Provider Web Portal (PWP) User Manual

Chapter Three: Claims

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Chapter 3. Claims

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

For provider specific billing information refer to the [Billing Guidelines (by Provider Type)](#).

3.1 Submit Claim

The **Claims** tab provides the ability to submit dental, institutional, and professional claims. To begin the claim submission process, select one of the submit claim options from the **Claims** submenu, or click on the **Claims** tab to be directed to the claims landing page.

Claims submenu options:
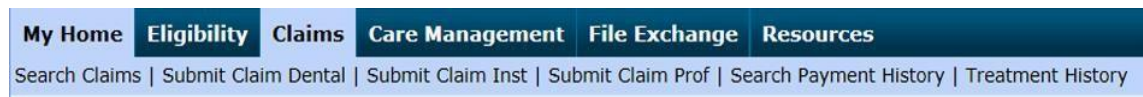
Claims landing page:

Navigation Notes

Do not use the links that appear at the top of the page to navigate between steps of the claims submission process. This could cause data to be lost. Always use the Back to Step buttons at the bottom of the pages to move between steps. If you have successfully updated any information on a step and return to the previous step, your information is not lost.

Example:

You completed Step 1 and continued to Step 2, where you successfully added or updated the diagnosis code information. You return to Step 1 to indicate that the claim is the result of an accident. When you return to Step 2, the diagnosis information you added previously still appears.

If you add or modify information on a step and click the **Continue** button without saving the information, a warning message will display.

Example:

You added a diagnosis code, but did not click Add. You click Continue to proceed to Step 3. You are prompted with a warning that you will lose unsaved data by navigating away from the page.

3.1.1   Submit Claim Dental

Select **Submit Claim Dental** to create and submit a dental claim.

Claim submission is a three-step process, click on the **Continue** button at the bottom of each page to continue on to the next step. Click on the **Cancel** button to cancel the creation of the claim.

- Step 1-Provider, Patient and Claim Information
- Step 2-Diagnosis Codes and Other Insurance Details
- Step 3-Service Details and Attachments

Submit Dental Claim: Step 1

All of the fields marked with a red asterisk (*****) are required fields.

Provider Information

The Billing Provider Information is automatically populated with the Billing Provider ID and ID Type of the provider that the signed-in user is associated with.

The following fields can be completed as follows:

- Billing Provider Service Location – Select the appropriate provider type/service location for the type of service being billed
- Rendering Provider ID – If applicable enter the rendering provider NPI
  - ID Type –Select NPI from the drop-down list
- Rendering Provider Service Location – If a rendering provider ID is entered, a rendering provider service location is required; Select the appropriate provider type/service location for rendering provider
- Referring Provider ID – If applicable enter the referring provider NPI
  - ID Type –Select NPI from the drop-down list
- Service Facility Location ID – If applicable enter the service facility NPI
  - ID Type – Select NPI from the drop-down list

Patient Information

Enter the 11-digit recipient ID in the Recipient ID field. The Last Name, First Name, and Birth Date will be automatically populated based for the recipient ID that is entered.

Claim Information

The following fields can be completed as follows:

- Accident Related – If the claim is related to accident, select the accident type from the drop-down list

- Accident Date – Enter the date of the accident

- Accident State – Displays if Auto Accident is selected in the Accident Related drop-down list

- Accident Country – Displays if Auto Accident is selected in the Accident Related drop-down list

- Place of Treatment – Select the place of treatment from the drop-down list

- Patient Number – Enter a patient number

- Authorization Number – If applicable, enter the prior authorization number for the service(s) being billed on the claim

- Include Other Insurance – If the recipient has other insurance that paid as primary, check this box; When this box is checked the Other Insurance Information panel will appear on the Submit Dental Claim: Step 2

- Total Charged Amount – Read only and displays the total charge amount associated with the claim

Submit Dental Claim: Step 2

When the Submit Dental Claim: Step 2 page is first displayed all of the panels are expanded. Click **Collapse All** to close all panels, or click the minus icons on each panel to close only that panel.

Click **Expand All** to expand all panels, or click the plus icons on each panel to open only that panel.

Diagnosis Codes

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- The PWP allows for up to 8 diagnosis codes
- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the **Add** button to add each diagnosis code
- Click the **Remove** link to remove any diagnosis codes added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

Other Insurance Details

If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto populate in the Other Insurance Details panel. Other Insurance Details fields are required only if you are adding other insurance payment information.

- Select the sequence number to add payment information.
- Click the **Save Insurance** button to save the information to the other insurance details line.
- Click the **Cancel Insurance** button to cancel any updates to the other insurance details
- Click the **Continue** button to continue to Submit Dental Claim: Step 3.
- Click the **Remove** link to remove any other insurance details not relevant to the claim.

Please note: For Dental claims, only payment information is required at the header level. The "Claim Adjustment Details" panel should be collapsed.

If the recipient does not have other insurance carrier information on file with Nevada Medicaid, the policy information will not auto populate in the Other Insurance Details panel. Other Insurance Details can be added by completing the following fields:

- Carrier Name – Enter the other insurance carrier name
- Carrier ID – Enter the other insurance carrier ID

- Policy Holder Last Name – Enter the last name of the policy holder

- First Name – Enter the first name of the policy holder

- MI – Enter the middle initial of the policy holder

- Policy ID – Enter the policy ID

- Insurance Type – Select the insurance type from the drop-down list

- Responsibility – Select the responsibility type from the drop-down list

- Patient Relationship to Insured – Select the patient relationship to insured from the drop-down list

- Payer Paid Amount – Enter the amount paid by the other insurance

- Paid Date – Enter the date the other insurance paid

- Remaining Patient Liability – Enter the remaining patient liability

- Claim Filing Indicator – Select the claim filing indicator from the drop-down list.

All of the fields marked with a red asterisk (*) are required fields.

Click the **Add Insurance** button to add the Other Insurance Details to the claim.

Updating Other Insurance Details

Select the sequence number of any other insurance line item to update details such as the allowed amount, paid amount, paid date and adjustment codes for the specific other insurance carrier.

- Click the **Save Insurance** button to save the information to the other insurance details line

- Click the **Cancel Insurance** button to cancel any updates to the other insurance details

- Click the **Remove** link to remove any other insurance details added to the claim in error

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	Blue Shield	12345	000000011	$15.00	01/01/2019	Remove

Carrier Name	Blue Shield	**Carrier ID**	12345	
*Policy Holder Last Name	KJUYD	***First Name**	PXMYE	**MI**
*Policy ID	000000011			
Insurance Type				
*Responsibility	P-Primary	***Patient Relationship to Insured**	18-Self	
Payer Paid Amount	15.00	***Paid Date** ❶	01/01/2019	
Remaining Patient Liability	100.00			
*Claim Filing Indicator	BL-Blue Cross/Blue Shield			

Claim Adjustment Details ➕

Save Insurance   **Cancel Insurance**

➕ Click to add a new other insurance.

Back to Step 1   **Continue**   **Cancel**

Click the **Continue** button to continue to Submit Dental Claim: Step 3.

Submit Dental Claim: Step 3

When the Submit Dental Claim: Step 3 page is first displayed not all of the panels are expanded.

- Click **Expand All** to expand all panels, or click the plus icons on each panel to open only that panel.

- Click **Collapse All** to close all panels, or click the minus icons on each panel to close only that panel.

All of the fields marked with a red asterisk (*) are required fields.

Service Details

- Up to 50 service details to be added to a dental claim

- Procedure codes are searchable

  - Enter the first three letters or the first three numbers of the code to use the predictive search

- Modifiers are searchable

        o   Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search

- Click the **Add** button to add each service detail

- Click the **Remove** link to remove any service detail added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

Updating Service Details

Select the sequence number of any service detail line item to update details such as the service date, procedure code, units or charge amount.

- Click the **Save** button to save the changes
- Click the **Reset** button to clear any of the changes to the service detail
- Click on the **Cancel** button to cancel any updates and close the service detail

Adding Other Insurance Details on Service Detail line

Select the sequence number of any service detail line item to add other insurance details and claim adjustment details.

