13 - Claims

For several years, Health Plan of Nevada (HPN) has been developing and refining a comprehensive policy on medical claim coding and adjudication. The goal of the policy is to fairly and consistently pay claims. Providers are expected to follow correct coding guidelines. HPN conducts claim reviews to ensure that claims are coded correctly and that incidental services are not unbundled from the primary service. HPN's claims processing time frames have been defined based upon Nevada State Statutes and Federal Regulations.

13.1 Claims Adjudication and Payment

For levels of care and up-to-date procedural coding, HPN relies upon the codes in the latest edition of Current Procedural Terminology (CPT). The Resource Based Relative Value Scale (RBRVS) along with other guidelines are used for the adjudication of claims. The following guidelines will explain how certain levels of service are evaluated to pay correctly for care provided to HPN members:

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient management
99211	N/A	N/A	N/A	N/A
99202 99212	**Straight forward**	**Minimal** **-1** self-limited or minor problem	**Minimal or none**	***Minimal risk of morbidity from additional diagnostic testing or treatment***
99203 99213	**Low**	Low - **2** or more self-limited or minor problems; **or** **-1** stable, chronic illness; **or** **-1** acute, uncomplicated illness or injury	Limited *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** **- Any combination of 2 from the following:** - Review of prior external note(s) from each unique source*; - Review of the result(s) of each unique test*; - Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

*From AMA CPT 2022 Professional Edition

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient management
99204 99214	**Moderate**	**Moderate** **- 1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** **- 2** or more stable, chronic illnesses; **or** **- 1** undiagnosed new problem with uncertain prognosis; **or** **- 1** acute illness with systemic systems; **or** **- 1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s):** **- Any combination of 3 from the following:** - Review of prior external note(s) from each unique source*; - Review of the result(s) of each unique test*; - Ordering of each unique test* - Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported): **or** **Category 3: Discussion of management or test interpretation** - Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* - Prescription drug management - Decision regarding minor surgery with identified patient or procedure risk factors - Decision regarding elective major surgery without identified patient or procedure risk factors - Diagnosis or treatment significantly limited by social determinants of health
99205 99215	**High**	**High** **- 1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** **- 1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s):** **- Any combination of 3 from the following:** - Review of prior external note(s) from each unique source*; - Review of the result(s) of each unique test*; - Ordering of each unique test* - Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported): **or** **Category 3: Discussion of management or test interpretation** - Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only* -Drug therapy requiring intensive monitoring for toxicity - Decision regarding elective major surgery with identified patient or procedure risk factors - Decision regarding emergency major surgery - Decision regarding hospitalization - Decision not to resuscitate or to de-escalate care because of poor prognosis

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Medical Records Required
Codes 99204, 99214, 99205, 99215, 99244, 99245

If you use these billing codes, HPN **requires a copy of the chart/progress** note to accompany the billing. The issue of confidentiality is strictly maintained by having only medical personnel review the chart/progress note.

As of October 1, 2022, HPN (excluding HPN Medicaid) is aligning with CMS and the UHC Commercial Reimbursement Policy and does not reimburse for consultation service codes 99241-99245, 99251-99255, including when reported with telehealth modifier for any practice or care provider, regardless of the fee schedule of payment methodology applied. The codes eligible for reimbursement are those that identify the appropriate Evaluation and Management (E/M) code which describes the office visit, hospital care, nursing facility care, home service or domiciliary/rest home care service provided to the patient.

As outlined above, **if a chart/progress note is required with the billing but one is not included by the physician's office, the claim will be coded to a limited level of service.** The claim can be re-submitted for consideration with the appropriate chart/progress note included with the appeal letter.

HPN recognizes that claim problems occur from time to time. We appreciate our physicians and providers bringing them to our attention. We handle these claims as expeditiously as we can. Reasonable procedural guidelines are established to manage them fairly.

Dental Claims Guidelines

Health Plan of Nevada (HPN) applies the following guidelines for claim processing:

- Periodontal charting is required for periodontal scaling and root planning, as well as periodontal surgeries.(Periodontal charting is mandatory and a current FMX)
- X-rays are required for crowns as well as documentation regarding whether the placement is an initial or a replacement including the age of the existing crown(s).
- X-rays and a narrative are required for non-cosmetic inlays and onlays when covered.
- X-rays are required for bridges, as well as documentation regarding whether the placement is an initial or a replacement including the age of the existing bridge(s).
- Extraction dates or treatment plan for extractions are required for dentures and partials, as well as documentation regarding whether the placement is an initial or a replacement including the age of the existing denture/partial.

