Applied Behavior Analysis (ABA)

Provider Type 85 Training
Objectives
Objectives

This presentation is a review of Applied Behavior Analysis (ABA) policy, program information, prior authorizations, provider billing and resources.

- Locate Medicaid Program Information and Policy
- Locate Public Notice/Hearings Information
- Review Web Announcements
- Utilize the Authorization Criteria Function
- Locate Prior Authorization Forms and Instructions
- Properly submit a Prior Authorization via the Electronic Verification System (EVS) on the Provider Web Portal
- Access the Search Fee Schedule and DHCFP Rates Unit
- Locate the Billing Information
- Submit Claims using Direct Data Entry (DDE) via the EVS Secure Provider Web Portal
Medicaid Website
EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

To access EVS, user must have internet access and a computer with a web browser. (Microsoft Internet Explorer 9.0 or higher recommended)
Program Information
Locating Program Information

- Select “DHCFP Home” from the Featured Links box or the top right hand side of the webpage.
Locating Program Information, continued

- Highlight “Programs” and select “Applied Behavior Analysis” from the sub-menu
Locating the Medicaid Services Manual

- Step 1: Highlight “Quick Links” from top blue tool bar
- Step 2: Select “Medicaid Services Manual” from the drop-down menu
- Note: MSM Chapters will open in a new webpage through the DHCFP website
Locating the Medicaid Services Manual, continued

To do a keyword search on any .PDF document, click Ctrl F to generate the search box. Enter the desired search word and click Previous or Next.

- Medicaid Services Manual - Complete
- 100 Medicaid Program
- 200 Hospital Services
- 300 Radiology Services
- 400 Mental Health and Alcohol and Substance Abuse Services
- 500 Nursing Facilities
- 600 Physician Services
- 700 Reimbursement, Analysis and Payment
- 800 Laboratory Services
- 900 Private Duty Nursing
- 1000 Dental
- 1100 Ocular Services
- 1200 Prescribed Drugs
- 1300 DME Disposable Supplies and Supplements
- 1400 Home Health Agency
- 1500 Healthy Kids Program
- 1600 Intermediate Care for Individuals with Intellectual Disabilities
- 1700 Therapy
- 1800 Adult Day Health Care
- 1900 Transportation Services
- 2000 Audiology Services
- 2100 Home and Community Based Waiver for Individuals with Intellectual Disabilities
- 2200 Home and Community Based Waiver for the Frail Elderly
- 2300 Waiver for Persons with Physical Disabilities
- 2400 Home Based Habilitation Services
- 2500 Case Management

- Select “Chapter 400” and “Chapter 1500”

- From the next page, always make sure that the “Current” policy is selected
Division of Health Care Financing and Policy Public Notices
Locating Public Notice Information

- Select “DHCFP Home” from the Featured Links box or the top right hand side of the webpage.
Locating Public Notice Information, continued

- From the “DHCFP Home” page, highlight Public Notices
- Select Meetings/Public Notices
- This will provide information pertaining to upcoming meetings
Viewing Web Announcements
Web Announcements

- Select “View All Web Announcements” to view Web Announcements pertaining to Applied Behavior Analysis
Web Announcements, continued

• Results can be narrowed by selecting a category from the drop-down menu or utilizing the “Ctrl F” to bring up a Search Box.
Web Announcements, continued

Web Announcement 1372

• All ABA services require an Ordering, Prescribing or Referring (OPR) provider.
• The referring provider’s name and National Provider Identifier (NPI) must be indicated in the claim form.
• The OPR provider must be an individual provider and cannot be the same as the servicing provider.
• The OPR provider must be operating within scope and one of the following: Physician, Physician’s Assistant, Advanced Practice Registered Nurse or Psychologist.

Reminder: Any provider NPI that is indicated on a claim MUST be enrolled with Nevada Medicaid.
Authorization Criteria Function
Authorization Criteria

Authorization Criteria is located at www.medicaid.nv.gov under “Featured Links”
Authorization Criteria, continued

- Step 1 – Select “Code Type”
- Step 2 – Input either a Procedure Code or Description. This field uses a predictive search
- Step 3: Input Provider Type
- Step 4: Select “Search”
Authorization Criteria, continued

- Verify that “Effective Date” ends in 2299. This will provide the current information.
Prior Authorization Forms
Locating Prior Authorization Forms

- Step 1: Highlight “Providers” from top blue tool bar
- Step 2: Select “Forms” from the drop-down menu
Locating Prior Authorization Forms, continued

