Objectives
Objectives

- Locate Medicaid Policy
- Locate Public Notice/Hearings Information
- Review Behavioral Health Information from the DHCFP
- Review Web Announcements
- Learn How to Utilize the Authorization Criteria Function
- Locate Prior Authorization Forms
- Properly Submit a Prior Authorization via the Electronic Verification System (EVS) Secure Provider Web Portal
- Locate Billing Information
- Utilize the Search Fee Schedule and the DHCFP Rates Unit
- Submit Claims using Direct Data Entry via the EVS Secure Provider Web Portal
Medicaid Website
Medicaid Website
www.medicaid.nv.gov

Welcome

New, Modernized Medicaid Management Information System
- Will Improve Electronic Claims Submission
- Will Enhance Electronic Options
- Will Implement in Early 2019

Welcome to the Nevada Medicaid and Nevada Check Up Provider Web Portal. Through this easy-to-use internet portal, healthcare providers have access to useful information and tools regarding provider enrollment and revalidation, recipient eligibility, verification, prior authorization, billing instructions, pharmacy news and training opportunities. The notifications and web announcements keep providers updated on enhancements to the online tools, as well as updates and reminders on policy changes and billing procedures.

Thank you for your participation in Nevada Medicaid and Nevada Check Up.

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)
Locating Medicaid Services Manual (MSM) Chapters

• Step 1: Highlight “Quick Links” from top blue toolbar at www.medicaid.nv.gov

• Step 2: Select “Medicaid Services Manual” from the drop-down menu

• Note: MSM Chapters will open in new webpage through the DHCFP website
Locating MSM Chapters, continued

- Provider types (PTs) 14, 26, 17 Specialty 215 and all other Behavioral Health providers must select Chapter 400
- PTs 16 and 83: also select Chapter 1600
- PT 20 Specialty 146: also select Chapter 600
- PT 82: also select Chapter 1500
- From the next page that opens, always be sure to select the “Current” policy
Division of Health Care Financing and Policy Public Notices
Locating Public Notice Information

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

• From the DHCFP Home Page dhcfp.nv.gov highlight “Public Notices”

• Select “Meetings/Public Notices”

• This will provide information pertaining to upcoming meetings
Program Information
Locating Program Information

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

- From the DHCFP Home Page highlight “Programs”
- Select appropriate program
- This will provide valuable information regarding Programs that are offered in the State of Nevada
Viewing Web Announcements
Web Announcements

- Select “View All Web Announcements” to view Web Announcements
Web Announcements, continued

• Results can be narrowed selecting a category from the drop-down menu or utilizing the “Ctrl F” to bring up a Search Box.
Authorization Criteria

• The Authorization Criteria tool on the Provider Web Portal allows a user to input a procedure code to determine if a Prior Authorization (PA) is required.

• If the search criteria does not return any results, providers are encouraged to verify all PA requirements by referring to the Medicaid Services Manual (MSM) Chapter for the appropriate provider type at dhcfp.nv.gov and the Billing Guidelines located at www.medicaid.nv.gov.
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 9999. This will provide the current information.

### Authorization Criteria

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Claim Type</th>
<th>PA Required</th>
<th>Age Restrictions</th>
<th>Effective Date</th>
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</thead>
<tbody>
<tr>
<td>0370T-FAM BEHAV TREATMENT GUIDANCE</td>
<td>085-Applied Behavior Analysis (ABA)</td>
<td>310-Licensed and Board Certified Behavior Analyst (BCBA)</td>
<td>PRACTITIONER</td>
<td>Always</td>
<td>0-20</td>
<td>01/01/2016 01/01/2016 12/31/9999</td>
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<tr>
<td>0370T-FAM BEHAV TREATMENT GUIDANCE</td>
<td>085-Applied Behavior Analysis (ABA)</td>
<td>311-Psychologist</td>
<td>PRACTITIONER</td>
<td>Always</td>
<td>0-20</td>
<td>01/01/2016 01/01/2016 12/31/9999</td>
</tr>
</tbody>
</table>
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

While on the Forms page, locate and choose appropriate forms.

