Billing Manual

for Nevada Medicaid and Nevada Check Up

Updated March 18, 2019

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.	
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
02/20/2015	Added DMEPOS to prior authorization submission deadlines list; updated Continued stay request section; added instructions for unscheduled revisions; added prior authorization appeals mailing address	21-24
07/01/2015	Retroeligibility time frame changed from five days to ten days; updated instructions under "Incomplete requests"	22 and 23
02/02/2016	Updated sections throughout	3, 4, 5, 9, 19, 23, 25, 29, 35 and 44
05/02/2016	Added quality measures requirements for Behavioral Health Community Network (BHCN) Providers; added documentation requirements for authorizations; updated Peer-to-Peer Review or Reconsideration section.	6, 23, 26-29
03/14/2017	Updated Policy Development & Program Management name and contact email; updated documentation for authorization requests; updated authorization submission deadlines; added MCO to FFS authorization process; added Termination of	7/8, 23, 24, 27, 31, 34

Date (mm/dd/yyyy)	Description of changes	Pages impacted
	Services instructions; added TPL vendor email	
07/24/2017	Updated Managed Care Organization (MCO) contact information. Updated applicable prior authorization text to reflect submission via the portal. Changed fiscal agent and Quality Improvement Organization (QIO) references (DXC Technology) to "Nevada Medicaid" throughout manual.	23, 27-29
01/08/2018	Added LIBERTY Dental Plan of Nevada's contact information.	Chapter 3
02/01/2018	Changed Amerigroup references to Anthem and updated contact information.	Chapter 3
09/07/2018	The Care Management Services Information section and MSM 3800 reference have been removed as the Health Care Guidance Program has been discontinued. Titles of Medicaid Services Manuals updated.	13, 24
02/01/2019	Updates made throughout per the implementation of the modernized Medicaid Management Information System (MMIS)	All
03/18/2019	Updates made throughout	All sections

Table of contents

About this manual

Introduction

DXC Technology, the fiscal agent for Nevada Medicaid, maintains this manual and the website, https://www.medicaid.nv.gov, to support Nevada Medicaid and Nevada Check Up billing. Hereafter, DXC Technology is referred to as Nevada Medicaid in this document and in all communications with the Nevada Medicaid and Nevada Check Up provider community.

Hereafter in this document, the Nevada Medicaid and Nevada Check Up programs 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 been 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 Nevada Medicaid Provider Customer Service Center at (877) 638-3472.

Copyright notices

Chapter 1: Introduction and provider enrollment

Medicaid goals

The Division of Health Care Financing and Policy 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 Nevada Medicaid daily.

DXC Technology (Fiscal Agent)

DXC Technology is the fiscal agent for Nevada Medicaid and Nevada Check Up. Effective June 26, 2017, DXC Technology is referred to as Nevada Medicaid in all communications with the Nevada Medicaid and Nevada Check Up provider community.

DXC Technology 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 a minimum of *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 Provider Enrollment webpage. If you have any questions, contact the provider enrollment unit at (877) 638-3472.

The federal regulation at 42 CFR 455.414 requires that state Medicaid agencies revalidate the enrollment of all providers, regardless of provider types, at least every five (5) years, with the exception of Durable Medical Equipment (DMEPOS) suppliers which must revalidate every three (3) years per 42 CFR 424.57. Nevada Medicaid and Nevada Check Up providers will receive a letter notifying them when to revalidate. Providers who do not revalidate within 60 days of the date on their notification will have their provider contract terminated. Revalidation documents and reports are located on the Provider Enrollment webpage, and providers must revalidate online by logging into the Provider Web Portal through the Provider Login (EVS) link and click on the "Revalidate-Update Provider" link on the My Home page.

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).

Providers must submit provider changes online by logging into the Provider Web Portal through the Provider Login (EVS) link and click on the "Revalidate-Update Provider" link on the My Home page.

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.

Reporting Fraud or Abuse

Providers have an obligation to report to the DHCFP any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers. Report suspected fraud or abuse to the Surveillance and Utilization Review (SUR) Unit by completing an online form by going to the DHCFP website at dhcfp.nv.gov and clicking on Report Medicaid Provider Fraud, or by calling and leaving a message at (775) 687-8405. For more information on fraud and abuse policies, please refer to 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.gov.

Behavioral Health Community Network (BHCN) Providers

Per Medicaid Services Manual (MSM), Chapter 400, Section 403.2.B a Behavioral Health Community Network (BHCN) provider is required to submit a Quality Assurance (QA) Program description upon enrollment and an updated program description with QA report results to the Division of Health Care Financing and Policy (DHCFP) annually.

As defined by the Medicaid Services Manual Addendum, Quality Assurance is a structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality of care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

For QA Program requirements please refer to MSM 403.2.B. The following is to provide additional direction on how to assess BHCN QA quality measures and how to submit QA Program documentation. Quality measures are assessed at the program level, not a specific population based on payer source.

Quality Measures

1. Effectiveness of Care

a. Identify the percentage of recipients demonstrating stable or improved functioning. BHCN will utilize a nationally recognized assessment tool appropriate to the BHCN service model. Sampling methodology must be random and reflect at least a 10% sample size of recipients.
b. Develop a chart audit tool to review Treatment Plans to assure compliance with requirements in MSM Chapter 400. Refer to MSM 403.2B for treatment plan criteria. The chart audit tool may include but need not be limited to the following: indicators to review treatment progress, care coordination, medication management, safety, presence of appropriate documentation and authorized signatures. Results will include a copy of the chart audit tool, the goal of the review, the number of treatment plans reviewed, overall findings, and what actions the BHCN took in response to adverse results. Sampling methodology must be random and reflect at least a 10% sample size of Treatment Plans.

