Claims Appeals, Adjustments and Voids Provider Training

2018 Nevada Medicaid Conference

Objectives

Objectives

- Review and Understand the Appeals Process
- Learn how to Adjust or Void a CMS-1500 Paper Claim Form
- Learn how to Adjust or Void a UB-04 Paper Claim Form
- Learn how to Adjust or Void an ADA Dental Paper Claim Form
- Locate Additional Resources

Claims Appeals Process

Claims Appeals Process

- Providers have the right to appeal a claim that has been ***denied.***
- Appeals must be postmarked or e-mailed to Nevada Medicaid no later than 30 calendar days from the date on the remittance advice.
- When filing a claim appeal, complete a Formal Claim Appeal Request (FA-90) and include:
  - A detailed explanation for the appeal
  - The provider's name and National Provider Identifier (NPI)
  - The Internal Control Number (ICN) of the denied claim
  - The name and telephone number of the person Nevada Medicaid can contact regarding the appeal
  - Documentation that supports the issue of why the claim is being appealed, such as medical records, prior authorization information and Explanation of Benefits or any additional information that a provider deems necessary
  - Original signed paper claim that may be used in processing should the appeal be approved
  - Any attachments

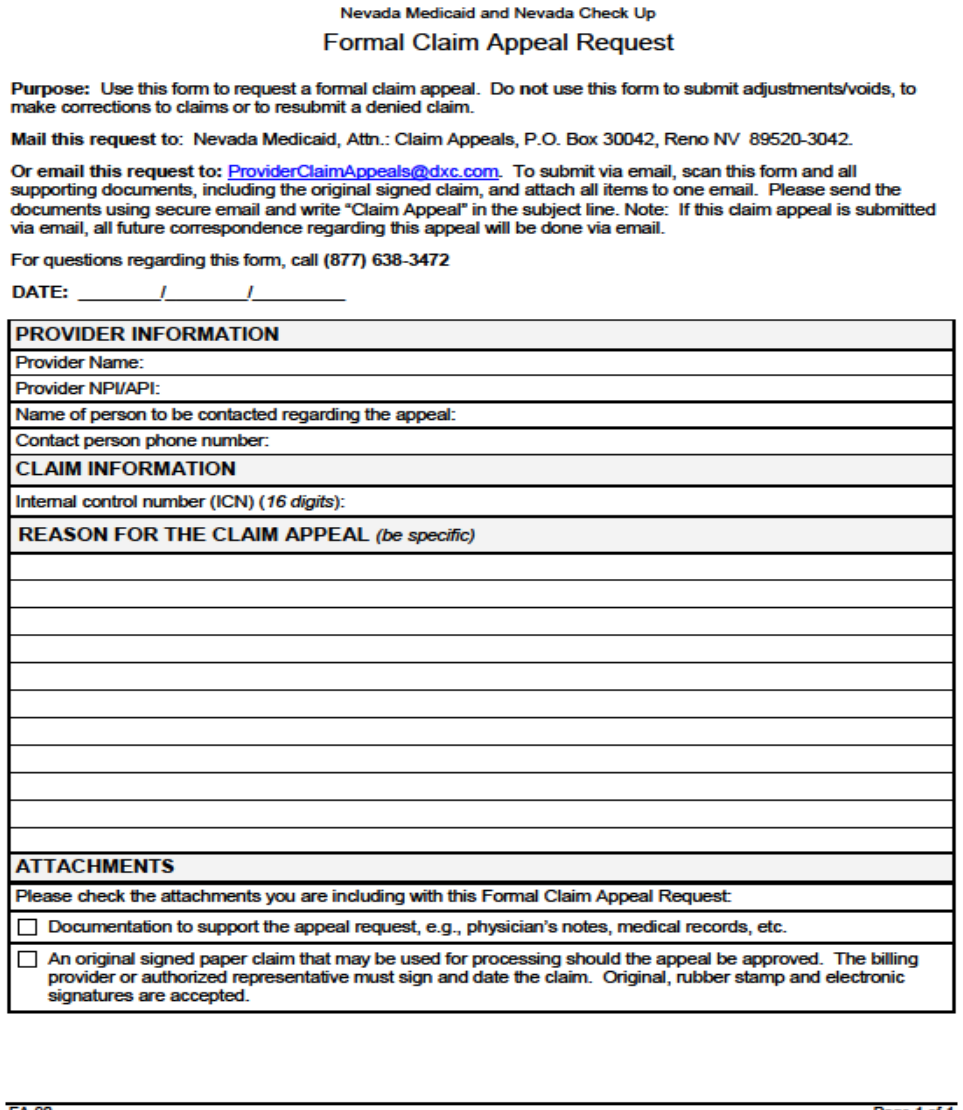
Claims Appeals Process, continued

- Send appeals separately from all other correspondence to:
  - Email: ProviderClaimAppeals@dxc.com or
    - When submitting an appeal via e-mail, send all necessary documents in one, secured e-mail and place “Claim Appeal” in the subject line. If submitting via e-mail, all responses from Nevada Medicaid will be sent back via e-mail.
  - Mail: Nevada Medicaid, Attn: Claim Appeals, P.O. Box 30042, Reno NV, 89520

- All providers submitting a claims appeal **must** read Chapter 8 (Claims Processing and Beyond) of the Billing Manual located on the Billing Information webpage of the Medicaid website at www.medicaid.nv.gov.

Claims Appeals Process, continued

- **FA-90** is located at: www.medicaid.nv.gov. Highlight “Providers” from the top blue tool bar and select “Forms” from the drop-down menu or select “Forms” from the “Provider Links” located on the right hand side of the website.
- Date: Date that the Appeals form is being completed
- Complete the form in its entirety including all items listed on page 5 of this document.
- For each appealed claim, a separate FA-90 must be attached. If the provider has multiple appeals, the provider must complete an FA-90 for each appeal.



Nevada Medicaid and Nevada Check Up

Formal Claim Appeal Request

Purpose: Use this form to request a formal claim appeal. Do not use this form to submit adjustments/voids, to make corrections to claims or to resubmit a denied claim.

Mail this request to: Nevada Medicaid, Attn.: Claim Appeals, P.O. Box 30042, Reno NV 89520-3042.

Or email this request to: ProviderClaimAppeals@dxc.com. To submit via email, scan this form and all supporting documents, including the original signed claim, and attach all items to one email. Please send the documents using secure email and write “Claim Appeal” in the subject line. Note: If this claim appeal is submitted via email, all future correspondence regarding this appeal will be done via email.

For questions regarding this form, call **(877) 638-3472**

DATE: _____/_____/_____

PROVIDER INFORMATION
Provider Name:
Provider NPI/API:
Name of person to be contacted regarding the appeal:
Contact person phone number:
CLAIM INFORMATION
Internal control number (ICN) (*16 digits*):
REASON FOR THE CLAIM APPEAL *(be specific)*
ATTACHMENTS
Please check the attachments you are including with this Formal Claim Appeal Request:
☐ Documentation to support the appeal request, e.g., physician’s notes, medical records, etc.
☐ An original signed paper claim that may be used for processing should the appeal be approved. The billing provider or authorized representative must sign and date the claim. Original, rubber stamp and electronic signatures are accepted.

FA-90
09/10/2014

Page 1 of 1

Claims Appeals Process, continued

When the request is received by Nevada Medicaid, the following steps are performed:

Step 1: The appeal and documentation are researched by Nevada Medicaid.

Step 2: A Notice of Decision (NOD) is sent advising that the appeal has been received and either accepted or rejected. A notice that the appeal has been accepted does not indicate the appeal has been approved.

Step 3: If the appeal was accepted, an additional NOD will be sent when the determination is completed advising if the appeal has been approved or denied.

Appeal Received

- A Notice of Receipt is generated when Nevada Medicaid has received a claims appeal request and the request has been accepted (not approved).

Notice of Receipt: Appeal Received

Notice Date:

<First Name> <Last Name>
<Address>
<City>, NV 00000

Attention:
Provider NPI/API:
Appeal Number:

Appeal Received

We have received your appeal for the claim with Internal Control Number(s) <##########> for recipient <Recipient Name> <########> on dates of service:

1/1/1900 - 1/1/1900

Your appeal was received on <Date>. We will review and respond to your appeal within 30 days from the date received.