Make sure that instructions are followed.

All active forms are fillable forms for easy uploading and online PA submission.

### Forms

Nevada Medicaid Forms Can Now Be Submitted Using the Provider Web Portal

On July 6, 2015, Nevada Medicaid completed updating all of the Nevada Medicaid forms that are available on this website. These forms have been updated to a format that allows them to be completed, downloaded and saved electronically. In addition, an enhancement has been made to allow some forms to be submitted online using the “Upload Files” page on the Provider Web Portal.

Please see Web Announcement 938 for the list of forms that can be uploaded using the “Upload Files” page on the Provider Web Portal, the types of forms that may not be uploaded, and screenshots and instructions for uploading forms. Upload Instructions are also available in the new Electronic Verification System (EVS) User Manual Chapter 8.

### 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 Instructions</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>
</tbody>
</table>
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
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:

6. Confirming that the **Site Key** and **Passphrase** are correct
7. Entering **Password**
8. 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.
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**: This is 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.
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 exists 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.
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.
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.
After clicking the **Add Service** button, the service details will display in the list.

**NOTE:** Manage additional details as needed. If a user wishes to copy a service detail, click **Copy** located in the **Action** column. To remove the detail, click **Remove**.
The **Transmission Method** will default to EL-Electronic Only as attachments must be sent via the Provider Web 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.
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 PA’s 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.
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**.

---

**Provider**

- **Name**: HOSPITALIST SERVICES OF NEVADA-MANDAVIA
- **Provider ID**: 1831573690 (NPI)
- **Location ID**: 100543194

- **My Profile**
- **Manage Accounts**

**Broadcast Messages**

**Hours of Availability**
The Nevada Provider Web Portal is unavailable 8 AM PST Monday-Saturday and between 8 PM and 12 AM PST Sunday.

**Welcome Health Care Professionals**
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.
6. Review the details listed in the **Decision / Date** and **Reason** columns.

### Viewing the Status of PAs, continued

<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>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td></td>
<td>CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NOV=SMOKING</td>
<td>Certified In Total 01/12/2018</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>

Nevada Medicaid Behavioral Health Provider Training
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.
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

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

<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>
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<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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<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>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>02/17/2013</td>
<td>02/20/2013</td>
<td>3</td>
<td>3</td>
<td></td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td></td>
<td>Certified In Total</td>
<td>02/24/2013</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Status Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select status to return authorization service lines with the chosen status.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status</strong></td>
</tr>
<tr>
<td>Select a status from this list to narrow search results to include only the selected status.</td>
</tr>
</tbody>
</table>

- **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.
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 National Provider Identifier (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.
Submitting Additional Information, continued

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 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” on the Provider Web Portal.
- 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.

• 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
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

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

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

- Locate the section header “Billing Guidelines (by Provider Type)”
- Select appropriate Provider Type Guideline

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<table>
<thead>
<tr>
<th>Number</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Behavioral Health Outpatient Treatment</td>
</tr>
<tr>
<td>16</td>
<td>Intermediate Care Facilities for Individuals with Intellectual Disabilities / Public</td>
</tr>
<tr>
<td>17 (Spec. 215)</td>
<td>Special Clinics: Substance Abuse Agency Model (SAAM)</td>
</tr>
<tr>
<td>26</td>
<td>Psychologist</td>
</tr>
<tr>
<td>82</td>
<td>Behavioral Health Rehabilitative Treatment</td>
</tr>
<tr>
<td>85</td>
<td>Applied Behavior Analysis (ABA) (Effective January 1, 2019)</td>
</tr>
</tbody>
</table>
Fee Schedule and DHCFP Rates Unit
Fee Schedule

- Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a Procedure Code
Fee Schedule, continued

• Step 1: Check “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
- Step 3: Select Service Category from drop-down menu
- Step 4: Click “Search” to populate results
Fee Schedule, continued

Note: Make sure that the Effective Date ends in 9999.
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
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.

