Nevada Medicaid and Nevada Check Up

Billing Manual

Prepared by:

First Health Services Corporation®

A Coventry Health Care Company




Table of Contents

About This Manual

Introduction

First Health Services maintains this manual and the website, http://nevada.fhsc.com, to support Nevada Medicaid and Nevada Check Up billing.

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

Audience

Please make this manual available to billing agents and medical and administrative staff. The provider is responsible for maintaining current reference documents for Medicaid billing.

Authority

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

Questions?

If you have questions regarding this manual, please contact First Health Services' Customer Service Center at (877) NEV-FHSC (638-3472).

Copyright Notices

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

Special Features

Bold Text

Bold text within a paragraph highlights a main point or draws special attention to key words.

Hyperlinks

Throughout this manual, there are instances of blue, underlined text called hyperlinks (or just "links"). Links point to one of the following:

- A document on First Health Services' website
- A page on First Health Services' website
- Another place in this manual
- Another website

Click the link to activate it. If the link points to a document or webpage, a new browser window (or tab) opens, leaving your original window unchanged.

Glossary

Look to the glossary for definitions of all acronyms used within the text of this manual.

Special Notes

Special notes are included throughout this manual to emphasize an idea or to add information to a topic.

Special notes marked with the symbol to the left convey important messages for providers and staff.

Revision History

The revision history below shows recent content changes to this manual.

March 10, 2009: This update included the removal of nevadamedicaid@fhsc.com as a valid contact email address for First Health Services. Providers should now call the Customer Service Center with any questions rather than sending an email to this address.

January 30, 2009: There were numerous updates in Chapter 3, "Recipient Eligibility," that reflect new policies and that update Welfare information. In Chapter 8, "Claims Processing and Beyond," an update was made in the list of potential 8th digit characters for a paid claim's ICN. For clarification, the following sentence was added to the "How to File an Appeal" section: If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days.

August 8, 2008: Updated Chapter 8 of this manual to reflect the mandatory Electronic Funds Transfer (EFT) payment policy for all new Nevada Medicaid providers and for all existing Nevada Medicaid providers upon re-enrollment.

July 13, 2007: Many changes were made to this manual in the July 13, 2007 revision. It is recommended that each provider review this manual in its entirety due to the large number of changes and updates, which include:

- NPI/API updates
- New Frequently Asked Questions throughout the manual
- Updated First Health Services mailing address
- Links to Internet documents and websites including forms and MSM Chapters
- Prior authorization requirements
- New TPL contractor contact information
- New MCO contact information

Chapter 1: Introduction and Provider Enrollment

Medicaid Goals

Nevada Medicaid strives to:

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

Roles and Responsibilities

Division of Health Care Financing and Policy

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

Division of Welfare and Supportive Services

The Division of Welfare and Supportive Services accepts applications for Medicaid assistance (not Nevada Check Up), **determines eligibility**, and creates and updates recipient case files. The latest information is transferred from the Division of Welfare and Supportive Services to First Health Services daily.

First Health Services (Fiscal Agent)

Effective October 1, 2003, First Health Services became the fiscal agent for Medicaid.

First Health Services handles:

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

Provider

Each provider is responsible to:

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

Records Retention

A provider's medical records must contain all information necessary to disclose the full extent of services (i.e., financial and clinical data).

Nevada Medicaid requires providers to retain medical records for at least five years; but recommends keeping them for at least six years from the date of payment.

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

Recipient

A recipient or their designated representative is responsible to:

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

Provider Enrollment

All providers must be enrolled with Medicaid to bill for services rendered to a Medicaid recipient.

Everything you need to enroll is on First Health Services' Provider Enrollment webpage. If you have any questions, contact the Provider Enrollment Unit at (877) 638-3472.

Changes to Enrollment Information

Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery (per Medicaid Services Manual, Chapter 100, section 103.3, December 2008).

Use form FH-33 to report changes. You may fax an address, fax or phone number change, to (775) 784-7932. All other changes must be submitted by mail, as they require the provider's **original signature**.

Discrimination

Federal law prohibits discrimination against any person on the grounds of age, color, disability, gender, illness, national origin, race, religion or sexual orientation that would deny a person the benefits of any federally financed program.

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

Fraud and Abuse

Federal law requires Medicaid to review suspected fraud and abuse and impose appropriate actions upon offending parties. Persons knowingly assisting a recipient or provider in committing fraud may also be held responsible.

Please **report suspected fraud and/or abuse to First Health Services at (877) 638-3472**. For more information on fraud and abuse policies, see MSM Chapter 3300.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA - Public Law 104-191) gives individuals certain rights concerning their health information, sets boundaries on how it is used, establishes formal safeguards and holds violators accountable.

HIPAA requires that healthcare workers never release personal health information to anyone who does not have a need to know.

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

Chapter 2: Contacts and Resources

Appeals Unit

To appeal a claim, mail the required documents to:

First Health Services
Appeals
P.O. Box 30042
Reno, NV 89520-3042

Appeal requirements are discussed later in this manual.

Automated Response System (ARS)

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

Phone: (800) 942-6511

Billing Manual and Billing Guidelines

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

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

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

It is important to be familiar with the Billing Guidelines for your provider type.

Claims Mailing Address

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

First Health Services
Claims
P.O. Box 30042
Reno NV 89520-3042

Mail **pharmacy** paper claims to:

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

Electronic Verification System (EVS)

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

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

Refer to the EVS User Manual if you have any questions or call, (877) 638-3472 and select the option for "EVS / Web Access Issues."

To obtain access to EVS, new users must contact the User Administration Console (UAC) Delegated or Local administrator for their office/facility. Your UAC administrator is also responsible for resetting lost or forgotten passwords. If you do not know who your UAC administrator is, call First Health Services' Web Support Call Center at (800) 241-8726.

First Health Services

Customer Service Center

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

When calling, have pertinent information ready (e.g., a claim's Internal Control Number (ICN), Recipient ID, National Provider Identifier (NPI) or Atypical Provider Identifier (API), Authorization Number).

