Billing Manual

for Nevada Medicaid and Nevada Check Up

Updated October 8, 2026

NEVADA HEALTH AUTHORITY
NevadaMedicaid.nv.gov

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. This manual previously listed phone numbers (775) 684-3687 and (775) 684-3628. The new number to call is (775) 684-3703	
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.	

Date (mm/dd/yyyy)	Description of changes	Pages impacted
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 Services instructions; added TPL vendor email	7/8, 23, 24, 27, 31, 34
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

Date (mm/dd/yyyy)	Description of changes	Pages impacted
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
11/21/2019	Updates made throughout	All sections
04/13/2020	Sample of recipient Medicaid ID card updated	Chapter 3
11/17/2020	Updates made throughout, including: Changed name of fiscal agent from DXC Technology to Gainwell Technologies. Updates made to Chapter 3: Recipient eligibility and managed care regarding identifying Qualified Medicare Beneficiary (QMB) and Managed Care Organization recipients. Updates made to Chapter 4: Prior and retrospective authorization regarding time frame to request authorization.	Throughout document
05/23/2022	Updates made throughout, including: Removed references to Atypical Provider Identifier (API). NVMedicaid App (for recipients) description added to Chapter 3. Updated Managed Care Organization contact information in Chapter 3. Updated Third Party Liability contact information in Chapter 5. Additions for claim attachments section in Chapter 7.	Throughout document
08/24/2022	Updated references to Pharmacy: billing, prior authorization, benefits management.	Throughout document
02/23/2023	Updated Chapter 4: Modify Request (Clinical Information) section and Claims for Prior Authorized Services section. Updated Chapter 7: What attachments can be required section.	Chapter 4 and Chapter 7
05/23/2023	Updated Chapter 4: Additional explanation under Retrospective Authorization.	Chapter 4
11/30/2023	Updated Chapter 4: Authorization reconsiderations for ABA services.	Chapter 4
03/13/2024	Updated Chapter 4: Authorization for vaginal deliveries.	Chapter 4
10/18/2024	Updated Pharmacy section to update Magellan to Prime Therapeutics.	Chapter 2
02/05/2025	Updated Adjustments and Voids section.	Chapter 8
02/20/2025	Removed Behavioral Health Community Network (BHCN) Providers.	Chapter 1
08/01/2025	Updated Chapter 4: Retroactive Authorization. Updated DHCFP references to Nevada Medicaid, EVS references to PWP, and Customer Service Center references to Gainwell Technologies Contact Center.	Chapter 4 and Throughout document

Date (mm/dd/yyyy)	Description of changes	Pages impacted
10/17/2025	Updated the Changes to Provider Information reporting requirement from 5 days to 30 days. Updated Chapter 4: Peer-to-Peer Review or Reconsideration for additional information Updates made throughout	3, 8 Chapter 4 Throughout document
12/15/2025	Updated title of Medicaid Services Manual Chapter 1300 to Durable Medical Equipment (DME), Disposable Supplies and Supplements	9
01/01/2026	Add Expedited Prior Authorization section	Chapter 4
02/20/2026	Updated the Recipient Changes Eligibility from MCO to FFS Authorization Process section for clarity Updates made throughout	Throughout document
07/10/2026	Updated Division of Health Care Financing and Policy (DHCFP) to Nevada Medicaid and Department of Health and Human Services (DHHS) to Department of Human Services (DHS) Updated Documentation for Retrospective Authorization Updated Fee For Service vs. Managed Care section Updated Peer-to-Peer Review or Reconsideration section	Throughout document Chapter 3, 4
10/08/2026	Updated Chapter 4: Recipient changes eligibility from MCO to FFS authorization process	24

Table of contents

About this manual 1
- Introduction 1
- Audiences 1
- Authority 1
- Questions 1
- Copyright notices 1

Chapter 1: Introduction and provider enrollment 2
- Medicaid goals 2
- Roles and responsibilities 2
- Provider enrollment 3
- Discrimination 4
- Reporting Fraud or Abuse 5
- Health Insurance Portability and Accountability Act (HIPAA) 5

Chapter 2: Contacts and resources 6
- Automated Response System (ARS) 6
- Billing Manual and Billing Guidelines 6
- Provider Web Portal (PWP) 6
- Gainwell Technologies Contact Center 6
- Medicaid Services Manual (MSM) 9
- Public hearings 10
- Websites 10