2. Access and Availability of Care
   a. Measure timeliness of care. Timeliness of appointment scheduling between initial contact and rendered face-to-face services will be measured as follows for each service category (i.e., Outpatient Services, Day Treatment Services, Medication Clinic, etc.):

Level of Need	**Wait Time**
Emergent	Same Day
Urgent	Within 2 calendar days
Routine	Within 45 calendar days

3. Satisfaction of Care
   a. Conduct a recipient and/or family satisfaction survey(s) on all patients and/or families and provide results. The satisfaction survey(s) questions may include but need not be limited to the following: Access to services, quality and appropriateness of services, outcome of services, recipient's participation in treatment planning, and general satisfaction of care. Include results from the recipient and/or family satisfaction survey(s).
      i. Results will include a copy of the survey, the frequency of the survey, the number of surveys administered, number of completed surveys received, and what actions the BHCN took in response to adverse results.
   b. Submit a detailed grievance policy and procedure (refer to addendum for definition of grievance). The policy and procedure shall outline how grievances and complaints are tracked and acted upon by the BHCN in a prompt and timely manner. Identify the number of grievances and complaints that have been received by the BHCN, the response time in which the agency addressed them, the percentage of grievances/complaints resolved, and a limited description of grievances/complaints filed.

Submission Process

1. BHCN Program documentation should include:
   a. Medicaid Provider ID
   b. BHCN Name

c. Mailing Address
d. Phone number
e. Fax number
f. E-mail
g. Contact person specific to BHCN QA reviews
(Note that general contact information updates should continue to go through the Quality Improvement Organization (QIO)-like vendor: DXC Technology. As explained on pages 1 and 2 of this Billing Manual, DXC Technology is referred to as Nevada Medicaid.)

2. New BHCN providers will submit a QA Program directly to Nevada Medicaid with provider enrollment documentation. Reference the Provider Enrollment checklists at https://www.medicaid.nv.gov/providers/checklist.aspx. Nevada Medicaid does not approve the QA Program. QA Programs will be forwarded to the DHCFP QA specialist for review. The BHCN will be notified of QA Program acceptance by letter within 45 calendar days of receipt by DHCFP. QA Report results will not be required in year one.

3. All BHCN providers will be expected to submit an updated QA Program and QA Report results every year on the anniversary of the BHCN enrollment month, or otherwise mutually agreed upon date if the facility reports to a crediting agency. A reminder letter will be sent in advance of the next scheduled QA Program review. BHCN providers will have 30 calendar days from notification to submit required documentation. QA Programs and QA Report results will be submitted directly to DHCFP at 1100 E William St. Carson City, NV 89701 Attn: Managed Care & Quality Team; or e-mailed to MCandQuality@dhcfp.nv.gov

4. If a Corrective Action Plan (CAP) is required, the BHCN will submit all components listed in MSM 403.2.B.6.e. The BHCN will adhere to all corrective actions, process changes, and follow-up activities in the timeframes identified in the Corrective Action Plan.

5. BHCN providers may be subject to sanctions, including suspension and/or termination if required timeframes are not met during any step of the submission process.

6. Useful BH definitions may be found within the Medicaid Services Manual Addendum located at: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMAddendum/MSMAddendum/

7. Questions about the QA process can be directed to the QA Program Specialist at 775-684-3724.

Chapter 2: Contacts and resources

Claim appeals unit

See *Appeal requirements* under "Claim Appeals" in Chapter 8 of 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.

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.

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
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 assists Trading Partners with the Trading Partner enrollment and certification process, and also troubleshoots electronic file issues. The EDI webpage located at https://www.medicaid.nv.gov/providers/edi.aspx contains companion guides for Inbound and Outbound transactions, , the Trading Partner User Guide, Trading Partner Agreement (TPA) and a sample compliant 835 Electronic Remit file. For more information, refer to the Electronic Data Interchange (EDI) chapter of this manual or contact the EDI Department at:

Email: NVMMIS.EDIsupport@dxc.com
Phone: (877) 638-3472, options 2, 0, then 3, Monday through Friday, 8 a.m. to 5 p.m. Pacific Time, with the exception of Nevada State holidays.

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)

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

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

Dental authorizations

Phone: (800) 525-2395
Mail: Nevada Medicaid
Dental PA
P.O. Box 30042
Reno NV 89520-3042

Personal Care Services (PCS) authorizations

Phone: (800) 525-2395

Pharmacy authorizations

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

Waiver authorizations

For the Waiver for Individuals with Intellectual Disabilities and Related Conditions (provider type 38), call the Aging and Disability Services Division Regional Center in your area. For the Reno area, call (775) 688-1930. For the Carson City and rural areas, call (775) 687-5162. For the Las Vegas area, call (702) 486-6200.

For the Waiver for the Frail Elderly (provider types 48, 57 and 59), call the Aging and Disability Services Division office in your area. For the Reno area, call (775) 688-2964. For the Carson City and rural areas, call (775) 687-4210. For the Las Vegas area, call (702) 486-3545.

