

Claims Appeals, Adjustments and Voids Provider Training



Nevada Medicaid Provider Training

2020



Objectives



Objectives

- Understand the Claims Appeals Process
- Learn how to Adjust or Void a Claim using the EVS Secure Provider Web Portal
- Locate Additional Resources
- Contact Nevada Medicaid



Claims Appeals Process



Claims Appeals Process

- Providers have the right to appeal a claim that has been ***denied***.
- Appeals must be submitted to Nevada Medicaid electronically, no later than 30 calendar days from the date on the remittance advice.
- When filing a claim appeal, complete a Formal Claim Appeal Request (FA-90) and include:
 - A detailed explanation for the appeal
 - The provider's name and National Provider Identifier (NPI)
 - The Internal Control Number (ICN) of the denied claim
 - The name and telephone number of the person Nevada Medicaid can contact regarding the appeal
 - Documentation that supports the issue of why the claim is being appealed, such as medical records, prior authorization information and Explanation of Benefits or any additional information that a provider deems necessary
 - See the Prior Authorization chapter of the Nevada Medicaid Billing Manual for the instructions for submitting Prior Authorization appeals



Claims Appeals Process, continued

- Claim Appeals are to be sent to Nevada Medicaid by utilizing the Secure Correspondence option in the Electronic Verification System (EVS) secure Provider Web Portal.
- All providers submitting a claims appeal **must** read Chapter 8 (Claims Processing and Beyond) of the Billing Manual located on the Billing Information webpage of the Medicaid website at www.medicaid.nv.gov.

Claims Appeals Process, continued

- **FA-90** is located at: www.medicaid.nv.gov. Highlight “Providers” from the top blue tool bar and select “Forms” from the drop-down menu or by selecting “Forms” from the “Provider Links” located on the right hand side of the website.
- Date: Date that the Appeals form is being completed
- Complete the form in its entirety.
- For each appealed claim, a separate FA-90 must be attached. If a provider has multiple appeals, the provider **must** submit each appeal separately for uploading, as well as complete an FA-90 for each appeal.

Nevada Medicaid and Nevada Check Up

Formal Claim Appeal Request

Purpose: Use this form to request a formal claim appeal. Do **not** use this form to submit adjustments/voids, to make corrections to claims or to resubmit a denied claim.

Claim appeals must be submitted via the Provider Web Portal (PWP). To submit a claim appeal, log on to the PWP and navigate to Secure Correspondence. For detailed information regarding how to use Secure Correspondence for claim appeals, refer to Electronic Verification System (EVS) User Manual Chapter 1 (Getting Started) and Chapter 3 (Claims) on the EVS User Manual webpage at www.medicaid.nv.gov.

For questions regarding this form, call **(877) 638-3472**

DATE: ____/____/____

PROVIDER INFORMATION
Provider Name:
Provider NPI/API:
Name of person to be contacted regarding the appeal:
Contact person phone number:
CLAIM INFORMATION
Internal control number (ICN) (13 digits):
REASON FOR THE CLAIM APPEAL (be specific)
ATTACHMENTS
Please check the box if you are including attachments with this Formal Claim Appeal Request: <input type="checkbox"/> Documentation to support the appeal request, e.g., physician's notes, medical records, etc.

Claims Appeals Process, continued

Delegate for Role IDs Location

Provider

Welcome

Name

Provider ID

Location ID

▶ [My Profile](#)

▶ [Switch Provider](#)

Broadcast Messages

Hours of Availability
The Nevada Provider Web Portal is unavailable between midnight and 12:25 AM PST Monday-Saturday and between 8 PM and 12:25 AM PST on Sunday.

[Contact Us](#)

1

[Secure Correspondence](#)

Provider Services

▶ [Member Focused Viewing](#)

▶ [Search Payment History](#)

▶ [Revalidate-Update Provider](#)

▶ [Pharmacy PA](#)

▶ [PASRR](#)

▶ [EHR Incentive Program](#)

▶ [EPSDT](#)

▶ [Presumptive Eligibility](#)

Welcome Health Care Professional!



We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and search for claims, payment information, and access Remittance Advices, our secure site provides access to eligibility, answers to frequently asked questions, and the ability to process authorizations.

