Billing Manual

for Nevada Medicaid and Nevada Check Up

Updated January 13, 2015

Change history

Date (mm/dd/yyyy)	Description of changes	Pages impacted
07/13/2007	Large number of changes and updates including: • NPI/API Updates • New Frequently Asked Questions throughout the manual • Updated First Health Services mailing address • Links to Internet documents and websites including forms and MSM Chapters • Prior Authorization requirements • New TPL contractor contact information • New MCO contact information	All
08/08/2008	Chapter 8 updated to reflect the mandatory Electronic Funds Transfer (EFT) payment policy for all new Nevada Medicaid providers and for all existing Nevada Medicaid providers upon re-enrollment	Chapter 8
01/30/2009	Chapter 3, "Recipient Eligibility" updates reflecting new policies that update Welfare information. Chapter 8, "Claims Processing and Beyond", list of potential 8th digit characters for paid claims ICN updated. For clarification the following sentence was added to the "How to File an Appeal" section: If your appeal is rejected (e.g. for incomplete information) there is no extension to the original 30 calendar days	Chapter 3, Chapter 8
03/10/2009	This update included the removal of nevadamedicaid@fhsc.com as a valid contact email address for First Health Services. Providers should now call the customer service center with any questions rather than sending an email to this address.	
08/26/2009	Revised the phone number for updating or inquiring on a recipient's Medicare information on file with DHCFP. This manual previously listed phone numbers (775) 684-3687 and (775) 684-3628. The new number to call is (775) 684-3703	

Date (mm/dd/yyyy)	Description of changes	Pages impacted
03/17/2010	First Health Services' email domain name has changed. When contacting First Health Services via email, please use <ContactName>@magellanhealth.com. Claim appeals information was updated to include State policy that prohibits First Health Services from considering appeals for subsequent same service claim submissions. Form FH-72 is now obsolete. References to this form have been removed. A new section titled, overpayments, has been added with instructions for providers on how to handle overpayments. The phone number and email address for First Health Services' TPL vendor, Health Management Services, has been updated in chapters 2 and 5.	
05/28/2010	Clarified, under the claims processing heading in chapter 8, the responsibility of providers to submit claims that are in compliance with Nevada Medicaid and Nevada Check Up policies.	Chapter 8
06/14/2010	Updated Amerigroup's physician contracting phone number to (702) 228-1308 ext. 59840.	
12/05/2011	Document updated with HP Enterprise Services logo and template	All
04/21/2014	Multiple updates include: Updated Provider Enrollment section; updated Pharmacy claims addresses; updated Prior and retrospective authorization section; updated hyperlinks; added reference to Provider Preventable Conditions (PPCs)	All
01/13/2015	Multiple updates and clarifications throughout, including: updated ICN designations; updated requirements for the Claim Appeal process; and ICD-10 effective date	38, 40-41, 33 and 43

Table of contents

About this manual

Introduction

HP Enterprise Services (HPES) maintains this manual and the website, https://www.medicaid.nv.gov, to support Nevada Medicaid and Nevada Check Up billing.

Hereafter, Nevada Medicaid and Nevada Check Up are referred to as Medicaid unless otherwise specified.

Audiences

Please make this manual available to providers, their billing staffs and billing entities. The provider is responsible for maintaining current reference documents for Medicaid billing.

Authority

This manual does not have the effect of law or regulation. Every effort has made to ensure accuracy, however, should there be a conflict between this manual and pertinent laws, regulations or contracts, the latter will prevail.

Questions

If you have questions regarding this manual, please contact the HPES Customer Service Center at (877) 638-3472.

Copyright notices

Chapter 1: Introduction and provider enrollment

Medicaid goals

Nevada Medicaid strives to:

- Purchase quality health care for low income Nevadans
- Promote equal access to health care at an affordable cost to taxpayers
- Control the growth of health care costs
- Maximize federal revenue

Roles and responsibilities

Division of Health Care Financing and Policy

In accordance with federal and state regulations, the Division of Health Care Financing and Policy (DHCFP) develops Medicaid policy, **oversees Medicaid administration**, and advises recipients in all aspects of Nevada Check Up coverage.

Division of Welfare and Supportive Services

The Division of Welfare and Supportive Services (DWSS) accepts applications for Medicaid assistance, **determines eligibility**, and creates and updates recipient case files. The latest information is transferred from DWSS to HPES daily.

HP Enterprise Services (HPES) (Fiscal Agent)

Effective December 2, 2011, HPES became the fiscal agent for Nevada Medicaid and Nevada Check Up. All business relating to Pharmacy claims, contact information, etc. were effective December 2, 2011. All other Medical claims, appeals, contact information, etc. were effective December 5, 2011.

HPES handles:

- Claims adjudication and adjustment
- Pharmacy drug program
- Prior authorization
- Provider enrollment
- Provider inquiries
- Provider training
- Provider/Recipient files

Provider

Each provider is responsible to:

- Follow regulations set forth in the Medicaid Services Manual (see Medicaid Services Manual (MSM) Chapter 100 Medicaid Program and MSM Chapter 3300 Program Integrity)
- Obtain prior authorization (if applicable)
- Pursue third-party payment resources before billing Medicaid
- Retain a proper record of services
- Submit claims timely, completely and accurately (errors made by a billing agency are the provider's responsibility)
- Verify eligibility prior to rendering services

Records Retention

A provider's medical records must contain all information necessary to disclose the full extent of services (i.e., financial and clinical data). Nevada Medicaid requires providers to retain medical records for at least five years, but recommends keeping them for at least *six* years from the date of payment.

Upon request, records must be provided free of charge to a designated Medicaid agency, the Secretary of Health and Human Services or Nevada's Medicaid Fraud Control Unit. Records in electronic format must be readily accessible.

Recipient

According to the "Welcome to NV Medicaid and NV Check Up" brochure published by DHCFP, a recipient or their designated representative is responsible to:

- Advise caseworker of third-party coverage
- Allow no one else to use their Medicaid card
- Keep or cancel in advance appointments with providers (Medicaid does not pay providers for missed appointments)
- Pick up eyeglasses, hearing aids, medical devices and so forth, which are authorized and paid for by Medicaid
- Present their Medicaid card when services are rendered
- See a provider who participates in their private insurance plan when applicable

Provider enrollment

All providers must be enrolled as a full Medicaid provider to bill for services rendered to a Medicaid recipient. Providers who are enrolled as an Ordering, Prescribing or Referring (OPR) provider cannot bill for services rendered to a Medicaid recipient.

Everything you need to enroll is on the HPES Provider Enrollment webpage. If you have any questions, contact the provider enrollment unit at (877) 638-3472.

Providers are required to re-enroll in Nevada Medicaid and Nevada Check Up once every 36 months. Providers will receive a letter notifying them when to re-enroll. Providers who do not re-enroll within 60 days of the date on their notification will have their provider contract terminated. Re-enrollment documents are located on the Provider Enrollment webpage.

Changes to Enrollment Information

Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, any change in ownership, address, addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery (per Medicaid Services Manual, Chapter 100, Section 103.3).

Use the Provider Information Change Form (FA-33) to report changes and fax the completed form to (775) 335-8593.

Catchment Areas

If your business/practice/facility is in one of the following "catchment areas," submit Nevada Medicaid enrollment documents as described for in-state providers (see "Required Documents"). To qualify, the provider must meet all federal requirements, Nevada Medicaid state requirements and be a Medicaid provider in the state where services are rendered.

Catchment Areas	
State	**Cities/Zip Codes**
Arizona	**Bullhead City:** 86426, 86427, 86429, 86430, 86439, 86442, 86446 **Kingman:** 86401, 86402, 86411, 86412, 86413, 86437, 86445 **Littlefield:** 86432
California	**Bishop:** 93512, 93514, 93515 **Bridgeport:** 93517 **Davis:** 95616, 95617, 95618 **Loyalton:** 96118 **Markleeville:** 96120 **Needles:** 92363 **Sacramento:** 94203, 94204, 94205, 94206, 94207, 94208, 94209, 94211, 94229, 94230, 94232, 94234, 94235, 94236, 94237, 94239, 94240, 94244, 94245, 94246, 94247, 94248, 94249, 94250, 94252, 94254, 94256, 94257, 94258, 94259, 94261, 94262, 94263, 94267, 94268, 94269, 94271, 94273, 94274, 94277, 94278, 94279, 94280, 94282, 94283, 94284, 94285, 94286, 94287, 94288, 94289, 94290, 94291, 94293, 94294, 94295, 94296, 94297, 94298, 94299, 95811, 95812, 95813, 95814, 95815, 95816, 95817, 95818, 95819, 95820, 95821, 95822, 95823, 95824, 94825, 95826, 95827, 95828, 95829, 95830, 95831, 95832, 95833, 95834, 95835, 95836, 95837, 95838, 95840, 95841, 95842, 95843, 95851, 95852, 95853, 95860, 95864, 95865, 95866, 95867, 95887, 95894, 95899 **South Lake Tahoe:** 96150, 96151, 96152, 96154, 96155, 96156, 96157, 96158 **Susanville:** 96127, 96130 **Truckee:** 96160, 96161, 96162
Idaho	**Boise:** 83701, 83702, 83703, 83704, 83705, 83706, 83707, 83708, 83709, 83711, 83712, 83713, 83714, 83715, 83716, 83717, 83719, 83720, 83721, 83722, 83724, 83725, 83726, 83727, 83728, 83729, 83730, 83731, 83732, 83733, 83735, 83756, 83757, 83799 **Mountain Home:** 83647 **Twin Falls:** 83301, 83302, 83303

Utah	**Cedar City:** 84720, 84721 **Enterprise:** 84725 **Orem:** 84057, 84058, 84059, 84097 **Provo:** 84601, 84602, 84603, 84604, 84605, 84606 **Salt Lake City:** 84101, 84102, 84103, 84104, 84105, 84106, 84107, 84108, 84109, 84110, 84111, 84112, 84113, 84114, 84115, 84116, 84117, 84118, 84119, 84120, 84121, 84122, 84123, 84124, 84125, 84126, 84127, 84128, 84130, 84131, 84132, 84133, 84134, 84136, 84138, 84139, 84141, 84143, 84144, 84145, 84147, 84148, 84150, 84151, 84152, 84153, 84157, 84158, 84165, 84170, 84171, 84180, 84184, 84189, 84190, 84199 **St. George:** 84770, 84771, 84790, 84791 **Tooele:** 84074 **Wendover:** 84083 **West Jordan:** 84084

Discrimination

Federal law prohibits discrimination against any person on the grounds of age, color, disability, gender, illness, national origin, race, religion or sexual orientation that would deny a person the benefits of any federally financed program. Medicaid will only pay providers who comply with applicable federal and state laws. Billing Medicaid for services or supplies is considered evidence that the provider is complying with all such laws, including the Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the 1975 Age Discrimination Act.

