Nevada Medicaid and Nevada Check Up

Billing Manual for All Provider Types

December 29, 2005

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Revision History

Revisions to this manual are listed on this page as they become available. Check this page regularly to ensure you have the most recent information.

December 29, 2005: Instructions for "How to Request an Adjustment or Void a Claim" have been updated. Adjustments may now be submitted electronically or on paper. When submitting on a paper claim form, complete only one claim line per form. Full instructions are in Chapter I, "I've Submitted a Claim. What Happens Now?" **(pages 54 and 55)**

November 30, 2005: This manual was created from the general information chapters of the CMS-1500, UB-92 and Dental billing manuals as of November 30, 2005. There are no revisions to information at this time.

Chapter A: The Nevada Medicaid Program

Introduction

First Health Services has prepared this billing manual to support the Nevada Medicaid and Nevada Check Up billing process. This manual contains billing procedures and guidelines necessary for the correct preparation and submission of Medicaid claims in the State of Nevada.

Proper claim preparation allows First Health Services to process your claim promptly and accurately. Please make this manual available to medical and administrative staff in your office and to any billing agents that are submitting claims to First Health Services on your behalf.

First Health Services provides this manual solely for convenience and reference. This manual does not have the effect of law or regulation. First Health Services has made every effort to ensure accuracy, however, should there be any conflicts between material in this billing manual and pertinent laws, regulations, or contracts, the latter will prevail.

First Health Services and the Division of Health Care Financing and Policy (otherwise known as DHCFP or Nevada Medicaid) provide the Medicaid Services Manual (MSM), Provider Newsletters, weekly messages and web announcements to all contracted providers. These reference and informational materials are available through First Health Services' web site at http://nevada.fhsc.com or through the DHCFP's web site at http://dhcfp.state.nv.us. The provider and his/her billing staff are responsible for maintaining any necessary reference documents for Medicaid billing.

Should you have any questions regarding the information contained in this manual, please contact First Health Services' Customer Service Center at (877) NEV-FHSC (638-3472).

Nevada Medicaid Overview

The federal Medicaid program was established in 1965 to assist states in the provision of adequate medical care and bridge the health insurance gap for eligible, uninsured persons. Jointly regulated and funded between federal and state governments, Medicaid is the nation's largest health care program providing medical and health-related services and supplies to America's indigent population.

Objectives of the Nevada Medicaid and Nevada Check Up programs include:

- Purchasing and providing quality health care services to low-income Nevadans
- Promoting equal access to health care at an affordable cost to Nevada taxpayers
- Controlling the growth of health care costs
- Maximizing potential federal revenue by keeping abreast of the latest technology in the administration of the program

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA - Public Law 104-191) provides, among other things, strong protection for personal health information. It gives individuals certain rights concerning their health information, sets boundaries on how it is used,

establishes formal safeguards and holds violators accountable. It also requires that you never release personal health information to anyone who does not have a need to know that information.

Clients' personal health information is available to providers and staff on a daily basis. Personal health information is health care data plus any identifying information that allows someone using the data to tie the medical information to a particular person. This includes any health information whether verbal, written or electronic, that is created, received or maintained. It relates to the past, present and future physical or mental health of any individual or recipient. Claims data, prior authorization information and claim attachments are all considered personal health information.

The HIPAA Privacy regulation became effective April 14, 2003. For more information on HIPAA regulations, please visit the HIPAA section of the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.gov/hipaa.

Discriminatory Practices

Federal laws prohibit discrimination against any person in the United States on the grounds of race, color, national origin, gender, age, religion, sexual orientation, disability or type of illness which would deny that person participation in or benefits of any program or activity with federal financing.

Medicaid will make payment for services only to providers who comply with applicable federal and state laws. Billing for Medicaid services or supplies is considered evidence that the provider is complying with Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the 1975 Age Discrimination Act.

Roles and Responsibilities

Division of Health Care Financing and Policy

The Division of Health Care Financing and Policy (DHCFP) develops Nevada Medicaid and Nevada Check Up policy and oversees administration of the State of Nevada Medicaid program (Title XIX) and the Nevada Check Up program (Title XXI) in accordance with federal and state regulations.

First Health Services (Fiscal Agent)

First Health Services is the fiscal agent for the Nevada Medicaid and Nevada Check Up programs beginning October 1, 2003. First Health Services' fiscal agent responsibilities include:

- Performing provider enrollment and training
- Maintaining files for providers and recipients
- Issuing prior authorizations for specified services
- Adjudicating claims and performing claim adjustments
- Processing point-of-sale (POS) pharmacy claims
- Recovering third party payment when applicable

First Health Services' Customer Service Center also addresses all inquiries from providers and billing staff. If you have any questions, please contact the Customer Service Center at nevadamedicaid@fhsc.com or (877) 638-3472.

Welfare District Offices

The Welfare Division accepts all applications for Medicaid assistance, determines Medicaid eligibility and advises recipients in all aspects of Medicaid coverage.

Contact information for the Welfare District Offices is included in the "Recipient Eligibility" chapter of this manual. For more information, visit their web site at http://welfare.state.nv.us.

Provider

The provider is responsible for ensuring that all claims submitted to First Health Services are accurate and complete. Compensation for billing agents who submit claims to First Health Services on the provider's behalf must be related to the actual cost of claims billing. Compensation cannot be dependent upon the collection of payment in any way.

The provider is also responsible for:

- Verifying recipient eligibility prior to rendering services
- Pursuing third party payment resources before billing Medicaid
- Obtaining prior authorization (when applicable)
- Submitting claims timely and accurately

First Health Services does not accept claims for services rendered by anyone other than the provider whose name and Provider Medicaid Number are shown on the claim. Providers may not bill Nevada Medicaid or Nevada Check Up for services provided by, but not limited to:

- Another Physician
- Psychologist
- Medical Resident
- Counselor/Social Worker
- Physician's Assistant
- Therapist
- Nurse Practitioner

The provider is responsible for any claims submitted or payment received on his/her behalf. Errors made by a billing agency are the provider's responsibility.

Records Retention

In accordance with NRS 422.570, providers are required to retain recipients' medical records for a minimum of five years; however, Nevada Medicaid and Nevada Check Up may recoup overpayments from providers for up to six years from the payment date of a claim. Therefore, it is recommended that all providers maintain records for at least six years from the date of Nevada Medicaid or Nevada Check Up payment.

Provider records must include all information necessary to disclose the extent of services furnished to recipients. This includes financial, clinical and other records pertaining to the provision of goods or services on behalf of a Medicaid recipient.

Upon request, these records must be provided free of charge to a designated Medicaid agency, the Secretary of Health and Human Services (HHS), or Nevada's Medicaid Fraud Control Unit (MFCU). Providers who maintain records in an electronic format must ensure that the data is readily accessible.

Recipient

A Nevada Medicaid or Nevada Check Up recipient or their designated representative is responsible for:

- Presenting their Nevada Medicaid and Nevada Check Up card when services are provided and allowing no one else use of their card.
- Keeping or canceling in advance appointments with providers. Nevada Medicaid does not reimburse providers for missed appointments.
- Advising their Welfare caseworker of any third party coverage and seeing a provider who participates in their private insurance plan when applicable.
- Picking up eyeglasses, hearing aids, medical devices and so forth, which are authorized and paid for by Nevada Medicaid or Nevada Check Up.

Provider Enrollment

All providers must be enrolled in the Nevada Medicaid program to bill for reimbursement of health care services rendered to eligible Nevada Medicaid and Nevada Check Up recipients.

Electronic copies of all enrollment documents are on the web at http://nevada.fhsc.com. (Select "Provider Enrollment" from the "Quick Links" drop-down menu.) If you do not have Internet access, contact the Provider Enrollment Unit at (877) 638-3472.

It is important that you complete the required enrollment forms completely and accurately. Please read the instructions provided on each form.

Incomplete information or missing documentation will delay enrollment.

Copies of the following must be submitted with your enrollment documents:

- IRS form CP575 or other documentation prepared by the IRS indicating your legal entity name and Tax ID Number
- All business/professional licenses and certifications including your DEA certification if applicable
- Any other documentation as required by the relevant Nevada Medicaid Services Manual chapter

Out-of-State Provider: Enrollment and Regulations

In order to bill Nevada Medicaid for services, providers must first be enrolled in the Medicaid program in their own state.

Out-of-state providers are subject to all pertinent Nevada Medicaid and Nevada Check Up program regulations.

Payment may be issued to out-of-state providers when:

- Nevada Medicaid and/or Nevada Check Up has contracted that provider to render special services for Nevada Medicaid and/or Nevada Check Up recipients

Or

- Emergency services are rendered to an eligible Nevada Medicaid or Nevada Check Up recipient

When requesting payment for emergency services, you must submit, with your claim, a completed Provider Enrollment Application (FH-31) and supplemental documentation as listed in the previous section, "Provider Enrollment."

Change of Provider Information

Nevada Medicaid and Nevada Check Up providers are required to notify First Health Services of changes to any information presented on the Nevada Medicaid Provider Enrollment Application or Contract within five (5) business days.

To do this, complete the Nevada Medicaid Provider Information Change Form (FH-33) and mail the completed document to First Health Services' Provider Enrollment Unit. (An original signature is required to change a provider's information on file with First Health Services.)

Fraud and Abuse

Federal law requires Nevada Medicaid and Nevada Check Up to review cases of suspected fraud and abuse and impose appropriate actions upon offending parties. Penalties for fraud and abuse may include termination, suspension, exclusion or non-renewal of a provider's Contract.

For more information on Nevada Medicaid and Nevada Check Up fraud and abuse policies, see the Nevada Medicaid Services Manual, Chapter 3300.

Medicaid Fraud Control Unit (MFCU)

The Medicaid Provider Fraud Control Unit (MFCU) is authorized by Nevada Medicaid to investigate potential Medicaid fraud and abuse. The MFCU has the right to access all provider records and information necessary to disclose fully the extent of services or items furnished to Medicaid recipients.

Medicaid providers must comply with all MFCU requests for records or information regarding claims submitted to Medicaid or services provided to Medicaid recipients. *See also,* "Records Retention" earlier in this chapter.

Surveillance and Utilization Review Subsystem (SURS)

The Surveillance and Utilization Review Subsystem (SURS) collects all Nevada Medicaid claim data to detect and prevent abuse, over-utilization and fraud by providers and/or recipients on a case-by-case basis.

Using SURS, First Health Services, MFCU and the DHCFP work together to monitor and review potential Medicaid fraud and abuse.

Please report suspected fraud and/or abuse by providers or recipients to First Health Services at (877) 638-3472. Persons knowingly assisting the recipient or the provider in committing fraud may also be held responsible.

Copyright Notices

Current Procedural Terminology (CPT) Copyright Notice

Current Dental Terminology (CDT) Copyright Notice

Chapter B: How Do I Get Help?

When you have questions about Nevada Medicaid, First Health Services is here to help. First Health Services' resources for providers and billing staff include the Provider Billing Manual, the http://nevada.fhsc.com web site and the First Health Services staff who are available to answer your questions and help resolve any issues.

Reference Materials

Any new Medicaid information or changes in policy are disseminated to providers through the First Health Services web site and Provider Newsletters. This includes new procedures, clarifications, reminders and provider training dates and locations.

This manual and its updates are on the Internet at http://nevada.fhsc.com. To make suggestions regarding this manual or web site, please contact First Health Services' Customer Service Center at (877) 638-3472.

The First Health Services Web Site

The First Health Services web site includes the most current information available for Medicaid providers and billing staff. It provides answers to many of your questions and easy access to information that is pertinent to you and your practice.

On First Health Services' web site, you can:

- Verify recipient eligibility
- View prior authorization request status
- Download, print or view Provider Billing Manuals and forms
- Enroll in Nevada Medicaid or submit updates to your provider information
- Submit claims and view their status
- Read and submit questions/information to provider message boards
- Receive Medicaid policy and procedure updates

The Provider Billing Manual

First Health Services' Provider Billing Manual aids providers and billing staff in understanding Medicaid billing, recipient eligibility verification, covered and non-covered services, prior authorization, Third Party Liability, claims payment and more.

This manual is organized into these major topics:

Chapter Name	Description
Table of Contents	A quick and easy reference to find the information you need.
The Nevada Medicaid Program	An overview of the Nevada Medicaid and other important notices.

Chapter Name	Description
How Do I Get Help?	Information on who to contact when you have a question and important addresses and phone numbers.
Recipient Eligibility	Ways to verify recipient eligibility and more.
Prior Authorization	General information regarding First Health Services' Prior Authorization process.
Third Party Liability	Direction on billing Medicaid when a third party resource may be responsible for all or partial payment.
Medicare Crossover	Guidelines for submitting Medicare Crossover Claims to First Health Services.
Electronic Data Interchange (EDI)	An overview of how to bill electronically and the benefits of doing so.
Billing Guidelines	How to submit a claim to First Health Services.
I've Submitted a Claim. What Happens Now?	An explanation of claims processing and resolution.

This manual is not intended to discuss all applicable federal and state Medicaid policies and regulations. You must familiarize yourself and comply with all applicable state and federal policies and regulations as from time to time amended. If you are unsure of any of the current State of Nevada Medicaid laws, reference the Nevada Medicaid Services Manual online at http://dhcfp.state.nv.us.

The Nevada Medicaid Services Manual

All Nevada Medicaid Service Manual chapters are on the web at http://dhcfp.state.nv.us. On the left side navigation bar, you will see a menu item which reads, "Compliance." Place your mouse over this item and follow the pop up menu to "Policy" and click on "Nevada Medicaid Services Manual." There, you will find each of the Nevada Medicaid Services Manual chapters. To open a chapter, click on its chapter number (You will need Adobe Acrobat Reader to view the chapters.) You can print any or all of the chapters for your use. For help with this, please contact First Health Services' Customer Service Center.

The Nevada Medicaid Services Manual chapters contain Nevada Medicaid policies and descriptions of service benefits. These chapters were last updated in June 2003. Medicaid Provider Bulletins and Newsletters supplement the manuals as policies and rates change. Each provider office should maintain and refer to the Nevada Medicaid Services Manual, Provider Bulletins and Provider Newsletters to insure current billing procedures and guidelines are followed.