13.2 Risk Adjustment Data

U.S. Department of Health and Human Services (HHS) requires risk adjustment for commercial small group and individual benefit plans. HHS utilizes Hierarchical Condition Categories (HCCs) to calculate an annual patient risk score that represents the specific patient's disease burden. Every year, HHS requires information about the demographic and health of our members. Diagnoses do not carry forward to the following year and must be assessed and reported every year.

The risk adjustment data you give us, including clinical documentation and diagnosis codes, must be accurate and complete. It is critical for you to refer to the ICD-10-CM coding guide to code claims accurately. To comply with risk adjustment guidelines, specific ICD-10-CM codes are required.

- Medical records must support all conditions coded on the claims or encounters you submit using clear, complete, and specific language.
- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment, or management.
- Never use a diagnosis code for a “probable” or “questionable” diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results and/or other reasons for the visit.
- Specify whether conditions are chronic or acute in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member’s condition and pertinent history at the time of the visit. Do not code conditions that no longer exist.
- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member’s condition.
- Check the diagnosis code against the member’s gender.
- Sign chart entries with credentials.
- All claims and/or encounters submitted to us for risk adjustment consideration are subject audit. Audits may come from HHS, or us, where we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please give us any requested medical records quickly. Please provide all available medical documentation for the services rendered to the member.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous.

13.3 Billing Procedures

A managed system of health care necessitates that all providers be accountable for both the treatment dispensed to the patient and the charges billed to the payer for this treatment.

Plan Providers agree to accept the contracted amount paid by Health Plan of Nevada (HPN) as payment in full. The patient may be billed for the following:

- co-payment
- deductible
- coinsurance
- non-covered services - as defined in the member’s Evidence of Coverage. All such services must be fully explained to members prior to providing the services.

Billings for some members may involve coordination of benefits. For example:

If the member is covered as a dependent under HPN and an employee under other group coverage, the other group coverage has primary responsibility for the costs of services.

Dependent children carried on two plans may be primarily covered by either HPN or the other group coverage.

When a member is injured through the actions of another person (third party) and is entitled to compensation from that third party, members are asked to assign HPN any compensation for which they are entitled from the third party. This will allow HPN to seek reimbursement from the third party for claims it paid on behalf of the member.

Please follow these simple steps when billing HPN:

- Verify eligibility by using one of the following three options:
  - Calling the Member Services Department. Please refer to Section 3 Frequently Called Numbers for the appropriate Member Services Department phone number.
  - Online Provider Center – online eligibility system. *(For information or access to the Online Provider Center, please refer to section 7.4)*

  Interactive Voice Response HPN **(702) 242-7724** or **(800) 768-2808**
  - *(For more information about IVR, please refer to section 7.3)*
- Check the back of the member's ID card for claim and billing information.
- Note the member number listed on the HPN ID card on the claim.
- Collect the applicable co-payment, deductible and/or coinsurance from the member. Check with the Member Services Department on any questions about the member's coverage.
- Use industry standard EDI transactions or claim forms to bill HPN making sure to include the information below. *(Clean Claim elements can be found at the end of this section)*
  1. Patient's name
  2. Date of Birth
  3. Member number(s)
  4. Other insurance information
  5. Diagnosis(es) and ICD-10 code(s)
  6. Date(s) of service
  7. Services provided, CPT code(s), and appropriate modifiers and units
  8. Copy of chart/progress note*****
  9. Amount charged
  10. Provider's signature and tax ID number
  11. National Provider Identification Number (NPI)

- All billings for an extended or comprehensive level of service require a chart/progress note. If the documentation does not substantiate the code used, the claim will be coded to the appropriate level of service. The claim can be reconsidered by sending a copy of the EOP together with the additional chart/progress notes and indicate "resubmission" on the EOP.

- All billings that require a modifier to notate a separately payable service was performed require a chart/progress note. If the documentation does not support the separately payable service, then the code will remain bundled.