Fraud and abuse

Federal law requires Medicaid to review suspected fraud and abuse and impose appropriate actions upon offending parties. Persons knowingly assisting a recipient or provider in committing fraud shall also be held responsible. Please **report suspected fraud and/or abuse to HPES at (877) 638-3472**. For more information on fraud and abuse policies, see MSM Chapter 3300.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) gives individuals certain rights concerning their health information, sets boundaries on how it is used, establishes formal safeguards and holds violators accountable. HIPAA requires that healthcare workers never release personal health information to anyone who does not have a need to know. This regulation became effective April 14, 2003. For more information, please visit the HIPAA section of the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/HIPAAGenInfo.

Chapter 2: Contacts and resources

Appeals unit

To appeal a claim, mail the required documents to:

HP Enterprise Services
Claim Appeals
P.O. Box 30042
Reno, NV 89520-3042

See *Appeal requirements* later in this manual for instructions.

Automated Response System (ARS)

The ARS provides automated phone access to recipient eligibility, provider payments, claim status and prior authorization status.

Phone: (800) 942-6511

Billing Manual and Billing Guidelines

The Billing Manual (the manual you are reading now) provides general Medicaid information that applies to all provider types.

Billing Guidelines discuss provider type specific information such as prior authorization requirements, special claim form instructions, covered codes or other important billing information for that provider type.

The Billing Information webpage has a link to this manual and to all of the billing guidelines.

It is important to be familiar with the billing guidelines for your provider type.

Claims mailing address

Mail **CMS-1500, UB-04 and ADA** paper claims, adjustments and voids to:

HP Enterprise Services
Claims
P.O. Box 30042
Reno NV 89520-3042

Pharmacy paper claims: Please contact Catamaran at (866) 244-8554 for information on pharmacy paper claims.

Electronic Verification System (EVS)

EVS provides 24/7 online access to recipient eligibility, claim status, prior authorization status and payments. This information is also available through the ARS or a swipe card system.

You may log on to EVS 24 hours a day, 7 days a week using any internet-ready computer.

Refer to the EVS User Manual if you have any questions or call (877) 638-3472.

To obtain access to EVS, new users must register on the Provider Web Portal. Only one provider office registration is required with the ability to assign multiple delegates to perform clinical administration. You may also use the Provider Web Portal "Forgot Password?" link if you have lost or forgotten your password once you have registered. If you do need help in registering for the Provider Web Portal, contact the support call center at (877) 638-3472.

HPES

Provider Customer Service Center

The Provider Customer Service Center is available to respond to all provider inquiries.

When calling, have pertinent information ready (e.g., a claim's internal control number (ICN), recipient ID, National Provider Identifier (NPI) or Atypical Provider Identifier (API), authorization number).

Phone: (877) 638-3472.
Mail: HP Enterprise Services
Customer Service
P.O. Box 30042
Reno NV 89520-3042

To check the status of a claim, please use EVS, ARS or a swipe card system.

Electronic Data Interchange Department

The Electronic Data Interchange (EDI) Department handles electronic claims setup, testing and operations. The Electronic Claims/EDI webpage features EDI enrollment forms, companion guides, the Service Center User Manual, the Service Center Directory, a Payerpath presentation and more. For more information, refer to the Electronic Data Interchange (EDI) chapter of this manual or contact the EDI Department at:

Email: NVMMIS.EDIsupport@hp.com
Phone: (877) 638-3472 **Fax:** (775) 335-8594
Mail: HP Enterprise Services
EDI Coordinator
P.O. Box 30042
Reno NV 89520-3042

Pharmacy Department

The Pharmacy Department provides access to the following information and references for providers under the Pharmacy menu on the www.medicaid.nv.gov website:

- Announcements/Training
- Billing Information
- Diabetic Supplies
- Forms
- MAC Information
- Meetings: DUR Board and P&T Committee
- Pharmacy Web PA
- Preferred Drug List (PDL)
- Prescriber List (NPI Registry)

Technical call center phone (for claims, and edit/override inquiries): (866) 244-8554
Clinical call center phone (to request prior authorization or ProDUR overrides):
Toll free (855) 455-3311
Clinical call center fax: (855) 455-3303

Pharmacy paper claims:
Please contact Catamaran at (866) 244-8554 for information on pharmacy paper claims.

Prior Authorization Department

For prior authorization process and procedure, see the Prior Authorization chapter of this manual.

Authorizations for most services

For prior authorization questions regarding Adult Day Health Care, Audiology, Home Based Habilitation Services, Durable Medical Equipment, Home Health, Hospice, Intermediate Care Facility, Level of Care, Medical/Surgical, Mental Health, Ocular, Out-of-State services, Pre-Admission Screening and Resident Review (PASRR) Level II, Private Duty Nursing and Residential Treatment Center services, contact:

Phone: (800) 525-2395
Fax: (866) 480-9903

Dental authorizations

Phone: (800) 525-2395
Fax: (855) 709-6848
Mail: HP Enterprise Services
Dental PA
P.O. Box 30042
Reno NV 89520-3042

Personal Care Services (PCS) authorizations
Phone: (800) 525-2395
Fax: (866) 480-9903

Pharmacy authorizations
Phone: (855) 455-3311
Fax: (855) 455-3303

Waiver authorizations

Home and Community Based Waiver – Individuals with Intellectual Disabilities Services (provider type 38), call the Aging and Disability Services Division Regional Center at (775) 684-5943.

Home and Community Based Waiver for the Frail Elderly (the *CHIP* waiver, provider type (48), call the Aging and Disability Services Division (ADSD) at (775) 684-4210.

Elderly in Adult Residential Care Waiver (provider type 57), call DAS at (775) 684-4210.

Waiver for Persons with Physical Disabilities (the *WIN* waiver, provider type 58), call the DHCFP at: (775) 688-2811 in Reno, (775) 684-3653 in Carson City, (775) 753-1148 in Elko, and (702) 486-1535 in Las Vegas.

Provider Enrollment Unit

All enrollment documents are on the HPES website at https://www.medicaid.nv.gov. Contact the Provider Enrollment Unit with questions on enrollment certification and licensure requirements. Providers are required to notify Nevada Medicaid **within five days** of knowledge of changes in professional licensure, facility/business/practice address, provider group membership or business ownership. To do this, submit form FA-33.

Phone: (877) 638-3472

Mail: HP Enterprise Services
Provider Enrollment
P.O. Box 30042
Reno NV 89520-3042

Provider Training and Field Representative Unit

The Provider Training Unit keeps providers and staff up to date on the latest policies and procedures through regularly scheduled group training sessions and one-on-one support as needed. Announcements and training presentations are available on the Provider Training webpage.

Field Rep Contact List: www.medicaid.nv.gov/Downloads/provider/Team_Territories.pdf

Email: nevadaprovidertraining@hp.com

Mail: HP Enterprise Services
Provider Training Unit
P.O. Box 30042
Reno NV 89520-3042

Medicaid Services Manual (MSM)

The MSM is maintained by the DHCFP. It contains comprehensive State policy for all Medicaid providers and services. All providers should be familiar with MSM Chapter 100 and Chapter 3300 and any other chapters that discuss a relevant service type. The MSM chapters are:

100: Medicaid Program
200: Hospital Services
300: Radiology Services
400: Mental Health and Alcohol/Substance Abuse Services
500: Nursing Facilities
600: Physician Services
700: Rates and Cost Containment
800: Laboratory Services
900: Private Duty Nursing
1000: Dental
1100: Ocular Services
1200: Prescribed Drugs
1300: Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies
1400: Home Health Agency (HHS) Services
1500: Healthy Kids Program (EPSDT)
1600: Intermediate Care for Individuals with Intellectual Disabilities (ICF-IID)
1700: Therapy
1800: Adult Day Health Care
1900: Transportation Services
2000: Audiology Services
2100: Waiver for Individuals with Intellectual Disabilities
2200: Home and Community Based Waiver (HCBW) for the Frail Elderly
2300: Physical Disability Waiver
2400: Home Based Habilitation Services (HBHS)
2500: Case Management
2600: Intermediary Service Organization
2800: School Based Child Health Services
3000: Indian Health
3100: Hearings
3200: Hospice
3300: Program Integrity
3400: Telehealth Services
3500: Personal Care Services Program
3600: Managed Care Organization
3800: Care Management Organization and Medical/Health Homes
3900: Home and Community-Based Waiver (HCBW) for Assisted Living
Addendum: MSM Definitions

Public hearings

- Providers are encouraged to attend public hearings and voice their opinion on policy changes.
- Public hearing announcements are posted on the DHCFP website as they become available.
- To request email notices for scheduled public hearings, please email Rita Mackie at rmackie@dhcfp.nv.gov.

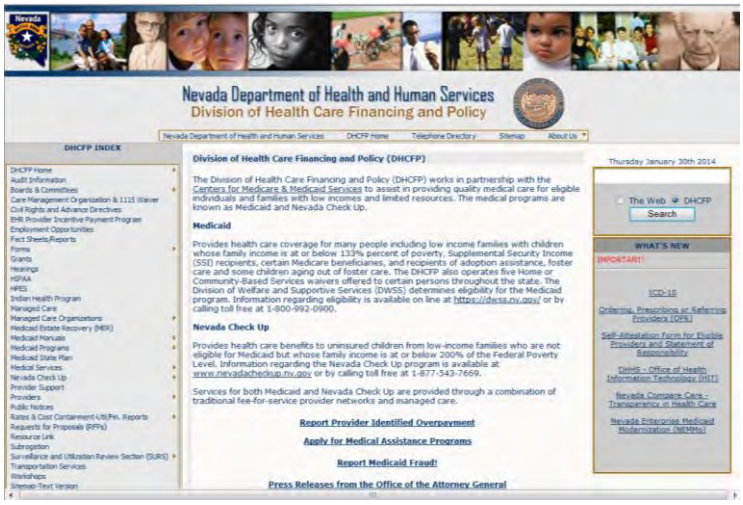
Web announcements

On average, HPES releases two web announcements per week. Each announcement appears on the Homepage for at least one week before it is archived on the Announcements/Newsletters webpage. Be sure to **check the website at least weekly** for these important updates.