Chapter 3: Recipient eligibility and managed care 14
- Determining eligibility 14
- Verifying eligibility and benefits 14
- Pending eligibility 16
- Retroactive eligibility 16
- Termination of eligibility 16
- Sample Medicaid card 16
- Fee For Service vs. Managed Care 17
- MCO contact information 17

Chapter 4: Prior and retrospective authorization 19
- Introduction 19
- Ways to request authorization 20
- Expedited Prior Authorization 21
- Drug requests 21
- Submission deadlines 21
- Continued stay request 23
- Retrospective authorization 23
- Hospital presumptive eligibility authorization process 24
- Recipient changes eligibility from MCO to FFS authorization process 24
- After submitting the request 24

Approved request 25
Adverse determination 25
Peer-to-Peer Review or Reconsideration 26
Special authorization requirements based on recipient eligibility 27
Claims for prior authorized services 28
Termination of Service Notices 28
Chapter 5: Third-Party Liability (TPL) 29
TPL policy 29
Ways to access TPL information 29
How to bill claims with TPL 29
Follow other payers' requirements 29
When Medicaid can be billed first 29
You can bill the recipient when… 30
You may NOT bill the recipient when… 30
Incorrect TPL information 30
Discovering TPL after Medicaid pays 30
Chapter 6: Electronic data interchange 32
EDI defined 32
Common EDI terms 32
Direct Data Entry (DDE) 32
Available transactions 33
EDI resources 33
How to enroll as a Trading Partner 34
Chapter 7: Frequently asked billing questions 35
Which NPI do I use on my claim? 35
Which code do I use on my claim? 35
What is the timely filing (stale date) period? 35
How much do I bill for a service? 35
What attachments can be required? 35
What else should I know about attachments? 37
Chapter 8: Claims processing and beyond 38
Claims processing 38
How to check claim status 38
Your remittance advice 38
Frequently asked RA questions 38
Parts of the ICN 39
Suspended claims 40
Denied claims 40
Resubmitting a denied claim 40
Adjustments and Voids 41
Overpayment 41
Claim Appeals 41
Provider payment 42
Glossary 43

About this manual

Introduction

Gainwell Technologies, 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 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 staff 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 Gainwell Technologies Contact Center at (877) 638-3472.

Copyright notices

Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) data are copyrighted by the American Medical Association (AMA), and the American Dental Association (ADA), respectively, all rights reserved. AMA and ADA assume no liability for data contained or not contained in this manual.

Chapter 1: Introduction and provider enrollment

Medicaid goals

The Division of Nevada Medicaid strives to:

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

Roles and responsibilities

Nevada Medicaid

In accordance with federal and state regulations, the Nevada Medicaid develops Medicaid policy, **oversees Medicaid administration**, and advises recipients in all aspects of Nevada Check Up coverage.

Nevada Health Authority

The Nevada Health Authority (NVHA) accepts applications for Medicaid assistance, **determines eligibility**, and creates and updates recipient case files. The latest information is transferred from NVHA to Nevada Medicaid daily.

Gainwell Technologies (Fiscal Agent)

Gainwell Technologies is the fiscal agent for Nevada Medicaid and Nevada Check Up.

Gainwell Technologies is responsible for the following services as the fiscal agent for Nevada Medicaid and Nevada Check Up:

- Claims adjudication and adjustment
- Prior authorization (PA)
- Provider enrollment
- Provider inquiries
- Provider training
- Provider/Recipient files

Provider

Each provider is responsible for:

- Following regulations set forth in the Medicaid Services Manual (MSM) (see MSM Chapter 100 Medicaid Program and MSM Chapter 3300 Program Integrity)
- Obtaining prior authorization (if applicable)
- Pursuing third-party payment resources before billing Medicaid
- Retaining a proper record of services
- Submitting claims timely, completely and accurately (errors made by a billing agency are the provider's responsibility)
- Verifying 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 Nevada Medicaid, 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, full dentures, partial dentures, 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 must be enrolled with Medicaid to render urgent/emergency services. 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 Gainwell Technologies Contact Center 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 type (PT), at least every five (5) years, with the exception of Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS) suppliers who 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 (PWP) 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 thirty (30) 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 (PWP) 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.

