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:
☐ Documentation to support the appeal request, e.g., physician's notes, medical records, etc.

FA-90
04/10/2019

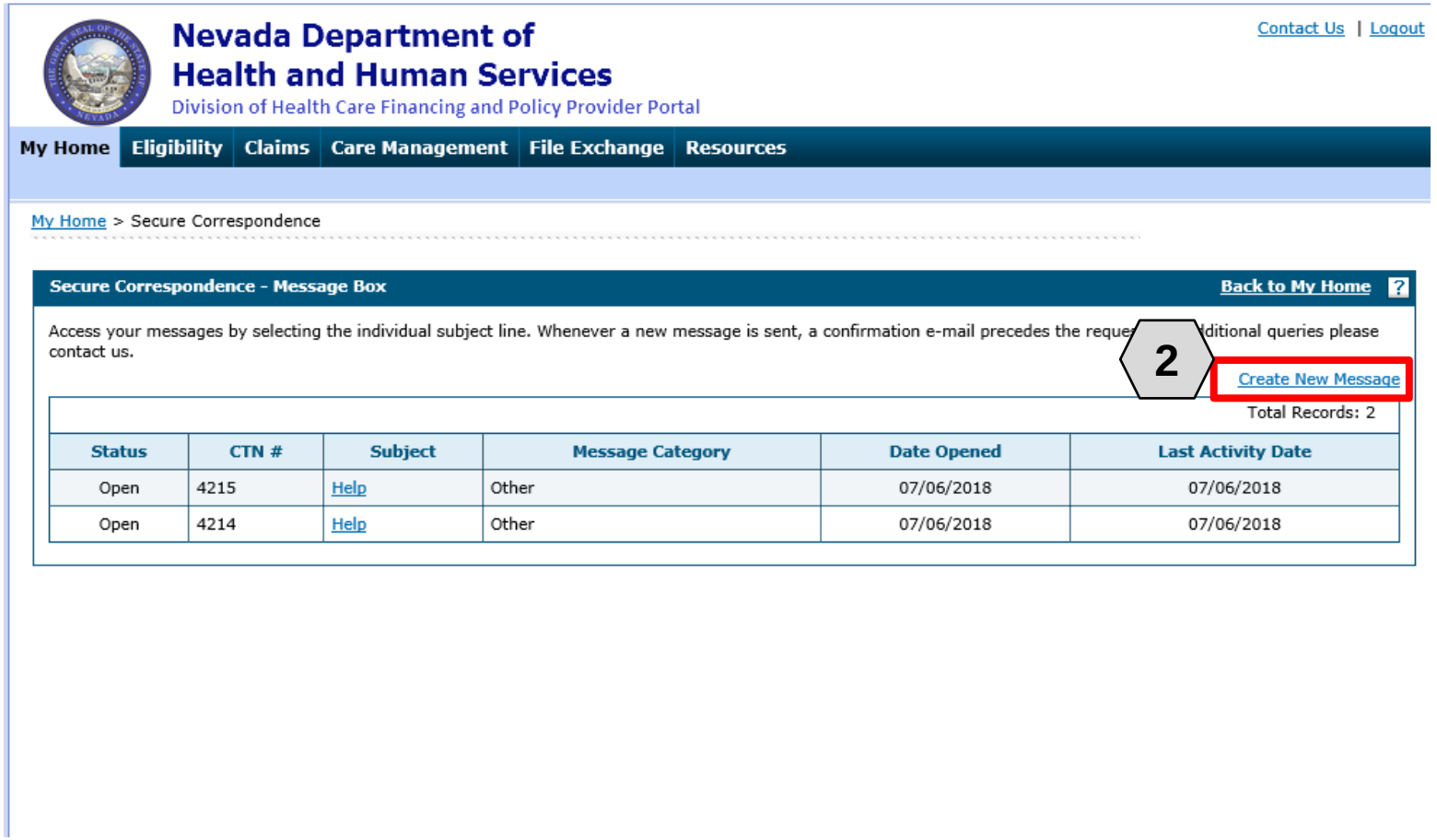
Page 1 of 1

Claims Appeals Process, continued

From the home page, the user will:

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

Claims Appeals Process, continued

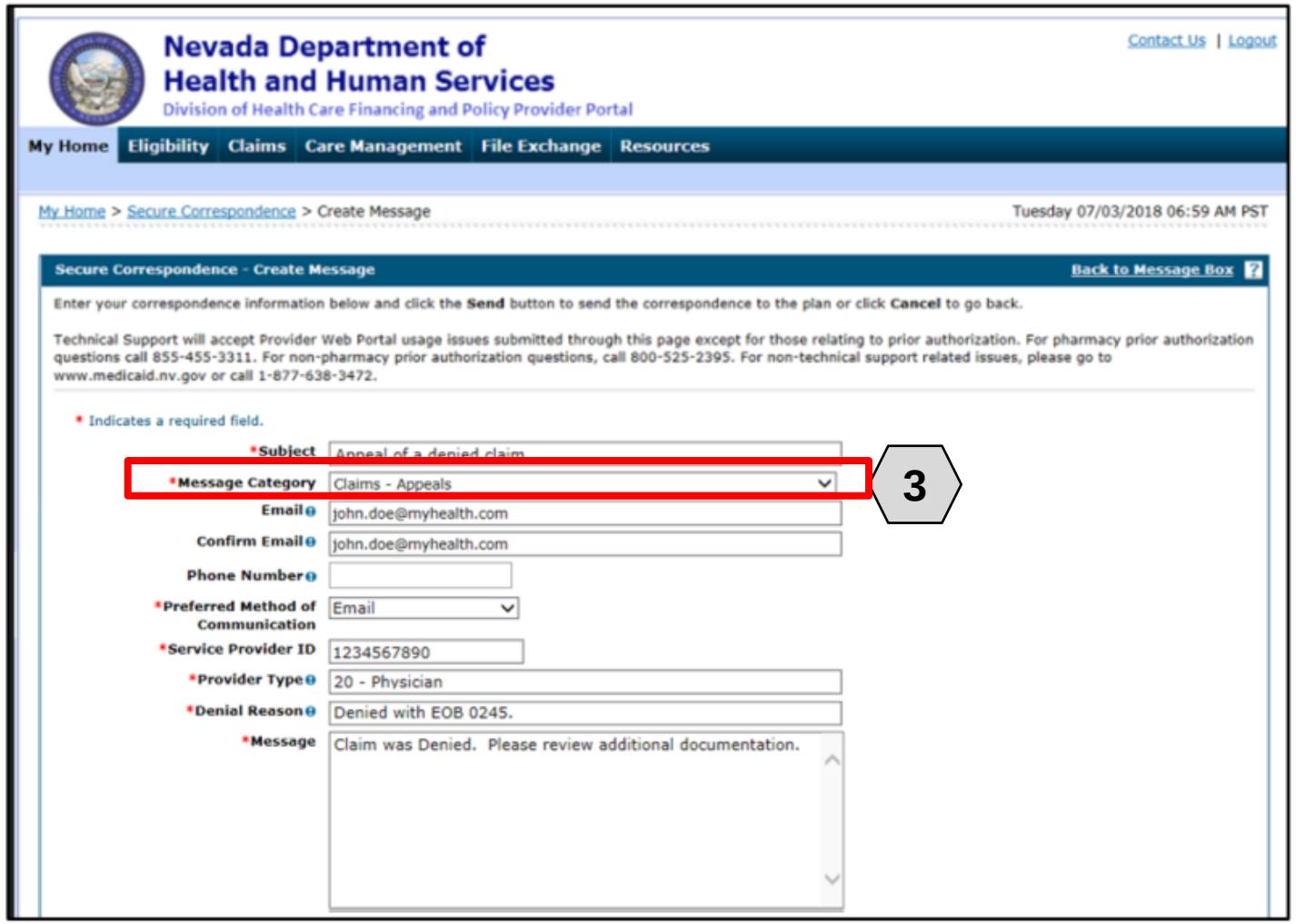


Once the user clicks the **Secure Correspondence** button, the "Secure Correspondence" page will appear. On this page, users will be able to review any previously submitted correspondence and create new ones.

From there, the user will:

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

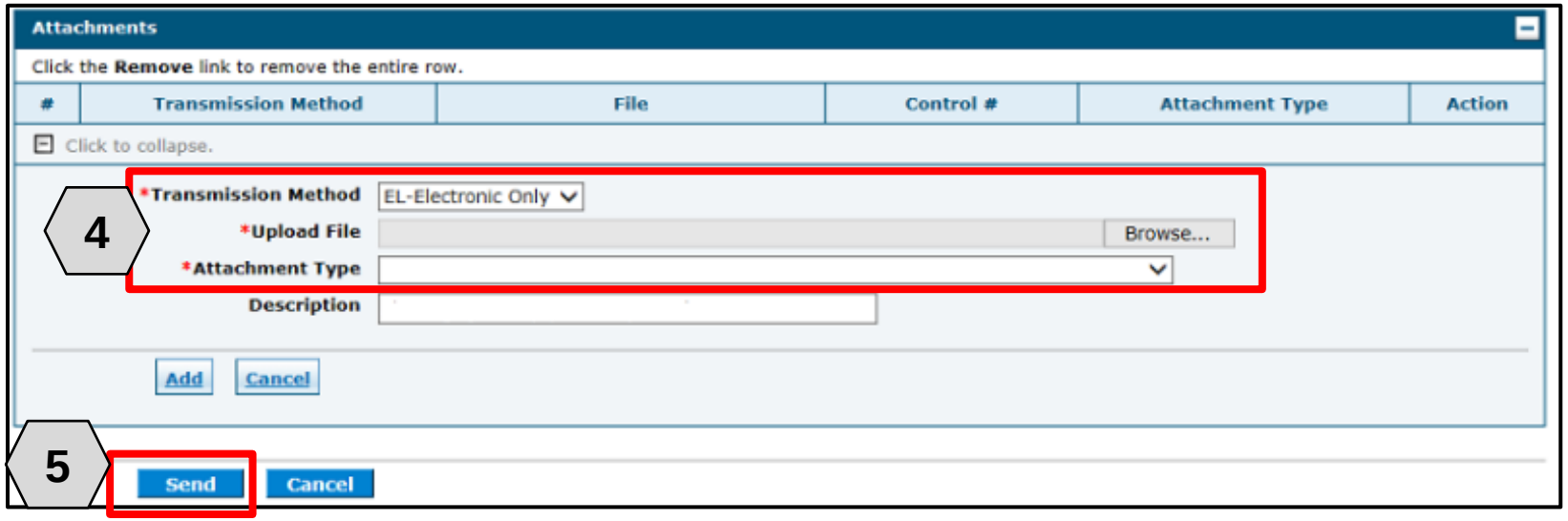
Claims Appeals Process, continued



The 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



Next, the user will need to:

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

5. Click the **Send** button

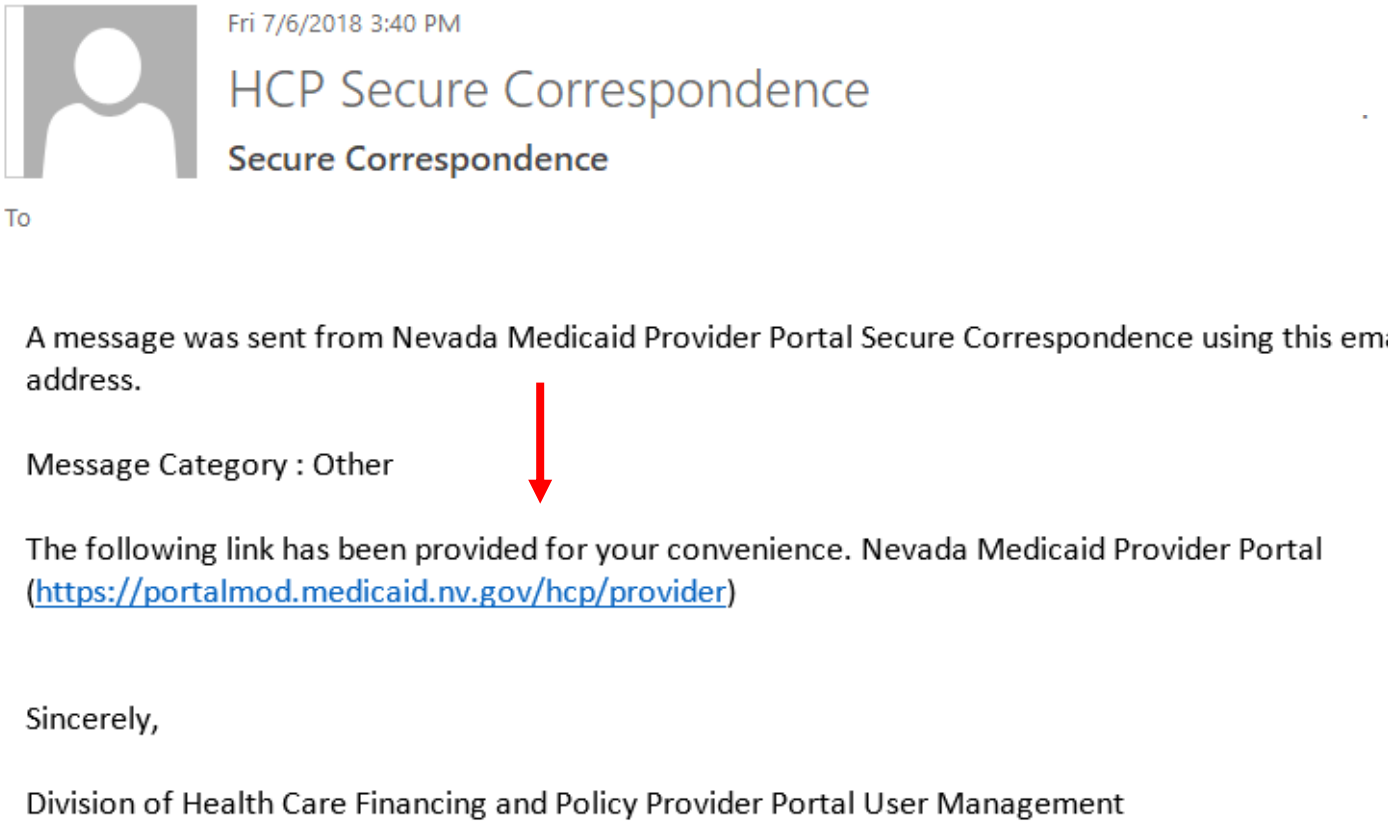
NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.

Claims Appeals Process, continued

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)

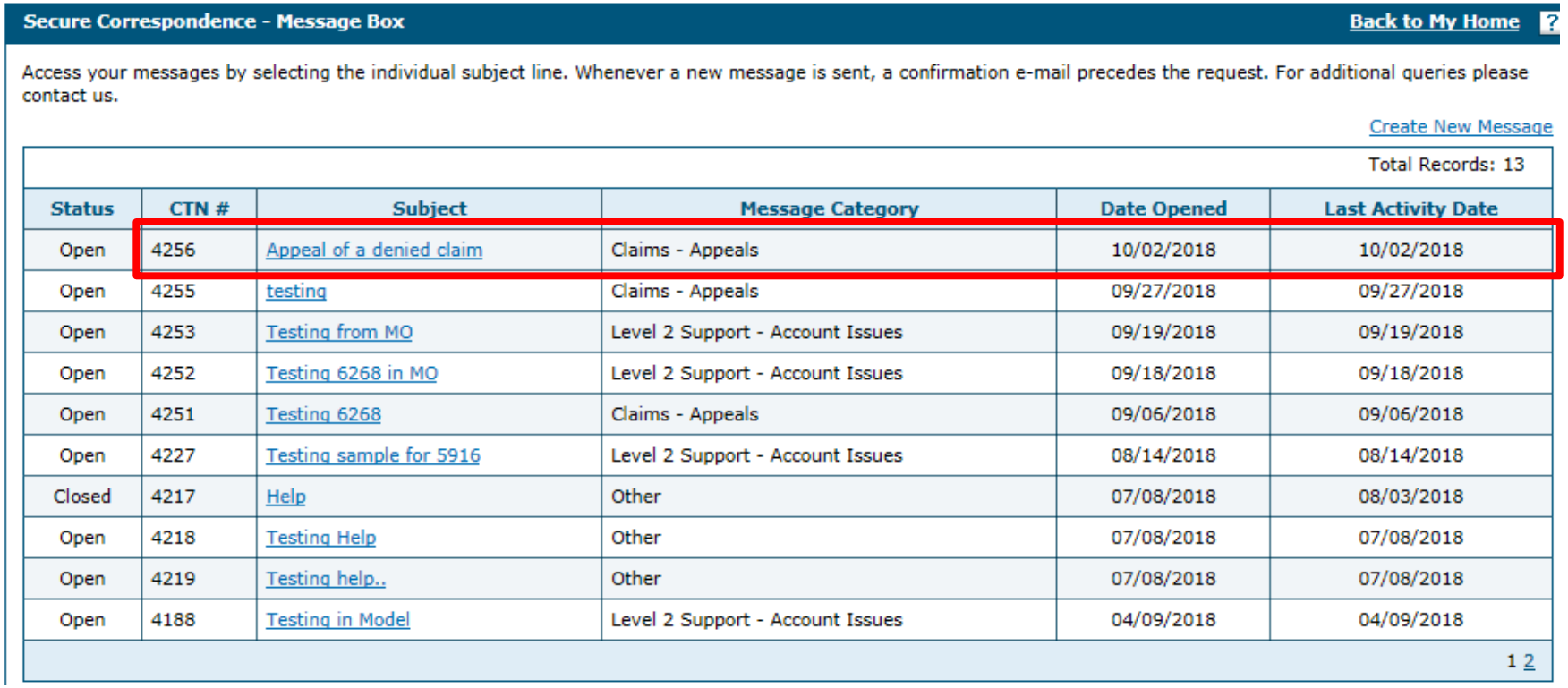
Sincerely,

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.