Websites

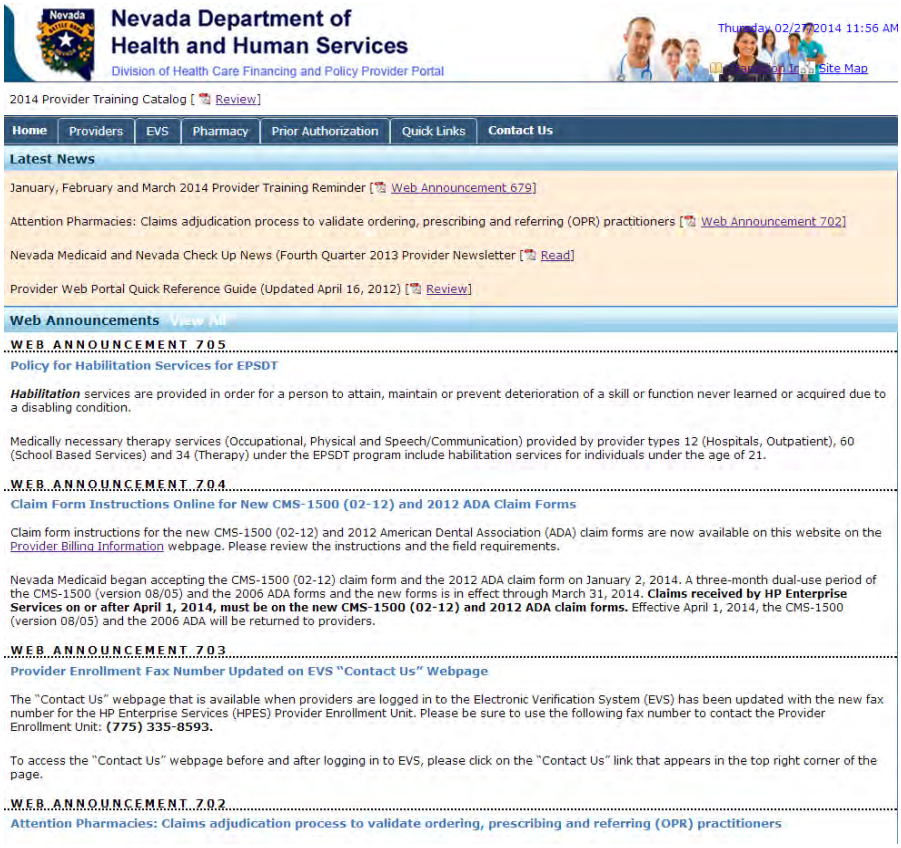
The Centers for Medicare & Medicaid Services (CMS)
CMS provides **federal-level guidance** for state Medicaid programs via their website at, http://www.cms.gov.

The Division of Health Care Financing and Policy (DHCFP)
The DHCFP provides Nevada Medicaid and Nevada Check Up policy, rates, public notices and more via their website at https://dhcfp.nv.gov/index.htm.



HPES Nevada Medicaid Website

The HPES Nevada Medicaid website at https://www.medicaid.nv.gov contains the most current billing information. It is updated regularly, and thus, we recommend visiting at least once a week. **In this manual, all references to webpages refer to the HPES website unless otherwise noted.**



Homepage

The homepage is the first page you arrive at when you go to https://www.medicaid.nv.gov. You can always come back to this page from anywhere on the site by clicking the *Home* link near the top of your screen.

Site map

The website has seven links across the top. Click on any menu tab to see items under that menu. To see what is under all menus at once, click the Site Map link near the top, right of your screen.

Chapter 3: Recipient eligibility, managed care and care management information

Determining eligibility

The Division of Welfare and Supportive Services determines recipient eligibility for Medicaid and Nevada Check Up.

Once the recipient is determined eligible, how long does it take before EVS/ARS reflects this?

24 hours

Verifying eligibility and benefits

It is important to verify a recipient's eligibility before providing services each time a service is provided. Please verify a recipient's eligibility each month as eligibility is reflected for only one month at a time. Eligibility can be verified through EVS, ARS, a swipe card system or a 270/271 electronic transaction (see Chapter 6 in this manual or the Companion Guide 270/271 for details). Each resource is updated daily to reflect the most current information.

EVS

You may log on to EVS 24 hours a day, 7 days a week using any Internet-ready computer.

Refer to the EVS User Manual if you have any questions or call, (877) 638-3472. To obtain access to EVS, new users must register on the Provider Web Portal at https://www.medicaid.nv.gov for their office/facility. The Provider Web Portal also allows you to reset lost or forgotten passwords. If you need help with the Provider Web Portal, call the HPES Call Center at (877) 638-3472.

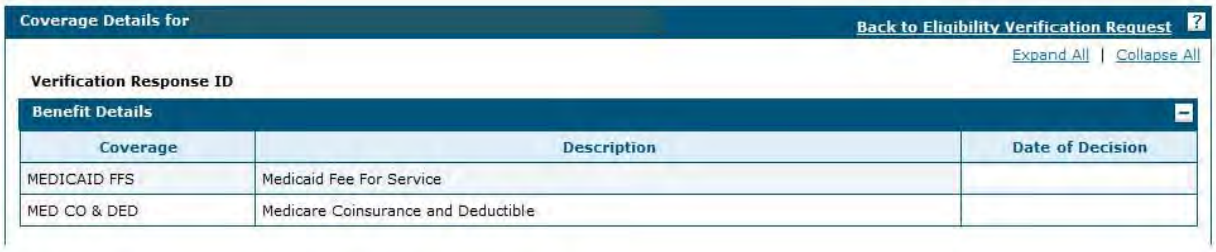
How long should I wait after submission to check claim status using EVS?

Wait 30 days before checking on paper claims and 24 hours before checking on electronic claims. Allow 30 days for claims to be adjudicated. If your claim has not processed within these time frames or if you have questions on how the claim was processed, contact the Customer Service

Identify dual eligibility using EVS

Some recipients are eligible for both Medicaid and Medicare benefits. These recipients have *dual eligibility*. The figure at the top of the next page shows a portion of the EVS eligibility response screen. In *Benefit Details, under the left column entitled Coverage*, the benefit plan(s) in which the recipient is enrolled will be listed. If EVS lists *MEDICAID FFS* in this column, the recipient is eligible to receive full Medicaid benefits. Under the Description column, it spells out what the coverage is. For instance, Medicaid FFS in the Coverage column stands for *Medicaid Fee For Service*, as listed in the Description column. In this example, the recipient is eligible for full

Medicaid benefits as well as a Medicare coinsurance and deductible payable up to the Medicaid maximum allowable amount.
If the recipient is a **Qualified Medicare Beneficiary (QMB)**, EVS will display *MED CO & DED* only in the Coverage field. If the recipient is Medicare Premium only, no other eligibility will be reflected for them in EVS or ARS.


Coverage Details for

Back to Eligibility Verification Request

Expand All | Collapse All

Verification Response ID

Benefit Details

Coverage	Description	Date of Decision
MEDICAID FFS	Medicaid Fee For Service	
MED CO & DED	Medicare Coinsurance and Deductible	

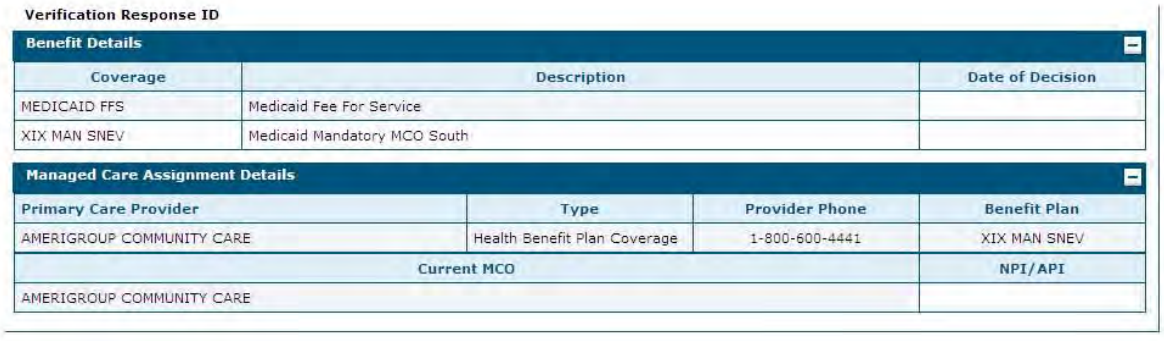
Identify MCO Enrollment Using EVS

If a recipient is enrolled in a Managed Care Organization (MCO), the first *line* of Benefit Details under the Coverage column will read *CHECK-UP FFS*, an abbreviation for Check Up Fee For Service or *MEDICAID FFS*, an abbreviation for Nevada Medicaid Fee For Service.

As shown in the figure below, the *second line* will read one of the following:

- *XIX MAN SNEV* for Medicaid Mandatory MCO South
- *XIX MAN NNEV* for Medicaid Mandatory MCO North
- *XXI MAN NNEV* for Check-Up Mandatory MCO North
- *XXI MAN SNEV* for Check-Up Mandatory MCO South

The second page, the Managed Care Assignment Details, will show the Managed Care Provider information, as shown below:


Verification Response ID

Benefit Details

Coverage	Description	Date of Decision
MEDICAID FFS	Medicaid Fee For Service	
XIX MAN SNEV	Medicaid Mandatory MCO South	