If you have questions, please call our Customer Service Center at (877) 638- 3472

Thank you,

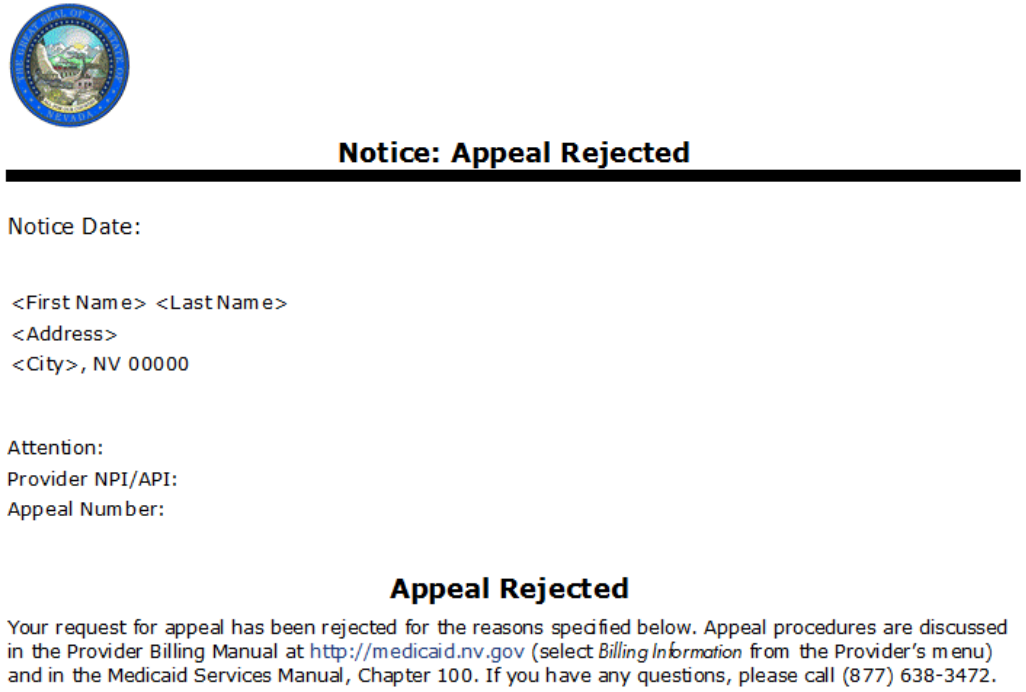
Nevada Medicaid
Appeals Unit

Appeal Rejected

- A Notice of Rejection is generated when Nevada Medicaid has received a claims appeal request and same has been rejected and will not be reviewed.

Possible rejection reasons:

- Appeal cannot be processed due to late submission (outside of the 30-day time frame)
- Appeal cannot be processed due to billing errors on the attached claim
- Appeal is incomplete (additional details as to why the appeal is incomplete will be indicated)
- Appeal requests for subsequent same service claim submission are not considered
- Please submit a claim adjustment to correct the payment of your claim



Notice: Appeal Rejected

Notice Date:

<First Name> <Last Name>
<Address>
<City>, NV 00000

Attention:
Provider NPI/API:
Appeal Number:

Appeal Rejected

Your request for appeal has been rejected for the reasons specified below. Appeal procedures are discussed in the Provider Billing Manual at http://medicaid.nv.gov (select *Billing Information* from the Provider's menu) and in the Medicaid Services Manual, Chapter 100. If you have any questions, please call (877) 638-3472.

Appeal Approved

- A NOD is generated when Nevada Medicaid has reviewed the appeal request and, based on the information provided, has been approved.
- If the appeal has been approved, Nevada Medicaid will re-process the claim and results will be reflected on a future remittance advice.

Notice of Decision: Appeal Approved

Notice Date:

<First Name> <Last Name>
<Address>
<City>, NV 00000

Attention:
Provider NPI/API:
Appeal Number:

Appeal Approved

Nevada Medicaid has approved your appeal for the claim with Internal Control Number <##########> for recipient <Recipient Name> on date(s) of service:

11/30/1999 - 11/30/1999

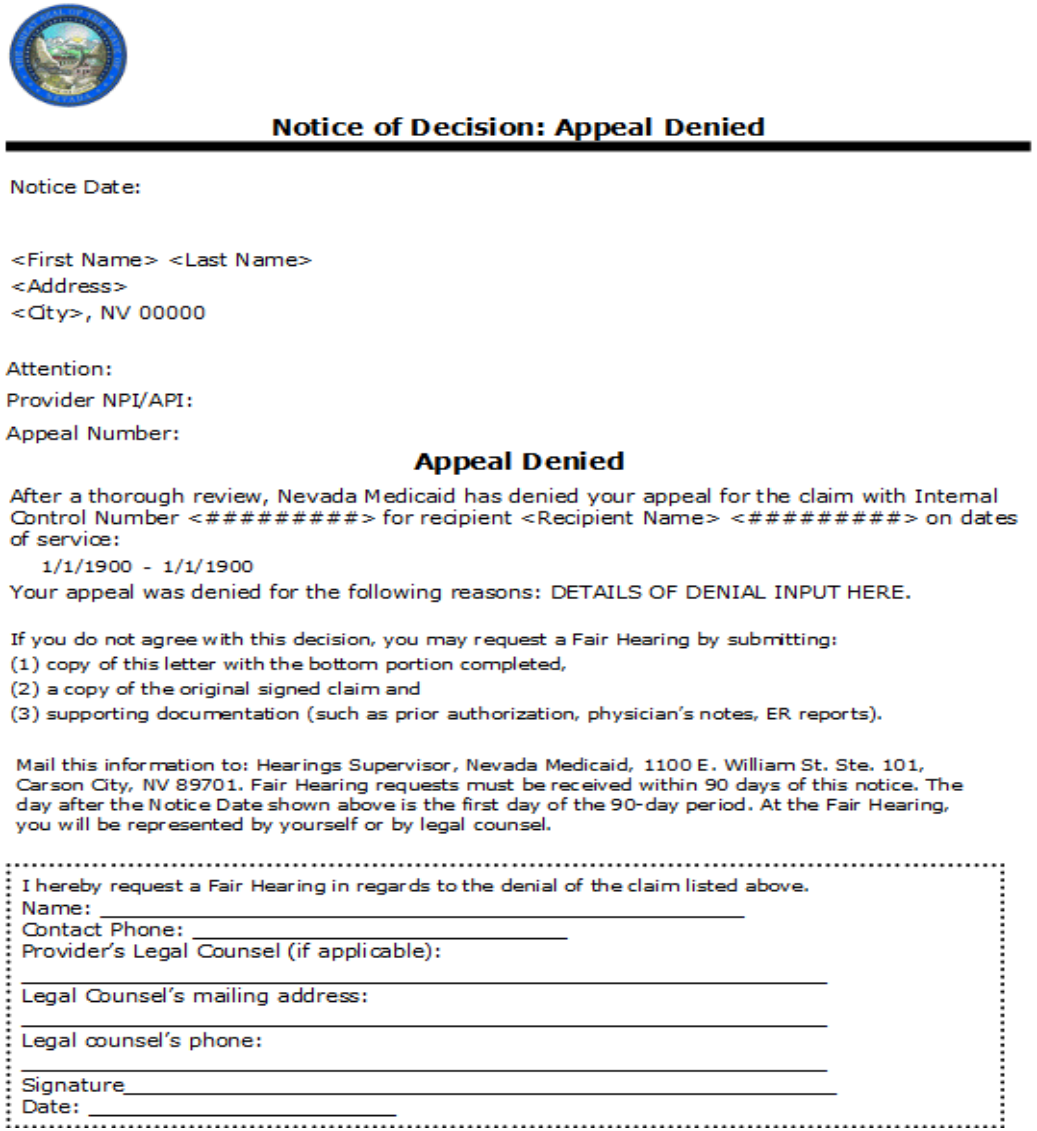
We will reprocess this claim and the results will be shown on a future remittance advice.

If you have any questions, please call the Customer Service Center at (877) 638-3472.

Thank you,
Nevada Medicaid
Provider Appeals Unit

Appeal Denied, page 1

- A NOD is generated when Nevada Medicaid has reviewed the appeal and has denied the appeal.
- If the appeal has been denied, the provider has rights, including the right to a Fair Hearing. The request for a Fair Hearing is listed on page 1 and instructions are listed on page 2.
- Page 1 lists all pertinent information regarding the appeals request as well as the reason that the appeal has been denied.



Notice of Decision: Appeal Denied

Notice Date:

<First Name> <Last Name>
<Address>
<City>, NV 00000

Attention:
Provider NPI/API:
Appeal Number:

Appeal Denied

After a thorough review, Nevada Medicaid has denied your appeal for the claim with Internal Control Number <########## > for recipient <Recipient Name> <########## > on dates of service:

1/1/1900 - 1/1/1900

Your appeal was denied for the following reasons: DETAILS OF DENIAL INPUT HERE.

If you do not agree with this decision, you may request a Fair Hearing by submitting:
(1) copy of this letter with the bottom portion completed,
(2) a copy of the original signed claim and
(3) supporting documentation (such as prior authorization, physician's notes, ER reports).

Mail this information to: Hearings Supervisor, Nevada Medicaid, 1100 E. William St. Ste. 101, Carson City, NV 89701. Fair Hearing requests must be received within 90 days of this notice. The day after the Notice Date shown above is the first day of the 90-day period. At the Fair Hearing, you will be represented by yourself or by legal counsel.

I hereby request a Fair Hearing in regards to the denial of the claim listed above.
Name: _____
Contact Phone: _____
Provider's Legal Counsel (if applicable):
_____
Legal Counsel's mailing address:
_____
Legal counsel's phone:
_____
Signature_____
Date: _____

Appeal Denied, page 2

- Page 2 contains information regarding the Fair Hearings, including Frequently Asked Questions (FAQs) such as who can request the Fair Hearing, what happens prior to and during the Fair Hearing and other important information.

