SUBSTANCE ABUSE AGENCY MODEL (SAAM)

Fee For Service Reports

Q3 CY 2017

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 3 2017	
			Providers Enrolled	Providers (Active)
Provider Type NV Code	**Provider Specialty NV Cd**	**Provider County**		
017	215	Carson City	2	2
		Churchill	1	1
		Clark	20	9
		Douglas	1	1
		Elko	1	1
		Lyon	1	1
		Nye	3	2
		Washoe	13	6
		Total	**42**	**23**

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)
Fee for Service Reports

Time Period: Incurred With Runoff Quarter		QTR 3 2017			
		Claims Paid	Claims % Paid	Claims Denied	Claims % Denied
Provider Type Claim NV Code	Provider Specialty Claim NV Code				
017	215	13,007	82.16%	2,825	17.84%

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.

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Time Period: Incurred With Runoff Quarter			QTR 3 2017
			Claims Denied
Provider Type Claim NV Code	**Provider Specialty Claim NV Code**	**Edit Error 1**	
017	215	Duplicate of History File Reco	733
		Procedure Requires Authorizati	679
		Unknown Edit Err1 0093	390
		BILL ANY OTHER AVAILABLE INSUR	291
		NUMBER OF PROCEDURES EXCEEDS N	205
		Duplicate Payment Request - Sa	181
		Recipient Not Eligible on DOS	103
		Invalid or Missing Recipient I	89
		ENROLLED IN HMO	35
		Unknown Edit Err1 0916	35
		NOT CLIA CERTIFIED TO PERFORM	33
		INVALID DIAGNOSIS CODE	9
		Unknown Edit Err1 4720	9
		PROCEDURE DISAGREES WITH AUTHO	6
		Unknown Edit Err1 0476	5
		BILLED AMOUNT MISSING OR INVAL	4
		Unknown Edit Err1 4730	4
		Approved Authorization Not on	3
		Recipient Not on File	3
		INVALID PROCEDURE/MODIFIER COM	2
		RECIPIENT NUMBER INCONSISTENT	2
		BILLING PROVIDER IS NOT A GROU	1
		MEDICARE REMITTANCE (EOMB) NOT	1
		Unknown Edit Err1 0181	1
		Unknown Edit Err1 4721	1
		Total	**2,825**