For the Waiver for Persons with Physical Disabilities (provider type 58), call the Aging and Disability Services Division office in your area. For the Reno area, call (775) 688-2964. For the Carson City and rural areas, call (775) 687-4210. For the Las Vegas area, call (702) 486-3545.

Provider Enrollment Unit

All enrollment documents are on the Nevada Medicaid 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. Providers must submit provider changes online by logging into the Provider Web Portal through the Provider Login (EVS) link and click on the "Revalidate-Update Provider" link on the My Home page.

Phone: (877) 638-3472

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@dxc.com

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 and Substance Abuse Services
500: Nursing Facilities
600: Physician Services
700: Reimbursement, Analysis and Payment
800: Laboratory Services
900: Private Duty Nursing
1000: Dental
1100: Ocular Services
1200: Prescribed Drugs
1300: Durable Medical Equipment (DME) Disposable Supplies and Supplements
1400: Home Health Agency
1500: Healthy Kids Program
1600: Intermediate Care for Individuals with Intellectual Disabilities
1700: Therapy
1800: Adult Day Health Care
1900: Transportation Services
2000: Audiology Services
2100: Home and Community Based Waiver for Individuals with Intellectual Disabilities
2200: Home and Community Based Waiver for the Frail Elderly
2300: Waiver for Persons with Physical Disabilities
2400: Home Based Habilitation Services
2500: Case Management
2600: Intermediary Service Organization
2800: School Based Child Health Services
2900: Federally Qualified Health Centers
3000: Indian Health
3100: Hearings
3200: Hospice
3300: Program Integrity
3400: Telehealth Services
3500: Personal Care Services Program
3600: Managed Care Organization
3900: Home and Community-Based Waiver for Assisted Living
Addendum

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.

Web announcements

The five most recent web announcements will appear in the Announcements area on the left side navigation area on the Homepage and all announcements appear 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)

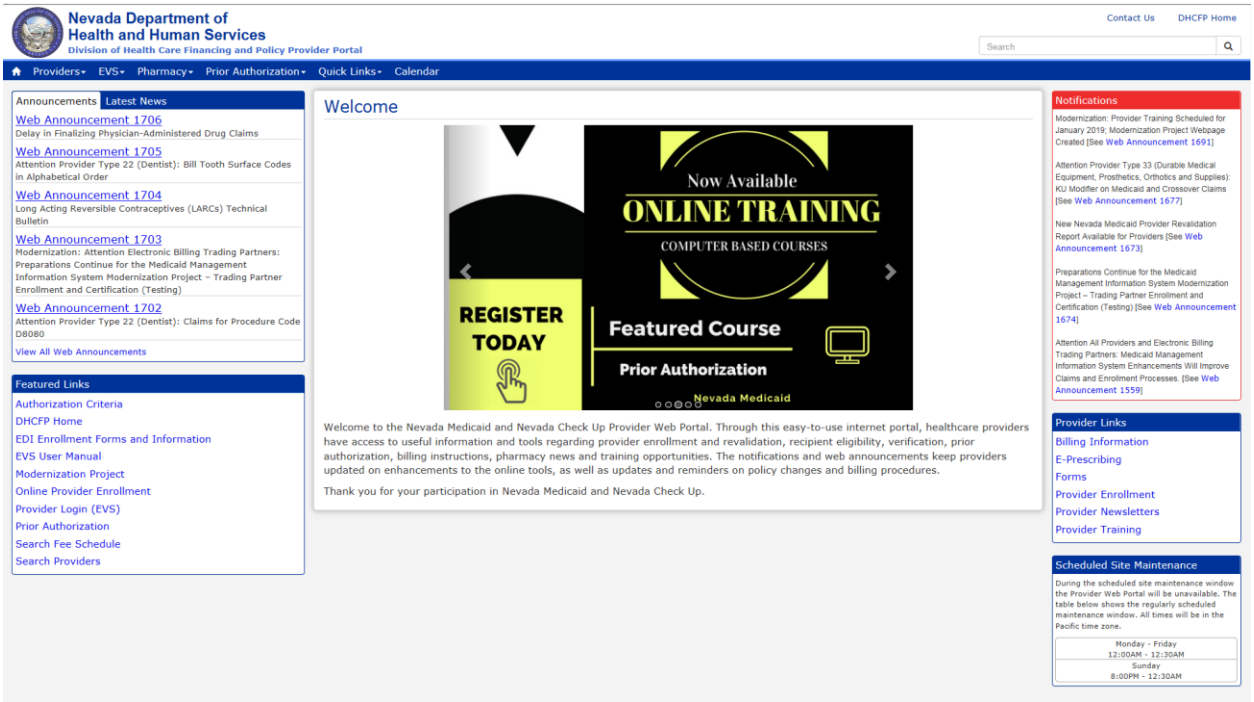
CMS provides **federal-level guidance** for state Medicaid programs via their website at http://www.cms.gov.

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 http://dhcfp.nv.gov/.

Nevada Medicaid Provider Website

The Nevada Medicaid provider 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 Nevada Medicaid provider 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 icon in the top left corner of the screen.

Website

The Menu Bar across the top of the website has drop-down menu selections for Providers, EVS (Electronic Verification System), Pharmacy, Prior Authorization and Quick Links. Hover over each selection to see the list of options available under each item. See Web Announcement 1204 for details regarding the features on the website.

Chapter 3: Recipient eligibility and managed care 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?

48 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.

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

Wait 24 hours before checking on claims. Allow 30 days for claims to be adjudicated. If your claim has not processed within this time frame or if you have questions on how the claim was processed, contact the Customer Service Center at (877) 638-3472.