Notice of Decision: Appeal Denied

Medicaid Service Manual (MSM) Chapter 100 Section 105.1C:

Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims editor program employs a nationally recognized standardized method of processing claims for professional services using clinical logic based on the most current CPT, HCPCS, International Classification of Diseases (ICD), American Medical Association (AMA), CMS and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.

Frequently Asked Questions about Hearing Preparation Meetings and Fair Hearings

WHO MAY REQUEST A FAIR HEARING? If a provider disagrees with a claim denial, a recoupment action or a termination of provider enrollment, the provider must first submit a written appeal to DXC Technology, which is referred to as Nevada Medicaid throughout this document. If the provider disagrees with the result of the appeal, the provider has the option to request a Fair Hearing through the Division of Health Care Financing Policy (DHCFP).

WHAT HAPPENS AT THE HEARING PREPARATION MEETING? Before the Fair Hearing takes place, the DHCFP holds a hearing preparation meeting to discuss the Fair Hearing request. Attendees of the meeting will include a representative from the DHCFP, a representative from Nevada Medicaid, and the provider and/or the provider's designated legal counsel. The purpose of a hearing preparation meeting is to supply the provider with an opportunity to furnish the DHCFP with information that he believes should be considered in reversing the appeal decision issued by Nevada Medicaid. All parties will have an opportunity to discuss their position on the issue.

WHAT HAPPENS AT A FAIR HEARING? A Fair Hearing is a proceeding during which the provider and/or his legal counsel can show the Fair Hearing Officer why the provider disagrees with Nevada Medicaid's appeal decision. The provider will be given an opportunity to comment on all documents and records pertaining to the appeal decision. (All documents and records are given to the provider within a reasonable time before the date of the Fair Hearing.) The provider is allowed to bring witnesses, present evidence, question or refute any testimony or evidence and cross-examine any witnesses. The DHCFP will also present their position in regards to the appeal decision.

WHO IS THE FAIR HEARING OFFICER? The Fair Hearing Officer may be an employee of the DHCFP or a person under contract with DHCFP. The Fair Hearing Officer will be an individual who has not been connected in any way with the action in question.

WHERE IS A FAIR HEARING HELD? Fair Hearings are usually held in or near the city where the provider's practice/business/facility is located. If the provider is unable to travel to the designated Fair Hearing location, the Fair Hearing may be held at another location or may be conducted by telephone when all parties are in agreement to do so.

WHAT DOES A FAIR HEARING COST? There is no charge to the provider for a Fair Hearing.

HOW IS A DECISION MADE? The Fair Hearing Officer's decision will be based on the evidence and testimony introduced at the Fair Hearing. The Department of Administration will notify the provider and the DHCFP in writing of the decision within 90 days from the date of the request for the Fair Hearing. Should the provider abandon or withdraw his Fair Hearing request or if the Fair Hearing Officer agrees with Nevada Medicaid's decision, the original appeal decision will stand.

PROVIDER'S RIGHT TO JUDICIAL REVIEW: If a provider is dissatisfied with the Fair Hearing decision, the case may be appealed to the provider's local District Court of the State of Nevada within 90 days after the date the written Fair Hearing decision was mailed. An official report of the hearing, together with all papers filed in the proceeding will constitute the record of the Fair Hearing. Fair Hearing records are on file in the Nevada Medicaid Office, 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Fair Hearing

- Instructions for requesting a Fair Hearing are included with the Appeal Denied Notice of Decision.
- Fair Hearings are requested through the Division of Health Care Financing and Policy (DHCFP).
- Fair Hearing requests must be received no later than 90 days from the notice date showing the appeal was denied; the day after the notice date is considered the first day of the 90-day period.
- For additional information concerning Fair Hearings, please refer to the Medicaid Services Manual (MSM) Chapter 3100.

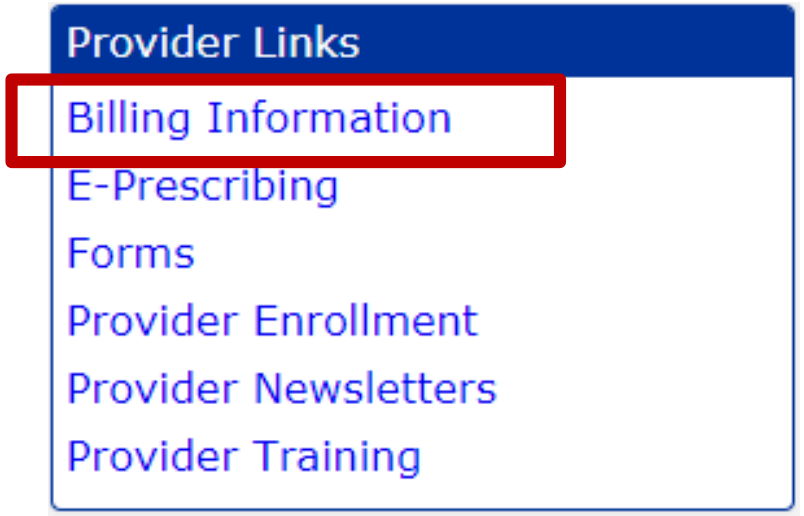
Claim Adjustments and Voids

Timely Filing for Claim Adjustments and Voids

Claim Adjustments and Void Requests must be received within:

- 180 days of the date of service, or date of eligibility decision, whichever is later for in-state providers and claims with no Third Party Liability (TPL)
- 365 days of the date of service, or date of eligibility decision, whichever is later for out-of-state providers and claims with TPL

Adjusting or Voiding a Paper Claim



– Open the Claim Form Instructions located at www.medicaid.nv.gov by highlighting “Providers” from the top blue tool bar and selecting “Billing Information” from the drop-down menu or by selecting “Billing Information” from the Provider Links, which is always located on the right hand side of the website.

Claim Adjustment Reason Codes

Code	Definition
1021	Late charges received by facility business office
1023	Primary carrier has made additional payment
1028	Correcting procedure/service code
1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units, visits or studies
1034	Correcting quantity dispensed
1035	Correcting drug code
1037	Services not covered by Medicare
1041	Incorrect amount paid for original claim
1042	Original claim has multiple incorrect items
1053	Adjustment (miscellaneous)

Claim Void Reason Codes

Code	Description
1044	Wrong provider identifier used
1045	Wrong Recipient ID used
1047	Duplicate payment
1048	Primary carrier has paid full charges
1052	Miscellaneous
1060	Other insurance is available

Adjusting or Voiding a CMS-1500 Paper Claim Form

- Claim Form Instructions will contain details regarding how to adjust or void a paid claim.
- Information is listed under the Adjustment/Void reason codes for Field 22.
- User will then navigate to the field-by-field instructions to locate the requirements for filling out a claim properly, including Field 22.

Adjusting or Voiding a CMS-1500 Paper Claim Form (Field 22)

22	Situational	**Resubmission Code:** Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. 1 • In the *Code* area, enter an adjustment or void reason code (see section, *Adjustment/Void reason codes for Field 22*). 2 • In the *Original Reference Number* area, enter the last *paid* Internal Control Number (ICN) of the claim. **Adjustments and voids apply to previously *paid* claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment.**

- Provider must input the correct 4-digit adjustment or void code and must indicate the last paid ICN.

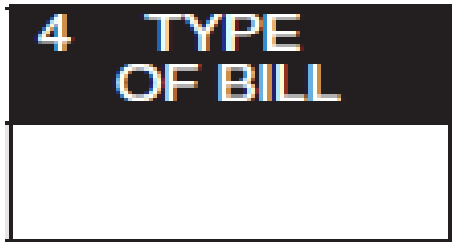
Adjusting or Voiding a UB-04 Paper Claim Form

- Claim Form Instructions will contain details regarding how to adjust or void a paid claim.
- Information is listed under the Adjustment/Void reason codes for Fields 4, 64 and 75.
- User will then navigate to the field-by-field instructions to locate the requirements for filling out a claim properly, including Fields 4, 64 and 75.

Adjusting or Voiding a UB-04 Paper Claim Form (Field 4)

*4	**Required**	**Type of bill:** Enter the appropriate type of bill code. • **Adjustments:** Use *7* for the last digit in your Type of Bill code. • **Voids:** Use *8* for the last digit in your Type of Bill code.