Provider Relations Department

The Provider Relations Department addresses provider inquiries, enrollment and training. This Department is divided into several Units as discussed below.

First Health Services' Customer Service Center is your resource for questions regarding recipient eligibility, billing, appeals and other Nevada Medicaid information. When contacting the Customer Service Center, please include or have ready all the pertinent information such as the claim's Internal Control Number (ICN), the Recipient ID Number, your Provider Medicaid Number or the Prior Authorization Number.

Contact First Health Services' Provider Enrollment Unit for questions regarding provider enrollment and certification, or with any changes to your provider information. If you need to make changes or additions to your current provider enrollment information, please visit the First Health Services web site. From the "Quick Links" drop-down menu, select "Change My Provider Information" and download the Provider Information Change Form (FH-33). Please note that you are responsible for notifying First Health Services of changes or updates to your provider information within five (5) business days of the change.

First Health Services' Provider Training Unit keeps you up to date on the newest advances in Medical information technology and policy that affect you and your practice. Through the First Health Services web site and regularly offered provider training sessions, you can learn and apply new information to ensure that your practice is in compliance with new Medicaid policies and procedures. Contact First Health Services' Provider Training Unit for more information on provider training or to schedule an on-site visit.

Contact the Provider Relations Department at the following:

Phone: (877) 638-3472
Fax: (775) 784-7932
Email: nevadamedicaid@fhsc.com

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026

Prior Authorization Department

First Health Services' Prior Authorization Department issues most prior authorizations for Nevada Medicaid. First Health Services' Prior Authorization Department can answer your prior authorization questions including how to submit, which form to use, whether or not a service requires prior authorization, or to inquire about the status of a submitted prior authorization request.

Prior Authorization Type	Contact
Inpatient and Outpatient Medical Surgical Inpatient and Outpatient Mental Health Adult Day Health Care Ocular Audiology Comprehensive Outpatient Rehabilitation ICF/MR Private Duty Nursing Hospice Durable Medical Equipment Residential Treatment Center Identification Screening PASRR Level II - Individual Evaluation Level of Care Home Health Out of State Services	Phone: (800) 525-2395 Fax: (866) 480-9903
Personal Care Aide	Phone: (800) 648-7593 Fax: (775) 784-7935
Pharmacy Prior Authorizations	Phone: (800) 505-9185 Fax: (800) 229-3928
Dental	Phone: (800) 648-7593 Fax: (775) 784-7935 First Health Services Corporation Health Care Management P.O. Box 30043 Reno, Nevada 89520-3043

Prior authorizations not issued by First Health Services are issued by the Nevada State agencies listed below.

Agency	Phone Number
For the CHIP Waiver (Waiver for the Frail Elderly at Home) or for the Waiver for the Elderly in Group Care call The Division for Aging Services (DAS).	(775) 684-4210
For the Waiver for Persons with Mental Retardation or Related Conditions call The Mental Health and Developmental Services Division (MHDS)	(775) 684-5943
For the Waiver for People with Physical Disabilities, call The Division of Health Care Financing and Policy (Nevada Medicaid).	(775) 688-2811 (Reno) (775) 684-3653 (Carson City) (775) 753-1148 (Elko) (702) 486-1535 (Las Vegas)

Electronic Data Interchange Department

First Health Services' Electronic Data Interchange (EDI) Department handles all electronic claims submission setup, testing and operations.

For more information on electronic data interchange, please see the Electronic Data Interchange (EDI) chapter of this manual or contact First Health Services' Electronic Data Interchange Department at:

First Health Services Corporation
Attention: EDI Coordinator
PO Box 30042
Reno NV 89520-3042

Email: nvedi@fhsc.com
Phone: (877) 638-3472
Fax: (775) 784-7932

Pharmacy Point-of-Sale Department

The Pharmacy Point-of-Sale (POS) Department addresses all inquiries from Pharmacy POS providers. This includes pharmacy claim submission errors, explanation of POS denials and overrides. Contact the Pharmacy POS Department at the following:

Phone: (800) 884-3238

If you are a prescriber inquiring about Clinical prior authorizations, please contact:

Phone: (800) 505-9185
Fax: (800) 229-3928

If you are mailing a paper Pharmacy claim, use the following address:

First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
P.O. Box C-85042
Richmond, VA 23261-5042

Chapter C: Recipient Eligibility

Recipient Enrollment

Nevada Medicaid

The Nevada State Welfare Division is responsible for accepting all recipient applications for Nevada Medicaid, determining eligibility and advising recipients in all aspects of coverage. To enroll in the Medicaid program, persons should contact their local Nevada State Welfare Division office using information in the table below, or visit the Nevada State Welfare Division's web site at http://welfare.state.nv.us.

For more information on Medicaid recipient eligibility, refer to Chapter 100 of the Nevada Medicaid Services Manual.

Welfare District Offices		
Carson City District Office	755 North Roop Street, Suite 201 Carson City, NV 89701	775-684-0800 775-684-0844 (fax)
Carson City - EAP (Energy Assistance Program)	559 South Saliman Rd, Suite 101 Carson City, NV 89701	775-687-4420 775-687-1272 (fax)
Elko District Office	850 Elm Street Elko, NV 89801	775-753-1233 775-777-1601 (fax)
Ely Office	725 Avenue K Ely, NV 89301	775-289-1650 775-289-1645 (fax)
Fallon District Office	111 Industrial Way Fallon, NV 89406	775-423-3161 775-423-1450 (fax)
Hawthorne Office	1000 'C' Street P.O. Box 1508 Hawthorne, NV 89415	775-945-3602 775-945-5714 (fax)
Henderson District Office	538-A South Boulder Hwy Henderson, NV 89015	702-486-1002 702-486-1270
Las Vegas District Office - Belrose	700 Belrose Street Las Vegas, NV 89107	702-486-1675 702-486-1628
Las Vegas - Cambridge Center	3900 Cambridge Street Suite 202 Las Vegas, NV 89119	702-486-8770 702-486-8790 (fax)
Las Vegas - Cannon/DI Center	3120 E. Desert Inn Las Vegas, NV 89121	702-486-8504 702-486-8565 (fax)
Las Vegas District Office - Charleston	3700 E. Charleston Blvd. Las Vegas, NV 89104	702-486-4851 702-486-4827 (fax)

Welfare District Offices		
Las Vegas District Office - Flamingo	3330 Flamingo Suite 55 Las Vegas, NV 89121	702-486-9400 (main) 702-486-9401 (fax) 702-486-9540 (fax) 702-486-9500 (Senior Services)
Las Vegas District Office - Owens	1040 / 1024 West Owens Avenue Las Vegas, NV 89106 (MASH Village)	702-486-1899 702-486-1877 (fax) 702-486-2878 702-486-1802
Las Vegas Hearings Office & Quality Control	701 North Rancho Drive Las Vegas, NV 89106	702-486-1437 702-486-1445 (fax)
Las Vegas - South Professional Development Center	701 North Rancho Drive Las Vegas, NV 89106	702-486-1401 702-486-1429 702-486-1430 (fax)
Pahrump Office	1316 East Calvada Blvd. Pahrump, NV 89048	775-751-7400 775-751-7404 (fax)
Reno - North Professional Development Center	680-690 South Rock Blvd. Reno, NV 89502	775-448-5238 775-856-8446
Reno District Office	3697 Kings Row Reno, NV 89503	775-448-5000 775-448-5094 (fax)
Reno - Bible Way (Investigations & Recovery)	1030 Bible Way Reno, NV 89502	775-688-2261 775-688-2815
Tonopah Office	Courthouse Road P.O. Box 1491 Tonopah, NV 89049	775-482-6626 775-482-3429 (fax)
Winnemucca Office	475 West Haskell Street, #6 Winnemucca, NV 89445	775-623-6557 775-623-6566
Yerington Office	215 W. Bridge Street, #6 (In the LaPinata Mall) Yerington, NV 89447	775-463-3028 775-463-7735

Nevada Check Up

The DHCFP is responsible for accepting applications for the Nevada Check Up Program, determining eligibility and advising recipients in all aspects of coverage. To apply for Nevada Check Up Program benefits, persons should contact the DHCFP at (800) 360-6044 or visit the Nevada Check Up web site at http://nevadacheckup.state.nv.us.

For more information on Check Up recipient eligibility, refer to Chapter 3700 of the Nevada Medicaid Services Manual.

Pending Eligibility

First Health Services cannot process authorization requests or claims for an individual whose Nevada Medicaid or Nevada Check Up eligibility has not yet been determined (i.e., a recipient whose eligibility is "pending").

When services are provided to an individual whose eligibility is pending, it is requested that providers await an eligibility decision before billing for service(s) provided. *See also*, "Retroactive Eligibility and Retroactive Authorizations" in this chapter.

Any payments a provider may have received or collected from a patient for a Medicaid covered service must be returned to that individual if they are later determined eligible for retroactive Medicaid coverage that includes those dates of service.

Medicaid eligibility is considered pending until such time the Welfare District Office issues a Notice of Decision letter to the recipient. Newly approved Medicaid recipients may present a Notice of Decision from the Nevada State Welfare Division as proof of eligibility, prior to receiving their plastic Nevada Medicaid and Nevada Check Up card.

Out of Network Services

If an individual in Clark or Washoe County who is pending Medicaid eligibility receives services outside of the HMO network and pays the provider for those services, that provider is not required to repay the individual after that individual has been determined eligible for Medicaid benefits. In this instance, the recipient is responsible for payment.

Retroactive Eligibility and Retroactive Authorizations

Nevada Check Up does not offer retroactive coverage. Unlike Medicaid, Nevada Check Up coverage always begins the first day of the administrative month following approval and enrollment.

A Nevada Welfare District Office may approve an individual for retroactive Medicaid eligibility if the individual met the eligibility requirements for any or all of the three months prior to the date in which they filed their application for Nevada Medicaid assistance.

If prior authorization is required for a service, and the patient's Medicaid eligibility is pending, the provider may request a retroactive authorization from First Health Services *after* eligibility has been determined. For more information on retroactive authorizations, please see the Prior Authorization chapter in this manual.

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 for Medicaid 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.

Recipient Non-Disclosure

As a rule, all providers should seek payment source information from recipients/patients before services are rendered. Any recipient not declaring their Nevada Medicaid or Nevada Check Up eligibility or pending eligibility, and thus denying the provider the right to reject that payment source, is viewed as entering into a "private patient" arrangement with the provider.

Therefore, if a recipient does not inform the provider at the time of service, or within Medicaid's stale date time period, that he or she is eligible for Nevada Medicaid or Nevada Check Up, the recipient assumes full responsibility for payment and may be billed by the provider.

How to Verify Recipient Eligibility and Benefits

Providers are responsible for verifying an individual's eligibility and benefit plan <u>each time</u> before providing services. It is also recommended that providers verify an individual's *identity* by requesting a driver's license, Social Security card or photo identification.

Nevada Medicaid and Nevada Check Up cards do not reflect dates of recipient eligibility or the benefits a recipient is eligible to receive. A recipient's Nevada Medicaid and Nevada Check Up card will look much like the following image.

SAMPLE NEVADA MEDICAID AND NEVADA CHECK UP CARD

If a recipient claims eligibility but cannot produce a Nevada Medicaid and Nevada Check Up card, the provider may still verify eligibility by using the EVS, the ARS or a swipe card system as described in the sections that follow.

Each eligibility verification resource is updated daily to reflect the most current information for each recipient, and provides you with an official confirmation/verification number for all information you receive.

Eligibility information provided through these resources includes:

- Dates of eligibility
- Which MCO (or "HMO") the recipient is enrolled in (if applicable)
- The services that recipient is eligible to receive (their benefit plan)
- The name of the recipient's other health care coverage, if applicable
- Service limits for certain types of services

The Electronic Verification System (EVS)

The HIPAA-compliant Electronic Verification System ("EVS") provides 24/7 Internet access to recipient eligibility and service limits, as well as prescribing provider information (for pharmacy providers only), and the status of prior authorization requests, submitted claims and provider payments. There is no limit to the number of inquires you can make per session.

To access EVS, go to First Health Services' web site at http://nevada.fhsc.com and select "EVS Logon" from the "Providers" drop-down menu.

To log on to EVS, you will need a User ID and password. If you do not already have these, complete and submit the Web Access Registration Form (FH-38) to First Health Services. All First Health Services forms are available through http://nevada.fhsc.com by selecting "Forms" from the "Providers" drop-down menu.

For your convenience, First Health Services provides an EVS User Manual, which provides basic instructions for the logon and use of EVS. This user manual is available by selecting "EVS User Manual" from the "Providers" drop-down menu at http://nevada.fhsc.com.

If you have any questions about using EVS, contact First Health Services at (877) 638-3472.

The Nevada Medicaid Audio Response System (ARS)

The Nevada Medicaid Audio Response System ("ARS") provides recipient eligibility and service limit information, as well as recent check amounts and the status of claims and prior authorization requests.

To access ARS, call 1 (800) 942-6511. The ARS is a phone verification system and does not require a computer with Internet access like the EVS system. Your Provider Medicaid Number is required to access the ARS.

Swipe Card System

Each Nevada Medicaid and Nevada Check Up card includes a magnetic strip on the back of the card. When used with a swipe card system, this magnetic strip provides Point-of-Service (or "real-time") access to recipient information.

Several private vendors provide swipe card systems and machinery. To implement a swipe card system, please contact the swipe card vendor directly.

Fee For Service and Managed Care

Typically, Nevada Medicaid and Nevada Check Up recipients are eligible for services under the Fee For Service ("FFS") program or they are enrolled in a Managed Care Organization ("MCO").

MCO enrollment is mandatory for most Nevada Medicaid and Nevada Check Up recipients in urban Washoe and Clark Counties. For a list of recipient groups in these areas that are not required to be enrolled in an HMO, please refer to the Nevada Medicaid Services Manual, Chapter 3600, section 3603.1.