- Submit claims(s) to:

  Health Plan of Nevada, Inc.
  Attention: Claims
  P. O. Box 15645
  Las Vegas, NV 89114-5645

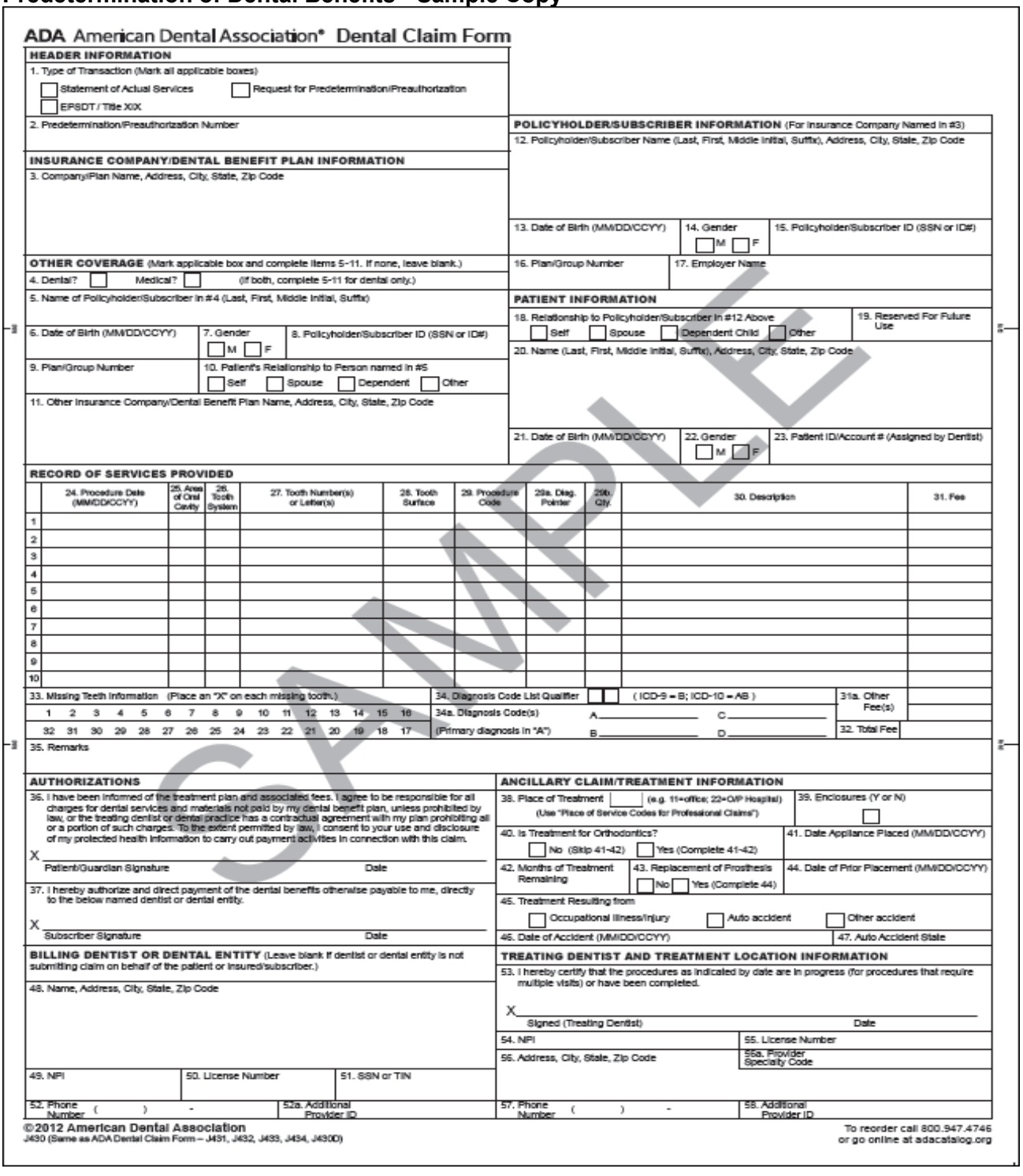
13.4 Dental Predetermination of Benefits

Dental predetermination of benefits is recommended for the treatment of any dental disease, defect, or injury. Predetermination of benefits is processed at the claim level and should be submitted to the claims billing address. Predetermination is not mandatory and benefits are not reduced as a result of predetermination not being submitted.