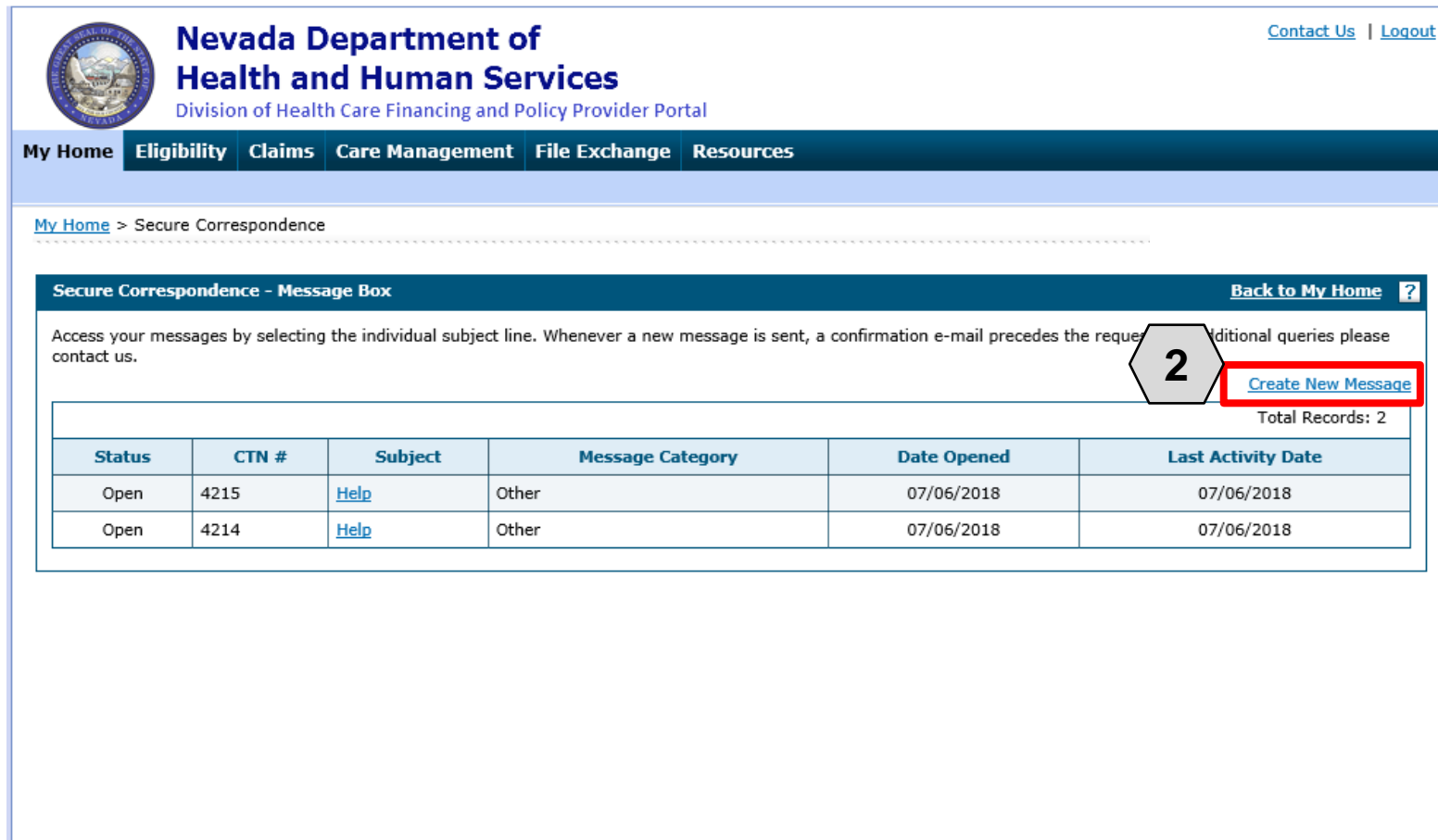
Prior Authorization Quick Reference Guide [\[Review\]](#)

Provider Web Portal Quick Reference Guide [\[Review\]](#)

From the home page, the user will:

1. Select **Secure Correspondence** to start the Appeal process

Claims Appeals Process, continued



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) | [Logout](#)

[My Home](#) | [Eligibility](#) | [Claims](#) | [Care Management](#) | [File Exchange](#) | [Resources](#)

[My Home](#) > Secure Correspondence

Secure Correspondence - Message Box [Back to My Home](#) ?

Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional queries please contact us.

[Create New Message](#)

Total Records: 2

Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4215	Help	Other	07/06/2018	07/06/2018
Open	4214	Help	Other	07/06/2018	07/06/2018

Once the user clicks the **Secure Correspondence** button, the “Secure Correspondence” page will appear. On this page, users will be able to review any previously submitted correspondence and create new ones.

From there, the user will:

2. Click the **Create New Message** link

Claims Appeals Process, continued

The screenshot shows the Nevada Department of Health and Human Services Provider Portal. The page title is "Nevada Department of Health and Human Services" with the subtitle "Division of Health Care Financing and Policy Provider Portal". The navigation bar includes "My Home", "Eligibility", "Claims", "Care Management", "File Exchange", and "Resources". The breadcrumb trail is "My Home > Secure Correspondence > Create Message". The date and time are "Tuesday 07/03/2018 06:59 AM PST".

The form is titled "Secure Correspondence - Create Message" and includes a "Back to Message Box" link. The instructions state: "Enter your correspondence information below and click the **Send** button to send the correspondence to the plan or click **Cancel** to go back. Technical Support will accept Provider Web Portal usage issues submitted through this page except for those relating to prior authorization. For pharmacy prior authorization questions call 855-455-3311. For non-pharmacy prior authorization questions, call 800-525-2395. For non-technical support related issues, please go to www.medicaid.nv.gov or call 1-877-638-3472.

The form fields are as follows:

- * Indicates a required field.
- *Subject: Appeal of a denied claim
- *Message Category: Claims - Appeals (highlighted with a red box and a callout bubble containing the number 3)
- Email: john.doe@myhealth.com
- Confirm Email: john.doe@myhealth.com
- Phone Number: (empty)
- *Preferred Method of Communication: Email
- *Service Provider ID: 1234567890
- *Provider Type: 20 - Physician
- *Denial Reason: Denied with EOB 0245.
- *Message: Claim was Denied. Please review additional documentation.

The user will then:

3. Select "Claims – Appeals" from the **Message Category** drop-down list and fill out all of the required fields.

Claims Appeals Process, continued

The screenshot shows a web form titled "Attachments". At the top, it says "Click the **Remove** link to remove the entire row." Below this is a table with columns: #, Transmission Method, File, Control #, Attachment Type, and Action. A "Click to collapse" link is visible. The form contains several fields: a dropdown for "Transmission Method" (set to "EL-Electronic Only"), a text input for "Upload File" with a "Browse..." button, a dropdown for "Attachment Type", and a text input for "Description". At the bottom of the form are "Add" and "Cancel" buttons. Below the form, there is a "Send" button and a "Cancel" button. Two numbered callouts are present: a hexagon with the number "4" pointing to the "Browse..." button, and a hexagon with the number "5" pointing to the "Send" button. Both the "Browse..." button and the "Send" button are highlighted with red rectangles.