Providers (individuals/groups) located in a catchment area are required to submit a Group or Individual provider enrollment application through the Online Provider Enrollment (OPE) tool. Catchment area providers cannot enroll as an urgent/emergency provider.

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, 95825, 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 Nevada Medicaid any suspicion of fraud or abuse in Nevada Medicaid 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 Nevada Medicaid website at https://www.nevadamedicaid.nv.gov/resources/surveillance-utilization-review-unit/ and select 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.

Health Insurance Portability and Accountability Act (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.

Chapter 2: Contacts and resources

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 billing guidelines.

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

Provider Web Portal (PWP)

PWP 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 PWP 24 hours a day, 7 days a week using any internet-ready computer.

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

To obtain access to PWP, 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 Gainwell Technologies Contact Center at (877) 638-3472.

Gainwell Technologies Contact Center

The Gainwell Technologies Contact 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 authorization number).

Phone: (877) 638-3472
To check the status of a claim, please use PWP, 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@gainwelltechnologies.com

Phone: (877) 638-3472, Monday through Friday, 8 a.m. to 5 p.m. Pacific Time, with the exception of Nevada State holidays.

Pharmacy

Prime Therapeutics State Government Solutions is the Pharmacy Benefits Manager. Pharmacy benefit related announcements, prior authorization forms and billing information may be obtained from the Prime Therapeutics website (https://nv.primetherapeutics.com/home).

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 Audiology, 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 Psychiatric Residential Treatment Facility (PRTF) services, contact:

Phone: (800) 525-2395

Adult Day Health Care, Home-Based Habilitation Services and Residential Habilitation authorizations

Email Nevada Medicaid: 1915i@nvha.nv.gov

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

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 Carson City and the 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 Carson City and the 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 Provider 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 thirty (30) 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 (PWP) 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@gainwelltechnologies.com

Medicaid Services Manual (MSM)

The MSM is maintained by Nevada Medicaid. 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 Services
500: Nursing Facilities
600: Physician Services
700: Rates and Supplemental Reimbursement
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: 1915(i) - Home and Community Based State Plan Option Adult Day Health Care and Habilitation Service
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 and Community-Based Services Structured Family Caregiving Waiver
2500: Case Management
2600: Intermediary Service Organization
2700: Certified Community Behavioral Health Center Services
2800: School 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
3700: Applied Behavior Analysis
3800: Medication Assisted Treatment
4000: 1915(i) HCBS State Plan Option Intensive In-Home Services and Crisis Stabilization
4100: Substance Use Disorder Treatment Services and Coverage
4200: Medicaid Health Home for Beneficiaries with Fetal Alcohol Spectrum Disorder

4300: Peer Support Services
4400: Crisis Services
Addendum: Definitions
Addendum B: Electronic Verification System (EVV)

Public hearings

- Providers are encouraged to attend public hearings and voice their opinion on policy changes.
- Public hearing announcements are posted on the Nevada Medicaid website as they become available.

Websites

The Centers for Medicare & Medicaid Services (CMS)

