Applied Behavior Analysis (ABA)

Provider Type 85 Training

Nevada Medicaid Provider 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

Medicaid Website
www.medicaid.nv.gov

EVS

EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

System Requirements

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

Medicaid Services Manual

Locating the Medicaid Services Manual
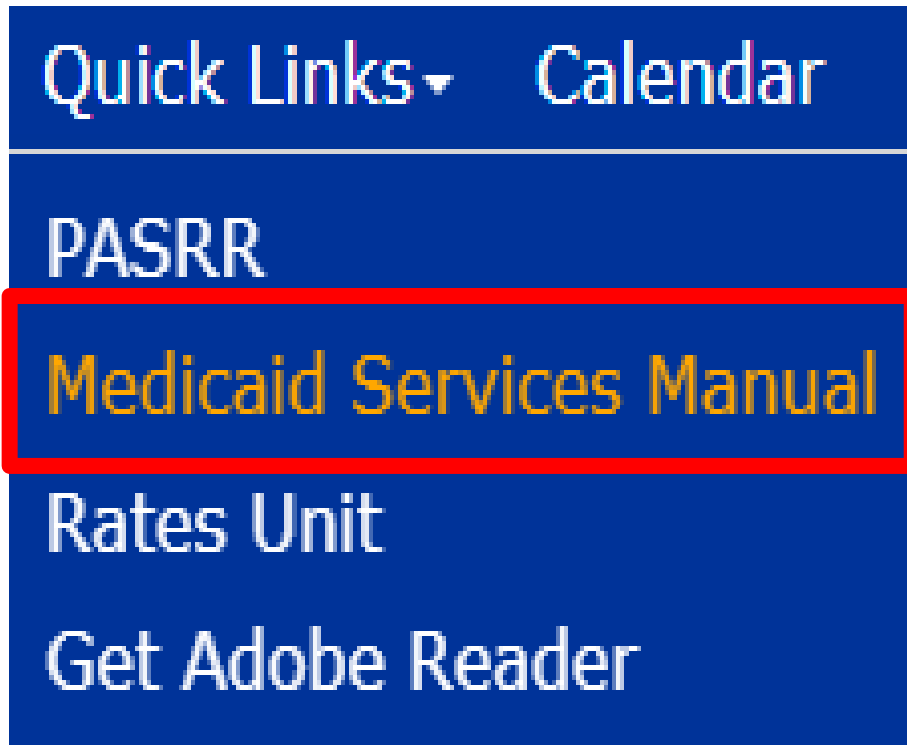
- Step 1: Highlight "Quick Links" from top blue tool bar

- 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 Cntrl 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.

May 16, 2017 (Updated July 27, 2017)
Announcement 1372

Attention All Providers:

Reminder of Requirements Regarding Ordering, Prescribing or Referring Provider on Claims

If the service you are billing was ordered, prescribed or referred by another physician or other eligible professional, you must enter that Ordering, Prescribing or Referring (OPR) provider's National Provider Identifier (NPI) on the claim form. The following provider types are always required to include the NPI of the OPR provider on their claim: 16, 17 (specialties 167, 169, 196 and 215), 19 (specialties 184 and 186), 23, 27, 28, 29, 33, 34, 37, 43, 45, 46, 55, 63, 64, 68 and 85. Electronic Verification System (EVS) User Manual Chapter 7 (Search Provider) provides instructions on how to search the Provider Web Portal for OPR providers.

It is the responsibility of the billing provider to ensure that the NPI which they enter on a claim belongs to an individual provider (not an organization or group): who ordered, prescribed or referred the service being billed; is authorized to do so; and is an active Nevada Medicaid provider on the date of service. Any claims which do not conform to these requirements may deny, and if they pay in error, they are subject to recoupment.

If an OPR provider's NPI is submitted on the claim when it is not mandatory, the NPI will still be validated by the system and the claim will deny if the OPR provider's NPI is not valid or the OPR provider is not enrolled in 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

Authorization Criteria

* Indicates a required field.

Select a Code Type from the drop-down list, then enter the Procedure Code or Description.

*Code Type	Medical ▼
*Procedure Code or Description ⊕	97153-Adaptive behavior tx by tech
*Provider Type ⊕	85-Applied Behavior Analysis (ABA)
Provider Specialty ⊕	

Search **Reset**

Search Results

To show/hide Service Limits click on Required if exceeding service limitations hyperlink.

Total Records: 4

Procedure	Provider Type	Provider Specialty	Claim Type	PA Required	Age Restrictions	Effective Date ▲
97153-Adaptive behavior tx by tech	85-Applied Behavior Analysis (ABA)	314-Registered Behavior Technician (RBT)	Professional Xover Claims	Always	000-020	01/01/2019 - 12/31/2299
97153-Adaptive behavior tx by tech	85-Applied Behavior Analysis (ABA)	314-Registered Behavior Technician (RBT)	Professional Claims	Always	000-020	01/01/2019 - 12/31/2299
97153-Adaptive behavior tx by tech	85-Applied Behavior Analysis (ABA)	313-Certified Autism Behavior Interventionist	Professional Xover Claims	Always	000-999	01/01/2019 - 12/31/2299
97153-Adaptive behavior tx by tech	85-Applied Behavior Analysis (ABA)	313-Certified Autism Behavior Interventionist	Professional Claims	Always	000-999	01/01/2019 - 12/31/2299

- Verify that "Effective Date" ends in 2299. This will provide the current information.

Prior Authorization Forms

Locating Prior Authorization Forms

Providers ▾   EVS ▾   Pharmac

Announcements/Newsletters
Billing Information
Electronic Claims/EDI
E-Prescribing
Forms
NDC
Provider Enrollment
Provider Training
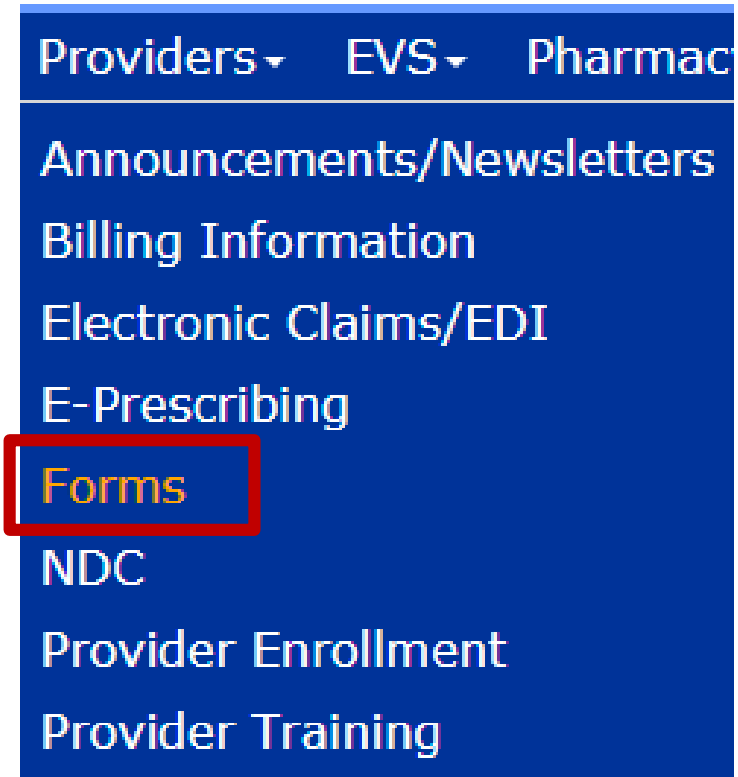
- Step 1: Highlight "Providers" from top blue tool bar