Next, the user will need to:

4. Click the **Browse** button and locate the file supporting the appeal request

5. Click the **Send** button

NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.

Claims Appeals Process, continued

Secure Correspondence - Message Box

Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional information, contact us.

Status	CTN #	Subject	Opened	Last
Open	4256	Appeal of a denial	09/18/2018	
Open	4255	testing	09/18/2018	
Open	4253	Testing from MO	09/18/2018	
Open	4252	Testing 6268 in MO	09/18/2018	
Open	4251	Testing 6268	09/06/2018	

Confirmation

6 Your secure message was successfully sent.

OK

After the user clicks the **Send** button, a confirmation message will populate with “Your secure message was successfully sent”

User will then need to:
6. Click the **OK** button

Claims Appeals Process, continued



Fri 7/6/2018 3:40 PM

HCP Secure Correspondence

Secure Correspondence

To

A message was sent from Nevada Medicaid Provider Portal Secure Correspondence using this email address.

Message Category : Other



The following link has been provided for your convenience. Nevada Medicaid Provider Portal (<https://portalmod.medicaid.nv.gov/hcp/provider>)

Sincerely,

Division of Health Care Financing and Policy Provider Portal User Management

Additionally, once the correspondence has been submitted, the user will receive an email confirmation. The email will also contain a link to the correspondence for convenience.

NOTE: Once the user clicks the link in the email, they will need to log in to the portal to review the correspondence.

Claims Appeals Process, continued

Secure Correspondence - Message Box					Back to My Home ?
Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional queries please contact us.					
					Create New Message
					Total Records: 13
Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4256	Appeal of a denied claim	Claims - Appeals	10/02/2018	10/02/2018
Open	4255	testing	Claims - Appeals	09/27/2018	09/27/2018
Open	4253	Testing from MO	Level 2 Support - Account Issues	09/19/2018	09/19/2018
Open	4252	Testing 6268 in MO	Level 2 Support - Account Issues	09/18/2018	09/18/2018
Open	4251	Testing 6268	Claims - Appeals	09/06/2018	09/06/2018
Open	4227	Testing sample for 5916	Level 2 Support - Account Issues	08/14/2018	08/14/2018
Closed	4217	Help	Other	07/08/2018	08/03/2018
Open	4218	Testing Help	Other	07/08/2018	07/08/2018
Open	4219	Testing help..	Other	07/08/2018	07/08/2018
Open	4188	Testing in Model	Level 2 Support - Account Issues	04/09/2018	04/09/2018
					1 2

After the user clicks the **OK** button, they will be directed to the **Secure Correspondence - Message Box**, where the new CTN can be seen.

It will be the Provider's responsibility to view their Secure Correspondence to verify the status of their Claim Appeal.



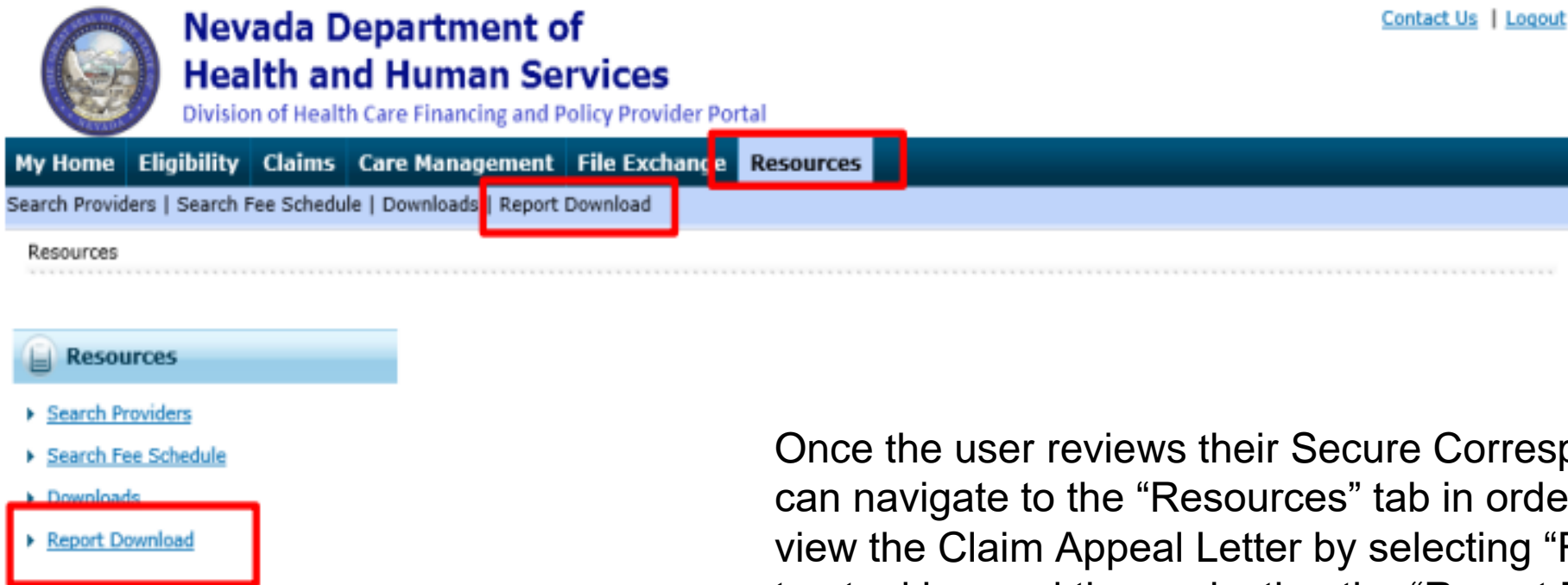
Claims Appeals Process, continued

When the request is received by Nevada Medicaid, the following steps are performed:

Step 1: Nevada Medicaid will review all documentation submitted by the provider.

