# Nevada Medicaid News

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## *Reminders from the EDI Unit*

**Eligibility Batch Request:**

Nevada Medicaid and Nevada Check Up providers have a fast, easy way to check eligibility for multiple recipients. When providers submit an electronic 270 Eligibility Batch Request, within 24 to 48 hours First Health Services will return an electronic 271 response with eligibility information on the entire recipient list.

To take advantage of this feature, contact your software vendor and coordinate with your service center or clearinghouse. You may also refer to the Service Center Directory posted at https://medicaid.nv.gov (select "Electronic Claims/EDI" from the "Providers" menu) for centers that provide Eligibility Batch File services.

The EDI Companion Guide titled "Transaction 270/271 – Health Care Eligibility Inquiry and Response" also posted online under "Electronic Claims/EDI" contains details and instructions.

The same website mentioned above contains information and forms to enroll in electronic billing.

**Secondary Claims:**

Please work with your software vendor and service center when considering electronic billing of secondary claims. Your software vendor and service center will ensure you are set up to submit secondary claims and that all essential data is included in the claim submission.

# NPI Implementation Requires Revision of All Claim Forms

The claim forms in use today to bill Nevada Medicaid and Nevada Check Up (CMS-1500, UB-92 and ADA) are being revised to accommodate the implementation of the National Provider Identifier (NPI).

NPI is the national standard health care identifier number mandated by the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The 10-digit NPI will replace health care provider numbers in use today. Health plans such as Medicaid, Medicare, private health insurance issuers and health care clearinghouses must accept and use NPI in standard electronic transactions by May 23, 2007.

As of Aug. 1, 2006, the effective dates for the implementation of the claim forms are:

**1500 Claim Form:**

- Jan. 1, 2007, through March 31, 2007: Providers may use either the current (12/90) version or the revised (08/05) version.
- April 1, 2007: The current (12/90) version of the 1500 Claim Form will be discontinued and only the revised (08/05) form is to be used. All rebilling of claims should also use the revised (08/05) form starting April 1.

**UB-04 Claim Form:** March 1, 2007

**ADA Dental Claim Form:** Jan. 1, 2007

The effective dates for the new forms apply to the date the claim is submitted, not the date of the service rendered. Contact your forms distributor regarding the availability of the new claim forms.

Even though you may use the new claim forms before May 23, 2007, please do not put your NPI on the new forms until May 23, 2007, or until the DHCFP or First Health Services notify you to begin doing so.

**Effective dates for the new claim forms are subject to change.** First Health Services will keep you updated on effective dates of the new claim forms and implementation of NPI by posting Web Announcements at https://medicaid.nv.gov, posting messages on page 1 of your Remittance Advices and including articles in this quarterly newsletter. Providers can also expect to receive letters requesting you to furnish your NPI to First Health Services. Nevada Medicaid and Nevada Check Up providers who are not eligible to receive an NPI will be notified by letter and will receive a new provider number from First Health Services.

Once the new claim form instructions are revised to incorporate NPI, they will be posted

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**CONTENTS:**

# Tips to Assist You with Adjustments/Voids and Recipient Eligibility

## Checking for Recipient Eligibility

Recipients must be eligible for Nevada Medicaid and Nevada Check Up benefits before you render services. Access to information regarding recipient eligibility, managed care, recipient restrictions and Third Party Liability is through the following methods:

- First Health Services' Electronic Verification System (EVS) – log on to https://medicaid.nv.gov (from the "Providers" menu select "EVS Logon" or "EVS User Manual").
- The Nevada Medicaid Audio Response System (ARS) – call (800) 942-6511.
- A swipe card system – contact your swipe card vendor for details.

## Adjustments or Voids

When submitting a request to adjust or void a previously paid claim, please refer to the Claim Form Instructions posted at https://medicaid.nv.gov (select "Billing Manuals" from the "Providers" menu, and then click on the links to the individual Claim Form Instructions).

### CMS-1500

Field 22: In the "Code" area, enter an adjustment or void reason code (Claim Form Codes are listed in the CMS-1500 Claim Form Instructions).

Field 22 : In the "Original Ref. No." area, enter the **last paid** Internal Control Number (ICN) of the claim.

### UB-92

Field 4: Enter the appropriate Type of Bill code. If you are adjusting a previously paid claim, "7" must be the 3rd digit in your Type of Bill code. If you are voiding a previously paid claim, "8" must be the 3rd digit in your Type of Bill code.

Field 37: Enter the **last paid** ICN of the claim you are voiding or adjusting.

Field 56, Line 2 : Enter the appropriate 4-digit Adjustment or Void Reason Code on Line 2 . Valid values are listed in the UB-92 Claim Form Instructions.