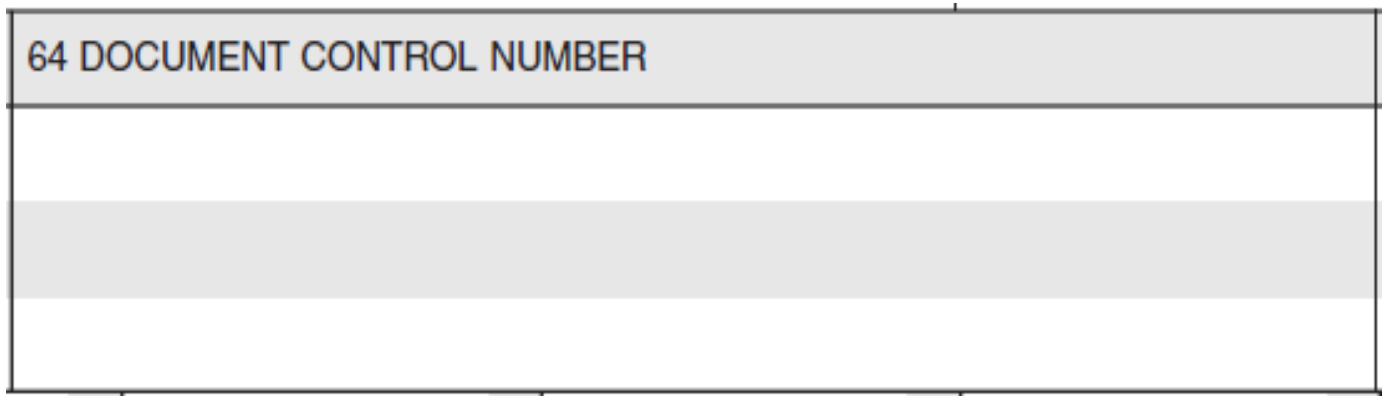
- Provider must input the correct digit as listed in the instructions for Field 4.



Adjusting or Voiding a UB-04 Paper Claim Form (Field 64)

64A-C	**Situational**	**Document control number:** When **adjusting or voiding** a previously paid claim, enter the claim's last paid Internal Control Number (ICN) on the line that shows payer, *Medicaid*. Only *one* ICN may be entered per claim.

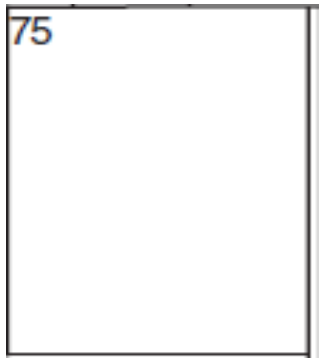
- Provider must input the last paid ICN in Field 64.



Adjusting or Voiding a UB-04 Paper Claim Form (Field 75)

75	**Situational**	To **adjust or void** a claim, enter the appropriate 4-digit *reason code* in this Field. See also instructions for Fields 4 and 64.

- Insert the 4-digit adjustment/void code.



Adjusting or Voiding an ADA Dental Paper Claim Form

- Claim Form Instructions will contain details regarding how to adjust or void a paid claim.
- Information is listed under the Adjustment/Void reason codes for Fields 16 and 17.
- User will then navigate to the field-by-field instructions to locate the requirements for filling out a claim properly, including Fields 16 and 17.

Adjusting or Voiding an ADA Dental Paper Claim Form (Fields 16 and 17)

16	**Conditional**	**Plan/Group number:** For *previously paid* claims only: To adjust or void a claim, enter the appropriate adjustment/void reason code that identifies why the claim is being adjusted or voided. The reason codes are shown on pages 1-2 of this document.
17	**Conditional**	**Employer name:** For *previously paid* claims only: To adjust or void a claim, enter the *last paid* ICN assigned to the claim (must be 16 digits).

- Provider must input the correct 4-digit adjustment/void reason in Field 16 and the ICN of the last paid claim in Field 17.

Resources

Additional Resources

- Billing Manual (Appeals Information) and Claim Form Instructions (Adjustment/Void Information):
  https://medicaid.nv.gov/providers/BillingInfo.aspx

- Medicaid Services Manual (Chapter 3100 – Fair Hearings):
  http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C3100/Chapter3100/

- Formal Claim Appeal Request (FA-90):
  https://medicaid.nv.gov/providers/forms/forms.aspx

DHCFP Contact Information:

Contact Form:
http://dhcfp.nv.gov/Contact/ContactUsForm/

Thank you

Submitting Prior Authorization Requests Online

2018 Nevada Medicaid Conference

Nevada Medicaid Provider Training

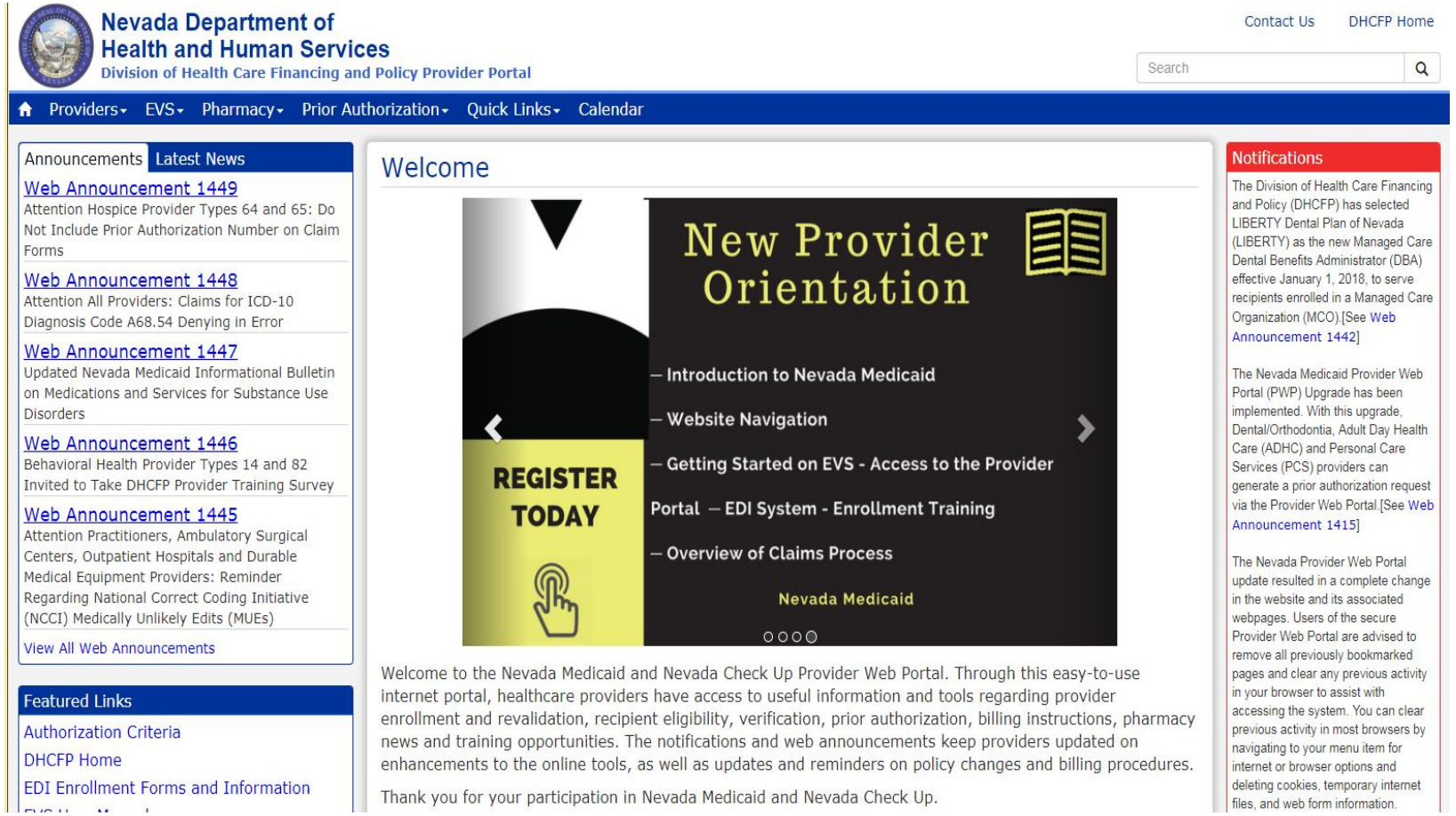
Objectives

Objectives

- Navigate the Electronic Verification System (EVS) Web Portal
- Understand how to submit a prior authorization (PA) request via the Web Portal
- Understand how to:
  - View the status of a PA
  - Search for PAs
  - Copy a PA
  - Submit additional PA attachments via fax or mail
- Discuss options if a PA is not approved