To submit a predetermination of benefits, prepare a standard claim form using American Dental Association (ADA) codes and submit the predetermination to:

Health Plan of Nevada, Inc.
Attention: Dental Claims
P.O. Box 15645
Las Vegas, NV 89114-5645

Predetermination of Dental Benefits - Sample Copy



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at adacatalog.org

13.5 National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses use the NPIs in the administrative and financial transactions adopted under HIPAA. A valid NPI is required on all covered claims (paper and electronic) in addition to the TIN.

What is the NPI – National Provider Identifier?

- The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). Intelligence free means that the numbers do not carry information about health care providers, such as the state they practice or their provider type or specialization.
- The NPI replaces health care provider identifiers in use today in HIPPA transactions. Those numbers include Medicare legacy IDs (UPIN, OSCAR, PIN and National Supplier Clearinghouse or NSC).
- The provider's NPI does not change and remains with the provider regardless of job or location.

For more information regarding NPI you can contact CMS at **(800) 465-3203**, Provider Services at **(702)-242-7088 or (800) 745-7065,** or information is available on a CMS web page: **https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/**

13.6 Imaging, Batch Processing, Claims Processing

All claims are scanned into the work flow system within 7-8 business days of receipt. To assist in the scanning process of your claim, please avoid the following:

- light images
- red ink
- printing alignment where the print is on the line
- highlighting on the claim
- font sizes smaller than 10 pt.

They make the image illegible and may result in the claim being delayed or returned. Images of the claims are keyed into our work flow system. The claims are then automatically adjudicated nightly through batch processing on our claims payment system. Pended claims are reviewed using the image, not the paper claim.

The system improves our overall efficiency and turnaround time, as well as enables all departments within HPN to provide our customers with superior service.

13.7 Altered Claim Images

Federal requirements regarding fraud review have prompted the need for restrictions regarding altered claim images. All claim images received which have an apparent alteration (i.e. handwritten dates of service, charges, diagnosis, CPT code information, and/or information crossed out, etc.) will be returned to the provider's office with a cover letter stating,

"This claim cannot be processed for payment. It is apparent that some of the information on the claim form has been altered. Pursuant to company policy we cannot accept altered claim forms or photocopies of claim forms. All claims must be submitted on the correct form with clean unaltered information."

This process allows Health Plan of Nevada to follow industry standard guidelines with regard to altered claim images and ensures that HPN maintains compliance with Federal Regulations.

13.8 Electronic Claims Submission

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 included administrative simplification provisions requiring standards be adopted for electronic health care transactions.

The transaction with the most discussion has been electronic claim submission. Any claim submitted by a provider to a health plan must be in the HIPAA approved ANSI 837 format as of October 16, 2003. Many plans and providers have opted to use intermediaries to meet this deadline.

HPN has chosen to use intermediaries for the receipt of electronic claims data. HPN has completed compliance testing and is able to receive HIPAA compliant electronic claims from the following clearinghouse:

OptumInsight
1755 Telstar Drive, #400
Colorado Springs, CO 80920
(800) 341-6141

For Electronic Claims Submission, please use the following Payor ID's:
Claims – Payor ID 76342 or 76343

Although the health plan has one contracted clearinghouse, you may coordinate with your clearinghouse to transmit your electronic claims and encounter data to OptumInsight.

HPN will continue to receive paper claims. If an electronic claim is received which requires an attachment, the claim will be adjudicated without the attachment and the explanation of payment will need to be submitted with the attachment for reconsideration of the claim. Please contact us to discuss options for submitting attachments with your electronic claims.

13.9 Electronic Explanation of Payment (EOP) Requests

Explanations of Payments (EOP's) are generated each time a claim or encounter is processed by the health plan. EOP's contain detailed information such as claim adjudication, processed date and check numbers, as applicable.

An electronic copy of the EOP may be obtained through the **Online Provider Center**, which offers providers the opportunity to view the EOP on line. For more information regarding the **Online Provider Center** see Section 7.4.

Explanation of Payments can be printed by logging into your **Online Provider Center** account. If you do not have an Online Provider Center account, please go to

provider.healthplanofnevada.com and click on “Create an Account” and follow the instructions. For additional information or questions please contact your Provider Advocate.