In all other areas of Nevada, MCO enrollment is not mandatory and recipients are eligible for services under the FFS program.

Fee For Service

Enrollment in the FFS program means that (for services to be covered by Nevada Medicaid or Nevada Check Up) a recipient must receive services from an in-state Nevada Medicaid provider, unless otherwise prior authorized. A recipient's choice of provider is not limited to providers within an MCO provider network.

When services are provided to a recipient enrolled in the FFS program, providers must submit their claims directly to First Health Services. First Health Services processes the claim and provides you with feedback in the form of a Remittance Advice or RA. *See also*, "Your Remittance Advice" in Chapter J of this manual.

For additional information on the FFS program, please refer to the Nevada Medicaid Services Manual, Chapter 100.

Managed Care

Enrollment in an MCO means that (for services to be covered by Nevada Medicaid or Nevada Check Up) a recipient must receive services from a Nevada Medicaid provider who is a member of their MCO's provider network. This rule does not apply to emergency services, which may be rendered by a provider within or outside of the MCO's provider network. For more information on coverage and payment of emergency services for a recipient who is enrolled in an MCO, refer to the Nevada Medicaid Services Manual, Chapter 3600, Section 3603.5.

When services are provided to a recipient enrolled in an MCO, the provider must submit their claim to the recipient's MCO. Each MCO has their own billing guidelines and time limitations for submitting claims. Please contact the recipient's MCO directly if you have any billing questions.

In Clark and Washoe Counties, a Medicaid recipient's MCO coverage begins the first day of the month after the recipient is determined eligible for Medicaid benefits. For example, if the Nevada State Welfare Division determines the recipient is eligible for Nevada Medicaid benefits on October 1, 2003, the recipient's MCO coverage would begin on November 1, 2003. Prior dates of service are covered under the FFS program. The MCO is not financially responsible for any services rendered during a period of retroactive eligibility.

The MCOs currently participating in the Medicaid Managed Care Program for the State of Nevada are:

Health Plan of Nevada (HPN)
Phone: (800) 962-8074
Fax: (702) 242-9124

Submit claims to: P.O. Box 15645
Las Vegas, NV 89114

NevadaCare
Phone Toll Free: (800) 447-9834
Phone for Clark County: (702) 474-7241
Fax: (866) 823-3764
Email: nevadacareproviderservices@imxinc.com

Submit claims to: PO Box 379020
Las Vegas, NV 89137-9020

Please see the Nevada Medicaid Services Manual, Chapter 3600 for additional information on MCOs.

Chapter D – Prior Authorization

What is Prior Authorization?

First Health Services or the DHCFP (depending on the type of prior authorization you are requesting) must grant prior authorization for certain services or medical procedures. State and federal guidelines are used to verify that the proposed services meet the necessary Medicaid requirements for payment.

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

To request prior authorization for a service, complete and submit the appropriate prior authorization form. All prior authorization forms are available online at http://nevada.fhsc.com. (Select "Prior Authorization" from the "Providers" drop-down menu.) The requesting provider is responsible for providing demographic information (recipient's name, date of birth, social security number and Medicaid ID Number) and clinical information to support the medical necessity of the requested service(s). First Health Services and DHCFP use this form to conduct a review of the proposed services.

You will be notified via fax or phone if additional information is needed to make the prior authorization determination. If First Health Services or DHCFP does not receive requested information within two (2) business days, a Technical Denial is issued for that prior authorization request.

Which Services Require Prior Authorization?

Only certain services require that you obtain prior authorization before providing them. It is your responsibility to verify whether or not a service requires prior authorization before providing it.

Retrospective authorization is available for retrospective eligible cases.

Prior authorization requirements apply to Medicaid Fee-For-Service clients who are Medicaid eligible or have Medicaid coverage secondary to any other payer except Medicare Part A (unless all Medicare benefits have been used).

First Health Services is responsible for review and certification of all inpatient admissions. For emergent admissions, First Health Services must be contacted for authorization within one business day of admission.

Other common services that require prior authorization include:

- Non-emergency hospital admissions (medical, surgical, psychiatric, rehabilitation, substance abuse treatment, detoxification)
- Outpatient surgical procedures as defined in the Ambulatory Surgical Center Procedures List
- Residential Treatment Center admissions
- Non-emergency transfers to other acute facilities

- In-house transfers to a rehabilitation unit
- In-house transfers to and from medical and psychiatric/substance abuse units, and between psychiatric and substance abuse units
- Rollover admissions from observation and same-day-surgery services
- Psychologist services
- Some diagnostic tests
- Out-of-state inpatient and outpatient services
- Outpatient physical/occupational/speech therapy
- Home Health services
- DME

Recipients in a Managed Care Program

When a recipient is enrolled in one of Medicaid's Managed Care programs, be sure to communicate with the recipient's Health Maintenance Organization (HMO) to ensure you are complying with all of the HMO's requirements. The HMOs currently participating in the Medicaid Managed Care program for the State of Nevada are:

Health Plan of Nevada (HPN)
Service Area: Clark County and Washoe Counties
Office: (800) 962-8074
Fax: (702) 242-6456
Web Address: http://www.healthplanofnevada.com

NevadaCare Inc. d.b.a. Nevada Health Solutions (NHS)
Service Area: Clark and Washoe Counties
Office: (702) 474-7241
Fax: (702) 474-7592

PASRR and LOC

A Pre-admission Screening and Resident Review (PASRR) must be performed prior to a recipient's admission to a Medicaid certified nursing facility, regardless of payment source. A Level of Care (LOC) screening is required for all Medicaid eligible individuals seeking nursing facility placement.

First Health Services conducts all PASRR and Level of Care Screening (LOC) reviews. Requests for PASRR screening and/or Level of Care screening should be requested as soon as it has been determined that an individual is seeking nursing facility placement, but at least one business day prior to admission to the nursing facility.

For questions about the review and certification process, contact First Health Services at the following toll free numbers:

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

Which Medications Require Prior Authorization?

To find out which medications require prior authorization, refer to the Pharmacy Provider Claims Processing Manual on the web at http://nevada.fhsc.com. (Select "Billing Manuals" from the "Providers" drop-down menu.)

For questions or concerns, please contact First Health Services' Pharmacy POS Department at:

Phone: (800) 505-9185
Fax: (800) 229-3928

First Health Services' Prior Authorization Process

First Health Services' prior authorization process is as follows:

Initiate a prior authorization request by calling First Health Services' Prior Authorization Department at (800) 525-2395 or by faxing or mailing the appropriate prior authorization request form to First Health Services. You can print all prior authorization request forms from the First Health Services web site at http://nevada.fhsc.com. Select "Prior Authorization" from the "Providers" drop-down menu. If you do not have Internet access, you may contact First Health Services at (800) 525-2395 to request the appropriate forms be sent to you.

First Health Services assigns a unique Prior Authorization Number to the request.

A First Health Services reviewer determines whether or not the service is medically necessary by Medicaid's standards and assigns an initial service date range (if applicable).

Prior authorization requests are usually reviewed within the following time frames:

Number of Business Days	Type of Prior Authorization
1	Inpatient Medical Surgical Outpatient Medical Surgical Inpatient Psychiatric Mental Health Identification Screening Level of Care Dental
5	Home Health Initial Residential Treatment Center
7	PASRR Level II – Individual Evaluation
10	Home Health Reassessment

You will be notified via fax or phone if additional information is needed to make the prior authorization determination. If First Health Services or DHCFP does not receive requested information within two (2) business days, a Technical Denial is issued for that prior authorization request.

If the initial reviewer is unable to approve the prior authorization request after legible and complete information is received, the request is referred to a physician reviewer. At least one additional business day is required for the physician reviewer to complete a deferred review and make a determination. The physician reviewer may contact the provider to discuss the request.

First Health Services notifies the provider of the results of the prior authorization request and its unique Prior Authorization Number (if approved) by either phone or fax. In addition, First Health Services mails written confirmation of the approved prior authorization request to the provider. If the prior authorization request is denied, both the provider and the recipient receive notification by mail.

 **Complete all required fields on the form clearly and legibly.**

Prior Authorizations from the DHCFP

Services for programs listed in the following table require prior authorization from the DHCFP. For questions regarding any of the following types of prior authorization, please contact the appropriate office at the phone numbers listed. All other prior authorization requests are submitted to First Health Services.

Agency	Phone Number
For the CHIP Waiver (Waiver for the Frail Elderly at Home) or for the Waiver for the Elderly in Group Care call The Division for Aging Services (DAS).	(775) 684-4210
For the Waiver for Persons with Mental Retardation or Related Conditions call The Mental Health and Developmental Services Division (MHDS)	(775) 684-5943
For the Waiver for People with Physical Disabilities, call The Division of Health Care Financing and Policy (Nevada Medicaid).	(775) 688-2811 (Reno) (775) 684-3653 (Carson City) (775) 753-1148 (Elko) (702) 486-1535 (Las Vegas)

Updating a Prior Authorization

There may be times when you need to modify an approved prior authorization. For example, you may need to change the date of service.

To modify an approved prior authorization request, provide the Prior Authorization Department with the information that needs to be changed (e.g., dates of service, CPT codes, ICD-9 codes). You may call First Health Services' Prior Authorization Department at (800) 525-2395 or fax a modified prior authorization request form to (866) 480-9903.

Modified prior authorization request forms may also by sent via mail to First Health Services at the following address:

First Health Services Corporation
Health Care Management Division
4805 Lake Brook Dr, Suite 100
Glen Allen, Virginia 23060

 **Modifications to an approved prior authorization request must be completed prior to the date of service.**

Submitting Claims for Prior Authorized Services

To submit a claim listing a service that has been prior authorized, enter the Prior Authorization Number in the appropriate field on the claim form.

Before submitting the claim to First Health Services, confirm the following:

- The Prior Authorization Number was entered correctly.
- The Procedure code(s) listed on the prior authorization request form is the same as the Procedure code(s) on the claim form.
- The units and charges listed on the claim form for the prior authorized procedure are not greater than what was authorized.
- The service was provided within the dates shown on the Notice of Medical Necessity Decision letter sent by First Health Services.

What If I Could Not Obtain Prior Authorization Before Providing a Service?

Requests for retrospective authorization must be submitted within 90 days of the date of eligibility decision for recipients not currently in facilities and within 5 days for recipients currently in a facility.

Retrospective authorization is only available for cases in which the patient was not Medicaid eligible on the date of service, but becomes eligible with a retroactive effective date that includes the actual date of service.

Call First Health Services' Prior Authorization Department at (800) 525-2395 or submit a completed a Retrospective Authorization Request Form to the following:

First Health Services Corporation
4300 Cox Road
Glen Allen, VA 23060
Fax: (866) 480-9903

What If the Prior Authorization Request is Denied?

If the First Health Services denies a prior authorization request, a Notice of Decision for Payment Authorization Request Form and a Hearing Information and Hearing Request Form are mailed to the recipient.

In addition, First Health Services mails the following two forms to the Provider:

- Notice of Medical Necessity Determination Form
- Request for Reconsideration Form

If First Health Services denies your prior authorization request, you may request a reconsideration of the decision within 30 days from the receipt of the denial. To request that First Health Services reconsider a denied prior authorization request, the requesting provider must complete and return the Request for Reconsideration Form with a copy of the recipient's medical record to First Health Services at the following address:

First Health Services Corporation
Health Care Management Division
Attn: Reconsiderations
4805 Lake Brook Dr, Suite 100
Glen Allen, Virginia 23060

First Health Services mails the results of the Request for Reconsideration to the provider within 30 days of its receipt.

If the original decision of denial is upheld, the recipient or his/her guardian may choose to send an appeal to the DHCFP. For more information on recipient appeals, please contact the Prior Authorization Department at (800) 525-2395 or see the Nevada Medicaid Services Manual, Chapter 3100.

Prior Authorization Time Limits

Prior authorizations are valid for the dates shown on the Notice of Medical Necessity Determination letter only. If additional dates of service are required, you must request continued authorization by contacting First Health Services prior to the end of the authorized service dates.

Peer to peer review is available to providers and may be requested by contacting the Prior Authorization Department at (800) 648-7593 for Dental and PCA prior authorizations. For all other prior authorizations, contact First Health Services at (800) 525-2395 to schedule a peer to peer review.

Chapter E – Third Party Liability

What is Third Party Liability?

Third Party Liability (TPL) is the legal obligation of a recipient's other health care coverage to pay all or part of the expenditures for medical assistance furnished under Nevada Medicaid.

A recipient's other health care coverage may include, but is not limited to the following:

- Private health insurance
- Employment-related health insurance
- Medical support from absent parents
- Automobile insurance (including no-fault insurance)
- Court judgments or settlements from a liability insurer
- State workers' compensation
- Medicare
- First party probate-estate recoveries
- Other Federal programs (unless excluded by statute; i.e., Indian Health, Community Health, and Migrant Health programs)

Does the Recipient Have Other Health Insurance?

Recipients are required to provide the Nevada State Welfare Division District Office with documentation of their third party health care coverage. This includes their existing coverage and any changes to that coverage. Recipients are also required to notify the Welfare Division District Office of any impending legal actions regarding trauma situations (accidents).

It is your responsibility to retrieve this third party information prior to rendering services. This can be accomplished in one of the following ways:

- Visit First Health Services web site at http://nevada.fhsc.com. Select "Secure Provider Inquiry" from the "Quick Links" drop-down menu and log on using your unique User ID and password assigned by First Health Services. Select "Eligibility Benefit Verification and Service Limits (DDE 270/271)" from the EVS Main Menu. Follow the on-screen instructions to enter the recipient's Medicaid ID Number or Social Security Number and Date of Birth.
- Call the Nevada Medicaid Audio Response System at (800) 942-6511 and log on using your Provider Medicaid Number. You will also need the recipient's Medicaid ID Number OR Social Security Number and Date of Birth.
- Utilize a swipe card system.
- Request from the recipient a copy of all TPL documentation including an Explanation of Benefits (EOB).

