February 15, 2023

Nevada Medicaid Web Announcement 3008

Reminder for All Providers:

When Attachments May Be Required On Claims

Nevada Medicaid would like to remind providers that some claims may require additional information to be included via an attachment to the claim in order for the claim to be adjudicated. Some claim attachments and situations when attachments are required include:

1. **Hysterectomy Acknowledgement Form**

   Attach the Nevada Medicaid Hysterectomy Acknowledgement Form (FA-50) with the appropriate section completed for hysterectomy services. Complete section I if the woman received the required hysterectomy information before surgery; complete section II if the woman received the information after the surgery; or complete section III if the woman was already sterile at the time of the surgery or if the surgery was performed on an emergency basis.

2. **Sterilization Consent Form**

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

3. **Abortion Declaration Forms**

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

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

4. **Invoices for Durable Medical Equipment**

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

5. **Clinical Documentation**

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

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

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

6. **Specialized Foster Care 1915(i) Home and Community Based Services Needs Based Eligibility Checklist**

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

7. **Delivery Receipt Form Required with Claims for Dentures**

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

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

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

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

9. **Exception Batch Process**

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

For instructions on submitting a claim with an attachment or exception batch processing, refer to the Electronic Verification System (EVS) Chapter 3: Claims and Chapter 8: File Exchange.