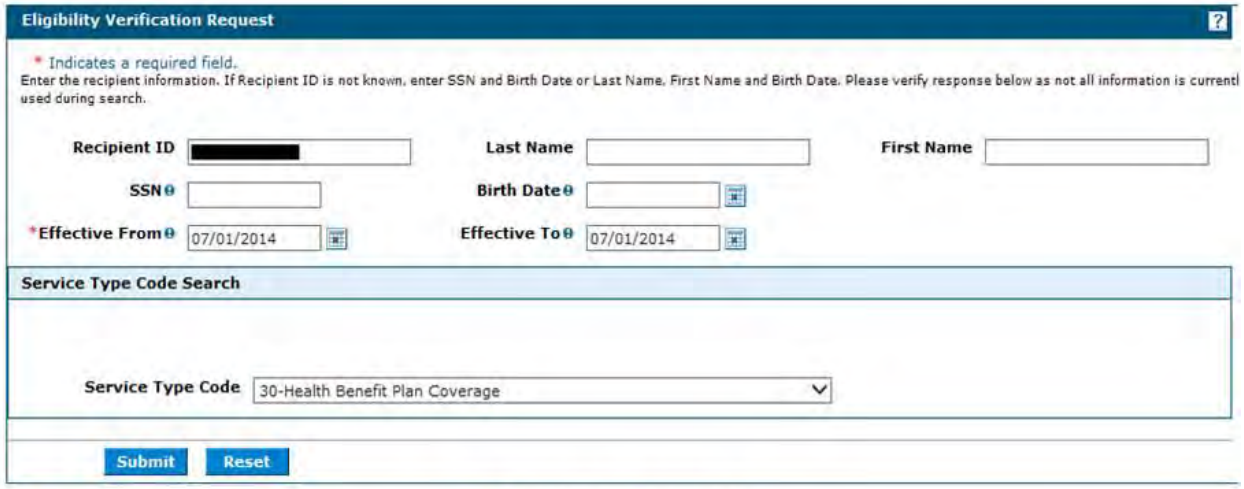
Managed Care Assignment Details

Primary Care Provider	Type	Provider Phone	Benefit Plan
AMERIGROUP COMMUNITY CARE	Health Benefit Plan Coverage	1-800-600-4441	XIX MAN SNEV
Current MCO			NPI/API
AMERIGROUP COMMUNITY CARE			

Identify FFS-CMO Enrollment Using EVS

When providers verify recipient eligibility, they will notice that EVS currently reflects the acronym "CMO-FFS" to indicate Care Management Organization. See the screenshots below. **This**

indicator is informational only and there are no differences in benefits or billing procedures from any other FFS recipient.



Eligibility Verification Request

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date or Last Name, First Name and Birth Date. Please verify response below as not all information is current
used during search.

Recipient ID [redacted] Last Name First Name

SSN Birth Date

*Effective From 07/01/2014 Effective To 07/01/2014

Service Type Code Search

Service Type Code 30-Health Benefit Plan Coverage

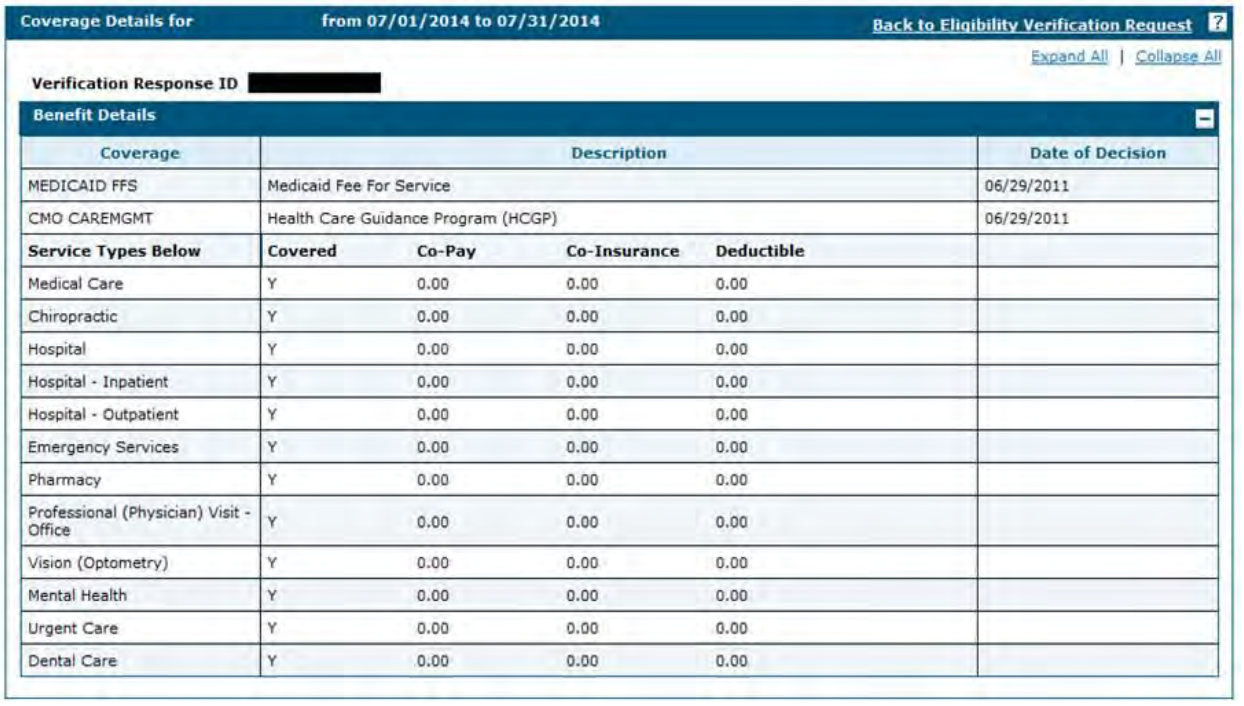
Submit Reset

Eligibility Verification Information for from 07/01/2014 to 07/01/2014

Recipient ID [redacted] Birth Date [redacted]

Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS	07/01/2014	07/31/2014	0000000000
CMO CAREMGMT	07/01/2014	07/31/2014	0000000000

Other Insurance Detail Information



Coverage Details for from 07/01/2014 to 07/31/2014 Back to Eligibility Verification Request

Expand All | Collapse All

Verification Response ID [redacted]

Benefit Details

Coverage	Description				Date of Decision
MEDICAID FFS	Medicaid Fee For Service				06/29/2011
CMO CAREMGMT	Health Care Guidance Program (HCGP)				06/29/2011
Service Types Below	**Covered**	**Co-Pay**	**Co-Insurance**	**Deductible**	
Medical Care	Y	0.00	0.00	0.00	
Chiropractic	Y	0.00	0.00	0.00	
Hospital	Y	0.00	0.00	0.00	
Hospital - Inpatient	Y	0.00	0.00	0.00	
Hospital - Outpatient	Y	0.00	0.00	0.00	
Emergency Services	Y	0.00	0.00	0.00	
Pharmacy	Y	0.00	0.00	0.00	
Professional (Physician) Visit - Office	Y	0.00	0.00	0.00	
Vision (Optometry)	Y	0.00	0.00	0.00	
Mental Health	Y	0.00	0.00	0.00	
Urgent Care	Y	0.00	0.00	0.00	
Dental Care	Y	0.00	0.00	0.00	

The EVS User Manual provides additional details on the EVS eligibility request and response screens.

ARS

The ARS provides the **same information as** EVS, only via the phone. Your NPI/API is required to log on.

Phone: (800) 942-6511

Swipe Card System

A recipient's Medicaid card includes a magnetic strip on the back. When used with a swipe card system, this magnetic strip provides *real-time* access to recipient information. To implement a swipe card system, please **contact a swipe card vendor directly**. Vendors that are already certified with Nevada Medicaid/HPES are listed in the Service Center Directory.

Pending eligibility

HPES cannot process prior authorization requests or claims for a recipient who is pending eligibility. If prior authorization is required for a service, and the patient's eligibility is pending, the provider may request a **retroactive authorization** after eligibility has been determined (see the Prior Authorization chapter in this manual).

Any payment collected from a Nevada Medicaid recipient for a covered service must be returned to the recipient if they are later determined eligible for retroactive coverage that includes those dates of service.

Retroactive eligibility

Nevada Check Up does not offer retroactive coverage.

Nevada Medicaid offers up to three months of retroactive eligibility from the date in which the individual filed their application for assistance. Medicaid eligibility is determined by the DWSS.

Termination of eligibility

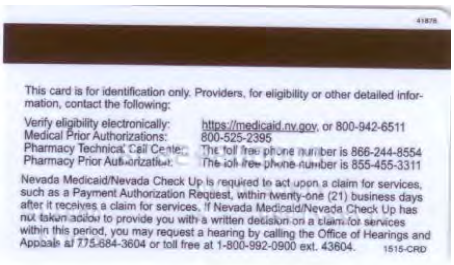
Nevada Medicaid and Nevada Check Up eligibility generally stops at the **end of the month** in which a recipient's circumstances change. A **pregnant woman** remains eligible through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income.

Are recipients notified when their Medicaid eligibility is terminated?

Yes. The DWSS mails a notification to the recipient's address on file at least 13 days prior to the termination.

Sample Medicaid card

When the recipient becomes eligible, he/she will receive a Medicaid card that will look similar to the image below.



Note: A **Medicaid card does *not* reflect dates of eligibility or benefits** a recipient is eligible to receive. Eligibility must be determined as described in the previous sections.

Fee For Service vs. Managed Care

Most recipients are eligible for benefits under the Fee For Service (FFS) program **or** the MCO program.

Outside of urban Washoe and Clark counties, most recipients are in the FFS program. In this program, recipients must receive services from an in-state Nevada Medicaid provider, unless prior authorized to receive services out-of-state. For recipients in the FFS program, providers submit claims to HPES. For more information on the FFS program including payment for emergency services, see MSM Chapter 100.

Enrollment in the MCO program is mandatory for most recipients in urban Washoe and Clark counties.

MCO enrolled recipients must receive services from an MCO network provider in order for Medicaid to cover the services. Providers in the MCO network must submit claims to the MCO. Because each MCO has unique billing guidelines, please contact the MCO directly if you have any billing questions.

Most **Nevada Check Up recipients** in urban Clark and Washoe counties are enrolled in an MCO beginning on their their first day of coverage. Most **Nevada Medicaid recipients** in urban Clark and Washoe counties are eligible to receive services under the FFS program

If a mother is enrolled in an MCO, is her newborn automatically enrolled in that MCO?

Yes. Please refer to the MSM Chapter 3600, section 3603.13.b for payment and reporting specifications.

beginning on their first day of coverage, and are then transitioned to an MCO on the first day of the following month.

Emergency services coverage for an MCO enrolled recipient is discussed in MSM Chapter 3600, Section 3603.5.

MCO contact information

The two contracted MCOs are AMERIGROUP Community Care (effective February 1, 2009) and Health Plan of Nevada. If you have any questions about the MCOs, please call the DHCFP at (775) 684-3692.