Prior Authorization Forms

All prior authorization forms are for completion and submission by current Medicaid providers only.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-1</td>
<td>Durable Medical Equipment Prior Authorization Request</td>
</tr>
<tr>
<td>FA-1A</td>
<td>Usage Evaluation for Continuing Use of BIPAP and CPAP Devices</td>
</tr>
<tr>
<td>FA-1B</td>
<td>Mobility Assessment and Prior Authorization (PA), Revised 12/29/10</td>
</tr>
<tr>
<td>FA-1B</td>
<td>Mobility Assessment and Prior Authorization (PA) Instructions</td>
</tr>
<tr>
<td>FA-1C</td>
<td>Oxygen Equipment and Supplies Prior Authorization Request</td>
</tr>
<tr>
<td>FA-1D</td>
<td>Wheelchair Repair Form</td>
</tr>
<tr>
<td>FA-3</td>
<td>Inpatient Rehabilitation Referral/Assignment</td>
</tr>
<tr>
<td>FA-4</td>
<td>Long Term Acute Care Prior Authorization</td>
</tr>
<tr>
<td>FA-6</td>
<td>Outpatient Medical/Surgical Services Prior Authorization Request</td>
</tr>
<tr>
<td>FA-7</td>
<td>Outpatient Rehabilitation and Therapy Services Prior Authorization Request</td>
</tr>
<tr>
<td>FA-8</td>
<td>Inpatient Medical/Surgical Prior Authorization Request</td>
</tr>
<tr>
<td>FA-8A</td>
<td>Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections</td>
</tr>
<tr>
<td>FA-10A</td>
<td>Psychological Testing</td>
</tr>
<tr>
<td>FA-10B</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>FA-10C</td>
<td>Developmental Testing</td>
</tr>
<tr>
<td>FA-10D</td>
<td>Neurobehavioral Status Exam</td>
</tr>
<tr>
<td>FA-11</td>
<td>Outpatient Mental Health Request</td>
</tr>
<tr>
<td>FA-11A</td>
<td>Behavioral Health Authorization</td>
</tr>
<tr>
<td>FA-11B</td>
<td>Substance Use Certification with Prior Authorization Request</td>
</tr>
<tr>
<td>FA-11E</td>
<td>Applied Behavior Analysis (ABA) Authorization Request</td>
</tr>
<tr>
<td>FA-11F</td>
<td>Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services</td>
</tr>
<tr>
<td>FA-12</td>
<td>Inpatient Mental Health Prior Authorization</td>
</tr>
</tbody>
</table>

- While on the “Forms” page, locate and choose appropriate forms
- Make sure that all instructions are followed
- All active forms are fillable forms for easy uploading into EVS for PA request submission
FA-11E Applied Behavior Analysis (ABA) Authorization Request

Page 1

- Page 1 must be filled out entirely
- Signature of guardian/parent must be prior to start date of service (DOS) (Section V)
Page 2

- Page 2 is for targeted behaviors
- The dates of service must match the current dates of service requested for the 180 days and must match dates of service on Treatment plan
• Section VI is for concurrent requests and must list progression/regression with services.

• Section VII is for BOTH Initial and Concurrent requests and must list goals for parent/guardian training if services are requested accordingly.

• Section VIII must be check marked.

• Section IX must include documentation and signature of the Individualized Education Plan/Program (IEP) if this is checked yes. If marked “no” or N/A, no signature or summary is required.
• Pages 4 and 5 are for services requested. This is where “Focused” or “Comprehensive” must be marked indicating the service delivery model as this will indicate the appropriate units/hours needed to fulfill the model being delivered.
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Page 5 of requested services must be signed by Licensed Psychologist or Board Certified Behavioral Analyst (BCBA).
FA-11E Applied Behavior Analysis (ABA) Authorization Request, continued

• For all 2019 codes: 1 unit equals 15 minutes
  • 97153
  • 97155
  • 0373T
  • 97154
  • 97158
  • 97156
  • 97157

• Modifier UD is added to indicate the services are being performed by a Lower Level Professional and is used to identify “under the direction of”. UD/HQ Modifiers: Code 97155 with the UD modifier is for a BCaBA or an RBT to perform oversight vs. the BCBA.

• Form FA-11F is required on all initial requests.
• Documentation is important when requesting services. Additional pages can be submitted if necessary.
• Unscheduled revisions are utilized to request additional units when there is a change in the status of the recipient.
• If a service is modified/reduced the appeals process needs to be utilized: Peer to Peer within 10 business days, or Reconsideration within 30 days of denial.

Data Correction, form FA-29, is utilized to change a date submitted in error, end services, or make a correction to an existing PA as long as it does not include increasing units on a modified request as that is the purpose of the appeals process.
FA-11F Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services

- Required for all initial requests
- Must be submitted with supporting documents
- Diagnosis determined by clinical evaluation
- Must be signed by diagnosing physician and include credentials, NPI, date of diagnosis
- Diagnosis of autism must be performed by Physician, Physician’s Assistant, Advanced Practice Registered Nurse or Psychologist
Submitting a Prior Authorization via the EVS Secure Provider Web Portal
Once registered, users may access their accounts from the PWP “Home” page by:

- Entering the User ID
- Clicking the Log In button
Logging in to the Provider Web Portal, continued

Once the user has clicked the Log In button, the user will need to provide identity verification as follows:

- Answer the **Challenge Question** to verify identity
- Choose whether log in is on a **personal computer** or **public computer**
- Click the **Continue** button
The user will continue providing identity verification as follows:
1. Confirming that the **Site Key** and **Passphrase** are correct
2. Entering **Password**
3. Clicking the **Sign In** button

NOTE: If this information is incorrect, users should not enter their password. Instead, they should contact the help desk by clicking the **Customer help desk** link.
Welcome Screen

Once the provider information has been verified, the user may explore the features of the PWP, including:

A. Additional tabs for users to research eligibility, submit claims and PAs, access additional resources, and more
B. Important broadcast messages
C. Links to contact customer support services
D. Links to manage user account settings, such as passwords and delegate access
E. Links to additional information regarding Medicaid programs and services
F. Links to additional PWP resources
Navigating the Provider Web Portal

