

Nevada Medicaid News

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**First Health
Services Corporation®**

Nevada Medicaid and Nevada Check Up
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National Provider Identifier (NPI) Update

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard unique health identifier for health care providers. The compliance date for all covered entities is **May 23, 2007**. Exception: small health plans do not need to comply until **May 23, 2008**. When the NPI is implemented, covered entities will use only the NPI to identify health care providers in all standard transactions.

The Nevada Division of Health Care Financing and Policy (DHCFP) and First Health Services Corporation are working together to define the billing procedure changes that will be required to meet the HHS deadlines.

Please note that while you may start applying for NPI's on May 23, 2005, DHCFP and First Health Services will not accept claims with NPI until May 23, 2007. You should continue to use your Nevada Provider Medicaid Number until we notify you to begin using NPI.

Watch for more updates on NPI in this quarterly newsletter.

Quarterly Update on Claims Paid

Nearly 100 percent of current Nevada Medicaid and Nevada Check Up claims continue to be adjudicated within 30 days. The State Medicaid program paid out to providers more than \$258,730,989 in claims during the three-month period of January, February and March 2005.

The efforts of all providers help to ensure that the State Medicaid program is available and beneficial to Nevada's residents. The Nevada Division of Health Care Financing and Policy and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

Online Option Available for Prior Authorization Requests

First Health Services has implemented a new Online Prior Authorization System for Nevada Medicaid and Nevada Check Up providers. The Nevada Division of Health Care Financing and Policy (DHCFP) approves and supports this program, which is compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Fax and telephone options for requesting a prior authorization (PA) remain in place, but providers using the system are

experiencing many significant advantages by being able to perform the following functions:

- Submit prior authorization requests electronically through a secure website.
- Access the system 24 hours a day, 7 days a week.
- Submit additional information electronically when requested by First Health Services.
- Check the status of a prior authorization request.
- Look up prior authorization numbers.
- Manage the prior authorization process with greater efficiency.
- Eliminate fax backs and fax and telephone issues (illegible handwriting or missed calls).
- Use convenient drop-down fields for Current Procedural Terminology (CPT) and Diagnosis (DX) codes.
- Submit more complete requests due to required fields.
- Receive quicker responses for insufficient information.
- Access preloaded provider and recipient demographic information.
- Receive eligibility confirmation.
- Access PA history.

The system is currently available for the following Provider Types: **10** (Outpatient Surgery, Hospital Based), **11** (Hospital, Inpatient), **12** (Hospital, Outpatient), **17** (Special Clinics), **21** (Podiatrist), **23** (Hearing Aid Dispenser and Related Supplies), **25** (Optometrist), **27** (Radiology/Noninvasive Diagnosis Centers), **29** (Home Health Agency), **33** (Durable Medical Equipment, Disposable, Prosthetics), **34** (Therapy), **36** (Chiropractor), **37** (Intravenous Therapy TPN), **41** (Optician, Optical Business), **44** (Swing-bed, Acute Hospital), **46** (Ambulatory Surgical Centers), **55** (Transitional Rehabilitative Center, Outpatient), **56** (Medical Hospital,

“The Online PA system has allowed us to track ongoing authorizations in a more timely manner. It has also allowed us to respond to requests for more information or changes using the online system. This shortens the determination period and allows better communication with the PA department. We are excited about the new online system, and plan to utilize it to the fullest extent. The review staff has been excellent to work with and always willing to assist us as we make this transition. We appreciate any technology that allows us to be more efficient, and look forward to improvements that mutually benefit our companies.”

Rick Graver, ATS, CRTS
Owner, Medtech Services Inc.

Rehabilitation or Specialty, Inpatient), **75** (Critical Access Hospital, Inpatient) and **76** (Audiologist).

Additional provider types will be phased in over the next few months.

If you are one of the provider types listed above and have not received registration information to participate in the Online Prior Authorization System, please call (800) 241-8726. Additional information is available online at <https://medicaid.nv.gov> by selecting “Prior Authorization” from the “Providers” drop-down menu, then clicking the “Online Prior Authorization” link. The website contains an Introduction/Registration Tutorial, Registration Guidelines and Frequently Asked Questions.

Billing Tips and Reminders for All Providers

Recipient Eligibility

The first step you can take toward being paid quickly for Nevada Medicaid and Nevada Check Up services you render is to check that your recipient is eligible to receive the services. Remember: if a recipient is not eligible for Nevada Medicaid/Nevada Check Up benefits, the claim will be denied.