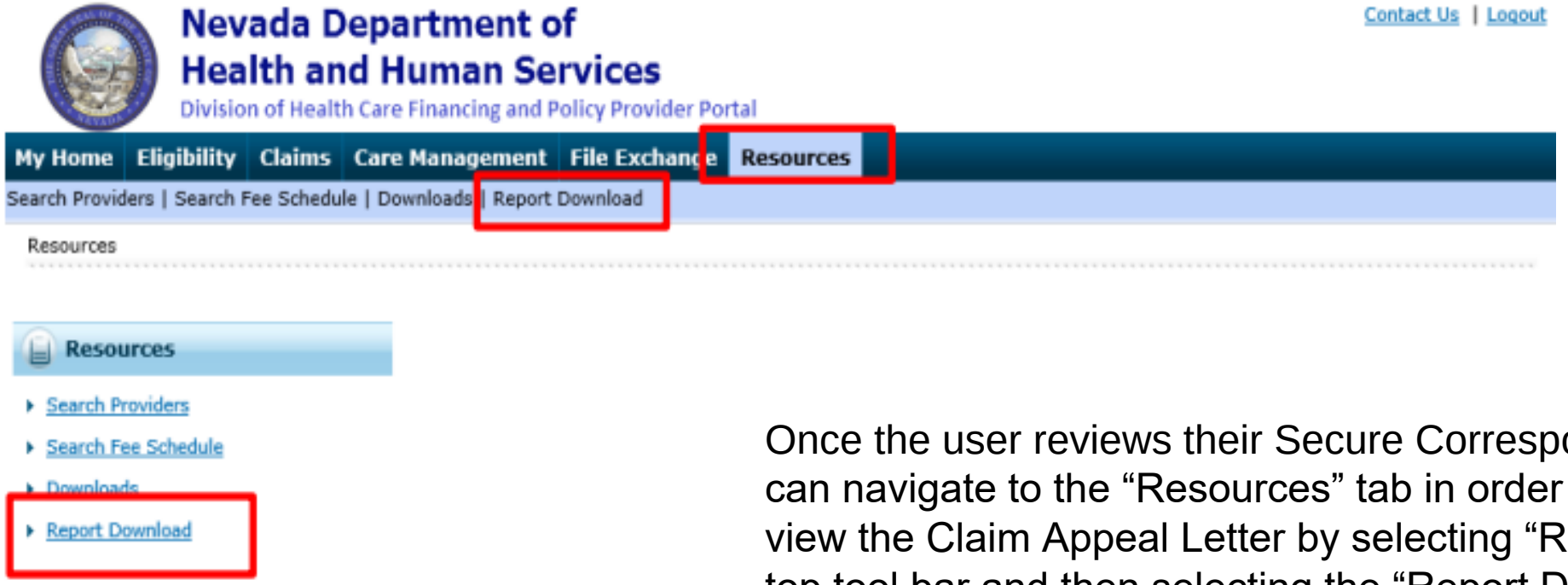
Claims Appeals Process, continued

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.

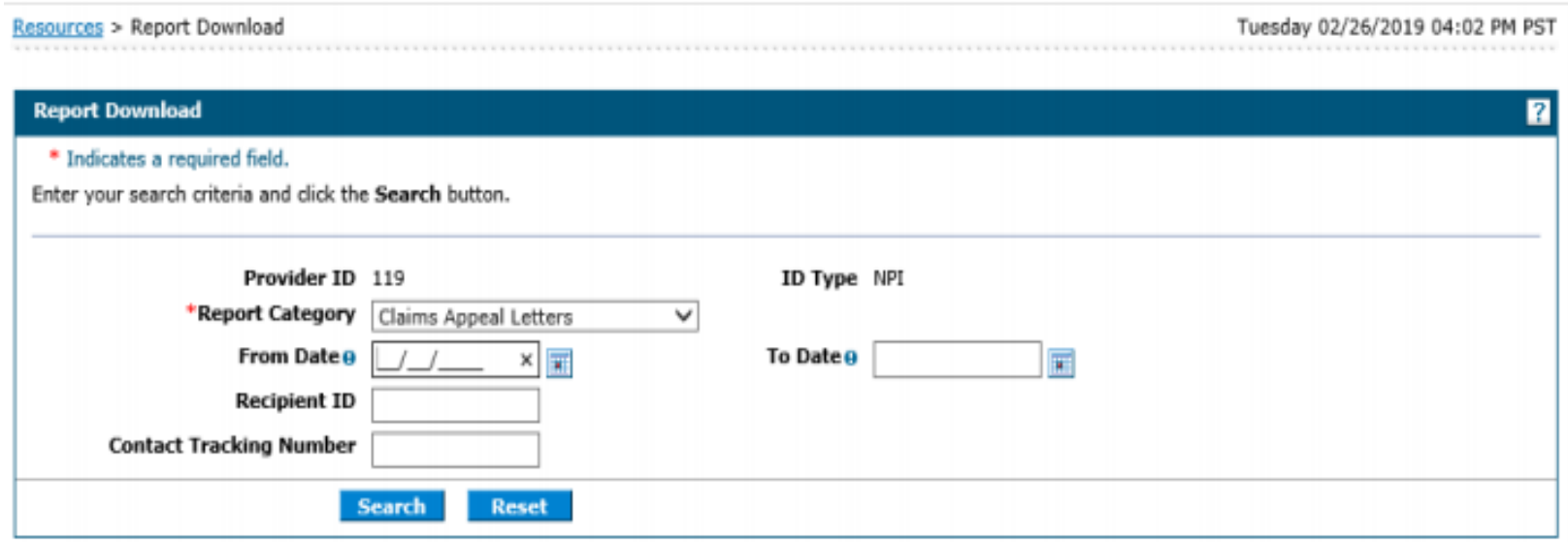
Step 2: Nevada Medicaid will make a determination of Approved, Denied or Rejected. It is the provider's responsibility to review their Secure Correspondence to verify the outcome of the Claim Appeal, as there will not be a notification sent to the provider indicating that there is new information to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

Accessing Claim Appeal Letters



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



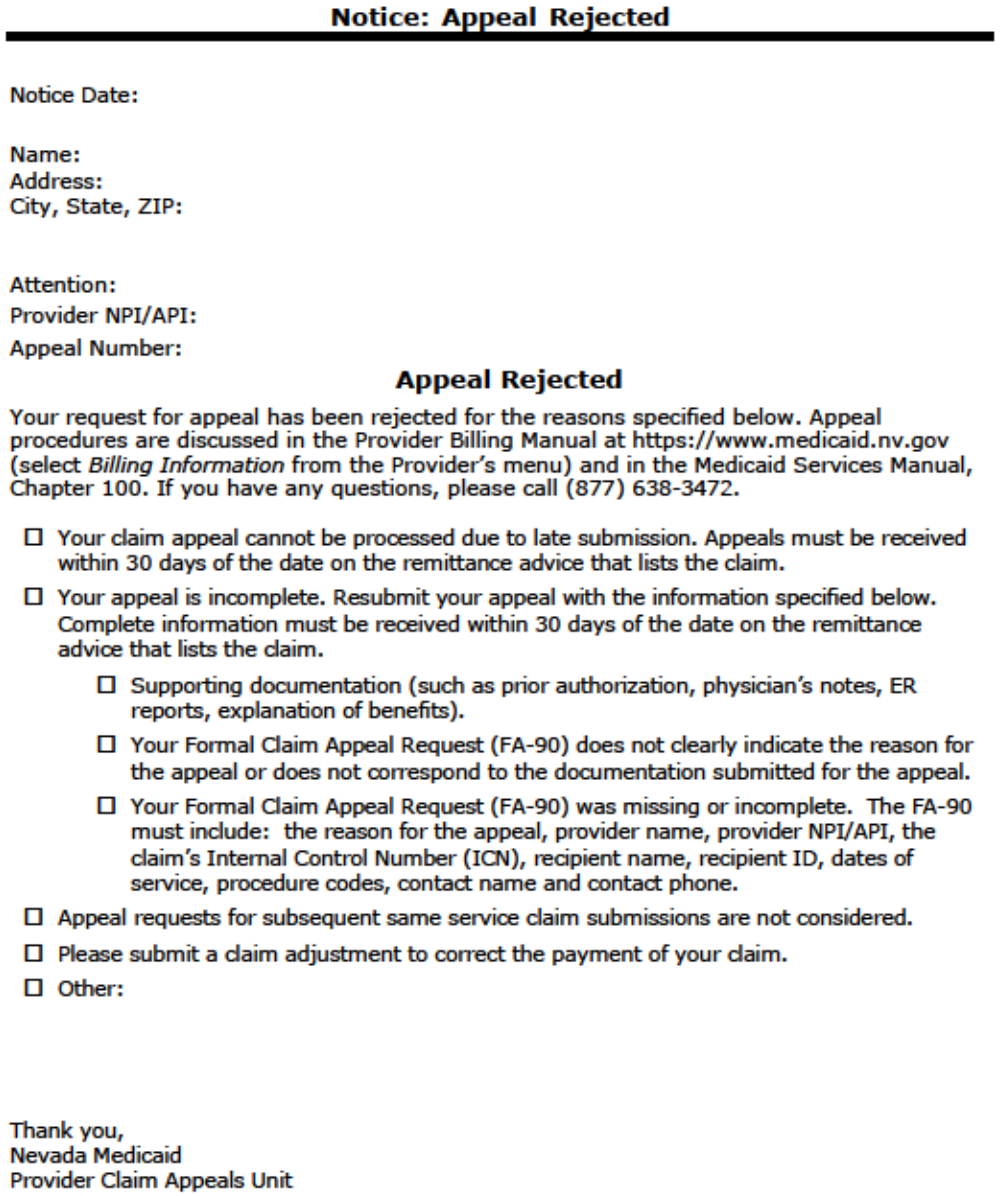
On the Report Download page, select “Claim Appeal Letters” from the Report Category drop-down list. Input the appropriate search criteria and select the “Search” button.