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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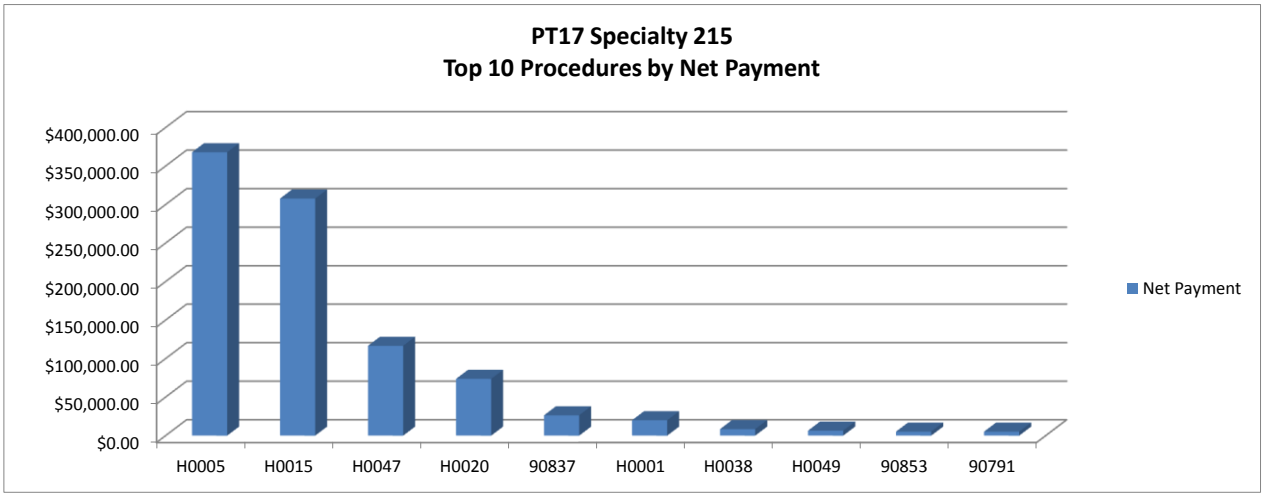
Time Period: Incurred With Runoff Quarter				QTR 3 2017		
				Patients	Service Count Paid	Net Payment
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Procedure Code	Procedure			
017	215	H0005	Alcohol/drug services-group counsel by clinician	441	12,324	$367,871.40
		H0015	Alcohol/drug svc-intensive outpatient program	128	2,194	$307,744.73
		H0047	Alcohol/drug abuse svc not otherwise specified	504	2,020	$116,659.74
		H0020	Alcohol/drug svc-methadone admin/service	269	18,694	$73,654.36
		90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	65	244	$26,388.60
		H0001	Alcohol and/or drug assessment	155	156	$19,908.03
		H0038	Self-help/peer services per 15 minutes	80	1,070	$8,431.60
		H0049	Alcohol &/or drug screening	235	664	$6,474.00
		90853	GROUP PSYCHOTHERAPY	28	174	$5,193.90
		90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	37	37	$5,140.56
		H0002	Behav health screen-eligibility for Tx program	135	135	$4,153.95
		99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	65	67	$4,061.54
		H0034	Medication training & support per 15 minutes	105	237	$4,022.86
		90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	11	43	$3,178.56
		80305	DRUG TEST PRSMV QUAL DIR OPTICAL OBS PER DAY	26	121	$1,719.41
		99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	29	30	$1,052.40
		99213	OFFICE OUTPATIENT VISIT 15 MINUTES	17	22	$968.00
		90839	PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	6	8	$900.40
		H0007	Alcohol/drug services-crisis intervention-outpt	23	26	$564.46
		90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	2	4	$391.40
		90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	4	8	$304.48
		99205	OFFICE OUTPATIENT NEW 60 MINUTES	2	2	$289.24
		90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	2	2	$227.52
		99202	OFFICE OUTPATIENT NEW 20 MINUTES	4	4	$214.16
		99212	OFFICE OUTPATIENT VISIT 10 MINUTES	6	6	$190.14
		99203	OFFICE OUTPATIENT NEW 30 MINUTES	2	2	$160.62
		90840	PSYCHOTHERAPY FOR CRISIS EACH ADDL 30 MINUTES	1	2	$112.54
			Total	**2,382**	**38,296**	**$959,978.60**