The tabs at the top of the page provide users quick access to helpful pages and information:

A. **My Home**: Confirm and update provider information and check messages
B. **Eligibility**: Search for recipient eligibility information
C. **Claims**: Submit claims, search claims, view claims and search payment history
D. **Care Management**: Request PAs, view PA statuses, and maintain favorite providers
E. **File Exchange**: Upload forms online
F. **Resources**: Download forms and documents
G. **Switch Providers**: Where delegates can switch between providers to whom they are assigned. The tab is only present when the user is logged in as a delegate
Care Management Tab

Create Authorization
— Create authorizations for eligible recipients

View Authorization Status
— Prospective authorizations that identify the requesting or servicing provider

Maintain Favorite Providers
— Create a list of frequently used providers
— Select the facility or servicing provider from the providers on the list when creating an authorization
— Maintain a favorites list of up to 20 providers
Before You Create a Web Portal Prior Authorization Request
Before You Create a Prior Authorization Request

- Verify eligibility to ensure that the recipient is eligible on the date of service for the requested services.
- Use the Provider Web Portal’s PA search function to see if a request for the dates of service, units, and service(s) already exist and is associated with your individual, state or local agency, or corporate or business entity.
- Review the coverage, limitations, and PA requirements for the Nevada Medicaid Program before submitting PA requests.
- Use the Provider Web Portal to check PAs in pending status for additional information.
Create a Prior Authorization Request
Key Information

Recipient Demographics

— First Name, Last Name and Birth Date will be auto-populated based on the recipient ID entered.

Diagnosis Codes

— All PAs will require at least one valid diagnosis code.

Searchable Diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)

— Enter the first three letters or the first three numbers of the code to use the predictive search.

PA Attachments

— Attachments are required with all PA requests. Attachments can only be submitted electronically.
— PA requests received without an attachment will remain in pended status for 30 days.
— If no attachment is received within 30 days, the PA request will automatically be canceled.
Submitting a PA Request

1. Hover over the Care Management tab
2. Click Create Authorization from the sub-menu
3. Select the authorization type (Medical).
4. Choose an appropriate Process Type from the drop-down list (ABA or Retro ABA).
5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.
6. Enter the **Recipient ID**. The Last Name, First Name and Birth Date will populate automatically.
7. Enter **Referring Provider Information** using one of three ways.

Nevada Medicaid Applied Behavior Analysis Provider Training
Submitting a PA Request, continued

A. Check the Referring Provider Same as Requesting Provider box.
B. Choose an option from the Select from Favorites drop-down. This drop-down displays a list of providers that the user has indicated as favorites.
C. Enter the Provider ID and ID Type. Both fields must be completed when using this option.
D. Click the Add to Favorites checkbox. Use this after entering a provider ID to add it to the Select from Favorites drop-down.
Submitting a PA Request, continued

8. Enter Service Provider Information.

Service Provider Information

Referring Provider Information

Referring Provider same as Requesting Provider
Select from Favorites
Provider ID 1831573690
ID Type NPI
Name HOSPITALIST SERVICES OF NEVADA-MANDAVIA
Add to Favorites

*Provider ID
*ID Type
Name
Location
9. Select a **Diagnosis Type** from the drop-down list.

10. Enter the **Diagnosis Code**. Once the user begins typing, the field will automatically search for matching codes.

11. Click the **Add** button.

**NOTE:** Repeat steps 9-11 to enter up to nine codes. The first code entered will be considered the primary.
If you click the Add button with an invalid diagnosis code, an error will display. You must ensure the diagnosis code is correct, up-to-date with the selected Diagnosis Type, and does not include decimals.
Once a diagnosis code has been entered accurately, and the **Add** button has been clicked, the diagnosis code will display under the **Diagnosis Information section**. If a code needs to be removed from the PA request, click **Remove** located in the **Action** column.
12. Enter detail regarding the service(s) provided into the Service Details section.
13. Click the Add Service button.
Submitting a PA Request, continued

After clicking the **Add Service** button, the service details will display in the list.

**NOTE:** If a user wishes to copy a service detail, click **Copy** located in the **Action** column. To remove the detail, click **Remove**.
Submitting a PA Request, continued

The **Transmission Method** will default to EL-Electronic Only as attachments must be sent via the portal.
14. Choose the type of attachment being submitted from the Attachment Type drop-down list.
15. Click the **Browse** button.
16. Select the desired attachment.
17. Click the **Open** button.

Allowable file types include: .doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.
18. Click the **Add** button.
Submitting a PA Request, continued

The added attachment displays in the list.

To remove the attachment, click **Remove** in the **Action** column.

Add additional attachments by repeating steps 14-18.

NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards, go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.
Submitting a PA Request, continued

19. Click the Submit button.
20. Review the information on the PA request.

21. Click the **Confirm** button to submit the PA for processing. Only click the Confirm button once. If a user clicks Confirm multiple times, multiple PAs will be submitted and denied due to multiple submissions.

