Advice messages as they become available.

Training topics include:

- Submitting Prior Authorization Requests.
- Electronic Data Interchange (EDI).
- Recipient Eligibility Verification.
- Billing Guidelines.
- Electronic Funds Transfer.
- Using the First Health Services website.
- Understanding the Remittance Advice form.

Call our Provider Training Unit at (877) NEV-FHSC (877-638-3472) to schedule a training session.

Plastic Nevada Medicaid and Nevada Check Up Cards

In 2003, plastic Nevada Medicaid and Nevada Check Up cards were issued for each eligible recipient to replace the paper Medicaid cards previously issued. As of January 2004, all paper cards are obsolete. The new plastic Medicaid cards are valid as long as the individual is qualified for medical assistance through Nevada Medicaid. The new plastic cards differ from the paper versions in that they do not include dates of recipient eligibility. **Recipient eligibility must be verified each time a service is rendered**, as discussed in the Recipient Eligibility chapter of the Provider Billing Manuals.

Reading Your Remittance Advice

First Health Services Corporation generates a Remittance Advice (RA) report for all Nevada Medicaid and Nevada Check Up providers with claims activity in a given week.

The RA details the status and determination of all claims and the amount of payment to be received for services rendered. An RA is a tool that enables First Health Services to provide feedback to you on a weekly basis regarding claims you have submitted and activity on your account.

The format First Health Services uses to create RAs is designed to simplify the process. Instead of issuing remittances one week and transaction records the next week, we combine the reports by placing everything you need to know all in one document.

If you have been a Nevada Medicaid provider since First Health Services became the fiscal agent on Oct. 1, 2003, then your RAs list transactions that go back to Oct. 1, 2003. Don't let the

amount of information confuse you – it is meant to provide a good reference for you to determine billing procedures and records on services rendered to Medicaid recipients.

The first page of a remittance advice is always a check if you have one coming to you for that week. The first page also includes valuable, timely information directly related to your provider type, such as changes in program coverage or rules, billing procedures, helpful reminders and training schedules. Each time you receive a remittance check, be sure to read the message area. The RA is a fast, efficient way we can keep you informed on a weekly basis.

Page 2 of the RA is where all of the details begin that pertain to your account for the week. The top left corner first lists a number and date that tell us the RA number, page number, payment cycle date and time the RA was processed. This corner also lists your nine-digit Provider Medicaid Number (payee ID) and your address. The remittance date and number on the right side of the page are the numbers to refer to when you call the Customer Service Department at First Health Services to answer any of your questions regarding the current remittance.

Directly under your information we show a legend that guides you through each line and field on that page. The level of service a professional medical provider renders differs from a facility provider, which means the legends also differ. Please note that we fill in only the fields that pertain to that recipient and services rendered to that recipient. At the end of this article you will find definitions of fields found on remittance advices.

The Claims Status pages detail each denied, pended and approved claim.

DENIED CLAIMS – This record is provided to you so you can review the reason the claim was denied and compare the denial reason with your record. For example, if the claim denied because the recipient was not eligible for Medicaid on the date of service, check your records for any information on the recipient’s eligibility and verify that the correct date of service was entered on the claim. If the recipient was not eligible for Medicaid, please make note of the denial for your records.

PENDED CLAIMS – Claims “pend” when First Health Services needs to manually review the claim or determine the reason the claim was not accepted by the Medicaid Management Information System (MMIS). While a claim is pending, no action is required by you. It is advisable for you to review this section and watch subsequent RAs for information on these claims.

If First Health Services pends the claim for review and determines that no additional information is needed from you, the claim will continue to be processed. If there are no issues with the claim, it will show as paid on a subsequent RA. If we need additional or corrected information, you will be notified.

APPROVED CLAIMS – We suggest you review the amount paid for each service and post claims as paid for your records. The report will show a trace number for an EFT (electronically transferred funds) transaction and a check number for a paper check.

Please note: when you submit CMS-1500 forms, we treat each line as a claim. One service you provide to a recipient may be denied, another service to that same recipient may pend, and yet another service to that same recipient may be approved and remitted to you. Be sure to look in each section to get the full picture on payment for services rendered to one recipient.