- Step 2: Select "Forms" from the drop-down menu

Nevada Medicaid Applied Behavior Analysis Provider Training

Locating Prior Authorization Forms, continued

Prior Authorization Forms

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

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

- 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)

Nevada Medicaid and Nevada Check Up
Applied Behavior Analysis (ABA) Authorization Request

Upload this request through the Provider Web Portal.   Questions? Call: (800) 525-2395

Request Date:

REQUEST TYPE:

☐ Initial Prior Authorization *For initial requests please attach the ASD Diagnosis Certification for Requesting Initial ABA Services (FA-11F)*   Start date of services: _____

☐ Continued Service   ☐ Unscheduled Revision   ☐ Reconsideration

☐ Retrospective Authorization – Date of Eligibility Decision: _____

NOTES:

I. REQUESTING PROVIDER

Practitioner's Name:		Credentials:
Provider Group Name:	Provider Group Email:	
Provider Group NPI:	Phone:	Fax:

II. SERVICING PROVIDER   ☐ Check if servicing provider is the same as requesting provider

Practitioner's Name:		Credentials:
Provider Group Name:	Provider Group Email:	
Provider Group NPI:	Phone:	Fax:

III. RECIPIENT

Name:	DOB:
Recipient ID:	Age:

Recipient's Living Arrangements (e.g., group home, foster home, parents):

Is the recipient in State custody? ☐Yes ☐No	Date recipient went into State custody:

IV. CO-OCCURRING DIAGNOSES, CURRENT SYMPTOMS, RELEVANT HISTORY

Co-occurring diagnoses:

Current symptoms and relevant history:

V. RESPONSIBLE PARTY

Parent/Guardian Name:	Phone:

Relationship to Recipient:

By signing below the parent/guardian agrees to the parent/guardian responsibilities as outlined in the Medicaid Services Manual (MSM) Chapter 1500.

Signature:	Date:

FA-11E   Page 1 of 5
Updated 01/30/2019 *(pv12/17/2018)*

FA-11E Applied Behavior Analysis (ABA) Authorization Request 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

Nevada Medicaid and Nevada Check Up
Applied Behavior Analysis (ABA) Authorization Request

V. Behavioral Targets/Behavior Disorders and Treatment Plan *(List the targeted behaviors that have an impact on development, communication, interaction with peers or others in the environment or adjustment to the settings in which the recipient's functions have diminished and update the anticipated target date for mastery. For initial requests please document baseline, and for continued service requests document baseline and quantify progress or regression over the previous 90 days.)*

Target Behavior Start Date and Anticipated Date for Mastery	Baseline Level Narrative / %	Current Level	Short Term Goal	Intermediate Goal	Long Term Goal

FA-11E
Updated 01/30/2019 *(pv12/17/2018)*

Page 2 of 5

FA-11E Applied Behavior Analysis (ABA) Authorization Request Page 3

- 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.

Nevada Medicaid and Nevada Check Up
Applied Behavior Analysis (ABA) Authorization Request

VI. Review of Services Provided Over the Previously Authorized Period *(Provider will report what services were provided since the last review and overall responsiveness to interventions.)*

VII. Parent/Guardian Training and Response to Training *(Have the parent(s) (or guardians) been actively involved in training in behavioral techniques so that they can provide additional hours of intervention? Please explain.)*

VIII. Treatment Plan and Care Coordination *(Check all that apply.)*

☐ Treatment interventions are consistent with ABA techniques
☐ The treatment plan and requested services are based upon the functional assessment/re-assessment
☐ Care coordination involving appropriate entities is occurring
☐ The Licensed Psychologist or BCBA is responsible for all aspects of clinical direction supervision and case management and this includes evaluation of discharge requirements

IX. ABA Services may not be duplicative of services under an Individualized Family Service Plan (IFSP) or an Individualized Educational Program (IEP).

The recipient's IFSP or IEP has been reviewed and the proposed treatment and treatment plan are not duplicative, but have been formulated and coordinated with these.

☐ Yes ☐ No ☐ N/A

Summary of services provided:

Signature:

FA-11E Applied Behavior Analysis (ABA) Authorization Request Page 4

- 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.

Applied Behavior Analysis (ABA) Authorization Request

X. Services Requested *(Providers may request review for up to 180 days which represents an authorization span of up to 6 months. The behavioral initial assessment and re-assessment do not require prior authorization). The requested services are based upon either a focused or comprehensive service delivery model. Provider is to indicate which delivery model is being utilized.*

☐ Focused   ☐ Comprehensive

	Code	Required Modifier	Code Description	Start Date and End Date (May request up to 180 days, may not exceed 180 days)	Units Per Day	Days Per Week	Total Units Requested
1	97153		Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes				
2	97155		Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes				
3	0373T		Adaptive behavior treatment by protocol with modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on-site • with the assistance of two or more technicians • for a patient who exhibits destructive behavior • completed in an environment that is customized to the patient's behavior				
4	97154		Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes				

FA-11E
Updated 01/30/2019 *(pv12/17/2018)*

Page 4 of 5

FA-11E Applied Behavior Analysis (ABA) Authorization Request Page 5

- 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.

- Page 5 of requested services must be signed by Licensed Psychologist or Board Certified Behavioral Analyst (BCBA).

Applied Behavior Analysis (ABA) Authorization Request

5	97158		Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes				
6	97156		Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes				
7	97157		Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s), each 15 minutes				

XI. Coverage of ABA Services

By signing below the provider ensures the following: Treatment interventions are consistent with ABA techniques; Care coordination involving appropriate entities is occurring; The Licensed Psychologist or BCBA is responsible for all aspects of clinical direction, supervision and case management; The treatment plan and requested services are based upon the functional assessment.

Signature:	Date:

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

FA-11E
Updated 01/30/2019 *(pv12/17/2018)*

Page 5 of 5

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

Nevada Medicaid and Nevada Check Up

Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services

Instructions: Submit this certification with **initial requests** for ABA services along with FA-11E. Do not submit this form with requests for continued service.

Request Date:

Recipient Name: _____ Recipient Medicaid ID: _____

Practitioner Certification Ordering ABA Services: *Practitioner must be a Physician, Physician's Assistant, Advanced Practice Registered Nurse (APRN) or Psychologist acting within their scope of practice.*

A Practitioner acting within their scope of practice as defined by State law certifies the following:

1. This individual is between 0 and 21 years of age and has an established diagnosis of ASD or other related condition for which ABA is recognized as medically necessary.
2. ABA services are required to develop, maintain or restore to the maximum extent practical the functions of the individual for whom they are requested.
3. The individual exhibits excesses and/or deficits of behavior that impede access to age appropriate home or community activities.
4. There is a reasonable expectation that the individual will improve, or maintain function to the maximum extent practical with ABA services.
5. Please identify the diagnostic tool utilized to establish the ASD diagnosis as well as qualifying score. Please check the appropriate box below and enter the individual's score for the diagnostic tool used:

☐ Autism Diagnostic Observation Schedule (ADOS)   Score:_____
   Subscales Scores:_____

☐ Childhood Autism Rating Scale (CARS)   Score:_____
   Subscales Scores:_____

☐ Gilliam Autism Rating Scale (GARS-2)   Score:_____
   Please indicate the subscales presenting concern observed on the rating sheets:
   _____

☐ Other: _____   Score:_____

Name of Practitioner: _____
Credentials: _____
National Provider Identifier (NPI): _____
Signature:_____
Date of Diagnosis:_____

Submitting a Prior Authorization via the EVS Secure Provider Web Portal

Logging into the Provider Web Portal

Nevada Department of Health and Human Services

Division of Health Care Financing and Policy Provider Portal

Home

Home

Login [?]