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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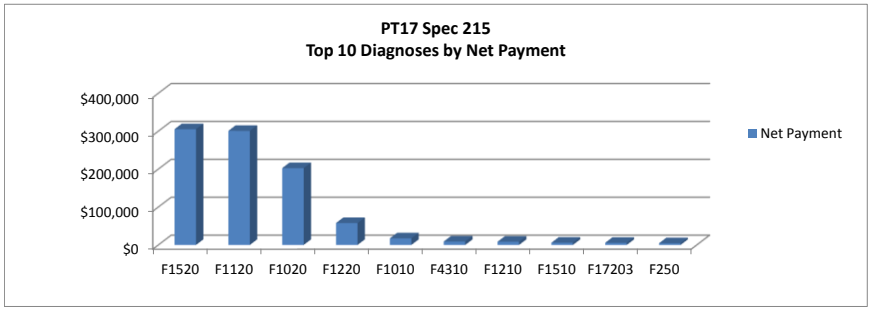
Time Period: Incurred With Runoff Quarter				QTR 3 2017		
				Patients	Service Count Paid	Net Payment
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Diagnosis Code Principal	Diagnosis Principal			
017	215	F1520	Other stimulant dependence, uncomplicated	219	7,266	$305,192.03
		F1120	Opioid dependence, uncomplicated	367	23,846	$300,798.30
		F1020	Alcohol dependence, uncomplicated	162	4,478	$202,538.11
		F1220	Cannabis dependence, uncomplicated	67	965	$57,811.70
		F1010	Alcohol abuse, uncomplicated	20	319	$17,459.45
		F4310	Post-traumatic stress disorder, unspecified	19	88	$8,947.49
		F1210	Cannabis abuse, uncomplicated	16	182	$8,438.78
		F1510	Other stimulant abuse, uncomplicated	15	125	$5,769.42
		F17203	Nicotine dependence unspecified, with withdrawal	64	106	$5,688.66
		F250	Schizoaffective disorder, bipolar type	2	33	$4,525.17
		F259	Schizoaffective disorder, unspecified	1	29	$4,073.05
		F411	Generalized anxiety disorder	6	42	$3,928.72
		F1110	Opioid abuse, uncomplicated	16	460	$3,810.13
		F10229	Alcohol dependence with intoxication, unspecified	1	24	$3,370.80
		F341	Dysthymic disorder	3	23	$2,959.17
		F322	Major depressive disorder, single episode, severe w/o psychotic features	6	27	$2,735.12
		F4323	Adjustment disorder with mixed anxiety and depressed mood	9	25	$2,608.69
		F4325	Adjustment disorder with mixed disturbance of emotions and conduct	7	27	$2,275.77
		R69	Illness, unspecified	7	18	$1,343.88
		Z62820	Parent-biological child conflict	1	12	$1,297.80
		F3130	Bipolar disorder, current episode depressed, mild or moderate, unspec	1	9	$1,264.05
		F418	Other specified anxiety disorders	1	8	$896.51
		F11120	Opioid abuse with intoxication, uncomplicated	6	6	$836.76
		F348	Other persistent mood [affective] disorders	1	14	$775.42
		F331	Major depressive disorder, recurrent, moderate	2	7	$762.66
		F251	Schizoaffective disorder, depressive type	1	15	$760.95
		Z0389	Encounter for observation for oth suspect disease & conditions ruled out	5	14	$756.40
		F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder	3	20	$734.54
		F330	Major depressive disorder, recurrent, mild	1	9	$665.28
		F4320	Adjustment disorder, unspecified	1	9	$665.28
		F3181	Bipolar II disorder	1	6	$648.90
		F321	Major depressive disorder, single episode, moderate	1	6	$648.90
		Z62810	Personal history of physical and sexual abuse in childhood	1	5	$540.75
		F1420	Cocaine dependence, uncomplicated	1	14	$501.69
		F1524	Other stimulant dependence with stimulant-induced mood disorder	2	7	$476.08
		N943	Premenstrual tension syndrome	1	4	$432.60
		F419	Anxiety disorder, unspecified	1	6	$414.00
		F1290	Cannabis use, unspecified, uncomplicated	1	10	$410.22
		F3112	Bipolar disorder, current episode manic w/o psychotic features, moderate	1	3	$324.45
		F1920	Other psychoactive substance dependence, uncomplicated	2	2	$279.91
		F319	Bipolar disorder, unspecified	1	3	$278.38
		F17209	Nicotine dependence, unspecified, with unspec nicotine-induced disorders	1	2	$149.21
		F1299	Cannabis use, unspecified with unspecified cannabis-induced disorder	1	1	$139.46
		F3132	Bipolar disorder, current episode depressed, moderate	1	1	$139.46
		F332	Major depressive disorder, recurrent severe without psychotic features	1	1	$139.46
		F329	Major depressive disorder, single episode, unspecified	1	1	$120.00
		F10129	Alcohol abuse with intoxication, unspecified	1	3	$117.41
		F333	Major depressive disorder, recurrent, severe with psychotic symptoms	1	1	$108.15
		F941	Reactive attachment disorder of childhood	1	1	$108.15
		Z590	Homelessness	2	2	$61.54
		F1590	Other stimulant use, unspecified, uncomplicated	1	2	$59.70
		F99	Mental disorder, not otherwise specified	4	4	$39.00
		F323	Major depressive disorder, single episode, severe w psychotic features	1	1	$30.77
		Z711	Person with feared health complaint in whom no diagnosis is made	1	1	$30.77
		F1421	Cocaine dependence, in remission	1	1	$29.85
		F339	Major depressive disorder, recurrent, unspecified	1	1	$29.85
		F918	Other conduct disorders	1	1	$29.85
			Total	**1,063**	**38,296**	**$959,978.60**



