STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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What Happens After Attestation

Upon attestation completion (Confirm and Submit), Provider enrollment is set to "Payment Pending". At that time, the following processes occur:

1. Pre-payment Review

Providers may be selected for pre-payment review and may be asked to provide additional information to support their attestation volumes and documentation proving they have adopted, implemented or upgraded (AIU) to certified EHR technology.

DHCFP may request the following:

- Payer-mix report and/or;
- Detailed report showing all encounters and/or;
- Any additional documents as deemed necessary by the reviewer including, but not limited to signed contracts, invoices, or purchase agreements to validate AIU attestation.

Once the Provider has successfully passed through the pre-payment review, State level checks (Provider and Payee Checks) are performed.

2. Provider Check

The Provider is checked to determine if any state exclusions/sanctions have been applied since the attestation. If any exclusions and/or sanctions exist, the Provider is set to "Not Eligible" and the process is stopped.

3. Payee Check

The Payee is checked to determine if any state exclusions/sanctions have been applied since the attestation. If any exclusions and/or sanctions exist, Provider is set back to "In Progress" and sent an email stating they need to select a new Payee either with CMS or in NEIPS (if another matching enrollment for the NPI/TIN combination is active) prior to receiving payment.

4. Payment Approval Queue

The State reviews Providers that have successfully been passed through the above processes and approves them for payment. The Provider and Payee are evaluated against State Sanction/Exclusion data again to ensure no changes have occurred while sitting in the payment queue.

5. Federal Payment Check

A request for payment review is sent to CMS. CMS will deny request if:

- Provider is federally sanctioned;
- Provider is participating in the Medicare program and is not a dually eligible hospital;
- An Eligible Provider (EP) has been paid for the same program year by another state; and/or;
- Provider's registration record is NOT "Active" with CMS.

PLEASE NOTE: If the Provider enters the CMS site to review their registration, their registration resets to "In Progress". The State cannot pay a Provider whose status is "In Progress" within the CMS system. The Provider must remember to confirm all changes before they exit the CMS portal - EVEN IF NO CHANGES ARE MADE.

6. State Payment Request

Payment request is sent to the State's MMIS system where it passes through validation edits. If the Payee is valid, the payment request is processed based on the State defined payment cycle. Upon confirmation of the request acceptance from the MMIS payment system, the Provider is set to "Paid" status and payment confirmation is sent to CMS (D18).

7. Payment Disbursement

The State issues payment only after all of the above checks and reviews have been passed. The Provider should expect their incentive payment within 45 days following the completion of above reviews and checks.