*User ID

hospizona1

Log In

Forgot User ID?

Register Now

Broadcast Messages

Hours of Availability
The Nevada Provider Web Portal is unavailable betwee
12:25 AM PST on Sunday.

What can you do in the Provider Po
Through this secure and easy to use internet portal, hea

Once registered, users may access their accounts from the PWP "Home" page by:

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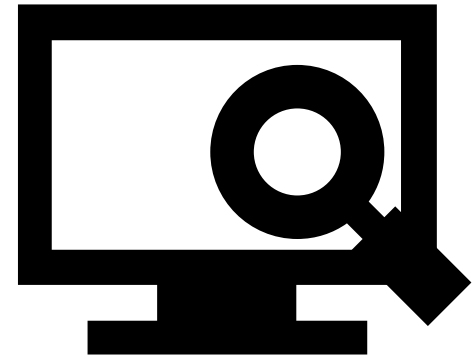
Logging in to the Provider Web Portal, continued

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

Logging in to the Provider Web Portal, continued

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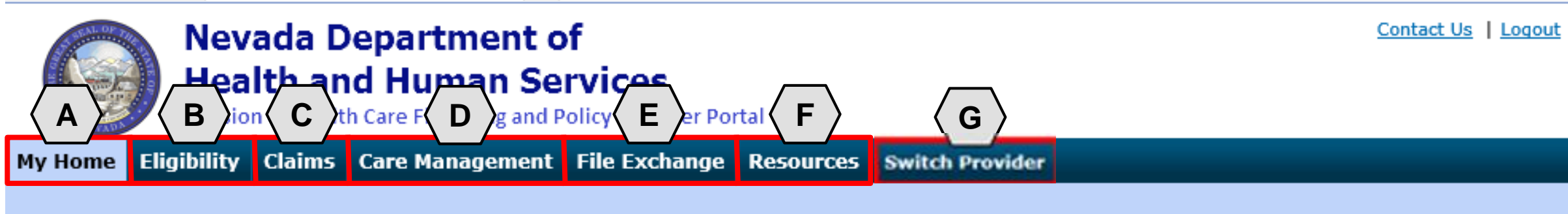
The tabs at the top of the page provide users quick access to helpful pages and information:

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
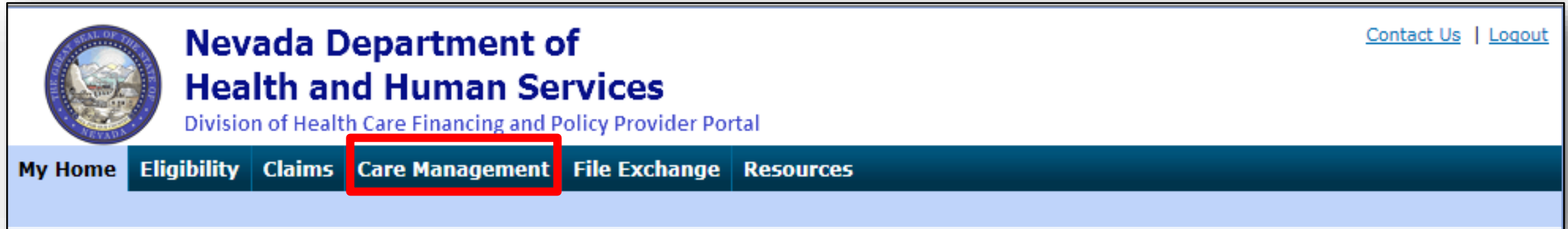
Create Authorization

— 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

Submitting a PA Request, continued

3. Select the authorization type (Medical).
4. Choose an appropriate **Process Type** from the drop-down list (ABA or Retro ABA).

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

6. Enter the **Recipient ID.** The Last Name, First Name and Birth Date will populate automatically**.**

Submitting a PA Request, continued

7. Enter **Referring Provider Information** using one of three ways.

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.**

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

14. Choose the type of attachment being submitted from the **Attachment Type** drop-down list.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

Prior Authorization Forms

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

Transmission Method	File	Action

Click to collapse.

*Transmission Method: EL Electronic Only

*Upload File: C:\Users\bargera\Desktop\Nurse Notes.docx   Browse...

*Attachment Type:

18 Add   Cancel

Submit   Cancel

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.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

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**.

Viewing the Status of PAs, continued

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

Service Provider / Service Details Information [−]

Provider ID 1831573690 **ID Type** NPI **Name** HOSPITALIST SERVICES OF NEVADA-MANDAVIA

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

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.

Viewing the Status of PAs, continued

Service Provider / Service Details Information

Provider ID 1306097878　　　ID Type NPI　　　Name KHOSSROW HAKIMPOUR

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
08/29/2017	08/29/2017	1	1	$125.00	CPT/HCPCS 80061-Lipid panel	View	Certified Partial 06/11/2018	Product/service/procedure delivery pattern (e.g., units, days, visits, weeks, hours, months)
08/30/2017	08/30/2017	1	0	—	CPT/HCPCS 36415-Routine venipuncture	View	Not Certified 06/11/2018	Non-covered Service

A　　　**B**

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).

Viewing the Status of PAs, continued

Service Provider / Service Details Information

Provider 1573690 ID Type NPI Name HOSPIT... RVICES OF NEVADA-MANDA...

C D E F G

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

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).

Viewing the Status of PAs, continued

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
02/17/2013	02/17/2013	3	0	—	Revenue 0121-R&B-2 BED-MED-SURG-GYN	Hide	Not Certified 02/21/2013	—
Medical Citation 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid. **Notes To Provider** Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted.								
02/20/2031	02/20/2031	2	0	—	Revenue 0121-R&B-2 BED-MED-SURG-GYN	View	Not Certified 02/22/2013	—
02/17/2013	02/20/2013	3	3	—	Revenue 0121-R&B-2 BED-MED-SURG-GYN	—	Certified In Total 02/24/2013	—

Edit   **View Provider Request**   **Print Preview**

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.

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

Authorization Information

A. Authorization Tracking Number

Select a Day Range or specify a Service Date

B. Day Range Last 30 days OR C. Service Date

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.

Searching for PAs, continued

Status Information

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

D | **Status**

- Cancel
- Certified In Total
- Certified Partial
- Not Certified
- Pended

Recipient Information

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

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.