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 diagnosis codes).

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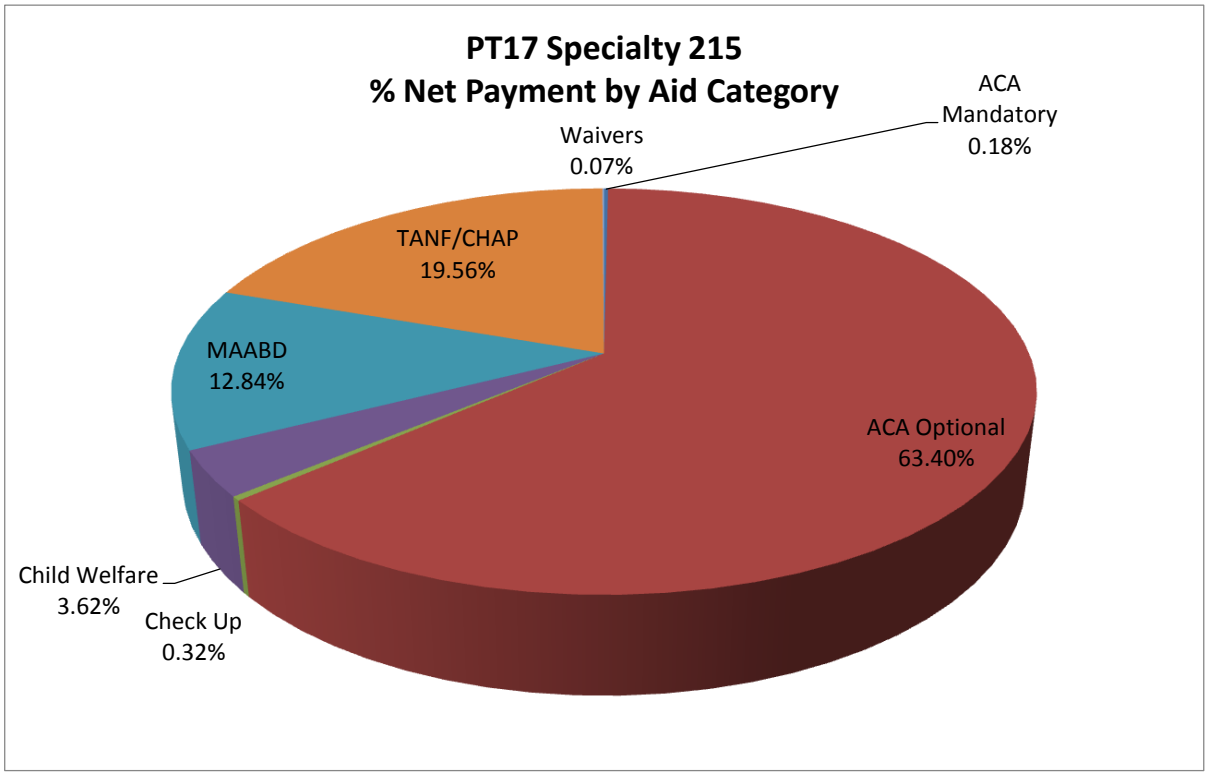
Time Period: Incurred With Runoff Quarter			QTR 3 2017		
			Patients	Service Count Paid	Net Payment
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Category			
017	215	ACA Mandatory	3	37	$1,746.84
		ACA Optional	537	21,760	$608,637.72
		Check Up	3	32	$3,083.32
		Child Welfare	29	443	$34,729.74
		MAABD	235	9,361	$123,270.38
		TANF/CHAP	210	6,569	$187,796.93
		Waivers	2	94	$713.67
		Total	**1,019**	**38,296**	**$959,978.60**