- Hospital Rates and Revenue Codes
- Provider Type 16 Outpatient Surgery-ASC Procedures and Payment Groups
- Provider Type 17 Behavioral Health Outpatient Treatment
- Provider Type 18 Comprehensive Outpatient Rehabilitation Facilities/Retarded (Public)
- Provider Type 19 Home Health Agencies
- Provider Type 20 Physician, MD., Osteopath
- Provider Type 21 Podiatrists
- Provider Type 22 Dentists
- Provider Type 23 Hearing Aid Dispenser & Supplies
- Provider Type 24 Advanced Practice Registered Nurse
- Provider Type 25 Optometrist
- Provider Type 26 Psychologist
- Provider Type 27 Radiology
- Provider Type 28 Home Health Agency
- Provider Type 29 and 30 Personal Care Services
- Provider Type 31 Ambulance, Air or Ground

- Provider Type 32 Nursing Home/Extended Care Facility
- Provider Type 33 OtherHCPC Code

- Provider Type 14 Behavioral Health Outpatient Treatment

- Provider Type 17
  - Specialty 166, Special Clinic, Family Planning
  - Specialty 169, Special Clinic, Obstetrical Care Clinic, Birthing Centers
  - Specialty 174, Special Clinic, Public Health
  - Specialty 179, School Based Health Centers
  - Specialty 183, Comprehensive Outpatient Rehabilitation Facilities
  - Specialty 195, Special Clinic, Community Health
  - Specialty 196, Special Clinic, Early Intervention
  - Specialty 198, Special Clinic, HIV
  - Specialty 215, Substance Abuse Agency Model (SAAM)

- Provider Type 20 Physician, MD., Osteopath
- Provider Type 21 Podiatrists
- Provider Type 22 Dentists
- Provider Type 23 Hearing Aid Dispenser & Supplies
- Provider Type 24 Advanced Practice Registered Nurse
- Provider Type 25 Optometrist
- Provider Type 26 Psychologist
- Provider Type 27 Radiology
- Provider Type 28 Home Health Agencies
- Provider Type 29 and 30 Personal Care Services
- Provider Type 31 Ambulance, Air or Ground
- Provider Type 32 Nursing Home/Extended Care Facility
- Provider Type 33 OtherHCPC Code

- Select appropriate title to open the PDF pertaining to the Reimbursement Schedule
Submitting a Professional Claim via the EVS Secure Provider Web Portal (DDE)
Understanding Claim 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

“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.
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.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Provider Name</th>
<th>Provider Type</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1009192328 (NPI)</td>
<td>CHAEL A SMITH</td>
<td>Mental Health Outpatient Services</td>
<td>6130 ELTON AVE</td>
<td>LAS VEGAS</td>
<td>NEVADA</td>
<td>89107-2338</td>
</tr>
<tr>
<td>1013216659 (NPI)</td>
<td>GWEN M SMITHSON</td>
<td>Mental Health Outpatient Services</td>
<td>224 E WINNIE LN STE 222</td>
<td>CARSON CITY</td>
<td>NEVADA</td>
<td>89706-2251</td>
</tr>
<tr>
<td>1013301133 (NPI)</td>
<td>WILLIAM R SMITH</td>
<td>Nurse, Anesthetist</td>
<td>1050 E SOUTH TEMPLE</td>
<td>SALT LAKE CITY</td>
<td>UTAH</td>
<td>84102-1507</td>
</tr>
<tr>
<td>1013302783 (NPI)</td>
<td>JEFFREY D SMITH</td>
<td>Physician Assistant</td>
<td>520 S EAGLE RD STE 2209</td>
<td>MERIDIAN</td>
<td>IDAHO</td>
<td>83642-6354</td>
</tr>
<tr>
<td>1013307086 (NPI)</td>
<td>AMY P SMITH</td>
<td>Nurse, APRN</td>
<td>2201 SOUTH AVE</td>
<td>S LAKE TAHOE</td>
<td>CALIFORNIA</td>
<td>96150-7023</td>
</tr>
<tr>
<td>1013306224 (NPI)</td>
<td>COURTNEY M SMITH</td>
<td>Audiologist</td>
<td>3150 N TENAVA WAY STE 112</td>
<td>LAS VEGAS</td>
<td>NEVADA</td>
<td>89128-0446</td>
</tr>
</tbody>
</table>
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.
### Patient Information

