Nevada Medicaid News

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First Health Services Corporation®

Nevada Medicaid and Nevada Check Up
Fiscal Agent
P.O. Box 30042
Reno, NV 89520-3042
(877) 638-3472

Have You Checked Your Recipient's Eligibility?

Before you render services to a Medicaid recipient, do you remember to check the recipient's eligibility to receive Nevada Medicaid services or to determine if they are in Medicaid managed care? If a recipient is not eligible, the claim will be denied. If a recipient is enrolled in a managed care plan, the claim must be submitted to the HMO.

For the month of November (2004), 11,216 provider claims were denied due to Edit Code 0318 (Recipient Not Eligible on Date of Service). This total does not include provider claims that were denied for other related edits, such as 0081 (Recipient Not Eligible for Benefits on Date of Service), 0128 (Recipient Not Authorized for Dates of Service), 0456 (Recipient not Covered for this Service), or 0453 (Recipient Enrolled in HMO).

You can eliminate the problem of being denied payment for services rendered due to recipient eligibility reasons by checking the recipient's eligibility every time before you render services. The following four easy methods are available to you and your staff:

- The Electronic Verification System (EVS) offers an online method to verify recipient eligibility for Medicaid services 24 hours a day, 7 days a week. For a full introduction to EVS, review the EVS User Manual, which is accessed online at https://medicaid.nv.gov by selecting "EVS User Manual" from the "Providers" drop-down menu. If you already have an EVS logon, select "EVS Logon" from the "Providers" drop-down menu.
- You may check recipient eligibility by calling the Nevada Medicaid Audio Response System (ARS) at (800) 942-6511. Your Provider Medicaid Number is required to access this system.
- If you have a Swipe Card system, now is a great time to start using it. Each Nevada Medicaid card has a magnetic strip on the back containing recipient information. Verifying eligibility is as simple as swiping the recipient's Nevada Medicaid card and waiting for the reply. Contact your swipe card (credit card) vendor to help you set up your system.

- You may also check recipient eligibility by calling First Health Services' Customer Service Center at (877) 638-3472.

Reminder: Enter the date ranges for the period you are checking from the first of the month to the last day of the same month.

Reminder: An existing prior authorization is not honored if the recipient loses eligibility. It is the provider's responsibility to check eligibility for this reason as well.

Advance Payments for Unprocessed Claims Suspended as of December 2004

The Nevada Division of Health Care Financing and Policy (DHCFP) determined that claims submitted by Nevada Medicaid and Nevada Check Up providers are being processed timely and more accurately. Based on improved claims processing, the DHCFP approved a policy to suspend cash advances for unprocessed Nevada Medicaid claims effective December 31, 2004.

DHCFP policy also requires that all negative balances for cash advances be brought to zero no later than June 15, 2005. These negative balances include those transactions created under Anthem and converted over to First Health Services. First Health Services, on behalf of the DHCFP, has been in contact with providers who are carrying negative balances to discuss their outstanding amounts, and to assist with repayment options. If there are extenuating circumstances specific to a provider type and claims payment, First Health Services and DHCFP are discussing any exceptions with individual providers as they call.

If you have any questions regarding the policy change, please call First Health Services at (877) 638-3472.

Quarterly Update on Claims Paid

First Health Services and the Nevada Division of Health Care Financing and Policy (DHCFP) continue to make progress in customizing the Medicaid Management Information System (MMIS) for the State of Nevada. The progress made is benefiting providers in two essential ways: nearly 100 percent of current claims are being paid within 30 days, and the State Medicaid program paid out to providers more than $299,773,275 in claims during the three-month period of October, November and December 2004.

Many Providers are Switching to EDI

The Fall edition of Nevada Medicaid News carried an article that described some of the benefits for providers who use Electronic Data Interchange (EDI) to submit their Medicaid claims. This article will provide even more information to help you make the decision to switch from paper claims to electronic billing.

To begin, you have the option of submitting claims directly to us via the Internet. However, if you submit forms electronically without enrolling first, your claims will pend for Edit Code 0961 (Provider Not Approved for Electronic Billing).

Our website has everything you need to get started: explanation of how to enroll in the program; enrollment forms FH-35, FH-36 and FH-37; testing requirements; and secure file transfer procedures.

The first step is to visit First Health Services' website and review the Electronic Billing instructions and information. Go to https://medicaid.nv.gov and select "Electronic Billing/EDI" from the "Providers" drop-down menu.

The website also contains a directory of approved service centers you may contact to submit claims on your behalf. A service center may be a one-person provider office or a clearinghouse servicing thousands of providers. Recent additions to the service center directory include two clearinghouses certified to serve dental providers: Claims Processing Services (a division of WebMD) and Quality Systems Inc. A free web-based clearinghouse courtesy of First Health Services, Payerpath, also serves dental providers in addition to other provider types.