Step 2: Nevada Medicaid will make a determination of Approved, Denied or Rejected. It is the provider's responsibility to review their Secure Correspondence to verify the outcome of the Claim Appeal, as there will not be a notification sent to the provider indicating that there is new information to review.

Accessing Claim Appeal Letters



The screenshot shows the Nevada Department of Health and Human Services website. The header includes the state seal and the text "Nevada Department of Health and Human Services" and "Division of Health Care Financing and Policy Provider Portal". In the top right corner, there are links for "Contact Us" and "Logout". A dark blue navigation bar contains the following tabs: "My Home", "Eligibility", "Claims", "Care Management", "File Exchange", and "Resources". The "Resources" tab is highlighted with a red box. Below this bar, a light blue bar contains links: "Search Providers", "Search Fee Schedule", "Downloads", and "Report Download". The "Report Download" link is highlighted with a red box. Below this, the "Resources" section is displayed, featuring a "Resources" header with a document icon. Underneath, there is a list of links: "Search Providers", "Search Fee Schedule", "Downloads", and "Report Download". The "Report Download" link is highlighted with a red box.

Once the user reviews their Secure Correspondence, the user can navigate to the “Resources” tab in order to download and view the Claim Appeal Letter by selecting “Resources” from the top tool bar and then selecting the “Report Download” link.

Accessing Claim Appeal Letters, continued

[Resources](#) > Report Download

Tuesday 02/26/2019 04:02 PM PST

Report Download ?

* Indicates a required field.
Enter your search criteria and click the **Search** button.

Provider ID	119	ID Type	NPI
*Report Category	Claims Appeal Letters	To Date	
From Date			
Recipient ID			
Contact Tracking Number			

Search **Reset**

On the Report Download page, select “Claim Appeal Letters” from the Report Category drop-down list. Input the appropriate search criteria and select the “Search” button.

Appeal Rejected

- A Notice of Appeal Rejection is generated when Nevada Medicaid has received a claim appeal request that has not been accepted.

Possible rejection reasons:

- Appeal cannot be processed due to late submission (no later than 30 calendar days from the date on the remittance advice)
- Appeal cannot be processed due to billing errors
- Appeal is incomplete (additional details as to why the appeal is incomplete will be indicated)
- Appeal requests for subsequent same service claim submission are not considered
- Please submit a claim adjustment to correct the payment of a claim

Notice: Appeal Rejected

Notice Date:

Name:

Address:

City, State, ZIP:

Attention:

Provider NPI/API:

Appeal Number:

Appeal Rejected

Your request for appeal has been rejected for the reasons specified below. Appeal procedures are discussed in the Provider Billing Manual at <https://www.medicaid.nv.gov> (select *Billing Information* from the Provider's menu) and in the Medicaid Services Manual, Chapter 100. If you have any questions, please call (877) 638-3472.

- ☐ Your claim appeal cannot be processed due to late submission. Appeals must be received within 30 days of the date on the remittance advice that lists the claim.
- ☐ Your appeal is incomplete. Resubmit your appeal with the information specified below. Complete information must be received within 30 days of the date on the remittance advice that lists the claim.
 - ☐ Supporting documentation (such as prior authorization, physician's notes, ER reports, explanation of benefits).
 - ☐ Your Formal Claim Appeal Request (FA-90) does not clearly indicate the reason for the appeal or does not correspond to the documentation submitted for the appeal.
 - ☐ Your Formal Claim Appeal Request (FA-90) was missing or incomplete. The FA-90 must include: the reason for the appeal, provider name, provider NPI/API, the claim's Internal Control Number (ICN), recipient name, recipient ID, dates of service, procedure codes, contact name and contact phone.
- ☐ Appeal requests for subsequent same service claim submissions are not considered.
- ☐ Please submit a claim adjustment to correct the payment of your claim.
- ☐ Other:

Thank you,
Nevada Medicaid
Provider Claim Appeals Unit

Appeal Approved

- A Notice Of Decision (NOD) is generated when Nevada Medicaid has reviewed the appeal request and based on the information provided, has been approved.
- If the appeal has been approved, Nevada Medicaid will advise the provider to submit the Appealed Claim via the Exception Batch Process. Providers will need to review Chapter 3 of the EVS User Manual for more information.

Notice of Decision: Appeal Approved

Notice Date:

Name:

Address:

City, State, ZIP:

Attention:

Provider NPI/API:

Appeal Number:

Appeal Approved

Nevada Medicaid has approved your appeal for the claim

with Internal Control Number:

for recipient:

on date(s) of service:

Please resubmit your claim through the Provider Web Portal as an EXCP Batch and include a copy of the approved appeal letter or an attachment referencing the approved appeal number. Instructions for submitting an EXCP Batch claim can be found in the Electronic Verification System (EVS) User Manual Chapter 3, which is online under the EVS tab on the Nevada Medicaid website:
<https://www.medicaid.nv.gov/providers/evsusermanual.aspx>

Please note: When claims are processed, please be aware that all system and clinical claim editor edits are applicable. As a result, there may be no (additional) payment, and other claim denials may be received.

If you have any questions, please call the Customer Service Center at (877) 638-3472.