AMERIGROUP Community Care
Physician Contracting
Phone: (702) 228-1308 ext. 59844
Provider Inquiry Line (for eligibility, claims and pre-certification):
Phone: (800) 454-3730
Notification/Pre-certification:
Phone: (800) 454-3730
Fax: (800) 964-3627
Claims Address:
AMERIGROUP Community Care
Attn: Nevada Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Health Plan of Nevada (HPN)
Phone: (800) 962-8074
Fax: (702) 240-6281
Claims Address:
Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89114

Care management services information

The DHCFP's Health Care Guidance Program (HCGP) provides care management services to eligible Medicaid fee-for-service (FFS) recipients. The program is designed to help improve health outcomes for individuals who live with chronic health conditions by offering additional support to enrollees and providers. Coordinating transitional care, follow-up appointments, support services, preventive health and use of health information technology are all components of this program.

When providers verify recipient eligibility, they will notice that EVS currently reflects the acronym "CMO-FFS" to indicate Care Management Organization. **This indicator is informational only and there are no differences in benefits or billing procedures from any other FFS recipient.**

Providers with questions regarding this program may call the Health Care Guidance Program at (855) 606-7875, option 2, or send an email to caremanagement@dhcfp.nv.gov.

Chapter 4: Prior and retrospective authorization

Introduction

Some services/products require authorization. You can determine if authorization is required by referring to the Medicaid Services Manual, the Fee Schedules, the Billing Guidelines, the PA Requirements for Outpatient Procedures or by calling the Authorization Department at **(800) 525-2395.**

Providers are responsible for verifying recipient eligibility and authorization requirements *before* providing services/products (the Authorization Department does not handle recipient eligibility inquiries.)

An approved authorization does not confirm recipient eligibility or guarantee claims payment.

Common services that require authorization are:

- Non-emergency hospital admission (e.g., psychiatric, rehabilitation, detoxification)
- Hospital admission for *elective/avoidable* cesarean sections and early induction of labor prior to 39 weeks gestation
- Outpatient surgical procedure
- Residential Treatment Center admission
- Non-emergency transfer between acute facilities
- In-house transfer to a rehabilitation unit
- In-house transfer to and from medical and psychiatric/substance abuse units, and between Psychiatric and substance abuse units
- Rollover admission from observation and same-day-surgery services
- Psychologist services
- Some diagnostic tests
- Services provided out-of-state or outside catchment areas
- Physical/Occupational/Speech therapy
- Home Health services
- Durable Medical Equipment

Ways to request authorization

Online Authorization

The HPES Provider Web Portal, https://www.medicaid.nv.gov, can be used to request authorization for Inpatient, Outpatient, Behavioral Health, Home Health, PASRR, Therapy and DME services.

Paper Requests

Services that cannot be requested online must be requested via a paper form. The Forms webpage has links to paper forms for all services. Form users can type information directly into all form fields. While Adobe Reader cannot save the inputted information for future use, it allows

users to print a paper copy of the form with the entered information. Requests may be faxed or mailed.

The prior authorization fax number for all services is: **(866) 480-9903.**

Drug requests and ProDUR overrides

MSM Chapter 1200 and the Pharmacy Billing Manual discuss requirements for drug prior authorizations. The generic pharmacy prior authorization request form, request form for PDL Exception, and other forms for drugs with clinical PA criteria are on the Pharmacy Forms webpage. See Medicaid Services Manual (MSM) Chapter 1200 for drugs requiring clinical PA criteria.

Fax paper requests to **(855) 455-3303.**

For questions on prior authorization or ProDUR overrides, contact the Clinical Call Center at **(855) 455-3311.**

Submission deadlines

In general, it is best to submit a request as soon as you know there is a need. Some provider types have special time limitations, so be sure you are familiar with the Billing Guidelines for your provider type.

An authorization request is not complete until HPES receives all pertinent clinical information.

Services listed below must be requested within the specified timeframes.

At least *two* business days prior to service:

- Inpatient Medical/Surgical
- Level of Care (LOC) assessment
- Routine Dental Services
- Neuropsychological Services
- Inpatient Acute Care (non-RTC)

At least *three* business days prior to service:

- Outpatient Services

At least *five* business days prior to service:

- Initial Home Health Evaluation
- Complex Dental Services
- Initial Residential Treatment Center Evaluation

At least *seven* business days prior to service:

- PASRR Level I Evaluation

At least *ten* business days prior to service:

- Home Health re-assessment

Behavioral Health and Substance Abuse Agency Model (SAAM) Authorization Requests

Provider Types 14, 82 and 17 (specialty 215) are encouraged to review authorization request timelines specified in the Billing Guidelines for those provider types. The Billing Guidelines are located on the Provider Billing Information webpage at https://www.medicaid.nv.gov/providers/BillingInfo.aspx

Inpatient Acute Care

The provider is required to request authorization within *one* business day following admission for:

- **Emergency** admission from a physician's office, ER, observation, or urgent care or an emergency transfer from one in-state and/or out-of-state hospital to another
- **Obstetric/maternity and newborns** admission greater than 3 days for vaginal delivery, and greater than 4 days for medically necessary or emergent cesarean section
- **Neonatal Intensive Care Unit (NICU)** admission
- **An obstetric or newborn admission** when delivery of a newborn occurs immediately prior to recipient arrival at a hospital
- **Antepartum admissions** for the purpose of delivery when an additional elective procedure is planned (excluding tubal ligations)
    - **Note:** An *inpatient admission* specifically for tubal ligation must be prior authorized.

Date of Decision During Inpatient Stay

If a patient is not eligible for Medicaid benefits upon admission, but is later determined eligible *during their inpatient stay*, the provider must request prior authorization within *five* business days of the date of eligibility decision (DOD).

For newborns, this is *five* days from the birth date. If the recipient's DOD includes the admission date, an approved request can cover the entire stay, including day of admission.

If the provider fails to request authorization within the five day window, and the recipient is determined eligible while in the facility, authorized days can begin the day that HPES receives the authorization request *including* all required clinical documentation.

Continued stay request

If the recipient requires service dates that were not requested/approved in the initial authorization, you may request these services by submitting a *continued stay* request *prior* to the end of the authorized dates. Use the Provider Web Portal or a paper form as usual, and mark the checkbox for *Continued Stay Request*.

Retrospective authorization

If a recipient is determined eligible for Medicaid benefits *after* service is provided (or after discharge), a *retrospective* authorization may be requested **within *90 days*** from the DOD.

Retroactive eligibility does not apply to Nevada Check Up recipients (Medicaid only).

After submitting the request

HPES uses standard, industry guidelines to determine if the requested service/product meets payment requirements.

Incomplete Request

If HPES needs additional information to make a determination for your request, you will be notified through the Provider Web Portal and by letter. You have ***five*** **business days** to submit the requested information or the request will be denied for insufficient information (a *technical denial*).

Modify Request (Clinical Information)

Call HPES or the DHCFP, as appropriate, if you need to modify clinical information on an *approved* request (e.g., CPT code or units requested). Any modifications must be approved *before* the scheduled service date.

Correct Request (Non-clinical Information)

Submit the prior authorization data correction form, FA-29, to correct or modify non-clinical, identifying data on a previously submitted request. Form FA-29 cannot be used to request re-determination of medical necessity, nor does it take the place of a prior authorization request.

- Residential Treatment Centers (RTC) providers: Submit an FA-29 if the date of admission differs from the date of admission on the prior authorization. Please note that the prior authorization end date will remain the same.
- Inpatient Psychiatric and RTC providers: Submit an FA-29 if the recipient is discharged before the last authorized date of service.

Approved request

When a request is approved, HPES or DHCFP provides notification by phone, fax or through the Provider Web Portal, as appropriate. Approved requests are assigned an 11-digit authorization number and a service date range.

Approved requests are only valid for the dates shown on the Notice of Medical Necessity Determination letter.

Adverse determination

A denied or reduced authorization request is called an adverse determination.
There are three types of *adverse determination*:

- **Technical Denial:** Issued for a variety of technical reasons such as the recipient is not eligible for services or there is not enough information for HPES or DHCFP to make a determination on the request and, after notification, the provider has not submitted the requested information within *five* business days. A Notice of Decision (NOD) for a technical denial is mailed to both the provider and the recipient.
- **Denial:** Issued when the service does not meet medical necessity based on clinical documentation submitted by the provider.
- **Reduction:** Issued when the requested service does not fully meet medical necessity based on clinical documentation submitted by the provider. The physician reviewer may approve a portion of the request, but will not approve a lower level of care without a request from the provider.

Reconsideration

Reconsideration is a written request from the provider asking HPES or DHCFP (as appropriate) to re-review a denied or reduced authorization request.

Reconsideration is not available for technical denials.

The provider must request reconsideration within *30* calendar days from the date of the original determination, except for **RTC services**, which must be requested within *90* calendar days.

HPES or DHCFP will notify the provider of the outcome of the reconsideration within 30 calendar days. The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review.

Peer-to-Peer Review

Before submitting a written reconsideration, a provider may request a peer-to-peer review by calling (800) 525-2395 within 10 calendar days of the adverse determination. A peer-to-peer review does not extend the 30-day deadline for reconsideration.

Peer-to-peer reviews are a physician-to-physician discussion or in some cases between the HPES second level clinical review specialist and a licensed clinical professional operating within the scope of their practice.

Special authorization requirements based on recipient eligibility

Dual Eligibility

For recipients with Medicare and Medicaid coverage (dual eligibility), prior authorization is not required for Medicare covered services. However, if a service is not covered by Medicare, the provider must follow Medicaid's authorization requirements.

FFS

Medicaid authorization requirements apply to recipients enrolled in the FFS plan (regardless of TPL coverage), with the exception of recipients also covered by Medicare and recipients who have exhausted their Medicare benefits (see below, Medicare Benefits Exhausted). In these cases, follow Medicare's authorization requirements.

Managed Care

For recipients enrolled in an MCO, follow the MCO's prior authorization requirements.

Medicare Benefits Exhausted

If Medicare benefits are exhausted (e.g., inpatient), an authorization request is required within 30 days of receipt of the Medicare EOB.

QMB Only

Prior authorization requests are unnecessary for recipients in the *QMB Only* program since Medicaid pays only co-pay and deductible up to the Medicaid allowable amount.

Claims for prior authorized services

To submit a claim with a service that has been prior authorized, verify that the:

- Authorization Number is in the appropriate field on the claim
- Dates on the claim are within the date range of the approved authorization
- Units on the claim are not greater than the units authorized *(outpatient claims only)*
- Total units/days billed on a claim are not greater than total units/days authorized *(inpatient claims only)*
- Procedure codes on the claim match codes on the authorization *(outpatient claims only)*

Inpatient claims: DHCFP's revenue code groups (e.g., medical/surgical/ICU, maternity, newborn, NICU, psych/detoxification, intermediate and skilled administrative days, level I trauma) can be found on the DHCFP Rates Unit webpage at http://dhcfp.nv.gov/RatesUnit.htm. Revenue code groups are based on levels of care assigned to the revenue codes within these groups.