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

**Recipient ID**: 67770816236

**Last Name**: TRNXEUK

**Birth Date**: 02/11/1985

**First Name**: UGNWLA

### Claim Information

- **Date Type**: [ ]
- **Date of Current**: [ ]
- **Accident Related**: [ ]
- **Admission Date**: [ ]
- ***Patient Number**: [ ]
- **Authorization Number**: [ ]
- **Transport Certification**: [ ] Yes [ ] No
- **Does the provider have a signature on file?**: [ ] Yes [ ] No
- **Include Other Insurance**: [ ]
- **Total Charged Amount**: $0.00

### Instructions

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

Claim Information

<table>
<thead>
<tr>
<th>Date Type</th>
<th>□</th>
<th>Date of Current (  )</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related</td>
<td>□</td>
<td>Admission Date (  )</td>
<td>□</td>
</tr>
<tr>
<td>*Patient Number</td>
<td></td>
<td>Authorization Number</td>
<td></td>
</tr>
<tr>
<td>*Transport Certification</td>
<td>□</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>*Certification Condition Indicator</td>
<td>□</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>*Condition Indicator</td>
<td></td>
<td>Patient was admitted to a hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Transport Distance</td>
<td></td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>*Ambulance Transport Reason</td>
<td></td>
<td>Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient</td>
<td></td>
</tr>
<tr>
<td>*Does the provider have a signature on file?</td>
<td>□</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Include Other Insurance</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Indicate whether the provider has a signature on file
18. Click the Continue button
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.
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 drop-down
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

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

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.
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
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 a 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.
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 drop-down

**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

### 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>$15,000.00</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>Serv #</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-Aneost hip 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>0.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Attachments

6. Click the **Submit** button
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

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.
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
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.
If the claim is denied, the user may review the errors as follows:

7. Click the (+) symbol adjacent to the **Adjudication Errors** panel
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.

---

<table>
<thead>
<tr>
<th>Certification Condition Indicator</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition Indicator</td>
<td>Patient was admitted to a hospital</td>
</tr>
<tr>
<td>Transport Distance</td>
<td>1.00</td>
</tr>
<tr>
<td>Ambulance Transport Reason</td>
<td>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.</td>
</tr>
<tr>
<td>Previous Claim ICN</td>
<td>_</td>
</tr>
<tr>
<td>Note</td>
<td>_</td>
</tr>
<tr>
<td>Does the provider have a signature on file?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

**Adjudication Errors**

<table>
<thead>
<tr>
<th>Claim / Service #</th>
<th>HIPAA Adj</th>
<th>Description</th>
<th>EOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service # 1</td>
<td>1010</td>
<td>RENDERING PROV NOT MEMBER OF BILLING PROV GROUP</td>
<td>3110</td>
</tr>
<tr>
<td>Service # 2</td>
<td>1010</td>
<td>RENDERING PROV NOT MEMBER OF BILLING PROV GROUP</td>
<td>3110</td>
</tr>
</tbody>
</table>