Searching for PAs, continued

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

Submitting Additional Information, continued

2. Add additional diagnosis codes, service details and/or attachments.

Submitting Additional Information, continued

3. Click the **Resubmit** button to review the PA information.

Submitting Additional Information, continued

Referring Provider Information

| Provider ID | 1831573690 | ID Type | NPI | Name | HOSPITALIST SERVICES OF NEVADA-MANDAVIA |

Service Provider Information

| Provider ID | 1831573690 | ID Type | NPI | Name | HOSPITALIST SERVICES OF NEVADA-MANDAVIA |
| Location | _ | | | | |

Expand All | Collapse All

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Diagnosis Type	Diagnosis Code
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter

Service Details

	Line #	From Date	To Date	Code	Modifiers	Units
⊞	1	01/01/2018	01/01/2019	CPT/HCPCS A6413-Adhesive bandage, first-aid		1

Attachments

Transmission Method	File	Attachment Type
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes
EL-Electronic Only	Benefit Letter.docx	59-Benefit Letter

Back   **Confirm**   **Cancel**

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

Fee Schedule

Featured Links

Authorization Criteria

DHCFP Home

EDI Information

EVS User Manual

Modernization Project

Online Provider Enrollment

Provider Login (EVS)

Prior Authorization
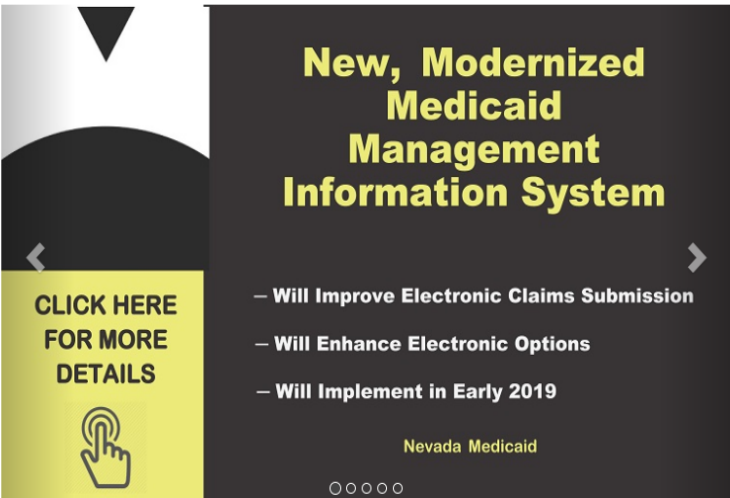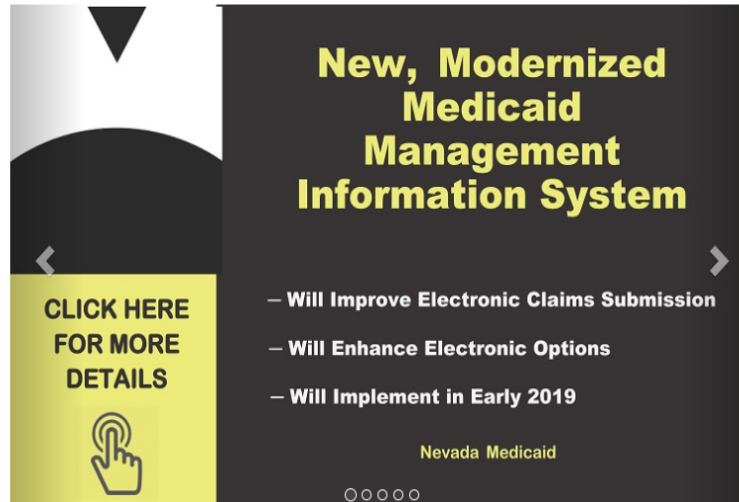
Search Fee Schedule

Search Providers

Claims

Trading Partner

- 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

Search Fee Schedule

* Indicates a required field.

Select a code type, then enter the procedure code or description and provider type.

- This page is used only for Nevada Fee For Service (FFS) rates.
- The fee displayed to the user as a result of the search may not be the amount the provider receives; Information on the claim may affect actual fee amount. The information contained in the schedule 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. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.
- Revenue code pricing for inpatient and nursing home provider types 011, 013, 019, 051, 056, 063, 065, 075, and 078 that is specific to a provider is not available through the Fee Schedule. Provider specific rates override the fee schedule. In addition, fees are not currently available for PT 064.
- Modifier and specialty do not affect ASC and ESRD bundled rates, so the modifier and specialty will not be used or displayed in the search results for these rates.

Financial Payer and Benefit Nevada Medicaid Title XIX Fee For Service
*Code Type Select
*Procedure Code or Description ⓘ
*Service Category Select

[Search] [Reset]

- 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

Fee Schedule, continued

Search Fee Schedule ?

*Indicates a required field.

Select a code type, then enter the procedure code or description and provider type.

- This page is used only for Nevada Fee For Service (FFS) rates.

- The fee displayed to the user as a result of the search may not be the amount the provider receives; Information on the claim may affect actual fee amount. The information contained in the schedule 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. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.

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- Modifier and specialty do not affect ASC and ESRD bundled rates, so the modifier and specialty will not be used or displayed in the search results for these rates.

Financial Payer and Benefit	Nevada Medicaid Title XIX Fee For Service
*Code Type	Procedure ▼
*Procedure Code or Description ❶	0362T-BHV ID SUPRT ASSMT EA 15 MIN
*Service Category	Behavioral Treatment ▼

[Search] [Reset]

Note: Make sure that the Effective Date ends in 2299.

Search Results

Total Records: 6

Procedure	Provider Type	Provider Specialty	Modifier	Fee Amount	Age Restrictions	Effective Date ▼
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	312-Lic. Board Certified Assist Behavior Analyst			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	312-Lic. Board Certified Assist Behavior Analyst	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	310-Lic. Board Certified Behavior Analyst			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	310-Lic. Board Certified Behavior Analyst	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	311-Psychologist			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	311-Psychologist	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299

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

DHCFP Rates Unit, continued

▶ RATE ANALYSIS & DEVELOPMENT

Nevada Medicaid

The Rate Analysis & Development Unit is responsible for: rate development; rate study/review; rate appeals; annual and quarterly updates; and nursing facility rates.

Nevada Medicaid administers the program with provisions of the Nevada Medicaid State Plan, Titles XI and XIX for the Social Security Act, all applicable Federal regulations and other official issuance of the Department. Methods and standards used to determine rates for inpatient and outpatient services are located in the State Plan under Attachments 4.19 A through E.

- How Medicaid Financing and Reimbursement Work

New Codes for 2019

- Annual New Code Update Process
- 2019 Annual Update
- Update on the 2019 New Codes
- 2019 Covered Codes
- 2019 ASC Covered Codes

Fee Schedule Search

Nevada Medicaid has a new feature on the Medicaid.nv.gov website under the Provider "Home" page (EVS). The new feature will allow Providers to not only view fee schedules, but also the ability to verify member eligibility, search for claims, payment information and Remittance Advices. For modifier or anesthesia base units, see the appropriate links below. Please refer to the appropriate Medicaid policy to fully determine coverage as well as any coverage limitations. Medicaid policy takes precedence over any code and rate listed here for a particular provider type.

- Fee Schedule Search
- Web Portal User Manual
- Anesthesiology Unit Values
- Nevada Medicaid Modifier Listing

Contact

rates@dhcfp.nv.gov

Rate Recycles

Rate Recycle Reports will be posted here weekly. Please check this section regularly to stay informed.

Pending Recycles

Fee Schedules

The fee schedules found here are updated on an annual basis, sometimes more frequently. Information regarding the annual new code update may be found on this website.