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 Nevada Medicaid Provider Call Center at (877) 638-3472.

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. The Description column 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	

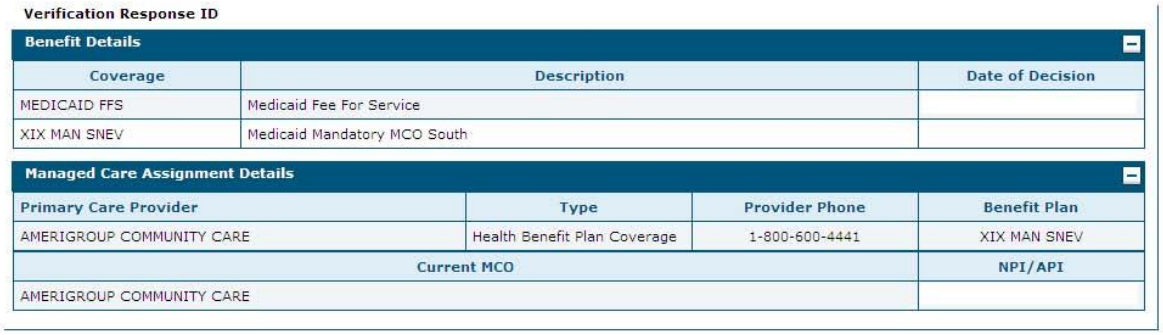
Identify MCO Enrollment Using EVS

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			

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 are listed in the Service Center Directory.

Pending eligibility

Nevada Medicaid 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

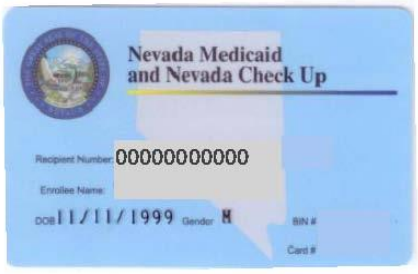
Nevada Medicaid and Nevada Check Up eligibility generally stops at the **end of the month** in which a recipient's circumstances change. A **pregnant woman** remains eligible through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in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

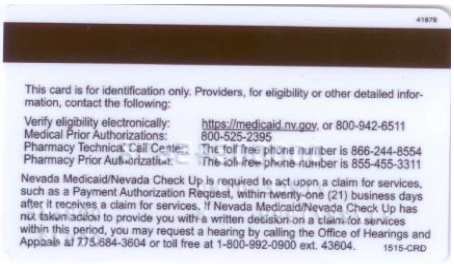
Are recipients notified when their Medicaid eligibility is terminated?

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 Managed Care Organization (MCO) program.

Outside of urban Washoe and urban 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 Nevada Medicaid. 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 urban 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.

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 3603.15.

Most **Nevada Check Up recipients** in urban Clark and urban Washoe counties are enrolled in an MCO beginning on their first day of coverage. Most **Nevada Medicaid recipients** in urban Clark and urban Washoe counties are enrolled in an MCO effective the day eligibility is received to the Medicaid Management Information System (MMIS), usually within two days of DWSS determination.

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

MCO contact information

The contracted MCOs are Anthem Blue Cross and Blue Shield Healthcare Solutions, Health Plan of Nevada and SilverSummit Healthplan. LIBERTY Dental Plan of Nevada is the Dental Benefits Administrator (DBA). If you have any questions about the MCOs, please call the DHCFP at (775) 684-3692.

Anthem Blue Cross and Blue Shield Healthcare Solutions

Provider Contracting

Phone: (702) 228-1308 Fax: (866) 495-8711

Provider Customer Service (for eligibility, claims and pre-certification):

Phone: (844) 396-2330 Fax: (866) 495-8711 (except pre-cert)

Pre-certification:

Fax: (800) 964-3627 (For all other pre-certification requests, including ALL elective inpatient or outpatient services)

Fax: (866) 920-8362 (For durable medical equipment (DME), outpatient rehabilitation (PT/OT/ST), pain management, home care, home infusion, hyperbaric treatment, and wound care)

Claims Address:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Attn: Nevada Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Provider Self-Service Website: https://mediproviders.anthem.com/nv
Anthem Nevada Member Services:
Phone: (844) 396-2329 Website: www.anthem.com/nvmedicaid

Health Plan of Nevada (HPN)
Provider Relations and Provider Contracting: (702) 242-7088 or (800) 745-7065
Member Services Phone: (800) 962-8074 Fax: (702) 240-6281
Claims Address:
Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89114
EDI Claims Submission Clearinghouse:
OptumInsight
1755 Telstar Drive #400
Colorado Springs, CO 80920

LIBERTY Dental Plan of Nevada
Provider Relations and Provider Contracting
Phone: (888) 700-0643
Email: prinquiries@libertydentalplan.com
Website: www.libertydentalplan.com/NVMedicaid

Member Services
Phone: (866) 609-0418
Website: www.libertydentalplan.com/NVMedicaid

Claims Address
LIBERTY Dental Plan of Nevada
Attn: Claims
P.O. Box 401086
Las Vegas, NV 89140

Payor ID: CX083

SilverSummit Healthplan
Provider Contracting (844) 366-2880
Provider Inquiry Telephone Numbers:
Medical/Behavioral Health: (844) 366-2880
Pharmacy: (844) 366-2880