If you are a Provider for both Medicaid and the recipient's third party plan, bill the third party plan first following their requirements. If the third party denies the claim because you did not follow its requirements, Medicaid will also deny the claim. You are not allowed to collect

payment from the recipient due to your non-compliance with the policies of Medicaid and/or the third party health care plan.

Not all third party coverage can be discovered prior to claims payment. If you discover third party coverage after Medicaid has paid the claim, Medicaid will recover payment from you and require you to bill the third party for payment of that claim.

Who Do I Bill First?

A recipient's other health care resources must be billed prior to submitting a claim to Medicaid. Medicaid is always the payer of last resort with the following exceptions.

- In certain trauma situations, there may be additional sources of payment such as automobile, homeowner's or liability insurance. In these cases, you may bill or file a lien against those sources, or you may bill Medicaid first. If you bill Medicaid first, Medicaid then attempts to collect payment from the recipient's other health care coverage.
- If a recipient is eligible for both Medicare and Medicaid, and Medicare does not offer coverage for a specific service that Medicaid does. In this case, you may bill Medicaid before Medicare.
- The Indian/Tribal Health Services plan is a secondary payer to Medicaid. If a recipient is eligible for both, you may bill Medicaid first.
- The Children with Special Health Care Needs (previously known as Crippled Children's Service) program is a secondary payer to Medicaid. If a recipient is eligible for both, you may bill Medicaid first.
- The State Victims of Crime program is a secondary payer to Medicaid. If a recipient is eligible for both, you may bill Medicaid first.
- Medicaid Managed Care is not considered third party health care coverage; therefore, you may bill Medicaid first. Please refer recipients enrolled in Medicaid Managed Care to the appropriate plan unless you are authorized to treat under that plan.

It is not necessary to bill the third party if you know the specific service provided is not a covered benefit under that policy. In this instance, note on each claim, the date, phone number and name of the person from whom the information on the insurance was obtained and submit the claim to First Health Services.

If you are aware that the recipient is receiving treatment for injuries caused negligently or intentionally by another person, business or organization, notify First Health Services or the DHCFP. If known, you may give an example that proof of liability exists, and bill the responsible party. If liability is undeterminable, notify First Health Services or the DHCFP of potential liability and bill Medicaid; reimbursement will not be delayed.

Billing Medicaid When There is TPL

If a third party insurance carrier denies your claim, you may submit the claim to First Health Services. You must include a copy of the EOB from the other insurance carrier. The EOB must

reflect the name of the recipient, date of service, service provided, the insurance company name and the amounts billed, approved and paid.

The total combined payment of other insurance and Medicaid cannot exceed the Medicaid maximum allowable amount. In all instances, Medicaid payment, even a zero paid amount, is considered payment in full and no additional amount may be billed to the recipient, his/her authorized representative or any other source.

If a third party insurance reimburses you for an amount greater than or equal to the Medicaid allowable amount, you are still required to submit a claim to Medicaid - if only for a zero dollar amount. This allows Medicaid to track all services received by that recipient.

Is the Recipient Responsible for Payment?

Providers may bill recipients only in the following situations:

The recipient's Medicaid eligibility status is pending.

In this case, Nevada Medicaid requests that you await an eligibility decision before billing for the service. If you decide not to wait for the decision, you may request payment from the recipient while the decision is pending. However, once the recipient is found eligible for Medicaid, and the date of service for which payment was collected is covered (as in the case of retroactive eligibility), you must return the entire amount collected from the recipient before billing Medicaid. The payment subsequently received from Medicaid is payment in full and no additional payment may be requested from the recipient. In addition, no part of the payment made by the recipient may be retained by the Provider.

Medicaid does not cover the service and the recipient agrees to accept financial responsibility.

You may bill a recipient for services not covered by Medicaid if the recipient agrees to accept full responsibility for the cost. The Provider must inform the recipient before services are provided that they will be financially responsible for the cost of services.

If the recipient chooses to continue with the service, the Provider must secure a written and signed statement at the time of the agreement that includes the date, type of service, cost of the service, verification that the Provider has informed the recipient that Medicaid will not pay for the service and that the recipient agrees to accept full responsibility for payment. This agreement may not be in the form of a blanket authorization secured only once (for example, at the time of consent for all treatment). It must be specific to each incident or arrangement for which the client accepts financial responsibility.

The third party payment made directly to the recipient or his/her parent or guardian.

If the third party makes a payment for services directly to the recipient or his/her parent or guardian, he/she is responsible to submit the payment to the Provider. If the recipient or his/her parent or guardian fails to do so, you may bill the recipient for the services, but may not collect more than the exact dollar amount paid by the third party insurance for services rendered.

The recipient fails to disclose Medicaid eligibility information.

You may bill Medicaid recipients when the recipient does not disclose Medicaid eligibility information at the time the services is provided, or at any other time before the expiration of your time limit for billing Medicaid.

As a rule, all Providers seek payment source information from recipients/patients before services are rendered. Any recipient not declaring their Medicaid eligibility or pending eligibility and thus denying you the right to reject that payment source, is viewed as entering into a "private patient" agreement with you. Therefore, if a recipient does not inform you before the service, at the time of service or within Medicaid's stale date time period that he/she is eligible for Medicaid, the recipient assumes full responsibility for payment.

You may not bill the recipient:

- For co-payment indicated on a private insurance card
- For the difference between the amount billed and the amount paid by Medicaid or a third party coverage
- When Medicaid returns claims to the Provider because other resources must be billed first
- When a claim was denied due to stale date
- When the Provider failed to follow Medicaid policy

Payments From a Third Party

All third party payments received by the Provider for Medicaid covered services must be applied against the Provider's charges for those services except for in certain trauma situations. See heading, "Who Do I Bill First?" in this chapter for more information.

Medicaid's reimbursement for services is the amount remaining after deducting the third party's payment from the Medicaid allowable amount. Medicaid does not provide reimbursement when a third party has paid you an amount greater than or equal to Medicaid allowable amount.

If you receive payment from a third party after receiving Medicaid reimbursement, you must refund Medicaid for the amount Medicaid paid you for those services.

If you have further questions or concerns, please contact First Health Services' Customer Service Center or refer to the Nevada Medicaid Services Manual, Chapter 3800.

Chapter F – Medicare Crossover

What is Medicare Crossover?

Medicare and Medicaid cover many of the same services. In most cases, when an individual has both Medicare and Medicaid coverage, you must submit your claim to Medicare first. After Medicare processes the claim, the claim data is sent to Medicaid for additional payment. This process is called "Medicare crossover." A claim first submitted to Medicare and later submitted to Medicaid is called a "crossover claim."

Not a Medicare Covered Benefit

Please contact our Customer Service Center at (877) 638-3472 for special instructions on how to bill us for a service that Medicaid covers, but Medicare does not.

Automatic Crossover

Some Medicare carriers process claims and then forward the data to us. In this case, we receive the data, process it and issue payment without further action from you. This is called, "automatic crossover."

Contact your Medicare carrier to find out if they automatically forward your claim data to Nevada Medicaid. Any carrier who would like to begin forwarding claim data to us should contact our Customer Service Center at (877) 638-3472.

When to Submit a Manual Crossover Claim

You must submit your crossover claim manually when:

1. Your Medicare carrier does not forward your claims data to us. In this case, submit your crossover claim as soon as you receive your Medicare EOB.

OR

2. Your Medicare EOB shows that your claim was forwarded to us but you have not received payment within 60 days from the date on your Medicare EOB. In this case, submit your claim manually and then notify our Customer Service Center at (877) 638-3472.

How to Submit a Manual Crossover Claim

We receive and process crossover claims (1) through a Medicare carrier or (2) on a paper claim form. At this time, we do not accept electronic crossover claims from providers.

Mail your crossover claim to First Health Services, Medicare Crossover, PO Box 30028, Reno, NV 89520-3028.

Providers Who Bill on the UB-92 Claim Form

If you bill Medicaid on a UB-92 claim form, you must use the Medicare Crossover Claim Form (FH-40) to submit a crossover claim. This change became effective on October 1, 2004.

Providers Who Bill on the CMS-1500 Claim Form

If you bill Medicaid on a CMS-1500 claim form, you may use form FH-40 or the CMS-1500 claim form with your Medicare EOB – whichever you prefer.

If you use the CMS-1500 claim form:

- Follow the instructions for completing the claim form in Chapter C of this manual
- List Medicare as the recipient's other insurance carrier
- Attach a copy of your Medicare EOB with your claim.

Using the Medicare Crossover Claim Form (FH-40)

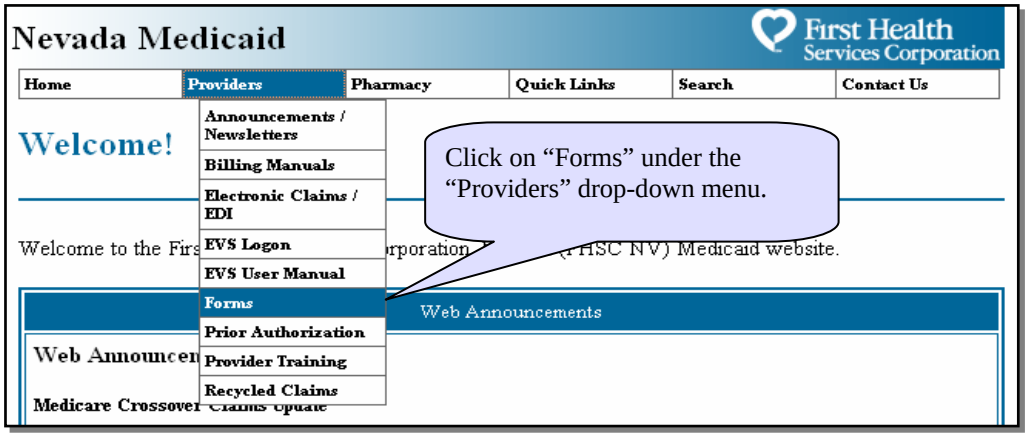
When submitting form FH-40, you do not need to attach a copy of your Medicare EOB.

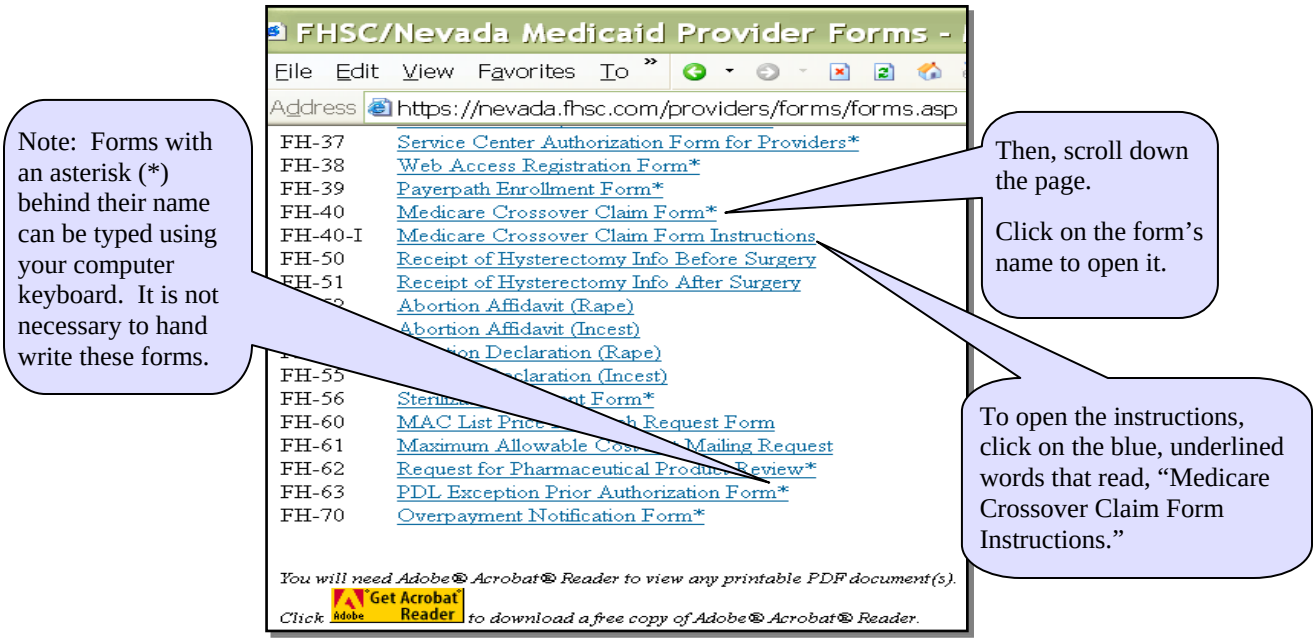
Please note that if service was provided on multiple days, you must complete one FH-40 form for each date of service.

Using Form FH-40, you can submit a claim for one date of service only.

Locating Form FH-40 Online

As illustrated below, Form FH-40 and its instructions (FH-40-I) are both available on our web site at http://nevada.fhsc.com.





Your Medicare Billing Number

We must have your Medicare billing number on file to process your crossover claims.

If you are having payment issues with your crossover claims, contact the Provider Enrollment Unit at (877) 638-3472 to verify that we have your correct Medicare billing number on file.

How to Send Us Your Medicare Billing Number

To update your Medicare billing number or to request that we add this number to your provider file, complete and mail the Provider Information Change Form (FH-33) to the address shown below.

Please note that we must have the provider's original signature in order to add or make changes to this information.

Provider Enrollment
First Health Services Corporation
PO Box 30047
Reno, NV 89520-3047

Medicare and Medicaid Dual Eligibility

Some recipients are eligible for both Medicaid and Medicare benefits. We refer to these recipients as having "dual eligibility."

It is important to verify a recipient's eligibility each time before providing services. The Recipient Eligibility chapter of this manual describes several ways to do this.

Using EVS to Verify Dual Eligibility

A benefit plan indicates which benefits a recipient is eligible to receive. A recipient may be eligible for more than one benefit plan.

The best way to verify a recipient's eligibility and benefit plan is through our online Electronic Verification System ("EVS").