1. Add Other Insurance Details first and click the **Add Insurance** button.

2. Click the sequence number in the Other Insurance for Service Detail panel to add the Adjustment Details.

3. Enter the Claim Adjustment Details and click the **Add Adjustment** button to add adjustment information for the other insurance.

4. Click the **Save Insurance** button to save the other insurance information with the claim adjustment details.

5. Click the **Save** button to save the updates to the Service Detail Line.

Attachments

To include attachments electronically with a claim:

- Transmission Method – FT - File Transfer is selected by default

- Upload file – click the **Browse** button and locate the file on your computer to be attached

- Attachment Type – select the type of attachment from the drop-down list

- A description of the attachment can be entered, but it is not required

- Click the **Add** button to attach the file

- Repeat for additional attachments if needed up to 10 attachments can be added per claim (Note: the combined size of all attachments cannot exceed 4MB)

- To remove any attachments that were attached incorrectly, use the "Remove" link

- Click on the **Cancel** button to cancel and close the attachment line

#	Transmission Method	File	Control #	Attachment Type	Action
1	FT-File Transfer	Test doc.pdf (104K)	20180613570143	OZ-Support Data for Claim	Remove

All of the fields marked with a red asterisk (*) are required fields.

Claim Submission

Click the Submit button to complete the claim creation process.

Confirm Dental Claim

After clicking the Submit button, the Confirm Dental Claim page will display with the claim details to review before submission.

Confirm Dental Claim [?]

Select Print Preview **before** you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

Provider Information

Billing Provider ID	1124098421	ID Type	NPI
Billing Provider Service Location	20-RENOWN REGIONAL MEDICAL CENTER-1155 MILL ST,RENO,NEVADA,895021576		
Rendering Provider ID	_	ID Type	_
Rendering Provider Service Location	_		
Referring Provider ID	_	ID Type	_
Service Facility Location ID	_	ID Type	_

Patient Information

Recipient ID	53239301555		
Recipient	ILHWL H MZDAIF	Gender	Male
Birth Date	12/16/2002		

Claim Information

Accident Related	_	Accident Date	_
Place of Treatment	11-Physician's Office		
Patient Number	12345		
Authorization Number	_		
Previous Claim ICN	_		
Note	_		
		Total Charged Amount	$150.00

Expand All | Collapse All

Diagnosis Codes [+]

Other Insurance Details [-]

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date
1	DELTA HEALTH SYSTEMS	02324	50998842		11/01/2019

Service Details [-]

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Svc Date	Oral Cavity Area	Tooth Number	Tooth Surface	Procedure Code	Mod	Units	Charge Amount
1	04/01/2018		2-2nd Molar-UR-Permanent		D0350		1	$150.00

No Attachments exist for this claim

[Back to Step 1] [Back to Step 2] [Back to Step 3] [Print Preview]   [Confirm] [Cancel]

- Click the **Confirm** button to submit the claim
- Click the **Print Preview** button to print a copy of the Confirm Dental Claim page
- Click on the **Cancel** button to cancel the claim submission

Submit Dental Claim: Confirmation

The Submit Dental Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

- Click the **Print Preview** button to view the claim details
- Click the **Copy** button to copy claim data
- Click the **Adjust** button to resubmit the claim
- Click the **New** button to submit a new claim
- Click the **View** button to view the details of the submitted claim

3.1.2   Submit Claim Inst

Select **Submit Claim Inst** to create and submit an **Institutional** claim.

Claim submission is a three-step process, click on the **Continue** button at the bottom of each page to continue on to the next step. Click on the **Cancel** button to cancel the creation of the claim.

- Step 1-Provider, Patient and Claim Information
- Step 2-Diagnosis Codes and Other Insurance Details
- Step 3-Service Details and Attachments

Submit Inst Claim: Step 1

All of the fields marked with a red asterisk (*) are required fields.

Claim Type

Use the Claim Type drop-down to indicate the type of institutional claim.

Provider Information

The Billing Provider Information is automatically populated with the Billing Provider ID and ID Type of the provider that the signed-in user is associated with.

All of the fields marked with a red asterisk (*) are required fields. The following fields can be completed as follows:

- Billing Provider Service Location – Select the appropriate provider type/service location for the type of service being billed

- Institutional Provider ID – If applicable enter the institutional provider NPI

    o ID Type –Select NPI from the drop-down list

- Attending Provider ID – If applicable enter the attending provider NPI

    o ID Type –Select NPI from the drop-down list

- Operating Provider ID – If applicable enter the operating provider NPI

    o ID Type –Select NPI from the drop-down list

Patient Information

Enter the 11-digit recipient ID in the Recipient ID field. The Last Name, First Name, and Birth Date will be automatically populated based on the recipient ID that is entered.

All of the fields marked with a red asterisk (*) are required fields.

Claim Information

The required information in the Claims Information panel depends on the type of institutional claim that is being created.

Admission Type, Admission Source, Admitting Diagnosis, and Patient Status are searchable. Enter the first three letters or the first numbers of the code to use the predictive search.

For example:

Claim Information panel for Inpatient, Inpatient Crossover and Long Term Care claims

All of the fields marked with a red asterisk (*) are required fields

Claim Information panel for Outpatient and Outpatient Crossover claims

All of the fields marked with a red asterisk (*) are required fields.

The following fields can be completed as follows:

- Covered Dates – Enter the covered dates of service for the claim

- Admission Date/Hour – Enter the date and time of admission

- Discharge Hour – Enter the time the recipient was discharged from care

- Admission Type – Enter a patient number

- Admission Source – Enter the source of admission

- Admitting Diagnosis Type – ICD-10-CM is selected by default, ICD-9-CM can also be selected if applicable

- Admitting Diagnosis – Enter the diagnosis code for the diagnosis that was present at time of admission

- Patient Status – Enter the patient status

- Facility Type Code – Select the correct facility type code from the drop-down list

- Patient Number – Enter patient number

- Authorization Number – If applicable, enter the prior authorization number for the service(s) being billed on the claim

- Include Other Insurance – If the recipient has other insurance that paid as primary, check this box; When this box is checked the Other Insurance Information panel will appear on the Submit Institutional Claim: Step 2

- Total Charged Amount – Read only and displays the total charge amount associated with the claim

Medicare Crossover Details

The Medicare Crossover Details panel will display when Crossover Inpatient or Crossover Outpatient is selected as the claim type.

Use the Medicare Explanation of Benefits to complete the following fields as applicable:

- Allowed Medicare Amount

- Deductible Amount

- Co-insurance Amount

- Blood Deductible Amount

- Medicare Payment Date

- Medicare Payment Amount

Submit Institutional Claim: Step 2

When the Submit Institutional Claim: Step 2 page is first displayed all of the panels except for diagnosis are collapsed. Click **Expand All** to open all panels, or click the plus icons on each panel to open only that panel.

Submit Institutional Claim: Step 2 ?

* Indicates a required field.

Claim Type	Inpatient

Provider Information

Billing Provider ID	1407146111	**ID Type**	NPI

Patient and Claim Information

Recipient ID	53239301555		
Recipient	ILHWL H MZDAIF	**Gender**	Male
Birth Date	12/16/2002	**Total Charged Amount**	$0.00
Covered Dates	07/01/2018 - 07/05/2018	**Admission Date/Hour**	07/01/2018 - 05:23
Admitting Diagnosis Type	ICD-10-CM	**Admitting Diagnosis**	V80010A-Animl-ridr injured by fall fr horse in nonclsn acc, init

Expand All | Collapse All

Diagnosis Codes −

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	POA	Action
1				

1 *Diagnosis Type [ICD-10-CM ▼]   *Diagnosis Code ⓘ [_____]
   Present on Admission [No   ▼]

[Add]   [Reset]

External Cause of Injury Diagnosis Codes ➕

Condition Codes ➕

Occurrence Codes ➕

Value Codes ➕

Surgical Procedures ➕

[Back to Step 1]   [Continue]   [Cancel]

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Click **Collapse All** to close all panels, or click the minus icons on each panel to close only that panel.