Phone: (877) 638-3472, select the option to "verify or inquire on the status of a claim"

Mail: First Health Services
Customer Service
P.O. Box 30042
Reno NV 89520-3042

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

Electronic Data Interchange Department

The Electronic Data Interchange (EDI) Department handles electronic claims setup, testing and operations.

The Electronic Claims/EDI web page features EDI enrollment forms, Companion Guides, the Service Center User Manual, the Service Center Directory, a Payerpath presentation and more.

For more information, refer to the Electronic Data Interchange (EDI) chapter of this manual or contact the EDI Department at:

Email: nvedi@fhsc.com

Phone: (877) 638-3472, select the option for "electronic billing"

Fax: (775) 784-7932

Mail: First Health Services
EDI Coordinator
P.O. Box 30042
Reno NV 89520-3042

Pharmacy Department

The pharmacy department provides access to the following documentation for providers under the Pharmacy menu on First Health Services' website:

- Announcements/Training
- Billing Information
- Diabetic Supplies
- Forms
- MAC Information
- Meetings
- Pharmacy Web PA
- Preferred Drug List (PDL)
- Prescriber List

Technical Call Center Phone (for claims, and edit/override inquiries)**:** (800) 884-3238

Clinical Call Center Phone (to request prior authorization or ProDUR overrides)**:** (800) 505-9185

Clinical Call Center Fax: (800) 229-3943

Mail pharmacy paper claims to:

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

Prior Authorization Department

For prior authorization process and procedure, and information about the Online Prior Authorization System (OPAS), see the Prior Authorization chapter of this manual.

Authorizations for Most Services

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

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

Dental Authorizations
Phone: (800) 648-7593
Fax: (775) 784-7935
Mail: First Health Services, Dental PA,
P.O. Box 30042, Reno NV 89520-3042

Personal Care Services (PCS) Authorizations
Phone: (800) 648-7593, **Fax:** (775) 784-7935

Pharmacy Authorizations
Phone: (800) 505-9185, **Fax:** (800) 229-3943

Waiver Authorizations

Home and Community Based Waiver – Mental Retardation Services (provider type 38), call the Nevada Mental Health and Developmental Services (MHDS) at (775) 684-5943.

Home and Community Based Waiver for the Frail Elderly (the "CHIP" waiver, provider type 48), call the Department of Aging Services (DAS) at (775) 684-4210.

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

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

Provider Enrollment Unit

All enrollment documents are on the Provider Enrollment webpage under the Providers menu.

Contact the Provider Enrollment Unit with questions on enrollment certification and licensure requirements.

Providers are required to notify Nevada Medicaid **within five days** of knowledge of changes in professional licensure, facility/business/practice address, provider group membership or business ownership. To do this, submit form FH-33.

Phone: (877) 638-3472, select the option for "provider enrollment"

Mail: First Health Services
Provider Enrollment
P.O. Box 30042
Reno NV 89520-3042

Provider Training Unit

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

The Provider Training Catalog, special training announcements and training presentations are available on the Provider Training webpage.

Email: nvtraining@fhsc.com

Phone: (877) 638-3472

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

Medicaid Services Manual (MSM)

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

The MSM chapters are:

100: Eligibility, Coverage and Limitations
200: Hospital Services Program
300: Diagnostic Testing and Radiology Services
400: Mental Health and Alcohol/Substance Abuse Services
500: Nursing Facilities
600: Physicians
700: Rates
800: Laboratory Services
900: Private Duty Nursing
1000: Dental Services
1100: Ocular Program
1200: Prescription Services (Rx)
1300: Durable Medical Equipment (DME)
1400: Home Health Agency (HHS) Services
1500: Healthy Kids (EPSDT)
1600: Intermediate Care Facility for the Mentally Retarded (ICF-MR)
1700: Therapy Services
1800: Adult Day Health Care
1900: Transportation
2100: Home and Community Based Waiver (MR)
2200: Aging Waiver
2300: Physical Disability Waiver
2400: Comprehensive Outpatient Rehabilitation Services
2500: Targeted Case Management (TCM)
2700: Waiver for the Elderly in Adult Residential Care
2800: School Based Child Health Services
3100: Fair Hearing Process
3200: Hospice Services
3300: Surveillance and Utilization Review Section (SURS)
3500: Personal Care Services Program
3600: Managed Care Program (MCO)

Public Hearings

Providers are encouraged to attend public hearings and voice their opinion on policy changes.

Public hearing announcements are posted on the DHCFP website as they become available.

To request email notices for scheduled public hearings, please email Rita Mackie at rmackie@dhcfp.nv.gov.

Third Party Liability Records

Private Insurance

As of September 13, 2006, Health Management Systems (HMS) and Public Consulting Group (PCG) merged to become one company under HMS. HMS works with First Health Services to perform Third Party Liability (TPL) identification and recovery.

If you believe a recipient's private insurance records are incorrect, please contact HMS at:

Phone: (800) 856-8839
(775) 335-1040 in the Reno area

Email: renotpl@hmsy.com

HMS will research the issue and update the recipient's file if necessary.

Medicare

If you believe a recipient's Medicare record is incorrect, please contact the DHCFP at:

Phone: (775) 684-3687 or (775) 684-3628

Web Announcements

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

Websites

CMS

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

DHCFP

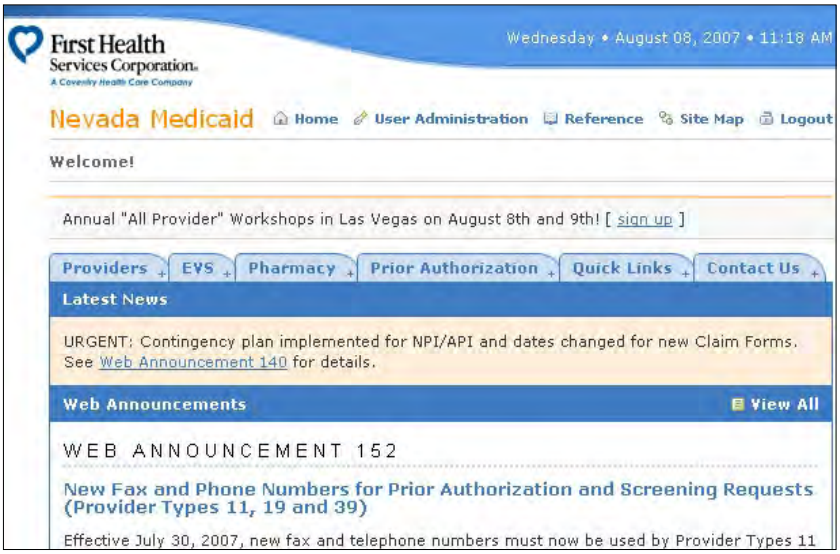
The DHCFP provides Nevada Medicaid and Nevada Check Up policy, rates, public notices and more via their website at http://www.dhcfp.nv.gov.

