SUBSTANCE ABUSE AGENCY MODEL (SAAM)

Fee For Service Reports

Q1 CY 2018

1. Provider
2. Claims
3. Denials
4. Procedures
5. Diagnoses
6. Aid Category
7. Demographics
8. Definitions

Substance Abuse Agency Model (SAAM)
Fee for Service Reports

Time Period: Incurred With Runoff Quarter			QTR 1 2018	
			Providers Enrolled	Providers (Active)
Provider Type NV Code	**Provider Specialty NV Cd**	**Provider County**		
017	215	Carson City	3	2
		Churchill	1	1
		Clark	28	10
		Douglas	1	1
		Elko	1	1
		Lyon	1	1
		Nye	3	3
		Washoe	14	6
		Total	**52**	**25**

Providers Enrolled is the unique count of providers who are enrolled to provide services under the plan. This includes all providers authorized to provide services even if they have not provided services to any patients.

Providers is the unique count of providers who performed any facility, professional, or pharmacy services.

The DHCFP data warehouse is comprised of claims data submitted by over 28,000 Medicaid providers from within Nevada and across the country. While DHCFP staff conscientiously make their best efforts to validate this data through continuous provider education and the use of a highly experienced audit staff, the Division heavily relies on its providers to submit accurate and complete information on our Medicaid patients. It should therefore be understood by the users of DHCFP reports on disease morbidity and patient health that the data source for these reports is based solely on patient claims data and may not be a complete and comprehensive health record.

Substance Abuse Agency Model (SAAM)
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Time Period: Incurred With Runoff Quarter		QTR 1 2018			
		Claims Paid	Claims % Paid	Claims Denied	Claims % Denied
Provider Type Claim NV Code	Provider Specialty Claim NV Code				
017	215	17,028	84.01%	3,242	15.99%

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Time Period: Incurred With Runoff Quarter			QTR 1 2018
			Claims Denied
Provider Type Claim NV Code	**Provider Specialty Claim NV Code**	**Edit Error 1**	
017	215	Duplicate of History File Reco	887
		Service Center Not Authorized	708
		Procedure Requires Authorizati	303
		Duplicate Payment Request - Sa	261
		ENROLLED IN HMO	244
		NOT CLIA CERTIFIED TO PERFORM	144
		BILL ANY OTHER AVAILABLE INSUR	139
		Recipient Not Eligible on DOS	122
		NUMBER OF PROCEDURES EXCEEDS N	107
		Recipient Not on File	82
		Unknown Edit Err1 0916	52
		ALLOWED AMOUNT > THRESHOLD	34
		Invalid or Missing Recipient I	32
		Unknown Edit Err1 0093	30
		Unknown Edit Err1 0181	20
		NON-EMERG SVS NOT AUTH N-CTZN	17
		NCCI audit crnt proc denied	16
		Rendering Provider Not Certifi	16
		PROCEDURE DISAGREES WITH AUTHO	6
		Unknown Edit Err1 4721	6
		SERVICES NOT COVERED	4
		PROCEDURE MODIFIER DISAGREES W	3
		INVALID DIAGNOSIS CODE	2
		RECIPIENT NUMBER INCONSISTENT	2
		SERVICING PROVIDER NOT MEMBER	2
		Charges Span 2 Fiscal Years	1
		PAYMENT REQUEST FILED AFTER LI	1
		Unknown Edit Err1 0312	1
		Total	**3,242**

Edit Error 1 is the description for the edit error (claim denial reason) in the primary position. A single claim can have up to 30 different edit error codes. Error description may be incomplete due to limited character space in the reporting database.

