

# Nevada Medicaid News

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## Reminders and Useful Tips for Completing Claim Forms

Following are some reminders to all Nevada Medicaid and Nevada Check Up providers to avoid claim billing errors. While incomplete claims have steadily decreased since December, a small number of claims are still rejected due to lack of provider number, recipient number or other key data. Please review the following list and double check each point to help us process your claims as quickly as possible.

**Provider Signature:** Please make sure the claim form has been signed by the provider. Without the provider signature, the claim will be returned.

**Illegible Claims:** Once we receive the claim forms, we scan them electronically into our system. If the ink or type is too faded, the image will not be read accurately by the scanner, and these illegible claims will deny.

**Accurate Provider Numbers:** Provider numbers are nine digits in length with no letters, no dashes, no backslashes and no spaces.

**UB-92 Claim Forms:** Every claim line on a UB-92 form must be correct or the entire claim will deny since everything references something else on the page. Please double check each line for accuracy.

**Claim Reminder for PT12:** Outpatient Hospital Providers (Provider Type 12) who render outpatient services are required to bill with a revenue code AND a procedure code (CPT or HCPCS) on each line of the UB-92 claim form. (See Fields 42 REV.CD. and 44 HCPCS/RATES.) The procedure code, not the revenue code, determines the rate of payment for the services rendered. Without the appropriate procedure code, the claim will deny.

**Adult Day Health Care (ADHC):** ADHC providers now use HCPCS code S5100 exclusively for Prior Authorization requests for services, instead of the HCPCS code S5102. This change went into effect May 1, 2004.

**Prior Authorizations:** When you receive Prior Authorization (PA) for a procedure, be sure to use that same PA number on your claim form as well as the correct revenue, HCPCS, CPT or ADA code for the procedure for which you are billing.

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## Provider Billing Manuals Revised

As progress continues toward full implementation of the Nevada Medicaid Management Information System (MMIS), First Health Services is making changes to the billing manuals that providers turn to for instructions on filing claims. These changes may reflect State policy changes or clarification of billing procedures.

First, the billing manuals can be accessed online from the <https://medicaid.nv.gov> homepage by selecting “Billing Manuals” under the “Providers” drop-down menu. The “Provider Manuals” page offers links to the CMS-1500, Dental, Pharmacy, and UB-92 provider billing manuals.

Each manual is posted in its entirety, along with appendices. If you already have a print copy of the manual, you can review the “Revision History” pages, which detail the sections of each manual that have been updated. You may print out the revised portions to compare to, or replace, your pages of the manuals.

The following is an example of an update listed on the “Revision History” page of the Dental Provider Billing Manual:

**April 20, 2004:** “Chapter C – Dental Services” was revised. This includes instructions for completing the ADA claim form and Nevada Medicaid covered dental codes.

The recently completed Electronic Verification System (EVS) User Manual is accessed by selecting “EVS User Manual” under the “Providers” drop-down menu. The EVS User Manual provides instructions on accessing: recipient eligibility and service limits; the status of submitted claims and prior authorization requests; provider payment amounts; and prescribing provider information (for pharmacy providers).

## Check Recipient Eligibility Every Time

### By Internet:

Use the Electronic Verification System (EVS) online at <https://medicaid.nv.gov> by selecting “EVS Logon” under the “Providers” drop-down menu.

### By Telephone:

Call the Automated Response System (ARS) at (800) 942-6511. Please listen to the entire message to determine your correct responses.

### Remember:

- Enter the date ranges for the period you are checking from the first of the month to the last day of the same month.
- If a recipient is not eligible on the date of service, then the claim will be denied.
- The verification number you are given is for your files and should not be entered on the claim form.

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# Nevada Medicaid Preferred Drug List Implementation

The Nevada Division of Health Care Financing and Policy (DHCFP), in conjunction with First Health Services Corporation, will begin implementing the Preferred Drug List (PDL) on August 17, 2004.