First Health Services Website

The First Health Services website, http://nevada.fhsc.com (exclude "www" after the "http://"), contains the most current billing information. It is updated regularly, and thus, we recommend visiting at least once a week. **In this manual, all references to webpages refer to First Health Services' website unless otherwise noted.**

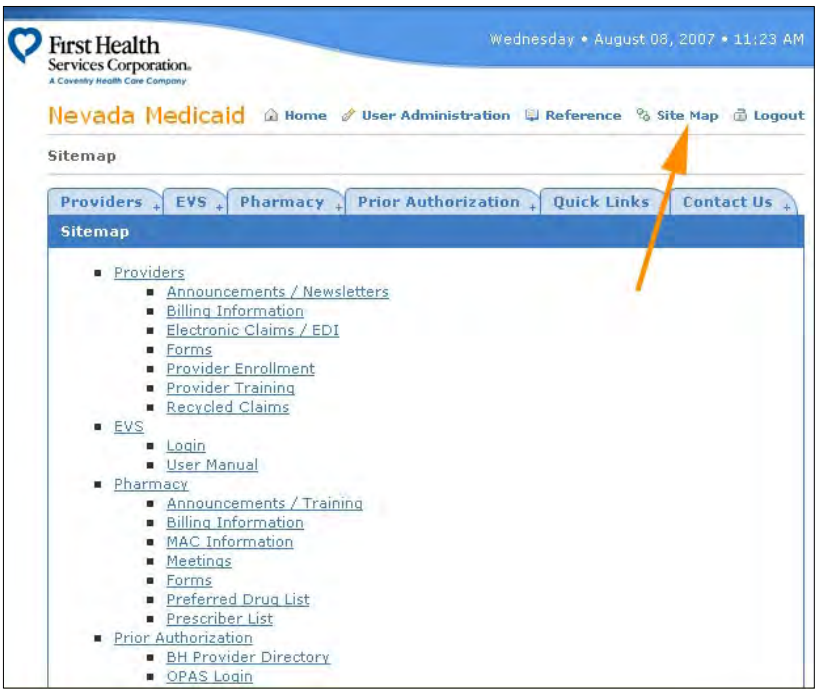
Homepage

This is the First Health Services homepage. This is the first page you arrive at when you go to http://nevada.fhsc.com. You can always come back to this page from anywhere on the site by clicking the "Home" link near the top, right of your screen.



Site Map

The website has 5 links across the top and 6 menus. Hover your mouse over any menu to see items under that menu. To see what is under all menus at once, click the Site Map link near the top, right of your screen.



Chapter 3: Recipient Eligibility and Managed Care

Determining Eligibility

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

The DHCFP determines recipient eligibility for Nevada Check Up. Related policy is in the Nevada Check Up Manual, Section 1000.

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

From 2-3 business days.

Verifying Eligibility and Benefits

It is important to verify a recipient's eligibility before providing services.

Eligibility can be verified through EVS, ARS, a swipe card system or a 270/271 electronic transaction (see Chapter 6 in this manual or the Companion Guide 270/271 for details). Each resource is updated daily to reflect the most current information.

EVS

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

Refer to the EVS User Manual if you have any questions or call, (877) 638-3472 and select the option for "EVS / Web Access Issues."

To obtain access to EVS, new users must contact the UAC **Delegated or Local administrator** for their office/facility. Your UAC administrator is also responsible for resetting lost or forgotten passwords. If you do not know who your UAC administrator is, call First Health Services' Web Support Call Center at (800) 241-8726.

Why can I query only 30 days of recipient eligibility status at a time?

EVS was designed around Nevada Medicaid's eligibility policy. If a recipient is determined eligible for a given month, they are eligible for all days within that month. Hence, EVS limits search capabilities to one month at a time.

Does EVS provide records of the recipient's service history?

Yes, but only the rendering provider can view a record of the service on EVS.

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

Wait 30 days before checking on paper claims and 3 days before checking on electronic claims. If your claim has not processed within these timeframes or if you have questions on how the claim was processed, contact the Customer Service Center at (877) 638-3472.

Identify Dual Eligibility Using EVS

Some recipients are eligible for both Medicaid and Medicare benefits. These recipients have "dual eligibility."

The figure at the top of the next page shows a portion of the EVS eligibility response screen. The left column, "Benefit Plan (Plan Coverage Desc)," lists the benefit plan(s) in which the recipient is enrolled.

If EVS lists "MEDICAID FFS" in this column, the recipient is eligible to receive full Medicaid benefits. In this example, the recipient is eligible for full Medicaid benefits as well as a Medicare coinsurance and deductible payable up to the Medicaid maximum allowable amount.

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

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

Identify MCO Enrollment Using EVS

If a recipient is enrolled in a Managed Care Organization (MCO), their first Benefit Plan line will read "CHECK-UP FFS," an abbreviation for Check Up Fee For Service or "MEDICAID FFS," an abbreviation for Nevada Medicaid Fee For Service.

As shown in the bottom figure on this page, the second line will read one of the following:

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

In this example of a Nevada Check Up recipient who is enrolled in an MCO, the white space near the top of the screen provides the name of the recipient's current MCO and the date of decision.

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

ARS

The ARS provides the **same information as** EVS, only via the phone.