FINANCIAL – A benefit to the financial section of an RA is that we provide a full record of all financial transactions, not just the remittance for that week. All information and every transaction are documented.

The Claim Transaction section lists amounts billed for each category – approved, pended and denied – and the amount paid for each. The Financial Transaction section details balances affected by voided checks, add-pays and cutbacks.

If an overpayment has occurred, First Health Services will notify you through your Remittance Advice within 120 days of the overpayment. The RA will specify the actions taken to correct the overpayment through a recoupment transaction. Overpayments may occur when Medicaid reimburses you for a non-covered service; a service without prior authorization; an amount you had identified as an overpayment; an excessive amount as a result of automated claim processing error or omission; among other possible reasons.

SUMMARY – The summary page shows:

- Total number of claims that were approved, pended and denied.
- Adjustment debits and credits.
- Void and refund checks credited.
- Negative balance activity (prepayment for claims that are pending in the system).
- Any add-pays and/or recoupments applied during the payment cycle.
- Notification and the need for a claim to be resubmitted or voided.

Don't skip the pages toward the back of the document that list the Explanation of Benefits (EOB) codes and descriptions. These numbers explain the payment or nonpayment of a specific claim processed.

If you have questions or need an explanation about something on an RA you receive, call the First Health Services Customer Service Center at (877) NEV-FHSC (877-638-3472) or e-mail nevadamedicaid@fhsc.com, and please refer to the RA number in the top right corner.

The following lists the fields on remittance advices with descriptions of data we enter into each field.

Professional Medical Remittance Advice:

PATIENT NAME - the name of the recipient eligible for Medicaid programs.

PATIENT ID NUMBER - the recipient's 11-digit Nevada Medicaid or Nevada Check Up number issued by the DHCFP.

PT ACCT/RX NO - the provider's internal number to track the recipient.

ICN NUMBER - a transaction control number that identifies each claim transaction record.

FROM/THRU DATE - dates on which the service was first and last rendered.

PROC - the claim principal procedure code used to identify a specific procedure performed.

NDC # - an 11-digit National Drug Code sequence number.

MOD - the claims procedure code modifier; the standard HCFA or HCPCS modifier entered with the procedure code.

BILLED AMT - the charge submitted on a claim.

NON-COV-AMT - the amount of the billed charges that is not covered.

COVERED BY PGM - the calculated claim payment amount (before reductions due to co-pay, third-party liability, patient liability or denial).

DEDUCT/COINS - the deductible amount or the coinsurance amount entered on the crossover claim.

CO - the co-payment amount that the recipient has paid or is to pay on the claim.

PT PAY - amount the recipient is scheduled to pay per month while confined to a long-term care facility.

PRIM CAR PAY - the payment amount made by a third party toward a medical or dental claim.

TOOTH# - a code identifying the type and location of tooth treatment.

SURFACE - code identifying dental surface for treatment.

UNITS - number of units, visits or studies of the procedure performed by the provider.

PA NUMBER - a nine-digit number identifying prior authorization for a service.

FINANCIAL RSN CODE - a code specifying the reason for revising or voiding an individual claim.

TOTAL PAYMENT - claim payment amount for any claim.

LINE ITEM CONTROL NUMBER - the line number of each revenue code on the claim.

EOB CLAIM CODES - code assigned to each edit error identified in the processing of the claim.

Facility Remittance Advice:

PATIENT NAME - the name of the recipient eligible for Medicaid programs.

PATIENT ID NUMBER - the recipient's 11-digit Nevada Medicaid or Nevada Check Up number issued by the DHCFP.

PT CNTL NUMBER - the provider's internal number to track the recipient.

ICN NUMBER - a transaction control number that identifies each claim transaction record.

DRG PYMT - not applicable.

PRIM CAR PYMT - the payment amount made by a third party toward a medical claim.

TRANSFER AMT - not applicable.

ADMIT DATE - the date on which a recipient was admitted to a medical facility or the date on which service began.