13.10 Electronic Funds Transfer (EFT’s)

HPN/SHL offers free electronic funds transfer (EFT) through InstaMed, a new EFT/ERA Provider. InstaMed offers the free Payer Payments solution to deliver your payments as electronic remittance advice (ERA) and electronic funds transfer (EFT). To receive your HPN and SHL payments as free ERA/EFT, please register at **www.instamed.com/eraeft**.

You may also contact InstaMed directly at (866) 945-7990 or **connect@instamed.com** with any questions.

13.11 HIPAA 5010

The Centers for Medicare & Medicaid Services (CMS) mandated that all physicians/hospitals and payers (including clearinghouses and health plans) exchange key business transactional data using the HIPAA 5010.

5010 is the newest version of the HIPAA electronic transaction standards. The 5010 standards include improvements in health care transactions such as structural, scope and overview of the transaction (also known as front matter), technical and data content such as improved eligibility responses and better search options. The 5010 standards are more specific in requiring the data that is needed, collected and transmitted in a transaction. The new claims transactions standard contains significant improvements for reporting of clinical data, by requiring diagnosis codes and procedure codes to be captured based on principle diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions are intended to improve the understanding of clinical data and to improve monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, hospital lengths of stay for certain conditions, and clinical reasons for patients’ decisions to seek hospital care.

CMS requires that all 5010 data elements are included in each claim submission, therefore HPN will not accept 5010 claim submissions if data elements are missing.

To learn more about the 5010 mandate please visit the government website at:
https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/Version_5010.html

The 5010 requirements apply to all types of claims and claim related transactions, including claims that are reimbursed through capitated payment arrangements or claims from delegated entities.

13.12 Timely Filing Period

Commercial claims for all covered services shall be submitted to the Health Plan within thirty (30) calendar days of the date of service but, in any event, no later than ninety (90) calendar days following the date of service. Claims which are not submitted within this timely filing period or with incomplete or inaccurate information shall not be honored for payment. Re-considerations or resubmission or any follow-up must be clearly identified and submitted within one year from the date of service.

Medicaid claims should be submitted within 30 calendar days from the date of service, but in any event, no later than 180 calendar days after the date of service. Medicaid claims submitted by out-of-state providers must be received within 365 days of the date of service. The 180 or 365 days is calculated by subtracting the last date of service from the date the claim was received. Re-considerations or resubmission or any follow-up must be clearly identified and submitted within 30 calendar days from the date on the remittance advice.

Claims not submitted within these timely filing periods will not be honored for payment. Timely filing is always based on date of service or date of eligibility. You will be notified of any denials of requested covered services. You may request an appeal by the HPN Medical Director and/or the peer review committee.

13.13 Coordination of Benefits

When HPN is the secondary insurance payer, timely filing is 9 months from the date of service.

13.14 Claim Reconsideration Process

A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly and confirm your contract is set up correctly in our system.

The most efficient way to submit a single claim reconsideration request is through our online provider center.

After you log into the online provider center:

- Select Claim Search
- Then choose the “Search by” Function (Claim ID, Member ID, Member Name or Claim Status) and enter the appropriate information and click on “Submit”
- Next, click on the claim number (which will be highlighted blue) of the claim you wish to have reconsidered.
- Once you are on the “Claims Detail” page, click on **Submit Reconsideration Request**

This is where you would attach any supporting documents needed (records, billing statements, EOB from a primary carrier etc.), as well as make note of what you are appealing with the claim. **Please provide a detailed explanation as to why you are submitting a reconsideration request**. In order to attach more documents, you would click “Add another file…”. You will **NOT** need to submit a Claims Reconsideration Form.

After Clicking submit you’ll get a confirmation that your request has been submitted successfully.

Currently the online provider center ***does not*** accept project requests or capitated claim reconsideration requests. Please continue to submit your claims project request spreadsheets with 20 or more claims and your capitated claim reconsideration requests to **PRI@uhc.com.**

Health Plan of Nevada has developed a Quick Reference Guide for our Providers to assist you in the reconsideration process when submitting a reconsideration by mail, phone or project request by email. Please visit our website at **www.healthplanofnevada.com/Provider**. Click on “I need help with”, then “Submit/Appeal a Claim” to access the Quick Reference Guide.