Your NPI/API is required to log on.

Phone: (800) 942-6511

Swipe Card System

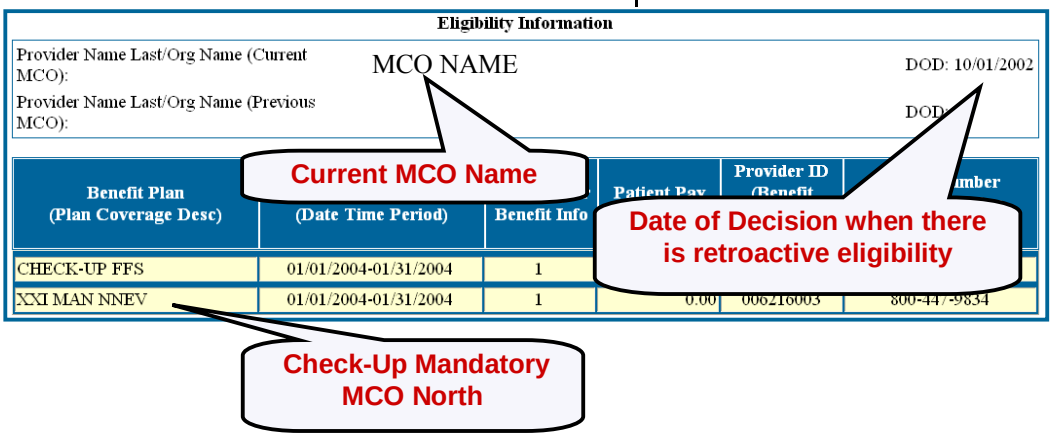
A recipient's Medicaid card includes a magnetic strip on the back. When used with a swipe card system, this magnetic strip provides "real-time" access to recipient information.

To implement a swipe card system, please **contact a swipe card vendor directly**. Vendors that are already certified with us are listed in the Service Center Directory.

Pending Eligibility

First Health Services cannot process prior authorization requests or claims for a recipient who is pending eligibility.

If prior authorization is required for a service, and the patient's eligibility is pending, the provider may request a **retroactive authorization** after eligibility has been determined (see the Prior Authorization chapter in this manual).



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

Can First Health Services' Customer Service Center tell a provider if the recipient is pending eligibility?

Yes, however, "pending" status simply means the individual has submitted their application for Medicaid benefits. It does not guarantee that they will be determined eligible.

Retroactive Eligibility

Nevada Check Up does not offer retroactive coverage.

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

Termination of Eligibility

Nevada Medicaid and Nevada Check Up eligibility generally stops at the **end of the month** in which a recipient's circumstances change.

A **pregnant woman** remains eligible through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income.

Are recipients notified when their Medicaid eligibility is terminated?

Yes. The Division of Welfare and Supportive Services mails notification to the recipient's address on file at least 13 days prior to the termination.

Sample Medicaid Card

When the recipient becomes eligible, he/she will receive a Medicaid card that will look similar to the image below. Note that a **Medicaid card does <u>not</u> reflect dates of eligibility or benefits** a recipient is eligible to receive. Eligibility must be determined as described in the previous sections.

Fee For Service vs. Managed Care

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

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

Enrollment in the MCO program is mandatory for most recipients in urban Washoe and Clark counties. MCO-enrolled recipients must receive services from an MCO network provider in order for Medicaid to cover the services. Providers in the MCO network must submit claims to the MCO. Because each MCO has unique billing guidelines, please contact the MCO directly if you have any billing questions.

Most **Nevada Check Up recipients** in urban Clark and Washoe counties are enrolled in an MCO beginning on their Date of Decision (i.e., their first day of coverage).

Most **Nevada Medicaid recipients** in urban Clark and Washoe counties are eligible to receive services under the FFS program beginning on their Date of Decision (i.e., their first day of coverage), and are then transitioned to an MCO on the first day of the following month.

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

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

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

MCO Contact Information

The two contracted MCOs are AMERIGROUP Community Care (effective February 1, 2009) and Health Plan of Nevada. If you have any questions about the MCOs, please call the DHCFP at (775) 684-3692 or refer to First Health Services' Web Announcement 239.

AMERIGROUP Community Care

Physician Contracting

Phone: (888) 281-1108

Provider Inquiry Line
(for eligibility, claims and pre-certification)

Phone: (800) 454-3730

Notification/Pre-certification

Phone: (800) 454-3730
Fax: (800)-964-3627

Claims Address:

AMERIGROUP Community Care
Attn: Nevada Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Health Plan of Nevada (HPN)

Phone: (800) 962-8074

Fax: (702) 242-9124

Claims Address:

Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89114

Chapter 4: Prior and Retrospective Authorization

Introduction

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

(800) 648-7593 – Dental services and PCS
(800) 525-2395 – All other services

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

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

Common services that require authorization are:

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

Ways to Request Authorization

Online Authorization

OPAS can be used to request authorization for Inpatient, Outpatient, Behavioral Health, Home Health, PASRR, Therapy and DME services.

Log in to OPAS through First Health Services' website at http://nevada.fhsc.com (select OPAS Login from the Prior Authorization menu).

To obtain access to OPAS, new users must contact the UAC Delegated or Local administrator for their office/facility. Your UAC administrator is also responsible for resetting lost or forgotten passwords. If you do not know who your UAC administrator is, call First Health Services' Web Support Call Center at (800) 241-8726.

OPAS tutorials are available on First Health Services' website and require a valid username and password to view.

Paper Requests

Services that cannot be requested through OPAS must be requested via a paper form. The Forms webpage has links to paper forms for all services.

Form users can type information directly into all form fields. While Adobe Reader cannot save the inputted information for future use, it allows users to print a paper copy of the form with the entered information. Requests may be faxed or mailed.

Prior authorization fax numbers are:

(775) 784-7935 – Dental services and PCS
(866) 480-9903 – All other services

Drug Requests and ProDUR Overrides

MSM Chapter 1200 and the Pharmacy Billing Manual discuss requirements for drug prior authorization. The generic pharmacy prior authorization request form and request forms for PDL Exception, COX-II, Proton Pump Inhibitors, Growth Hormones and ADHD treatment are on the Pharmacy Forms webpage.