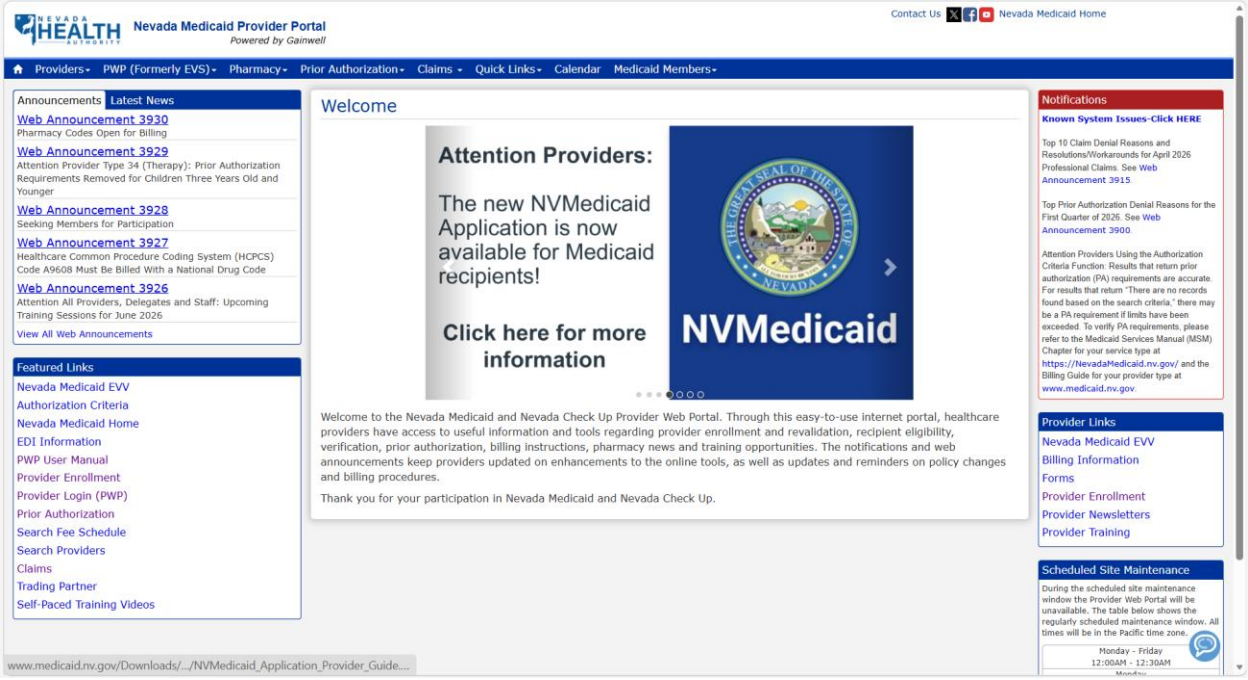
CMS provides **federal-level guidance** for state Medicaid programs via their website at http://www.cms.gov.

Nevada Medicaid

Nevada Medicaid provides Nevada Medicaid and Nevada Check Up policy, rates, public notices and more via their website at https://www.nevadamedicaid.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, providers are encouraged to visit 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, PWP, 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.

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.

Known System Issues

Providers are encouraged to review the Known System Issues list for updates on issues impacting claim processing. The link is posted on the website in the upper right corner of each page under Notifications.

The top part of the Known System Issues list contains the descriptions and resolutions/ workarounds for issues that are currently being researched. The list provides the impacted provider types, procedure codes and error codes. When the issues are resolved, the list is updated with the date the claims were reprocessed, if applicable, and the issues are moved to the lower section of the document under Closed Issues. Be sure to **check the Known System Issues at least weekly** for updates.

Chapter 3: Recipient eligibility and managed care

Determining eligibility

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

Once the recipient is determined eligible, how long does it take before PWP/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 PWP, 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.

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

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 Gainwell Technologies Contact Center at (877) 638-3472.

PWP

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

Refer to the PWP User Manual if you have any questions or call (877) 638-3472. To obtain access to PWP, new users must register on the Provider Web Portal at 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 Gainwell Technologies Contact Center at (877) 638-3472.

Identify dual eligibility using PWP

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 PWP 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 PWP 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)**, PWP will display *Qualified Medicare Beneficiaries* in the Coverage field. If the recipient is Medicare Premium only, eligibility will be reflected as either *Qualified Individuals* or *Special Low Income Medicare Beneficiaries.*

Coverage	Effective Date	End Date	Primary Care Provider	Date of Decision
Qualified Medicare Beneficiaries	08/01/2019	08/31/2019	0000000000	10/25/2017

Coverage	Effective Date	End Date	Primary Care Provider	Date of Decision
Qualified Individuals	08/01/2019	08/31/2019	0000000000	01/03/2019
Special Low Income Medicare Beneficiaries	08/01/2019	08/31/2019	0000000000	01/03/2019

Identify MCO Enrollment Using PWP

Many recipients in Nevada are required to be enrolled in an MCO program. PWP displays Medicaid Fee For Service or Nevada Check Up and Managed Care Organization coverage plans to indicate that a recipient is enrolled in an MCO.

As shown in the figure below, the full names of the coverage plans are displayed.

To review coverage, click on the hyperlinks below the Coverage field. All MCO coverage details can be found in the *Managed Care Assignment Details* panel.