Thank you,
Nevada Medicaid
Provider Claim Appeals Unit

Appeal Denied, Page 1

- A NOD is generated when Nevada Medicaid has reviewed the appeal and has denied the appeal.
- If the appeal has been denied, the provider has rights, including the right to a Fair Hearing. The request for a Fair Hearing is listed on page 1 and instructions are listed on page 2.
- Page 1 lists all pertinent information regarding the appeals request as well as the reason that the appeal has been denied.

Notice of Decision: Appeal Denied

Notice Date:

Name:

Address:

City, State, ZIP:

Attention:

Provider NPI/API:

Appeal Number:

Appeal Denied

After a thorough review, Nevada Medicaid has denied your appeal for the claim with Internal Control Number:

for recipient:

on dates of service:

Your appeal was denied for the following reasons:

If you do not agree with this decision, you may request a Fair Hearing by submitting:

- (1) copy of this letter with the bottom portion completed,
- (2) a copy of the original signed claim and
- (3) supporting documentation (such as prior authorization, physician's notes, ER reports).

Mail this information to: Hearings Supervisor, Nevada Medicaid, 1100 E. William St. Ste. 101, Carson City, NV 89701. Fair Hearing requests must be received within 90 days of this notice. The day after the Notice Date shown above is the first day of the 90-day period. At the Fair Hearing, you will be represented by yourself or by legal counsel.

I hereby request a Fair Hearing in regards to the denial of the claim listed above.

Name: _____

Contact Phone: _____

Provider's Legal Counsel (if applicable): _____

Legal Counsel's mailing address: _____

Legal counsel's phone: _____

Signature _____

Date: _____

Appeal Denied, page 2

- Page 2 contains information regarding the Fair Hearings, including Frequently Asked Questions (FAQs), such as who can request the Fair Hearing, what happens prior to and during the Fair Hearing and other important information.

Notice of Decision: Appeal Denied

Medicaid Service Manual (MSM) Chapter 100 Section 105.1C:

Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims editor program employs a nationally recognized standardized method of processing claims for professional services using clinical logic based on the most current CPT, HCPCS, International Classification of Diseases (ICD), American Medical Association (AMA), CMS and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.

Frequently Asked Questions about Hearing Preparation Meetings and Fair Hearings

WHO MAY REQUEST A FAIR HEARING? If a provider disagrees with a claim denial, a recoupment action or a termination of provider enrollment, the provider must first submit a written appeal to Nevada Medicaid. If the provider disagrees with the result of the appeal, the provider has the option to request a Fair Hearing through the Division of Health Care Financing Policy (DHCFP).

WHAT HAPPENS AT THE HEARING PREPARATION MEETING? Before the Fair Hearing takes place, the DHCFP holds a hearing preparation meeting to discuss the Fair Hearing request. Attendees of the meeting will include a representative from the DHCFP, a representative from Nevada Medicaid, and the provider and/or the provider's designated legal counsel. The purpose of a hearing preparation meeting is to supply the provider with an opportunity to furnish the DHCFP with information that he believes should be considered in reversing the appeal decision issued by Nevada Medicaid. All parties will have an opportunity to discuss their position on the issue.

WHAT HAPPENS AT A FAIR HEARING? A Fair Hearing is a proceeding during which the provider and/or his legal counsel can show the Fair Hearing Officer why the provider disagrees with Nevada Medicaid's appeal decision. The provider will be given an opportunity to comment on all documents and records pertaining to the appeal decision. (All documents and records are given to the provider within a reasonable time before the date of the Fair Hearing.) The provider is allowed to bring witnesses, present evidence, question or refute any testimony or evidence and cross-examine any witnesses. The DHCFP will also present their position in regards to the appeal decision.

WHO IS THE FAIR HEARING OFFICER? The Fair Hearing Officer may be an employee of the DHCFP or a person under contract with DHCFP. The Fair Hearing Officer will be an individual who has not been connected in any way with the action in question.

WHERE IS A FAIR HEARING HELD? Fair Hearings are usually held in or near the city where the provider's practice/business/facility is located. If the provider is unable to travel to the designated Fair Hearing location, the Fair Hearing may be held at another location or may be conducted by telephone when all parties are in agreement to do so.

WHAT DOES A FAIR HEARING COST? There is no charge to the provider for a Fair Hearing.

HOW IS A DECISION MADE? The Fair Hearing Officer's decision will be based on the evidence and testimony introduced at the Fair Hearing. The Department of Administration will notify the provider and the DHCFP in writing of the decision within 90 days from the date of the request for the Fair Hearing. Should the provider abandon or withdraw his Fair Hearing request or if the Fair Hearing Officer agrees with Nevada Medicaid's decision, the original appeal decision will stand.

PROVIDER'S RIGHT TO JUDICIAL REVIEW: If a provider is dissatisfied with the Fair Hearing decision, the case may be appealed to the provider's local District Court of the State of Nevada within 90 days after the date the written Fair Hearing decision was mailed. An official report of the hearing, together with all papers filed in the proceeding will constitute the record of the Fair Hearing. Fair Hearing records are on file in the Nevada Medicaid Office, 1100 East William Street, Suite 101, Carson City, Nevada 89701.



Fair Hearing

- Instructions for requesting a Fair Hearing are included with the Appeal Denied Notice of Decision.
- Fair Hearings are requested through the Division of Health Care Financing and Policy (DHCFP).
- Fair Hearing requests must be received no later than 90 days from the notice date showing the appeal was denied; the day after the notice date is considered the first day of the 90-day period.
- For additional information concerning Fair Hearings, please refer to the Medicaid Services Manual (MSM) Chapter 3100.