Submit Institutional Claim: Step 2

* Indicates a required field.

Claim Type   Inpatient

Provider Information

| Billing Provider ID | 1538 | . | ID Type | NPI |

Patient and Claim Information

Recipient ID	00000000001			
Recipient	ISAAC E CLMGLZ		Gender	Male
Birth Date	01/01/1999		Total Charged Amount	$0.00
Covered Dates	05/01/2018 - 05/10/2018		Admission Date/Hour	05/01/2018 - _
Admitting Diagnosis Type	ICD-10-CM		Admitting Diagnosis	W261XXA-Contact with sword or dagger, initial encounter

Expand All   Collapse All

Diagnosis Codes   −

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	POA	Action
1				

1	*Diagnosis Type [ICD-10-CM ∨]	*Diagnosis Code ❶ [ ]
	Present on Admission [No ∨]	

[Add]   [Reset]

External Cause of Injury Diagnosis Codes   −

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Diagnosis Type	External Cause of Injury Diagnosis Code	Action
1			

1	*Diagnosis Type [ICD-10-CM ∨]	*External Cause of Injury Diagnosis Code ❶ [ ]

[Add]   [Reset]

Other Insurance Details   −

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
⊞ Click to add a new other insurance.						

Condition Codes   −

Click the **Remove** link to remove the entire row.

#	Condition Code	Action
1		

1	*Condition Code ❶ [ ]

[Add]   [Reset]

Occurrence Codes   −

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
For an Occurrence Code enter the same From and To Date. For an Occurrence Span enter the From and To dates of the span.

#	Occurrence Code	From Date	To Date	Action
1		_	_	

1	*Occurrence Code ❶ [ ]	*From Date ❶ [ ] 📅	*To Date ❶ [ ] 📅

[Add]   [Reset]

Value Codes   −

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Value Code	Amount	Action
1			

1	*Value Code ❶ [ ]	*Amount [ ]

[Add]   [Reset]

Surgical Procedures   −

Operating Provider is required to be entered back on Step 1 to allow for entry of surgical procedure codes within this panel.

[Back to Step 1]   [Continue]   [Cancel]

Go to Top

Diagnosis Codes

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- The PWP allows for up to 8 diagnosis codes

- Diagnosis codes are searchable

    o Enter the first three letters or the first three numbers of the code to use the predictive search

- Click the **Add** button to add each diagnosis code

- Click the **Remove** link to remove any diagnosis codes added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

External Cause of Injury Diagnosis Codes

If applicable enter the external cause of injury diagnosis codes.

- Diagnosis codes are searchable

    o Enter the first three letters or the first three numbers of the code to use the predictive search

- Click the **Add** button to add each diagnosis code

- Click the **Remove** link to remove any diagnosis codes added to the claim in error

Patient Reason for Visit Diagnosis Codes

The patient reason for visit diagnosis codes only displays on institutional claims with an outpatient claim type. If applicable enter the patient reason for visit diagnosis codes.

- Diagnosis codes are searchable

    o Enter the first three letters or the first three numbers of the code to use the predictive search

- Click the **Add** button to add each diagnosis code

- Click the **Remove** link to remove any diagnosis codes added to the claim in error

Other Insurance Details

If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto populate in the Other Insurance Details panel. Other Insurance Details fields are required only if you are adding other insurance payment information.

- Click **Add Adjustment** to add claim adjustment details to the other insurance details line

- Click **Save Insurance** to save the information to the other insurance details line

- Click **Cancel Adjustment** to cancel any updates to the claims adjustment details

- Click **Cancel Insurance** to cancel any updates to the other insurance details

- Click the **Remove** link to remove any other insurance details added to the claim in error

If the recipient does not have other insurance carrier information on file with Nevada Medicaid, the policy information will not auto populate in the Other Insurance Details panel. Other Insurance Details can be added by completing the following fields:

- Carrier Name – Enter the other insurance carrier name

- Carrier ID – Enter the other insurance carrier ID

- Policy Holder Last Name – Enter the last name of the policy holder

- First Name – Enter the first name of the policy holder

- MI – Enter the middle initial of the policy holder

- Policy ID – Enter the policy ID

- Insurance Type – Select the insurance type from the drop-down list

- Responsibility – Select the responsibility type from the drop-down list

- Patient Relationship to Insured – Select the patient relationship to insured from the drop-down list

- Payer Paid Amount – Enter the amount paid by the other insurance

- Paid Date – Enter the date the other insurance paid

- Remaining Patient Liability – Enter the remaining patient liability

- Claim Filing Indicator – Select the claim filing indicator from the drop-down list.

All of the fields marked with a red asterisk (*) are required fields.

Click **Add Insurance** to add the Other Insurance Details to the claim.

Updating Other Insurance Details

Click the sequence number of any other insurance line item to update details such as the allowed amount, paid amount, paid date and adjustment codes for the specific other insurance carrier.

- Click **Add Adjustment** to add claim adjustment details to the other insurance details line
- Click **Save Insurance** to save the information to the other insurance details line
- Click **Cancel Adjustment** to cancel any updates to the claims adjustment details
- Click **Cancel Insurance** to cancel any updates to the other insurance details
- Click the **Remove** link to remove any other insurance details added to the claim in error

Condition Codes

If applicable enter condition codes for the claim.

- The PWP allows for up to 24 condition codes
- Condition codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Click the **Add** button to add each condition code
- Click the **Remove** link to remove any condition codes added to the claim in error

Occurrence Codes

If applicable enter occurrence codes for the claim.

- The PWP allows for up to 24 occurrence codes
- Occurrence codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Click the **Add** button to add each occurrence code
- Click the **Remove** link to remove any occurrence codes added to the claim in error

Value Codes

If applicable enter value codes for the claim.

- The PWP allows for up to 24 value codes
- Value codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Value code amounts are displayed as a decimal. The amount can either be a number, such as days, or a dollar amount.
  - For value codes 80 – Covered Days and 81 – Non Covered Days enter the number of days.
- Click the **Add** button to add each value code
- Click the **Remove** link to remove any value codes added to the claim in error

Surgical Procedures

In order to add surgical procedure codes to the claim, an operating provider needs to be entered on Submit Institutional Claim: Step 1.

- The PWP allows for up to 24 surgical procedures

- The first surgical procedure code entered is considered to be the principal surgical procedure code

- Surgical procedures are searchable

    o Enter the first three letters or the first two numbers of the code to use the predictive search

- Click the **Add** button to add each surgical procedure

- Click the **Remove** link to remove any surgical procedures added to the claim in error

Click the **Continue** button to continue to Submit Institutional Claim: Step 3.

Submit Institutional Claim: Step 3

When the Submit Institutional Claim: Step 3 page is first displayed not all of the panels are expanded.

- Click **Expand All** to expand all panels, or click the plus icons on each panel to open only that panel.
- Click **Collapse All** to close all panels, or click the minus icons on each panel to close only that panel.

All of the fields marked with a red asterisk (*) are required fields.

Service Details Inpatient Claim Types

- Up to 50 service details to be added to an institutional claim

- Revenue Codes are searchable

    o Enter the first three letters or the first three numbers of the code to use the predictive search

- HCPCS/Proc codes are searchable

    o Enter the first three letters or the first three numbers of the code to use the predictive search

- Modifiers are searchable

- o Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search
- Click the **Add** button to add each service detail
- Click the **Remove** link to remove any service detail added to the claim in error

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0121-R&B-2 Bed-Med-Surg-Gyn		05/01/2018	05/10/2018	10.00 Days	$1,000.00	Remove
2					0.000		

2 *Revenue Code ❶ [   ]   HCPCS/Proc Code ❶ [   ]
Modifiers ❶ [   ] [   ] [   ] [   ]
From Date ❶ [   ] 🗓   To Date ❶ [   ] 🗓   *Units [0.000]   *Unit Type [Unit ⌄]
*Charge Amount [   ]

[**Add**] [Reset]

All of the fields marked with a red asterisk (*) are required fields.

