Claims Appeals, Adjustments and Voids Provider Training

Nevada Medicaid Provider Training

2020
Objectives
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- 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.
From the home page, the user will:

1. Select **Secure Correspondence**

   to start the Appeal process.
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.
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
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.
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
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.
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.
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.
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
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.
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.
10. Click the **Resubmit** button
11. Click the **Confirm** button

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

6. Click the Void button
7. Click the **OK** button
Voiding a Claim, continued

8. Click the OK button
Resources
Additional Resources

- Medicaid Services Manual (Chapter 3100 – Fair Hearings): http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C3100/Chapter3100/

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