www.medicaid.nv.gov

Medicaid website
www.medicaid.nv.gov



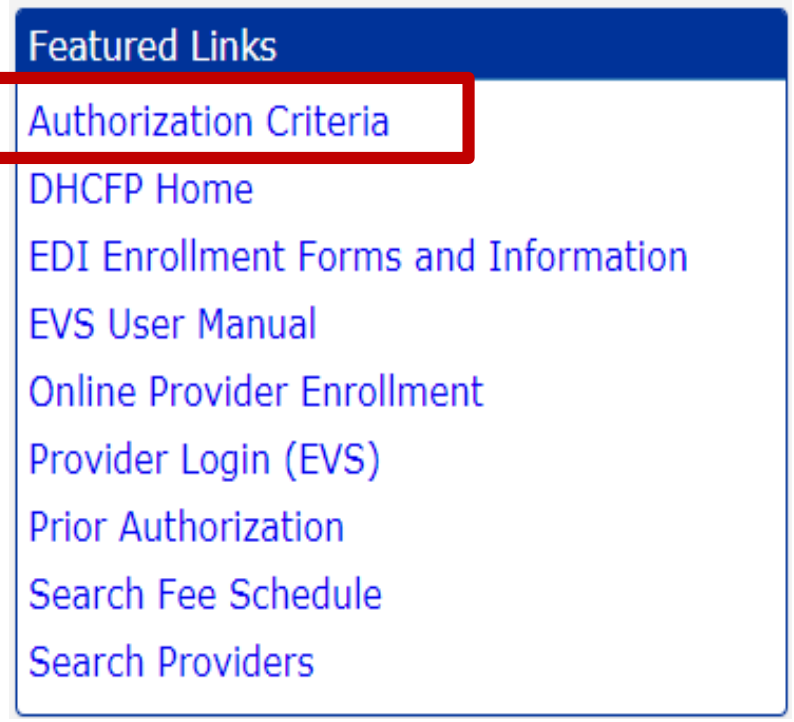
Authorization Criteria Function

Authorization Criteria

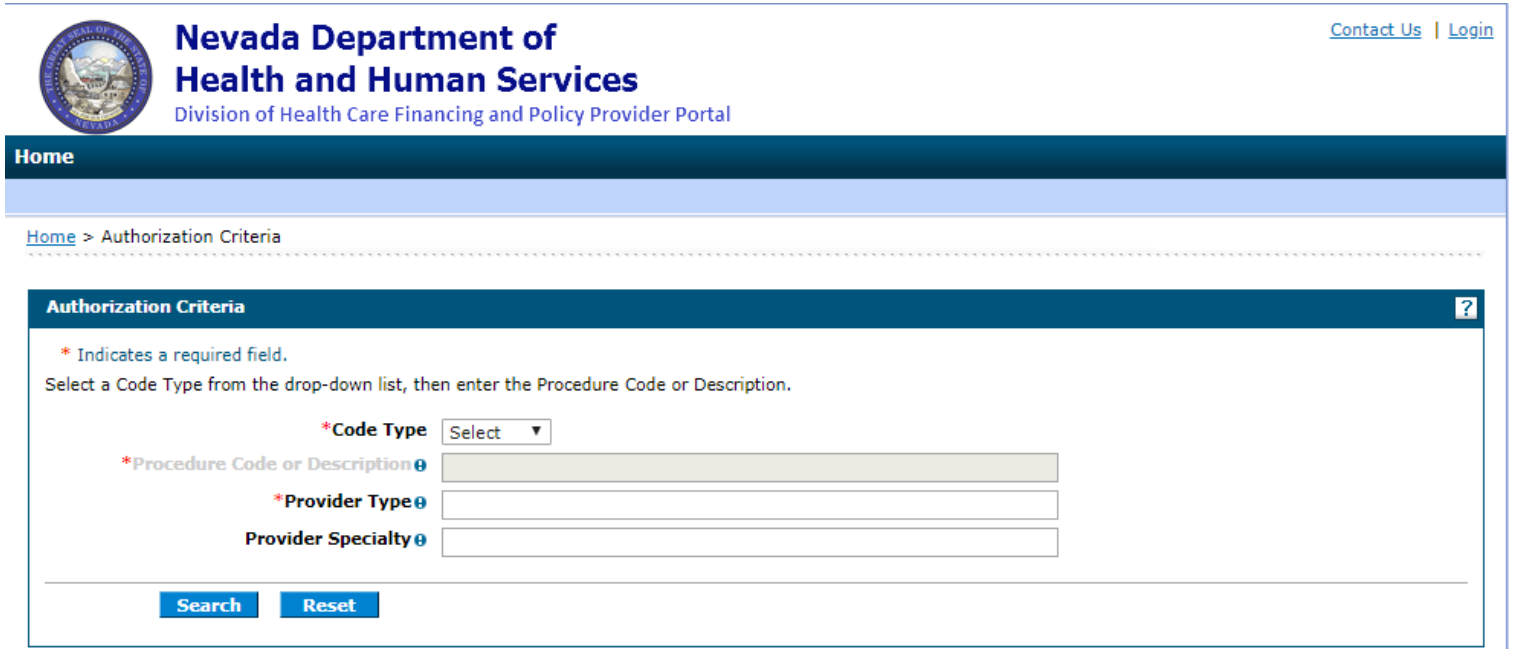
- The Authorization Criteria tool on the Provider Web Portal allows a user to input a procedure code to determine if a PA is required
- If the search criteria does not return any results, providers are encouraged to verify all PA requirements by referring to the Medicaid Services Manual (MSM) Chapter for the service type. The MSM is located at dhcfp.nv.gov and the Billing Guides for each provider type are located at www.medicaid.nv.gov

Authorization Criteria

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

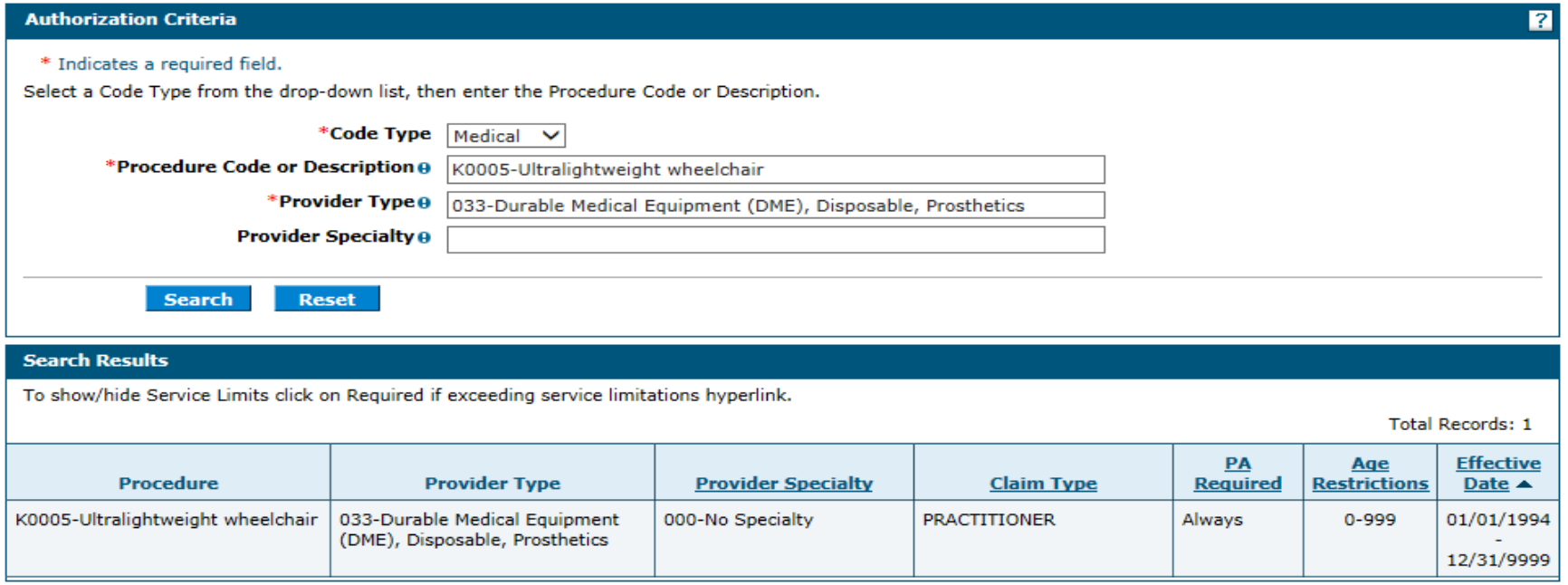


Authorization Criteria, continued



- 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. Note that “0” must be input before the typical two-digit provider type.
- Step 4: Select “Search”
- Step 5: Results will then populate on the next screen

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	K0005-Ultralightweight wheelchair
*Provider Type	033-Durable Medical Equipment (DME), Disposable, Prosthetics
Provider Specialty	

Search Reset

Search Results

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

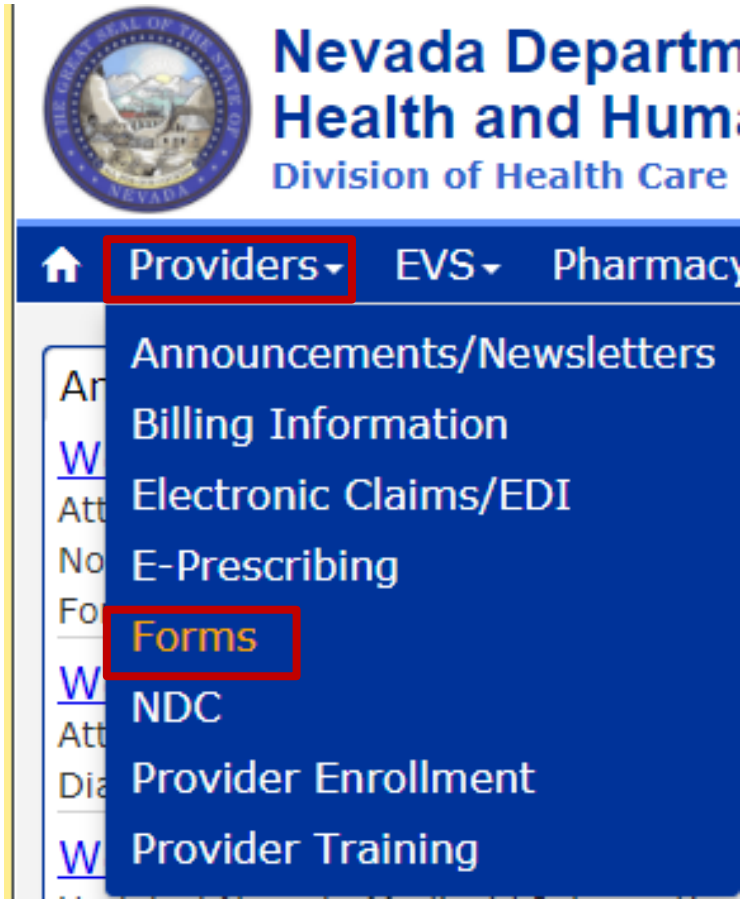
Total Records: 1

Procedure	Provider Type	Provider Specialty	Claim Type	PA Required	Age Restrictions	Effective Date
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	PRACTITIONER	Always	0-999	01/01/1994 - 12/31/9999