Claim Adjustments and Voids



Timely Filing for Claim Adjustments and Voids

Claim Adjustments and Void Requests must be received within:

- 180 days of the date of service, or date of eligibility decision, whichever is later for in-state providers and claims with no Third Party Liability (TPL)
- 365 days of the date of service, or date of eligibility decision, whichever is later for out-of-state providers and claims with TPL
- Only paid claims can be adjusted or voided (adjustments/voids do not apply to pending or denied claims)



Adjusting a Claim

Adjusting a Claim

My Home | Eligibility | **Claims** | Care Management | File Exchange | Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

> Search Claims Wednesday 09/19/2018 03:25 PM PST

1

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.
Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type
Service From To Claim Status

2

Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID.

Total Records: 1

Claim ID	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
<input type="button" value="+"/> 2218262000035	Professional	Finalized Payment	09/18/2018	67032685329	1841251725	\$44.62	-	

3

4

To begin the claim adjustment process:

1. Select the “Search Claims” page from the Claims Tab
2. Enter the search criteria
3. Click the **Search** button
4. Click the [blue Claim ID](#) link

NOTE: Denied Claims cannot be adjusted. The **Claim Status** column will indicate “Finalized Payment” if a claim is paid.

Adjusting a Claim, continued

Recipient: FRODOLEY, V. GIOVANNI
Birth Date: 05/01/2002

Claim Information

Claim Status	Finalized Payment	Date of Current	—
Date Type	—	Admission Date	09/18/2018
Accident Related	—	Authorization Number	—
Patient Number	053036404FKE		
Related Claim ICN	—		
Transport Certification	No		
Previous Claim ICN	—		
Note	—		

5 Does the provider have a signature on file? Yes

Total Allowed Amount	\$44.62	Total Co-pay Amount	\$0.00	Total Charged Amount	\$175.00	Total Paid Amount	\$44.62
-----------------------------	---------	----------------------------	--------	-----------------------------	----------	--------------------------	---------

[Expand All](#) | [Collapse All](#)

Adjudication Errors +

Diagnosis Codes +

Service Details -

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	\$175.00	\$44.62	\$0.00	\$44.62

No Other Insurance Details exist for this claim

No Attachments exist for this claim

6

Adjust **Copy** **Void** **Print Preview**

On the “View Claim” page, the user will:

5. Scroll down to the bottom of the page
6. Click the **Adjust** button

Adjusting a Claim, continued

Resubmit Professional Claim ID 2218262000035: Step 1

* Indicates a required field.

Claim Type Professional

7

Provider Information

Billing Provider ID 1578564860 ID Type NPI
*Billing Provider Service Location 20-HOSPITALISTS OF ARIZONA-2510 W DUNLAP AVE STE 290,PHOENIX,ARIZONA,850212759
Rendering Provider ID 1841251725 ID Type NPI
Rendering Provider Service Location 24-SHAVER, NANCY C-1919 E THOMAS RD EAST BLDG,PHOENIX,ARIZONA,850167710
Referring Provider ID ID Type
Supervising Provider ID ID Type
Service Facility Location ID ID Type

Patient Information

Claim Status Finalized Payment
*Recipient ID 67032685329
Last Name GIOXBIK First Name MROBMLV
Birth Date 05/01/2002

Claim Information

Date Type Date of Current
Accident Related Admission Date 09/18/2018
*Patient Number 053036404FKE Authorization Number
*Transport Certification Yes No
*Does the provider have a signature on file? Yes No
Include Other Insurance Total Charged Amount \$175.00

8

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	EOB
Claim	7499	CLAIM PROCESSED BY CLINICAL CLAIM EDITOR	7499
Service # 1	4084	ALLOWED AMT LESS THAN BILLED AMOUNT VARIANCE	0507

9 Continue Cancel

From here, the user may:

7. Review and make any necessary edits to the provider, patient or claim information
8. Review the **Adjudication Errors** panel to identify any issues that may need to be resolved
9. Click on the **Continue** button at the bottom of the page to proceed to the next step

Adjusting a Claim, continued

[Expand All](#) | [Collapse All](#)

Adjudication Errors +

Diagnosis Codes +

Service Details -
Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
<u>1</u>	09/18/2018	09/18/2018	32-Nursing Facility	99308-Nursing fac care subseq	\$175.00	1.000 Unit	
2						0.000	

2 *From Date To Date *Place of Service EMG
*Procedure Code Modifiers *Diagnosis Pointers
*Charge Amount *Units *Unit Type EPSDT ☐ Family Plan ☐
Cia Number Authorization Number
Rendering Provider ID ID Type
Rendering Provider Service Location
Referring Provider ID ID Type
NDCs for Svc. # 2