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.
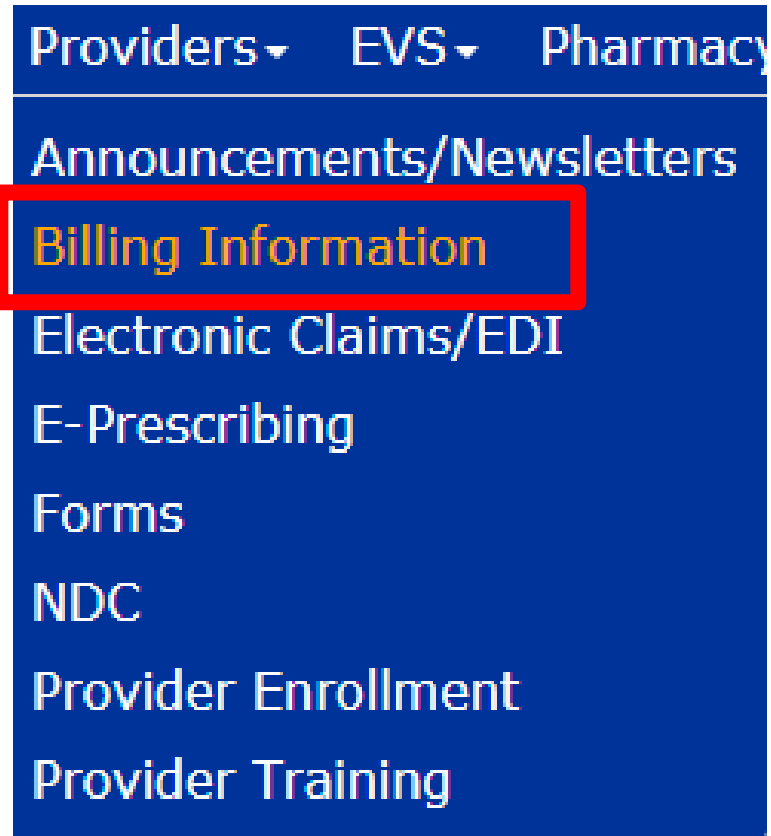
- Managed Care Capitation Rates - Pending CMS Approval
- Fee-for-Service PDF Fee Schedules

- 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 Behaviorial Anaylsis Fee Schedule

- Select Appropriate Title to open the PDF pertaining to the Reimbursement Schedule

Medicaid Billing Information

Locating Medicaid Billing Information

Providers ▾   EVS ▾   Pharmacy

Announcements/Newsletters

Billing Information

Electronic Claims/EDI

E-Prescribing

Forms

NDC

Provider Enrollment

Provider Training

- 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

Title	File Size	Last Update
Billing Manual	1 MB	02/01/2019

- 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

Understanding Claims Sub Menus, continued
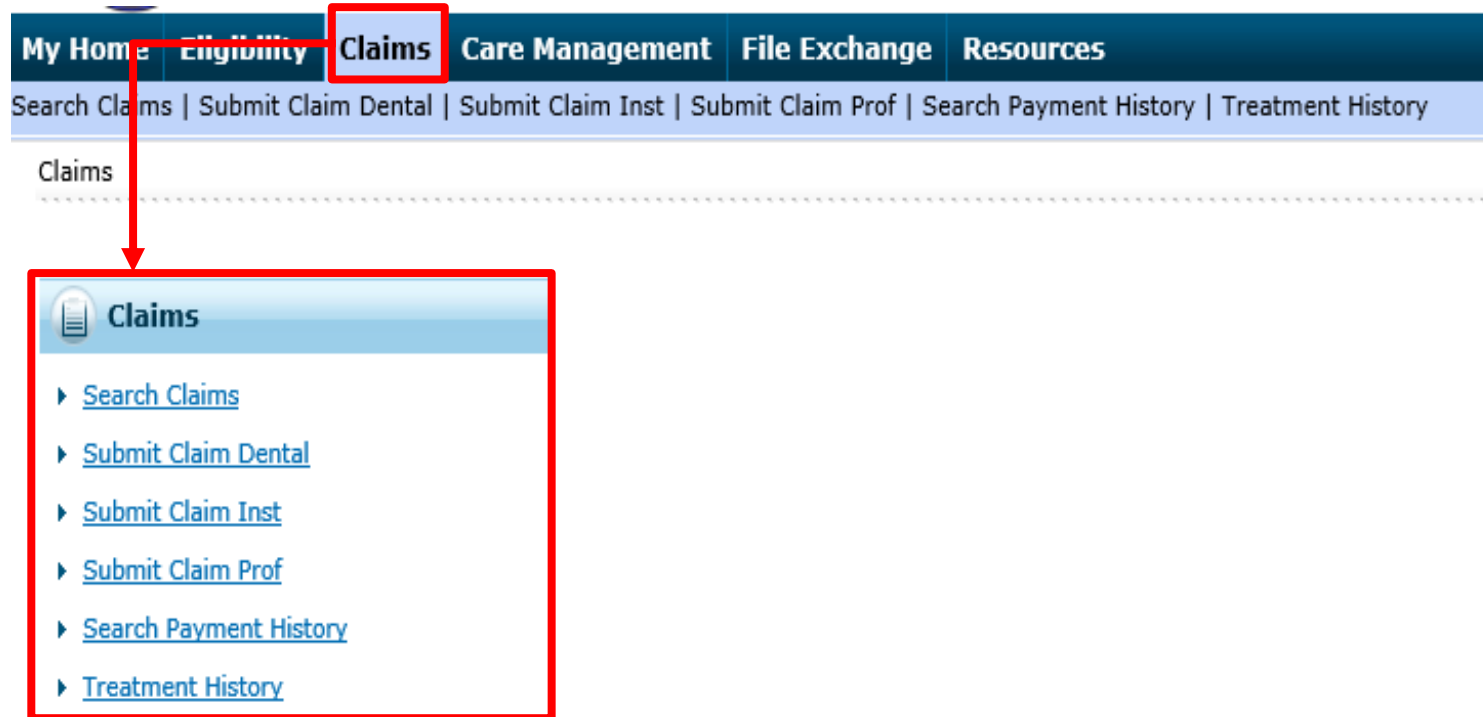
The page will display a list of Claims activities for the user to choose from.
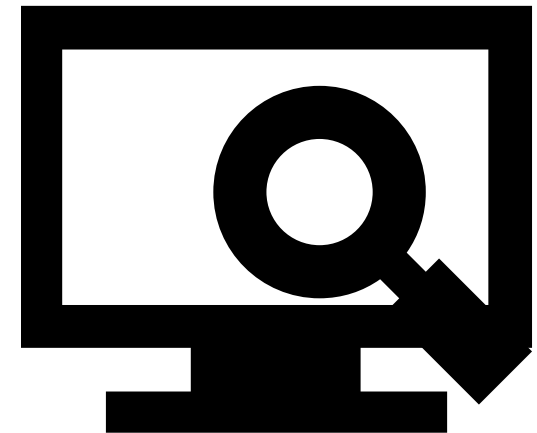
Submitting a Professional Claim

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**

Submitting a Professional Claim: Step 1, continued

Provider 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.

Submitting a Professional Claim: Step 1, continued

Provider Information

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.