Fax paper requests to **(800) 229-3943**.

For questions on prior authorization or ProDUR overrides, contact the Clinical Call Center at **(800) 505-9185**.

Submission Deadlines

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

An authorization request is not complete until First Health Services receives all pertinent clinical information.

Services listed below must be requested within the specified timeframes.

At least two business days prior to service:

- Inpatient Medical/Surgical
- Level of Care (LOC) assessment
- Routine Dental Services
- Inpatient Psychiatric Mental Health Identification Screening
- Neuropsychological Services
- Inpatient Acute Care (non-RTC)

At least three business days prior to service:

- Outpatient services

At least five business days prior to service:

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

At least seven business days prior to service:

- PASRR Level I evaluation

At least ten business days prior to service:

- Home Health re-assessment

Inpatient Acute Care

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

- **Emergency** admission transferred from a physician's office or emergency room
- **Obstetrical, maternity and newborn** admission greater than 3 days for vaginal delivery, and greater than 4 days for cesarean section (elective and emergency)
- **Tubal ligation** performed at the time of obstetric delivery
- **Neonatal Intensive Care Unit (NICU)** admission

Date of Decision During Inpatient Stay

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

If the recipient's DOD includes the admission date, an approved request can cover the entire stay, including day of admission.

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

Retrospective Authorization

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

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

After Submitting the Request

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

Incomplete Request

If First Health Services needs additional information to make a determination for your request, you will be notified by fax, phone or through OPAS (depending on how the request was submitted). You have **five business days** to submit the requested information or the request will be denied for insufficient information (a "technical denial").

Modify Request (Clinical Information)

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

Correct Request (Non-clinical Information)

Submit the Prior Authorization Data Correction Form, form FH-29, to correct or modify non-clinical, administrative data on a previously submitted request (e.g., dates of service).

Approved Request

When a request is approved, First Health Services or DHCFP provides an unofficial notification by phone, fax or through OPAS, as appropriate. The official written confirmation, the "Notice of Medical Necessity Determination" letter, is mailed to the provider the following day. Approved requests are assigned an 11-digit Authorization Number and a service date range.

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

Continued Stay Request

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

Adverse Determination

A denied or reduced authorization request is called an "adverse determination."

There are three types of adverse determination:

- **Technical Denial:** Issued when the provider has not submitted enough information for First Health Services or DHCFP to make a determination on the request and, after notification, the provider has not submitted the requested information within five business days.
- **Denial:** Issued when the service does not meet medical necessity based on clinical documentation submitted by the provider.
- **Reduction:** Issued when the requested service does not fully meet medical necessity based on clinical documentation submitted by the provider. The physician reviewer may approve a portion of the request, but will not approve a lower level of care without a request from the provider.

Reconsideration

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

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

First Health Services or DHCFP will notify the provider of the outcome of the reconsideration within 30 calendar days.

The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review.

Peer-to-Peer Review

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

Special Authorization Requirements Based on Recipient Eligibility

Dual Eligibility

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

Dual eligibles in Clark and Washoe Counties can join Molina's Medicare Advantage Special Needs Plan (MA-SNP) to manage all their Medicare health care benefits, including prescription drugs. To learn more about Molina Advantage, recipients can call (866) 403-8293 or visit the Molina website at www.molinahealthcare.com.

FFS

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

Managed Care

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

Medicare Benefits Exhausted

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

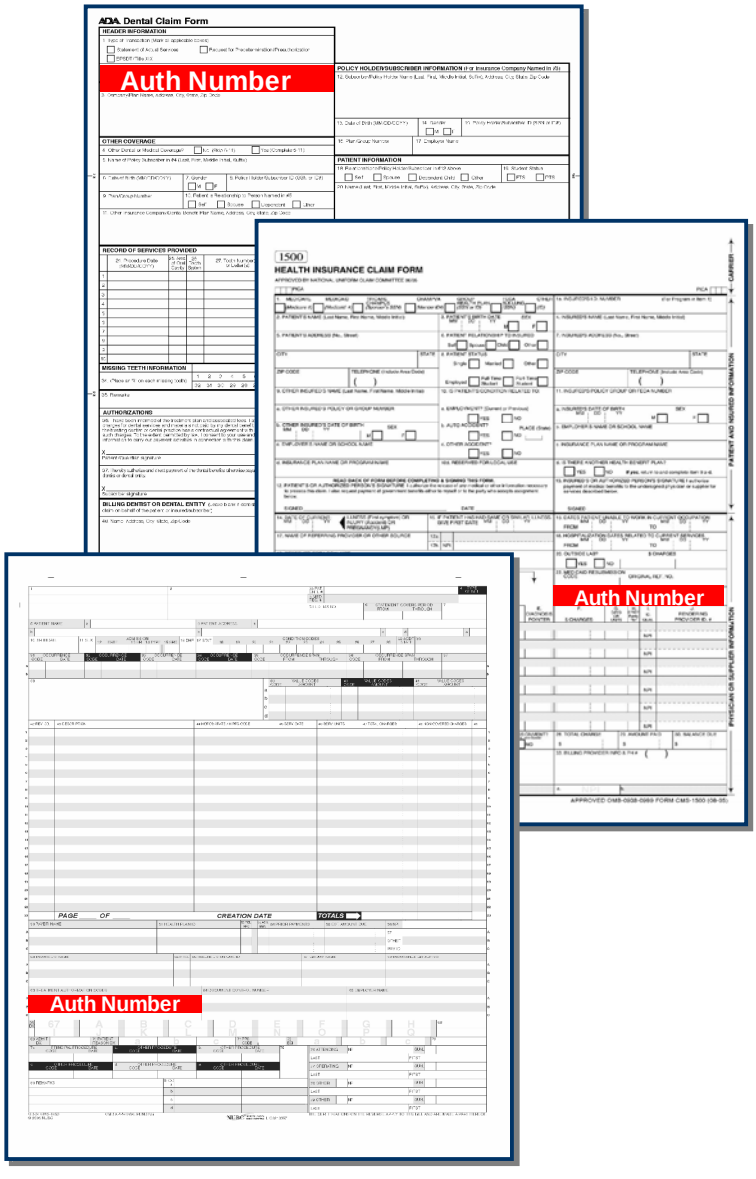
QMB Only

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

Claims for Prior Authorized Services

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

- Dates on the claim are within the date range of the approved authorization.
- Procedure codes on the claim match codes on the authorization.
- Units on the claim are not greater than the units authorized.
- Authorization Number is in the appropriate field on the claim.