On August 17th, soft edits will begin for all classes on the PDL. Soft edits will allow the prescription to be filled, but will come back with the following message: **“Effective (date to be entered), this drug will require prior authorization. Please have the prescriber contact First Health Services at 1-800-505-9185.”** This telephone number connects the prescriber to First Health Services’ Clinical Call Center to obtain a prior authorization.

Beginning August 25th, hard edits will begin for the first phase of drugs to be implemented on the list. Hard edits will send the message: **“Non-preferred drugs require prior authorization at the point of sale.”** At this time the prescriber will need to change to a preferred drug or contact First Health Services for a prior authorization. The three-part phase-in for hard edits is as follows: August 25th, September 8th and September 22nd. Additional information on the drug classes to be phased in will be available online at <https://medicaid.nv.gov> under the “Pharmacy” tab.

First Health Services will present one-hour educational sessions addressing the impact this initiative will have on providers and recipients. Topics will include the drug selection and prior authorization processes. Session dates are:

**Monday, August 2nd: Carson City**

National Guard Armory Auditorium  
2460 Fairview Drive (enter off Carson St.)  
Carson City, NV

**Wednesday, August 4th: Reno**

Washoe Medical Center  
Mack Auditorium  
77 Pringle Way, Reno, NV

**Thursday, August 5th: Las Vegas**

**Tuesday, August 10th: Las Vegas**

Las Vegas Chamber of Commerce  
3720 Howard Hughes Pkwy  
Las Vegas, NV

**Monday, August 9th: Elko**

Red Lion Inn  
2065 Idaho Street  
Elko, NV

All sessions listed above will begin at 7 p.m. Light refreshments will be provided. No advanced registration is required. If you have questions on the Las Vegas session, call Jamie Wyels at (702) 914-2131 or (702) 279-2489. For information on the Carson City, Reno and Elko sessions, call Dawn Daly at (775) 784-3906. Call Jamie or Dawn if you would like directions to the seminar locations.

In addition to the sessions listed above, a special session will be offered via videoconference for all rural providers at 2 p.m. on July 28th. Contact Dawn Daly at (775) 784-3906 for details.

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# Nevada Medicaid Issues and Resolutions

During the period January 2004 through May 2004, First Health Services Corporation paid out \$351 million to the provider community. This is \$13 million over the amount budgeted by the State. Part of this excess is due to processing of older claims.

Although good progress has been made, First Health Services Corporation realizes that the implementation phase of the Nevada Medicaid Management Information System (MMIS) has created some system and processing errors affecting claims payment and adjudication for Nevada Medicaid and Nevada Check Up providers. We apologize for the delays in processing claim payments. Over the past few months we have researched and resolved many of the problems, and send our thanks to all providers and their entire staffs for your patience and cooperation. Your efforts have helped us to eliminate the majority of the pended claims backlog.

The resolution and status of these issues have been reported to you on your Remittance Advices (RAs), by mailed letter, through the various provider associations, or by announcements posted on the homepage of our website: <https://medicaid.nv.gov>. The homepage also allows you to read all messages that have been posted, as well as provider newsletters, by clicking once on the "View all web announcements" link.

Following are some of the specific issues and their resolutions:

**Claims denied due to Edit Codes 0318 and 0983** (recipient not eligible on the date of service and recipient not found in system, respectively): First Health Services corrected an internal operational process that may have erroneously pended claims for Edit Codes 0318 and 0983. The week of April 26 we sent out communications on your Remittance Advice (RA) and posted a website announcement advising you to validate eligibility documentation and resubmit the claims with a cover letter referencing the edit code and date of your remittance advice. Your efforts in resubmitting claims with these edit codes helped us resolve this issue in a timely manner.

**Claims denied due to Edit Codes 0130 and 0729** (billing provider not on file or servicing provider not on file, respectively): Those providers who believed that they received claim denials with Edit Codes 0130 and 0729 in error were requested to ensure the forms were correct with the billing provider number in Field 33 GRP# and the servicing provider number in Field 24K on CMS-1500 claim forms. If the billing and servicing providers are the same, the same number would be entered in both boxes. The week of April 26, First Health Services advised providers (through a remittance advice message and web announcement) to resubmit the claims. First Health Services has been able to promptly adjudicate claims coming in with these fields correctly filled out.