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

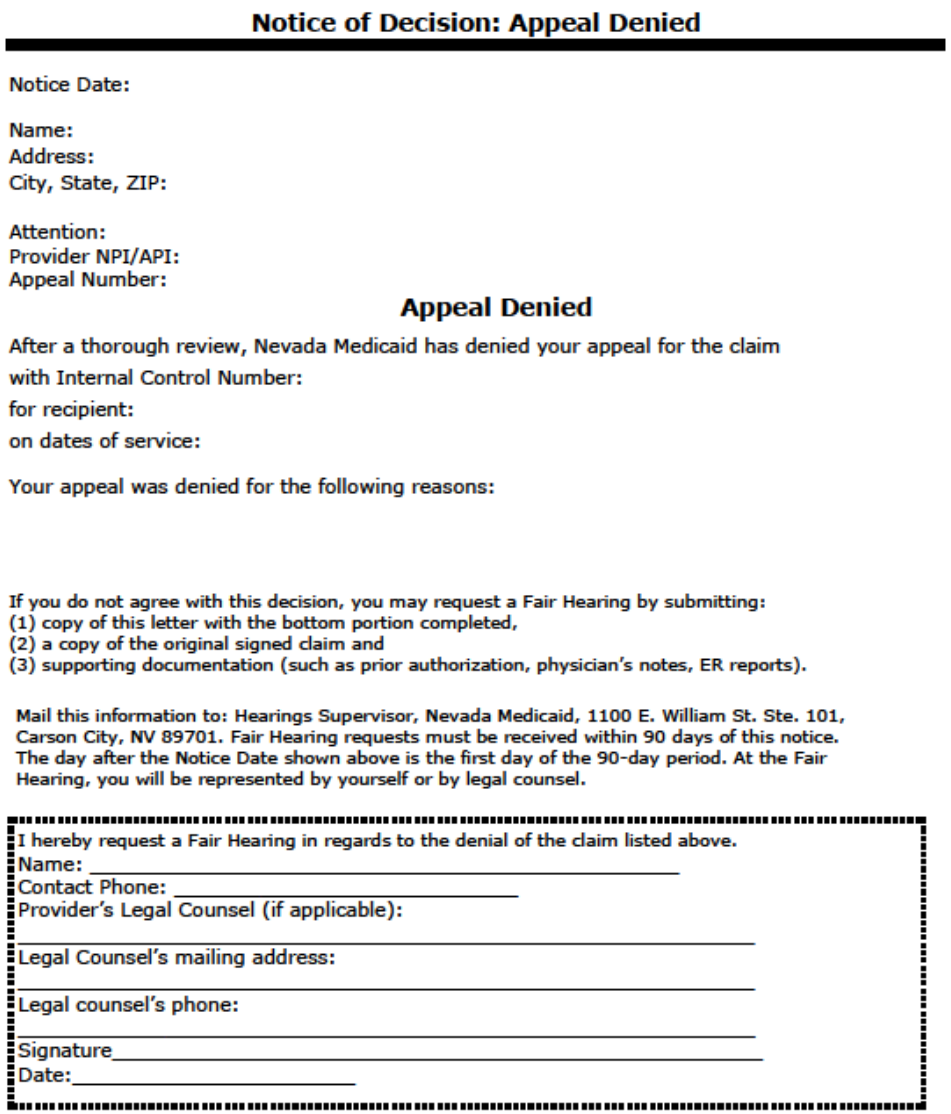
Please note: When claims are processed, please be aware that all system and clinical claim editor edits are applicable. As a result, there may be no (additional) payment, and other claim denials may be received.

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:

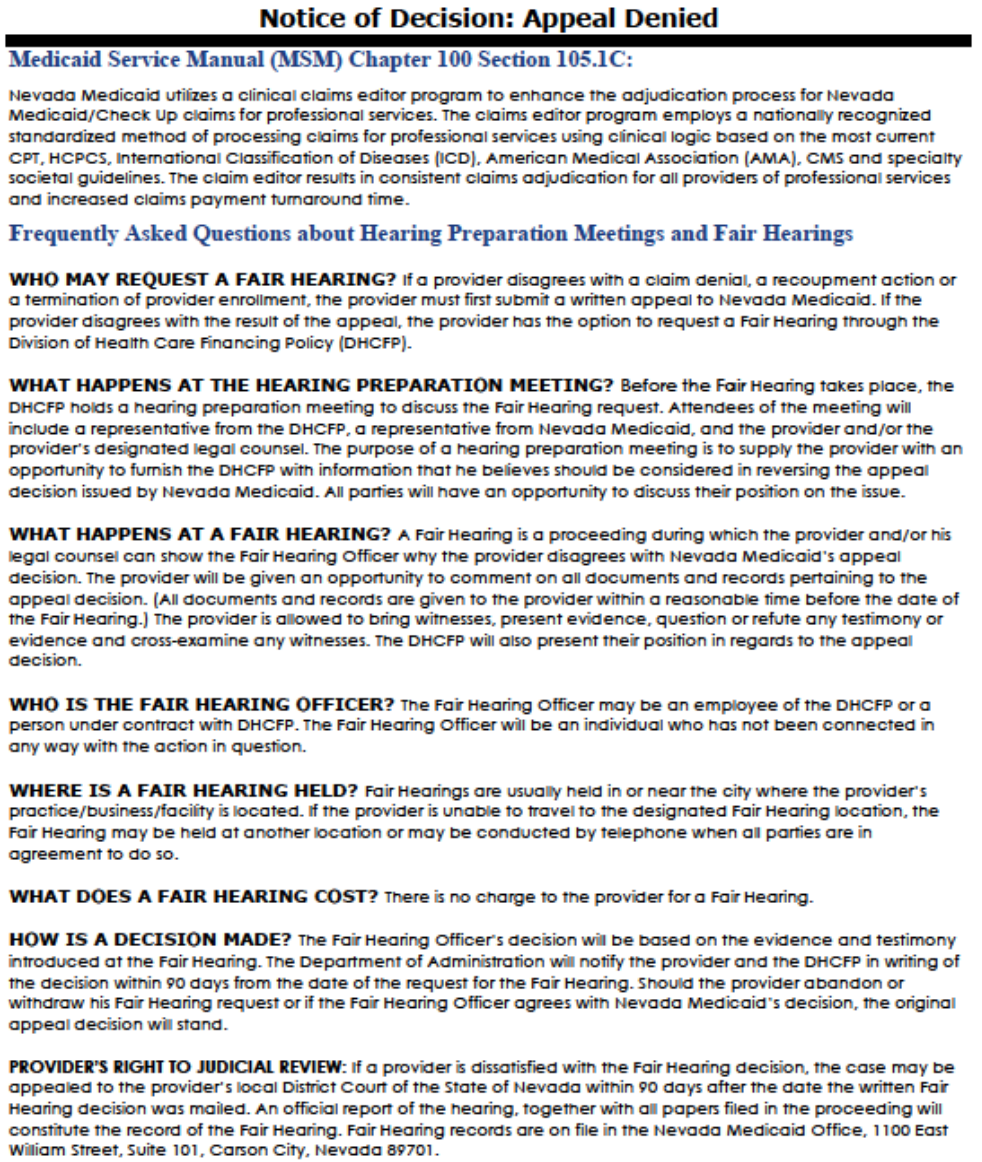
If you do not agree with this decision, you may request a Fair Hearing by submitting:
(1) copy of this letter with the bottom portion completed,
(2) a copy of the original signed claim and
(3) supporting documentation (such as prior authorization, physician's notes, ER reports).

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

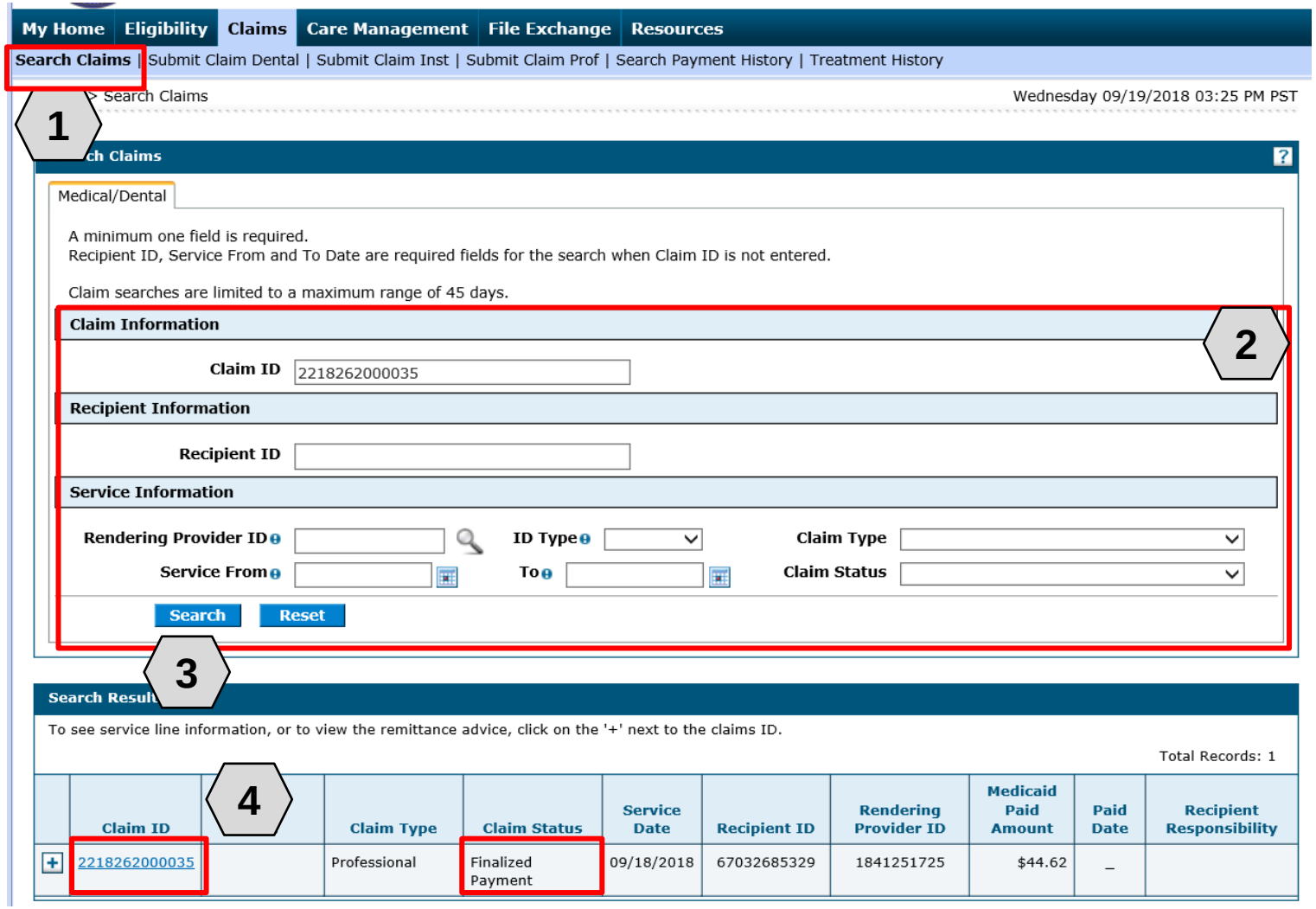
Timely Filing for Claim Adjustments and Voids