Chapter 5: Third Party Liability (TPL)

TPL Policy

State policy regarding TPL is discussed in MSM Chapter 100.

Ways to Access TPL Information

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

How to Bill Claims with TPL

Refer to the CMS-1500, UB and ADA form instructions when submitting paper claims with TPL. The 837P, 837I and 837D Companion Guides contain First Health Services' specifications for electronic claim submission.

When billing claims with TPL:

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

Electronic Claims with TPL

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

Follow Other Payors' Requirements

Always follow other payors' billing requirements. If the other payor denies a claim because you did not follow their requirements, Medicaid will also deny the claim.

You may not collect payment from a recipient because you did not comply with the policies of Medicaid and/or the TPL.

How is payment determined on TPL claims?

Medicaid is usually the payer of last resort. The total combined payment of other insurance and Medicaid will not exceed the Medicaid maximum allowable payment.

When Medicaid Can be Billed First

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

- The recipient is involved in a trauma situation, e.g., an **auto accident**.
- The recipient is enrolled in an MCO and the service is billable under the FFS benefit plan (e.g., **orthodontia**). Note: Recipients enrolled in MCO must receive services from MCO providers unless the service is billable under the FFS benefit plan.
- The **service is not covered** by the recipient's TPL (e.g., Medicare).
- The recipient is enrolled in an **Indian/Tribal Health Services** plan.
- The recipient is enrolled in the **Children with Special Health Care Needs** program.
- The recipient is enrolled in the **State Victims of Crime** program.

You Can Bill the Recipient When…

You may bill recipients only in the following situations:

- The recipient's Medicaid **eligibility status is pending**. If you bill the recipient and they are found eligible for Medicaid with a retroactive date that includes the date of service, you must return the entire amount collected from the recipient and then bill Medicaid. For this reason, it is recommended that you hold claims until after eligibility is determined.
- **Medicaid does not cover the service and the recipient agrees to pay** by completing a written, signed agreement that includes the date, type of service, cost, verification

that the provider informed the recipient that Medicaid will not pay for the service, and recipient agreement to accept full responsibility for payment. This agreement must be specific to each incident or arrangement for which the client accepts financial responsibility.

- The TPL **payment was made directly to the recipient** or his/her parent or guardian. You may not bill for more than the TPL paid for services rendered.
- The **recipient fails to disclose** Medicaid eligibility or TPL information. If a recipient does not disclose Medicaid eligibility or TPL information at the time of service or within Medicaid's stale date period, the recipient assumes full responsibility for payment of services.

You May NOT Bill the Recipient When…

You may not bill the recipient:

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

Incorrect TPL Information

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

HMS can be reached at:

Phone: (800) 856-8839
Fax: (775) 335-1050
Email: renotpl@hmsy.com
Mail: 5257 Fairview Avenue, Suite 195, Boise, ID 83706

Do not send claims to HMS.

How should providers handle Medicare TPL discrepancies?

Contact the Department of Health Care Financing and Policy (DHCFP) at (775) 684-3703. They will research the request and update the Medicaid Management Information System (MMIS) as needed.

Claim Attachment for Incorrect TPL

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

Discovering TPL after Medicaid Pays

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

- Bill the primary insurance.
- After you have received payment from the primary insurance, submit a claim adjustment to First Health Services.

How often does First Health Services update their TPL information?

The Division of Welfare and Supportive Services sends the most recent TPL information to First Health Services daily.

Chapter 6: Electronic Data Interchange (EDI)

EDI Defined

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

The American National Standards Institute (ANSI) X12N committee sets the technical standards for health care EDI transactions. For more information, visit the ANSI web site.

Benefits of EDI

There are many benefits to using EDI, such as:

- Save money on envelopes, preprinted forms and postage.
- Eliminate certain data entry and document handling tasks.
- Reduce claim errors by validating fields before the claim reaches First Health Services.
- Quicker claims processing and quicker claims payment.
- Verify claim status within 48 hours of submission.

Common EDI Terms

The following are terms used by First Health Services when discussing EDI:

Clearinghouse

A "clearinghouse" is a business that submits claims to First Health Services on behalf of a provider. Payerpath is one example of a clearinghouse.

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

Direct Submitter

A provider that submits electronic claims to First Health Services using their practice management software is a "direct submitter."

Service Center

A "Service Center" is any entity that submits electronic claims to First Health Services. Clearinghouses and direct submitters are both Service Centers. If your business submits claims through a clearinghouse, your business is not a Service Center.

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

Introducing Payerpath

Payerpath is a clearinghouse contracted with First Health Services to provide free electronic claim submission for Medicaid claims.

Medicaid claims submitted through Payerpath are free of charge to Medicaid providers.

Payerpath is a claims management system that is accessed over the Internet. Users can also interface Payerpath with their current practice management system to upload claims (see the Payerpath Slideshow for New Users on First Health Services' EDI webpage).

Submitting claims through Payerpath requires an Internet-ready computer and Internet Explorer, version 6.0 or higher. You will also need to register as discussed later in this chapter.

Visit the Payerpath website for more information.

Available Transactions

The following is a list of EDI transactions used by First Health Services:

- **Transaction 270/271:** A request from you (the provider) to verify recipient eligibility including program coverage and benefits and First Health Services' response to your request.
- **Transaction 276/277:** A request from you to verify the status of a claim and First Health Services' response to your claim status request.
- **Transaction 278:** Your inquiry and First Health Services response to verify the status of one or more prior authorization requests.