Benefit Details

Coverage	Description	Effective Date	End Date	Date of Decision
Medicaid Fee For Service	The Medicaid Program is a State administered, federal grant-in-aid program. Its purpose is to help meet the cost of medical services of those individuals receiving public assistance payments, and those individuals and families with low income. The program objective is to provide a broad range of medical and related services to assist individuals to attain or retain an optimal level of health care. Medicaid is jointly funded by the federal and state governments and is administered by the State.	08/01/2019	08/31/2019	

Copayment Details

Coinsurance Details

Deductible Details

Managed Care Assignment Details

Primary Care Provider	Type	Provider Phone	Benefit Plan
MEDICAL TRANSPORTATION MANAGEMENT INC	Health Benefit Plan Coverage	1-999-999-9999	Non Emergency Transportation
LIBERTY DENTAL PLAN OF NEVADA INC	Health Benefit Plan Coverage	1-999-999-9999	Dental Benefit Administrator
ANTHEM BLUE CROSS AND BLUE SHIELD	Health Benefit Plan Coverage	1-999-999-9999	Managed Care Organization

Current MCO and DBA	NPI/API
MEDICAL TRANSPORTATION MANAGEMENT INC	
LIBERTY DENTAL PLAN OF NEVADA INC	
ANTHEM BLUE CROSS AND BLUE SHIELD	

Living Arrangement Details

Demographic Details

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

ARS

The ARS provides the **same information as** PWP, only via the telephone. Your NPI is needed to access the ARS by telephone.

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**.

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 on which the individual filed their application for assistance. Medicaid eligibility is determined by the NVHA.

Termination of eligibility

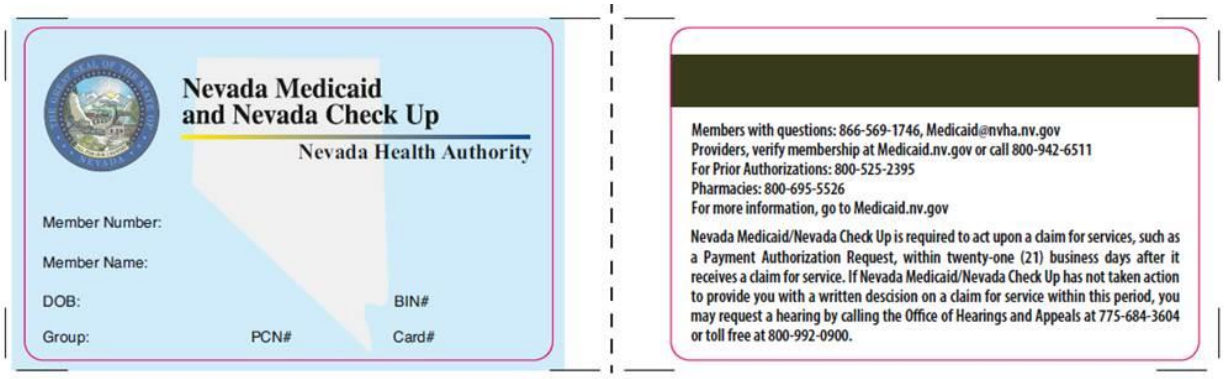
Nevada Medicaid and Nevada Check Up eligibility generally stops at the **end of the month** in which a recipient's circumstances change. A **pregnant woman** remains eligible through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in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

Are recipients notified when their Medicaid eligibility is terminated?

Yes. The NVHA 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.

The NVMedicaid App provides Nevada Medicaid recipients with a digital Medicaid identification card that can be presented for services under the Medicaid program. The application provides the ability for the recipient to securely share the digital card with a provider, including the option to print if needed for record purposes. Providers are asked to notify your staff that digital cards may be presented by recipients.

The NVMedicaid Application (Digital Recipient Medicaid ID Cards) Provider Quick Reference Guide is designed as a quick reference for Nevada Medicaid providers to assist recipients in using the NVMedicaid App.

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.

For recipients in the FFS program, providers submit claims to Nevada Medicaid for reimbursement. 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 statewide.

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

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

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.