Figure G-1 shows a portion of the EVS eligibility response screen. The left-most table column (the Benefit Plan field) indicates which benefit plan(s) the recipient is enrolled in.

Figure G-1

Eligibility Information

Provider Name Last/Org Name (Current MCO): DOD: 06/13/2003

Provider Name Last/Org Name (Previous MCO): DOD:

Benefit Plan (Plan Coverage Desc)	Begin-End (Date Time Period)	Eligibility or Benefit Info	Patient Pay (Benefit Amt)	Provider ID (Benefit Related Entity ID)	Phone Number Communication Number
MEDICAID FFS	01/01/2004-01/31/2004	1	0.00	000000000	000-000-0000
MED CO & DED	01/01/2004-01/31/2004	1	0.00	000000000	000-000-0000

If EVS displays "MEDICAID FFS" in the "Benefit Plan" field, the recipient is eligible to receive full Medicaid benefits. In the example above, the recipient is eligible for full Medicaid benefits as well a payment of their Medicare coinsurance and deductible.

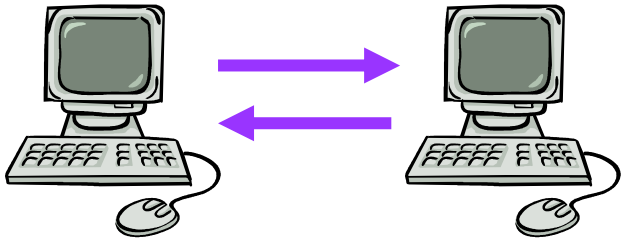
If the recipient is a Qualified Medicare Beneficiary (QMB), EVS will display "MED CO & DED" only in the Benefit Plan field.

For more information about verifying recipient eligibility through EVS, refer to our EVS User Manual online (select "EVS User Manual" from the "Providers" drop-down menu).

Chapter G - Electronic Data Interchange (EDI)

What is EDI?

Short for Electronic Data Interchange, "EDI" is the transfer of data between companies by use of a computer network.



Each electronic data transfer is called a "transaction." Each transaction has a unique function that relates to the transfer of health care data.

The transactions we currently use are:

Transaction Number	Function
270	A request from you (the provider) to verify recipient eligibility including program coverage and benefits.
271	Our response to your eligibility request.
276	A request from you to verify the status of a claim.
277	Our response to your claim status request.
277u	We send this transaction to notify you that one or more of your claims are pended.
278	Your inquiry and our response to verify the status of one or more prior authorization requests.
820	Premium payment for enrolled HMO members
834	Enrollment/Dis-Enrollment to an HMO
835	This transaction is an electronic Remittance Advice from First Health Services showing the status and payment amounts of the provider's recent claims.
837D	Electronic dental claim submitted by the provider (paper equivalent is the ADA claim form).
837I	Electronic institutional claim submitted by the provider (paper equivalent is the UB-92 claim form).
837P	Electronic professional claim submitted by the provider (paper equivalent is the CMS-1500 claim form).
NCPDP	National Council for Prescription Drug Programs Batch (for pharmacy providers)

The American National Standards Institute's X12N committee sets the technical standards for health care EDI transactions. For more information on ANSI, visit their web site at http://www.ansi.org.

The Benefits of EDI

As a direct result of EDI, you can save money on envelopes, preprinted forms and postage.

EDI will eliminate certain data entry and document handling tasks.

EDI reduces claim errors by validating fields before the claim reaches the Medicaid Management Information System (MMIS) for processing.

When a claim is submitted electronically, we receive and process it the same day. Quicker submission means quicker payment.

You can check to see whether the claim was paid or denied within 48 hours of submission.

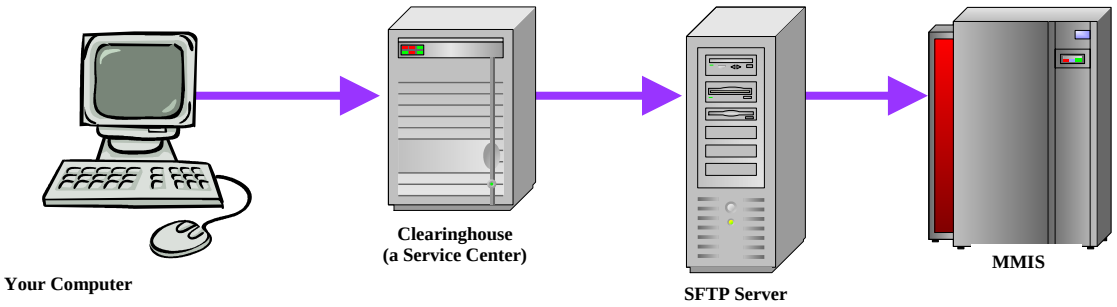
Common EDI Terms

Clearinghouse

A clearinghouse is a business that submits claim data to us on behalf of a provider. Payerpath is one example of a clearinghouse.

When you use a clearinghouse to submit your electronic claims, the claim data is first sent from your computer to the clearinghouse. The clearinghouse performs a series of validation checks on the claim and then forwards it to our Secure File Transfer Protocol (SFTP) server. Next, our SFTP server forwards the claim to the MMIS for processing and payment.

The following diagram shows how the claim travels to the MMIS when you use a clearinghouse to submit your electronic claims.



Direct Submitter

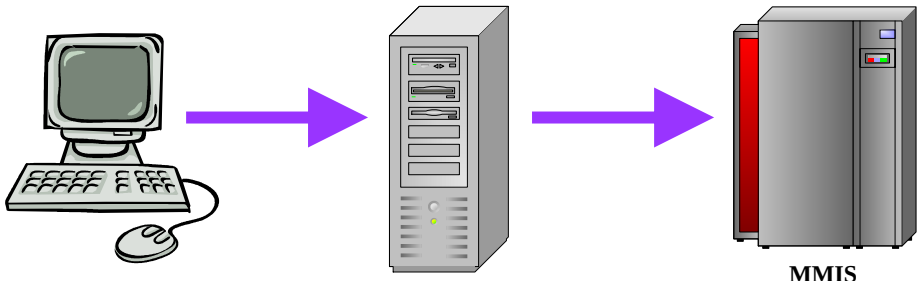
A direct submitter is a provider that submits electronic claims to us using their practice management software.

Claim data is sent from the provider's computer to our Secure File Transfer Protocol (SFTP) server and then on to the MMIS for processing as shown in the following diagram.

Service Center

A Service Center is an entity that submits electronic claims to us directly. Clearinghouses and direct submitters are both referred to as Service Centers.

If your business will be submitting claims through Payerpath or another clearinghouse, your business is not a Service Center.



Who is Payerpath?

Payerpath is one of several clearinghouses that accept CMS-1500, UB-92 and ADA claims over the Internet.

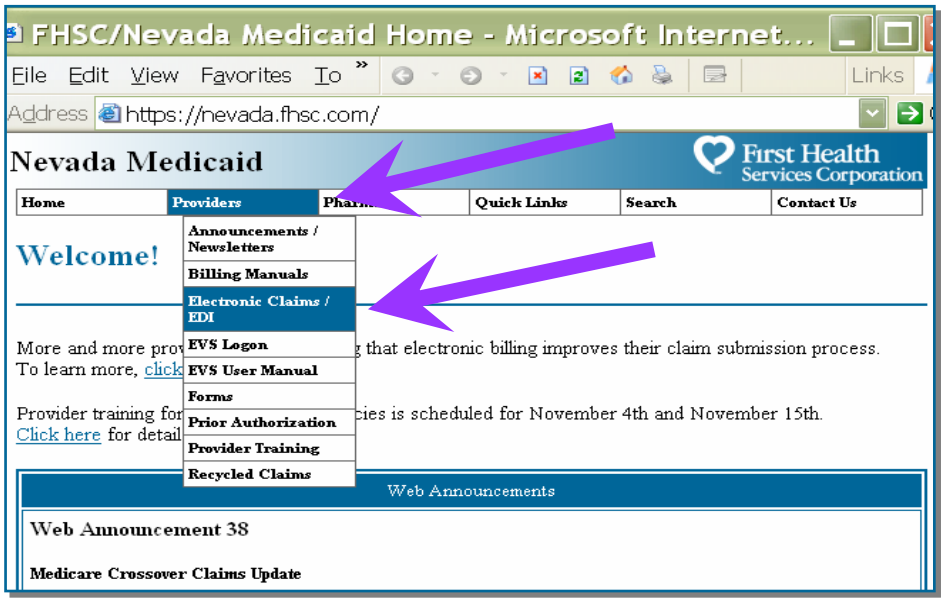
Through Payerpath, you can submit your Nevada Medicaid and Nevada Check Up claims for free.

To submit claims through Payerpath, all you need is a computer that is connected to the Internet and the Internet Explorer web browser (version 6.0 or higher). Internet Explorer can be downloaded for free from http://www.microsoft.com/downloads.

After we process your registration and assign your username and password, you will be able to log in to Payerpath's secure web site (http://www.payerpath.com). You may key claims directly into the web site or Payerpath can interface with your existing practice or hospital management software to upload the claims.

EDI Resources on our Web Site

To locate EDI resources on our web site, go to http://nevada.fhsc.com, then select "Electronic Claims / EDI" from the "Providers" drop-down menu as illustrated below. Materials available on our web site are described in the following sections.



The Service Center Directory

If you are considering submitting your electronic claims through a clearinghouse, refer to our Service Center Directory. This directory lists clearinghouses authorized to submit claims to us and also provides a link to each of their web sites.

Payerpath Presentation

The Payerpath Presentation introduces Payerpath and illustrates use of their web interface to submit claims electronically.

The Service Center User Manual

The Service Center User Manual is written for clearinghouses and direct submitters. It describes the HIPAA requirements, the technical requirements for SFTP and SSL, transaction testing, how to handle login and password problems and much more.

The Companion Guides

There are nine Companion Guides on our web site. These guides provide clearinghouses and direct submitters with specific technical requirements for the submission of electronic claim data to First Health Services.

How to Register

To begin submitting electronic claims to us, first complete the enrollment forms as explained in the table below.

Mail your registration forms to:

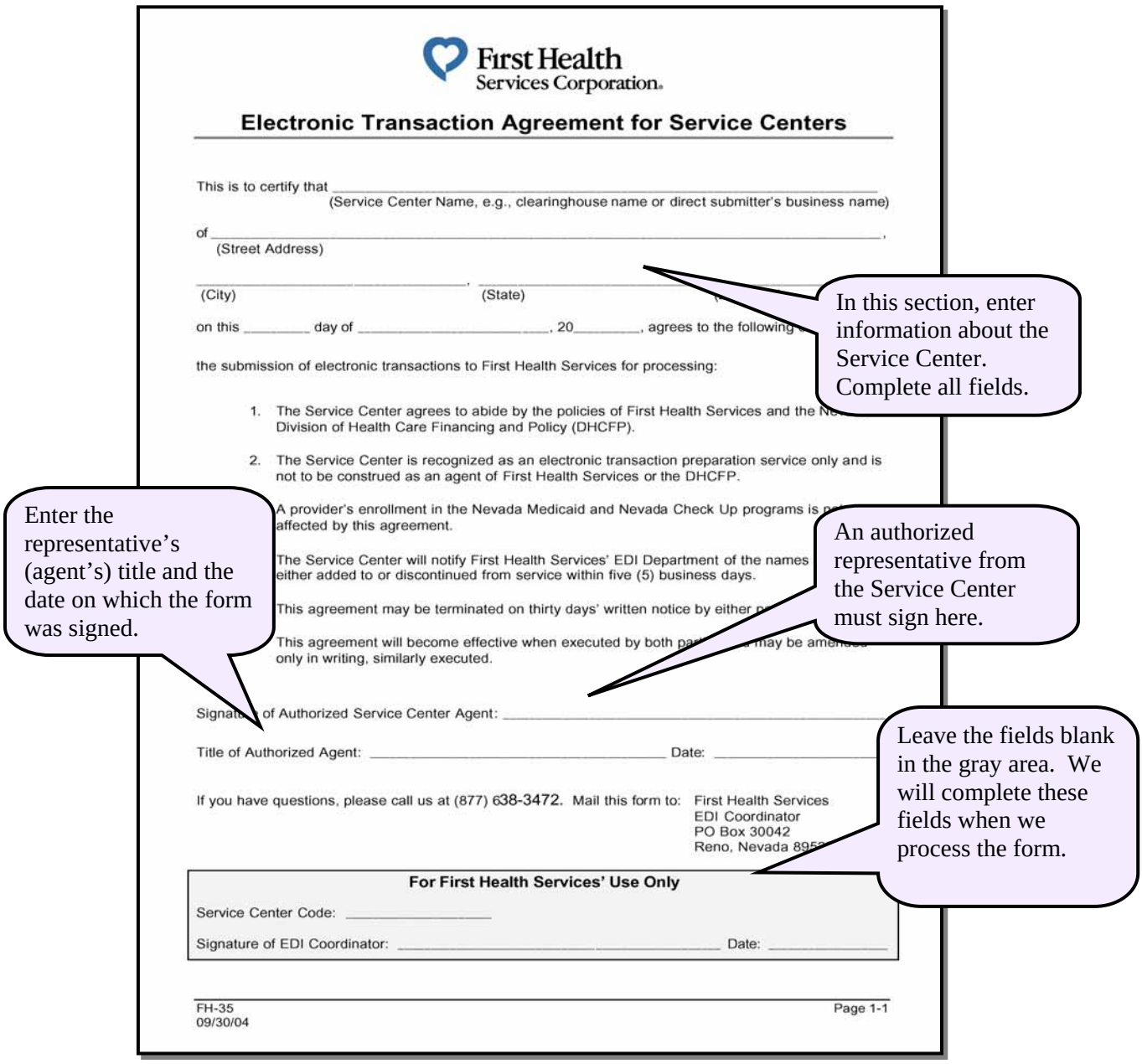
First Health Services Corporation
EDI Coordinator
PO Box 30042
Reno, Nevada 89520-3042

Submission Method	Forms to Submit	After you Submit the Forms
I would like to submit my claims free of charge through Payerpath.	• Submit one FH-37 form for each Provider Medicaid Number you use. • Submit one FH-39 form.	The EDI Coordinator will contact you with your username and initial password. You will need this information to log on to Payerpath's web site and begin submitting claims.
I will be submitting my claims to a clearinghouse. The clearinghouse will then send the claim to First Health Services.	Submit one FH-37 form for each Provider Medicaid Number you use.	We notify the clearinghouse that you have registered with us to send/receive electronic transactions. Please contact your clearing-house. They will assist you in further setup and/or testing.
I plan to submit claims directly from my business to First Health Services, using my current practice management software.	• Submit one FH-35 form. • Submit one FH-36 form. • Submit one FH-37 form for each Provider Medicaid Number you will use in billing First Health Services.	We will contact you with your SFTP username, your initial password and your Service Center Code so that you may begin testing with us.
I am a clearinghouse who would like to begin sending claims to First Health Services on behalf of providers.	• Submit one FH-35 form. • Submit one FH-36 form.	We will contact you with your SFTP username, your initial password and your Service Center Code so that you may begin testing.