Service Details Outpatient Claim Types

- Up to 50 service details to be added to an institutional claim
- Revenue Codes are searchable
  - o Enter the first three letters or the first three numbers of the code to use the predictive search
- HCPCS/Proc codes are searchable
  - o Enter the first three letters or the first three numbers of the code to use the predictive search
- Modifiers are searchable
  - o Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search
- Click the **Add** button to add each service detail
- Click the **Remove** link to remove any service detail added to the claim in error

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0450-Emergency Room-General	77012-Ct scan for needle biopsy	05/01/2018	05/01/2018	1.000 Unit	$250.00	Remove
2					0.000		

2 *Revenue Code ❶ [   ]   HCPCS/Proc Code ❶ [   ]
Modifiers ❶ [   ] [   ] [   ] [   ]
From Date ❶ [   ] 🗓   To Date ❶ [   ] 🗓   *Units [0.000]   *Unit Type [Unit ⌄]
*Charge Amount [   ]

NDCs for Svc. # 2   ⊞

[**Add**] [Reset]

Adding NDC information for Physician-Administered Drugs

Nevada Medicaid requires a National Drug Code (NDC) and an NDC quantity for each claim line with a physician administered drug. To add NDC information to the service line, expand the NDCs for Svc section by clicking on the plus icon. The HCPCS/Proc Code and NDC are both required for Physician- Administered Drugs.

Updating Service Details

Select the sequence number of any service detail line item to update details such as the service date, procedure code, units or charge amount.

- Click the **Save** button to save the changes
- Click the **Reset** button to clear any of the changes to the service detail
- Click on the **Cancel** button to cancel any updates and close the service detail

Attachments

To include attachments electronically with a claim:

- Transmission Method – FT - File Transfer is selected by default

- Upload file – click the **Browse** button and locate the file on your computer to be attached

- Attachment Type – select the type of attachment from the drop-down list

- A description of the attachment can be entered, but it is not required

- Click the **Add** button to attach the file

- Repeat for additional attachments if needed up to 10 attachments can be added per claim (Note: the combined size of all attachments cannot exceed 4MB)

- To remove any attachments that were attached incorrectly, use the "Remove" link

- Click on the **Cancel** button to cancel and close the attachment line

All of the fields marked with a red asterisk (*) are required fields.

Claim Submission

Click the **Submit** button to complete the claim creation process.

Confirm Institutional Claim

After clicking the Submit button, the Confirm Institutional Claim page will display with the claim details to review before submission.

Print Preview

Confirm Institutional Claim   [?]

Select Print Preview **before** you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

Claim Type Outpatient

Provider Information

Billing Provider ID	1538	**ID Type**	NPI
Billing Provider Service Location	11-MEDICAL CENTER-1303 N MAIN ST,LAS VEGAS,NEVADA,89030		
Institutional Provider ID	_	**ID Type**	_
Attending Provider ID	_	**ID Type**	_
Operating Provider ID	1437	**ID Type**	NPI
Operating Provider Service Location	20-JACKSON, MICHAEL E--1303 N MAIN ST,LAS VEGAS,NEVADA,89030		
Other Operating Provider ID	_	**ID Type**	_
Referring Provider ID	_	**ID Type**	_

Patient Information

Recipient ID	00000000001		
Recipient	ISAAC E CLMGLZ	**Gender**	Male
Birth Date	01/01/1999		

Claim Information

Covered Dates	05/01/2018	**Admission Date/Hour**	05/01/2018 - _
Admission Type	1-Emergency	**Admission Source**	2
Admitting Diagnosis Type	_	**Discharge Hour**	_
Admitting Diagnosis	_	**Facility Type Code**	131-Hospital Outpatient: Admit through Discharge Claim
Patient Status	01	**Authorization Number**	12345678900
Patient Number	12345		
Previous Claim ICN	_		
Note	_		
		Total Charged Amount	$250.00

Expand All | Collapse All

Diagnosis Codes   [+]

External Cause of Injury Diagnosis Codes   [+]

Patient Reason for Visit Diagnosis Codes   [+]

Other Insurance Details   [−]

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date
1	Blue Shield	BS001	00000000001	$100.00	06/01/2018

Condition Codes   [+]

Occurrence Codes   [+]

Value Codes   [+]

Surgical Procedures   [+]

Service Details   [−]

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount
1	0450-Emergency Room-General	77012-Ct scan for needle biopsy	TC	05/01/2018	05/01/2018	1.000 Unit	$250.00

Attachments   [+]

Back to Step 1   Back to Step 2   Back to Step 3   Print Preview   Confirm   Cancel

- Click the **Confirm** button to submit the claim
- Click the **Print Preview** button to print a copy of the Confirm Institutional Claim page
- Click on the **Cancel** button to cancel the claim submission

Submit Institutional Claim: Confirmation

The Submit Institutional Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

- Click the **Print Preview** button to view the claim details
- Click the **Copy** button to copy claim data
- Click the **Adjust** button to resubmit the claim
- Click the **New** button to submit a new claim
- Click the **View** button to view the details of the submitted claim

3.1.3   Submit Claim Prof

Select **Submit Claim Prof** to create and submit a professional claim.

Claim submission is a three-step process, click on the **Continue** button at the bottom of each page to continue on to the next step. Click on the **Cancel** button to cancel the creation of the claim.

- Step 1-Provider, Patient and Claim Information
- Step 2-Diagnosis Codes and Other Insurance Details
- Step 3-Service Details and Attachments

Submit Professional Claim: Step 1

All of the fields marked with a red asterisk (*) are required fields.

Claim Type

Use the Claim Type drop-down to indicate the type of professional claim.

Provider Information

The Billing Provider Information is automatically populated with the Billing Provider ID and ID Type of the provider that the signed-in user is associated with.

The following fields can be completed as follows:

- Billing Provider Service Location – Select the appropriate provider type/service location for the type of service being billed

- Rendering Provider ID – If applicable enter the rendering provider NPI

    o ID Type –Select NPI from the drop-down list

- Rendering Provider Service Location – If a rendering provider ID is entered, a rendering provider service location is required; Select the appropriate provider type/service location for rendering provider

- Referring Provider ID – If applicable enter the referring provider NPI

    o ID Type –Select NPI from the drop-down list

- Service Facility Location ID – If applicable enter the service facility NPI

    o ID Type – Select NPI from the drop-down list

Patient Information

Enter the 11-digit recipient ID in the Recipient ID field. The Last Name, First Name, and Birth Date will be automatically populated based on the recipient ID that is entered.

Claim Information

All of the fields marked with a red asterisk (*) are required fields.

The following fields can be completed as follows:

- Date Type – Select illness, injury or pregnancy from the drop-down list if applicable.
- Date of Current – Enter the start date of the illness, injury, or pregnancy that is related to this claim
- Accident Related – If the claim is related to accident, select the accident type from the drop-down list
- Admission Date – Enter the admission date if this claim is related to a hospital admission
- Accident State – Displays if Auto Accident is selected in the Accident Related drop-down list
- Accident Country – Displays if Auto Accident is selected in the Accident Related drop-down list
- Patient Number – Enter a patient number
- Authorization Number – If applicable, enter the prior authorization number for the service(s) being billed on the claim
- Transport Certification – Select yes or no
- Certification Condition Indicator – This question displays and is required if yes is marked for

Transport Certification; Select yes or no

- Condition Indicator – These fields appear and are required if yes is marked for Transport Certification; select the correct value from the drop-down list
- Transport Distance – This field displays and is required if yes is marked for Transport

Certification; enter the number of miles patient was transported

- Ambulance Transport Reason – This field displays and is required if yes is marked for Transport Certification; Select the ambulance transport reason from the drop-down list
- Does the provider have a signature on file? – Select yes or no
- Include Other Insurance – If the recipient has other insurance that paid as primary, check this box; When this box is checked the Other Insurance Information panel will appear on the Submit Dental Claim: Step 2
- Total Charged Amount – Read only and displays the total charge amount associated with the claim

Medicare Crossover Details

The Medicare Crossover Details panel will display when Crossover Professional is selected as the claim type.