Chapter 5: Third-Party Liability (TPL)

TPL policy

State policy regarding TPL is discussed in MSM Chapter 100.

Ways to access TPL information

You can access a recipient's TPL information in the same ways you verify eligibility: through EVS, through a swipe card system, or by calling the ARS at (800) 942-6511.

How to bill claims with TPL

Refer to the CMS-1500, UB and ADA claim form instructions on the Provider Billing Information webpage when submitting paper claims with TPL. The 837P, 837I and 837D companion guides on the Provider Electronic Claims/EDI webpage contain the HPES specifications for electronic claim submission.

When billing claims with TPL:

- Bill only one claim line per paper form
- Do not include write-off or contractual adjustment amounts on the claim
- If the provider has a capitated agreement with Medicaid, enter the contract amount minus co-pay (not a zero paid amount)
- An EOB showing reason codes and definitions must be attached to each paper claim. Claims with two or more payers in addition to Medicaid must be billed on a paper claim form.

Electronic Claims with TPL

For **electronic claims where Medicaid is the secondary payer**, enter TPL information from your EOB into the appropriate electronic fields (no attachment required). Electronic claims with **more than one payer prior to Medicaid** must be submitted on paper.

Follow other payers' requirements

Always follow other payers' billing requirements. If the other payer denies a claim because you did not follow their requirements, Medicaid will also deny the claim. You may not collect payment from a recipient because you did not comply with the policies of Medicaid and/or the TPL.

When Medicaid can be billed first

Medicaid is the payer of last resort and must be billed *after* all other payment sources with the following exceptions:

- The recipient is involved in a trauma situation, e.g., an **auto accident**
- The recipient is enrolled in a mandatory Medicaid MCO and the service is billable under the FFS benefit plan (e.g., **orthodontia**). Note: Recipients enrolled in MCO must receive services from MCO providers unless the service is billable under the FFS benefit plan
- The **service is not covered** by the recipient's TPL (e.g., Medicare)
- Medicaid is the primary payer to the following three programs; however, this does not negate the provider's responsibility to pursue other health coverage or TPL if it exists:
    - ***Indian/Tribal Health Services*** *plan (If the claim is processed by TPL and Medicaid has already paid, the claim must be adjusted. See the "Adjustments and Voids" section in this Billing Manual on pages 38-39 for instructions.)*
    - **Children with Special Health Care Needs** program
    - **State Victims of Crime** program

You can bill the recipient when…

You may bill recipients only in the following situations:

- The recipient's Medicaid **eligibility status is pending**. If you bill the recipient and they are found eligible for Medicaid with a retroactive date that includes the date of service, you must return the entire amount collected from the recipient and then bill Medicaid. For this reason, it is recommended that you hold claims until after eligibility is determined.
- **Medicaid does not cover the service and the recipient agrees to pay** by completing a written, signed agreement that includes the date, type of service, cost, verification that the provider informed the recipient that Medicaid will not pay for the service, and recipient agreement to accept full responsibility for payment. This agreement must be specific to each incident or arrangement for which the client accepts financial responsibility.
- The TPL **payment was made directly to the recipient** or his/her parent or guardian. You may not bill for more than the TPL paid for services rendered.
- The **recipient fails to disclose** Medicaid eligibility or TPL information. If a recipient does not disclose Medicaid eligibility or TPL information at the time of service or within Medicaid's stale date period, the recipient assumes full responsibility for payment of services.

You may NOT bill the recipient when…

You may not bill the recipient:

- For a missed appointment

- For co-payment indicated on a private insurance card
- For the difference between the amount billed and the amount paid by Medicaid or a TPL
- When Medicaid denies the claim because the provider failed to follow Medicaid policy

Incorrect TPL information

If you believe there are errors in a recipient's private insurance record, please contact HPES' TPL vendor, Emdeon, who will research and update the recipient's file if necessary.

Emdeon can be reached at:
Phone: (855) 528-2596
Fax: (855) 650-5753
Email: TPL-NV@emdeon.com
Mail: Emdeon TPL Unit; PO Box 148850
Nashville, TN 37214-8850

Do not send claims to Emdeon.

How should providers handle Medicare TPL discrepancies?

Contact the Division of Health Care Financing and Policy (DHCFP) at TPL@dhcfp.nv.gov. They will research the request and update the Medicaid Management Information System (MMIS) as needed.

Claim attachment for incorrect TPL

After you have contacted Emdeon or DHCFP with the updated TPL information, you may submit your claim with an attachment letter stating the change (this is not required). If sending, the letter should be on your company letterhead and include dates of policy termination and the name of the insurance company representative with whom you spoke.

Discovering TPL after Medicaid pays

If you discover the recipient has TPL after Medicaid has paid the claim:

- Bill the primary insurance
- After you have received payment from the primary insurance, submit a claim adjustment to HPES

How often does HP Enterprise Services update their TPL information?

The DWSS sends the most recent TPL information to HP Enterprise Services daily.

Chapter 6: Electronic data interchange

EDI defined

Short for electronic data interchange, EDI is the transfer of data between companies by use of a computer network. Electronic data transfers are called transactions. Different transactions have unique functions in transferring health care data. These will be described in this chapter.

The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N sets the technical standards for health care EDI transactions. For more information on health care EDI transactions, visit http://www.x12.org.

Benefits of EDI

There are many benefits to using EDI, such as:

- Quicker claims processing and quicker claims payment
- Verify claim status within 48 hours of submission
- Reduce claim errors by validating fields before the claim reaches HPES
- Save money on envelopes, preprinted forms and postage

Eliminate certain data entry and document handling tasksCommon EDI terms

The following are terms used by HPES when discussing EDI:

Clearinghouse

A clearinghouse is a business that submits claims to HPES on behalf of a provider. Payerpath is one example of a clearinghouse.

When you use a clearinghouse, you send claim data from your computer to the clearinghouse. The clearinghouse performs a series of validation checks on the claim and then forwards it to HPES.

Direct submitter

A provider that submits electronic claims to HPES using their practice management software is a direct submitter.

Service Center

A Service Center is any entity that submits electronic claims to HPES. Clearinghouses and direct submitters are both service centers. If your business submits claims through a clearinghouse, your business is not a service center.

All Service Centers must test with HPES and become approved before electronic claims from that Service Center can be processed.

Introducing Payerpath

Payerpath is a clearinghouse contracted with HPES to provide free electronic claim submission for Medicaid claims. **Medicaid claims submitted through Payerpath are free of charge to Medicaid providers.**

Payerpath is a claims management system that is accessed over the Internet. Users can also interface Payerpath with their current practice management system to upload claims. Submitting claims through Payerpath requires an internet-ready computer and Internet Explorer version 8.0 or higher. You will also need to register as discussed later in this chapter.

Visit the Payerpath website at http://www.payerpath.com for more information.

Available transactions

The following is a list of EDI transactions used by HPES:

- **Transaction 270/271:** A request from you (the provider) to verify recipient eligibility including program coverage and benefits and the HP Enterprise Services response to your request
- **Transaction 820:** Premium payment for enrolled MCO recipients
- **Transaction 834:** Recipient enrollment/disenrollment to an MCO
- **Transaction 835/277U:** The electronic Remittance Advice from HP Enterprise Services showing status and payment of the provider's most recent claims. The 277U transaction is also supplied to show claims with a pended status
- **Transaction 837D:** Electronic dental claim submitted by the provider (paper equivalent is the ADA claim form)
- **Transaction 837I:** Electronic institutional claim submitted by the provider (paper equivalent is the UB-92/UB-04 claim form)
- **Transaction 837P:** Electronic professional claim submitted by the provider (paper equivalent is the CMS-1500 claim form)
- **NCPDP:** National Council for Prescription Drug Programs Batch submitted by pharmacy providers

Electronic remittance advice: To receive an electronic remittance advice, submit the Service Center Authorization Form for Providers (FA-37) as described below. Although multiple clearinghouses may submit claims on your behalf, only one Service Center can accept your electronic remittance advice.

Paper remittance advices will cease approximately six billing cycles after you authorize an electronic remittance advice.

EDI resources

The following documents are provided on the Electronic Claims/EDI webpage.

The Service Center Directory

When considering electronic submission through a clearinghouse, you may want to refer to the Service Center Directory. This directory provides contact information for clearinghouses that currently meet HPES transaction requirements.

Service Center User Manual

The Service Center User Manual provides instruction for Service Centers, i.e., clearinghouses and direct submitters. It describes HIPAA requirements and HPES' technical requirements for Secure File Transfer Protocol (SFTP), Secure Sockets Layer (SSL), transaction testing and more.

Companion guides

There are 11 companion guides on the Electronic Claims/EDI webpage. These guides provide clearinghouses and direct submitters with specific technical requirements for the submission of electronic claim data to HPES.

Links

The following websites provide additional information on EDI practices and standards.

- ANSI ASC X12N website at http://www.x12.org
- WEDI website at http://www.wedi.org/
- CMS website http://www.cms.hhs.gov

How to register for EDI

Complete the forms as explained below and submit them using any of the three options below:

Email them to: nvmmis.edisupport@hp.com

Fax them to: (775) 335-8502

Mail them to: HP Enterprise Services
EDI Coordinator
P.O. Box 30042
Reno, Nevada 89520-3042

Service Center Electronic Transaction Agreement (FA-35)

The FA-35 defines the business relationship between the Service Center, the DHCFP and HPES. Complete this form if you are a direct submitter or clearinghouse that would like to send claims to HP Enterprise Services on behalf of providers.

Service Center Operational Information Form (FA-36)
The FA-36 provides HPES with your contact information, which electronic transactions you plan to provide and the contact information for your software vendor. Complete this form if you are a direct submitter or clearinghouse that would like to send claims to HPES on behalf of providers.

Service Center Authorization Form for Providers (FA-37)
The FA-37 allows you to:

- Authorize or terminate a transaction type
- Authorize or terminate processing of your electronic remittance advice

Submit one FA-37 form for each billing NPI/API.

Payerpath Registration Form (FA-39)
To register for Payerpath's free claim submission service, each provider business must complete one FA-39 form.

Registration scenarios
This section describes which forms to submit in each of four circumstances.