- **Transaction 820:** Premium payment for enrolled MCO recipients.
- **Transaction 834:** Recipient enrollment/disenrollment to an MCO.
- **Transaction 835/277u:** The electronic Remittance Advice from First Health Services showing status and payment of the provider's most recent claims. The 277u transaction is also supplied to show claims with a pended status.
- **Transaction 837D:** Electronic dental claim submitted by the provider (paper equivalent is the ADA claim form).
- **Transaction 837I:** Electronic institutional claim submitted by the provider (paper equivalent is the UB-92/UB-04 claim form).
- **Transaction 837P:** Electronic professional claim submitted by the provider (paper equivalent is the CMS-1500 claim form).

NDCs may be entered now (see 837P Companion Guide, page 73 Addenda), but will not be used to process claims until January 1, 2008.

- **NCPDP:** National Council for Prescription Drug Programs Batch submitted by pharmacy providers.

Electronic Remittance Advice

To receive an electronic remittance advice, submit FH-37 form as described on the next page.

Although multiple clearinghouses may submit claims on your behalf, only one Service Center can accept your electronic remittance advice.

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

EDI Resources

The following documents are provided on First Health Services' Electronic Claims/EDI webpage.

The Service Center Directory

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

Payerpath Introductory Presentation

The Payerpath Introductory Presentation introduces the Payerpath clearinghouse and illustrates use of their web interface to submit claims electronically via the Internet.

Service Center User Manual

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

Companion Guides

There are ten Companion Guides on the Electronic Claims/EDI webpage. These guides provide clearinghouses and direct submitters with specific technical requirements for the submission of electronic claim data to First Health Services.

Links

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

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

How to Register for EDI

To submit electronic claims, complete the forms as explained below and mail them to:

First Health Services
EDI Coordinator
P.O. Box 30042
Reno, Nevada 89520-3042

Service Center Electronic Transaction Agreement (FH-35)

The FH-35 form defines the business relationship between the Service Center, the DHCFP and First Health Services.

Complete this form if you are a direct submitter or clearinghouse that would like to send claims to First Health Services on behalf of providers.

Service Center Operational Information Form (FH-36)

The FH-36 form provides First Health Services with your contact information, which electronic transactions you plan to provide and the contact information for your software vendor.

Complete this form if you are a direct submitter or clearinghouse that would like to send claims to First Health Services on behalf of providers.

Service Center Authorization Form for Providers (FH-37)

The FH-37 form allows you to:

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

Submit one FH-37 form for each billing NPI.

Payerpath Registration Form (FH-39)

To register for Payerpath's free claim submission service, each provider business must complete one FH-39 form.

Registration Scenarios

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

Submit claims through Payerpath:

Submit the FH-37 form and the FH-39 form. After your registration forms are processed, First Health Services will contact you with your username and initial password, which you can use to log on to Payerpath's web site and begin submitting claims.

Submit claims through a clearinghouse:

Submit the FH-37 form to give the clearinghouse permission to send/receive transactions on your behalf. First Health Services will notify the clearinghouse that you have registered to send/receive electronic transactions through them. Your clearinghouse will assist you in further setup and/or testing.

Submit claims using your current practice management software:

Submit one FH-35 form, one FH-36 form and one FH-37 form. First Health Services will contact you with your username, your initial password and your Service Center Code so that you may begin testing.

Submit claims on behalf of providers (for clearinghouses):

Submit one FH-35 form and one FH-36 form. First Health Services will contact you with your username, your initial password and your Service Center Code so that you may begin testing.

Chapter 7: Frequently Asked Billing Questions

Which NPI Do I Use on My Claim?

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

How Do I Get an API?

If you are classified by CMS as an "atypical" provider type, First Health Services issues and mails you your 10-digit number called an API after your Nevada Medicaid enrollment packet is processed.

Which Code Do I Use on My Claim?

Use HIPAA-compliant codes from the Revenue code, CPT, International Classification of Diseases, version 9 (ICD-9) and Healthcare Common Procedure Coding System (HCPCS) books that are **current for the date of service** on the claim.

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

How Do I Submit a "Clean" Paper Claim?

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

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

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

How Should I Fix a Mistake on a Claim?

If you make a mistake on the claim, **"white out"** the error and enter the correct information using blue or black pen. Do not initial the correction.

What is the Timely Filing (Stale Date) Period?

Claims without TPL that are submitted by in-state providers must be received within 180 days of the Date of Service or Date of Eligibility Decision–whichever is later.

Claims with TPL and claims submitted by **out-of-state providers** must be received within 365 days of the Date of Service or Date of Eligibility Decision–whichever is later.

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

Inaccurate, Illegible or Incomplete Claims

If a claim is denied or returned to you (e.g., illegible or incomplete claims), you are not given an additional 180 or 365 days to re-submit. Timely filing is always based on Date of Service or Date of Eligibility.

Exception to the Stale Date Period

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

If this applies to your claim, submit your claim and receive a denial for timely filing limitations. Then, follow the requirements in the "Appeals" section of this manual to submit a claim appeal.

How Much Do I Bill for a Service?

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

What Attachments Can Be Required?

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

Explanation of Benefits

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

Hysterectomy Acknowledgement Form

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

Sterilization Consent Form

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

Abortion Affidavit or Declaration

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

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

Sterilization and abortion policy for Medicaid is located on the Billing Information webpage.

What Else Should I Know About Attachments?

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

Chapter 8: Claims Processing and Beyond

Claims Processing

First Health Services processes all claims using an MMIS—an intricate computer system programmed to reflect and enforce Nevada Medicaid and Nevada Check Up policy.

The MMIS performs hundreds of validations (edits) on each claim. Examples include:

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

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

How to Check Claim Status

Through EVS, ARS or a swipe card system, you can access the status of your claims. Please wait 72 hours to check claim status if the claim was submitted electronically and 30 days if the claim was submitted on paper.

Your Remittance Advice

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

First Health Services provides paper RA by default. You can receive electronic RAs by submitting the FH-37 form (setup takes 1-2 weeks).