### ADA

Field 3: Enter 182 to adjust a paid claim. Enter 184 to void a previously paid claim.

Field 4: Enter the **last paid** ICN (must be 16 digits) of the claim you wish to adjust or void.

Field 5: Enter the Reason Code that most closely describes the reason for the adjustment or void. Reason Codes are located in Appendix A of the ADA Claim Form Instructions.

**Reminder:** You may submit only one claim line or ICN per claim form.

# Log on to OPAS for Prior Authorization Requests

First Health Services' Online Prior Authorization System (OPAS) is a valuable, HIPAA-compliant tool some providers are using to facilitate prior authorization (PA) requests and tracking. Providers can submit PA requests through a secure website instead of faxing or mailing requests.

Provider service types currently using OPAS include Home Health Agency (provider type 29), Therapy Services (provider type 34 ), Durable Medical Equipment (DME provider types 23, 25, 33, 37, 41 and 76), Inpatient Services (provider types 11 , 44, 56 and 75) and Outpatient Services (provider types 12, 21, 36, 46 and 76).

Some of the advantages of using OPAS include: reduction of provider overhead; 24/7 access; generation of data and reports; more complete requests due to required fields; elimination of fax backs reducing hand-written documents; quicker responses for insufficient information; online training modules; PA history access for providers; drop-down fields for CPT and Dx codes; multiple lines for nursing notes; and pre-loaded provider and recipient demographics.

For information and registration guidelines, visit https://medicaid.nv.gov (select "Prior Authorization" from the "Providers" menu) or call (800) 241-8726.

# CONTACT INFORMATION

If you have a question on Claims Payment, please contact First Health Services Corporation by calling (877) 638-3472 or e-mailing nevadamedicaid@fhsc.com.

If you have questions about Medicaid Service Policy or Rates, you can go to the Division of Health Care Financing and Policy ( DHCFP) website: www.dhcfp.state.nv.us and look for the item labeled: Contact Information. Move your cursor to that item and follow the directions to find the person at DHCFP who can answer your question. You can either phone the contact person or send an e-mail.

## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $271,064,443.76 in claims during the three-month period of April, May and June 2006. Nearly 100 percent of current claims continue to be adjudicated within 30 days. The DHCFP and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

## A Message from DHCFP Regarding Prevention

Nevada Medicaid would like to invite providers to join with us as we strive to heighten the awareness of prevention and encourage early detection and treatment of disease in the male population. Nevada Medicaid provides coverage for lab work associated with preventing disease, such as PSA, lipid panels, EKGs, etc., and other leading diseases that significantly impact the health of men.

Although a preventive office visit for an adult is not a covered benefit, Nevada Medicaid provides payment for a full range of preventive lab/diagnostic screening services specific for men's health that aim to prevent disease from developing or prevent serious complications of disease.

# NPI Implementation

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at https://medicaid.nv.gov (select "Billing Manuals" from the "Providers" menu). Please be on the alert for these updates.

## NPIs are Free!

NPIs are free. Providers can apply for their NPI by visiting the website https://nppes.cms.hhs.gov or by calling the enumerator at (800) 465-3203.

Other websites that may be helpful as the new claim forms and NPI are implemented:

- 1500 Claim Form – http://www.nucc.org
- UB Claim Form – http://www.nubc.org
- ADA Claim Form – http://ada.org

### Electronic Claims Submission in the NPI Implementation Process

Providers who bill electronically are encouraged to coordinate NPI compliance with their software vendors, service centers/clearinghouses and practice management staff.

All service centers submitting electronic files to First Health Services will be required to test and certify for NPI compliance before May 23, 2007, or will be decertified and First Health Services will no longer accept EDI transactions from them.

For information on the testing and certification process, refer to the Service Center User Manual posted at https://medicaid.nv.gov (select "Electronic Claims/EDI" from the "Providers" menu) or call First Health Services' EDI Coordinator at (877) 638-3472.

If your facility is a direct submitter of EDI transactions, please contact the EDI Coordinator concerning NPI requirements.

### Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Providers

The Nevada Division of Health Care Financing and Policy and First Health Services would like DME providers to be aware of the following official NPI outreach communication from the Centers for Medicare and Medicaid Services (CMS):

*The Centers for Medicare and Medicaid Services (CMS) will be linking Medicare provider numbers with NPIs.*

*According to the paper titled "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA": Medicare DME suppliers are required to obtain an NPI for every location.*

*The only **exception** to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the supplier may have.*

*The requirement also applies regardless of how claims are submitted (e.g., electronically or on paper). For more information on Medicare Subpart Expectations, please visit* http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf

# Pharmacy Billing Notice and Update to the PDL

### Billing for Medicaid Recipients with Medicare Part B and/or Part D

Per Nevada Medicaid Services Manual Chapter 1200,1203.1D,7, Medicaid is the payer of last resort. Other sources of payment include, but are not limited to, Medicare Part B and Part D.