Use the Medicare Explanation of Benefits to complete the following fields as applicable:

- Allowed Medicare Amount
- Deductible Amount
- Co-insurance Amount
- Psychiatric Services Amount
- Medicare Payment Date
- Medicare Payment Amount

Submit Professional Claim: Step 2

When the Submit Prof Claim: Step 2 is first displayed all of the panels are expanded. Click **Collapse All** to close all panels, or click the minus icons on each panel to close only that panel.

Click **Expand All** to expand all panels, or click the plus icons on each panel to open only that panel.

Diagnosis Codes

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- The PWP allows for up to 8 diagnosis codes
- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the **Add** button to add each diagnosis code
- Click the **Remove** link to remove any diagnosis codes added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

Condition Codes

If applicable enter condition codes for the claim.

- The PWP allows for up to 24 condition codes
- Condition codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Click the **Add** button to add each condition code
- Click the **Remove** link to remove any condition codes added to the claim in error

Submit Professional Claim: Step 2

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 1811177454   **ID Type** NPI

Patient and Claim Information

Recipient ID 13420240003
Recipient 64742 FN 64742 LN   **Gender** Female
Birth Date 02/28/1990   **Total Charged Amount** $250.00

Expand All | Collapse All

Diagnosis Codes

Condition Codes

Click the **Remove** link to remove the entire row.

#	Condition Code	Action
1	AA-Abortion Performed due to Rape	Remove
2		

2 ***Condition Code** ⊙ [_____]

[Add] [Reset]

[Back to Step 1]   [Continue] [Cancel]

All of the fields marked with a red asterisk (*) are required fields.

Other Insurance Details

If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto populate in the Other Insurance Details panel. Other Insurance Details fields are required only if you are adding other insurance payment information.

- Click **Save Insurance** to save the information to the other insurance details line
- Click **Cancel Insurance** to cancel any updates to the other insurance details
- Click **Continue** button to continue to Submit Professional Claim: Step 3.
- Click the **Remove** link to remove any other insurance details not relevant to the claim.

Please note: For Professional claims, only payment information is required at the header level. The "Claim Adjustment Details" panel should be collapsed.

If the recipient does not have other insurance carrier information on file with Nevada Medicaid, the policy information will not auto populate in the Other Insurance Details panel. Other Insurance Details can be added by completing the following fields:

- Carrier Name – Enter the other insurance carrier name

- Carrier ID – Enter the other insurance carrier ID

- Policy Holder Last Name – Enter the last name of the policy holder

- First Name – Enter the first name of the policy holder

- MI – Enter the middle initial of the policy holder

- Policy ID – Enter the policy ID

- Insurance Type – Select the insurance type from the drop-down list

- Responsibility – Select the responsibility type from the drop-down list

- Patient Relationship to Insured – Select the patient relationship to insured from the drop-down list

- Payer Paid Amount – Enter the amount paid by the other insurance

- Paid Date – Enter the date the other insurance paid

- Remaining Patient Liability – Enter the remaining patient liability

- Claim Filing Indicator – Select the claim filing indicator from the drop-down list.

All of the fields marked with a red asterisk (*) are required fields.

Click **Add Insurance** to add the Other Insurance Details to the claim.

Updating Other Insurance Details

Select the sequence number of any other insurance line item to update details such as the allowed amount, paid amount, paid date and adjustment codes for the specific other insurance carrier.

- Click **Save Insurance** to save the information to the other insurance details line
- Click **Cancel Insurance** to cancel any updates to the other insurance details
- Click the **Remove** link to remove any other insurance details added to the claim in error

Click **Continue** button to continue to Submit Professional Claim: Step 3.

Submit Professional Claim: Step 3

When the Submit Professional Claim: Step 3 is first displayed not all of the panels are expanded.

- Click **Expand All** to expand all panels, or click the plus icons on each panel to open only that panel.
- Click **Collapse All** to close all panels, or click the minus icons on each panel to close only that panel.

All of the fields marked with a red asterisk (*) are required fields.

Service Details

- Up to 50 service details to be added to a professional claim
- Procedure codes are searchable
    - Enter the first three letters or the first three numbers of the code to use the predictive search
- Modifiers are searchable
    - Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search
- Click the **Add** button to add each service detail
- Click the **Reset** button to clear all of the information that has been entered
- Click the **Remove** link to remove any service detail added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

Adding NDC information for Physician-Administered Drugs

Nevada Medicaid requires a National Drug Code (NDC) and an NDC quantity for each claim line with a physician-administered drug. To add NDC information to the service line, expand the NDCs for Svc section by clicking on the plus icon. The HCPCS/Proc Code and NDC are both required for physician- administered drugs.

Updating Service Details

Select the sequence number of any service detail line item to update details such as the service date, procedure code, units or charge amount.

- Click the **Save** button to save the changes
- Click the **Reset** button to clear any of the changes to the service detail
- Click on the **Cancel** button to cancel any updates and close the service detail

Adding Other Insurance Details on Service Detail line

Select the sequence number of any service detail line item to add other insurance details and claim adjustment details.

1. Add Other Insurance Details and click the **Add Insurance** button.

2. Click the sequence number in the Other Insurance for Service Detail panel to add the Adjustment Details.

3. Enter the Claim Adjustment Details and click the **Add Adjustment** button to add adjustment information for the other insurance.

4. Click the **Save Insurance** button to save the other insurance information with the claim adjustment details.

5. Click the **Save** button to save the updates to the Service Detail Line.

Attachments

To include attachments electronically with a claim:

- Transmission Method – FT - File Transfer is selected by default

- Upload file – click the **Browse** button and locate the file on your computer to be attached

- Attachment Type – select the type of attachment from the drop-down list

- A description of the attachment can be entered, but it is not required

- Click the **Add** button to attach the file

- Repeat for additional attachments if needed up to 10 attachments can be added per claim (Note: the combined size of all attachments cannot exceed 4MB)

- To remove any attachments that were attached incorrectly, use the **Remove** link

- Click on the **Cancel** button to cancel and close the attachment line

All of the fields marked with a red asterisk (*) are required fields.

Claim Submission

Click the **Submit** button to complete the claim creation process.

Confirm Professional Claim

After clicking the Submit button, the Confirm Professional Claim page will display with the claim details to review before submission.

- Click the **Confirm** button to submit the claim
- Click the **Print Preview** button to print a copy of the Confirm Professional Claim page
- Click on the **Cancel** button to cancel the claim submission

Submit Professional Claim: Confirmation

The Submit Professional Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

- Click the **Print Preview** button to view the claim details
- Click the **Copy** button to copy claim data
- Click the **Adjust** button to resubmit the claim
- Click the **New** button to submit a new claim
- Click the **View** button to view the details of the submitted claim

3.1.4   Submit a Claim for Exception Batch Processing

To submit a claim for Exception Batch processing on the PWP, use the attachments panel to attach the batch processing letter. The attachment description must start with capital **EXCP** for the claim to be processed correctly.

To submit an EDI 837 X12 claim for Exception Batch processing, please refer to PWP User Manual Chapter 8 File Exchange.

Please note: Adjustment claims cannot be submitted as an exception batch. If a paid claim requiring exception batch requires a change, it will first need to be voided. The provider can resubmit the new claim as an exception batch after the void has been completed. Section 3.4 of this manual provides instructions for voiding a claim.

3.1.5   Third Party Liability (TPL) Claim Submission

Dental and Professional claims

- The total payment by other insurers must be entered at the header level.

- The adjustment reason codes that explain how/why the other insurer paid or denied each detail must be entered on the appropriate detail level.

Please refer to the above sections to see instructions for each Claim Form.