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 pended or denied claims)

Adjusting a Claim

Adjusting a Claim

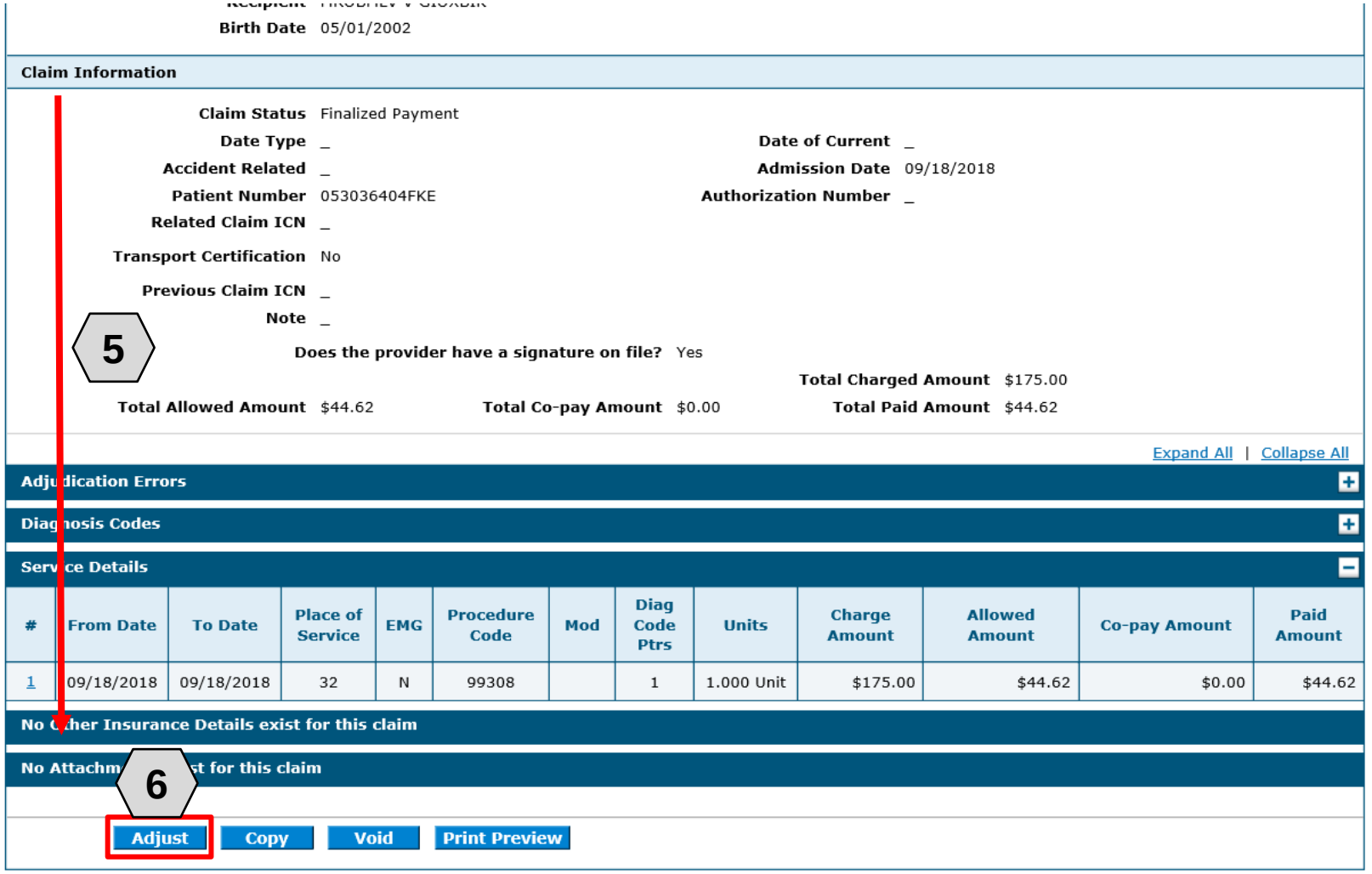


To begin the claim adjustment process:

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.