PA NUMBER - a nine-digit number identifying prior authorization for a service.

FROM/THRU DATE - dates on which service was first and last rendered.

PRIN DIAG - diagnosis code identifies a diagnosed medical condition; the ICD-9-CM code structure is used.

DRG ASSIGNED - not applicable.

COINSURANCE - the coinsurance that was used to price the claim.

TOTAL CHGS - the charge submitted on a claim.

FINANCIAL RSN CODE - a code specifying the reason for requesting an adjustment or voiding an individual claim.

BILL TYPE - a code indicating the bill type of a facility claim (refers to the facility type, the billing classification of the provider and the billing frequency).

PMT - hospital days paid on the claim.

ELIG - number of hospital days for which recipient is eligible.

RED - the number of days that represent the reduction in payment days.

DRG WEIGHT - not applicable.

CAPITAL PYMT - the amount or percentage of the provider rate.

DEDUCTIBLE - the deductible amount entered on the Medicare crossover claim.

NCOV CHGS - the amount of the revenue-billed charges not covered by Medicaid. The provider enters this amount.

OTHER DIAGS - identifies a diagnosed medical condition; the ICD-9-CM coding structure is used.

PRIN PROC - code used to identify a specific dental, medical, revenue or ICD-9-CM diagnosis/surgical procedure.

OUTLIER PYMT - not applicable.

CO PAY - not applicable.

PT PAY - amount the recipient is scheduled to pay per month while confined to a long-term care facility.

OTHER PROCS - code used to identify a specific dental, medical, revenue or ICD-9-CM diagnosis/surgical procedure.

TENT CONTR ADJ - the difference between the claim payment amount and the billed amount.

COVD BY PROGRAM - the calculated claim payment amount (before reductions due to copay, third-party liability, patient liability or denial).

NET TENT REIM - claim payment amount for any claim.

LINE ITEM CONTROL NUMBER - the line number of each revenue code on the claim.

EOB CLAIM CODES - code assigned to each edit error identified in the processing of the claim.

Financial Terms - The following are terms that may appear in the financial section of your remittance advice:

REV - a code that defines a specific accommodation, ancillary service or billing calculation.

REV-BILLED-AMT - total charges pertaining to related revenue codes for current billing period.

NON-COV-AMT - the amount of the revenue-billed charges that is not covered. This amount is entered by the provider.

REV-ALLWED-AMT - claim revenue line allowed amount.

CUTBACK-UNITS - the number of units or days reduced on the claim so that it could be paid without exceeding service or prior authorization limits.

CUTBACK-AMT - the charge amount reduced on the claim so that it could be paid without exceeding service or prior authorization limits or eligibility dates.

TPL INFO - policy number (the number assigned to the policy by the third party insurance carrier).

CARRIER NAME - the name of the TPL carrier to whom inquiries should be made.

CLAIMS LINES - the total number of claim lines for original, approved, pended and denied adjustments/debits and credits, the capitation payment and case management for this remittance advice.

AMOUNTS BILLED - total dollar billed amount for original, adjustment, capitation payments and case management claims for this remittance advice.

AMOUNT - total dollar paid amounts for original claims, adjustment claims, capitation payment claims and case management claims for this remittance advice.

PRIOR BALANCE - reflects the prior negative balance of monies owed to Nevada Medicaid by the provider for this remittance advice.

CYCLE INCREASE - the amount the negative balance increased during the current weekly cycle.

CYCLE DECREASE - the amount the negative balance decreased during the current weekly cycle.

NET CYCLE - the total sum of the increase/decrease to the negative balance for this remittance advice.

CURRENT BALANCE - the difference between the prior balance and the net cycle for this remittance advice.

NET CLAIMS TOTAL/#CLAIMS - the total number of claim lines for the claim transaction for this remittance advice.

NET CLAIMS TOTAL/AMOUNTS/BILLED - total billed dollar amounts for the claim transaction for this remittance advice.

NET CLAIMS TOTAL/AMOUNTS/PAID - total paid dollar amounts for the claim transaction for this remittance advice.

