# Nevada Medicaid and Nevada Check Up News

Volume 18, Issue 3
Third Quarter 2021

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## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,082,182,768.00 in claims during the three-month period of April, May and June 2021. Nearly 100 percent of current claims continue to be adjudicated within 30 days. Thank you for participating in Nevada Medicaid and Nevada Check Up.

***Reminder:***

# Resources for Novel Coronavirus (COVID-19) Public Health Emergency Information

Providers are reminded that multiple resources offer current information and instructions regarding the Novel Coronavirus (COVID-19) public health emergency as it pertains to Nevada Medicaid recipients and providers.

- The Division of Health Care Financing and Policy (DHCFP) has created a webpage at http://dhcfp.nv.gov/covid19/ to answer frequently asked questions and to share information and resources pertaining to the status of COVID-19 and its impact on Nevada Medicaid recipients and providers. The webpage provides the Nevada Medicaid Response to Novel Coronavirus (COVID-19), as well as many useful links for recipients and providers.

- Multiple web announcements have been posted on the provider website at https://www.medicaid.nv.gov. For example, Web Announcement 2589 notified providers of the additional Provider Relief Fund payments available due to COVID-19 pandemic. Providers may view all COVID-19 related web announcements by selecting the "COVID-19" category from the drop-down list on the Announcements/ Newsletters webpage. The full list of COVID-related announcements will appear for providers to review.

- Valuable information is also available in three COVID-19 billing guides: 1) COVID-19 General Billing Guide; 2) COVID-19 Community-Based Testing & Vaccination Billing Guide; and 3) the Provider Type 22 Dentist: COVID-19 Vaccination Administration Claim Reimbursement Guide, which contains information and instructions specific to dentists and dental hygienists. All Nevada Medicaid Fee-for-Service billing guides, including the three related to COVID-19, can be found on the Providers/Claims Billing Information webpage at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx. The COVID-19 Billing Guides section is located at the top of the webpage.

COVID-19 Billing Guides

| Title | Last Update |
|---|---|
| COVID-19 General Billing Guide | 05/05/2021 |
| COVID-19 Community-Based Testing & Vaccination Billing Guide | 05/05/2021 |
| Provider Type 22 Dentist: COVID-19 Vaccination Administration Claim Reimbursement Guide | 05/05/2021 |

The COVID-19 Billing Guides on the Providers/Claims Billing Information webpage.

# Useful Tools on the Public Website Provide Revalidation Dates and Claims Adjudication Information

### *Revalidation Report on Provider Enrollment Webpage:*

As all providers are aware, Nevada Medicaid requires every provider to revalidate their contract with Nevada Medicaid every 5 years (every 3 years for Durable Medical Equipment (DME), Disposable, Prosthetics providers) in order to continue rendering services to Nevada Medicaid recipients. Should a provider need to know when their contract is due to terminate, the provider can review the Provider Revalidation Report.

The Provider Revalidation Report is a PDF document that lists providers by revalidation due date. The Report, located on the Provider Enrollment webpage, is updated each month. Users can easily search for their name or National Provider Identifier (NPI) to find their revalidation due date. The provider can then complete revalidation timely and avoid their contract being terminated by Nevada Medicaid.

When a contract terminates, providers will have limited access to their Electronic Verification System (EVS) secure Provider Web Portal account. Also, if a contract terminates, the provider's NPI will not be active with Nevada Medicaid and, therefore, claims submissions will not be paid. It is essential that all providers begin the revalidation process early in order to avoid future delays in claims payment.

### *Claim Error/EOB Codes and Corresponding ANSI Claim Adjustment Codes List and Accounts Receivable Reason Codes List:*

Two documents on the Billing Information webpage provide information that assists providers in understanding the adjudication of their claims as they are reviewing their remittance advices.

- The "Claim Error/EOB/ANSI Code Crosswalk" is a detailed listing of Nevada Medicaid claim error codes, Explanation of Benefits (EOB) codes, and the corresponding American National Standards Institute (ANSI) claim adjustment reason and remark codes. The list includes descriptions of each code. Providers may reference the list to understand why claims are reported as denied on their remittance advice and to assist with reducing claim denials. This list is updated each month to ensure providers are receiving the most current information.
- The "Accounts Receivable Financial Reason Codes" provides a list of the reason codes that may appear on a remittance advice and the description of each code. Providers may reference this document to understand the definitions of the reason codes that appear on their remittance advice.

Providers may access the "Claim Error/EOB/ANSI Code Crosswalk" and the "Accounts Receivable Financial Reason Codes" from the "Remittance Advice Reference Material" section on the Providers Billing Information webpage and the Claims Billing Information webpage.