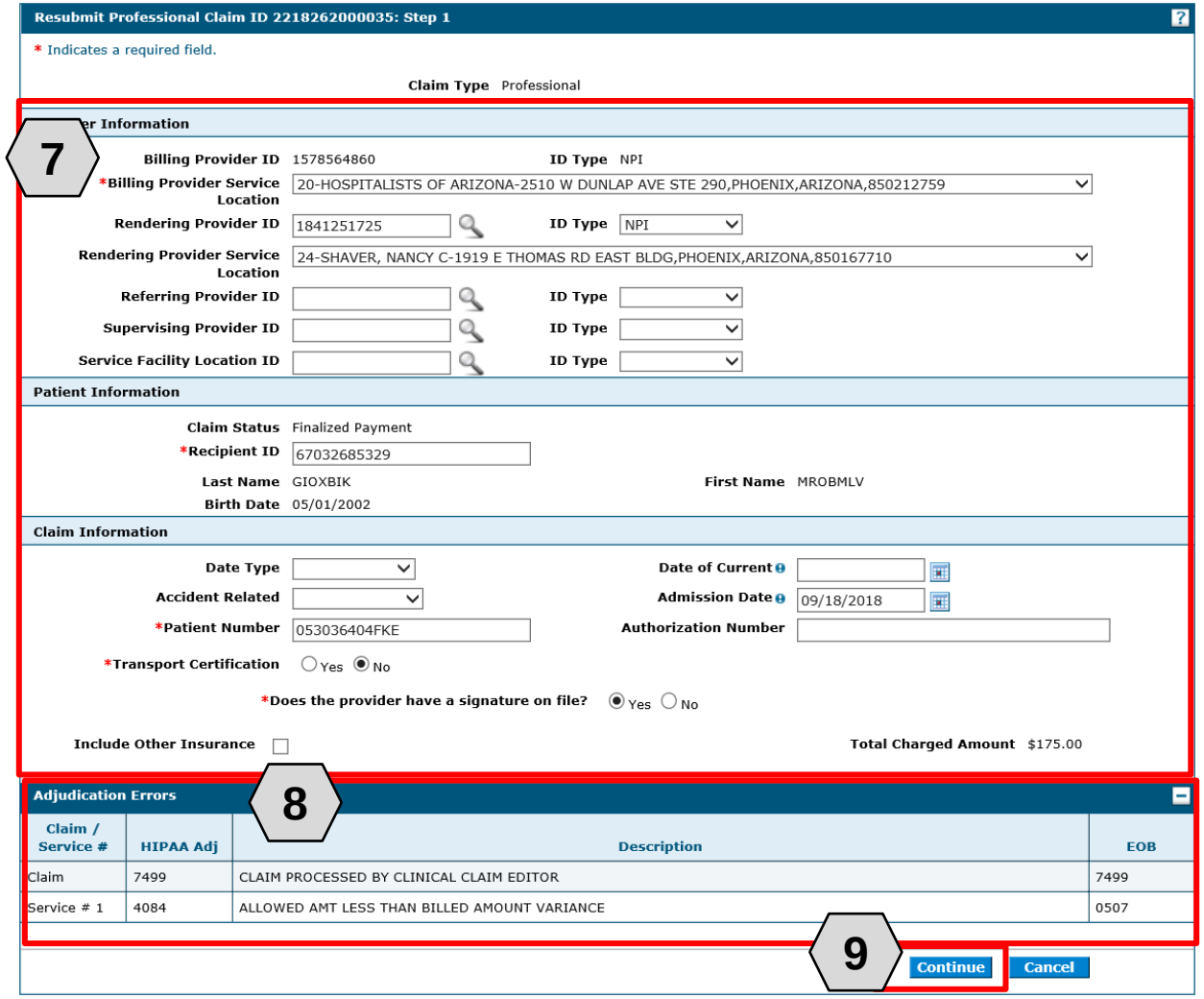
Adjusting a Claim, continued



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

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

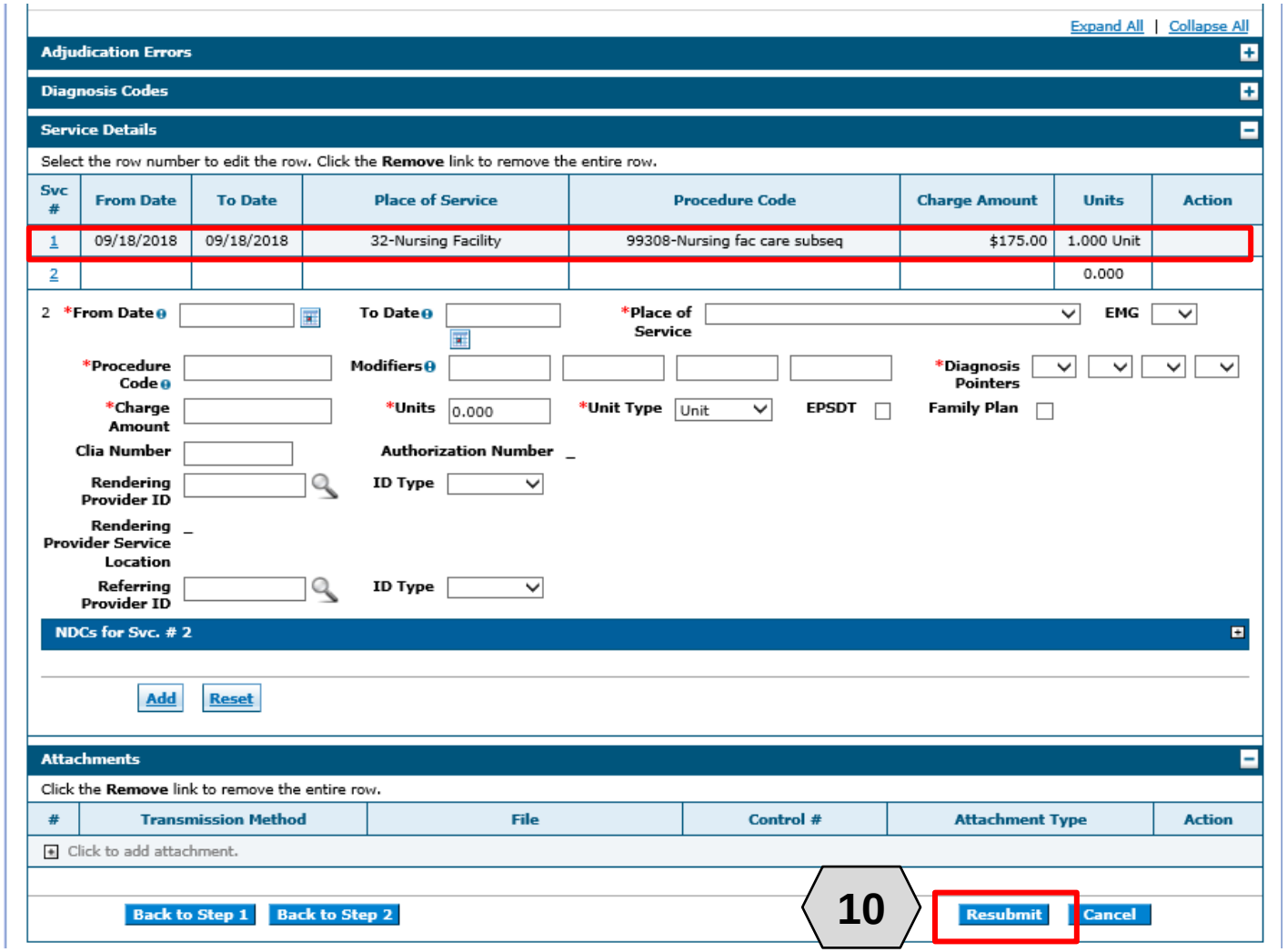
Adjusting a Claim, continued



From here, the user may:

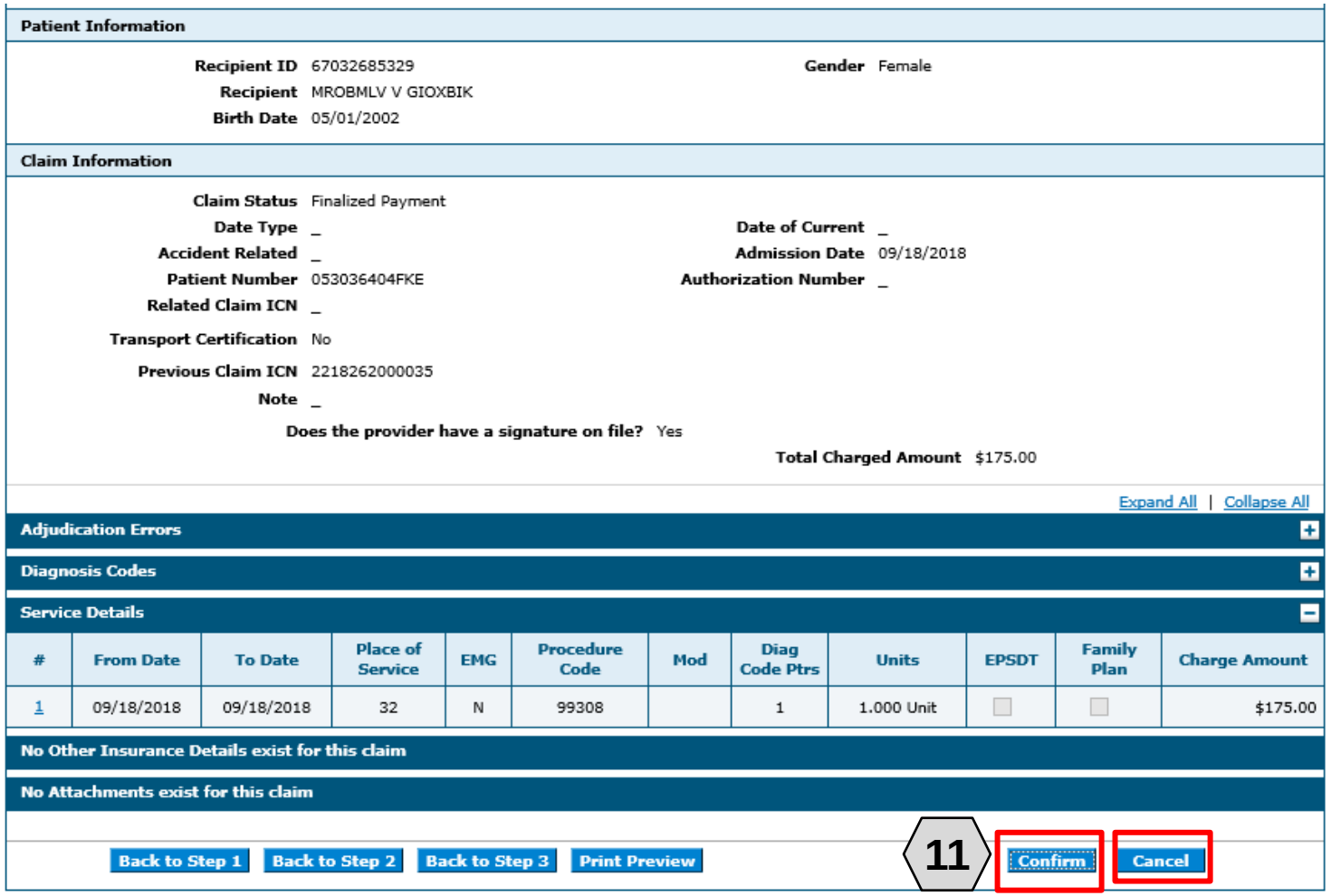
7. Review and make any necessary edits to the provider, patient or claim information
8. Review the **Adjudication Errors** panel to identify any issues that may need to be resolved
9. Click on the **Continue** button at the bottom of the page to proceed to the next step