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

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

Appendix A of this manual explains the RA for institutional (UB) claims and Appendix B explains the RA for professional and dental (CMS-1500 and ADA) claims.

RA Messages

Your weekly check or payment voucher may include important announcements for providers and billing staff. Please pay attention to these messages and disseminate them to all appropriate parties.

Frequently Asked RA Questions

Can I see my RA online?

No. However, you may register to receive an electronic RA by submitting the FH-37 form (setup takes 1-2 weeks). Contact the First Health Services EDI Unit at (877) 638-3472 if you have any questions.

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

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

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

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

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

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

What information is included on my RA?

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

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

Parts of the ICN

When First Health Services receives a claim, the claim is assigned an ICN for tracking purposes. An ICN contains the following information about the claim.

- Digits 1 and 2 denote the century.
- Digits 3 and 4 denote the year.
- Digits 5, 6 and 7 denote the Julian date.
- Digit 8 denotes the media type as follows:
  - 0 – Recycled claim
  - 2 – Original, paper claim
  - 5 – Special batch claim
  - 6 – POS claim
  - 7 – Electronic claim
  - 8 – Recycle, paper claim
  - 9 – Reprocessed claim
  - C – Clinical Claim Editor, new line
  - I – Provider-adjusted claim
  - K – Clinical Claim Editor, voided line
  - S – MMIS-generated mass adjustment
- Digits 9-14 denote the sequential document number assigned by First Health Services.
- Digits 15 and 16 denote the claim line.

ICNs for Electronic Claims

Every electronic claim line is viewed by the MMIS as its own claim. The document number (digits 9-14) is increased by one for each claim line. Electronic claims always have "01" as the last two ICN digits.

ICNs for Adjusted Claims

Each time First Health Services adjusts a claim, the claim is given a new ICN.

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

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

Pended Claims

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

Denied Claims

If your claim is denied, compare the "EOB Code" on the RA with your record of service. This is located near the end of your RA and is formatted as shown in the figure below.

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

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

Resubmitting a Denied Claim

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

When you resubmit a denied claim, the MMIS handles it as an original claim. **Do not include an ICN or Adjustment/Void Reason code** on your resubmission.

Adjustments and Voids

Can I adjust or void a claim electronically?

Yes. All claims can be adjusted/voided electronically.

Adjustments and voids must be submitted within the stale date period outlined in Chapter 7 of this manual.

Only a paid claim can be adjusted or voided (**adjustments/voids do not apply to pended and denied claims**). Remember that pended claims require no action from the provider and resending a denied claim is considered a "resubmission" as discussed in the previous section.

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

Paper Adjustments and Voids

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

Remember:

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

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

Electronic Adjustments and Voids

For electronic adjustments and voids, refer to instructions in the applicable Companion Guide: 837I, 837P or 837D.

Handling Processing Errors

If you have been overpaid for a claim, or if your claim was processed incorrectly, please notify First Health Services by submitting form FH-72.

Please note that form FH-72 cannot be used to correct an improperly billed claim or to dispute a denied claim. Adjustments, voids and appeals must be handled as described in the next section.

Filing a Claim Appeal

You can appeal a denied claim, but you cannot appeal a claim because it was paid incorrectly. Handle incorrect payments by submitting an adjustment as discussed in the previous sections.

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

How to File an Appeal

Appeals must be post marked no later than 30 calendar days from the date on the remittance advice listing the claim as denied. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days.

To submit an appeal, include each component listed below:

- A cover letter that contains all of the following:
  - A statement saying that you are appealing a denied claim
  - Reason for the appeal
  - Provider name and NPI/API
  - Recipient name and ID
  - The claim's ICN
  - Date(s) of service
  - Procedure code(s)
  - Name and phone number of the person First Health Services can contact regarding the appeal

- Documentation to support the issue, e.g., prior authorization, physician's notes, ER reports
- A copy of the most recent RA page showing the denial
- A copy of the original claim

Mail your appeal (cover letter, documentation, RA page and copy of original claim) to:

First Health Services
Attention: Appeals
P.O. Box 30042
Reno NV 89520-3042.

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

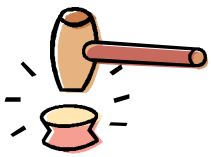
After You File an Appeal

First Health Services researches appeals and retains a copy of all documentation used in the determination process.

First Health Services sends a Notice of Decision letter when a determination has been reached.

Fair Hearings

If your appeal is denied, you can request a Fair Hearing. When applicable, instructions for requesting a Fair Hearing are included with your Notice of Decision.



A Fair Hearing request must be received no later than 90 days from the Notice Date on the Notice of Decision letter. The day after the Notice Date is considered the first day of the 90-day period.

For additional information on Fair Hearings, please refer to MSM Chapter 3100.

Provider Payment

Nevada Medicaid sends all provider payments via Electronic Funds Transfer (EFT). To change the bank account to which your funds are deposited, complete and submit form FH-33. First Health Services tracks and monitors all EFTs to detect and resolve problems that may arise.

Glossary

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

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

ANSI – American National Standards Institute: The Institute oversees the creation, promulgation and use of thousands of norms and guidelines that directly impact businesses in nearly every sector. http://www.ansi.org

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

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

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

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

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

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

DME – Durable Medical Equipment: A DME provider provides medical equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

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

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

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

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

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

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

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

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

HMS – Health Management Systems: HMS works with First Health Services to perform Third Party Liability (TPL) identification and recovery.

ICD-9 – International Classification of Diseases, 9th Revision: A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of recipients.

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

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

MMIS – Medicaid Management Information System: An intricate computer system programmed to reflect and enforce Nevada Medicaid and Nevada Check Up policy for providers, recipients, claims, pharmacy and health care management.

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

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

OPAS – Online Prior Authorization System: A First Health Services web application that allows certain provider types to request an authorization and communicate with reviewers via the Internet.

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

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

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

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

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

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

UAC – User Administration Console: A web-based registration and user management tool that allows providers to manage user access to First Health Services' web-based applications.