# Updates Regarding Expired Provider Enrollment Applications and Electronic Funds Transfer Form

### *Expired Provider Enrollment Applications and Change Requests:*

As of July 19, 2021, provider enrollment applications and change requests, which have been started in the Online Provider Enrollment (OPE) tool or returned for corrections and have been inactive for 120 days, automatically expire in OPE. The application or change request is considered active when the last save is less than 120 days from the current date.

After 120 days of inactivity, the request will expire, and the user will not be able to re-access their application, change request or returned application/change request to resume the process. Once expired, a new provider enrollment application or change request will be required. For more information, refer to the Online Provider Enrollment User Manual Chapter 1: Getting Started.

### *Electronic Funds Transfer (EFT) Authorization Form:*

Providers are required to complete the Electronic Funds Transfer (EFT) Authorization form when adding a new EFT account or changing an existing EFT on file. Effective July 19, 2021, two additional fields were added to the EFT Authorization form: the printed name and title of the person authorized to sign the form. All fields are required to be completed on the EFT form. All EFT changes must include the completed Authorization Form and a Voided Check or Bank Letter. The application or change/update will be returned if the EFT Authorization form is not completed and/or the Voided Check or Bank Letter is not included. The EFT Authorization form is available in the Online Provider Enrollment (OPE) tool and is posted on the Provider Enrollment webpage under Required Enrollment Documents.

# Free Provider Training Sessions Scheduled Each Month

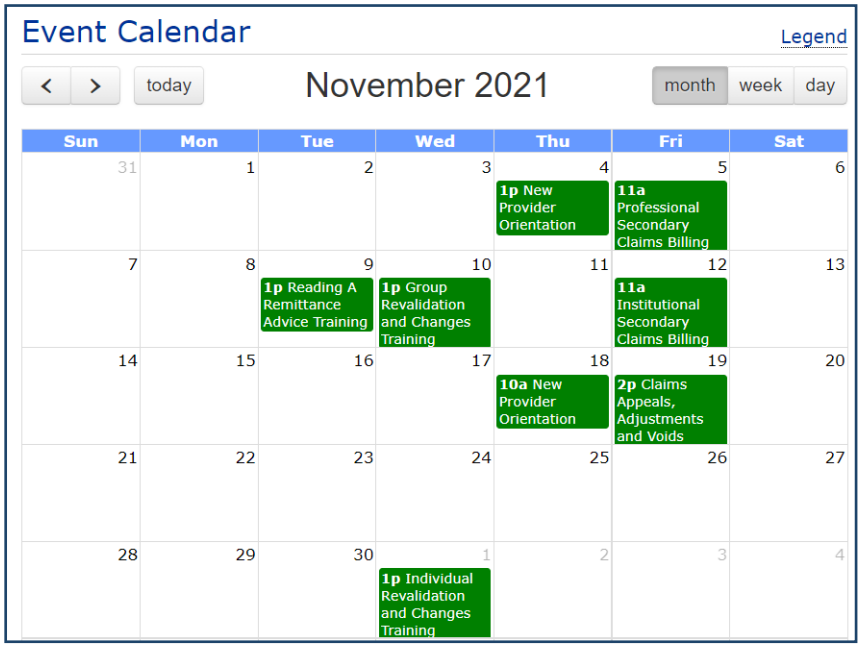
Providers are reminded that provider training sessions are scheduled throughout the year. The following sessions are open to all provider types and are offered each month:

- The **New Provider Orientation** virtual workshop includes a high-level overview of the Nevada Medicaid program, website navigation including locating billing information, forms and other helpful resources, getting started on the Electronic Verification System (EVS) and an overview of the EVS secure Provider Web Portal. New and current providers may attend.
- The **Reading a Remittance Advice** training session reviews the basics for viewing and reading a remittance advice.
- The **Claims Appeals, Adjustments and Voids** session includes how to properly appeal a denied claim, adjust or void a previously paid claim and locate valuable resources on the Nevada Medicaid website.
- The **Individual Revalidation and Changes** and **Group Revalidation and Changes** sessions include step-by-step instructions on how to properly fill out the Revalidation/Change applications located in the Electronic Verification System (EVS).
- The **Professional Secondary Claims** and **Institutional Secondary Claims** sessions include a high-level overview of how to submit Medicare crossover claims and claims with Third Party Liability (TPL).

The Training Announcements section on the Provider Training webpage lists all web announcements published regarding upcoming sessions. The website Calendar lists each session with a link to the announcement that describes the content of the training. Register to attend provider training by using the following link: 2021 Provider Training Registration Website.

**NEW:**

In addition to the above sessions scheduled each month, providers are invited to view the self-paced, computer-based training available on the new Nevada Medicaid YouTube® Training Channel. A variety of videos are being posted, including short videos that provide step-by-step instructions on completing provider enrollment applications.