Adjusting a Claim, continued



10. Click the **Resubmit** button

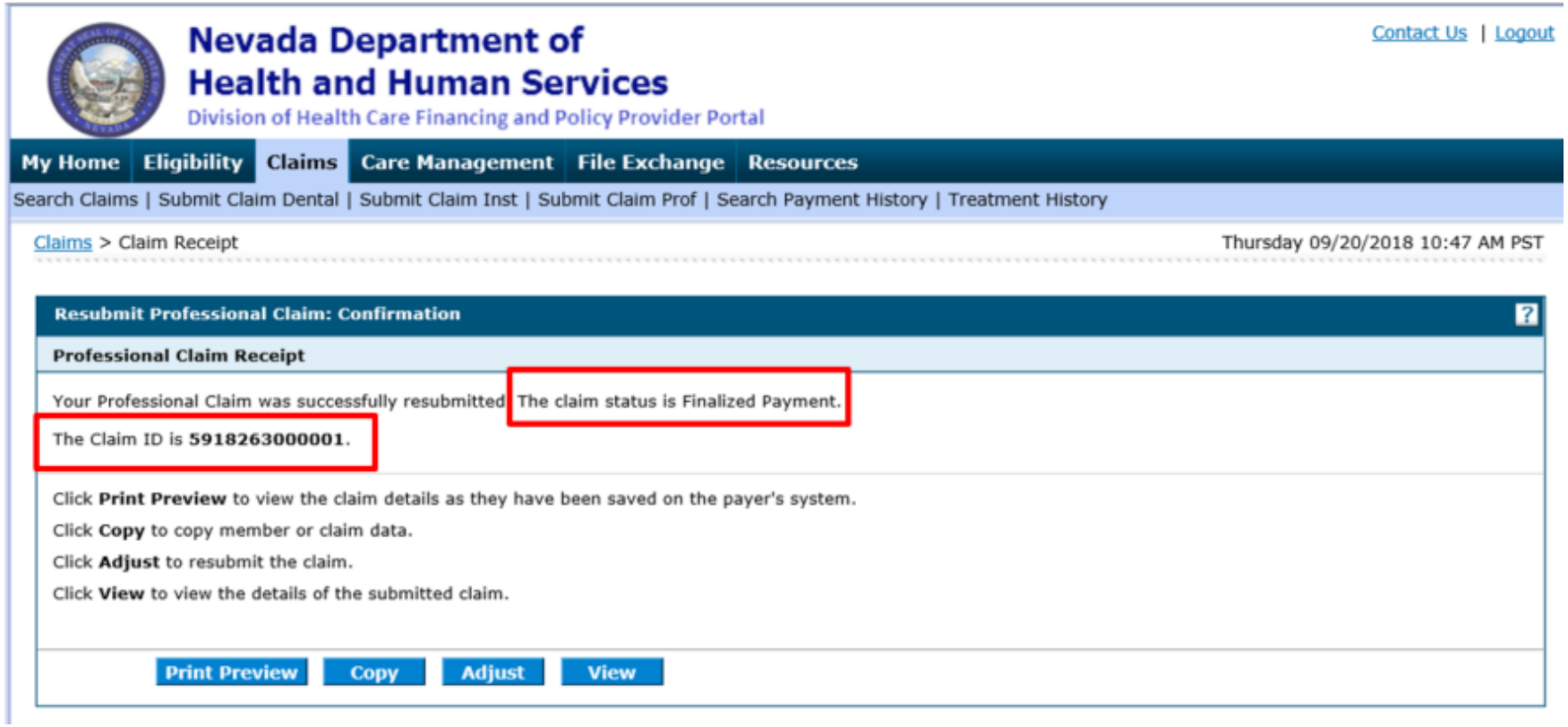
Adjusting a Claim, continued



11. Click the **Confirm** button

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

Adjusting a Claim, continued

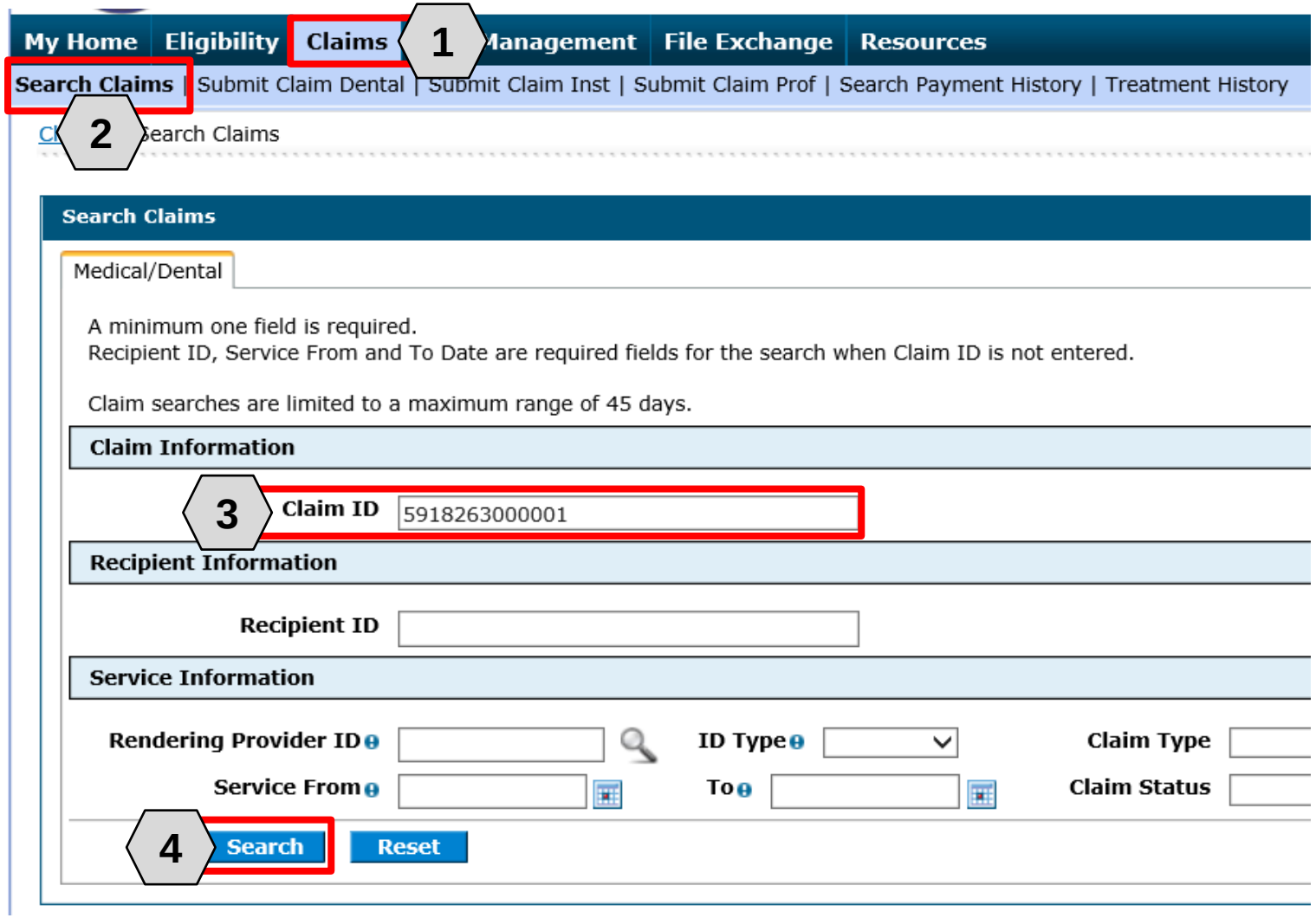


The “Resubmit Claim: Confirmation” page will appear after the claim has been submitted.

It will display the claim status and adjusted Claim ID.

Voiding a Claim

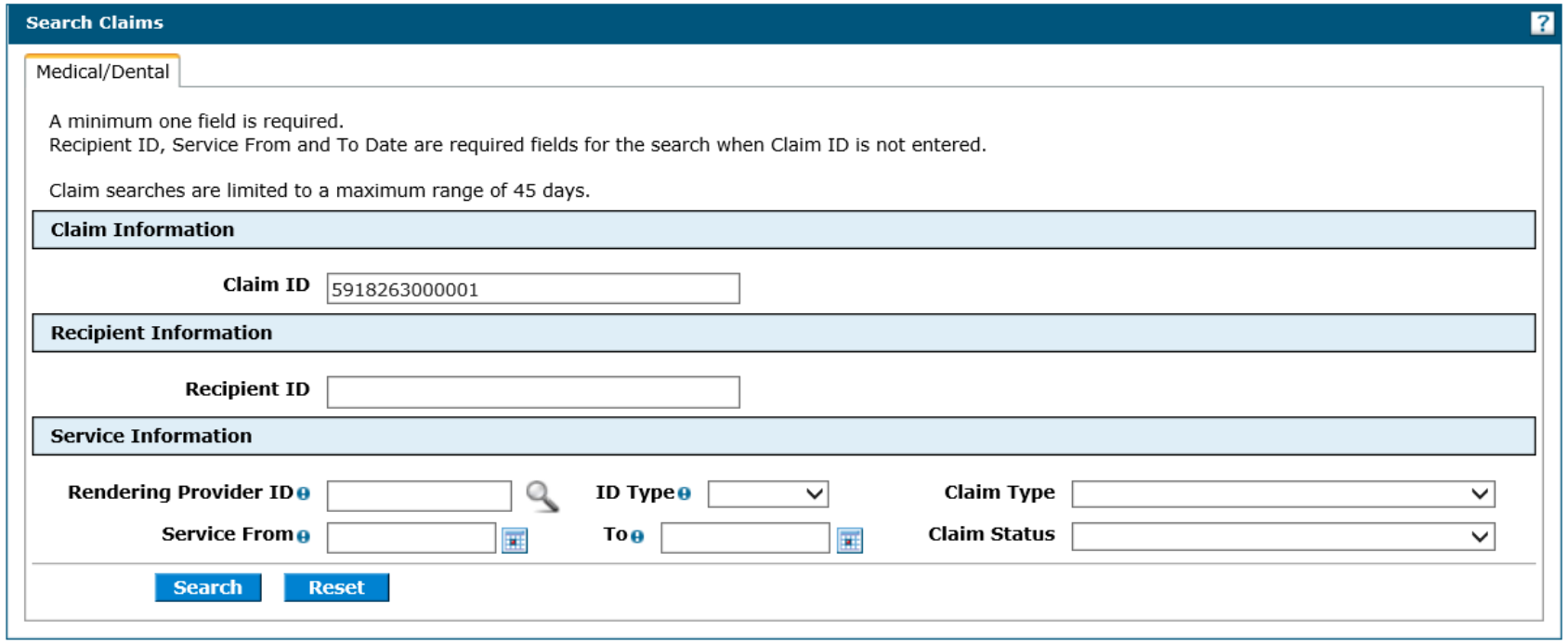
Voiding a Claim

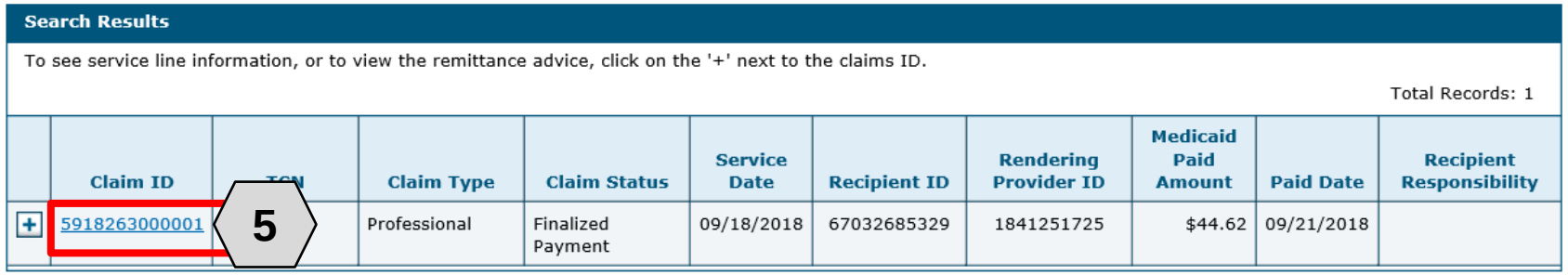


To search for a claim, the user will need to:

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

Voiding a Claim, continued





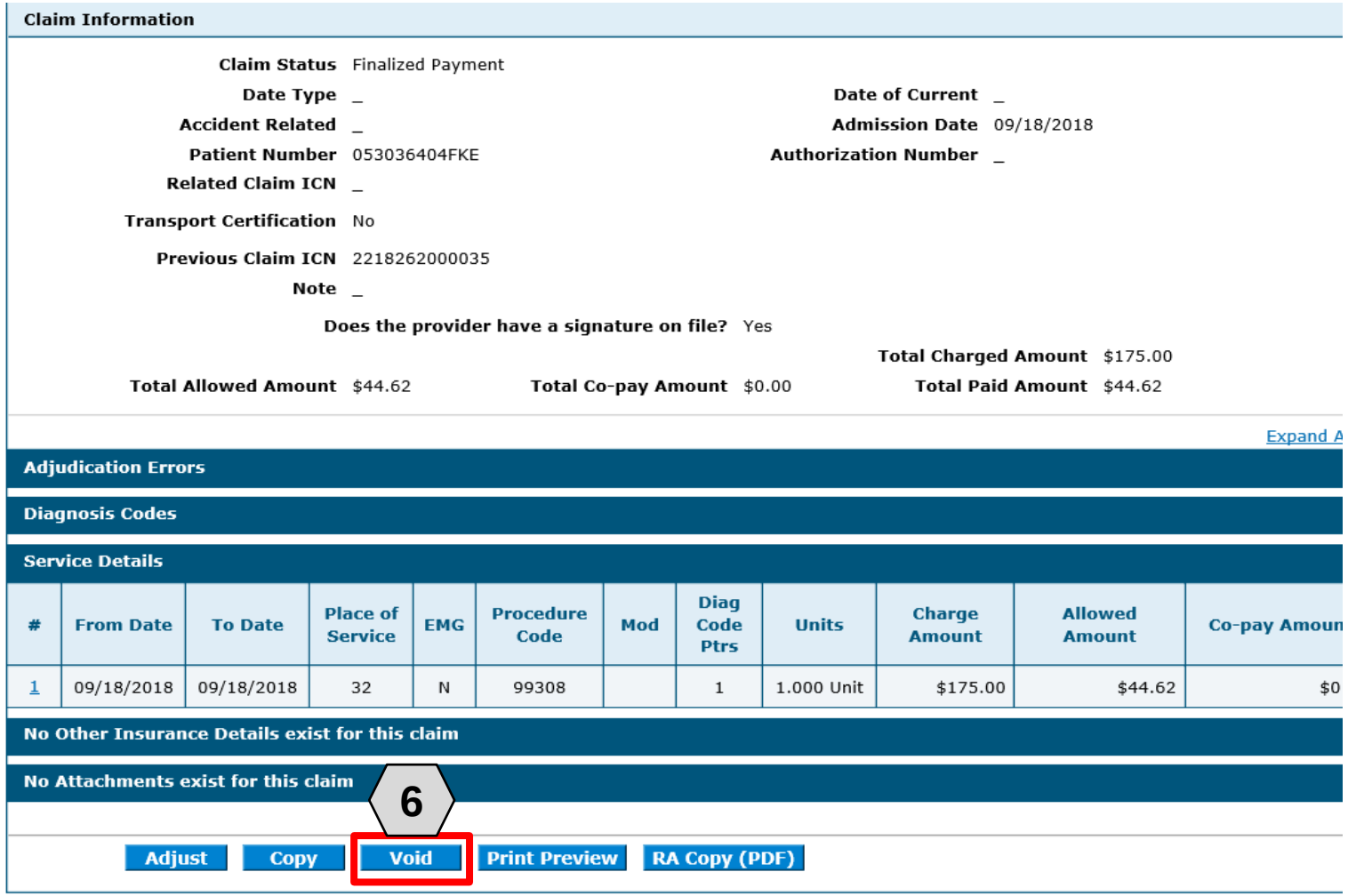
Once the user has clicked the **Search** button, the results will display below.

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.

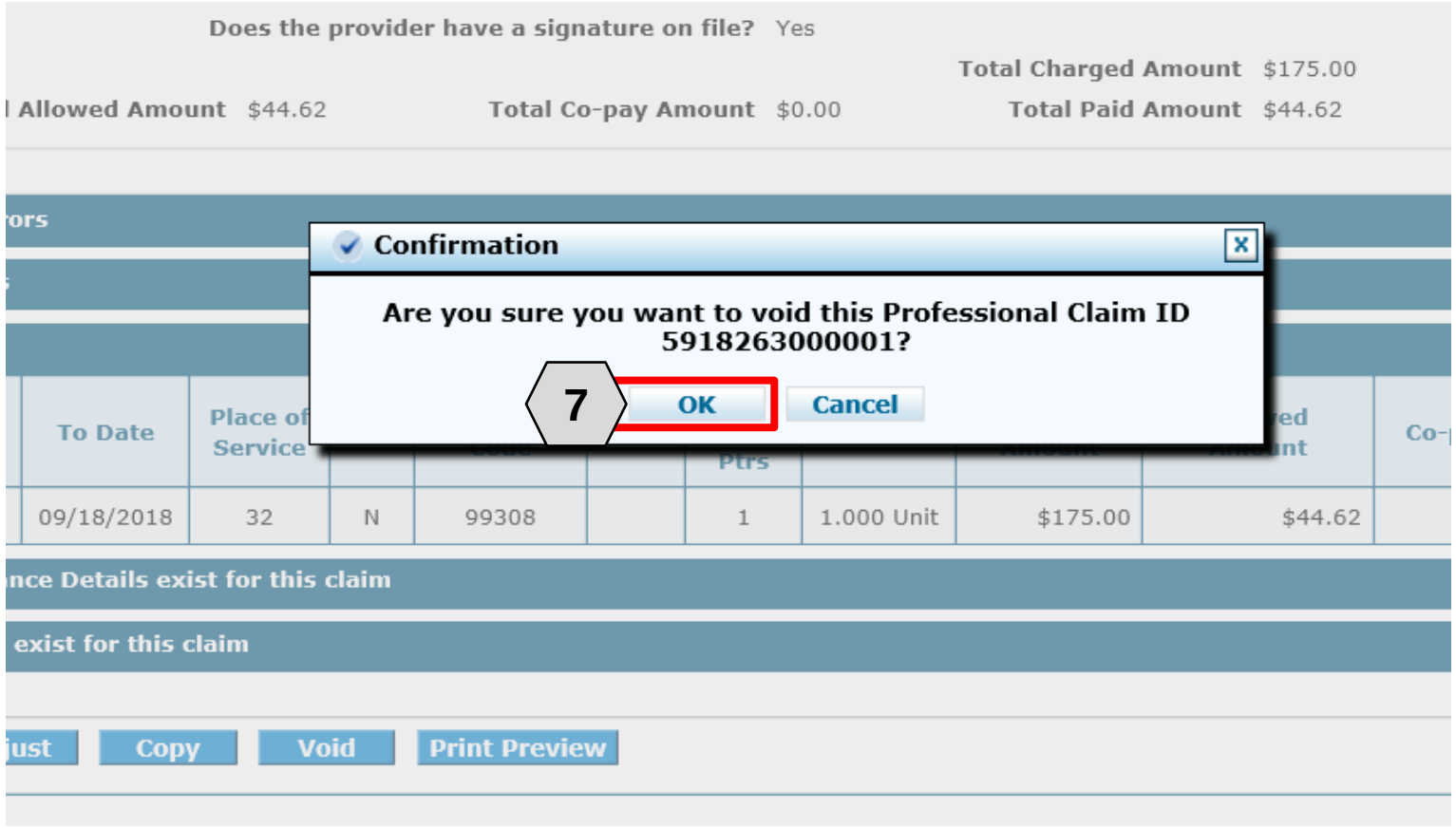
Voiding a Claim, continued



To void the claim, the user will:

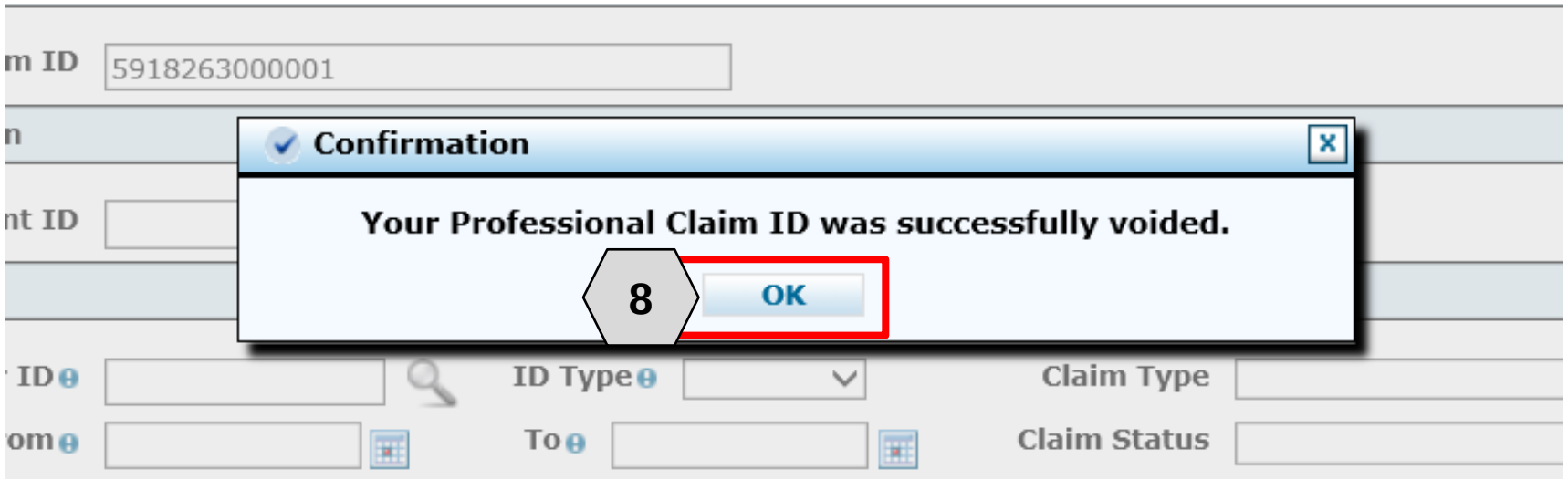
6. Click the **Void** button

Voiding a Claim, continued



7. Click the **OK** button

Voiding a Claim, continued



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