Make sure that the effective date ends in “9999” to verify that the user is viewing the most accurate information

Prior Authorization (PA) Forms

Locating Prior Authorization Forms



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

Locating Prior Authorization Forms, continued

Prior Authorization Forms

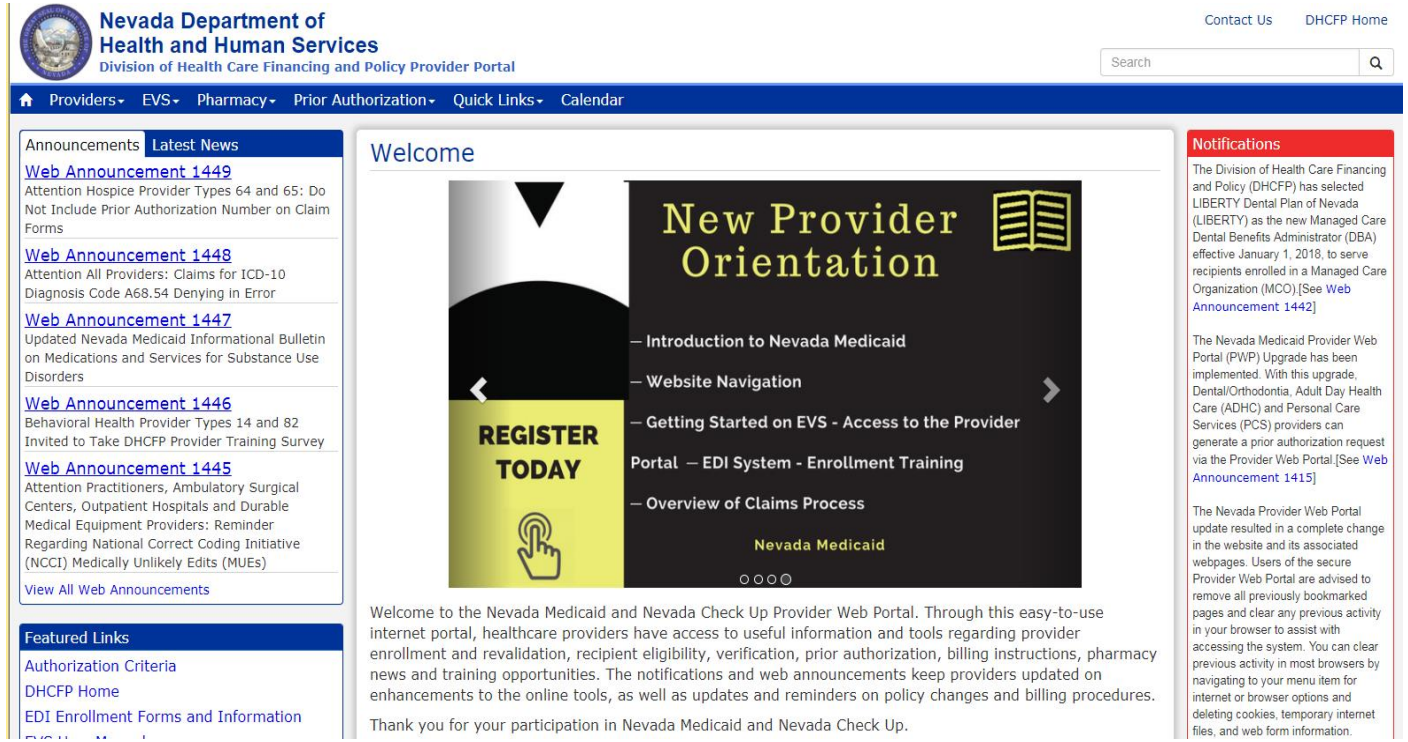
All prior authorization forms are for completion and submission by current Medicaid providers only.

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 the correct FA form
- Follow the instructions on the form
- All forms are fillable for easy uploading for PA submission online
- Any form that is not legible will not be accepted

Electronic Verification System (EVS) Secure Web Portal

Provider Web Portal
www.medicaid.nv.gov



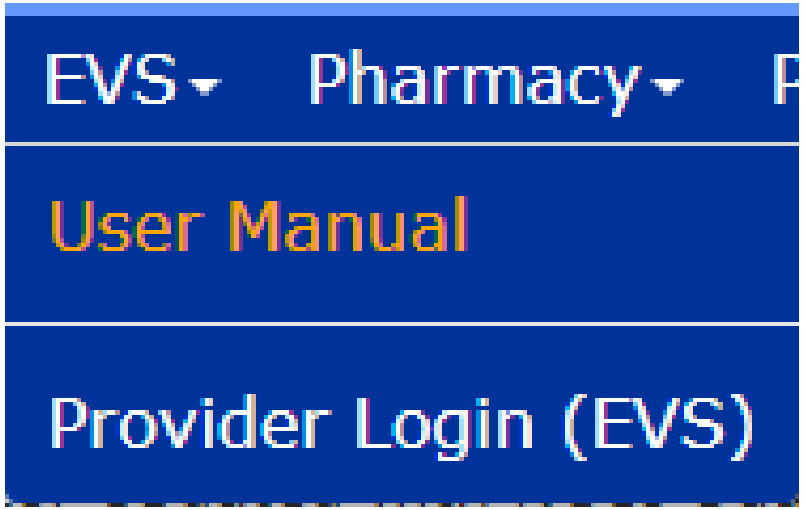
EVS

EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period, Monday through Friday from 12:00–12:30 a.m. Pacific Time (PT) and Sunday 8:00 p.m.–12:30 a.m. PT

System Requirements

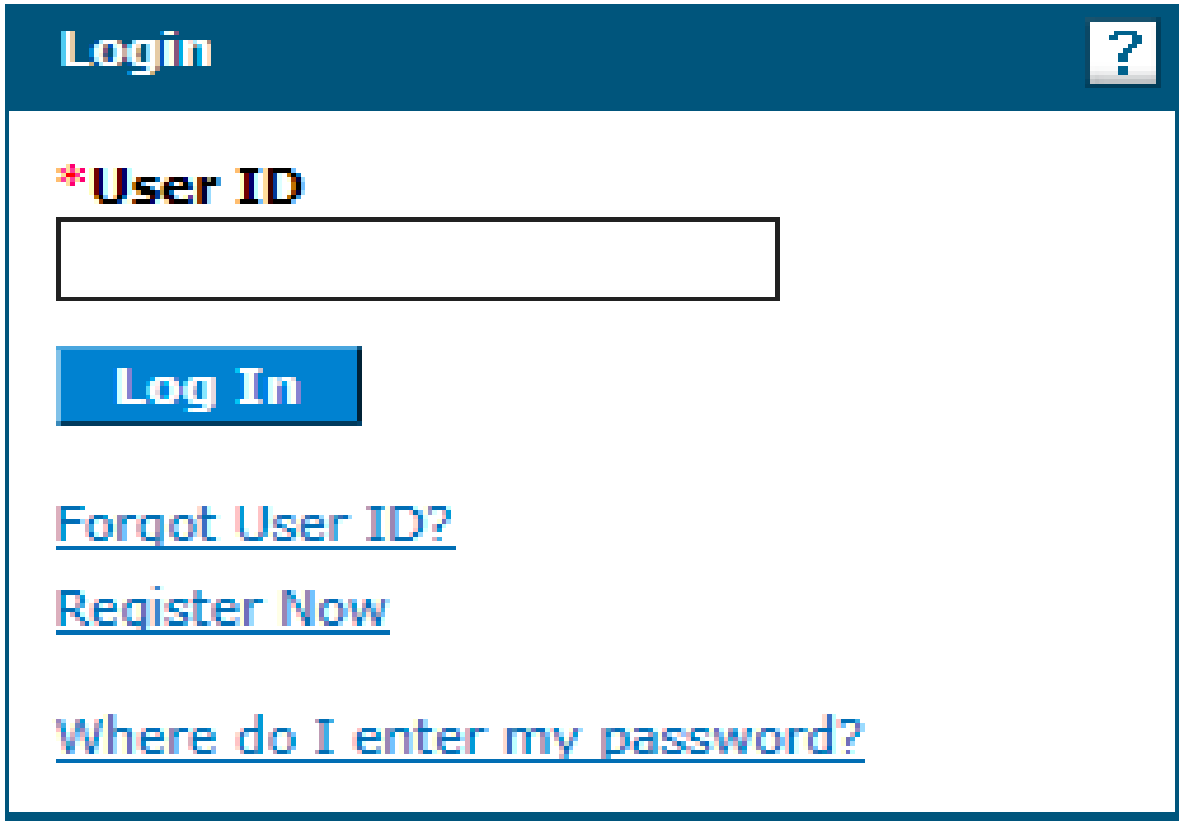
To access EVS, you must have internet access and a computer with a web browser. (Microsoft Internet Explorer 9.0 or higher, Mozilla Firefox, or Google Chrome recommended.)

