Frequently Asked Questions

National Provider Identifier (NPI)

Where can if find *federal specifications* for NPI?

The Centers for Medicare and Medicaid Services (CMS) has published the *NPI Final Rule* at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf.

Where can I find *taxonomy codes*?

Taxonomy codes are online at http://www.wpc-edi.com/taxonomy.

Do *all providers* need to obtain an NPI?

No. The NPI Final Rule provides guidelines to help providers decide if enumeration is appropriate. The Final Rule is online at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf.

How should I *report my new* NPI and taxonomy code to HPES?

Use form FA-33. The Provider Information Change Form (form FA-33) has a field that you can use to report your NPI to HP Enterprise Services.

When will NPI be required on claims?

NPI eligible providers must use their NPI on all claims submitted on or after May 23, 2007.

Eligibility

What is the *earliest day that I can verify eligibility* for a given month?

On the first of the month. During the first week of each month, we recommend verifying eligibility for *all* recipients scheduled to receive services within that month.

Can HP Enterprise Services tell a provider if the recipient is *pending eligibility*?

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

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.

How long does it take the Division of Welfare and Supportive Services to update HP Enterprise Services with eligibility information?

From 1-3 days. Once the Division of Welfare and Supportive Services enters eligibility information into the system, it is electronically transferred to HP Enterprise Services within one day.

Third Party Liability

How should providers handle *Medicare TPL discrepancies*?

Contact the Department of Health Care Financing and Policy (DHCFP) at (775) 684-3703 or (775) 684-3628. They will research the request and update the MMIS if applicable.

When should providers *contact Emdeon*?

Call (855) 828-2596 or email TPL-NV@emdeon.com (recommended) when Medicaid does not have the most recent *private insurance* information for a recipient. Emdeon will research, and if appropriate, update the Medicaid Management Information System (MMIS) accordingly.

How is *payment determined* on TPL claims?

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

Eligibility Verification System (EVS)

How does EVS notify me that a *recipient is in a Managed Care Organization (MCO)?*

If a recipient is enrolled in an MCO, the detail may display *CHECK-UP FFS* for check up fee for service or *MEDICAID FFS* for Nevada Medicaid fee for service. As shown below, it will also show one of the following:

- XIX MAN SNEV for Medicaid mandatory MCO South
- XIX MAN NNEV for Medicaid mandatory MCO North
- XIX MAN DFLT for Medicaid default MCO
- XXI MAN NNEV for Check-Up mandatory MCO North
- XXI MAN SNEV for Check-Up mandatory MCO South
- XXI MAN DFLT for Check-Up default MCO

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 question on how the claim was processed, contact the customer service center at (877) 638-3472.

If a mother is enrolled in a Managed Care Organization (MCO), is her *newborn automatically enrolled* in that MCO?

Yes. Please refer to the Medicaid Services Manual (MSM), Chapter 3600, section 3603.13.b for payment and reporting specifications.

Billing

When calling the customer service center, *what information do I need* to have available?

Please have ready your NPI/API, the Recipient ID, the date of service and the amount billed on the claim.

What if I am *overpaid or underpaid* for a claim?

An incorrect payment can be corrected by 1) adjusting the claim or 2) voiding and then resubmitting the claim.

Can I *adjust or void* a claim electronically?

Yes. Currently, all claims can be adjusted or voided electronically.

How much time does a provider have to submit a claim *(stale date period)?*

In-state providers: A complete, accurate, HIPAA-compliant claim must be received within 180 days of the date of service or date of eligibility decision, whichever is later.

Out-of-state providers: A complete, accurate, HIPAA-compliant claim must be received within 365 days of the date of service or date of eligibility decision, whichever is later.

When there is TPL (applies to in-state and out of-state providers): A complete, accurate, HIPAA-compliant claim must be received within 365 days of the date of service or date of eligibility decision, whichever is later.

If the recipient requests a *non-covered service*, can the provider charge the recipient?

Yes, however, state policy requires that the provider secure a written and signed agreement from the recipient accepting full financial responsibility before the service is rendered. For additional Requirements concerning non-covered benefits, see Medicaid Service Manual, Chapter 100, Section 103.10A.

Does HP Enterprise Services *key all claims* into the Medicaid Management Information System (MMIS)?

No. When a paper claim is received, a digital image of the claim is created and the claim is keyed into the MMIS; however, information from electronic claims is sent directly from the service center to the MMIS for processing (no keying).

What *obstetric services* are covered for nonresident aliens?

Delivery and newborn follow-up care are covered. All other services must be paid by the recipient.

A provider is scheduled to perform a Healthy Kids screening for a child. During the visit the provider discovers the child is sick. Should the provider use modifier 25 when billing for the Healthy Kids screening?

No. Providers should consider the visit a sick child visit rather than a Healthy Kids screening and bill accordingly. The Healthy Kids screening must be rescheduled for another day and once the service has been rendered.

Remittance advice

Can I see my *remittance advice online*?

Yes. You can access your remittance advice online through the Provider Web Portal. Please access via the Secure Provider pages under "Search Payment History".

What does an *asterisk in front of an ICN* signify on my remittance advice?

An asterisk (*) in front of an Internal Control Number (ICN) identifies the claim as an historical claim. HP Enterprise 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 the remittance advice. Therefore, the total reimbursement will not balance to the claims on the remittance advice.

On my remittance advice, some paid amounts include the *letters CR and DR*. What do these mean?

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