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
  - https://providers.anthem.com/nevada-provider/home
- Health Plan of Nevada Medicaid
  - https://myhpnmedicaid.com/Provider
- Molina Healthcare of Nevada
  - https://www.molinahealthcare.com/providers/nv/medicaid/home.aspx
- SilverSummit Healthplan
  - https://www.silversummithealthplan.com/providers.html
- CareSource

- https://www.caresource.com/nv/providers/medicaid/

The contracted Dental Benefits Administrator (DBA) is:

- LIBERTY Dental Plan of Nevada
  - https://www.libertydentalplan.com/Providers/Providers-1.aspx

For additional information regarding each MCO and DBA, please visit the Nevada Medicaid Health Plan website at: https://www.nevadamedicaid.nv.gov/medicaid-members/health-plan-home/. If you have any questions about the MCOs, please email managedcare@nvha.nv.gov.

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 (PWP) 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 early induction of labor prior to 39 weeks gestation
- Outpatient surgical procedure
- Psychiatric Residential Treatment Facility (PRTF) 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

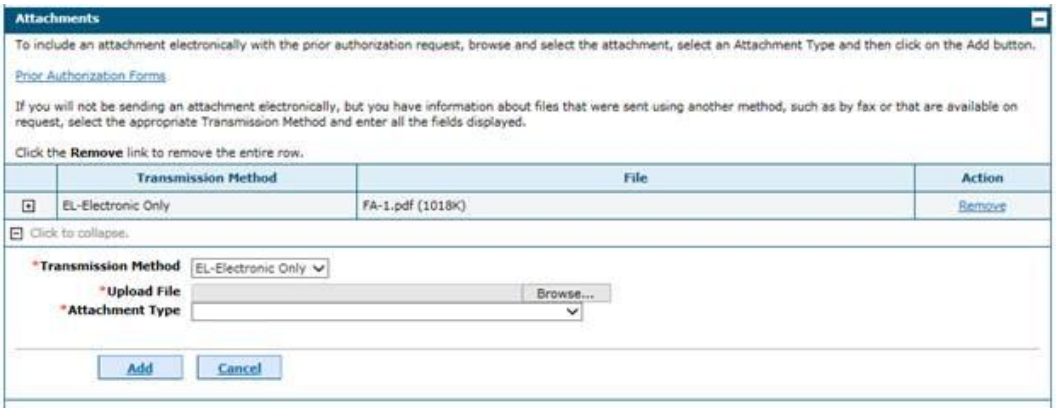
Online Authorization

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 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

Expedited Prior Authorization

The expedited PA process is only applicable for services that require authorization prior to the service being provided. To be considered expedited, PA must match the following definition:

Definition: An expedited PA is required only when the standard timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

To request an expedited review and decision of a PA request, send an email with the PA number to NV Expedited PA at NVExpeditedPA@gainwelltechnologies.com. If the clinical criteria meets the above definition, the PA will be completed within 72 hours of the date and time of submission unless there is a need to request further information.

Drug requests

MSM Chapter 1200 discusses requirements for drug prior authorizations.

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-PRTF)
- Outpatient Surgery

At least *three* business days prior to service:

- All Outpatient Services other than Outpatient Surgery
- DME

At least *five* business days prior to service:

- Complex Dental Services
- Initial Psychiatric Residential Treatment Facility 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 *five* business days following admission for:

- **Emergency** admission from a physician's office, emergency department (ED), 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 2 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 within five business days of the last day of the current/existing authorization period. Continued service requests for all other services must be submitted 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 hospital concurrent service requests** must be received within five business days of the last day of the current/existing authorization period. For example, if the current authorization period is Monday 05/11/2020 through Friday 05/15/2020, then the concurrent authorization request is due no later than five business days following 05/15/2020, that last day authorized. 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. Nevada Medicaid 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 05/11/2020 through 05/15/2020, then the concurrent authorization request is due by 05/15/2020, 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).

If a provider is determined ineligible due to revalidation and once reinstated their enrollment is backdated to eliminate gaps in eligibility, the PA may be requested within 90 calendar days of the date

the provider was reinstated. This applies to Change of Ownership (CHOW) and/or a revalidation that is identified as a CHOW.

For PTs 11, 12, 13, 29, 30, 56, 64, 65, 75, 83, and 96 whose initial enrollment is backdated, the PA may be requested within 90 calendar days of the date the eligibility becomes active.

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.
  Note: 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.
- Discharge (DC) Summary (only if the recipient has been discharged).

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 PWP, 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.