The four easy methods to verify recipient eligibility and service limits, and to determine if a recipient is currently enrolled in a Health Maintenance Organization (HMO), also referred to as a Managed Care Organization (MCO), are:

- Log on to the Electronic Verification System (EVS) 24 hours a day, 7 days a week at <https://medicaid.nv.gov>. From the “Providers” drop-down menu select “EVS Logon” or for information about the system select “EVS User Manual.”
- Call the Nevada Medicaid Audio Response System (ARS) at (800) 942-6511.
- Swipe the recipient’s Nevada Medicaid card on your swipe card system and wait for the reply. Contact your swipe card vendor to help you set up your system.
- Call First Health Services’ Customer Service Center at (877) 638-3472.

Please verify your recipient’s eligibility and benefit plan each time before providing services.

Keep Updated

The CMS-1500, UB-92, Dental and Pharmacy Nevada Medicaid and Nevada Check Up provider billing manuals are constantly being revised and improved to reflect changes in State policy or to add clarifying language. To keep up-to-date on changes to billing manuals and State Medicaid policy regarding your service specialty, please review the billing manuals and the Medicaid Service Manuals at least once per week.

- The billing manuals are posted online at <https://medicaid.nv.gov>. Select “Billing Manuals” from the “Providers” drop-down menu. The “Revision History” describes recent changes.
- The Service Manuals are also available from <https://medicaid.nv.gov> by selecting “DHCFP Web Site” from the “Quick Links” drop-down menu, then clicking on “Medicaid Service Manuals.” Click on the area of interest that pertains to you.

Financial Benefits of EDI and EFT

The greatest benefit to filing Nevada Medicaid and Nevada Check Up claims electronically through Electronic Data Interchange (EDI) and signing up for Electronic Funds Transfer (EFT) is receiving remittance payments faster. The sooner First Health Services receives your claim, the sooner your payment will be on its way and deposited into your bank account.

EDI allows providers to submit claims directly to First Health Services via the Internet. Electronic billing not only speeds payments, but also eliminates many steps associated with filing paper claims that can add to providers' costs, such as buying and preparing envelopes and postage, spending time preparing the paper claim, and taking the time to research and resend claims that are returned. If you file electronically and a claim is returned to you for missing or incorrect data, you can correct the information requested and resubmit the claim that same day.



Electronic claims may be submitted to First Health Services through an approved clearinghouse or through your existing, HIPAA-compliant business software. When choosing a clearinghouse, remember that Payerpath is provided free to all providers courtesy of First Health Services for their Nevada Medicaid and Nevada Check Up claims. Enrollment information and a list of approved clearinghouses (Service Center Directory) are available at <https://medicaid.nv.gov> by selecting “Electronic Claims/EDI” from the “Providers” drop-down menu.

If a specific concern is keeping you from using EDI to submit your claims, please don't hesitate to send your question via email to nvedi@fhsc.com or call (877) 638-3472, press 2 for “Providers” then 5 for the “Electronic Billing” department. Certain Medicare claims require special processing; please call a First Health Services' Customer Service Representative at (877) 638-3472 for that information.

You can also elect to have First Health Services electronically deposit your Nevada Medicaid and Nevada Check Up payments directly into your bank account by enrolling in the EFT program. Instructions for direct deposit are posted at <https://medicaid.nv.gov> by selecting “Forms” from the “Providers” drop-down menu, then clicking on form FH-32 Electronic Funds Transfer Agreement.

Forms, Forms and More Forms

Many forms you will find posted on the Nevada Medicaid website are now active, which means they can be completed online and printed. Active forms are indicated with an asterisk on the list posted at <https://medicaid.nv.gov>; select “Forms” from the “Providers” drop-down menu.

In addition to FH-32 mentioned above, two other useful forms among the many posted on the website are:

- FH-33 Nevada Medicaid Provider Information Change Form – This is the form you are required to fill out and submit within five business days of a change occurring to your provider information, such as address, name, license/certification, etc. Please mail the completed form to First Health Services, P.O. Box 30026, Reno NV 89520-3026.

- FH-24 Personal Care Aide (PCA) Prior Authorization Form – This form has been updated along with new instructions for completing forms online.