NOTE: If updates are needed prior to clicking the Confirm button, click the **Back** button to return to the “Create Authorization” page.
After the Confirm button has clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.
Submitting a PA Request, continued

A. **Print Preview**: Allows a user to view the PA details and receipt for printing.
B. **Copy**: Allows a user to copy member or authorization data for another authorization.
C. **New**: Allows a user to begin a new PA request for a different member.
Viewing Status
Viewing the Status of PAs

1. Hover over the Care Management tab.
2. Click View Authorization Status.
3. Click the ATN hyperlink of the PA to be viewed.
Viewing the Status of PAs, continued

4. Click the plus symbol to the right of a section to display its information.

5. Review the information as needed.
Viewing the Status of PAs, continued

6. Review the details listed in the Decision / Date and Reason columns.
Viewing the Status of PAs, continued

In the Decision / Date column, you may see one of the following decisions:

- **Certified in Total**: The PA request is approved for exactly as requested.
- **Certified Partial**: The PA request has been approved, but not as requested.
- **Not Certified**: The PA request is not approved.
- **Pended**: The PA request is pending approval.
- **Cancel**: The PA request has been canceled.

![Service Provider / Service Details Information](image)

- **From Date**: 01/12/2018
- **To Date**: 01/12/2019
- **Units**: 10
- **Remaining Units**: 10
- **Amount**: 
- **Code**: CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING
- **Decision / Date**: Certified In Total 01/12/2018
- **Reason**: 

Nevada Medicaid Applied Behavior Analysis Provider Training
When the Decision / Date column is not “Certified in Total”, information will be provided in the Reason column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).
C. **From Date** and **To Date**: Display the start and end dates for the PA.

D. **Units**: Displays the number of units originally on the PA.

E. **Remaining Units** or **Amount**: Display the units or amount left on the PA as claims are processed.

F. **Code**: Displays the CPT/HCPCS code on the PA.

G. **Medical Citation**: Indicates when additional information is needed for authorizations (including denied).
The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/17/2013</td>
<td>02/17/2013</td>
<td>3</td>
<td>0</td>
<td>--</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>Hide</td>
<td>Not Certified</td>
<td>02/21/2013</td>
</tr>
<tr>
<td>02/20/2031</td>
<td>02/20/2031</td>
<td>2</td>
<td>0</td>
<td>--</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified</td>
<td>02/22/2013</td>
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<td></td>
<td>Certified In Total</td>
<td>02/24/2013</td>
</tr>
</tbody>
</table>
Viewing the Status of PAs, continued

H. **Edit:** Edit the PA.

I. **View Provider Request:** Expand all sections to view the information.

J. **Print Preview:** Display a printable version of the PA with options to print.
Searching for PAs
Searching for PAs

1. Click the **Search Options** tab.
2. Enter search criteria into the search fields.
Searching for PAs, continued

A. **Authorization Tracking Number:** Enter the ATN to locate a specific PA.
B. **Day Range:** Select an option from this list to view PA results within the selected time period.
C. **Service Date:** Enter the date of service to display PA with that service date.

NOTE: Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.
### Status Information

Select status to return authorization service lines with the chosen status.

#### Recipient Information

Recipient information is not mandatory. You can either enter the Recipient ID; or the Last Name, First Name, and Birth Date.

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**D. Status:** Select a status from this list to narrow search results to include only the selected status.
Searching for PAs, continued

E. **Recipient ID:** Enter the unique Medicaid ID of the client.

F. **Birth Date:** Enter the date of birth for the client.

G. **Last Name** and **First Name:** Enter the client’s first and last name.

NOTE: Enter only the **Recipient ID** number or the client’s last name, first name and date of birth.
H. **Provider ID:** Enter the provider’s unique NPI.

I. **ID Type:** Select the provider’s ID type from the drop-down list.

J. **This Provider is the:** Select whether the provider is the servicing or referring provider on the PA request.
Searching for PAs, continued

3. Click the **Search** button.
4. Select an **ATN** hyperlink to review the PA.
Submitting Additional Information
Submitting Additional Information

1. Click the **Edit** button to edit a submitted PA request.

Additional information may include:
- Requests for additional services
- Attachments
- “FA-29 Prior Authorization Data Correction” form
- “FA-29A Request for Termination of Service” form
2. Add additional diagnosis codes, service details and/or attachments.
3. Click the **Resubmit** button to review the PA information.
4. Review the information.
5. Click the Confirm button.

NOTE: The PA number remains the same as the original PA request when resubmitting the PA request.
Options if a PA is not approved
Denied Prior Authorization

If a prior authorization request is denied by Nevada Medicaid, the provider has the following options:

– Request for a Peer-to-Peer Review (avenue used in order to clarify why the request was denied or approved with modifications)

– Submit a Reconsideration Request (avenue used when the provider has additional information that was not included in the original request)

– Request a Medicaid Provider Hearing
Peer-to-Peer Review

- The intent of a peer-to-peer review is to clarify the reason the PA request was denied or approved but modified.
- This is a verbal discussion between the requesting clinician and the clinician that reviewed the request for medical necessity.
- The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the peer-to-peer review.
- Additional information is not allowed to be presented because all medical information must be in writing and attached to the case.
- Must be requested within 10 business days of the denial.
- Peer-to-peer reviews can be requested by emailing peertopeer@groups.ext.dxc.com.
- Only available for denials related to the medical necessity of the service.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
Reconsideration Request

- Reconsiderations can be uploaded via the Provider Web Portal by completing an FA-29B form and uploading to the “File Exchange”
- Additional medical documentation is reviewed to support the medical necessity
- The information is reviewed by a different clinician than reviewed the original documentation
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option
Reconsideration Request, continued