Eligibility is determined on a month-to-month basis. It is the provider's responsibility to check eligibility regularly. Please refer to Chapter 3 of this Billing Manual as well as the PWP User Manual regarding how to verify whether a recipient is MCO vs. FFS. If the recipient's eligibility changes from MCO to FFS after the service is provided or while in house, but the eligibility is backdated to cover the actual date of service, the authorization request must be received within 90 calendar days of receipt of the Explanation of Benefits or notification 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

- **Psychiatric Residential Treatment Facility (PRTF):** 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)

Submit an unscheduled revision on the appropriate form for the prior authorization type if you need to modify clinical information on an *approved* request (e.g., revenue code, CPT code or units requested).

- **Unscheduled revisions**: Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services.
- Time frames for submission of unscheduled revision for increase in level of care:
  - Planned change must be submitted prior the change.
  - Emergent change must be submitted within five business days of the change.
- Time frame for submission of lateral change in level of care or decrease in level of care:
  - Prior to submission of claim.

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.

- Psychiatric Residential Treatment Facility (PRTF) 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 if the recipient is admitted later than the prior authorization start date. If admitting prior to the prior authorization start date, once the change request has been received, the end date on the prior authorization will be moved up to match units authorized.
- Inpatient Psychiatric and PRTF 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 Gainwell Technologies 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 Gainwell Technologies 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 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. One Peer-to-Peer and one Reconsideration are allowed per PA line that is denied or modified in the Prior Authorization review.

Peer-to-Peer Review

A provider may request a Peer-to-Peer Review by emailing nvpeer_to_peer@gainwelltechnologies.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 Gainwell Technologies (as appropriate) to re-review a denied or reduced authorization request. Form FA-29B (Prior Authorization Reconsideration Request) is utilized to request a reconsideration. Upload reconsideration requests using form FA-29B via the File Exchange – Upload Files page in the Provider Web Portal. Upload the form as a File Type FA-29B Prior Authorization Reconsideration Request. See Web Announcement 3747 and PWP User Manual Chapter 8 (File Exchange) for instructions for uploading forms using the Provider Web Portal.

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 **PRTF services**, which must be requested within *90* calendar days, and **ABA services**, which can be requested at any point within the date range requested on the PA.

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 Gainwell Technologies 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.

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)*
- The revenue code on the claim must match the revenue code on the approved prior authorization *(inpatient claims).* When claims are processed, the MMIS will not automatically match the claim and PA based only on the revenue code grouping.

Inpatient claims: Nevada Medicaid'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 Nevada Medicaid Rates webpage at https://www.nevadamedicaid.nv.gov/programs/rates/. 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 PWP.

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 PWP, 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 PWP User Manual Chapter 3 Claims on the PWP User Manual Chapter 3 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 or Medicare Replacement 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@gainwelltechnologies.com
Mail: HMS – NV Third Party Liability
PO Box 843421
Los Angeles, CA 90084-3421

Do not send claims to HMS.

How should providers handle Medicare TPL discrepancies?

Contact Nevada Medicaid at TPL@nvha.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.

PWP User Manual

PWP 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 PWP 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.

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 NVHA, Nevada Medicaid, or Gainwell Technologies. 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. Some claim attachments and situations when attachments are required 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**
   The Federal Consent for Sterilization (form HHS-687) must be attached to Nevada Medicaid claims for sterilization procedures. The form is available on the U.S. Department of Health and Human Services website on the Grant Programs Key Resources for Title X Grantees webpage. Instructions for Completing Form HHS-687 – Consent for Sterilization are posted on the Providers Forms webpage on line FA-56.

3. **Abortion Declaration**
   If the procedure terminates a pregnancy resulting from of an act of rape or incest, providers must attach form FA-54 (Abortion Declaration – Rape) or form FA-55 (Abortion Declaration – Incest) to the claim showing the recipient's declaration of the decision to proceed with the service.

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

4. **Invoices**
   Provider type 33 (Durable Medical Equipment, Prosthetics, Orthotics and Supplies) must attach a cost or manufacturer's invoice when a Nevada Medicaid rate has not been established and no prior authorization is required. The Provider Type 33 Billing Guide and Web Announcement 2957 have additional information on invoice requirements when billing.