Header level example (Dental claim):

Detail level example (Dental claim):

Header level example (Professional claim):

Detail level example (Professional claim):

Institutional claims

- The total payment by other insurers must be entered at the header level.

- The adjustment reason codes that explain how/why the other insurer paid or denied the claim must be entered at the header level.

Header level example (Institutional claim):

3.1.6 Crossover Claim Submission

When Medicare is the primary insurer and a payment is made or coinsurance/ deductible is applied, the claim must be submitted as a Crossover claim type. Use the Medicare Explanation of Benefits to complete the Medicare Crossover Details fields.

If Medicare denies a claim and the claim crosses over to Nevada Medicaid with no Medicare payment or coinsurance/deductible, then the provider will need to submit the claim to Nevada Medicaid through the PWP Direct Data Entry (DDE) as a regular Fee-for-Service (FFS) claim.

- For Professional claims where the primary carrier is Medicare: Submit the claim as a Fee-for-Service claim and include payment information, payment date and carrier information at the

header level. Include the claim adjustment reason code for each detail.

- For Institutional claims where the primary carrier is Medicare: Submit the claim as a Fee-for-Service claim and include the claim adjustment reason code, carrier information, payment information and payment date at the header level.

3.2 View a Claim

Once a claim has been submitted, the claim can be viewed by selecting the "View" button on the Submit Receipt page or selecting the ICN from the Search Results grid.

Submit Receipt page

Search Results grid

Viewing the claim displays a summary of the claim that was submitted, with the first panel expanded. Select "Expand All" to expand all panels, or select plus icons on each panel to open only that panel.

Print Preview

View Institutional Claim - ID 2218178000021			Back to Claims	?

Claim Type Inpatient

Provider Information

Billing Provider ID	1538	**ID Type**	NPI
Billing Provider Service Location	11- MEDICAL CENTER-1303 N MAIN ST,LAS VEGAS,NEVADA,89119		
Institutional Provider ID	_	**ID Type**	_
Attending Provider ID	_	**ID Type**	_
Operating Provider ID	_	**ID Type**	_
Operating Provider Service Location	_		
Other Operating Provider ID	_	**ID Type**	_
Referring Provider ID	_	**ID Type**	_

Patient Information

Recipient ID	3035653		
Recipient	HVXQOSDCN I IRAPSEU	**Gender**	Female
Birth Date	07/27/2002		

Claim Information

Claim Status	Finalized Denied		
Covered Dates	06/01/2018	**Admission Date/Hour**	06/01/2018 - _
Admission Type	1-Emergency	**Admission Source**	E-Transfer from Ambulatory Surgery Center
Admitting Diagnosis Type	ICD-10-CM	**Discharge Hour**	_
Admitting Diagnosis	R4020	**Facility Type Code**	115-Hospital Inpatient (Including Medicare Part A)- Late Charge(s) Only
Patient Status	01-Discharged to Home or Self Care (Routine Discharge)	**Authorization Number**	_
Patient Number	1234	**Related Claim ICN**	_
Previous Claim ICN	_		
Note	_		
		Total Charged Amount	$1,050.00
Total Allowed Amount $0.00	**Total Co-pay Amount** $0.00	**Total Paid Amount**	$0.00

Expand All   Collapse All

Adjudication Errors	+

Diagnosis Codes	+

Service Details   −

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	0121-R&B-2 Bed-Med-Surg-Gyn			06/01/2018	06/01/2018	1.000 Days	$1,050.00	$0.00	$0.00	$0.00

No External Cause of Injury Diagnosis Codes exist for this claim
No Other Insurance Details exist for this claim
No Condition Codes exist for this claim
No Occurrence Codes exist for this claim
No Value Codes exist for this claim
No Surgical Procedures exist for this claim
No Attachments exist for this claim

Copy   **Print Preview**

3.3 Adjust a Claim

Once a claim has been processed and paid, an adjustment can be submitted to correct data entry or billing errors. To begin the claim adjustment process select the "Adjust" button on the Submit Receipt page, or View claims page.

Submit Receipt page

View page

Clicking the **Adjust** button reopens the claim so that corrections can be made and the claim resubmitted for processing. Claim adjustment is a three-step process.

The adjudication details will display on Resubmit Claim: Step 1.

Click on the **Continue** button at the bottom of each page to continue on to the next step. Click on the **Cancel** button to cancel the adjustment.

Resubmit Institutional Claim ID 2018105000012: Step 1

* Indicates a required field.

Claim Type   Outpatient

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	1538	ID Type	NPI
*Billing Provider Service Location	11- MEDICAL CENTER-1303 N MAIN ST,LAS VEGAS,NEVADA,89119		
Institutional Provider ID		ID Type	
Attending Provider ID	1801	ID Type	NPI
Operating Provider ID		ID Type	
Other Operating Provider ID		ID Type	
Referring Provider ID	1801195276	ID Type	NPI

Patient Information

*Recipient ID	3545636		
Last Name	MDKKDZSC	First Name	YDYE
Birth Date	01/29/1940		

Claim Information

Claim Status	Finalized Payment		
*Covered Dates	02/07/2018 - *02/08/2018		
Admission Date/Hour	02/07/2018 - 12:00 (hh:mm)	Discharge Hour	(hh:mm)
*Admission Type	1-Emergency	*Admission Source	1-Non - Health Care Facility Point of Origin
Admitting Diagnosis Type	ICD-10-CM	Admitting Diagnosis	
*Patient Status	01-Discharged to Home or Self Ca	*Facility Type Code	130-Hospital Outpatient: Non-Payment/Ze
*Patient Number	TTG-CLAIM	Authorization Number	
Include Other Insurance	☐	Total Charged Amount	$800.00

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	EOB
Claim	282	COVERED DAYS MISSING	1930
Claim	7499	CLAIM PROCESSED BY CLINICAL CLAIM EDITOR	7499
Service # 2	3959	NO REIMB RULE FOR REV CODE	1178

[Continue] [Cancel]

Navigate through each step of the claim and make any necessary updates. Select the "Resubmit" button.

Resubmit Claim: Step 3

Resubmit Institutional Claim ID 2018105000012: Step 3							?

* Indicates a required field.

Claim Type	Outpatient

Provider Information

Billing Provider ID	1538	**ID Type**	NPI

Patient and Claim Information

Claim Status	Finalized Payment		
Recipient ID	3545636		
Recipient	YDYE J MDKKDZSC	**Gender**	Male
Birth Date	01/29/1940	**Total Charged Amount**	$8.00
Covered Dates	02/07/2018 - 02/08/2018	**Admission Date/Hour**	02/07/2018 - 12:00

Expand All | Collapse All

Adjudication Errors	+
Diagnosis Codes	+
External Cause of Injury Diagnosis Codes	+
Patient Reason for Visit Diagnosis Codes	+
Condition Codes	+
Occurrence Codes	+
Value Codes	+
Service Details	−

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0112-R&B-Pvt-Obstetric	40650-Repair lip	02/07/2018	02/07/2018	1.000 Unit	$400.00	
2	0120-R&B-Semi-Pvt-2 Bed-General		02/08/2018	02/08/2018	1.000 Unit	$400.00	
3					0.000		

Attachments	−

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
+ Click to add attachment.					

Back to Step 1   Back to Step 2   Resubmit   Cancel

Click the **Confirm** button on the Confirm page to submit the adjustment claim.

Confirmation page

Resubmit Claim: Confirmation

The Resubmit Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

3.4 Void a Claim

Once a claim has been processed and paid, a void can be submitted to void the payment. To begin the claim void process select the "Void" button on the View claims page. To access the View claims page, search for the claim that needs to be voided, and select the Claim ID in the search results grid.

Search claims response with Search Results grid.

View claims page

Print Preview

View Institutional Claim - ID 2218178000008	Back to Search Results ?