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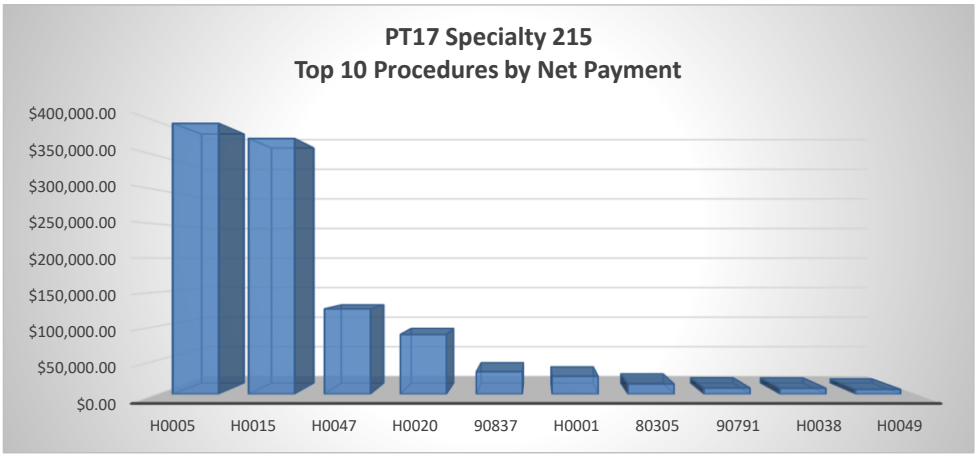
Time Period: Incurred With Runoff Quarter				QTR 1 2018		
				Patients	Service Count Paid	Net Payment
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Procedure Code	Procedure			
017	215	H0005	Alcohol/drug services-group counsel by clinician	405	13,325	$397,751.25
		H0015	Alcohol/drug svc-intensive outpatient program	151	2,674	$375,563.30
		H0047	Alcohol/drug abuse svc not otherwise specified	482	2,175	$125,395.97
		H0020	Alcohol/drug svc-methadone admin/service	344	22,385	$87,691.81
		90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	80	304	$32,845.00
		H0001	Alcohol and/or drug assessment	188	188	$26,218.48
		80305	DRUG TEST PRSMV READ DIRECT OPTICAL OBS PR DATE	194	1,050	$14,920.50
		90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	65	65	$8,939.90
		H0038	Self-help/peer services per 15 minutes	77	1,102	$8,683.76
		H0049	Alcohol &/or drug screening	260	714	$6,920.46
		H0002	Behav health screen-eligibility for Tx program	219	219	$6,738.63
		90853	GROUP PSYCHOTHERAPY	41	213	$6,358.05
		H0007	Alcohol/drug services-crisis intervention-outpt	129	139	$3,017.69
		90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	8	33	$2,439.36
		H0034	Medication training & support per 15 minutes	60	87	$1,474.06
		90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	8	23	$1,328.94
		99213	OFFICE OUTPATIENT VISIT 15 MINUTES	25	28	$1,232.00
		90839	PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	7	10	$1,125.50
		99205	OFFICE OUTPATIENT NEW 60 MINUTES	6	6	$867.72
		99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	22	24	$841.92
		99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	10	10	$606.20
		99203	OFFICE OUTPATIENT NEW 30 MINUTES	7	7	$562.17
		90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	2	4	$391.40
		90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	3	3	$341.28
		90840	PSYCHOTHERAPY FOR CRISIS EACH ADDL 30 MINUTES	2	3	$168.81
		99202	OFFICE OUTPATIENT NEW 20 MINUTES	3	3	$160.62
		90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	4	4	$152.24
		99212	OFFICE OUTPATIENT VISIT 10 MINUTES	4	4	$126.76
		99204	OFFICE OUTPATIENT NEW 45 MINUTES	1	1	$113.85
		99214	OFFICE OUTPATIENT VISIT 25 MINUTES	1	1	$66.82
		99211	OFFICE OUTPATIENT VISIT 5 MINUTES	1	2	$35.70
			Total	**2,809**	**44,806**	**$1,113,080.15**



Net Payment is the net amount paid for all claims. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

Total Patient Count is not unique (i.e. patient counts may be duplicated across procedure codes).