EVS Secure Web Portal



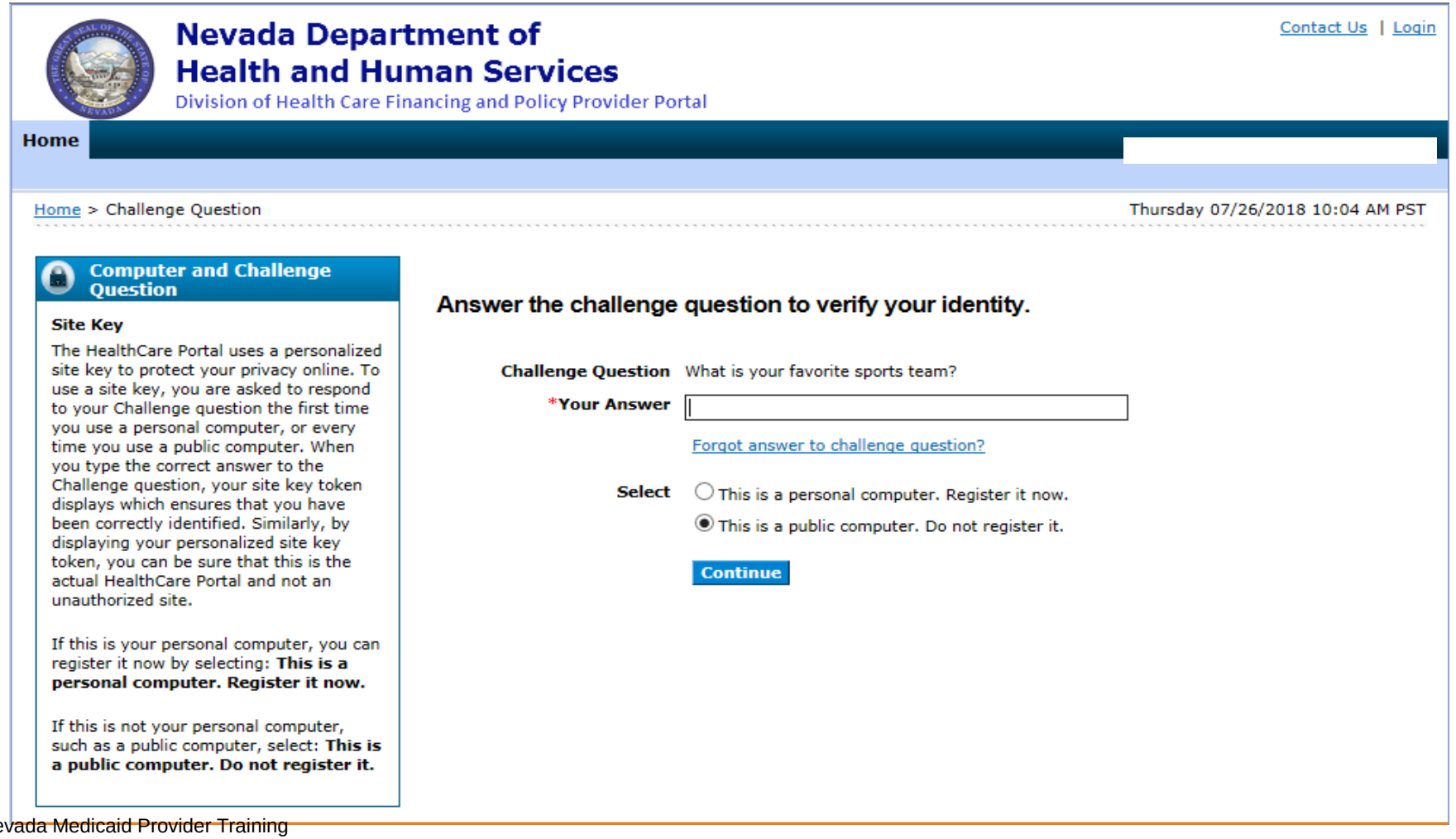
- EVS Web Portal can be accessed by highlighting EVS from the top tool bar and selecting “Provider Login (EVS)” or “Provider Login (EVS)” can be selected from the Featured Links section

EVS Secure Web Portal, continued



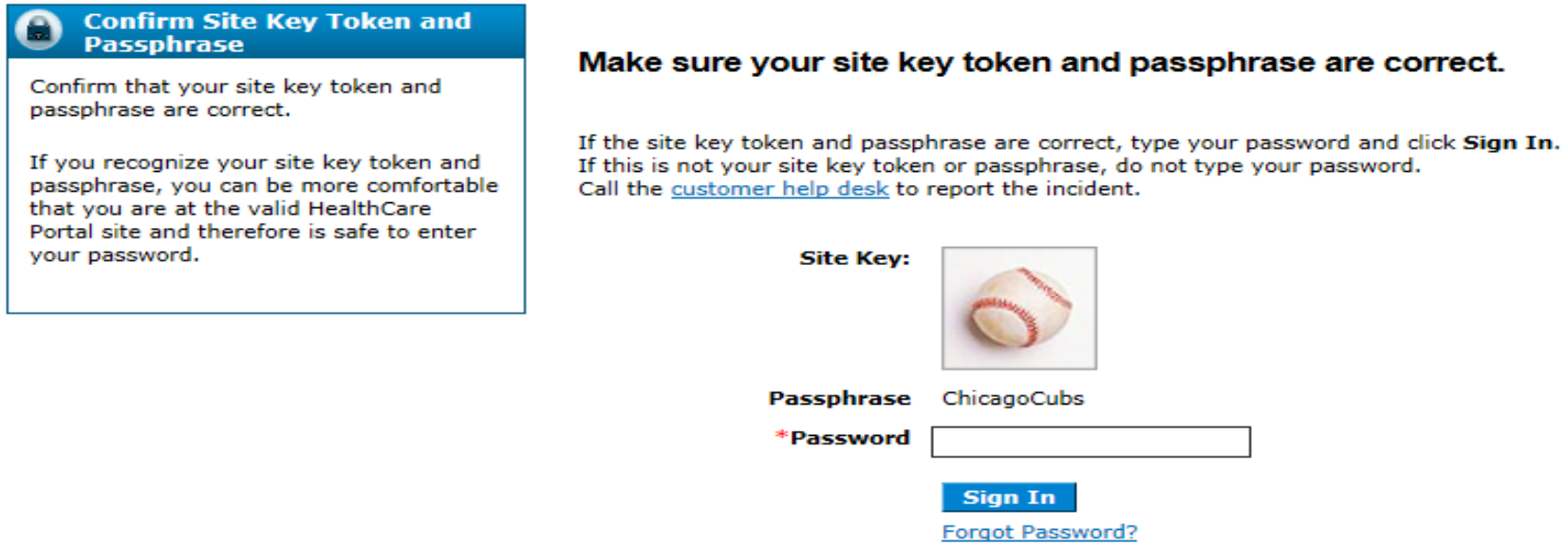
- Step 1: Input User ID
- Step 2: Select “Log In”
- If an account has not been created, select “Register Now” to begin creating a web portal account. See Chapter 1: Getting Started of the EVS User Manual for reference.

Logging in to the Provider Web Portal, continued



- Answer the challenge question to verify the user's identity the first time the user logs in from a personal computer or every time a user utilizes a public computer
- Select personal computer or a public computer
- Click "Continue"

EVS Secure Web Portal, continued

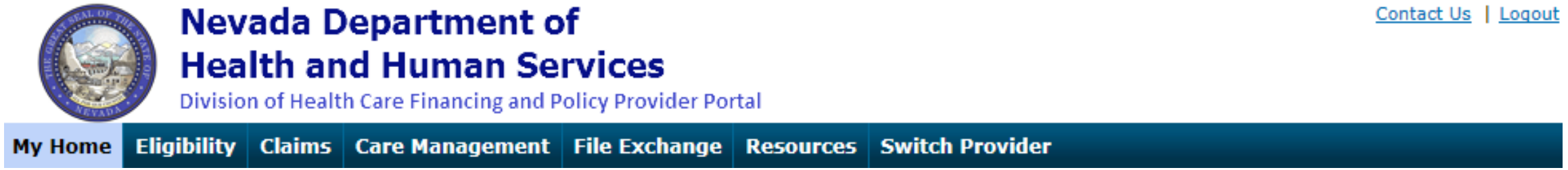


- Confirm that the **site key token** and **passphrase** are correct. If the user recognizes the site key token and passphrase, user can be assured that it is safe to enter the correct password
- Enter correct Password
- Select “Forgot Password” to start the reset process

EVS Secure Web Portal, continued

- Verify all Provider Information
- Utilize Provider Services
- Use “Contact Us” or “Secure Correspondence” to contact Nevada Medicaid

EVS Secure Web Portal, continued



My Home

Confirm provider information and contact information and check messages.