NET CLAIMS - the total sum of claim transaction originals and adjustments for this remittance advice.

ADD-PAYS - the total sum of add-pay transactions for this remittance advice.

NEGATIVE BALANCE - the amount of the negative balance recouped during the current weekly cycle run for this remittance advice.

PROGRAM TOTAL - total sum of the net claims plus the add pays less negative balance dollar amounts for a specific program for this remittance advice.

YEAR-TO-DATE TOTAL PAID - total dollar amount paid to the provider's 1099 for the current year.

Tips to Avoid Billing Errors

The following tips will help you avoid some common claim billing errors.

Procedure Code Descriptions Are Unnecessary: Procedure code descriptions on your claim form are unnecessary. They cause the claim to be scanned incorrectly and delay the processing of your claim. Please enter the Procedure code in the proper field and omit any descriptions. The only exception being the inclusion of a description on the claim for unlisted or miscellaneous procedures.

Entering Third Party Payment Amounts on the Claim Form: If you received payment from another insurance carrier, you must enter the amount paid by the other carrier on your claim to Medicaid. Enter this amount in Field 29 for CMS-1500 claims and Field 54 for UB-92 claims, and include the Explanation of Benefits from the primary payor.

Entering Your Provider Medicaid Number on Claim Forms: Under the new Medicaid Management Information System (MMIS), all Provider Medicaid Numbers are numeric. Do not use alpha characters or hyphens when entering your number on a claim form, otherwise your claim will be denied or returned to you for correction. For example, 123456789 shows a correct nine-digit Provider Medicaid Number, with no spaces, no letters and no hyphens.

When submitting a CMS-1500 claim form: You must enter your nine-digit servicing (rendering) Provider Medicaid Number in column 24K. When the servicing provider is not a member of a provider group (provider groups have their own Group Medicaid ID Number), enter the same number from column 24K into the GRP# area of Field 33. Please note that if no Provider Medicaid Number is entered in column 24K, the claim will be denied. Leave blank the area of Field 33 marked PIN#. Do not enter any other information (such as zip codes or phone numbers) in any area of this field.

Claim Attachments: It is not necessary to submit copies of Medicaid cards, printouts of recipient eligibility verification, or medical reports with your claim. The only necessary claim attachments are the following:

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- A copy of the third party insurance carrier's Explanation of Benefits (EOB), when the recipient has Third Party Liability (TPL). You must mail the EOB to First Health Services regardless of whether you are submitting a hard copy or electronic claim, and also regardless of whether the third party insurance carrier has approved or denied your claim to them.
 - Federal Sterilization Consent Form, when applicable.
 - Hysterectomy Acknowledgement (FH-50 or FH-51), when applicable.
 - Abortion Affidavit (FH-52 or FH-53) or Abortion Declaration (FH-54 or FH-55), when applicable.

Medicare Crossover Claims: You now have two options for submitting Medicare Crossover Claims to First Health Services. You may submit a CMS-1500 or UB-92 claim form with a copy of your Medicare EOB, **or** you may submit the Medicare Crossover Claim Form (FH-40). If you submit form FH-40, there is no need to include a copy of your Medicare EOB.

Correct Version of the ADA Claim Form: When submitting claims for dental services, make sure you are using the proper version of the American Dental Association (ADA) claim form. Do not use the ADS 85 version of the dental claim form or the new 2004 ADA form (yet), as we cannot process claims on these forms. The use of all other ADA claim form versions, the 1999 version or the 1999 version 2000 or the revision 2000, or any revision thereof, however, is acceptable.

Nursing Facility Claim Submission Tips: Use only those Revenue codes listed in the Nursing Facilities section of Chapter C in the UB-92 Provider Billing Manual. Please note that state-devised codes are no longer valid. Your claim will be denied if state-devised codes are used.

Certain out-of-state Nursing Facilities: May be required to enter a Prior Authorization (PA) number on their claim form to obtain a differential rate; however, a PA number is not required on claims submitted by in-state Nursing Facilities.