**Recycles for Edit Code 0159** (provider number inconsistent with authorization): This recycle affected those practitioners filing a CMS-1500 claim form for services rendered in an inpatient hospital setting. We sent out a remittance advice message to these practitioners to not include the prior authorization number for the recipient's inpatient hospital stay on their CMS-1500 submissions. The only time it is appropriate to include a prior authorization number on a practitioner claim is when the services themselves, rendered by the practitioner, require prior authorization. First Health Services recycled (reprocessed claims through the system) these pended claims twice to facilitate claims adjudication and/or payment. Effective April 16, 2004, First Health Services is no longer accepting the inclusion of unnecessary prior authorization numbers on practitioner claims. Please adjust your billing practices accordingly.

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**Medicare crossover claims:** In an effort to be able to pay Medicare crossover claims efficiently, First Health Services has been updating provider information files. We mailed to all providers a letter dated May 19, 2004, along with a form requesting Title XVIII (Medicare) information, such as Name of Your Medicare Carrier and your Medicare Provider Number. Your Medicare Provider Number is the number that Medicaid uses to reimburse you for Medicare crossover claims, making it essential for claims payment that we have your Medicare Provider Number. Thank you for your prompt response to our request for information and documentation. If you do not bill Medicare, please disregard this request.

**Edit Codes 0301, 0302, 0249 and 0330** (duplicate of history file – same provider, same recipient, same date of service and same procedure, respectively): Duplicate information on claims has also been pending transactions. First Health Services detected the problem and recycled claims with these errors, instead of asking providers to resubmit claims. Be advised that future duplicate claims submitted will be denied. The first week in May we notified you about this recycle (through a Remittance Advice message and a web announcement) and that the status of the claims would be noted on upcoming Remittance Advices.

**Edit Codes 0002 and 0155** (special edit on HCFA claim for a third party liability amount and procedure requires authorization, respectively): In early May, First Health Services identified a large number of older claims that were pending due to Edit Codes 0002 and 0155. We corrected the database problem that created the pends, then we recycled the claims May 18th through May 21st. The results of these claims were reported on providers' remittance advices starting the following week.

**Edit Codes 0208 and 0308** (the payment request is past the filing limit and the payment request was filed past the filing time, respectively): Due to the backlog of claims pended for Edit Codes 0208 and 0308, First Health Services has appointed a special team to concentrate on manually reviewing and adjudicating the affected claims.

As we proceed with the MMIS implementation, one tool we are providing to you is our Claims Recycle Schedule posted on our website. The schedule lists edit codes that may be referenced on your Remittance Advice. Along with the edit code number, we provide a description of the code (such as "Recipient Not Eligible on Date of Service"), the provider types affected by that code, and the time line for recycling claims affected by each code. The time line refers to when First Health Services programmed our computers to correct the error and process the claims that may have been denied or pended due to the edit. To access the Claims Recycle Schedule at <https://medicaid.nv.gov>, select "Recycled Claims" under the "Providers" drop-down menu. First Health Services will update the schedule on a regular basis.

When you see edits listed on the Claims Recycle Schedule that affect you, look for the results of those edits on your Remittance Advice. Additionally, through Remittance Advice messages and/or website announcements, First Health Services will continue to keep you informed regarding recycles and edits, and advise you when action is required on your part.

Again, First Health Services thanks all providers and their staffs for their patience and cooperation. We will endeavor to keep you informed of issues and resolutions as we progress with the Nevada MMIS. If you have any questions or comments regarding the issues mentioned in this article, please call First Health Services' Customer Service Center at (877) NEV-FHSC (877-638-3472).

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## **Reminder**

In order for First Health Services to adjudicate Medicare crossover claims, we need to have the name of your Medicare carrier and your individual Medicare provider number in our files. If you have not returned the Medicare Information forms we mailed to all providers in May, please do so now. Any questions regarding this request can be directed to the First Health Services Customer Service Center at (877) 638-3472.