Completing the Service Center Electronic Transaction Agreement (FH-35)

When to complete this form: Complete this form if (1) you are a direct submitter or (2) you are a clearinghouse who would like to begin sending claims to First Health Services on behalf of providers.

Purpose: This form defines the business relationship between the Service Center, the Division of Health Care Financing and Policy (DHCFP) and First Health Services.



First Health Services Corporation

Electronic Transaction Agreement for Service Centers

This is to certify that _____
(Service Center Name, e.g., clearinghouse name or direct submitter's business name)

of _____,
(Street Address)

_____, _____
(City) (State)

on this _____ day of _____, 20_____, agrees to the following

the submission of electronic transactions to First Health Services for processing:

1. The Service Center agrees to abide by the policies of First Health Services and the N Division of Health Care Financing and Policy (DHCFP).
2. The Service Center is recognized as an electronic transaction preparation service only and is not to be construed as an agent of First Health Services or the DHCFP.

A provider's enrollment in the Nevada Medicaid and Nevada Check Up programs is n affected by this agreement.

The Service Center will notify First Health Services' EDI Department of the names either added to or discontinued from service within five (5) business days.

This agreement may be terminated on thirty days' written notice by either p

This agreement will become effective when executed by both pa may be amende only in writing, similarly executed.

Signat of Authorized Service Center Agent: _____

Title of Authorized Agent: _____ Date: _____

If you have questions, please call us at (877) 638-3472. Mail this form to: First Health Services
EDI Coordinator
PO Box 30042
Reno, Nevada 895

For First Health Services' Use Only

Service Center Code: _____

Signature of EDI Coordinator: _____ Date: _____

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In this section, enter information about the Service Center. Complete all fields.

Enter the representative's (agent's) title and the date on which the form was signed.

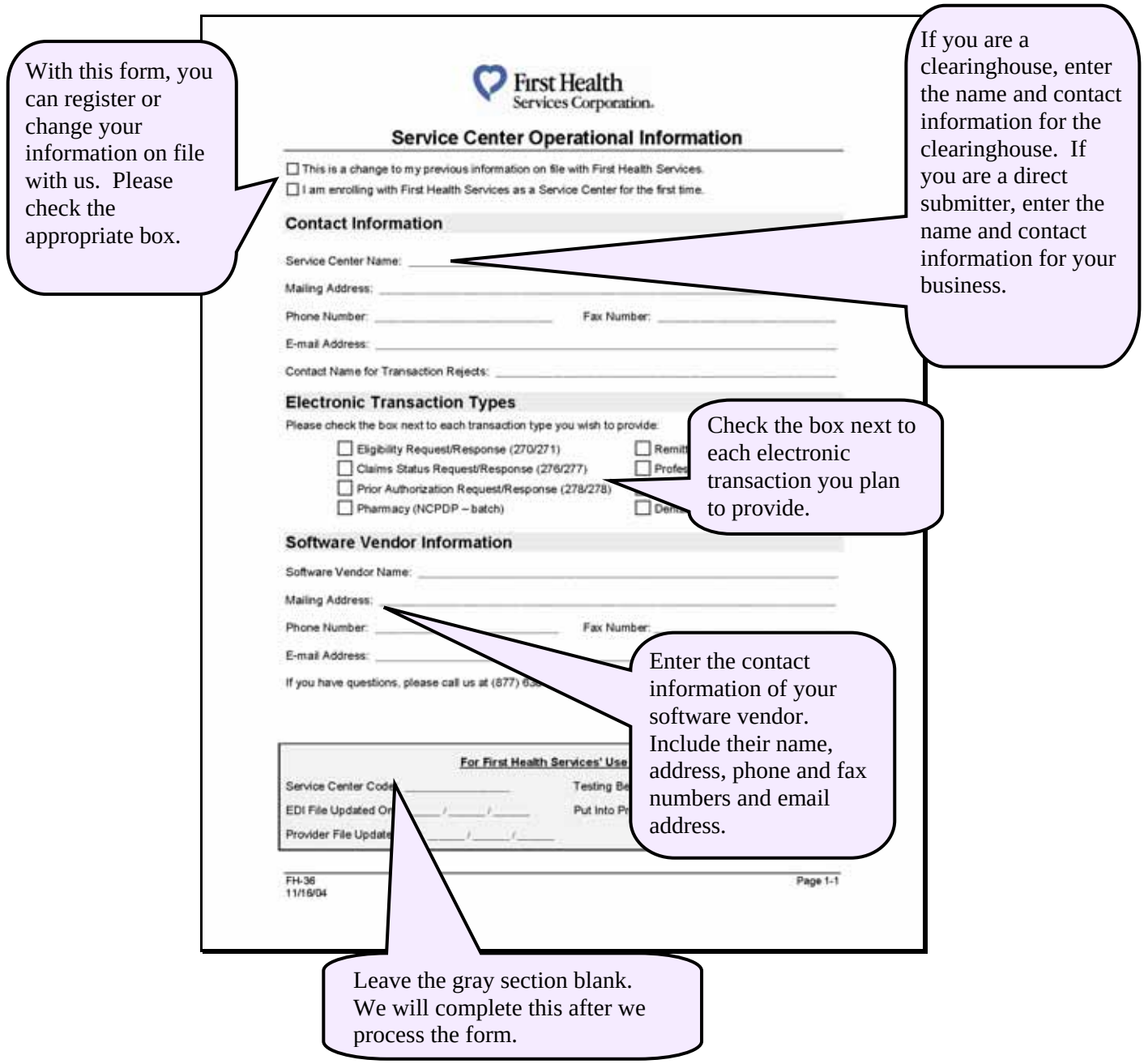
An authorized representative from the Service Center must sign here.

Leave the fields blank in the gray area. We will complete these fields when we process the form.

Completing the Service Center Operational Information Form (FH-36)

When to complete this form: Complete this form if (1) you are a direct submitter or (2) you are a clearinghouse who would like to begin sending claims to First Health Services on behalf of providers.

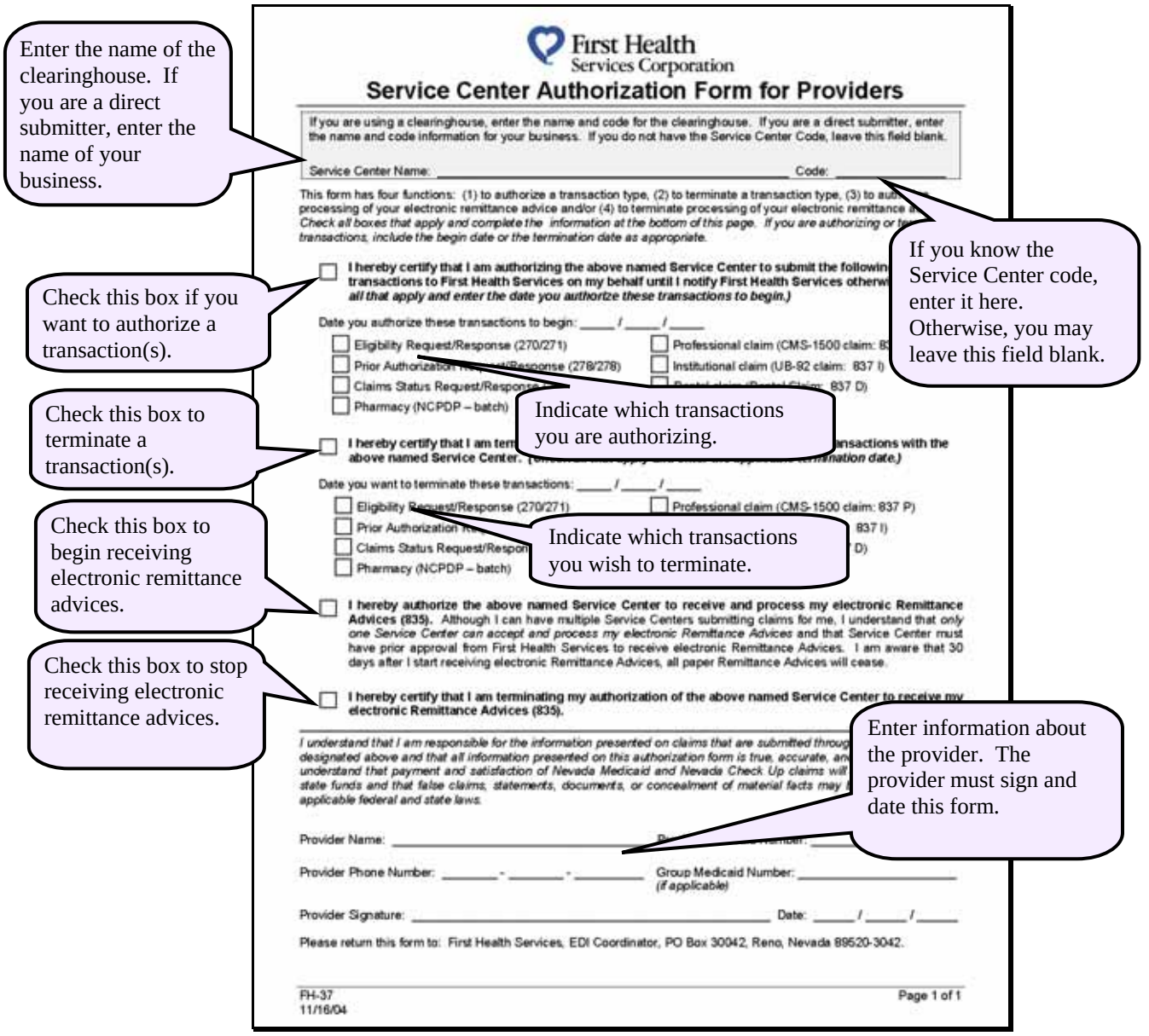
Purpose: This form provides us with your contact information, which electronic transaction types you will provide and the contact information for your software vendor.



Completing the Service Center Authorization Form for Providers (FH-37)

When to complete this form: A provider must submit one FH-37 form for *each* Provider Medicaid Number that will be used on their Nevada Medicaid and Nevada Check Up claims. For example, if a provider has three different Provider Medicaid Numbers, that provider must submit three FH-37 forms.

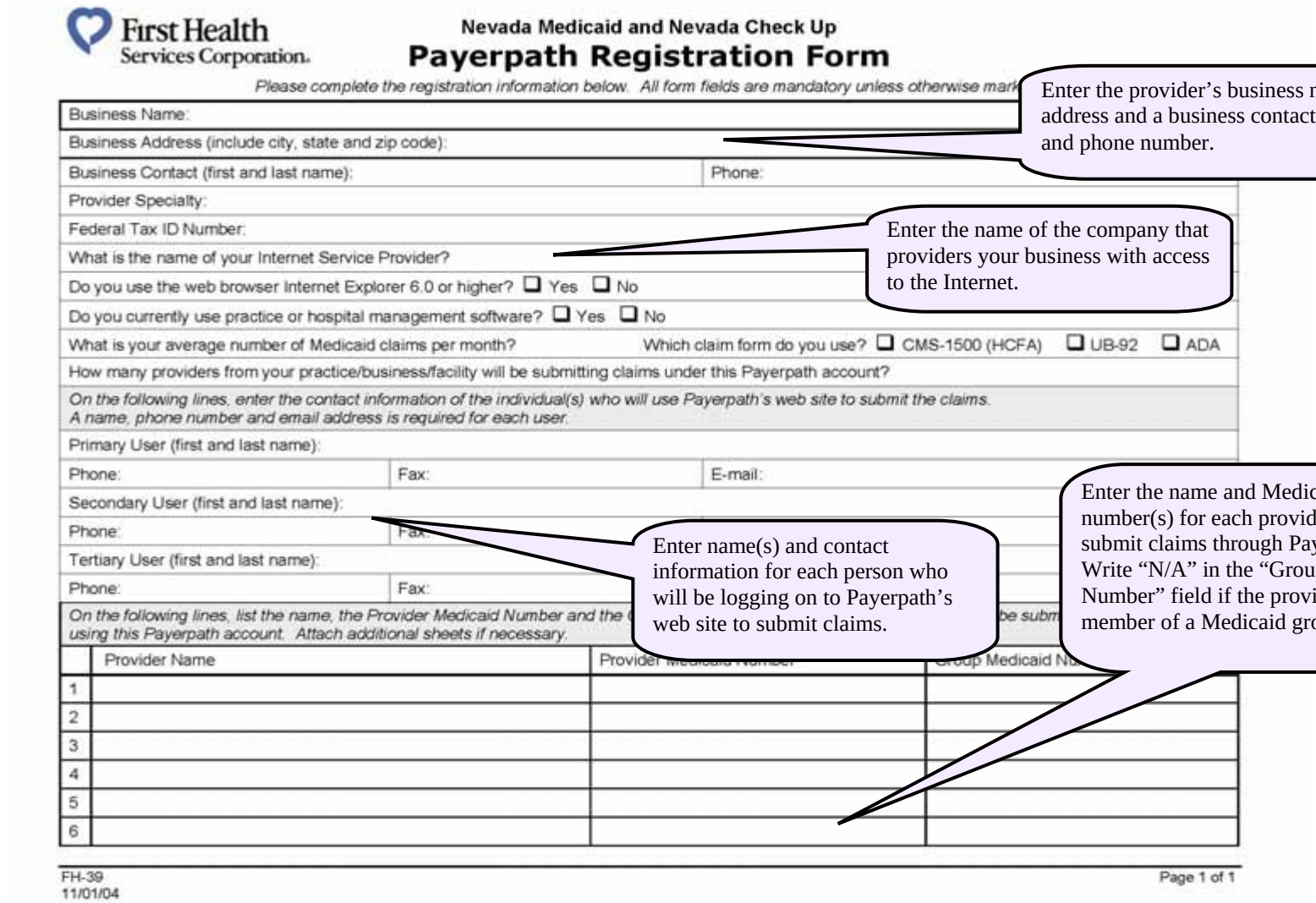
Purpose: This form has four functions. These functions are:
(1) to authorize a transaction type, (2) to terminate a transaction type, (3) to authorize processing of your electronic remittance advice or (4) to terminate processing of your electronic remittance advice.