Pharmacy (Prior Authorization): (855) 565-9520
Vision: (855) 896-8572
Claims Addresses:

Medical/Behavioral Health:
P.O. Box 5090
Farmington, MO 63640

Pharmacy:
5 River Park Place E, Suite 210
Fresno, CA 93720

Vision:
Attn: Claims Processing
P.O. 7548
Rocky Mount, NC 27804

Fax Numbers:
Prior Authorization Requests:

Medical: (844) 367-7022 Behavioral Health: (855) 868-4940 Pharmacy: (866) 399-0929

Medical Records (for nurse use): (844) 518-7889
Admissions Census/Facesheets: (844) 868-7399
Concurrent Review: (844) 755-1370
Case Management: (844) 851-1023
Medical Management General: (844) 367-7015
Nevada Quality Improvement: (855) 565-9517
Nevada Grievance and Appeals: (855) 742-0125

Chapter 4: Prior and retrospective authorization

Introduction

Some services/products require authorization (PA). You can determine if authorization is required by referring to the Medicaid Services Manual that is specific to the service being provided, the Fee Schedules or the Billing Guidelines. Providers may also search criteria for PA requirements by selecting Authorization Criteria from the Provider Login (EVS) page (see Web Announcement 867 and Web Announcement 1581 for access tips).

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

Documentation for Authorization Requests:

- Give a synopsis of the medical necessity that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.
- A trauma center requesting Level I activation must specify "Trauma Level I" or "Trauma Level I Activation" in the initial inpatient authorization request and request authorization of the initial inpatient days using the appropriate intensive or acute care revenue code. This must be documented in a prominent place on the initial authorization request.

Ways to request authorization

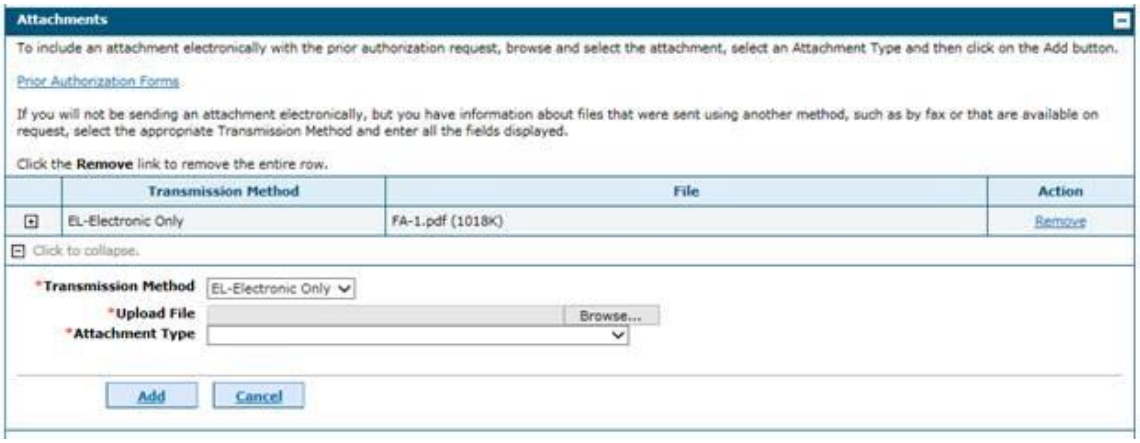
Online Authorization

The Provider Web Portal, https://www.medicaid.nv.gov, can be used to request authorization for all services including: Inpatient, Outpatient, Behavioral Health, Home Health, PASRR, Therapy, DME, Hospice, Dental/Orthodontia, Adult Day Health Care (ADHC) and PCS. This will eliminate the need to mail or fax in prior authorizations. All prior authorizations require an attachment to be processed. If no attachment is received, the prior authorization will remain in pended status for 30 days and will then be cancelled.

Uploading Attachments via the Portal

To include attachments electronically with a prior authorization request:

- Select the Transmission Method – Electronic Only.
- Upload File – Click the Browse button and locate file to be attached and click to attach.
- Attachment type – Select from the drop-down box the type of attachment being sent.
- Select the Add button to attach your file.
- Repeat for additional attachments if needed (Note: the combined size of all attachments cannot exceed 4 MB per submission; multiple submissions can be made by using the Edit button).
- Once attachments are added, a control number will be visible.
- To remove any attachments that were attached incorrectly, use the Remove link.
- Recipient ID – Enter the Recipient ID associated with the authorization tracking number.
- Authorization Tracking Number – Enter the Authorization Tracking Number for the prior authorization.
  Note: Prior authorization forms will require input of the appropriate authorization tracking number and recipient ID.



Required fields are marked with a red asterisk (*)

Submitting Dental X-rays via Mail

If you are a dental or orthodontia provider and have submitted your prior authorization request via the Provider Web Portal, and have non-digital x-rays that need to be submitted to support the medical necessity of the service, those x-rays may be mailed.

To submit non-digital x-rays by mail:

- Indicate in the Medical Justification field that you are submitting x-rays via mail.
- You MUST reference the original prior authorization tracking number on your x-rays to ensure they will be matched to the correct prior authorization request. If the original prior authorization tracking number is not on the x-rays, the prior authorization will be rejected.
- Include your NPI and provider type (i.e., 10, 11, 12, 20, etc.) on the mailed x-rays. These elements can be written or typed on your cover sheet or on the x-rays you are submitting.

- Prior authorization requests will not be reviewed until the x-rays are received.
- If the documents are not received within 30 days, the prior authorization will be cancelled.