The Quick Reference Guide will outline instructions for submitting Claim Reconsideration requests using the 3 following methods.

Mail: Using the Claim Reconsideration form you can submit a claims reconsideration request and include all pertinent documentation for reconsideration. The claim reconsideration form is available for download on **www.healthplanofnevada.com/provider**, "I need help with" then "Frequently Used Forms" or in the Frequently Used Forms, Section 24, of this summary guide.

Telephone: You can call Member Services to request an adjustment for a claim that does not require written documentation. For HPN members please call **(800) 962-8074**.

Claims Project: If you have a request involving 20 or more paid or denied claims, you may send a claims project request to us. The project may be sent via secure email to **pri@uhc.com**. An Excel template is also available for download on **www.healthplanofnevada.com/provider**. Click on "I need help with", then "Submit/Appeal a Claim". Please follow the instructions in the Claims Quick Reference Guide.

Please allow 30 days from the received date of the claims reconsideration for review.

13.15 Clean Claim Elements

NAC by Comm'r of Insurance

NAC 686A.280 Definitions. (NRS 679B.130, 686A.015) As used in **NAC 686A.280** to **686A.306**, inclusive, unless the context otherwise requires, the words and terms defined in **NAC 686A.282**, **686A.284** and **686A.286** have the meanings ascribed to them in those sections.
(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.282 "Clean claim" defined. (NRS 679B.130, 686A.015) A "clean claim" means a claim:
1. That contains the information required to be included for the applicable use of a form prescribed in **NAC 686A.288**; and
2. For which any additional information that has been requested pursuant to subsection 2 of **NRS 683A.0879**, **689A.410**, **689B.255**, **689C.485**, **695B.2505** or **695C.185** because of any particular or unusual circumstances that would have impeded the payer from paying the claim has been received.
(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R026-12, 9-14-2012)

NAC 686A.284 "Health care practitioner" defined. (NRS 679B.130, 686A.015) "Health care practitioner" means a person licensed to practice one of the health professions regulated by title 54 of NRS.
(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.286 "Payer" defined. (NRS 679B.130, 686A.015) "Payer" includes administrators, individual health insurers, group health insurers, nonprofit hospitals, medical and dental service corporations and health maintenance organizations who pay claims under any contract for health insurance.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.288 Forms for submission of claims. (NRS 679B.130, 679B.138, 686A.015)

1. The payer of a claim under a contract for health insurance:

(a) Shall accept a claim submitted on a form that:

(1) Has been approved by the United States Department of Health and Human Services for the filing of a claim under a contract for health insurance; and

(2) Contains the information necessary to constitute a clean claim.

(b) Shall not require the completion of any other form for the purpose of processing the claim.

2. For the purposes of this section, a "form that has been approved by the United States Department of Health and Human Services" means:

(a) For claims submitted by a hospital or other institutional provider, Centers for Medicare and Medicaid Services Form CMS-1450, which is commonly referred to as UB-04, or its successor form; and

(b) For claims submitted by a health care practitioner or other person entitled to reimbursement, Centers for Medicare and Medicaid Services Form CMS-1500, or its successor form.

3. Form CMS-1450, also known as the UB-04 claim form, published by the National Uniform Billing Committee, is available from the American Hospital Association on the Internet at **http://aha.org/**, by telephone at (800) 242-2626, or by mail at 155 North Wacker Drive, Chicago, Illinois 60606, at the price of $46 for members and $56 for nonmembers. Copies of the form may also be available through office supply stores.

4. Form CMS-1500, published by the National Uniform Claim Committee, is available from the United States Government Printing Office on the Internet website **http://bookstore.gpo.gov**, by mail at P.O. Box 979050, St. Louis, Missouri 63197-9000, or by toll-free telephone at (866) 512-1800, at the price of $29. Copies of the form may also be available through local printing companies and office supply stores.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R026-12, 9-14-2012)

NAC 686A.290 Commencement of time for adjudication and payment of claims. (NRS 679B.130, 686A.015) The time for a payer to adjudicate and pay claims pursuant to **NRS 683A.0879**, **689A.410**, **689B.255**, **689C.485**, **695B.2505** and **695C.185** begins when the payer receives a clean claim.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.302 Claim by hospital or other institutional provider: Prohibited use of field; optional inclusion of additional data. (NRS 679B.130, 679B.138, 686A.015)

1. A payer shall not use or require a hospital or other institutional provider to use any field for purposes that are inconsistent with the data required for the submission of a clean claim, or in addition to the applicable standard code set.