Completing the Payerpath Registration Form (FH-39)

When to complete this form: Each provider business must submit one FH-39 form to register for claim submission claims through Payerpath.

Purpose: This form registers you for Payerpath's free claim submission service.



First Health Services Corporation.

Nevada Medicaid and Nevada Check Up

Payerpath Registration Form

Please complete the registration information below. All form fields are mandatory unless otherwise mark

Business Name:		
Business Address (include city, state and zip code):		
Business Contact (first and last name):		Phone:
Provider Specialty:		
Federal Tax ID Number:		
What is the name of your Internet Service Provider?		
Do you use the web browser Internet Explorer 6.0 or higher? ❑ Yes ❑ No		
Do you currently use practice or hospital management software? ❑ Yes ❑ No		
What is your average number of Medicaid claims per month?	Which claim form do you use? ❑ CMS-1500 (HCFA) ❑ UB-92 ❑ ADA	
How many providers from your practice/business/facility will be submitting claims under this Payerpath account?		
On the following lines, enter the contact information of the individual(s) who will use Payerpath's web site to submit the claims. A name, phone number and email address is required for each user.		
Primary User (first and last name):		
Phone:	Fax:	E-mail:
Secondary User (first and last name):		
Phone:	Fax:	
Tertiary User (first and last name):		
Phone:	Fax:	

On the following lines, list the name, the Provider Medicaid Number and the ( ) be subm using this Payerpath account. Attach additional sheets if necessary.

	Provider Name	Provider Medicaid Number	Group Medicaid Nu
1			
2			
3			
4			
5			
6			

FH-39
11/01/04

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Enter the provider's business name, address and a business contact name and phone number.

Enter the name of the company that providers your business with access to the Internet.

Enter name(s) and contact information for each person who will be logging on to Payerpath's web site to submit claims.

Enter the name and Medicaid number(s) for each provider who will submit claims through Payerpath. Write "N/A" in the "Group Medicaid Number" field if the provider is not a member of a Medicaid group.

Electronic Remittance Advice

For each week in which you have claims activity, we send you a Remittance Advice (RA). The RA contains information about the adjudication of your claims. Use form FH-37 to request that we send your RA electronically.

You can have more than one clearinghouse submit claims on your behalf; however, you may authorize only one clearinghouse to accept your electronic RA. Your paper RA will cease 30 days after you authorize an electronic RA.

Authorizing an electronic RA, this does not authorize electronic transfer of your claims payment. To authorize us to deposit electronic payments into your bank account, you must complete and submit form FH-32. This form and instructions is available on our web site (select "Forms" from the "Providers" drop-down menu).

Checking the Status of Your Claim

With electronic claim submission and our Electronic Verification System (EVS), you will be able to check the status of your claims within 48 hours after submission.

EVS provides a Claims Log that contains available information about submitted claims. To use EVS, you will need a computer that is connected to the Internet and a username and password assigned by First Health Services.

Registering to Use EVS

To register for an EVS username and password, simply complete and submit form FH-38 on our web site (select "Forms" from the "Providers" drop-down menu). The EVS User Manual, also on our web site, tells you everything you need to know about using EVS. To access the EVS User Manual, select "EVS User Manual" from the "Providers" drop-down menu.

Questions? Contact the EDI Coordinator

Our EDI Coordinator is available to assist you with any questions you may have regarding EDI enrollment, testing and technical support.

Contact the EDI Coordinator at:

First Health Services
EDI Coordinator
PO Box 30042
Reno, Nevada 89520-3042

Phone: (877) NEV-FHSC (638-3472)
Fax: (775) 784-7932
E-mail: nvedi@fhsc.com

Chapter H – Billing Guidelines

Nevada Medicaid Provider Types

The following table shows all Nevada Medicaid Provider Type numbers and descriptions.

Number	Description
10	Outpatient Surgery, Hospital Based
11	Hospital, Inpatient
12	Hospital, Outpatient
13	Psychiatric Hospital, Inpatient
14	Mental Health, Outpatient
16	Intermediate Care Facilities for Mentally Retarded / Public
17	Special Clinics
18	Skilled Nursing Facilities/Skilled Level - No Longer Used
19	Nursing Facility
20	Physician, M.D., Osteopath
21	Podiatrist
22	Dentist
23	Hearing Aid Dispenser & Related Supplies
24	Certified R.N. Practitioner
25	Optometrist
26	Psychologist
27	Radiology & Noninvasive Diagnostic Centers
28	Pharmacy
29	Home Health Agency
30	Personal Care Aide - Provider Agency
31	Healthy Kids Screening
32	Ambulance, Air or Ground
33	Durable Medical Equipment, Disposable, Prosthetics
34	Therapy
35	Travel
36	Chiropractor
37	Intravenous Therapy (TPN)
38	Home & Community Based Waiver - MR Services
39	Adult Day Health Center
40	Primary Care Case Management (PCCM) Services
41	Optician, Optical Business
42	Outpatient Psychiatric Hosp. Private, and Community Health Center
43	Laboratory, Pathology/Clinical
44	Swing-bed, Acute Hospital

Number	Description
45	End Stage Renal Disease (ESRD) Facility
46	Ambulatory Surgical Centers
47	Indian Health Services (IHS) and Tribal Clinics
48	Senior Waiver (Frail Elderly)
49	IHS Travel (Tribal)
51	Indian Health Service Hospital, Inpatient (Tribal)
52	Indian Health Service Hospital, Outpatient (Tribal)
54	Targeted Case Management
55	Transitional Rehabilitative Center, Outpatient
56	Medical Hospital (Rehabilitation or Specialty), Inpatient
57	Adult Group Care Waiver
58	Physically Disabled Waiver
60	School Based
61	Mental Health Rehabilitative Treatment Services
62	Health Maintenance Organizations (HMO)
63	Residential Treatment Centers (RTC)
64	Hospice
65	Hospice, Long Term Care
68	Intermediate Care Facilities for Mentally Retarded / Private
72	Nurse Anesthetist
74	Nurse Midwife
75	Critical Access Hospital (CAH), Inpatient
76	Audiologist
77	Physician's Assistant
78	Indian Health Service Hospital, Inpatient (Non-Tribal)
79	Indian Health Service Hospital, Outpatient (Non-Tribal)
80	IHS Travel (Non-Tribal)
82	Mental Health Rehabilitative Treatment Services / Public
83	Personal Care Aide - Intermediary Service Organization
84	Personal Care Aide - Independent Contractor

Which Provider Medicaid Number Do I Use?

You may have more than one Provider Medicaid Number - one for each different type of service you offer. When submitting a claim, it is important to enter the Provider Medicaid Number that corresponds to the type of service performed.

Medicaid does not reimburse for services rendered by anyone other than the Provider whose name and Provider Medicaid Number appears on the claim. For example, Medicaid would not reimburse a physician for services when a psychologist or other personnel actually provided the service.

Which Code Do I Use?

When submitting a claim, use the HIPAA-compliant, national code sets as defined in the most current Revenue code, CPT, ICD-9 and HCPCS books.

Unspecified procedure codes may be used only when you are unable to locate a suitable code for the procedure or service provided.

Submitting Paper Claim Forms

We recommend using electronic claims submission rather than paper claim forms. If you are not yet submitting claims electronically, please adhere to the following instructions when submitting paper claims. This will ensure that we are able to process the claim accurately.

We scan and index all paper claims for future reference. Claim accuracy, completeness and clarity are very important.

- Do not fold or crease claims.
- Use blue or black ink.
- If handwriting, be sure to print legibly.
- Keep names, numbers, codes, etc., within the designated boxes and lines.
- Rubber stamp Provider signatures are acceptable.
- Include a return address on all claims envelopes.

Make any corrections carefully. Use one line to cross out errors, and then initial the correction. Remember to send any needed attachments with your claim. If you have questions about what attachments are needed, please contact our Customer Service Center.

Send paper claim forms to the appropriate address shown below:

First Health Services CMS-1500 Claim PO Box 30031 Reno NV 89520-3031	First Health Services UB-92 Claim PO Box 30035 Reno NV 89520-3035	First Health Services Dental Claim PO Box 30036 Reno NV 89520-3036

How Much Time Do I Have to Submit a Claim?

Claims for in-state providers must be received within 180 days of the Date of Service or within 180 days of the Date of Eligibility Decision, whichever is later.

Claims for out-of-state providers must be received within 365 days of the Date of Service or within 365 days of the Date of Eligibility Decision, whichever is later.

When a recipient has one or more primary insurance carriers, claims for in-state and out-of-state providers must be received within 365 days of the Date of Service or the date of Eligibility Decision, whichever is later.

The method for calculating 180 or 365 days is as follows:

- For a Single Service Date, calculate 180 or 365 days by subtracting the date of service from the date the claim was received.
- For Service Date Ranges, calculate 180 or 365 days by subtracting the last day in the range of dates of service from the date the claim was received.

 **If a claim is returned to you due to inaccurate, illegible, or incomplete information, you do not have an additional 180 or 365 days (whichever pertains to you as discussed above) to re-send the claim. You may resubmit the claim, but it must be received within the time limits noted above.**

Exception

An exception to the timely filing limitation may be granted if you document delays due to errors on the part of the Welfare Division, DHCFP or First Health Services.

You must first submit your claim and receive a denial due to timely filing limitations. Next, follow the requirements in the "Appeals" section of this manual to submit an appeal to us.

How Much Do I Bill for a Service?

Bill Medicaid your lowest advertised charge that is quoted, posted or billed for that procedure and unit of service. Exceptions to this are:

Medicare Assignment. The Medicare assignment exception applies when you accept a Medicare recipient, which requires billing Medicare at the Medicare fee schedule. You are not required to bill Medicaid at the Medicare fee schedule.

Sliding Fee Schedule. The sliding fee schedule exception applies when you have a written policy that establishes a sliding fee schedule based on the federal poverty level for Nevada (families and individuals with incomes equal to or less than 250 percent of the federal poverty level). You are not required to bill Medicaid at the sliding fee discounted rate.

Contract for Group Discounts. This exception applies when you execute or enter into a contract to provide health care services at a discounted rate for a specified group of recipients. You are not required to bill Medicaid at the discounted rate if the revenue from a single contract does not exceed 20 percent of your annual gross income, or if the contract is with a state or federal agency.

Provider's Employee Benefits. The employee benefits exception applies when you offer a reduced rate for health care services to your employees as part of an employment benefit package. You are not required to bill Medicaid at that reduced rate.

Claim Attachments

Attachments are additional documentation that must be submitted with your original claim for services. Please do not submit other documentation with your original claim such as a copy of the recipient's medical records or proof of their Nevada Medicaid eligibility. Such documentation may be necessary when submitting a prior authorization request or appealing a

claim denial, however, only the attachments discussed in this section should be submitted with a claim.

Claims that require attachments should be submitted on a paper claim form (not electronically). If multiple claim forms refer to the same attachment, make a separate copy of the attachment for each claim form. For multiple page UB-92 claims, only one copy of the attachment is required.

If an attachment has information on both sides of the page, make a copy of the backside and include it with the claim.

 **Place the claim form on top of its corresponding attachment. You may use paper clips, binder clips or rubber bands to group claims and/or attachments. Please refrain from using staples.**

Explanation of Benefits from Primary Insurance Carrier

If a recipient has a primary insurance carrier in addition to Nevada Medicaid benefits, we require that you attach a copy of the other carrier's Explanation of Benefits (EOB) to your claim regardless of whether the other insurance carrier paid or denied your claim.

The one exception to this rule is submitting a crossover claim using the Medicare Crossover Claim Form (FH-40). When submitting form FH-40, an EOB is not required.

Hysterectomy Acknowledgement Form

For hysterectomy procedures, submit form FH-50 if the woman received the required hysterectomy information *before* surgery. Submit form FH-51 if the woman received the required hysterectomy information *after* surgery.

See “Hysterectomy” in Chapter C of this manual for additional requirements.

Sterilization Consent Form

For sterilization procedures, attach the Sterilization Consent Form (FH-56).

See “Sterilization” in Chapter C of this manual for additional requirements.

Abortion Affidavit or Declaration

If the procedure is to terminate a pregnancy that is the result of an act of rape or incest, submit a completed FH-52 or FH-53 form as applicable.

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

See “Abortion” in Chapter C of this manual for additional requirements.

Chapter I – I've Submitted a Claim. What Happens Now?

First Health Services processes all claims using a Medicaid Management Information System ("MMIS"). The Nevada MMIS is an intricate computer system programmed to reflect Nevada Medicaid and Nevada Check Up policy.

The MMIS performs hundreds of validation checks on each claim. A few examples are:

- Does the provider have a valid contract with Nevada Medicaid?
- Was the recipient eligible to receive services?
- Are the CPT and ICD-9 codes compatible?
- Was prior authorization obtained for the service (if applicable) and was the service provided within the approved dates?
- Was a third party insurance carrier billed prior to Medicaid (if applicable)?
- Has this claim been sent to First Health Services previously (duplicate claim)?