Submitting a Professional Claim: Step 1, continued

Provider Information

9. Select a **Rendering Provider Service Location** from the drop-down

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.

Submitting a Professional Claim: Step 1, continued

Patient Information

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.

Submitting a Professional Claim: Step 1, continued

Claim Information

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**

Submitting a Professional Claim: Step 1, continued

Claim Information

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.

Submitting a Professional Claim: Step 2, continued

Diagnosis Codes

Submit Professional Claim: Step 2

* Indicates a required field.

	Claim Type	Professional

Provider Information

Billing Provider ID	1578564860	ID Type	NPI

Patient and Claim Information

Recipient ID	67770816236		
Recipient	UGNWLA TRNXEUK	Gender	Male
Birth Date	02/11/1985	Total Charged Amount	$0.00

Expand All | Collapse All

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.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	R401-Stupor	Remove
2			

2   ***Diagnosis Type** [ICD-10-CM ∨]   ***Diagnosis Code** 🛈 [_____]

[Add] [Reset]

[Back to Step 1]   **4** [Continue] [Cancel]

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

Submitting a Professional Claim: Step 3
Service Details

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

Service Details

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.

Submitting a Professional Claim: Step 3, continued

Service Details

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.

Submitting a Professional Claim: Step 3, continued

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	$100.00	1.000 Unit	Remove
2	01/12/2018	01/12/2018	11-Office	96361-Hydrate iv infusion add-on	$200.00	1.000 Unit	Remove
3						0.000	

3 *From Date ⓘ [   ] 🔲   To Date ⓘ [   ] 🔲   *Place of Service [▾]   EMG [▾]

*Procedure Code ⓘ [   ]   Modifiers ⓘ [   ] [   ] [   ] [   ]   *Diagnosis Pointers [▾] [▾] [▾] [▾]

*Charge Amount [   ]   *Units [0.000]   *Unit Type [Unit ▾]   EPSDT ☐   Family Plan ☐

Clia Number [   ]

Rendering Provider ID [   ] 🔍   ID Type [▾]

Rendering Provider Service Location _

Referring Provider ID [   ] 🔍   ID Type [▾]

NDCs for Svc. # 3   ⊞

[Add] [Reset]

Attachments   ⊟

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
⊞ Click to add attachment.					

[Back to Step 1] [Back to Step 2]   ⬡9 [Submit] [Cancel]

9. Click the **Submit** button
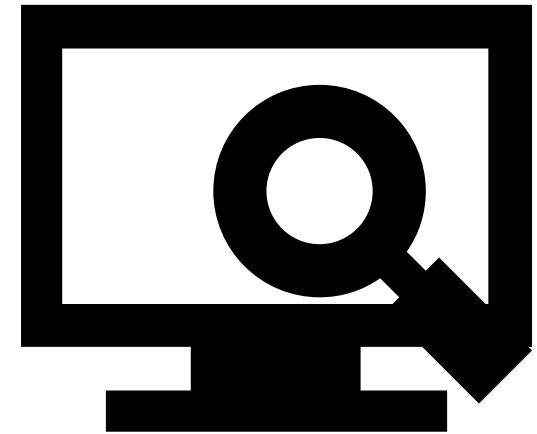
Submitting a Professional Claim: Step 3, continued

Date Type	_	
Accident Related	_	
Patient Number	123456789	
Transport Certification	Yes	
Certification Condition Indicator	Yes	
Condition Indicator	Patient was admitted to a hospital	
	_	
	_	
	_	
	_	
Transport Distance	1.00	
Ambulance Transport Reason	Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility.	
Previous Claim ICN	_	
Note	_	

Date of Current	_
Admission Date	_
Authorization Number	_

Does the provider have a signature on file? Yes

Total Charged Amount $300.00

Expand All | Collapse All

Diagnosis Codes   ⊞

Service Details   ⊟

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
1	09/12/2018	09/12/2018	11		2018F		1	1.000 Unit	☐	☐	$100.00
2	01/12/2018	01/12/2018	11		96361		1	1.000 Unit	☐	☐	$200.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Back to Step 1   Back to Step 2   Back to Step 3   Print Preview   ⬡ 10   Confirm   Cancel

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

1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	$100.00	1.000 Unit	Remove
2	01/12/2018	01/12/2018	11-Office	96361-Hydrate iv infusion add-on	$200.00	1.000 Unit	Remove
3						0.000	

3 ***From Date** ❶ [_____] 🔲 **To Date** ❶ [_____] 🔲 ***Place of Service** [_____ ▾] **EMG** [▾]

*Procedure Code ❶ [_____] **Modifiers** ❶ [_____] [_____] [_____] [_____] ***Diagnosis Pointers** [▾] [▾] [▾] [▾]

*Charge Amount [_____] ***Units** [0.000] ***Unit Type** [Unit ▾] **EPSDT** ☐ **Family Plan** ☐

Clia Number [_____]

Rendering Provider ID [_____] 🔍 **ID Type** [_____ ▾]

Rendering Provider Service Location _

Referring Provider ID [_____] 🔍 **ID Type** [_____ ▾]

NDCs for Svc. # 3 ⊞

[Add] [Reset]

Attachments ⊟

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
⊞ Click to add attachment.					

[Back to Step 1] [Back to Step 2] [Submit] [Cancel]

To upload attachments to a professional claim:

1. Click the (+) sign on the **Attachments** panel

Submitting a Professional Claim: Attachments, continued

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.

Submitting a Professional Claim: Attachments, continued

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.

Submitting a Professional Claim: Attachments, continued

7. Click the **Submit** button to proceed

NOTE: To remove any attachments, click the **Remove** link.

Submitting a Professional Claim: Other Insurance Details

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

Submitting a Professional Claim: Other Insurance Details, continued

Patient and Claim Information

Recipient ID	36596364392		
Recipient	ALMA SMITH	**Gender**	Male
Birth Date	10/15/1999	**Total Charged Amount**	$300.00

Expand All | Collapse All

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.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	R401-Stupor	Remove
2			

2 　　*Diagnosis Type [ICD-10-CM ▾]　　　*Diagnosis Code 🛈 [_____]

Add　**Reset**

Other Insurance Details ⊟

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	HEALTH PLAN OF NEVADA	07762	05060442803		_	Remove
2	HEALTH PLAN OF NEVADA	07...	050604428-00		_	Remove
⊞ Click to add a new other insurance.						

3

Back to Step 1　　　　　　　　　　　　　　　**Continue**　**Cancel**

Go to Top

To add a policy or other insurance carrier information:
3. Click (+) in the **Other Insurance Details** panel at the bottom of the page

Submitting a Professional Claim: Other Insurance Details, continued

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	HEALTH PLAN OF NEVADA	07762	05060442803		–	Remove
2	HEALTH PLAN OF NEVADA	07549	050604428-00		–	Remove

Refresh Other Insurance

Click to collapse.