**Diagnosis Codes**

**Service Details**

<table>
<thead>
<tr>
<th>#</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code</th>
<th>Pts</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/13/2018</td>
<td>09/12/2018</td>
<td>11</td>
<td>N</td>
<td>2018F</td>
<td>1</td>
<td>1.000</td>
<td>Unit</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>01/10/2018</td>
<td>02/12/2018</td>
<td>11</td>
<td>N</td>
<td>96361</td>
<td>1</td>
<td>1.000</td>
<td>Unit</td>
<td>$200.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

No Other Insurance Details exist for this claim

No Attachments exist for this claim

---

Nevada Medicaid Behavioral Health Provider Training

150
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 Portal for the past 6 months. The default search range is for the past 90 days.
Viewing a Professional Claim’s RA, continued

5. Click on the RA Copy (PDF) icon

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Payment Method</th>
<th>Payment Type</th>
<th>Check # / RA #</th>
<th>Total Paid Amount</th>
<th>RA Copy (PDF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/14/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/100005447</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>09/07/2018</td>
<td>CHK</td>
<td>C</td>
<td>000012397/100005394</td>
<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>09/07/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930866/100005361</td>
<td>$130.00</td>
<td></td>
</tr>
<tr>
<td>08/31/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/100005323</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>08/17/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/100005263</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>08/10/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930835/100005216</td>
<td>$300.00</td>
<td></td>
</tr>
<tr>
<td>08/10/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930819/100005155</td>
<td>$610.00</td>
<td></td>
</tr>
<tr>
<td>07/13/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930500/100004985</td>
<td>$50.00</td>
<td></td>
</tr>
<tr>
<td>07/06/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930797/100004953</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>06/29/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930780/100004925</td>
<td>$10.00</td>
<td></td>
</tr>
</tbody>
</table>
Viewing a Professional Claim’s RA, continued

6. User will click the Open button

![Image of RA search results]

**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.

Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes, descriptions and data are copyrighted by the American Medical Association (AMA) and the American Dental Association (ADA), respectively, all rights reserved. AMA and ADA assume no liability for data contained or not contained on this website and on documents posted herein.

CPT is a registered trademark of the AMA. CDT is a registered trademark of the ADA. Applicable FAR/S/DFARS apply.

![Image of RA download dialog box]

**Do you want to open or save RA 100005447.pdf (4.10 KB) from portaimd.nvad.xnv.dcs-usps.com?**
After clicking Open, the user can review the RA.

Viewing a Professional Claim’s RA, continued
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
Adjusting a Professional Claim, continued

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.

Adjusting a Professional Claim, continued
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.
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

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
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

---

### Claim Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Finalized Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Type</td>
<td></td>
</tr>
<tr>
<td>Accident Related</td>
<td></td>
</tr>
<tr>
<td>Patient Number</td>
<td>053036404FKE</td>
</tr>
<tr>
<td>Related Claim ICN</td>
<td></td>
</tr>
<tr>
<td>Transport Certification</td>
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</tr>
<tr>
<td>Previous Claim ICN</td>
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<tr>
<td>Note</td>
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</tr>
</tbody>
</table>

**Does the provider have a signature on file?** Yes

<table>
<thead>
<tr>
<th>Total Allowed Amount</th>
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</thead>
<tbody>
<tr>
<td>Total Co-pay Amount</td>
<td>$0.00</td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>$175.00</td>
</tr>
<tr>
<td>Total Paid Amount</td>
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</tbody>
</table>

---

### Adjudication Errors

---

### Diagnostic Codes

---

### Service Details

<table>
<thead>
<tr>
<th>#</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Ptrs</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
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</thead>
<tbody>
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<td>09/18/2018</td>
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<td>99308</td>
<td>1</td>
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<td>$175.00</td>
<td>$44.62</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### No Other Insurance Details exist for this claim

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### No Attachments exist for this claim

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

8. Click the **OK** button
Additional Resources

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

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

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

Prior Authorization Department: 800-525-2395

Provider Field Representative: NevadaProviderTraining@dxc.com
Thank You