If a claim fails any of these checks, the MMIS will deny or "pend" it. *See also* "Pended Claims" and "Denied Claims" later in this chapter.

How to Check the Status of a Claim

We provide the following methods for you to monitor the status of your claim:

1. The First Health Services web site at http://nevada.fhsc.com. Select "EVS Logon" from the "Providers" drop-down menu and use your unique User ID and password to log on.
    - Also on our web site, the EVS User Manual explains how to use the EVS online interface. Select "EVS User Manual" from the "Providers" drop-down menu.
    - You can request a User ID and password by submitting the Web Access Registration Form (FH-38). To locate this form, select "Forms" from the "Providers" drop-down menu.
2. The Nevada Medicaid Audio Response System ("ARS") at (800) 942-6511. Log in using your 9-digit Provider Medicaid Number. Have ready the Recipient ID Number (11-digit Enrollee Number) and the date of service for the claim. For more information on ARS, see "How to Verify Recipient Eligibility and Program Benefits" in Chapter D of this manual.
3. The Customer Service Center at (877) 638-3472. When calling, please have ready the following information for each claim:
    - Provider name and Medicaid Number
    - Recipient name and ID Number
    - Date(s) of service
    - Amount(s) billed

Your Remittance Advice

We generate a Remittance Advice ("RA") for all providers with claims activity in the given week. The RA provides details about the adjudication of your claim.

Claim information on your RA is first grouped according to benefit plan (Nevada Medicaid or Nevada Check Up) and then by claim status (approved, denied, pended and/or financial transactions).

Your RA also includes a summary page(s) with the following information:

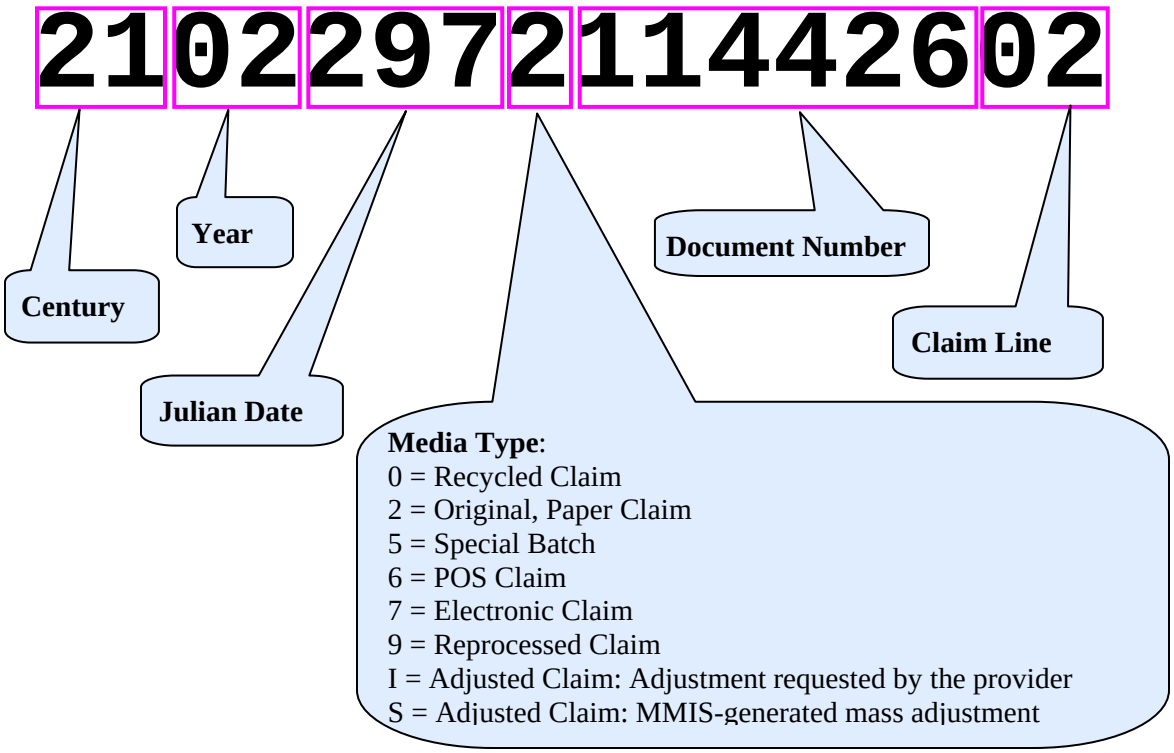
- Total amount paid for the claims on the RA
- Negative balance activity (if any)
- Year-to-Date total of Nevada Medicaid and Nevada Check Up payments
- The check number (or electronic funds transfer number) associated with payment for claims on this RA

How to Read a Claim's Internal Control Number

When we receive a claim, we immediately assign it an Internal Control Number ("ICN") for tracking purposes.

An ICN contains pieces of information about the claim as shown in the following diagram.

Figure J1



ICNs for Electronic Claims

Every claim line submitted electronically is viewed by the MMIS as one claim. The Document Number (see Figure J1 above) is increased by one for each electronic claim line. Electronic claims will always show "01" for the last two ICN digits.

ICNs for Adjusted Claims

Each time we adjust a claim, the claim is given a new, 16-digit ICN.

A claim's "original" ICN is the last ICN that was assigned to the claim. Always refer to the claim's last paid ICN when requesting an adjustment.

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

Receiving Your Payment

You can choose to receive your Nevada Medicaid and/or Nevada Check Up payment via a live check or an Electronic Funds Transfer ("EFT").

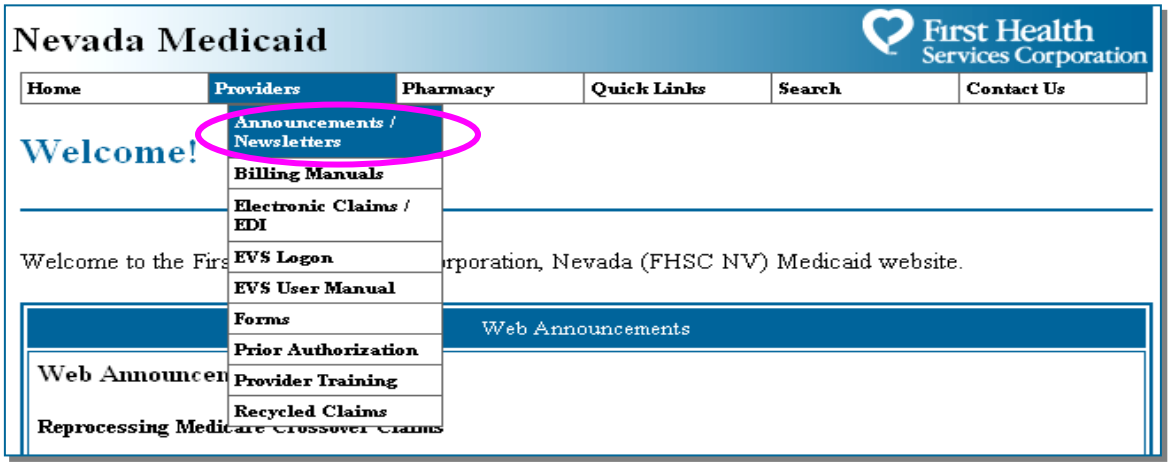
Reading Weekly Messages

Your weekly check or payment voucher may contain important messages for providers and billing staff.

Be sure to read these messages and disseminate them to all appropriate parties.

The most recent message is posted to the home page of First Health Services' web site, http://nevada.fhsc.com. If you do not have claims activity for a given week, you will need to go to the web site to read that week's message.

All old RA messages are accessible by selecting "Announcements / Newsletters" from the "Providers" drop-down menu.



Electronic Funds Transfer

If you are receiving a live check but would like to receive EFTs instead, submit an Electronic Funds Transfer Agreement (form FH-32).

Upon receipt of this form, we will test transfers with your banking institution and resolve any detected errors. The testing period is approximately four weeks.

You will continue to receive a paper check during the testing period.

After testing is complete, your payment will be deposited into your bank account each Tuesday. Instead of a live check, you will receive a payment voucher that includes the amount of payment and the transmittal number that was assigned to your EFT.

We track and monitor all EFTs to detect and resolve problems that may arise.

Your Payment Address and Remittance Advice Address

We mail your RA with your payment voucher or check unless you have requested, on your Provider Enrollment Application (FH-31), that these documents be mailed to separate addresses.

Changing Your Address

If you would like to change where these documents are being sent, mail the Provider Information Change Form (FH-33) to First Health Services and we will make the appropriate updates to your provider file.

Pended Claims

A claim "pends" or suspends processing when the MMIS determines there is cause for us to review it manually.

While a claim is pending, there is no action required by you.

Denied Claims

If your claim is denied, check the EOB Claim Code on your Remittance Advice. This tells you the claim error that was detected.

For example, if a claim is denied for recipient ineligibility, check your records to verify that (1) the correct dates of service were entered on your claim and (2) the recipient was Medicaid eligible on the date of service.

If you have questions regarding a claim that has been denied, please contact First Health Services' Customer Service Center at (877) 638-3472.

Resubmitting a Denied Claim

You can resubmit a claim if it has been denied. Before you resubmit, look at the EOB Claim Code on your Remittance Advice. This tells you the claim error that was detected.

Do not include the ICN of the original claim or an Adjustment/Void Reason code. Correct previous claims error(s) and resubmit. The MMIS handles these claims as an original submission.

Complete the claim form as described in the claim form instructions. Be sure that all required information is on your claim and that the code you are billing is a covered code.

When to Adjust or Void a Claim

Adjustments and voids apply only to claims that have been paid. You cannot adjust or void a claim that is pended or has been denied.

If a claim payment is incorrect, contact our Customer Service Center at (877) 638-3472. We may be able to identify and resolve the issue over the phone.

You must request an adjustment or void a claim within the Medicaid stale date period.

How to Request an Adjustment or Void a Claim

To request an adjustment or void a paper claim, refer to the CMS-1500, UB-92 or ADA claim form instructions as appropriate for your service type. Adjustments and voids may also be submitted electronically.

Unlike an original claim, on an adjustment or void submission, you must include:

1. The last paid Internal Control Number ("ICN") assigned to the claim.
2. The most appropriate Adjustment or Void Reason code.

Mail adjusted and voided paper claims to:

First Health Services
CMS-1500 Claim
PO Box 30031
Reno NV 89520-3031

Using the Overpayment Notification Form (FH-70)

If you have been overpaid for a claim, you may submit form FH-70 (the Overpayment Notification Form) instead of completing a new claim form as described above.

If there have been multiple adjustments to a claim, provide the last paid ICN assigned to the claim.

Appeals

You can appeal a claim that has been denied. You cannot appeal a claim that was paid incorrectly. If your claim was paid incorrectly, you must request an adjustment as described in earlier in this chapter.

If you do not agree with a denial of a claim, please contact our Customer Service Center at (877) 638-3472. We may be able to identify and resolve the issue over the phone or direct you on how to resubmit your claim so it can be paid.

How to File an Appeal

Appeals must be post marked no later than 30 days from the date on the RA showing the claim as denied.

An appeal must contain the following information:

1. A copy of the RA page(s) showing the denial.
2. A copy of the original signed claim.
3. Any documentation to support the issue, e.g., prior authorization, physician's notes, ER reports.
4. A cover letter. Your cover letter must state that you are appealing the denial of a claim and include the following information related to the appeal:
   - Reason for the appeal
   - Provider name and Medicaid Number
   - Internal Control Number (ICN) of the claim
   - Recipient's name and ID Number
   - Date(s) of service
   - Procedure code(s)
   - Name and phone number of the person First Health Services can contact regarding the appeal

Mail your appeal to us at the following address:

First Health Services
Attn: Appeals
PO Box 30026
Reno NV 89520-3026

Be sure to include "Attn: Appeals" on the outside of your envelope. Do not send claims in the same envelope with your appeal as this will delay the processing of your claim.

After You Submit an Appeal

We research all appeals and retain a copy of any documentation used in the determination process.

After processing your appeal, we will mail a Notice of Decision letter to you. This letter contains our decision regarding the appeal. Also included with the Notice of Decision letter is information on how to request a Fair Hearing through the DHCFP if you disagree with our decision.

How to Request a Fair Hearing

You may request a Fair Hearing through the DHCFP if you have already appealed the claim to First Health Services.

To request a Fair Hearing:

1. Complete the bottom portion of your Notice of Decision letter.
2. Attach a copy of the RA page(s) showing the denial
3. Include a copy of the original signed claim
4. Attach any documentation to support the issue (e.g., prior authorizations, physician's notes, ER reports)
5. Mail the Fair Hearing request to the address shown on your Notice of Decision letter.

The DHCFP must receive your Fair Hearing request no more than 30 days from the Notice Date shown on your Notice of Decision letter. The day after the Notice Date is considered the first day of the 30-day period.

After You Submit a Fair Hearing Request

Upon receipt of your Fair Hearing request, DHCFP will contact you to schedule a hearing preparation meeting. The hearing preparation meeting is offered by DHCFP as a way to assist all parties in understanding why the appeal was denied.

The meeting will include you, a representative from the DHCFP and a representative from First Health Services. You may have legal council represent you by indicating this on the Notice of Decision letter submitted with your Fair Hearing request.

The DHCFP representative attempts to reach an agreement between all parties during the hearing preparation meeting.

If an agreement cannot be reached, the DHCFP representative will advise you at that time of how to proceed with a Fair Hearing.

State Policy for Fair Hearings

For more information on Fair Hearings, please refer to Chapter 3100 of the Nevada Medicaid Services Manual.

You can access Chapter 3100 by visiting First Health Services' web site at http://nevada.fhsc.com. Select "DHCFP Web Site" from the "Quick Links" drop-down menu. Click "Medicaid Service Manuals." Scroll down the page and click on the link that reads "3100."