- A reconsideration must be requested within 30 calendar days from the date of the denial, except for Residential Treatment Center (RTC) services, which must be requested within 90 calendar days.
- The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review.
- Give a synopsis of the medical necessity not presented previously. Include only the medical records that support the issues identified in the synopsis. Voluminous documentation will not be reviewed. It is the provider’s responsibility to identify the pertinent information in the synopsis.
- Reconsideration request is only available for denials related to the medical necessity of the service.
Medicaid Provider Hearing

- Review Chapter 3100 (Hearings) of the Medicaid Services Manual located on the DHCFP website for further information regarding the Hearing Process
Search Fee Schedule & DHCFP Rates Unit
Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a Procedure Code.
Fee Schedule, continued

- Step 1: Click “I Accept”
- Step 2: Click “Submit”
Fee Schedule, continued

- Step 1: Select Code Type from drop-down menu
- Step 2: Input Procedure Code of Description (See Billing Guide for codes)
- Step 3: Select Service Category from drop-down menu
- Step 4: Click “Search” to populate results
Note: Make sure that the Effective Date ends in 2299.
DHCFP Rates Unit

- Step 1: Highlight **Quick Links** from tool bar at www.medicaid.nv.gov
- Step 2: Select **Rates Unit**
- Step 3: From new window, select Accept
• Locate the “Fee-for-Service PDF Fee Schedules” from the Fee Schedules section
DHCFP Rates Unit, continued

FEE SCHEDULES

The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- Provider Type 85 Applied Behavioral Analysis Fee Schedule

- Select Appropriate Title to open the PDF pertaining to the Reimbursement Schedule
Medicaid Billing Information
Locating Medicaid Billing Information

- Step 1: Highlight **Providers** from top blue tool bar
- Step 2: Select **Billing Information** from the drop-down menu
Locating Medicaid Billing Information, continued

Billing Information

Effective February 1, 2019, all providers will be required to submit their claims electronically (using Trading Partners or Direct Data Entry [DDE]), as paper claims submission will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at https://www.medicaid.nv.gov/providers/Modernization.aspx for further details.

Attention All Providers: Requirements on When to Use the National Provider Identifier (NPI) of an Ordering, Prescribing or Referring (OPR) Provider on Claims [Web Announcement 1711]

FAQs: National Correct Coding Initiative (NCCI) Claim Review Edits [Review Now]
Clinical Claim Editor FAQs Updated December 5, 2011 [Review Now]
Third Party Liability Frequently Asked Questions [Review Now]

Billing Manual

For Archives Click here

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<th>Title</th>
<th>File Size</th>
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<tbody>
<tr>
<td>Billing Manual</td>
<td>1 MB</td>
<td>02/01/2019</td>
</tr>
</tbody>
</table>

- Review the Billing Manual for more information regarding:
  - Intro to Medicaid
  - Contact Info
  - Recipient Eligibility
  - PA
  - TPL
  - EDI
  - FAQ’s
  - Claims Processing and Beyond
Locating Medicaid Billing Information, continued

- Locate the section header “Billing Guidelines (by Provider Type)"
- Select appropriate Provider Type Guideline
Submitting a Professional Claim via the EVS Secure Provider Web Portal (DDE)
Understanding Claim Sub Menus
Understanding Claims Sub Menus

1. Hover over **Claims**
2. Select the appropriate sub menu from the options
The page will display a list of Claims activities for the user to choose from.
Submitting a Professional Claim
Submitting a Professional Claim

The Professional Claim submission process is broken out into three main steps:

- **Step 1** - Provider, Patient and Claim Information plus an option to add Other Insurance details
- **Step 2** - Diagnosis Codes
- **Step 3** - Service Details and Attachments
Submitting a Professional Claim: Step 1

1. Hover over the **Claims** tab
2. Select **Submit Claim Prof**
Submitting a Professional Claim: Step 1, continued

“Submit Professional Claim: Step 1” page sub-sections to complete:

A. Provider Information
B. Patient Information
C. Claim Information
3. Select the appropriate provider type/service location being billed from the Billing Provider Service Location drop-down option.

4. Enter the Rendering ID and ID Type. If the Rendering ID is unknown, click the button adjacent to the Rendering Provider ID field.

NOTE: If the Billing Provider has multiple locations, the user will use the drop-down option to locate and select the correct location for the claim.
5. Select the desired search method
6. Enter the provider’s last name
7. Click the Search button, and the search results populate at the bottom
8. Click the blue link in the Provider ID column with correct Provider ID

NOTE: The user can also search by the Search By ID or Search By Organization tabs.
9. Select a Rendering Provider Service Location from the drop-down menu.

NOTE: If needed, the user may enter a Referring Provider, Supervising Provider or Service Facility Location ID the same way the Rendering Provider ID was entered.
Patient Information

<table>
<thead>
<tr>
<th>Service Facility Location ID</th>
<th>ID Type</th>
</tr>
</thead>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>*Recipient ID</th>
<th>67770816236</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>TRNKEUK</td>
</tr>
<tr>
<td>Birth Date</td>
<td>02/11/1985</td>
</tr>
<tr>
<td>First Name</td>
<td>UGWNL</td>
</tr>
</tbody>
</table>

**Claim Information**

<table>
<thead>
<tr>
<th>Date Type</th>
<th>Date of Current</th>
<th>Accident Related</th>
<th>Admission Date</th>
<th>Authorization Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Transport Certification: Yes or No

*Does the provider have a signature on file: Yes or No

Include Other Insurance

Total Charged Amount: $0.00

10. Enter the 11-digit **Recipient ID** and click outside of the field to populate Last Name, First Name and Birth Date.
Submitting a Professional Claim: Step 1, continued

Claim Information

The following fields with an (*) must be completed as follows:

11. Enter the **Patient Number**

12. Choose “Yes” or “No” to indicate a **Transport Certification** (If “Yes,” additional details will be required. These are illustrated on the next slide.)