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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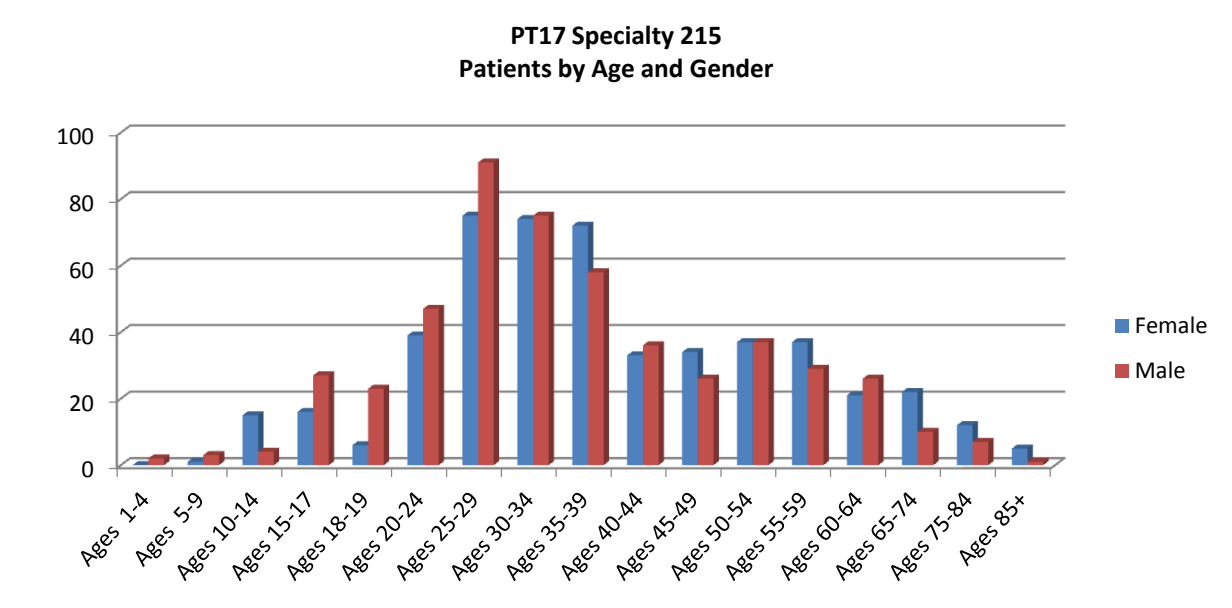
Time Period: Incurred With Runoff Quarter			QTR 3 2017	
			Patients	
Gender Code			F	M
Provider Type Claim NV Code	Provider Specialty Claim NV Code	Age Group Medstat		
017	215	Ages 1-4	0	2
		Ages 5-9	1	3
		Ages 10-14	15	4
		Ages 15-17	16	27
		Ages 18-19	6	23
		Ages 20-24	39	47
		Ages 25-29	75	91
		Ages 30-34	74	75
		Ages 35-39	72	58
		Ages 40-44	33	36
		Ages 45-49	34	26
		Ages 50-54	37	37
		Ages 55-59	37	29
		Ages 60-64	21	26
		Ages 65-74	22	10
		Ages 75-84	12	7
		Ages 85+	5	1
		Total	**499**	**502**



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.