Claim Type Outpatient

Provider Information

Billing Provider ID	1538178801	ID Type	NPI
Billing Provider Service Location	10-VALLEY VIEW MEDICAL CENTER-1303 N MAIN ST, CEDAR CITY, UTAH, 84721-9746		
Institutional Provider ID	_	ID Type	_
Attending Provider ID	1750363404	ID Type	NPI
Operating Provider ID	_	ID Type	_
Other Operating Provider ID	_	ID Type	_
Referring Provider ID	_	ID Type	_

Patient Information

Recipient ID	234567890123		
Recipient	DEF ABC	Gender	Female
Birth Date	06/29/1990		

Claim Information

Claim Status	Finalized Payment		
Covered Dates	02/28/2018	Admission Date/Hour	02/28/2018 - 01:00
Admission Type	2-Urgent	Admission Source	2-Clinic or Physician's Office
Admitting Diagnosis Type	_	Discharge Hour	_
Admitting Diagnosis	_	Facility Type Code	131-Hospital Outpatient: Admit through Discharge Claim
Patient Status	01-Discharged to Home or Self Care (Routine Discharge)	Authorization Number	45181080003
Patient Number	234567890123	Related Claim ICN	_
Previous Claim ICN	_		
Note	_		
		Total Charged Amount	$100.00
Total Allowed Amount	$100.00	Total Co-pay Amount $0.00	Total Paid Amount $100.00

Expand All | Collapse All

Adjudication Errors	+
Diagnosis Codes	+
Patient Reason for Visit Diagnosis Codes	+
Condition Codes	+
Occurrence Codes	+
Value Codes	+

Service Details −

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	0100-All Inclusive Rate (R&B + Ancillary)	58674-LAPS ABLTJ UTERINE FIBROIDS		02/28/2018	02/28/2018	1.000 Unit	$100.00	$100.00	$0.00	$0.00

No External Cause of Injury Diagnosis Codes exist for this claim
No Other Insurance Details exist for this claim
No Surgical Procedures exist for this claim
No Attachments exist for this claim

Adjust **Copy** **Void** **Print Preview** **RA Copy (PDF)**

A Confirmation message will appear to confirm that the user wants to void the claim.

After selecting OK, the user will be returned back to the search claims page and a confirmation message will appear indicating that the Claim ID was successfully voided.

3.5   Copy a Claim

Once a claim has been submitted, the details can be copied to quickly enter a new claim. To copy a claim, select the "Copy" button on the Submit Receipt page, or View claims page.

Submit Receipt page

View page

Copy Claim Information

- Select the information you would like to copy to a new claim.
- Click the **Copy** button to copy the selected information into a new claim. The Submit Claim: Step 1 page appears where you can continue entering the claim information.

3.6 Appeal a Claim

Once a claim has been processed and denied, an appeal can be submitted online using Secure Correspondence. Secure Correspondence is for authenticated (logged in) users to submit appeals, questions, comments or request technical assistance related to PWP functions in a secure environment and receive answers through the website. For more information on Secure Correspondence, refer to PWP User Manual Chapter 13.

Providers have the right to appeal a claim that has been denied. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days. Per Medicaid Services Manual (MSM) Chapter 100, Section 105.2C titled Disputed Payment, appeal requests for subsequent same service claim submissions will not be considered. That is, if a provider resubmits a claim that has already been denied and another denial is received, the provider does not have another 30-day window in which to submit an appeal. Such appeal requests will be rejected.

How to file a claim appeal

To submit a claim appeal, include each component listed below:

A completed form FA-90 (Formal Claim Appeal Request) that contains all of the following:

- Reason for the appeal.
- Provider name and NPI/API.
- The claim's ICN (claim number).
- Name and phone number of the person Nevada Medicaid can contact regarding the appeal.
- Documentation to support the issue, when applicable, e.g., physician's notes, emergency room reports.

1. From the My Home page, click **Secure Correspondence**.

2. From the Secure Correspondence Message Box screen, click **Create New Message.** From the Create Message screen, enter in information.

All fields with a red asterisk (*) are required.

3. Enter in a Subject for the appeal.

4. Select Claims Appeals from the **Message Category** drop-down box.

5. Enter an email address.

6. Confirm email address by re-entering the email address from above.

7. Enter the ICN number in the ICN field.

8. Enter the Service Provider ID in the Service Provider ID field. If there is more than one service location, select the correct service location from the Service Provider Location drop-down box.

9. Select Service Provider ID Type from the ID Type drop-down box.

10. Enter the denial reason in the Denial Reason field.

11. Enter the RA Issue Date in the RA Date field.

12. Enter comments limited to 1,000 characters.

13. Upload the supporting documentation for the appeal using the Upload File field. Note: multiple attachments can be submitted.

14. Select FA-90-Claim Appeal Request Form as the Attachment Type. Note: Select this for each attachment, if multiple attachments are being submitted.

15. Click the **Add** button to add the attachments to the appeal.

16. Click **Send**. The Confirmation screen box displays stating the secure message was successfully sent.

17. Click **OK**.
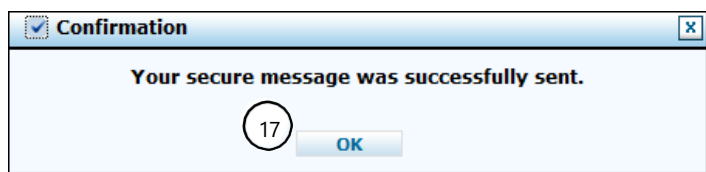
An email will be sent to the email address entered on the Secure Correspondence Message when a response is ready to your inquiry.

Please note: Claim appeals must be submitted electronically to Nevada Medicaid via the PWP no later than 30 calendar days from the date on the remittance advice (RA). If the RA date entered is greater than 30 calendar days from the date on the remittance advice, the following error message will display.

How to download a claim appeal letter

The Report Download page allows users to download Provider Letters. The Report Download page can be accessed under Resources.
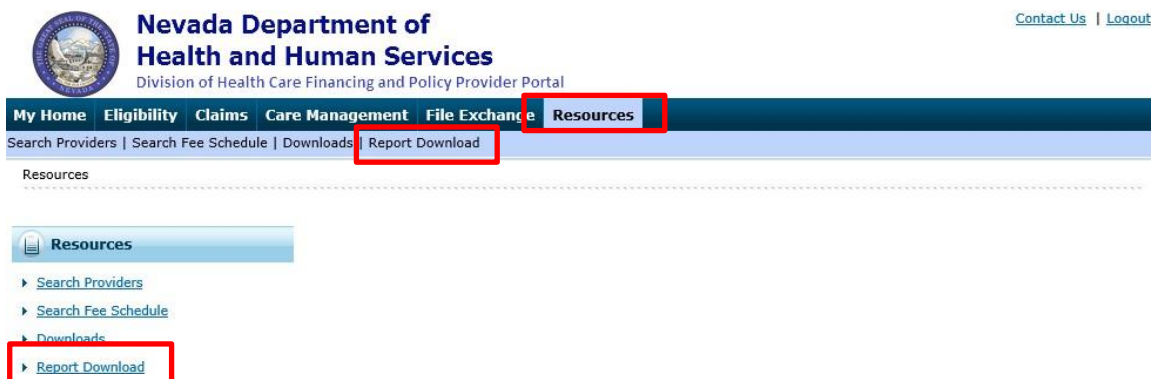
Select Claims Appeal Letters as the Report Category. To search for appeal letters, enter either of the following:

- From Date, To Date and Recipient ID.
- Contact Tracking Number (CTN) - The CTN can be found in the Secure Correspondence Message Box.

3.7   Verifying claim status

The **Search Claims** tab provides the ability to search and view a list of claims for recipients which the provider billed. The list can be filtered to search by various methods such as by claim or by recipient.

By clicking on the **Claims** tab, you will see two links that allow you to either search claims or to search your payment history.

3.7.1   Availability

The status of a direct data entry claim submitted using the PWP is usually available on the same day of submission.

3.7.2   Accessing the claim status request

To view claims status, select **Search Claims** from the **Claims** submenu, or click on the **Claims** tab to be directed to the claims landing page.