Mail x-rays to:

Dental Requests:

Nevada Medicaid
Attention: Dental PA
PO BOX 30042
Reno, NV 89520-3042

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 Nevada Medicaid receives all pertinent clinical information.

Services listed below must be requested within the specified time frames.

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)
- Outpatient Surgery

At least *three* business days prior to service:

- All Outpatient Services other than Outpatient Surgery
- DMEPOS

At least *five* business days prior to service:

- Complex Dental Services
- Initial Residential Treatment Center Evaluation

At least *seven* business days prior to service:

- PASRR Level I Evaluation

At least *10* business days prior to service:

- Home Health re-assessment
- Continuing Private Duty Nursing (PDN) services

Within *eight* business days *after* the start of care:

- Initial Home Health Evaluation
- New requests for PDN Services

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 authorization within *ten* business days of the date of eligibility decision (DOD).

For newborns, this is *ten* business 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 ten-day window, and the recipient is determined eligible while in the facility, authorized days can begin the day that Nevada Medicaid 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 request for concurrent review for inpatient services or by submitting a *continued service* request for all other services *prior* to or by the last day of the current/existing authorization period, unless specific requirements contrary to these instructions are outlined in the Billing Guidelines for your provider type. Use the Provider Web Portal, and mark the checkbox for *Continued Stay Request*.

- **Inpatient concurrent service requests** must be received by the anticipated discharge date of the current/existing authorization period. For example, if the current authorization period is 05/11/15 through 05/15/15, then the concurrent authorization request is due by 05/16/15, which is the anticipated discharge date. If a concurrent authorization request is not received within this time frame, a second authorization period, if clinically appropriate, can begin on the date Nevada Medicaid receives a concurrent authorization request. The DHCFP will not pay for unauthorized days between the end date of the first authorization period and the begin date of a second authorization period.
- **All other continued service requests:** If the recipient requires additional services or dates of service (DOS) beyond the last authorized date, you may request review for continued service(s) prior to the last authorized date. The request must be received by Nevada Medicaid by the last authorized date and it is recommended these be submitted 5 to 15 days prior to the last authorized date. For example, if the current authorization period is 05/11/15 through 05/15/15, then the concurrent authorization request is due by 05/15/15, which is the last authorized date.

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 calendar days*** from the DOD.

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

Documentation for Retrospective Authorizations:

- Give a synopsis of the medical necessity of all dates of service being requested.
- Include only the medical records that support the medical necessity issues identified in the synopsis.

- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Hospital presumptive eligibility authorization process

For recipients who are not eligible upon admission but become eligible through the presumptive eligibility process, the authorization requests are processed as retrospective authorizations:

- Once the eligibility is showing in EVS, the provider has 10 business days to submit the request to Nevada Medicaid.
- If the patient is still in house, Nevada Medicaid reviews the request in the same time frame as any other initial or concurrent review (one day).
- If the patient has been discharged on or prior to the date of Nevada Medicaid's receipt of the retrospective authorization request, Nevada Medicaid has 30 days to review the request.

Recipient changes eligibility from MCO to FFS authorization process

If the MCO has authorized the specific service and dates but the recipient changed to FFS, please include authorization documentation from the MCO in your authorization request to Nevada Medicaid. The authorization from the MCO will be considered in decisioning the authorization request.

If the recipient's eligibility changes from MCO to FFS after the service is provided, but the eligibility is backdated to cover the actual date of service, an authorization request is required to be submitted as noted above. The authorization request must be received within 30 calendar days of receipt of the Explanation of Benefits from the MCO indicating the change.

After submitting the request

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

Incomplete Requests

- **Residential Treatment Centers (RTC):** Incomplete requests will be technically denied within **10 business days** if the requested information is not received.
- **All other requests:** If Nevada Medicaid 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 a technical denial will be issued.

Modify Request (Clinical Information)

Call Nevada Medicaid Provider Customer Service 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.

- **Unscheduled revisions**: Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services.

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, Nevada Medicaid or DHCFP provides notification through the Provider Web Portal. 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 Nevada Medicaid or DHCFP to make a determination on the request and, after notification, the provider has not submitted the requested information. 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.

Peer-to-Peer Review or Reconsideration

A Peer-to-Peer Review or Reconsideration can be requested for prior authorizations that are denied or modified. If you request a Peer-to-Peer and afterward determine a Reconsideration is appropriate, the Reconsideration may be requested if within the timelines identified below. Once a Reconsideration is requested, you no longer have the option of requesting a Peer-to-Peer Review of the prior authorization.

Peer-to-Peer Review

A provider may request a Peer-to-Peer Review by emailing nvpeer_to_peer@dxc.com within 10 business 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 Nevada Medicaid second level clinical review specialist and a licensed clinical professional operating within the scope of their practice. The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the Peer-to-Peer Review. The purpose of the peer-to-peer review is to clarify the denial or modification rationale with the reviewing clinician.

Reconsideration

Reconsideration is a written request from the provider asking Nevada Medicaid 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.

For a Reconsideration request, the provider is responsible to provide additional medical information (e.g., intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Nevada Medicaid 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.

If proper medical justification is not provided to Nevada Medicaid in an initial/continued stay request, a Peer-to-Peer Review, and/or a Reconsideration review, this demonstrates failure of the provider to comply with proper documentation requirements. New information will not be considered at a hearing preparation meeting.