Field 57 on the UB-92 claim form: Is used to enter the amount of "voluntary payment" you received from the recipient. Do not enter the amount of patient liability on your claim form.

Billing manuals and appendices are located on the First Health Services website at <https://medicaid.nv.gov> under the "Providers" drop-down menu. Refer to the "Instructions for Completing the UB-92 Claim Form" starting on page 17 of the UB-92 Provider Billing Manual. Also, see Appendix B of the Provider Billing Manual for valid codes to be used in UB-92 claim form Fields 22, 24b and 24c.

PASRR News Update

The Division of Health Care Financing and Policy (DHCFP) and First Health Services are working together to improve the Pre-Admission and Resident Review (PASRR) evaluation process and to comply with federally mandated timeframes.

Beginning Feb. 1, 2004, providers saw a few changes in the PASRR II evaluation process including new faces conducting PASRR II evaluations in their facilities. Providers may also notice changes in the forms they receive after PASRR II evaluations are completed. With these changes, we expect PASRR II evaluations to be completed more promptly, especially in the rural areas. Also, shortened acute hospital stays and more timely placements are expected as a result of the new processes.

Please note that there is no change to the current procedure for submitting PASRR screening requests, which should be sent to First Health Services as usual.

Please refer to the DHCFP website at <http://dhcfp.state.nv.us> and select the “Providers” option for further details. You may also contact Kay Panelli, DHCFP, at (775) 684-3757 or Patsy Trent, First Health Services, at 1-800-525-2395 ext. 4947 or (804) 968-4947 if you have any questions regarding these changes.

Pharmacy News Update

Nevada’s Medicaid Maximum Allowable Cost (MAC) list, which sets provider reimbursement limits on commonly prescribed generic drugs, was implemented Dec. 17, 2003. Updated monthly, the Nevada Medicaid MAC list is available on First Health Services’ website at <https://medicaid.nv.gov>. (Select “Pharmacy” from the Navigation Bar.)

Assembly Bill 384, a law passed by the Nevada Legislature during the 2003 session, requires the Nevada Medicaid and Nevada Check Up programs to develop a list of preferred prescription drugs. The implementation of a Nevada Medicaid Preferred Drug List (PDL) will accomplish these requirements.

The State of Nevada’s Division of Health Care Financing and Policy’s Pharmacy & Therapeutics Committee is directing the implementation process. During the phase-in process, each drug class is reviewed and approved for the PDL. Thirty days after a drug’s approval, “soft edits” will be implemented, which allow a prescription to be filled, but includes a POS terminal message to the provider indicating that this drug must be changed to a drug on the PDL, or prior authorization will be required for the next refill. “Hard edits” will be put into practice 30 days after implementation of the “soft edits.” A “hard edit” will not allow the prescription to be filled without changing to a drug on the PDL or obtaining prior authorization from First Health Services’ Pharmacy Department.

The PDL program and the Drug Class Review Schedule are posted under “Pharmacy” on First Health Services’ website at <https://medicaid.nv.gov>.

Electronic Billing Speeds Payments

First Health Services is continuing to enroll providers and to certify Service Centers (or clearinghouses) to submit electronic claims. The benefit to submitting claims electronically is a faster turnaround time for your payment. Most valid claims submitted electronically can be paid within the same billing cycle (7 to 10 days). Valid claims submitted manually are usually processed and paid in 10 to 20 days.

If you have not yet enrolled to bill electronically, you can do so by completing forms located on the First Health Services website. To enroll, all providers must complete form FH-37. If you plan to use Payerpath as your Service Center (a free service for all Nevada Medicaid providers), you will also need to complete form FH-39. A link to the Payerpath product demonstration and a training program are available on our website at <https://medicaid.nv.gov> by selecting “Electronic Claims / EDI” from the “Providers” drop-down menu.

Both you and your Service Center (clearinghouse) must submit the proper forms to First Health Services in order for you to submit your claims electronically. A list of HIPAA-certified clearinghouses appears on our website. If you have received a Remittance Advice showing a 0961 code, contact the EDI Department for assistance. The 0961 code indicates that you are not properly enrolled to bill electronically.