*Carrier Name: Insurance Plan
*Carrier ID: 123456789
*Policy Holder Last Name: Smith
*First Name: John
MI:
*Policy ID: 987654321
Insurance Type: 12-Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
*Responsibility: S-Secondary
*Patient Relationship to Insured: 01-Spouse
Payer Paid Amount:
*Paid Date: 08/01/2018
Remaining Patient Liability:
*Claim Filing Indicator: DS-Disability

(4)
(5) Add Insurance   Cancel Insurance

Back to Step 1   Continue   Cancel

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

Other Insurance Details ▬

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.
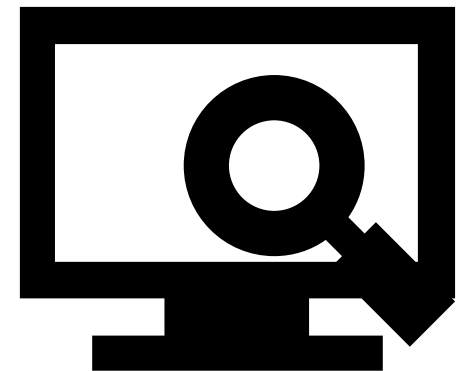
						Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	HEALTH PLAN OF NEVADA	07762	05060442803		_	Remove
2	HEALTH PLAN OF NEVADA	07549	050604428-00		_	Remove
3	Insurance Plan	123456789	987654321		08/01/2018	Remove

⊞ Click to add a new other insurance.

Back to Step 1   **Continue**   **Cancel**

Go to Top

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

Submitting a Professional Claim: Other Insurance Details, continued

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

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.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	R401-Stupor	Remove
2			

2   *Diagnosis Type [ICD-10-CM ▼]   *Diagnosis Code ⓘ [_____]

[Add] [Reset]

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

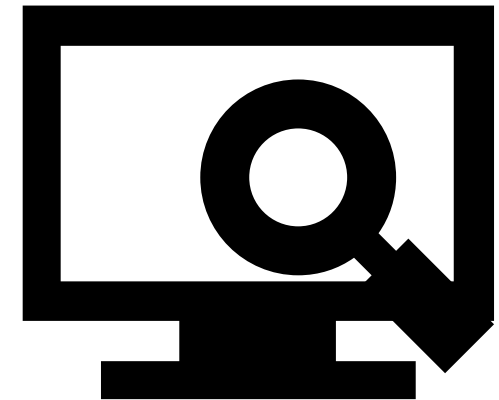Click the **Remove** link to remove the entire row.

[Refresh Other Insurance]

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	HEALTH PLAN OF NEVADA	07762	05060442803	$100.00	08/07/2018	Remove
2	HEALTH PLAN OF NEVADA	07549	050604428-00		_	Remove
3	Insurance Plan	123456789	987654321		08/01/2018	Remove

[+] Click to add a new other insurance.

[Back to Step 1]   **7** [Continue] [Cancel]

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

Submitting a Crossover Professional Claim, continued

Medicare Crossover Details

Allowed Medicare Amount	$5,000.00	Co-insurance Amount	$950.00
Deductible Amount	$250.00	Psychiatric Services Amount	$0.00
Medicare Payment Amount	$3,800.00	Medicare Payment Date	10/12/2018

Expand All | Collapse All

Diagnosis Codes ➕

Service Details ➖

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
1	09/20/2018	09/20/2018	21		01210		1	120.000 Unit	☐	☐	$6,500.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

| Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | | **7** | Confirm | Cancel |

7. Click the **Confirm** button

Submitting a Crossover Professional Claim, continued

Submit Crossover Professional Claim: Confirmation [?]

Crossover Professional Claim Receipt

Your Crossover Professional Claim was successfully submitted. The claim status is Finalized Payment.

The Claim ID is **2218297000010.**

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **Adjust** to resubmit the claim.

Click **New** to submit a new claim.

Click **View** to view the details of the submitted claim.

[Print Preview] [Copy] [Adjust] [New] [View]

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**

Searching for a Professional Claim, continued

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

Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID.

Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
–	2218256000002		Professional	Finalized Denied	09/12/2018	67770816236	1003195538	$0.00	09/14/2018	

6

Professional Claim Information

Recipient	UGNWLA TRNXEUK	**Total Charge Amount**	$300.00
Birth Date	02/11/1985	**Total Paid Amount**	$0.00
Rendering Provider	MICHAEL A SMITH	**Paid Date**	09/14/2018
Claim Status	Finalized Denied	**Reason Code**	Finalized/Denial-The claim/line has been denied.

Service Information

Service	Service Date	Line Status	Reason Code	Units	Procedure/ Modifiers	Charge	Paid
1	09/12/2018	Finalized Denied	Finalized/Denial-The claim/line has been denied.	1	2018F	$100.00	$0.00
2	01/12/2018	Finalized Denied	Finalized/Denial-The claim/line has been denied.	1	96361	$200.00	$0.00

RA Copy (PDF)

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

NOTE: The user may view the RA by clicking the **RA Copy (PDF)** button. Searching for RAs will be covered later in the training.

Searching for a Professional Claim, continued

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

Certification Condition Indicator	Yes	
Condition Indicator	Patient was admitted to a hospital	
	_	
	_	
	-	
	_	
Transport Distance	1.00	
Ambulance Transport Reason	Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility.	
Previous Claim ICN	_	
Note	_	
Does the provider have a signature on file?	Yes	

		Total Charged Amount	$300.00
Total Allowed Amount $0.00	Total Co-pay Amount $0.00	Total Paid Amount	$0.00

Expand All | Collapse All

Adjudication Errors −

Claim / Service #	HIPAA Adj	Description	EOB
Service # 1	1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110
Service # 2	1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110

Diagnosis Codes +

Service Details −

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	09/12/2018	09/12/2018	11	N	2018F		1	1.000 Unit	$100.00	$0.00	$0.00	$0.00
2	01/12/2018	01/12/2018	11	N	96361		1	1.000 Unit	$200.00	$0.00	$0.00	$0.00

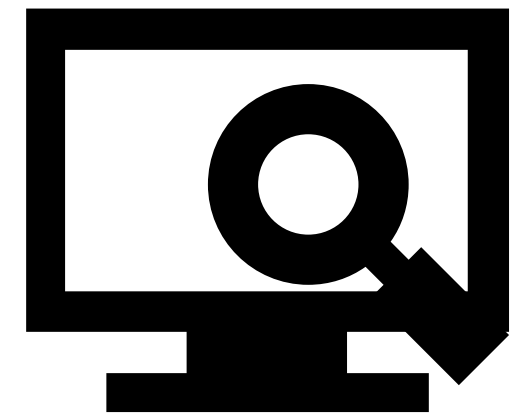**No Other Insurance Details exist for this claim**

No Attachments exist for this claim

Copy   Print Preview   RA Copy (PDF)

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.

Viewing a Professional Claim's RA, continued

Search Results

To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.

If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assistance.

Total Records: 11

Issue Date	Payment Method	Payment Type	Check # / RA #	Total Paid Amount	RA Copy (PDF)
09/14/2018	CHK	C	000000000/100005447	$0.00	[RA]
09/07/2018	CHK	C	000012397/100005394	$30.00	[RA]
09/07/2018	ACH	E	000930866/100005361	$130.00	[RA]
08/31/2018	CHK	C	000000000/100005323	$0.00	[RA]
08/17/2018	CHK	C	000000000/100005263	$0.00	[RA]
08/10/2018	ACH	E	000930835/100005216	$300.00	[RA]
08/10/2018	ACH	E	000930819/100005155	$610.00	[RA]
07/13/2018	ACH	E	000930802/100004985	$50.00	[RA]
07/06/2018	ACH	E	000930797/100004953	$20.00	[RA]
06/29/2018	ACH	E	000930789/100004925	$10.00	[RA]

1 2

5. Click on the **RA Copy (PDF)** icon

Viewing a Professional Claim's RA, continued

Search Results

To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.