> **"I** was a 'non-believer' when you first called me about electronic claim billing for our dental program but after a few tests of entering half my claims and mailing the other half, I began to see that our electronic dental claims were consistently paid faster. Now I am a 'believer'."
>
> Thanks,
> Chris Reagan
> Jr. Systems Analyst, Saint Mary's Mobile Dental Program

Once you are enrolled, you will notice how much more quickly the claim submission process proceeds. With electronic claims processing you can check the status of a claim within 48 hours of submission by logging on to the Electronic Verification System (EVS). If a claim has been denied for missing or incorrect data, you can correct the information requested and resubmit the claim that same day.

Payerpath makes the process even faster. Subscribers who submit claims to Payerpath by noon PST may log on to EVS first thing the following business morning and check the status of the claim. Payerpath sends the claims to First Health Services in time for overnight processing. Information regarding EVS and Payerpath are also available at the website: https://medicaid.nv.gov.

An additional benefit for providers who use EDI is receiving Remittance Advice (RA) electronically on a weekly basis. Once you import the RA into your Practice Management System, you will find it easier to post data and reconcile accounts without having to key in data. Ask about this service when you enroll in EDI.

Once again, if you have signed up for the EDI program, but have yet to file claims electronically due to specific questions not answered here, please e-mail our EDI department at nvedi@fhsc.com or call (877) 638-3472; once the recorded message begins press 2 for "Providers" then 5 to reach our "Electronic Billing" department.

Pharmacy or DME Billing – What's the Difference?

Does your pharmacy staff have questions regarding the proper way to bill for DME (Durable Medical Equipment) items?

One common scenario that First Health Services' Customer Service staff has reported is as follows: A pharmacist enters a claim for a DME item on the pharmacy's point-of-sale (POS) system, but receives an item reject as a non-covered service. The person entering the claim calls the First Health Services Pharmacy Call Center for an explanation. At that point the person is directed to the First Health Services Customer Service Center where DME calls are actually handled.

The following guidelines should help your pharmacy staff avoid this time-consuming scenario and submit DME claims properly and quickly:

- Diabetic supplies such as syringes, test strips, lancets, and glucometers are to be billed online using your pharmacy POS system. The corresponding ICD-9 code must be entered for diabetic supplies.
- All DME products, e.g. Depends®, ostomy supplies, gloves, inhaler spacers, nutritional supplements, etc., require a physician's order and must be billed on the CMS-1500 claim form. Submit claims to First Health Services, CMS, P.O. Box 30031, Reno, NV 89520-3031. Billing instructions can be found at our website at https://medicaid.nv.gov by selecting "Billing Manuals" from the "Providers" drop-down menu.

DME claims may also be submitted electronically. Your pharmacy's corporate office may offer instructions for the proper procedure, or if you use a service center to submit Medicaid claims, contact that company.

Nevada Medicaid policy relating to pharmacy or DME coverage, as well as current reimbursement rates, may be found at http://dhcfp.state.nv.us. Select "Medicaid Manuals" and then select "Chapter 1200" for Pharmacy or "Chapter 1300" for DME. If you have any questions, please call the appropriate toll-free telephone number to reach a First Health Services Customer Service Representative: Pharmacy questions (800) 884-3238 or DME and electronic billing questions (877) 638-3472.

Pharmacy News: New or Revised Guidelines for Some Drugs

The Nevada Division of Health Care Financing and Policy (DHCFP) implements clinical edits (i.e. guidelines) that Nevada Medicaid providers must follow when either prescribing or dispensing medications. These edits are the result of recommendations made by the Drug Use Review Board. New or revised edits went into effect December 1, 2004, regarding the following

drugs: Actiq®, AntiFungal Agents (Lamisil®, Sporanox®, and Penlac®), Sedative Hypnotics, Xopenex®, and Zelnorm®.

Details regarding coverage, quantity limitations, and clinical prior authorization guidelines for each of these drugs can be found at the following State of Nevada website: http://dhcfp.state.nv.us (select "Medicaid Manuals" and select "Chapter 1200-Prescription Services," then click on "Chapter 8-27-04" and scroll down to Appendix A).

For your reference, a complete, updated Preferred Drug List (PDL) is posted on the First Health Services' website at https://medicaid.nv.gov (select "Preferred Drug List" from the "Pharmacy" drop-down menu).

If you have questions regarding the PDL or the edits described above, please contact the First Health Services Clinical Call Center at (800) 505-9185.

Reminders for PCA Providers

Prior Authorization Requests:

When you are submitting a Prior Authorization (PA), please remember to:

- Fill in all information including complete address and zip code.
- Double check that you have the recipient's correct telephone number on the form.
- Enter the name of a contact person (guardian, parent or other family member) in case the recipient is unable to schedule the appointment.
- Specify the reason for the PA.
- Enter the provider's complete information, such as Provider Medicaid Number and contact person at the personal care aide provider agency (PCA).