If proper documentation is not submitted as described above, the authorization request will not be considered by Nevada Medicaid at any later date.

Documentation for Authorization Reconsideration:

- Give a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.

Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Upload reconsideration requests via the provider portal (see Uploading Attachments via the Portal section on page 26).

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 Third Party Liability 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 Explanation of Benefits (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 under Fee Schedules on the DHCFP Rates and Cost Containment's "Rates" webpage at http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/. Revenue code groups are based on levels of care assigned to the revenue codes within these groups.

Termination of Service Notices

When a recipient has decided to terminate services with their existing provider, the prior authorization on file will be end dated and a Notice of Termination of Service letter will be generated. This letter serves as a notice to the providers that their prior authorization's end date has been updated. All providers will receive the Notice of Termination of Service letter at their servicing address. No courtesy faxes or emails will be sent. Updates to prior authorizations will be reflected in the Electronic Verification System (EVS).

Providers are reminded to use the new FA-29A (Request for Termination of Service) or FA-24T (Personal Care Services Recipient Request for Provider Transfer) forms when submitting a Request for Termination of Service Authorization or request for a Recipient Provider Transfer.

All providers, except PCS providers, are to use the new FA-29A, which is submitted with the new provider's request for review for prior authorization. A request for review of a new authorization does not guarantee approval. Authorizations are based on Medicaid policy for coverage and medical necessity.

PCS providers are to use the new FA-24T, which requires that the recipient, their Legally Responsible Individual (LRI) or Personal Care Representative (PCR) acknowledge that they have notified their current provider of their last date of service with them and that the recipient understands they are only authorized to receive services from one agency at a time. See Web Announcement 1252.

All fields on the FA-29A and FA-24T forms must be completed with requested information and signatures. The forms are available on the Providers Forms webpage.

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

The 837P, 837I and 837D companion guides on the Provider Electronic Claims/EDI webpage and the Electronic Verification System (EVS) User Manual Chapter 3 Claims on the EVS User Manual webpage contain the Nevada Medicaid specifications for electronic claim submission.

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 page 40 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 agrees 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 Nevada Medicaid's TPL vendor, Health Management Systems, Inc. (HMS), who will research and update the recipient's file if necessary.

HMS can be reached at:
Phone: (775) 335-1040, Toll Free: (855) 528-2596
Fax: (972) 284-5959
Email: NVTPL@hms.com
Mail: HMS – NV Third Party Liability
PO Box 12610
Reno, NV 89510

Do not send claims to HMS.

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.

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 Nevada Medicaid

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.

Common EDI terms

The following are terms used by Nevada Medicaid when discussing EDI:

Trading Partner

- A Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Nevada Medicaid requires all Trading Partners to complete a Trading Partner Agreement regardless of the Trading Partner type listed below
- Vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
    - Software vendor is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
    - Billing service is a third party that prepares and/or submits claims for a provider.
    - Clearinghouse is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

Direct Data Entry (DDE)

The Nevada Medicaid and Nevada Check Up Provider Web Portal (PWP) allows providers, or their delegates, to create/submit, adjust and copy claims online using Direct Data Entry. They can also use the PWP to verify claim status.

To access the DDE go to https://www.medicaid.nv.gov/hcp/provider/Home.

Available transactions

Trading Partners can choose to enroll for the following HIPAA Standard electronic transactions supported by Nevada Medicaid within the enrollment application process:

- 270/271 Health Care Eligibility Request/Response Batch
- 276/277 Health Care Claim Status Request/Response Batch
- 270/271 Health Care Eligibility Request/Response Interactive
- 276/277 Health Care Claim Status Request/Response Interactive
- 820 Payroll Deducted and Other Group Premium Payment for Insurance Products
- 834 Benefit Enrollment and Maintenance
- 835 Health Care Claim Payment/Advice
- 837 Health Care Claim: Dental (Fee for Service and Encounter)
- 837 Health Care Claim: Institutional (Fee for Service and Encounter)
- 837 Health Care Claim: Professional (Fee for Service and Encounter)
- NCPDP: Batch Standard 1.2

EDI resources

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

Companion Guides

The companion guides provide clearinghouses, software vendors and billing services with specific technical requirements for the submission of electronic claim data to Nevada Medicaid.

Trading Partner User Guide

The Trading Partner User Guide provides instruction for establishing a Trading Partner Profile (TPP), selecting the appropriate connectivity method and the testing process.

EVS User Manual

EVS User Manual Chapter 3 Claims provides instruction for submitting claims using Direct Data Entry (DDE).

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 enroll as a Trading Partner

In order to submit and/or receive transactions with Nevada Medicaid, Trading Partners must complete a Trading Partner Profile (TPP) agreement, establish connectivity and certify transactions.

Establishing a Trading Partner Profile (TPP) agreement is a simple process which the Trading Partner completes using the Nevada Medicaid Provider Web Portal link at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx

The Trading Partner User Guide contains step-by-step instructions for completing the enrollment process.

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 companion guides and EVS User Manual Chapter 3 (Claims).

Which code do I use on my claim?

Use HIPAA-compliant codes from the Revenue code, CPT, International Classification of Diseases, 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-10 codes on claims with dates of service on or after October 1, 2015.**

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.

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 Nevada Medicaid. 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 three cases in which Nevada Medicaid requires an attachment are described below.