November page of the website Calendar.

## Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact the Nevada Medicaid Provider Customer Service Center by calling (877) 638-3472, press Option 2 for providers, then Option 0 and then Option 2 for claim status. If you have a question regarding prior authorizations, please call (800) 525-2395.

If you have a question about Medicaid Service Policy, you can go to the DHCFP website at http://dhcfp.nv.gov. Select "Resources" and then select "Telephone Directory" for the telephone number of the Administration Office you would like to contact.

# Attention All Providers: 2022 Managed Care Caseload Distribution Notice

The Nevada Division of Health Care Financing and Policy (DHCFP) executed, on September 14, 2021, a new contract with four managed care entities to become effective January 1, 2022. Medicaid recipient membership is currently with three plans, and DHCFP will distribute the membership across the four plans on January 1, 2022. Recipients will have a 90-day period where they can select a different plan if they wish.

Implementing this new contract with the plans will cause some member disruption. DHCFP is currently working with all four contracted vendors to implement transition of care procedures to reduce provider and recipient disruption.

**The DHCFP expects this implementation to impact all providers, but expects this to be most relevant to:**

- **Hospitals (acute, sub-acute and post-acute)**
- **Primary Care providers**
- **Behavioral Health Care providers**
- **Personal Care Service providers and**
- **Home Health Care providers**

The four Managed Care Organization (MCO) vendors will not be notified of their assigned membership in time to communicate to providers which members will be moving to another vendor. It is imperative that all providers utilize the Medicaid Electronic Verification System (EVS) to determine member eligibility and MCO assignment, and to facilitate appropriate billing to the correct MCO.

All managed care households will receive a letter by November 1 notifying them of this upcoming change and the possible impact to their coverage. In December, recipients will be notified if they are assigned to a new MCO beginning January 2022. A document with the summary and timeline regarding the Medicaid Managed Care Enrollment Changes is attached to this newsletter.

It may be beneficial as a provider to share with your patients which MCOs you are credentialed with, as this may inform their decision on whether to select a different plan within the 90-day period as allowed. All four MCOs will reimburse out-of-network providers during the initial transition period in order to ensure members receive the appropriate medically necessary care. MCOs will share prior authorization information on members that are transitioning. MCOs are expected to honor prior authorizations and referrals through the transition period. After the transition period, members will be re-assigned to in-network providers for further care and coverage.

If you have questions on how to appropriately bill an MCO that you are not currently credentialed with, please contact the specific MCO via their provider services line located below.

MCOs will make additional information regarding their plans available via websites located below for both providers and members.

**Anthem Blue Cross and Blue Shield Nevada Medicaid**
https://mss.anthem.com/nevada-medicaid/home.html

- Member Services (844) 396-2329
- Provider Services (844) 396-2330

**Health Plan of Nevada (HPN)**
https://myhpnmedicaid.com/Provider

- Member Services (800) 962-8074
- Provider Services (800) 745-7065

**Molina HealthCare**
**https://www.meetmolina.com/nv-medicaid**. ***(to be activated 10/27/2021)***

- Member Services (833) 685-2109 ***(to be activated 10/27/2021)***
- Nevada Provider Line (877) 902-1207

**SilverSummit Healthplan**
https://www.silversummithealthplan.com/

- Member and Provider Services (844) 366-2880

Additional information, including Frequently Asked Questions (FAQs), MCO change form, flyers and more, will be posted on the DHCFP website as it becomes available: https://dhcfp.nv.gov/Members/BLU/MCOMain/


Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY
Medicaid Managed Care Enrollment Changes
Nevada Medicaid
September 30, 2021
Summary
• 630,000 Nevadans are enrolled in Medicaid Managed Care Organizations (MCOs).
• 3 MCOs currently serve all enrollees.
HPN
silversummit healthplan
Anthem
• 4th MCO was added to offer enrollees more options. New MCO has no enrollees.
MOLINA HEALTHCARE
• Redistribute enrollees equally to ensure equal opportunity for MCOs & enhanced choices for Nevadans.
Action Date
Strategy
10/14/21
Pull list of existing enrollees.
10/15/21
Notify existing enrollees that changes are coming.
11/24/21
Pull list of all eligible enrollees & distribute 25% to each MCO.
12/10/21
Send distribution list to MCOs.
12/15/21
Notify enrollees of their assigned MCO.
12/26/21
List of new enrollees after 11/24 pulled & distributed across all MCOs.
12/28/21
New enrollees list sent to MCOs.
12/27-12/31/21
New enrollees pulled daily & file transferred nightly to MCOs.
1/1/22
Changes effective. Members have 90 days to switch to a preferred MCO.
For more information, write to: ManagedCare@DHCFP.nv.gov