Claims submenu

Claims landing page

3.7.3   Verifying claim status

To verify claim status, the user has the option to search by the following:

- Claim Information

- Recipient Information

- Service Information

Claim Status field requirements

Field	Format
Claim Information	
Claim ID	Optional field. Must enter in 16-digit Internal Claim Number (ICN). If ICN is not used, must enter recipient ID and service dates. If incorrect ICN is entered, will receive message: "There are no claims to show based on the search criteria selected."
Recipient Information	
Recipient ID	Optional field. Required field if no ICN is entered. Must enter 11-digit recipient ID. If the incorrect ID is entered or no claims found, will receive message: "There are no claims to show based on the search criteria selected."
Service Information	
Rendering Provider ID	Optional field. Must enter provider 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API). Claims are only shown when paid to the logged in provider, but the rendering provider on the claim can be different and used as search criteria. Provider ID Type is required if Rendering Provider ID is entered. You have the ability to search for providers by clicking on the magnifying glass icon. If the incorrect ID is entered or no claims found, will receive message: "There are no claims to show based on the search criteria selected."
ID Type	Must select the Provider ID Type in this field if searching by rendering provider.
Claim Type	Optional field. Drop-down menu defaults to "ALL." If no claims found, will receive message: "There are no claims to show based on the search criteria selected."
Service From	Optional field. Required field if no Claim ID entered. Service date searches cannot span more than 45 days or include future dates. If claim status is for one date of service, the From date must be the same as the To date. Must be entered in MMDDCCYY format. If no claims are found, will receive message: "There are no claims to show based on the search criteria selected."
Service To	Optional field. Required field if no Claim ID entered. Service date searches cannot span more than 45 days or include future dates. If claim status is for one date of service, the From date must be the same as the To date. Must be entered in MMDDCCYY format. If no claims are found, will receive message: "There are no claims to show based on the search criteria selected."
Claim Status	Optional field. Drop-down menu defaults to "ALL." If no claims found, will receive message: "There are no claims to show based on the search criteria selected."

A minimum of one field (claim ID or ICN) is required for searches. If the ICN is unknown, you can request a claim search by recipient ID and service date range. If the servicing/rendering provider is different than the billing provider, you should include the rendering Provider ID and Provider ID Type.

To search claims:

1. Enter information in the appropriate fields.

2. Click the **Search** button.

A successful response to the claim status inquiry when searching by recipient ID and Service From and To date is shown below.

- Claim ID – ICN is listed
- TCN – Transaction Control Number. Currently not used - field is blank
- Claim Type – Currently not use - field is blank
- Claim Status – Status of claim (paid, denied, or pending)
- Service Date – Date of service
- Recipient ID – Recipient identification
- Rendering Provider ID – The NPI or other identifier of the provider who rendered the service
- Medicaid Paid Amount – The payment received
- Paid Date – The date of the payment
- Recipient Responsibility – Currently not used - field is blank

3. To view more information about the claim, click on the expand all "➕" symbol located to the left of the **Claim ID** column to view the claim information page.

The claim information displays the services billed in more detail.

- Service – Service line

- Service Date – Date of service

- Line Status – Claim line status

- Reason Code – Codes for claim status

- Units – Units billed

- Revenue – Revenue code if applicable

- Procedure/Modifiers – Services billed with modifiers if applicable

- Charge – Charges billed

- Paid – Payment received

For claims that are finalized, the user will have the ability to click **RA Copy (PDF)** where a new window will open to gain access to a copy of the remittance advice. The user can then print or save the RA to his/her computer.

To view the claim, click on the Claim ID in the search results grid.

The View claims page is displayed.

Print Preview

View Institutional Claim - ID 2218178000008

Back to Search Results ?

Claim Type Outpatient

Provider Information

Billing Provider ID	**ID Type** NPI	
Billing Provider Service Location		
Institutional Provider ID	**ID Type** _	
Attending Provider ID	**ID Type** NPI	
Operating Provider ID _	**ID Type** _	
Other Operating Provider ID _	**ID Type** _	
Referring Provider ID _	**ID Type** _	

Patient Information

Recipient ID		
Recipient	**Gender** Female	
Birth Date		

Claim Information

Claim Status Finalized Payment	
Covered Dates 02/28/2018	**Admission Date/Hour** 02/28/2018 - 01:00
Admission Type 2-Urgent	**Admission Source** 2-Clinic or Physician's Office
Admitting Diagnosis Type _	**Discharge Hour** _
Admitting Diagnosis _	**Facility Type Code** 131-Hospital Outpatient: Admit through Discharge Claim
Patient Status 01-Discharged to Home or Self Care (Routine Discharge)	**Authorization Number**
Patient Number 234567890123	**Related Claim ICN**
Previous Claim ICN _	
Note _	
	Total Charged Amount $100.00
Total Allowed Amount $100.00 **Total Co-pay Amount** $0.00	**Total Paid Amount** $100.00

Expand All | Collapse All

Adjudication Errors	➕
Diagnosis Codes	➕
Patient Reason for Visit Diagnosis Codes	➕
Condition Codes	➕
Occurrence Codes	➕
Value Codes	➕
Service Details	➖

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	0100-All Inclusive Rate (R&B + Ancillary)	58674-LAPS ABLTJ UTERINE FIBROIDS		02/28/2018	02/28/2018	1.000 Unit	$100.00	$100.00	$0.00	$0.00

No External Cause of Injury Diagnosis Codes exist for this claim

No Other Insurance Details exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

Adjust **Copy** **Void** **Print Preview** **RA Copy (PDF)**

1. To clear the screen and access claim status on another claim, click the **Reset** button found on the search claims section of the page.

3.7.4   Verifying claim status through member focused viewing

The **Member Focused Viewing** link allows you to view a summary of all members' information on one page, based on the last 10 members previously viewed in PWP. When you search for other members in PWP, the **Member Focused Viewing** page remains available, so you do not have to repeat searches.

To check on claim status in Member Focus Viewing, click **Member Focused Viewing** from the **My Home page**.

The **Member Focus Search page** appears. This page displays two tabs. If the user has previously viewed members, the **Last Member Viewed** tab displays up to the last 10 searches. If no members have been previously viewed, then only the **Search** tab displays. Selection of an individual member from either tab displays the Member In Focus bar at the top of the page and summary information below, including their recent activity.

Click the name that is listed on the **Member Focus Search** page. The **Member Details** page appears. The member details displays the following:

- Member Details

- Coverage Details

- Claims information

- Authorization information

Note: At the top of the page, the member will remain in focus even if the user navigates away from the **Member Details** page. Click **Close Member Focus** link to close the member in focus.

Any recent claims billed for the Member in Focus are displayed under the heading **Your Member Claims**.

To search for more claims, click on the **View More Claims for This Member** link. This will take the user to the **Search Claims** page. The Recipient ID field will be pre-populated with the recipient ID. The Service From and To fields will also be pre-populated with a 30-day search range using the date of the search as the To date.

If there are any claims that match the search criteria they will be listed under the **Search Results**. The message "There are no claims to show based on the search criteria selected." will display if, there are no claims that match the search criteria.

1. To check claim status on another claim for the same member, fill in the **From** and **To** dates and click **Search**.

2. To check claim status for another member, click **Reset** and fill in the member's information, then click **Search**. Even if another member's information is displayed, the previous member will still remain in focus.

3. To go back to the previous members detail page, click **Return to Member Focus**.

4. To change the member in focus, click **Change** next to the name in the Member in Focus. This will take you back to the **Member in Focus** page. You can then select from the other members on the list.

5. To remove the member in focus while checking claim status on another member, click **Close Member Focus** or click on the " " icon. The **Claim Status** page will now be in view and the user will no longer be in Member Focus Viewing.

Additional Resources

Using the Provider Web Portal YouTube Videos:

Claims Tab

Member Focused Viewing

Dental Claim Submission

Institutional Claim Submission

Professional Claim Submission

Claim Appeals

Claim Adjustments and Voids