NOTE: Other fields can be completed based on additional details known about the claim.
If the user selects “Yes” in the Transport Certification field, additional details must be entered.

13. Choose “Yes” or “No” as the Certification Condition Indicator
14. Indicate the patient’s condition from the Condition Indicator drop-downs (up to five options may be selected)
15. Enter the distance (in miles) that the patient traveled into the Transport Distance field
16. Select the Ambulance Transport Reason
17. Indicate whether the provider has a signature on file
18. Click the Continue button
Submitting a Professional Claim: Step 2

Diagnosis Codes

Once the user clicks the **Continue** button, the “Submit Professional Claim: Step 2” page is displayed with all the panels expanded.
Submitting a Professional Claim: Step 2, continued

**Diagnosis Codes**

1. Choose a **Diagnosis Type**
2. Enter the **Diagnosis Code**
3. Click the **Add** button

**NOTE:** The **Diagnosis Code** field contains a predictive search feature using the first three characters of the code or code description.

---

**Submit Professional Claim: Step 2**

* Indicates a required field.

**Claim Type**: Professional

**Provider Information**

- **Billing Provider ID**: L57564680
- **ID Type**: NPI

**Patient and Claim Information**

- **Recipient**: UNYHIA TRNHEIKU
- **Gender**: Male
- **Birth Date**: 02/14/1983
- **Total Charged Amount**: $0.00

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>*Diagnosis Type</td>
<td>ICD-10-CM</td>
<td><strong>Add</strong></td>
</tr>
<tr>
<td>2</td>
<td>R4d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>R0109-Bennettos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>R0107-Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>R0106-Unspecified coma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>R0210-Coma scale, eyes open, never, unspecified time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>R0211-Coma scale, eyes open, never, in the field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>R0212-Coma scale, eyes open, never, EMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>R0213-Coma scale, eyes open, never, AC hospital admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>R0214-Coma scale, eyes open, never, 24hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>R0215-Coma scale, eyes open, to pain, unspecified time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>R0216-Coma scale, eyes open, to pain, in the field</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Submitting a Professional Claim: Step 2, continued

Diagnosis Codes

Click the Remove link to remove a diagnosis code from the claim.

Once all the diagnosis codes have been entered, the user will:

4. Click the Continue button.
Enter the following service details for the claim:

1. Enter the **From Date** and **To Date** that services were rendered.
2. Select the **Place of Service** from the dropdown.
Submitting a Professional Claim: Step 3, continued

Service Details

3. Enter the **Procedure Code**, which is searchable by entering at least the first three letters or numbers of the code description.

4. Enter at least one **Diagnosis Pointer**

**NOTE:** Diagnosis Pointers are used to show what diagnosis is applicable to a service detail.
Submitting a Professional Claim: Step 3, continued

With the Procedure Code and Diagnosis Pointers entered, the user will need to:

5. Enter a Charge Amount
6. Enter the number of Units
7. Select a Unit Type from the drop-down list
8. Click the Add button to add the procedure to the claim

NOTE: The user may enter any additional details, such as Modifiers, prior to clicking Add.
Repeat Steps 1-8 in this section for each additional procedure.
When editing a Service Detail, three buttons are available:

- **Save**: Saves any changes made to the detail.
- **Reset**: Clears all fields in the selected service detail.
- **Cancel**: Cancels any updates and closes the service detail.
Submitting a Professional Claim: Step 3, continued

Optionally, if the user needs to enter a National Drug Code for a Service Detail, the user will click the symbol to expand the NDC for Svc. panel.

From here, the user may enter and save NDC information to the service detail. To close this panel, the user will click the symbol.
9. Click the Submit button
10. Click the **Confirm** button
Submitting a Professional Claim: Step 3, continued

The **Submit Professional Claim: Confirmation** will appear after the claim has been submitted. It will display the claim status and **Claim ID**.

The user may then:

- Click the **Print Preview** button to view the claim details
- Click the **Copy** button to copy claim data
- Click the **New** button to submit a new claim
- Click the **View** button to view the details of the submitted claim, including adjudication errors
Submitting a Professional Claim: Attachments
Submitting a Professional Claim: Attachments

To upload attachments to a professional claim:

1. Click the (+) sign on the Attachments panel.
2. Click **Browse** button and locate the file on your computer to be attached. 

A window will then pop up. From there:

3. Locate and select the file.

4. Click the **Open** button.

NOTE: The **Transmission Method** field will populate with “FT - File Transfer” by default and does not need to be changed.
5. Select the type of attachment from the Attachment Type drop-down list

6. Click the Add button to attach the file OR click on the Cancel button to cancel and close the attachment line

NOTE: A description of the attachment may be entered into the Description field, but it is not required.
7. Click the **Submit** button to proceed.