❖ **Submit claims through Payerpath:**
Submit FA-37 and FA-39. After your registration forms are processed, HPES will contact you with your username and initial password, which you can use to log on to Payerpath's website and begin submitting claims.

❖ **Submit claims through a clearinghouse:**
Submit FA-37 to give the clearinghouse permission to send/receive transactions on your behalf. HPES will notify the clearinghouse that you have registered to send/receive electronic transactions through them. Your clearinghouse will assist you in further setup and/or testing.

❖ **Submit claims using your current practice management software*:***
Submit one FA-35 form, one FA-36 form, and one FA-37 form. HPES will contact you with your username, your initial password and your Service Center Code so that you may begin testing.

❖ **Submit claims on behalf of providers (for clearinghouses):**
Submit one FA-35 form and one FA-36 form. HP Enterprise Services will contact you with your username, your initial password and your Service Center Code so that you may begin testing.

Chapter 7: Frequently asked billing questions

Which NPI do I use on my claim?

If you work with a facility or a group practice, you will have one NPI for yourself and one for the entity. To properly complete and submit your claim, follow the claim form instructions (for paper claims) or companion guides (for electronic claims). These discuss field by field where to put provider and entity identifying information.

Which code do I use on my claim?

Use HIPAA-compliant codes from the Revenue code, CPT, International Classification of Diseases, version 9 (ICD-9) or version 10 (ICD-10) and Healthcare Common Procedure Coding System (HCPCS) books that are **current for the date of service** on the claim. Unspecified procedure codes may be used only when you are unable to locate a suitable code for the procedure or service provided. Use ICD-9 codes on claims with dates of service prior to October 1, 2015. **Use ICD-10 codes on claims with dates of service on or after October 1, 2015.**

How do I submit a *clean* paper claim?

Claim accuracy, completeness, and clarity are very important. Complete all fields as described in the claim form instructions. **Use only forms with *red drop-out ink* and:**

- Do *not* write on or cover the claim's bar code
- Do not fold, staple or crease claims
- Use blue or black ink
- If handwriting, print legibly
- Keep names, numbers, codes, etc., within the designated boxes and lines
- Rubber stamp signatures are acceptable
- Include a return address on all claim envelopes

Send any necessary attachments with your claim (claim form on top, attachment on the bottom).

What is the timely filing (stale date) period?

Claims without TPL that are submitted by in-state providers must be received within 180 days of the date of service or date of eligibility decision–whichever is later.

Claims with TPL and claims submitted by **out-of-state providers** must be received within 365 days of the date of service or date of eligibility decision – whichever is later.

The 180 or 365 days is calculated by subtracting the last date of service from the date the claim was received.

Inaccurate, illegible or incomplete claims

If a claim is denied or returned to you (e.g., illegible or incomplete claims), you are *not* given an additional 180 or 365 days to resubmit. Timely filing is always based on date of service or date of eligibility.

Exception to the stale date period

An exception to the timely filing limitation may be granted if you document delays due to errors on the part of the DWSS, DHCFP or HPES. If this applies to your claim, submit your claim and receive a denial for timely filing limitations. Then, follow the requirements in the appeals section of this manual to submit a claim appeal.

How much do I bill for a service?

Bill your **usual and customary charge** that is quoted, posted, or billed for that procedure and unit of service. Exceptions are Medicare assignment (billing at the Medicare fee schedule), sliding fee schedules that are based on a recipient's income, contracted group discount rates or discounts given to employees of the provider.

What attachments can be required?

Sometimes a claim will require additional documentation, called an attachment. The four cases in which HPES requires an attachment are described below.

1. **Explanation of Benefits**

   For paper claims, if a recipient has TPL, attach a copy of the other carrier's EOB to each claim. For **electronic claims where Medicaid is the secondary payer**, enter TPL information from your EOB into the appropriate electronic fields (no attachment required). Electronic claims with **more than one payer prior to Medicaid** must be submitted on paper.

2. **Hysterectomy Acknowledgement Form**

   A paper (not electronic) claim must be submitted for hysterectomy services. Attach the FA-50 form if the woman received the required hysterectomy information before surgery. Attach the FA-51 form if the woman received the required hysterectomy information after surgery.

3. **Sterilization Consent Form**

   A paper claim (not electronic) must be submitted for sterilization procedures. Attach a Sterilization Consent Form. You may use the FA-56 form on the HPES Nevada Medicaid website, or any Sterilization Consent Form that meets federal requirements.

4. **Abortion Affidavit or Declaration**

   A paper (not electronic) claim must be submitted for an abortion. If the procedure terminates a pregnancy resulting from of an act of rape or incest, submit the FA-52 form or FA-53 form as appropriate.

If, in the opinion of the physician, the pregnant woman is unable, for physical or psychological reasons, to comply with the reporting requirements for abortion services, the recipient may sign the FA-54 form for a pregnancy resulting from rape or the FA-55 form for a pregnancy resulting from incest.

Sterilization and Abortion Policy Billing Instructions guide for Medicaid is located on the Billing Information webpage.

What else should I know about attachments?

- A copy of the recipient's medical record and proof of eligibility are not required
- If multiple claims refer to the same attachment**, make a copy of the attachment for each claim.** Only one copy of the attachment is required for multi-page UB claims
- If an attachment has information on both sides of the page, **copy both sides** and attach the copies to the claim
- Attachments must be **size 8.5" x 11"** in order to be processed
- If the attachment is smaller than 8.5" x 11", tape the attachment to paper that size
- Place the **claim form on top** of its attachment
- **Please refrain from using staples.** You may use paper clips, binder clips or rubber bands to group claims and/or attachments
- Claims for **hysterectomy, sterilization and abortion** procedures must be submitted on paper—not electronically.

Chapter 8: Claims processing and beyond

Claims processing

Providers are required to submit claims that are in compliance with Nevada Medicaid and Nevada Check Up policies.

HPES uses a Medicaid Management Information System (MMIS) to process all claims. The MMIS performs hundreds of validations on each claim. Examples include (but are not limited to):

- Does the provider have a valid contract with Nevada Medicaid?
- Was the recipient eligible for services?
- Was prior authorization obtained for the service (if applicable) and was the service provided within the approved dates?
- Was TPL billed prior to Medicaid?
- Has this claim been sent to HPES previously (duplicate claim)?

If it fails one of these edits, the MMIS will issue a denial, pend status or partial payment (cutback).

Provider Preventable Condition (PPC) Denial: This denial is issued when the service or a portion of the service is directly related to an undesirable and preventable medical condition acquired by a recipient during the course of receiving treatment at that facility. This denial does not consider medical necessity. See MSM Chapter 100 Section 105.2A.4.

How to check claim status

Through EVS, ARS or a swipe card system, you can access the status of your claims. Please wait 24 hours to check claim status if the claim was submitted electronically and 30 days if the claim was submitted on paper.

Your remittance advice

HPES generates a Remittance Advice (RA) for all providers with claims activity in a given week. Your RA provides details about the adjudication of your claims.

HPES provides a paper RA by default. You can receive electronic RAs by submitting form FA-37 (setup takes 1-2 weeks).

Please work with your clearinghouse to ensure you receive all information that HPES sends in its electronic RA.

For paper RAs, you will receive one RA for Nevada Medicaid, one RA for Nevada Check Up (if applicable) and one RA labeled *ZZ* (if applicable) for recipients who are unassigned to a benefit plan at the time of claims processing.

RA messages

Your weekly remittance advices may include important announcements for providers and billing staff. Please pay attention to these messages and disseminate them to all appropriate parties.

Frequently asked RA questions

Can I see my RA online?

Yes. You can access your remittance advice online through the Provider Web Portal. Please access via the Secure Provider pages under "Search Payment History".

What does an asterisk in front of an ICN signify on my RA?

An asterisk (*) in front of an ICN identifies the claim as a historical claim. HPES is notifying the provider that the check submitted to reimburse Medicaid for an overpayment has been posted to the requested recipient account(s). Because this claim data is informational only, it is not included in the payment amount at the end of your RA. Therefore, the total reimbursement will not balance to the claims on the RA.

If my claim is denied for failing to bill TPL before Medicaid, will my RA display the TPL information?

Your RA shows the name and contact information for only one TPL source. It is important to check EVS to see if there are additional payers before you resubmit the claim to Medicaid.

On my RA, some paid amounts include *CR* and *DR* labels. What do these mean?

CR means that a credit has been applied to the account and money has been retracted from the provider. *DR* means that a debit has been applied to the account and money has been credited to the provider.

What information is included on my RA?

HPES sends the following information (and more) to providers via their RA. If you are receiving an electronic RA and do not see this information, please contact your RA vendor/clearinghouse so that they can update the information transmitted to you.

- Recipient ID and name
- NPI/API of the billing (Group) provider
- ICN of the processed claim
- RA messages (important billing updates/reminders from DHCFP or HPES)
- History adjustments
- TPL Information (one carrier only)
- Edit Codes and their descriptions
- CR (credits) and DR (debits) from adjustments
- Negative Balances
- Financial Transactions

Parts of the ICN

When HPES receives a claim, the claim is assigned an ICN for tracking purposes. An ICN contains the following information about the claim:

- Digits 1 through 7 denote the year and the Julian date in the format YYYYDDD
- Digit 8 denotes the media type as follows:
  - 0 – Recycled, paper claim
  - 2 – Original, paper claim
  - 5 – Special batch claim
  - 6 – POS claim
  - 7 – Electronic claim
  - 8 – Recycled, electronic/EDI claim
  - 9 – Reprocessed, encounter claim
  - C – Clinical Claim Editor, new line
  - I – Internally adjusted claim
  - K – Clinical Claim Editor, voided line
  - S – MMIS-generated mass adjustment
- Digits 9-14 denote the sequential document number assigned by HPES
- Digits 15 and 16 denote the claim line

ICNs for adjusted claims
Each time HPES adjusts a claim, the claim is given a new ICN.
A claim's *original* ICN is the *last ICN assigned to the claim.* Always refer to the claim's last paid ICN when requesting an adjustment.

To match an original claim with its adjustment, compare the Recipient ID and the date of service on the claims.

Pended claims

A claim suspends processing or *pends* when the MMIS determines there is cause to review it manually. While a claim is pending, there is no action required by you.

Denied claims

If your claim is denied, compare the *EOB Code* on the RA with your record of service.
This is located near the end of your RA.

For example, if a denied claim denotes recipient ineligibility, check your records to verify that the correct dates of service were entered on your claim and that the recipient was Medicaid eligible on the date of service.