1. Hysterectomy Acknowledgement Form

Attach the FA-50 form with the appropriate section completed for hysterectomy services. Complete section I if the woman received the required hysterectomy information before surgery; complete section II if the woman received the information after the surgery; or complete section III if the woman was already sterile at the time of the surgery or if the surgery was performed on an emergency basis.

2. Sterilization Consent Form

Attach a Sterilization Consent Form for sterilization procedures. You may use the FA-56 form on the Nevada Medicaid website, or any Sterilization Consent Form that meets federal requirements.

3. Abortion Affidavit or Declaration

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**, attach the document to each claim.**
- If an attachment has information on both sides of the page, **scan the attachment as a multiple page document**.
- See EVS User Manual Chapter 8 (File Exchange) for instructions for uploading forms using the Provider Web Portal.

Chapter 8: Claims processing and beyond

Claims processing

Providers are required to submit claims that are in compliance with Medicaid policies. All claims are required to be submitted electronically.

Nevada Medicaid 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 Nevada Medicaid 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.

Your remittance advice

Nevada Medicaid 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.

RAs may also be received in the 835 electronic format. Please work with your clearinghouse or software vendor to ensure you receive all information that Nevada Medicaid sends in its 835 electronic RA.

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".

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?

Nevada Medicaid 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
- Internal Control Number (ICN) of the processed claim
- RA messages (important billing updates/reminders from DHCFP or Nevada Medicaid)
- 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 Nevada Medicaid receives a claim, the claim is assigned an ICN for processing, tracking and reporting purposes. An ICN contains the following information about the claim:

Region Code RR	Year and Julian Date YYJJJ	Batch Number BBB	Claim Sequence SSS
99	99999	999	999

- Region Code descriptions are below:
  - 00 – All Claim Regions
  - 20 – Fee-for-Service Claims With No Attachments
  - 21 – Fee-for-Service Claims With Attachments
  - 22 – Internet Claims With No Attachments
  - 23 – Internet Claims With Attachments
  - 25 – PBM Pharmacy Claims
  - 31 – Mass Adjustments Converted From Old MMIS Overflow
  - 40 – Claims Converted From Old MMIS
  - 42 – Fee-for-Service Adjustments Converted From Old MMIS
  - 43 – Fee-for-Service Other Claims Converted From Old MMIS
  - 44 – History Only Converted From Old MMIS
  - 45 – Fee-for-Service Claims Converted From Old MMIS
  - 46 – History Only Adjustment Converted From Old MMIS
  - 48 – Fee-for-Service Void Converted From Old MMIS
  - 49 – History Only Recipient Link Claims
  - 51 – Adjustments – Check Related
  - 52 – Mass Adjustment, Non-Check Related
  - 53 – Mass Adjustments – Check Related
  - 54 – Mass Void, Initiated By TPL Void Request
  - 55 – Mass Adjustment – Institutional Provider Rate
  - 56 – Mass Void Request Or Single Claim Void
  - 57 – Adjustments – Void Check Related
  - 58 – Adjustment – Processed By Fiscal Agent
  - 59 – Provider Initiated Electronic Adjustment
  - 66 – History Only, Non-Check Related
  - 67 – History Only, Check Related Adjustment

ICNs for adjusted claims

Each time Nevada Medicaid 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

Resubmit denied claims using DDE or through your Trading Partner. See EVS User Manual Chapter 3 for instructions. 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.

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.

For instructions on adjusting or voiding a claim, refer to the applicable Companion Guide: 837I, 837D or 837P, which are posted on the Electronic Claims/EDI webpage, and EVS User Manual Chapter 3 (Claims), which is posted on the EVS User Manual webpage.

Overpayment

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

Nevada Medicaid
Attention: Finance Department
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 submitted 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 a claim appeal

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

Claim appeals must include *each* component listed below:

- A completed form FA-90 (Formal Claim Appeal Request) 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 Nevada Medicaid can contact regarding the appeal.
- Documentation to support the issue, when applicable, e.g., physician's notes, ER reports.

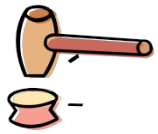
See the Prior Authorization chapter of this Billing Manual for the instructions for submitting prior authorization appeals.

After You File an Appeal

Nevada Medicaid researches appeals and retains a copy of all documentation used in the determination process. Nevada Medicaid 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, please update your provider information through the Online Provider Enrollment Portal by using the Revalidate-Update Provider function. See the Online Provider Enrollment User Manual Chapter 3 for instructions.

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

ADHC – Adult Day Health Care: ADHC facilities provide temporary or permanent daytime care for aged or infirm persons, age 18 years and older. ADHC consists of structured, comprehensive and continually supervised components provided in a protective setting. Halfway houses and services for recovering alcoholics or drug abusers are not a part of ADHC services.

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. DHCFP has discontinued the use of APIs effective February 2019.

ARS – Automated Response System: The Nevada Medicaid 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 & 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

DDE – Direct Data Entry: Direct online claim submission through the Provider Web Portal.

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 – Healthcare Common Procedure 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-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 October 1, 2015.**

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

MCO – Managed Care Organization: A company contracted with the DHCFP to ensure the provision of covered, medically necessary services to its eligible population. MCOs are paid a risk-based capitated rate for each eligible enrolled recipient. Each MCO contracts individually with certain providers to provide services in accordance with the standards and policies of Nevada Medicaid and Nevada Check Up.

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 federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

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.

PWP – Provider Web Portal: The secure and non-secure webpages on the Nevada Medicaid provider website at www.medicaid.nv.gov.

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.