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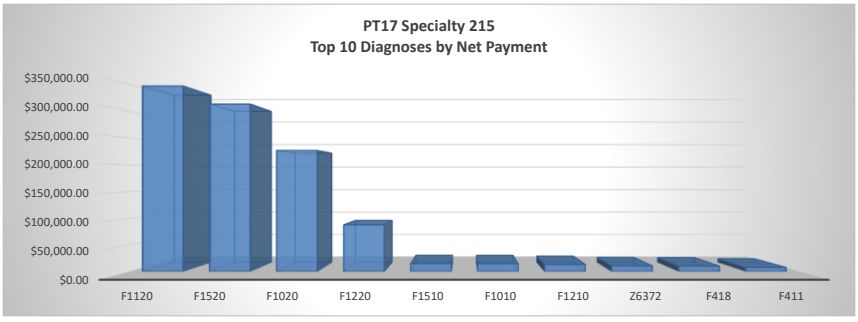
Time Period: Incurred With Runoff Quarter				QTR 1 2018		
				Patients	Service Count Paid	Net Payment
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Diagnosis Code Principal	Diagnosis Principal			
017	215	F1120	Opioid dependence, uncomplicated	487	29,721	$347,162.50
		F1520	Other stimulant dependence, uncomplicated	246	6,745	$313,588.52
		F1020	Alcohol dependence, uncomplicated	184	4,998	$227,115.28
		F1220	Cannabis dependence, uncomplicated	70	1,050	$88,014.81
		F1510	Other stimulant abuse, uncomplicated	17	258	$15,078.56
		F1010	Alcohol abuse, uncomplicated	28	394	$14,852.11
		F1210	Cannabis abuse, uncomplicated	28	215	$13,232.27
		Z6372	Alcoholism and drug addiction in family	165	172	$10,603.97
		F418	Other specified anxiety disorders	3	330	$10,242.92
		F411	Generalized anxiety disorder	8	152	$7,694.03
		F4323	Adjustment disorder with mixed anxiety and depressed mood	5	52	$6,446.09
		F319	Bipolar disorder, unspecified	4	46	$6,263.04
		R69	Illness, unspecified	18	107	$6,105.97
		F1420	Cocaine dependence, uncomplicated	4	92	$5,445.68
		F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated	3	40	$4,419.21
		F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder	4	58	$4,000.21
		F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated	1	26	$3,332.19
		F4310	Post-traumatic stress disorder, unspecified	9	42	$3,272.74
		F209	Schizophrenia, unspecified	4	27	$2,761.39
		F4325	Adjustment disorder with mixed disturbance of emotions and conduct	9	24	$2,542.56
		F3342	Major depressive disorder, recurrent, in full remission	2	36	$2,189.00
		F322	Major depressive disorder, single episode, severe w/o psychotic features	6	16	$1,855.64
		F1511	Other stimulant abuse, in remission	1	13	$1,716.17
		F3132	Bipolar disorder, current episode depressed, moderate	2	14	$1,583.60
		F341	Dysthymic disorder	6	11	$1,143.58
		Z62810	Personal history of physical and sexual abuse in childhood	1	10	$1,081.50
		F4322	Adjustment disorder with anxiety	4	8	$959.13
		F4324	Adjustment disorder with disturbance of conduct	3	8	$927.82
		F4321	Adjustment disorder with depressed mood	3	13	$881.02
		F3181	Bipolar II disorder	1	8	$865.20
		F6381	Intermittent explosive disorder	1	7	$757.05
		F332	Major depressive disorder, recurrent severe without psychotic features	1	6	$648.90
		F1820	Inhalant dependence, uncomplicated	1	11	$607.65
		F3481	Disruptive mood dysregulation disorder	1	10	$577.80
		F329	Major depressive disorder, single episode, unspecified	1	5	$540.75
		F321	Major depressive disorder, single episode, moderate	2	6	$504.43
		F4320	Adjustment disorder, unspecified	2	5	$429.14
		F331	Major depressive disorder, recurrent, moderate	2	4	$346.16
		F17203	Nicotine dependence unspecified, with withdrawal	6	6	$325.83
		F99	Mental disorder, not otherwise specified	3	5	$319.50
		Z0389	Encounter for observation for oth suspect disease & conditions ruled out	2	3	$309.69
		F912	Conduct disorder, adolescent-onset type	1	5	$260.97
		F902	Attention-deficit hyperactivity disorder, combined type	1	3	$247.07
		F251	Schizoaffective disorder, depressive type	1	6	$179.10
		F1011	Alcohol abuse, in remission	1	2	$170.23
		Z711	Person with feared health complaint in whom no diagnosis is made	2	2	$170.23
		F419	Anxiety disorder, unspecified	1	5	$149.25
		F29	Unspecified psychosis not due to substance or known physio condition	1	1	$140.45
		F17209	Nicotine dependence, unspecified, with unspec nicotine-induced disorders	1	1	$139.46
		F630	Pathological gambling	1	2	$115.56
		F1521	Other stimulant dependence, in remission	1	1	$108.15
		F1410	Cocaine abuse, uncomplicated	2	4	$100.22
		Z590	Homelessness	3	3	$92.31
		F3162	Bipolar disorder, current episode mixed, moderate	1	3	$89.55
		F330	Major depressive disorder, recurrent, mild	2	3	$74.16
		F3112	Bipolar disorder, current episode manic w/o psychotic features, moderate	1	2	$60.62
		F1121	Opioid dependence, in remission	1	2	$59.70
		F639	Impulse disorder, unspecified	2	2	$59.70
		F1021	Alcohol dependence, in remission	1	1	$30.77
		Z598	Other problems related to housing and economic circumstances	1	1	$30.77
		F1110	Opioid abuse, uncomplicated	1	1	$29.85
		F413	Other mixed anxiety disorders	1	2	$28.42
			Total	**1,375**	**44,806**	**$1,113,080.15**