"Eligibility" vs. "Criteria Not Met":

When you receive documentation from First Health Services, you may see the following terms, which are **not** interchangeable:

- "Eligibility" refers to the recipient having or not having full Medicaid benefits.
- "Criteria not met" refers to the recipient not meeting the requirements to qualify for the program as outlined in the Nevada Medicaid Services Manual Chapter 3500-Personal Care Aide Program. Select "Medicaid Manuals" from the Nevada Medicaid website at http://dhcfp.state.nv.us.

Types of PCA visits:

- "Initial" means the recipient has never been seen before or has had a break in services.
- "Recertification" refers to a significant change in condition (improvement or worsening) that will change the number of authorized hours.

- "Update" is a request to authorize the continuation of services. Such a request needs to be submitted to First Health Services 45 days prior to expiration of the existing authorization.

PCA vs. homemaker:

The Personal Care Aide program is not a homemaker program. Nevada Medicaid's Hospice program renders homemaker services. Please refer recipients who need only homemaker services to the Nevada Medicaid District Office in their area (the telephone numbers are listed in the "Welcome Manual" posted at http://dhcfp.state.nv.us) or to the Nevada Check Up (Children's Health Insurance Program) office at (800) 360-6044.

PCA transfers:

If a recipient transfers to your PCA agency from another PCA agency, please ask him or her to call the former agency to say that services will no longer be needed. The PA request for transfer that you submit should include the date you begin services for the recipient.

Status of a PA request:

The following list explains three methods that you may use to check the status of a Prior Authorization request and to verify authorizations:

- Fax – review and verify the fax that First Health Services returns in response to your request.
- Hard copy – review and verify the Notice of Decision letter that is mailed to you (usually within 7 days of your request).
- Electronic Verification System (EVS) – log on to EVS and look up a specific PA request. Access EVS online at https://medicaid.nv.gov by selecting "EVS Logon" or "EVS User Manual" from the "Providers" drop-down menu.

Important reminder: Once you receive a faxback or Notice of Decision letter, remember to give the letter to your billing department to ensure that the claim is billed accurately and your company receives a timely reimbursement.

News for Dental Providers Regarding ADA form 1999, version 2000

New instructions for completing American Dental Association (ADA) claim form 1999, version 2000 will go into effect March 1, 2005.

According to ADA form instructions, each field number on the form is designated as "Required," "Not Required" or "Conditional." The new instructions will change the requirements for the following fields: 5, 9, 10, 11, 12, 14, 43, 45, 46, 49, 50, 51, 52, 55, 59, 63, 64, 65 and 66. For example, as of March 1, 2005, it will be "Required" to fill in Field 45, which asks for the dentist's Social Security Number or Tax Identification Number. Instructions in effect until March 1 specify that Field 45 is "Not Required." These changes may affect your Practice Management System. Please notify your software vendor in advance to make any required

alterations to your system by the March 1, 2005, deadline. If you use old instructions to bill on the ADA form 1999, version 2000 on March 1, 2005, or after, your claims will deny.

Please refer to the Dental Provider Billing Manual for line-by-line instructions that specify the requirement for each field on the form. The Manual is online at https://medicaid.nv.gov by selecting "Billing Manuals" from the "Providers" drop-down menu, then selecting "Dental Provider Billing Manual." In Chapter C – Dental Services, scroll down to "Instructions Effective March 1, 2005" Table C-2.

If you have any questions regarding the ADA claim form, please call First Health Services' Customer Service Center at (877) 638-3472.

Guidance for the Vaccines For Children Program during 2004-2005 Influenza Season

The Nevada Division of Health Care Financing and Policy (DHCFP) received the following letter from the Centers for Medicare and Medicaid Services (CMS) and encourages all providers to review the contents. The letter addresses State Medicaid programs and offers guidance for State agencies and providers concerning the Vaccines For Children (VFC) Program during the 2004-2005 influenza season. The information focuses on eligible recipients and provider reimbursement. For additional information, call the Nevada Medicaid Central Office at (775) 684-3600 or (800) 992-0900, ext. 3600.

December 14, 2004

Dear State Medicaid Director:

The purpose of this letter is to clarify the procedures for assuring that Medicaid enrolled children who are eligible for the Vaccines for Children (VFC) Program (i.e., children younger than 19 years of age) receive their influenza shots. We want to stress that Medicaid providers should be vaccinating high priority VFC-eligible, Medicaid enrolled children with influenza vaccine they have on hand, regardless of whether the vaccine is available under the VFC program, when children present themselves at the provider's office. We also want to assure that Medicaid providers are appropriately reimbursed for the flu vaccines they provide to VFC-eligible, Medicaid enrolled children and that State Medicaid agencies receive federal reimbursement at the usual matching rate when appropriate.