Attachments -
Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

10

10. Click the **Resubmit** button

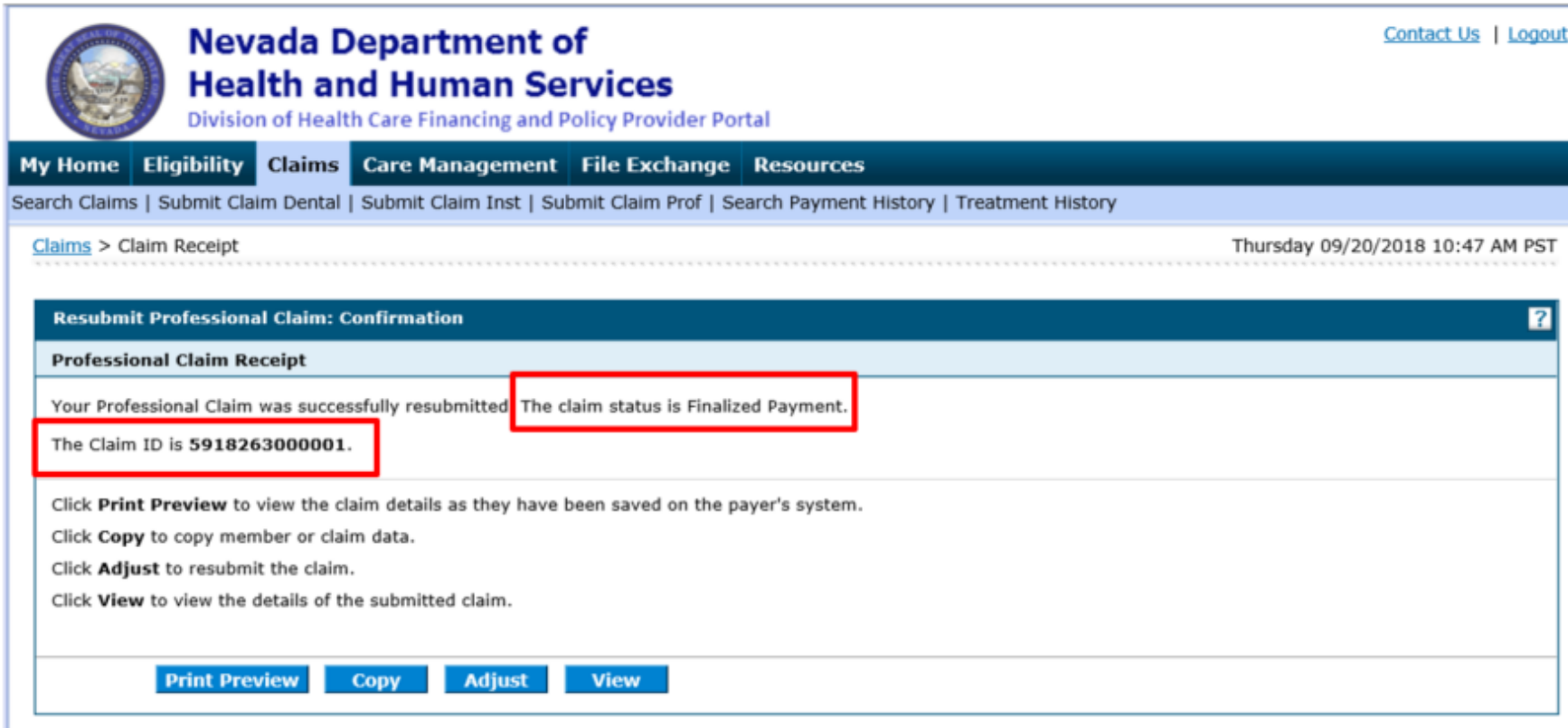
Adjusting a Claim, continued


Patient Information											
Recipient ID 67032685329						Gender Female					
Recipient MROBMLV V GIOXBIK											
Birth Date 05/01/2002											
Claim Information											
Claim Status Finalized Payment											
Date Type _						Date of Current _					
Accident Related _						Admission Date 09/18/2018					
Patient Number 053036404FKE						Authorization Number _					
Related Claim ICN _											
Transport Certification No											
Previous Claim ICN 2218262000035											
Note _											
Does the provider have a signature on file? Yes						Total Charged Amount \$175.00					
Expand All Collapse All											
Adjudication Errors											
Diagnosis Codes											
Service Details											
#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
<u>1</u>	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$175.00
No Other Insurance Details exist for this claim											
No Attachments exist for this claim											
Back to Step 1						Back to Step 2		Back to Step 3		Print Preview	
						11		Confirm		Cancel	

11. Click the **Confirm** button

NOTE: Click the **Cancel** button to cancel the adjustment.

Adjusting a Claim, continued




 **Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal

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My Home | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources**

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

[Claims](#) > Claim Receipt Thursday 09/20/2018 10:47 AM PST

Resubmit Professional Claim: Confirmation 

Professional Claim Receipt

Your Professional Claim was successfully resubmitted. The claim status is Finalized Payment.

The Claim ID is 59182630000001.

Click **Print Preview** to view the claim details as they have been saved on the payer's system.
Click **Copy** to copy member or claim data.
Click **Adjust** to resubmit the claim.
Click **View** to view the details of the submitted claim.

[Print Preview](#) [Copy](#) [Adjust](#) [View](#)

The “Resubmit Claim: Confirmation” page will appear after the claim has been submitted. It will display the claim status and adjusted Claim ID.



Voiding a Claim

Voiding a Claim

My Home Eligibility **Claims** Management File Exchange Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

Search Claims

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.

Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID 5918263000001

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

Search Reset

To search for a claim, the user will need to:

1. Hover over **Claims**
2. Select **Search Claims**
3. Enter **Claim ID**
4. Click the **Search** button

Voiding a Claim, continued

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.
Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID 5918263000001

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

Search Reset

Once the user has clicked the **Search** button, the results will display below.

To open the claim, the user will:

5. Click the [blue Claim ID](#) link to open the claim

NOTE: Denied Claims cannot be voided. The **Claim Status** column will indicate “Finalized Payment” if a claim is paid.