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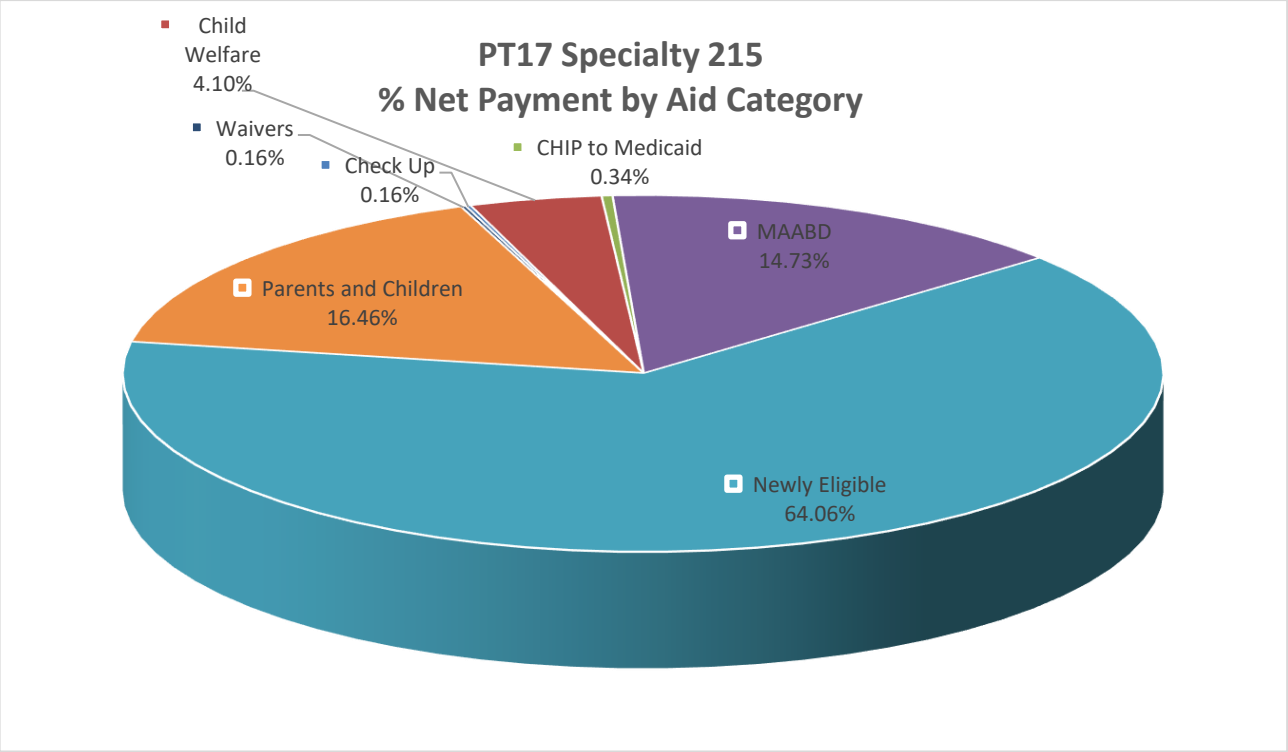
Time Period: Incurred With Runoff Quarter			QTR 1 2018		
			Patients	Service Count Paid	Net Payment
Provider Type Claim NV Code	**Provider Specialty Claim NV Code**	**Category**			
017	215	Check Up	6	21	$1,734.94
		Child Welfare	40	529	$45,690.89
		CHIP to Medicaid	3	28	$3,752.04
		MAABD	401	12,619	$163,923.08
		Newly Eligible	640	24,656	$712,997.95
		Parents and Children	221	6,751	$183,239.47
		Waivers	5	202	$1,741.78
		Total	**1,316**	**44,806**	**$1,113,080.15**



Net Payment is the net amount paid for all claims. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

Total Patient Count is not unique (i.e. patient counts may be duplicated across aid categories).