Medicare Crossover Claims

- If you submit claims to Medicare under a group number (vs. under an individual provider number), you must submit claims to Medicaid using your Nevada Medicaid or Nevada Check Up group provider number in order for claims to cross over automatically.
- If your Medicare Explanation of Benefits (EOB) shows that your claim was forwarded to Medicaid but you have not received payment within 60 days from the date on your Medicare EOB, please submit your claim manually to First Health Services and notify Customer Service by calling (877) 638-3472. Nevada Medicaid and Nevada Check Up providers who bill on the UB-92 claim form must use the Medicare Crossover Claim Form (FH-40) to submit a crossover claim. Providers who bill Medicaid on a CMS-1500 claim form may use form FH-40 **or** the CMS-1500 form with your Medicare EOB attached. **Do not** attach a copy of your Medicare EOB to form FH-40. FH-40 is available online at the web page listed above. Mail crossover claims to First Health Services, Medicare Crossover, P.O. Box 30028, Reno NV 89520-3028.
- When you attach a Medicare Explanation of Benefits with your Medicaid claim, be sure that all information on your claim matches the Medicare EOB, such as recipient name, charges, procedure code, date of service, modifiers, etc. Also ensure that the copy of the Medicare EOB is legible.

Contact Numbers for Recipients

If you have recipients who have questions regarding Medicaid coverage, their rights as a Medicaid recipient, or finding a doctor, dentist, specialist, etc., please refer them to their local Medicaid District Office. Please do not refer recipients to First Health Services. Refer the recipient to one of the following Medicaid District Offices:

- Carson City – (775) 684-3653
- Elko – (775) 753-1191
- Fallon – (775) 423-6730
- Las Vegas – (702) 486-1550
- Reno – (775) 688-2811, ext. 221



Provider Training Sessions

Training sessions for new and existing Nevada Medicaid and Nevada Check Up providers are now available. First Health Services and the Nevada Division of Health Care Financing and Policy are co-hosting provider training sessions that focus on a variety of topics, including Medicaid policy, enrollment and eligibility, prior authorization, claims submission and claims resolution issues, reading the Remittance Advice, and electronic billing. For details on upcoming training sessions, select “Provider Training” from the “Providers” drop-down menu at <https://medicaid.nv.gov>.

Pre-Admission Screening and Resident Review (PASRR) Reminders

A Pre-Admission Screening and Resident Review (PASRR) is federally mandated to identify individuals with mental illness, mental retardation, or related conditions before the individual's admission to a Medicaid-certified nursing facility and/or when there has been a significant change in the individual's physical or mental status.

The first step in the PASRR process is a Level I Identification Screening. In some cases, a Level II evaluation must be completed in order to determine the appropriate placement and services for individuals with mental health needs.

Providers are responsible for completion of the Level I Identification Screening form. ***In order to ensure valid determinations, the forms should be completed accurately by a nurse or social worker, whenever possible. Inaccurate information could result in inappropriate placements and determinations, and/or loss of reimbursement for nursing facilities.***

Please remember, for state and federal reviews, nursing facilities must maintain a copy of the Level I Identification Screening Determination letter and, when necessary, the PASRR Level II Screening Determination letter and the Level II Summary of Findings in the resident's *active* medical record.

The Level I Identification Screening for PASRR form, FH-18, and corresponding Provider Instructions, FH-18-I, are available at <https://medicaid.nv.gov> or <http://dhcfp.state.nv.us>.

For policy-related questions, please call the State PASRR Program Specialist at (775) 684-3754. For form completion and submission questions, please call First Health Services at (800) 525-2395.

System Change to Improve Newborn Eligibility Reporting and Medicaid Billing Identification

There has been a long-standing problem with Medicaid newborns not being identified in the Electronic Verification System (EVS) or the Medicaid Management Information System (MMIS) in a timely manner. This problem reflects the time lag between birth, notification, and eligibility status update. The time lag also impacts the ability to determine whether the newborn is enrolled in a Health Maintenance Organization (HMO).

A system change has been made to update eligibility status and provide Medicaid billing numbers (Recipient Medicaid Numbers) for newborns more promptly. Effective April 1, 2005, the MMIS began converting prospective births to eligible status at the beginning of the expected month of birth that is maintained on the pregnant mother's case record.