Search Results										
To see service line information, or to view the remittance advice, click on the '+' next to the claims ID.										
Total Records: 1										
	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
+	5918263000001	5	Professional	Finalized Payment	09/18/2018	67032685329	1841251725	\$44.62	09/21/2018	

Voiding a Claim, continued

Claim Information												
<div><div>Claim Status</div>Finalized Payment</div> <div><div>Date Type</div><div>—</div></div> <div><div>Accident Related</div><div>—</div></div> <div><div>Patient Number</div>053036404FKE</div> <div><div>Related Claim ICN</div><div>—</div></div> <div><div>Transport Certification</div>No</div> <div><div>Previous Claim ICN</div>2218262000035</div> <div><div>Note</div><div>—</div></div> <div><div>Does the provider have a signature on file?</div>Yes</div> <div><div>Date of Current</div><div>—</div></div> <div><div>Admission Date</div>09/18/2018</div> <div><div>Authorization Number</div><div>—</div></div> <div><div>Total Charged Amount</div>\$175.00</div> <div><div>Total Allowed Amount</div>\$44.62</div> <div><div>Total Co-pay Amount</div>\$0.00</div> <div><div>Total Paid Amount</div>\$44.62</div>												

Expand All

No Other Insurance Details exist for this claim

No Attachments exist for this claim

6

Adjust

Copy

Void

Print Preview

RA Copy (PDF)

To void the claim, the user will:

6. Click the **Void** button

Voiding a Claim, continued

Does the provider have a signature on file? Yes

Allowed Amount \$44.62 Total Co-pay Amount \$0.00 Total Charged Amount \$175.00 Total Paid Amount \$44.62

To Date	Place of Service	Diagnosis	ICD-9	ICD-10	Units	Charged Amount	Co-pay
09/18/2018	32	N	99308		1.000 Unit	\$175.00	\$44.62

Insurance Details exist for this claim

Insurance Details exist for this claim

Buttons: Just, Copy, Void, Print Preview

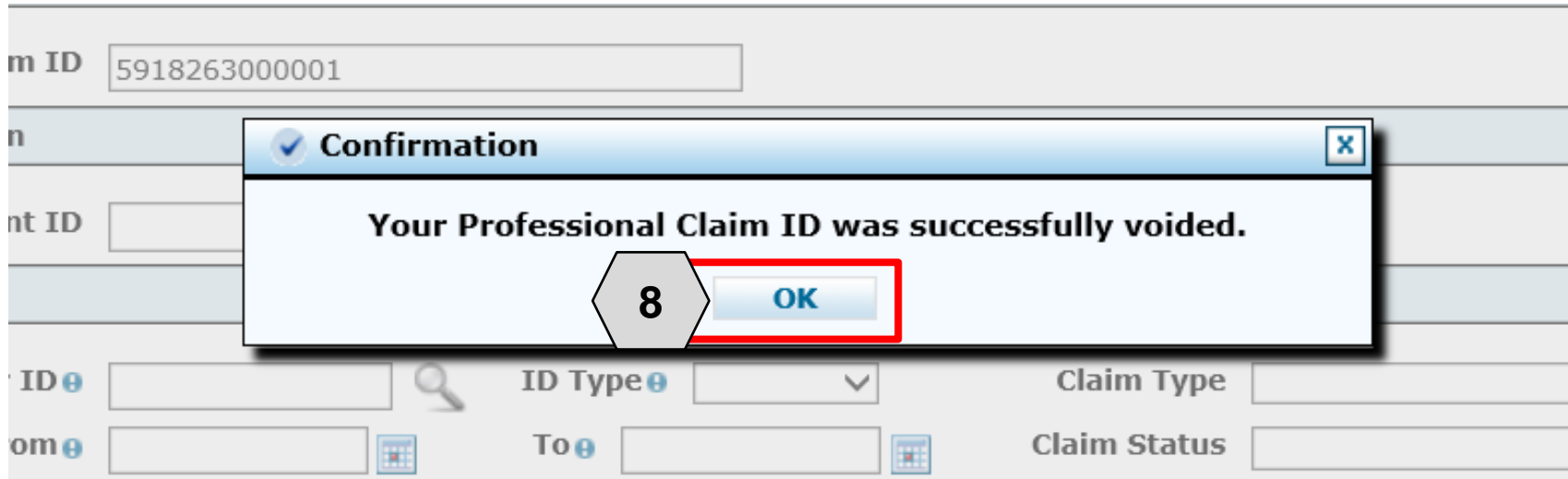
☒ Confirmation

Are you sure you want to void this Professional Claim ID 5918263000001?

7 OK Cancel

7. Click the **OK** button

Voiding a Claim, continued



The screenshot shows a software interface with a confirmation dialog box. The dialog box has a title bar with a checkmark icon and the word "Confirmation". The main text inside the dialog box reads "Your Professional Claim ID was successfully voided." Below this text is a button labeled "OK". A red rectangular box highlights the "OK" button. A grey hexagonal callout with the number "8" points to the "OK" button. In the background, there is a form with several fields: "m ID" with the value "5918263000001", "nt ID", "ID" with a search icon, "ID Type" with a dropdown arrow, "Claim Type", "om" with a calendar icon, "To" with a calendar icon, and "Claim Status".

8. Click the **OK** button



Resources

Additional Resources

- Billing Manual (Appeals Information): <https://www.medicaid.nv.gov/providers/BillingInfo.aspx>
- EVS User Manual: <https://www.medicaid.nv.gov/providers/evsusermanual.aspx>
- Medicaid Services Manual (Chapter 3100 – Fair Hearings):
<http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C3100/Chapter3100/>
- Formal Claim Appeal Request (FA-90): <https://www.medicaid.nv.gov/providers/forms/forms.aspx>

DHCFP Contact Information:

Contact Form:

<http://dhcfp.nv.gov/Contact/ContactUsForm/>



Contact Nevada Medicaid



Contact Us — Customer Service

- Customer Service Call Center:
877-638-3472 (Monday through Friday 8 a.m. to 5 p.m. Pacific Time)
- Provider Field Representative:
E-mail: NevadaProviderTraining@gainwelltechnologies.com



Thank you