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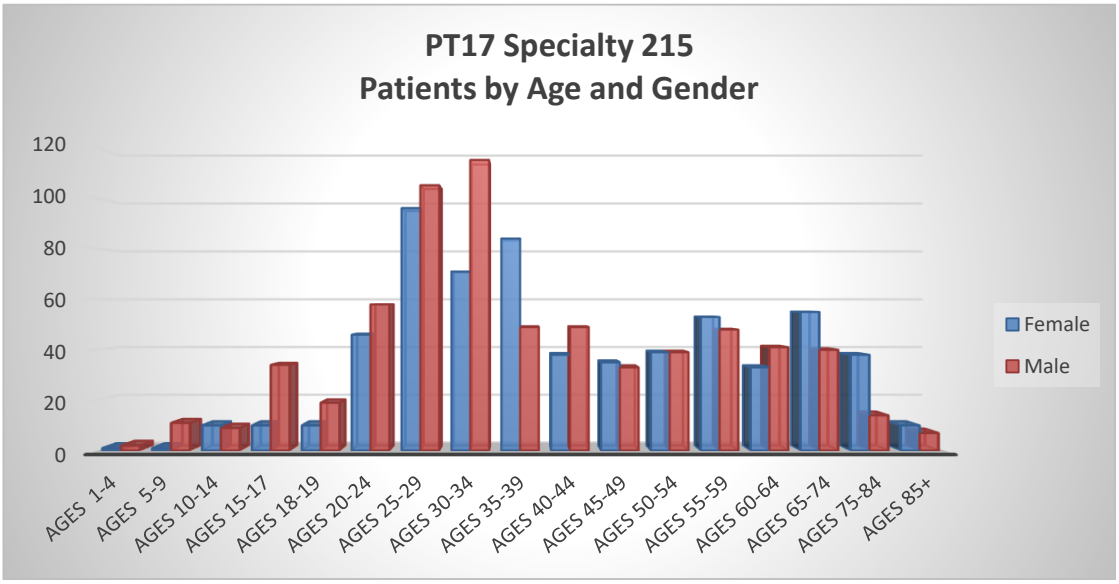
Time Period: Incurred With Runoff Quarter			QTR 1 2018	
			Patients	
Gender Code			F	M
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Age Group Medstat		
017	215	Ages 1-4	1	2
		Ages 5-9	1	11
		Ages 10-14	10	9
		Ages 15-17	10	34
		Ages 18-19	10	19
		Ages 20-24	46	58
		Ages 25-29	96	105
		Ages 30-34	71	115
		Ages 35-39	84	49
		Ages 40-44	38	49
		Ages 45-49	35	33
		Ages 50-54	39	39
		Ages 55-59	53	48
		Ages 60-64	33	41
		Ages 65-74	55	40
		Ages 75-84	38	14
		Ages 85+	10	7
		Total	**630**	**673**



Note: there is a small amount of Patients that change age during the quarter and fall into more than one age group.

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Dimension/Measure	Definition
Aid Category	Nevada - specific description for the local aid category.
Claims Denied	The number of claims denied based on the count of unique claim numbers. Adjustments and voids are excluded. Claims are counted at the document or header level, not at the service level.
Claims Paid	The number of claims paid based on the count of unique claim numbers. Adjustments and voids are excluded. Claims are counted at the document or header level, not at the service level.
Diagnosis Principal	The principal diagnosis description for a service, claim, or lab result.
Edit Error 1	The description for Edit Error.
Net Payment	The net amount paid for all claims. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Patients	The unique count of members who received facility, professional, or pharmacy services.
Procedure Code	The procedure code for the service record.
Provider County	The current county description of the provider of service.
Provider Specialty Claim NV Code	The Nevada specific code for the servicing provider specialty reported on the claim.
Provider Type Claim NV Code	The Nevada specific code for the servicing provider type on the claim record.
Providers	The unique count of providers who performed any facility, professional, or pharmacy services.
Providers Enrolled	The unique count of providers who are enrolled to provide services under the plan. This includes all providers authorized to provide services even if they have not provided services to any patients. The enrolled provider measures differ from the other provider measures in that those measures only include providers who have submitted claims for facility, professional, or pharmacy services under the plan.
Service Count Paid	The sum of the units paid across professional and facility claims.