If you do not agree with a claim denial, you may contact the Customer Service Center at (877) 638-3472. Certain denials can be resolved by phone. If this is not the case for your claim, the representative may be able to advise you how to resubmit your claim so it can be paid.

Resubmitting a denied claim

To resubmit a denied claim, complete and submit the claim form as specified in the CMS-1500, UB or ADA claim form instructions located on the Provider Billing Information webpage. You can refer to the claim's EOB Code on your remittance advice to help you fix the error (see previous section).

When you resubmit a denied claim, **do not include an ICN or Adjustment/Void Reason code** on your resubmission.

Adjustments and Voids

Adjustments and voids must be submitted within the stale date period outlined in Chapter 7 of this manual. Only a *paid* claim can be adjusted or voided (**adjustments/voids do not apply to pended and denied claims**). Remember that pended claims require no action from the provider and resending a denied claim is considered a resubmission as discussed in the previous section.

Can I adjust or void a claim electronically?

Claims can be adjusted/voided electronically, with the exception of Medicare and dental claims.

If you believe your claim was *paid* incorrectly, please call the Customer Service Center at (877) 638-3472. Certain errors can be corrected over the phone. If this is not the case for your claim, the representative can assist you in determining a course of action for correcting the error.

Paper adjustments and voids

To adjust or void a paper claim, complete the special adjustment/void instructions in the CMS-1500 or UB claim form instructions located on the Provider Billing Information webpage.

Remember:

- Include the last paid ICN assigned to the claim and an Adjustment/ Void Reason code. These codes are located with each of the claim form instructions.
- Attach a copy of the RA page that lists the claim.
- Submit only one claim line per paper form.
- Attach an EOB to show any TPL payments, if applicable.

Mail the claim form, RA page and the EOB (if applicable), to HP Enterprise Services, P.O. Box 30042, Reno NV 89520-3042.

Electronic adjustments and voids

For electronic adjustments and voids, refer to instructions in the applicable Companion Guide: 837I or 837P, which are posted on the Electronic Claims/EDI webpage.

Overpayment

If you have been overpaid for a claim, please refund Nevada Medicaid by sending a check for the overpayment amount to:

HP Enterprise Services
P.O. Box 30042
Reno, NV 89520-3042

Include with your check, a letter or other document that contains:

- Claim's ICN
- Recipient ID
- Amount paid
- Brief explanation of the overpayment

Claim Appeals

Providers have the right to appeal a claim that has been denied. Appeals must be post marked no later than 30 calendar days from the date on the remittance advice listing the claim as denied. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days. Per MSM Chapter 100, Section 105.2C titled *Disputed Payment*, appeal requests for subsequent same service claim submissions will not be considered. That is, if a provider resubmits a claim that has already been denied and another denial is received, the provider does not have another 30 day window in which to submit an appeal. Such appeal requests will be rejected.

How to file an appeal

To submit an appeal, include *each* component listed below:

- A completed form FA-90 (Formal Claim Appeal Request) or a cover letter that contains *all* of the following:
  - Reason for the appeal.
  - Provider name and NPI/API.
  - The claim's ICN (claim number).
  - Name and phone number of the person HPES can contact regarding the appeal.
- Documentation to support the issue, when applicable, e.g., physician's notes, ER reports.
- An original signed paper claim that may be used for processing should the appeal be approved. The billing provider or authorized representative must sign and date the claim. Original, rubber stamp and electronic signatures are accepted.

Mail your appeal (FA-90 or cover letter, documentation and original signed paper claim) to:

HP Enterprise Services
Attention: Claim Appeals
P.O. Box 30042
Reno NV 89520-3042.

Mail appeals (and appeal documentation cited above) separately from other claims, e.g., adjustments, voids, original submissions and resubmissions.

E-mail Option

The claim appeal may be submitted via e-mail to ProviderClaimAppeals@hp.com. To submit via email, scan the cover letter or the completed form FA-90 and all supporting documents, including the original signed claim, and attach all items to one email. Please send the documents using secure email and write "Claim Appeal" in the subject line. Please note: If the claim appeal is submitted via e-mail, all future correspondence regarding the appeal will be done via e-mail.

After You File an Appeal

HPES researches appeals and retains a copy of all documentation used in the determination process. HPES sends a Notice of Decision letter when a determination has been reached.

Fair Hearings

If your appeal is denied, you can request a fair hearing. When applicable, instructions for requesting a fair hearing are included with your Notice of Decision. A fair hearing request must be received no later than *90 days* from the notice date on the Notice of Decision letter. The day after the notice date is considered the first day of the 90-day period. For additional information on Fair Hearings, please refer to MSM Chapter 3100.

Provider payment

Nevada Medicaid sends all provider payments via electronic funds transfer (EFT). To change the bank account to which your funds are deposited, complete and submit form FA-33.
HPES tracks and monitors all EFTs to detect and resolve problems that may arise.

Glossary

ADA – American Dental Association: A professional association of dentists committed to the public's oral health, ethics, science and professional advancement. http://www.ada.org

AMA – American Medical Association: The American Medical Association helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues. http://www.ama-assn.org

ANSI (ASC X12N) – American National Standards Institute: The Institute oversees the creation, promulgation and use of thousands of norms and guidelines that directly impact businesses in nearly every sector. ASC X12, chartered by ANSI in 1979, develops electronic data interchange (EDI) standards for national and global markets. With more than 315 X12 EDI standards and increasing X12 XML schemas, ASC X12 enhances business processes, reduces costs and expands organizational reach. Members include standards experts from health care, insurance, transportation, finance, government, supply chain and other industries. http://www.x12.org

API – Atypical Provider Identifier: Atypical Providers are individuals or organizations that are not defined as healthcare providers under the National Provider Identifier (NPI) Final Rule. Atypical providers may supply non-healthcare services such as non-emergency transportation or carpentry.

ARS – Automated Response System: An HPES automated system that provides access to recipient eligibility, provider payments, claim status, prior authorization status, service limits and prescriber IDs via the phone.

CDT – Current Dental Terminology: Current Dental Terminology (CDT) is a reference manual published by the American Dental Association that contains a number of useful components, including the Code on Dental Procedures and Nomenclature (Code), instructions for use of the Code, Questions and Answers, the ADA Dental Claim Form Completion Instructions, and Tooth Numbering Systems. http://www.ada.org/ada/prod/catalog/cdt/index.asp

CMS – Centers for Medicare and Medicaid Services: A federal entity that operates to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. http://www.cms.hhs.gov

CPT – Current Procedural Terminology: CPT® was developed by the American Medical Association in 1966. Each year, an annual publication is prepared, that makes changes corresponding with significant updates in medical technology and practice. The 2007 version of CPT contains 8,611 codes and descriptors.
http://www.amaassn.org/ama/pub/category/3884.html

DHCFP – Division of Health Care Financing and Policy: Working in partnership with the Centers for Medicare & Medicaid Services, the DHCFP develops policy for and oversees the administration of the Nevada Medicaid and Nevada Check Up programs.

DME – Durable Medical Equipment: A DME provider provides medical equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is

generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

DOD – Date of Decision: The date on which a recipient was determined eligible to receive Nevada Medicaid or Nevada Check Up benefits.

EDI – Electronic Data Interchange: The transfer of data between companies by use of a computer network. Electronic data transfers are called *transactions*. Different transactions have unique functions in transferring health care data, e.g., eligibility requests/responses and claim submission.

EFT – Electronic Funds Transfer: EFT provides a safe, secure and efficient mode for electronic payments and collections.

EOB – Explanation of Benefits: An EOB gives details on services provided and lists the charges paid and owed for medical services received by an individual.

EVS – Electronic Verification System: EVS provides 24/7 online access to recipient eligibility, claim status, prior authorization status and payments.

FFS – Fee-For-Service: A payment method in which a provider is paid for each individual service rendered to a recipient versus a set monthly fee.

HCPCS – HCFA Common Procedural Coding System: An expansion set of CPT billing codes to account for additional services such as ambulance transport, supplies and equipment.

HIPAA – Health Insurance Portability and Accountability Act: A federal regulation that gives recipients greater access to their own medical records and more control over how their personally identifiable health information is used. The regulation also addresses the obligations of healthcare providers and health plans to protect health information.

ICD-9 – International Classification of Diseases, 9th Revision: A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of recipients. Use for claims with dates of service prior to the October 1, 2015, ICD-10 effective date.

ICD-10 – International Classification of Diseases, 10th Revision: A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of recipients. **Use for claims with dates of service on or after the October 1, 2015, ICD-10 effective date.**

ICN – Internal Control Number: The 16-digit tracking number that HPES assigns to each claim as it is received.

MCO – Managed Care Organization: A health care plan in which the health care provider manages all recipient care for a set monthly fee versus a payment method in which a provider is paid for each individual service.

MMIS – Medicaid Management Information System: An intricate computer system programmed to assist in enforcing Nevada Medicaid and Nevada Check Up policy.

MSM – Medicaid Services Manual: The manual maintained by the DHCFP that contains comprehensive State policy for all Medicaid providers and services.

NPI – National Provider Identifier: A 10-digit number that uniquely identifies all providers of health care services, supplies and equipment.

PASRR – Preadmission Screening and Resident Review: A federally mandated screening process for recipients with a serious mentally ill and/or mentally retarded/mentally retarded related diagnosis who apply or reside in Medicaid certified beds in a nursing facility regardless of the source of payment.

PCS – Personal Care Services: A Nevada Medicaid program that provides human assistance with certain activities of daily living that recipients would normally do for themselves if they did not have a disability or chronic condition. See MSM Chapter 3500 for details.

PDL – Preferred Drug List: A list of drug products typically covered by Nevada Medicaid and Nevada Check Up. The PDL limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement.

QMB – Qualified Medicare Beneficiary: A recipient who is entitled to Medicare Part A benefits has income of 100% Federal Poverty Level or less and resources that do not exceed twice the limit for SSI eligibility. QMB recipients who are also eligible for full Medicaid benefits have a *QMB Plus* eligibility status. QMB recipients not eligible for Medicaid benefits have a *QMB Only* eligibility status.

RA – Remittance Advice: A computer generated report sent to providers that explains the processing of a claim.

TPL – Third-Party Liability: An insurer or entity other than Medicaid who has financial liability for the services provided a recipient. For example, injuries resulting from an automobile accident or an accident in a home may be covered by auto or home owner's insurance.