**NOTE:** To remove any attachments, click the **Remove** link.
Submitting a Professional Claim: Other Insurance Details
1. Check the **Include Other Insurance** checkbox located at the bottom of the page.
2. Click the **Continue** button.
To add a policy or other insurance carrier information:
3. Click (+) in the Other Insurance Details panel at the bottom of the page
4. The user must enter all required fields.
5. Click the Add Insurance button to add the Other Insurance details to the claim.

NOTE: Click the Cancel Insurance button to cancel addition of new or other health insurance details.
Submitting a Professional Claim: Other Insurance Details, continued

After the user clicks the Add Insurance button, the new insurance will populate at the bottom of the list of carriers.

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Payer Paid Amount</th>
<th>Paid Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HEALTH PLAN OF NEVADA</td>
<td>07762</td>
<td>05060442803</td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td>HEALTH PLAN OF NEVADA</td>
<td>07549</td>
<td>029604428-99</td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
<tr>
<td>3</td>
<td>Insurance Plan</td>
<td>120456789</td>
<td>987654321</td>
<td></td>
<td>08/01/2018</td>
<td>Remove</td>
</tr>
</tbody>
</table>

☐ Click to add a new other insurance.
To update existing other insurance carrier information, the user will:

1. Select the sequence number of any other insurance line item
2. Update the payment and liability details
3. Select a Claim Filing Indicator from the dropdown

NOTE: Click the Remove link to remove any other insurance details unrelated to the claim.
Submitting a Professional Claim: Other Insurance Details, continued

To add an adjustment:

4. Enter the details of the adjustment
5. Click the **Add Adjustment** button to add claim adjustment details
6. Click the **Save Insurance** button to save the information to the other insurance details line OR click the **Cancel Insurance** button to cancel all changes
Submitting a Professional Claim: Other Insurance Details, continued

Continue to Step 3 of the claim submission process:

7. Click the Continue button
Submitting a Crossover Professional Claim
Submitting a Crossover Professional Claim

1. Select the Claim Type: Crossover Professional

NOTE: The user will follow the same steps as previously shown in the “Submitting a Professional Claim” section.
Submitting a Crossover Professional Claim, continued

2. Enter the Medicare Crossover Details:
   - Allowed Medicare Amount
   - Deductible Amount
   - Medicare Payment Amount
   - Medicare Payment Date

3. Click the Continue button
Submitting a Crossover Professional Claim, continued

4. Enter applicable service detail information. Required fields are marked with a red asterisk (*).
5. Click the Add button
Submitting a Crossover Professional Claim, continued

6. Click the Submit button

---

### Medicare Crossover Details

<table>
<thead>
<tr>
<th>Allowed Medicare Amount</th>
<th>Co-insurance Amount</th>
<th>Deductible Amount</th>
<th>Psychiatric Services Amount</th>
<th>Medicare Payment Amount</th>
<th>Medicare Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000.00</td>
<td>$950.00</td>
<td>$250.00</td>
<td>$0.00</td>
<td>$3,800.00</td>
<td>10/12/2018</td>
</tr>
</tbody>
</table>

---

### Diagnosis Codes

---

### Service Details

Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/10/2018</td>
<td>09/20/2018</td>
<td>21-Inpatient Hospital</td>
<td>01210-Anesthesia joint surgery</td>
<td>$6,500.00</td>
<td>120,000 Unit</td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Submitting a Crossover Professional Claim, continued

7. Click the **Confirm** button
Submitting a Crossover Professional Claim, continued

The user will receive a Confirmation with the Professional Claim Receipt.
Searching for a Professional Claim
Searching for a Professional Claim

To search for a claim the user will need to:

1. Hover over Claims
2. Select Search Claims
The fastest way to locate a claim is by entering the Claim ID.

To search without using the Claim ID:
3. Enter the search parameters
4. Click the Search button

NOTE: When searching for a claim without using the Claim ID, the user must enter the Recipient ID along with the Service From and To date range as shown in this example.
Searching for a Professional Claim, continued

Once the user has clicked the Search button, the results will display below. From there, the user may:

5. Click the (+) symbol to expand the claim details.
Searching for a Professional Claim, continued

6. Click the **blue Claim ID link** to open a specific claim.

### Professional Claim Information

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Total Charge Amount</th>
<th>Total Paid Amount</th>
<th>Paid Date</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>UGNWLA TRIXEUK</td>
<td>$300.00</td>
<td>$0.00</td>
<td>09/14/2018</td>
<td>Finalized/Denial: The claim/line has been denied.</td>
</tr>
</tbody>
</table>

**Recipient:** UGNWLA TRIXEUK  
**Birth Date:** 02/11/1985  
**Rendering Provider:** MICHAEL A SMITH  
**Claim Status:** Finalized Denied

### Service Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Date</th>
<th>Line Status</th>
<th>Reason Code</th>
<th>Units</th>
<th>Procedure/Modifiers</th>
<th>Charge</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/12/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial: The claim/line has been denied.</td>
<td>1</td>
<td>2018F</td>
<td>$100.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>01/12/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial: The claim/line has been denied.</td>
<td>1</td>
<td>06361</td>
<td>$200.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

NOTE: The user may view the RA by clicking the **RA Copy (PDF) button**. Searching for RAs will be covered later in the training.
If the claim is denied, the user may review the errors as follows:

7. Click the (+) symbol adjacent to the **Adjudication Errors** panel.
Searching for a Professional Claim, continued

With the Adjudication Errors panel expanded, the user may review the errors associated with the claim’s denial.