Questions have been raised regarding co-payment claims and diabetic supplies for recipients with Medicaid plus Part B and/or Part D coverage. These recipients are commonly referred to as dual-eligible recipients.

***Co-Payment Claims***

Current Medicaid co-payment logic does not allow for the reimbursement of a dual-eligible co-payment for an amount greater than $3. For Part B-covered drugs, the co-pay amount can and will exceed this amount in most cases. To exceed the current $3 co-pay maximum for Part B-covered drugs for recipients with Part B and D, please call the First Health Services Technical Call Center at (800) 884-3238 and have Part D coverage overridden.

This override cannot be automated because many Part B drugs are covered by Part D in certain situations. For example, oral anti-emetics are covered by Part B if used within 48 hours of chemotherapy, but are covered by Part D in all other situations.

For Part B only co-payment claims, submit the claim to Medicaid using standard Third Party Liability (TPL) processing with the Other Coverage Code of "2" (NCPDP Field 308-C8). Complete all required Coordination of Benefits (COB) processing fields including the Part B carrier code "04967" or "04968."

***Diabetic Supplies***

Blood glucose testing equipment and supplies, as well as injection devices, are a Part B-covered benefit. These items are not considered Part D drugs and therefore are not a Part D benefit. After billing Medicare Part B for these items, Medicaid can be billed as the secondary payer using standard other coverage billing practices. The Part D carrier code "07450" (NCPDP Field 340-7C) and Part B carrier code "04967" or "04968" are required for processing diabetic supply claims for recipients who are eligible for Medicaid, Medicare Part D and Medicare Part B. The Technical Call Center can override TPL denials if the pharmacy software prevents the entry of these codes.

If you have any questions, please contact the First Health Services Technical Call Center at (800) 884-3238.

### Preferred Drug List Review

The Pharmacy and Therapeutics Committee of the Nevada Department of Health and Human Services' Division of Health Care Financing and Policy performed the annual review of the Preferred Drug List (PDL) on July 27, 2006.

Pharmacy providers will be notified of the PDL revisions that will be made as a result of the Committee's review. The status of the drugs included on the PDL can be monitored at the following website: https://medicaid.nv.gov (select "Preferred Drug List" from the "Pharmacy" menu).

# Submitting a Notification of Hospital Admission

Effective Aug. 1, 2006, First Health Services no longer accepts a notification of hospital admission unless it is submitted with pertinent clinical information on the recipient's medical condition. Providers were previously notified of this change on July 25, 2006, through Web Announcement 94 posted at https://medicaid.nv.gov.

Historically, hospitals have submitted notifications of admissions that contain only demographic data. At this time, most hospitals utilize First Health Services' Online Prior Authorization System (OPAS) to submit requests for authorization and have eliminated the extra step of sending a Notification of Admission.

### *Notification Requirements*

Notification is when pertinent clinical information on the recipient's medical condition is submitted to First Health Services. When providing the following services, providers must notify First Health Services within one business day after the admission by submitting the pertinent clinical information on the recipient's medical condition:

- Emergency admissions transferred from a physician's office or emergency room.
- OB, maternity and newborn admissions greater than three days for the purpose of vaginal delivery, and greater than four days for C-Sections (elective and emergency).
- Tubal ligations performed at the time of obstetric delivery.

Information on the recipient's medical condition may be submitted via:

1. Inpatient Medical/Surgical PA Request Form (FH-8) faxed to (866) 480-9903, or
2. Telephone (800) 525-2395, or
3. OPAS (at https://medicaid.nv.gov select "Prior Authorization" from the "Providers" menu).

### *Notification Reminders*

All NICU admissions require authorization, and notification with appropriate clinical information is required within one business day.

If a recipient does not have a Medicaid ID number upon admission, but has a date of decision for Medicaid eligibility during the inpatient stay, authorization is required. In this case, notification with appropriate clinical information is required within five business days of the date of decision of eligibility. For newborns, the five days is from date of birth. The authorization in this case will cover the date of admission, as long as eligibility covers admit date. If notification with appropriate clinical information is received after five days of the date of decision of eligibility and the recipient is still an inpatient, the authorization start date will begin from the date First Health Services was notified with appropriate clinical information.

If the recipient's date of decision is after discharge, a retrospective authorization needs to be requested within 90 days of the date of decision.

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