Going forward, the MMIS and EVS will automatically update eligibility status for Medicaid births expected in the following month. For example, a birth that is expected anytime in the month of June will be shown as eligible on June 1. The actual date of birth will be updated when birth notification is processed through the Welfare Division caseworker. There will be instances where births occur earlier or later than in the expected month, but this system change will provide more timely eligibility information, including whether the newborn is enrolled in an HMO, for a large majority of cases.

“Continuation of Care” Policy Change for Urban Clark County Dental Providers

Dental providers are no longer allowed a 6-month period to complete treatment plans initiated while the recipient was enrolled in the Fee For Service (FFS) benefit plan.

In the first month of eligibility, a recipient is enrolled in the Fee for Service (FFS) benefit plan. Only emergency dental services will be reimbursed while recipient is FFS. Non-emergent dental services must be scheduled for following month after the recipient has transitioned to a Managed Care Organization (MCO).

Commencing with date of service June 1, 2005, we will deny claims for non-emergent dental services provided to recipient’s enrolled in FFS benefit prior to transition to MCO.

Note: This also affects claims for non-emergent dental services provided by Ambulatory Surgical Centers (provider type 46), anesthesia providers (provider type 20) and radiology providers (provider type 27).

Nursing Facility Level of Care Assessment Form Revised

The Level of Care (LOC) Assessment Form for Nursing Facilities, FH-19, and the corresponding Provider Instructions, FH-19-I, have recently been revised. The updated versions are now available at <https://medicaid.nv.gov> or <http://dhcfp.state.nv.us>.

Providers who use these forms include, but are not limited to, hospitals, nursing facilities, and assisted living and group homes. Form FH-19 assists First Health Services in determining the required service level for a recipient and if the recipient meets the level of care criteria for nursing facility placement.

Changes to the form include new fields related to the reasons for screenings and types of requests. Additionally, the recipient’s mailing address is now required on the form. The provider instructions have a new look as they have been revised and reformatted.

Avoid delays in Nursing Facility LOC assessment determinations by taking a few minutes to review the revised form and instructions. Accurately submitted requests are processed more quickly!

Providers will be happy to know that the form is now an active form, which means the form can be completed online. Once the form is completed, the provider prints, signs and dates a copy before faxing it to First Health Services.

Announcement from
Nevada Division of Health Care Financing and Policy
regarding the Payment Error Rate Measurement
(PERM) Program

The Improper Payments Information Act of 2002 (Public Law No. 107-300) was enacted in November 2002 and requires federal agencies to annually review and identify programs and activities that may be susceptible to significant erroneous payments. Federal agencies must estimate the amount of improper payments and report those estimates to Congress, and, if necessary, submit a report on actions the agency is taking to reduce erroneous payments.

To comply with the Improper Payments Information Act to provide a national payment error rate for the Medicaid and SCHIP programs, the Center for Medicare and Medicaid Services (CMS) is requiring each state to conduct monthly eligibility, medical, and processing reviews on a random sample of Medicaid and SCHIP (Nevada Check Up) claims to determine improper payments; identify programs and activities that may be susceptible to significant erroneous payments; and report the estimates and corrective actions to CMS by June 1 each year. CMS will then compile the state estimates to provide Congress with the national payment error rate for these programs. It is anticipated this program will reduce the rate of improper payments, thus producing a corresponding increase in program savings at both the state and federal levels.

On October 2, 2005, when Public Law 107-300 goes into effect, CMS will make payment error rate measurement, in the manner designated by this program, a mandatory requirement for all states. As a result of this legislation, all providers will be included in the sample pool and may be subject to a medical records request.

This is to inform all Nevada Medicaid and Check Up healthcare providers that you may be asked to provide, for review, documentation relative to this program such as: medical charts, billing information, patient notes, prescriptions, encounter logs and any other patient information as deemed necessary to support the amount, scope and duration of services provided. Any submitted information will not be returned to you, so copies will need to be sent instead of originals.

The medical records request is a permitted disclosure under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, as well as mandatory compliance statement contained in all provider agreements with the Division of Health Care Financing and Policy (DHCFP). Information collected for this study will be held in strict confidence in compliance with all applicable policies, requirements, regulations and statutes.

Any efforts the DHCFP can undertake to improve the accuracy of claims paid and reduce the error rates in the Medicaid and Nevada Check Up programs can only be beneficial and enhance the integrity of these programs.

Your cooperation in making this program successful for Nevada will be greatly appreciated.