If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assistance.

Total Records: 11

| Issue Date	Payment Method	Payment Type	Check # / RA #	Total Paid Amount	RA Copy (PDF)
09/14/2018	CHK	C	000000000/100005447	$0.00	RA
09/07/2018	CHK	C	000012397/100005394	$30.00	RA
09/07/2018	ACH	E	000930866/100005361	$130.00	RA
08/31/2018	CHK	C	000000000/100005323	$0.00	RA
08/17/2018	CHK	C	000000000/100005263	$0.00	RA
08/10/2018	ACH	E	000930835/100005216	$300.00	RA
08/10/2018	ACH	E	000930819/100005155	$610.00	RA
07/13/2018	ACH	E	000930802/100004985	$50.00	RA
07/06/2018	ACH	E	000930797/100004953	$20.00	RA
06/29/2018	ACH	E	000930789/100004925	$10.00	RA

1 2

PDF Files require Adobe Acrobat Reader

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CPT is a registered trademark ® of the AMA. CDT is a registered trademark ® of the ADA. Applicable FARS/DFARS apply.

Do you want to open or save **RA 100005447.pdf** (4.10 KB) from **portalmod.nvad.xnv.dcs-usps.com**?   6 | Open | Save ▾ | Cancel | ✕

6. User will click the **Open** button

Viewing a Professional Claim's RA, continued

```
REPORT:    CRA-HCDN-R                    NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY              DATE:  09/13/2018
  RA#:    100005447                              NEVADA MEDICAID (TXIX)                                   PAGE:         2
PAYER:    TXIX                                PROVIDER REMITTANCE ADVICE
                                           PROFESSIONAL SERVICES CLAIMS DENIED

GONZALEZ              KAREN       S                                              PAYEE ID        100506939   MCD
PO BOX 748356                                                                   NPI             1205806429
LOS ANGELES, CA 90074-4444                                                      CHECK/EFT NUMBER   000000000
                                                                               PAYMENT DATE     09/14/2018

  --ICN--         PCN          MRN       SERVICE DATES    BILLED      OTH INS       SPENDDOWN
                                          FROM    TO      AMOUNT      AMOUNT         AMOUNT
MEMBER NAME: ARS EAUNSXK                    MEMBER NO.: 97131704238
218256000001   UNLINK                     091318 091318        10.00        0.00          0.00
                              SERVICE DATES                  PA NUMBER
PROC CD  MODIFIERS  ALLW UNITS  FROM    TO     RENDERING PROVIDER   BILLED AMT     DETAIL EOBS
65436                  0.00   091318 091318 MCD 100506939                            3006
   NCPDP REJ:                                              10.00
          TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:        10.00        0.00          0.00
TOTAL NO. DENIED:        1
```

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

Copying a Professional Claim, continued

Recipient ~~HROBHLV V GLOXBIR~~
Birth Date 05/01/2002

Claim Information

Claim Status Finalized Payment			
Date Type _	**Date of Current** _		
Accident Related _	**Admission Date** 09/18/2018		
Patient Number 053036404FKE	**Authorization Number** _		
Related Claim ICN _			
Transport Certification No			
Previous Claim ICN _			
Note _			

Does the provider have a signature on file? Yes

Total Charged Amount $175.00

Total Allowed Amount $44.62   **Total Co-pay Amount** $0.00   **Total Paid Amount** $44.62

Expand All | Collapse All

Adjudication Errors ➕

Diagnosis Codes ➕

Service Details ➖

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	$175.00	$44.62	$0.00	$44.62

No Other Insurance Details exist for this claim

No Attachments exist for ~~this~~ ~~claim~~

[Adjust] [**Copy**] [Void] [Print Preview]

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

Copying a Professional Claim, continued

7. Select what portion of the claim to copy (for this example, the user has selected **Entire Claim**)
8. Click the **Copy** button

Copying a Professional Claim, continued

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.

Adjusting a Professional Claim, continued

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

Adjusting a Professional Claim, continued

10. Click the **Resubmit** button

Adjusting a Professional Claim, continued

Patient Information

Recipient ID	67032685329
Recipient	MROBMLV V GIOXBIK
Birth Date	05/01/2002
Gender	Female

Claim Information

Claim Status	Finalized Payment
Date Type	_
Accident Related	_
Patient Number	053036404FKE
Related Claim ICN	_
Transport Certification	No
Previous Claim ICN	2218262000035
Note	_
Date of Current	_
Admission Date	09/18/2018
Authorization Number	_

Does the provider have a signature on file?   Yes

Total Charged Amount $175.00

Expand All | Collapse All

Adjudication Errors ⊞

Diagnosis Codes ⊞

Service Details ⊟

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
1	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	☐	☐	$175.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Back to Step 1 Back to Step 2 Back to Step 3 Print Preview   ⬡11 **Confirm** **Cancel**

11. Click the **Confirm** button

NOTE: Click the **Cancel** button to cancel the adjustment.

Adjusting a Professional Claim, continued

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

Submitting an Appeal for a Claim, continued

Secure Correspondence – Message Box					Back to My Home ?

Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional queries please contact us.

Create New Message

Total Records: 13

Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4256	Appeal of a denied claim	Claims - Appeals	10/02/2018	10/02/2018
Open	4255	testing	Claims - Appeals	09/27/2018	09/27/2018
Open	4253	Testing from MO	Level 2 Support - Account Issues	09/19/2018	09/19/2018
Open	4252	Testing 6268 in MO	Level 2 Support - Account Issues	09/18/2018	09/18/2018
Open	4251	Testing 6268	Claims - Appeals	09/06/2018	09/06/2018
Open	4227	Testing sample for 5916	Level 2 Support - Account Issues	08/14/2018	08/14/2018
Closed	4217	Help	Other	07/08/2018	08/03/2018
Open	4218	Testing Help	Other	07/08/2018	07/08/2018
Open	4219	Testing help..	Other	07/08/2018	07/08/2018
Open	4188	Testing in Model	Level 2 Support - Account Issues	04/09/2018	04/09/2018

1 2

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

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

Voiding a Professional Claim, continued

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.

Voiding a Professional Claim, continued

To void the claim, the user will:

6. Click the **Void** button

Voiding a Professional Claim, continued

Does the provider have a signature on file? Yes

Allowed Amount $44.62   Total Co-pay Amount $0.00

Total Charged Amount $175.00

Total Paid Amount $44.62

ors

Confirmation

Are you sure you want to void this Professional Claim ID
5918263000001?

7   **OK**   **Cancel**

To Date	Place of Service			Ptrs				Co-
09/18/2018	32	N	99308	1	1.000 Unit	$175.00	$44.62	

nce Details exist for this claim

exist for this claim

just   **Copy**   **Void**   **Print Preview**

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:
  o **Initial request:** 15 business days before date of service or 15 calendar days after requested start date of service
  o **Continued service requests:** 5-15 days prior
  o **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.
  o **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

- For Secure EVS Web Portal: https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx

- For Billing Manual and Billing Guides: https://www.medicaid.nv.gov/providers/BillingInfo.aspx

- For Medicaid Services Manual: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

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@dxc.com

Thank You