NOTE: User will be shown how to adjust a claim later in the training.
Viewing Professional Claim Remittance Advice (RA)
Viewing a Professional Claim’s RA

To begin locating an RA, the user will:

1. Hover over Claims
2. Select Search Payment History
3. Enter search criteria to refine the search results
4. Click the Search button

NOTE: Users can only search for RAs on the Provider Web Portal for the past 6 months. The default search range is for the past 90 days.
5. Click on the RA Copy (PDF) icon
Viewing a Professional Claim’s RA, continued

6. User will click the Open button
After clicking Open, the user can review the RA.
Copying Professional Claims
Copying a Professional Claim

To copy a claim, the user will:

1. Return to the “Search Claims” page
2. Enter the search criteria
3. Click the **Search** button

Search results will populate at the bottom of the screen.

From the search results:

4. Click the **blue Claim ID** link
After the user has viewed the claim, user will:

5. Scroll down to the bottom of the “Claim Information” page
6. Click the **Copy** button
7. Select what portion of the claim to copy (for this example, the user has selected Entire Claim)
8. Click the Copy button
As the user goes through Steps 1-3, the user may make updates.

9. Click the Continue button
Adjusting a Professional Claim
Adjusting a Professional Claim

To begin the claim adjustment process:

1. Return to the “Search Claims” page
2. Enter the search criteria
3. Click the Search button
4. Click the blue Claim ID link

NOTE: Denied Claims cannot be adjusted. The Claim Status column will indicate “Finalized Payment” if a claim is paid.
On the “View Professional Claim” page, the user will:

5. Scroll down to the bottom of the page
6. Click the Adjust button
Adjusting a Professional Claim, continued

From here, the user may:

7. Review and make any necessary edits to the provider, patient or claim information

8. Review the **Adjudication Errors** panel to identify any issues that may need to be resolved

9. Click on the **Continue** button at the bottom of the page to proceed to the next step
10. Click the Resubmit button
11. Click the **Confirm** button

NOTE: Click the **Cancel** button to cancel the adjustment.
The “Resubmit Professional Claim: Confirmation” page will appear after the claim has been submitted. It will display the claim status and adjusted Claim ID.
Submitting an Appeal for a Claim
Submitting an Appeal for a Claim

From the home page, the user will:

1. Select Secure Correspondence to start the Appeal process
Submitting an Appeal for a Claim, continued

The user will then:

2. Select “Claims – Appeals” from the Message Category drop-down and fill out all of the required fields
Submitting an Appeal for a Claim, continued

Next, the user will need to:

3. Click the **Browse** button and locate the file supporting the appeal request

4. Click the **Send** button

NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.
Submitting an Appeal for a Claim, continued

After the user clicks the Send button, a confirmation message will populate with “Your secure message was successfully sent”.

User will then need to:
5. Click the OK button
After the user clicks the OK button, they will be directed to the Secure Correspondence - Message Box, where the new CTN can be seen.
Voiding a Professional Claim
To search for a claim the user will need to:

1. Hover over **Claims**
2. Select **Search Claims**
3. Enter **Claim ID**
4. Click the **Search** button
Once the user has clicked the Search button, the results will display below.

To open the claim, the user will:

5. Click the blue Claim ID link to open the claim

NOTE: Denied Claims cannot be voided. The Claim Status column will indicate “Finalized Payment” if a claim is paid.
To void the claim, the user will:

6. Click the **Void** button
7. Click the **OK** button
Voiding a Professional Claim, continued

8. Click the OK button
Reminders Regarding Prior Authorization and Billing
Reminders Regarding PA & Billing

- Initial Assessment and re-assessments do not require prior authorization.
- Assessments are limited to one in every 180 days or unless prior authorized.
- Request timelines for prior authorizations:
  - Initial request: 15 business days before date of service or 15 calendar days after requested start date of service
  - Continued service requests: 5-15 days prior
  - Unscheduled revisions: Whenever a significant change in the recipient's condition warrants a change to previously authorized services. Must be submitted during an existing authorization period and prior to revised units/services being rendered. The number of requested units should be appropriate for the remaining time in the existing authorization period.
  - Retrospective request: Submit no later than 90 days from the recipient's Date of Decision
- All Specialty 312 and 314 services require the UD modifier for prior authorization request and claim submission
- Providers are able to obtain dual enrollment as provider type 85 and 14. Providers will need to ensure that the taxonomy codes that are presented during enrollment are different.
- All claims must be submitted with an individual provider indicated as rendering provider
- Ensure the individual servicing provider is linked to the appropriate provider type
Resources
Additional Resources

- For Forms: https://www.medicaid.nv.gov/providers/forms/forms.aspx
- For EVS General Information: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

DHCFP Contact Information:
E-Mail: ABAServices@dhcfp.nv.gov
Contact Nevada Medicaid
Contact Us — Nevada Medicaid Customer Service

Customer Service Call Center: 877-638-3472 (M-F 8 am to 5 pm Pacific Time)

Prior Authorization Department: 800-525-2395

Provider Field Representative: NevadaProviderTraining@dx.com
Thank You