5. **Clinical Documentation**
   Attach clinical documentation for review as appropriate to support emergent criteria for recipients with Emergency Medicaid Only (EMO) coverage when a diagnosis code from the ICD-10-CM Emergency Diagnosis Codes for Non-U.S. Citizens with Emergency Only Coverage list is not included on the claim.

   Attach clinical documentation for review as appropriate to support a valid reason for two transport trips on the same day, or to verify transport include type of care described in the Advanced Life Support Level 2 (ALS-2) definition in the MSM Addendum (per policy).

   Providers may submit the documentation with the original claims prior to claims being denied.

6. **Specialized Foster Care 1915(i) Home and Community Based Services Needs Based Eligibility Checklist**
   Attach the Specialized Foster Care Needs Based Eligibility Checklist to the initial claim and annually thereafter through re-evaluation completion for the recipient.

7. **Delivery Receipt Form Required with Claims for Dentures**
   Attach the Partial Denture Delivery Receipt (form FA-27A) and/or the Denture Delivery Receipt (form FA-27B) as appropriate with claims for dentures. Providers may use an alternate form, but the alternate form must include the items listed in Medicaid Services Manual (MSM) Chapter 1000, Dental, under Prosthodontics Services (D5000-D6999).

8. **Timely Filing Delay Due to Third Party Liability**

Attach documentation when there is a delay submitting the claim for payment to Medicaid because the provider was pursuing payment from a Third Party Liability (TPL) resource.

a) The Medicaid claim must be submitted within 60 days from the date the provider was reimbursed or notified of non-coverage/denied services by the TPL vendor.
b) The provider must attach the Explanation of Benefits (EOB) and/or documentation from the primary insurance carrier.

9. **Exception Batch Process**
The provider will submit attachments via the Exception Batch Process only when instructed to or under the following circumstances: A Letter of Agreement (LOA) or other approved Nevada Medicaid rate letter, a copy of the State Plan Amendment (SPA) for transplant services, a cover letter referencing a Provider Payment Directive (PPD) number or a Contact Tracking Number (CTN) referencing an Approved Appeal.

Billing instructions for submitting a claim for exception batch processing can be found in Chapter 3 and Chapter 8 of the PWP User Manual.

What else should I know about attachments?

- 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**.
- For EDI claim attachments, see PWP User Manual Chapter 8 (File Exchange) for instructions.

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 PWP, 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?

No. TPL information is not shown on RAs. Check PWP to see if there are additional payers before you resubmit the claim to Medicaid.

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 of the billing (Group) provider
- Internal Control Number (ICN) of the processed claim
- RA messages (important billing updates/reminders from Nevada Medicaid or Gainwell Technologies)
- History adjustments
- Edit Codes and their descriptions
- 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 – EDI Fee-for-Service Claims With No Attachments
  - 21 – EDI 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

- 50 – Claim Adjustment Non-Check Related
- 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
- 97 – Single Resubmission
- 98 – Mass Resubmission

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.

Suspended claims

A claim suspends processing or *pends* when the MMIS determines there is cause to review it manually. While a claim is suspending or 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 need assistance with a claim denial, you may contact the Gainwell Technologies Contact 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 PWP User Manual Chapter 3: Claims 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 suspended and denied claims**). Remember that suspended 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 Gainwell Technologies Contact Center at (877) 638-3472. 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 PWP User Manual Chapter 3: Claims, which is posted on the PWP 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 PWP 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 through Secure Correspondence on the Provider Web Portal when a determination has been reached.

Fair Hearings

If your appeal is denied, you can request a fair hearing if you disagree with the outcome. 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 Provider Flex by using the Revalidate-Update Provider function. See the Provider Flex Revalidation and Updates User Guide 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

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. https://www.ama-assn.org/topics/cpt-codes

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

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.

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.

ICN – Internal Control Number: The 13-digit tracking number that Nevada Medicaid assigns to each claim as it is received.

MCO – Managed Care Organization: A company contracted with Nevada Medicaid 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 Nevada Medicaid that contains comprehensive state policy for all Medicaid providers and services.

Nevada Medicaid: Working in partnership with the Centers for Medicare & Medicaid Services, Nevada Medicaid develops policy for and oversees the administration of the Nevada Medicaid and Nevada Check Up programs.

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. The PWP provides 24/7 online access to recipient eligibility, claim status, prior authorization status and payments.

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.