The Advisory Committee on Immunization Practices (ACIP), an advisory committee to the Secretary of Health and Human Services and the Centers for Disease Control and Prevention (CDC), has identified the following high priority children to be vaccinated against influenza this year under the VFC Program:

- Children aged 6 months through 23 months.
- Children and adolescents aged 2 through 18 years with chronic disorders of the pulmonary or cardiovascular systems, including asthma.
- Children and adolescents aged 2 through 18 years who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic

diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]).

- Children and adolescents aged 2 through 18 years who are receiving long-term aspirin therapy and may therefore be at risk for developing Reye syndrome after influenza.
- Children and adolescents aged 2 through 18 years who are residents of nursing homes and other long-term care facilities that house persons at any age who have chronic medical conditions.
- Adolescent females aged <19 years who will be pregnant during the influenza season.
- Children and adolescents aged 2 through 18 years who are household contacts or out-of-home caregivers of children aged <6 months.

Many Medicaid providers will receive influenza vaccine from both the VFC Program and private sources. Medicaid providers with vaccine from both sources should take care to use the VFC vaccine only for federally vaccine-eligible high priority children and privately purchased vaccine for non-VFC-eligible high priority children. However, in the event a Medicaid provider does not have VFC supply on hand to vaccinate a high priority VFC-eligible Medicaid enrolled child, the provider should use vaccine from private stock, if available. The provider should not turn away, refer or reschedule that child for a later date, if vaccine is available. In instances where a VFC-eligible Medicaid child is vaccinated from private stock, the provider could either provide a replacement dose if VFC vaccine becomes available on a timely basis during this influenza season or, if no future VFC shipments are expected on a timely basis, bill the state Medicaid program directly for the vaccine itself and for administering the vaccine. The state Medicaid program will reimburse the Medicaid provider for both the vaccine as well as for administering the vaccine to high priority VFC-eligible Medicaid enrolled children and the Centers for Medicare & Medicaid Services (CMS) will match the state's expenses at the usual federal matching rate. Please note that Medicaid payment applies to vaccinations received by VFC-eligible Medicaid enrolled children but not to other federally vaccine-eligible children (i.e., American Indians/Alaska Natives, uninsured, and underinsured children served in a federally qualified health center or rural health center) who are not also enrolled in Medicaid.

There may be some instances where a Medicaid provider needs to borrow vaccine from VFC stock in order to vaccinate high priority, privately insured children. The VFC Program has a policy of allowing VFC/Medicaid providers to borrow limited VFC influenza vaccine doses to vaccinate such individuals as long as such loan/borrowing is adequately documented and the doses are replaced on a timely basis. Therefore, it is important that a Medicaid provider should only vaccinate a high priority, privately insured person using VFC vaccine, if the provider expects a shipment of private vaccine in the coming weeks that will replace the VFC vaccine borrowed and the provider has enough VFC doses available to assure that no VFC-eligible children will be turned away in the meantime.

Providers with insufficient influenza vaccine supply to vaccinate their high priority Medicaid children should contact their state and local health departments to determine if additional vaccine is available to order and to seek guidance regarding any efforts to reallocate vaccine among providers. If these providers are out of all vaccine stock, they should refer their Medicaid enrolled patients to other Medicaid providers in the community if they know these providers have influenza vaccine in stock.

Because there is increased demand for influenza vaccine this season, Medicaid providers should: ensure that parents/guardians and patients are educated about the benefits and risks of vaccination in a culturally appropriate manner and in understandable language; follow appropriate procedures for vaccine storage, handling, and documentation of vaccine administration; have systems in place to outreach to high priority Medicaid-enrolled children; and remind parents/guardians of high priority children due for vaccination, including children requiring a second dose of influenza vaccine.

Medicaid enrolled children under the age of 19 are VFC-eligible and are the focus of the above discussion. However, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services/benefit, Medicaid enrolled children under 21 years of age are required to be vaccinated based on the ACIP recommendations. Therefore, States also must cover and reimburse for influenza vaccinations provided to Medicaid enrolled children ages 19 and 20 years of age who fall into an ACIP high priority group. (CDC's Web site at www.cdc.gov/nip/flu identifies the high priority groups of children and adults recommended by the ACIP for influenza vaccination this season.) Note also that states that cover influenza vaccinations for adults 21 years of age or older as an optional Medicaid benefit should refer to the CDC website. Except as noted previously, private vaccine stock should be used to vaccinate high priority Medicaid enrolled persons who are not eligible for the VFC Program.

Please note that CDC has concurred with the contents and message in this letter.

Sincerely,

Dennis G. Smith, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services/U.S. Department of Health and Human Services