2. A hospital or other institutional provider may elect to include data in addition to the data required for the submission of a clean claim.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R026-12, 9-14-2012)

NAC 686A.303 Coverage for dental procedures for children. (NRS 679B.130, 686A.015)

1. A policy or contract of health insurance issued pursuant to **chapter 689A**, **689B**, **689C**, **695B** or **695C** of NRS which is delivered or issued for delivery in this State and which provides

coverage for medically required hospital services must not deny coverage for a dependent child covered by that policy or contract who is referred by a dentist to a hospital, a surgical center for ambulatory patients, an independent center for emergency medical care or a rural clinic, licensed pursuant to **chapter 449** of NRS, for general anesthesia and associated care and is being referred because, in the opinion of the dentist, the child:

(a) Has a physical, mental or medically compromising condition;

(b) Has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy;

(c) Is extremely uncooperative, unmanageable or anxious; or

(d) Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

2. An insurer may:

(a) Require prior authorization for the provision of general anesthesia and for hospitalization or the use of a surgical center for ambulatory patients for dental procedures in the same manner that the insurer requires prior authorization for hospitalization for the provision of general anesthesia for other diseases or conditions covered by the policy or contract of health insurance;

(b) Require that the benefits paid be adjusted according to the policy or contract of health insurance if the services are rendered by a provider who is not designated by or associated with the insurer, if applicable; and

(c) Restrict coverage to include only general anesthesia provided during procedures performed by:

(1) A qualified specialist in pediatric dentistry;

(2) A dentist who is qualified, by virtue of education, in a recognized dental specialty for which hospital privileges are granted; or

(3) A dentist who is certified by a hospital, by virtue of completion of an accredited program of postgraduate hospital training, and is granted hospital privileges.

3. The failure of an insurer to comply with the provisions of this section constitutes an unfair trade practice pursuant to **NRS 686A.170**.

4. A policy or contract of health insurance subject to the provisions of this section that is delivered, issued for delivery or renewed on or after April 24, 2003, has the legal effect of including the coverage required by this section, and any provision of such a policy or contract that conflicts with the provisions of this section is void.

(Added to NAC by Comm'r of Insurance by R088-02, eff. 4-24-2003)

NAC 686A.304 Processing of claims: Duties of payer; date of receipt of claim. (NRS 679B.130, 679B.136, 679B.138, 686A.015)

1. Each payer shall establish a tracking system to monitor the timeliness of the payer's processing of a claim.

2. Each payer shall:

(a) Maintain a written or electronic record of the date of receipt of a claim;

(b) For receipt of a written claim, date-stamp the claim with the date received; and

(c) For receipt of an electronic claim, assign the document a batch number that includes the date received.

3. Except as otherwise provided in subsection 5, a claim is deemed to have been received by a payer on the date of receipt of the claim stated in the written or electronic record required pursuant to subsection 2.

4. A payer shall provide, within 20 working days after a request by a health care practitioner, hospital, institutional provider or person entitled to reimbursement, verification of the date of receipt of a claim as stated in the written or electronic record pursuant to subsection 2, in:

(a) Electronic form, if the request was for electronic verification; or

(b) Written form, including microfilm, if the request was for written verification.

5. A claim shall be deemed received by a payer:

(a) Five working days after the date the health care practitioner, hospital, institutional provider or person entitled to reimbursement placed the claim in the United States mail, if the health care practitioner, hospital, institutional provider or person entitled to reimbursement possesses the receipt of mailing the claim; or

(b) On the date the receipt of the claim is recorded by a courier, if the claim was delivered by a courier.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.306 Proof of compliance by payer. (NRS 679B.130, 679B.136, 679B.138, 686A.015) The Commissioner, when deemed appropriate, will require a payer to report substantial compliance with the provisions of **NAC 686A.280** to **686A.306**, inclusive. Proof that claims are being paid by a payer within the specified limits includes, without limitation, records demonstrating that a tracking system required by **NAC 686A.304** has been developed and implemented.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R129-03, 4-16-2004)