Eligibility

Search recipient eligibility information.

Claims

Search claims and payment history.

Care Management

Create authorizations, view authorization status, and maintain favorite providers.

File Exchange

Upload forms online.

Resources

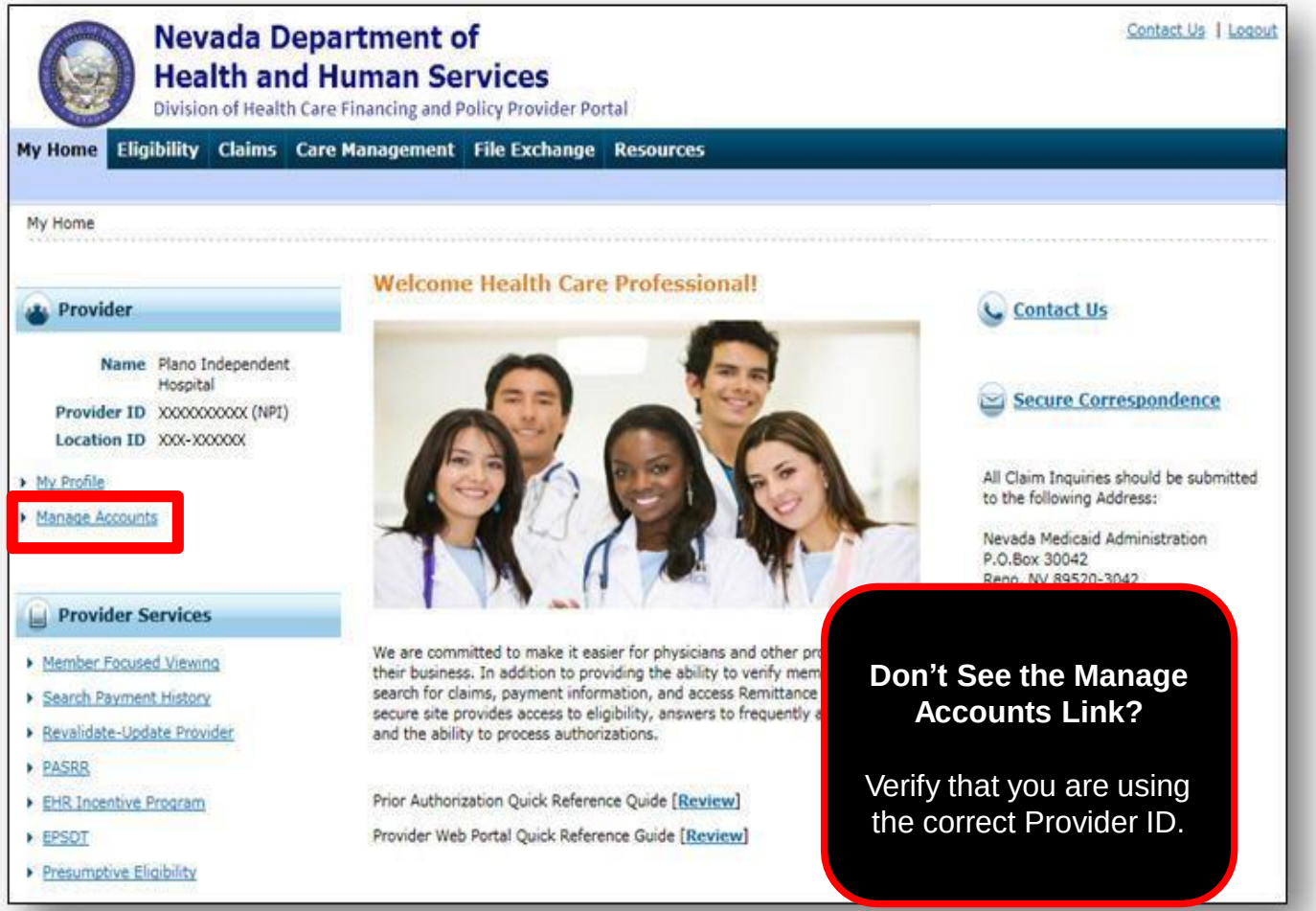
Download forms and documents.

Role-Based Security & Delegate Access

Granting Access to a Delegate

- A new delegate is a person who does not currently have a delegate code, including a code that was created by someone else
- An existing delegate is a person who was previously provided with a delegate code and is registered for a portal account
- Each delegate should only have one delegate code, which is created by the first provider to add them as a delegate

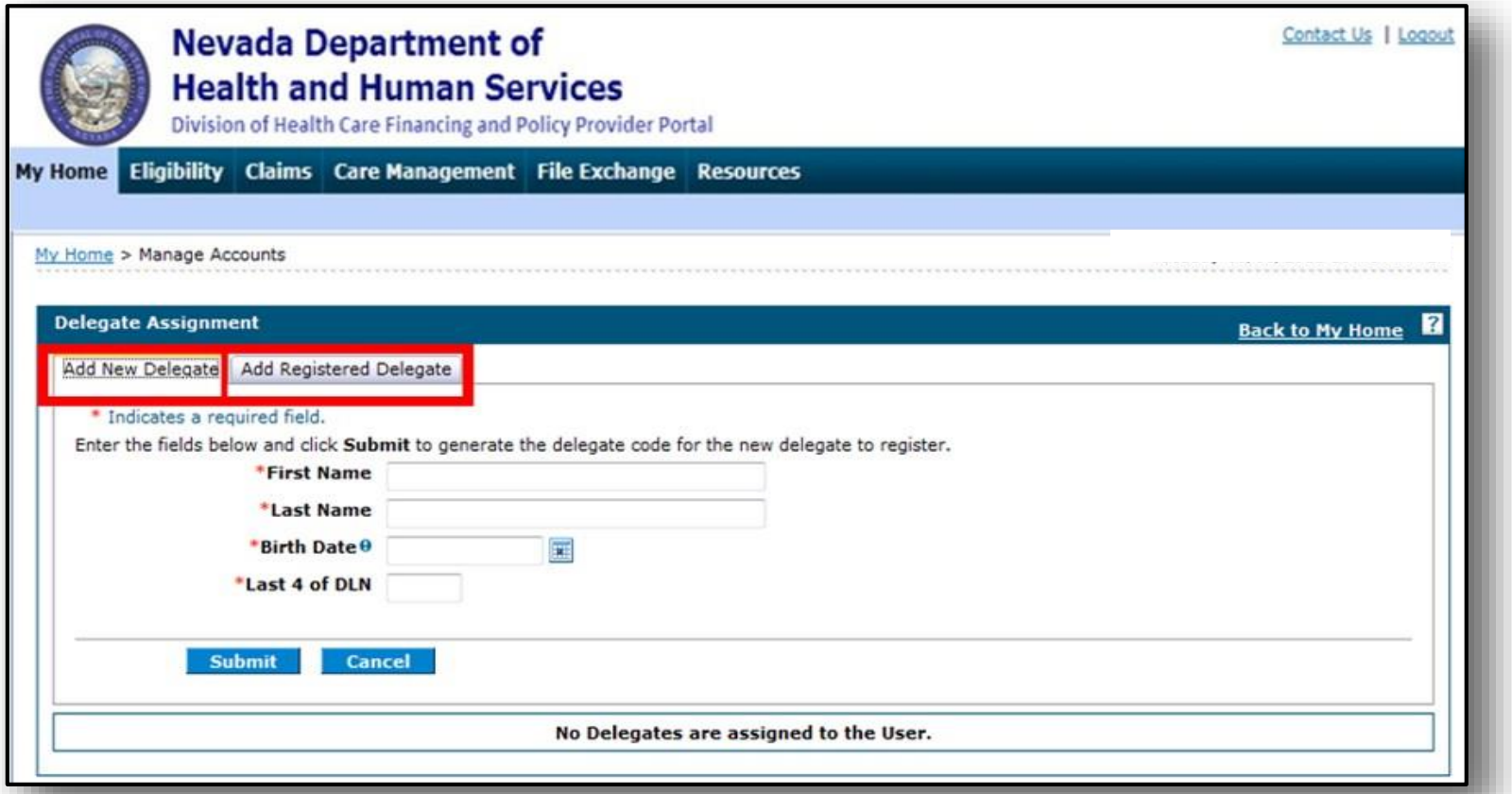
1. Log in to the Administrator account on “Provider Web Portal”
2. Click “Manage Accounts”



Delegate Assignment Tabs

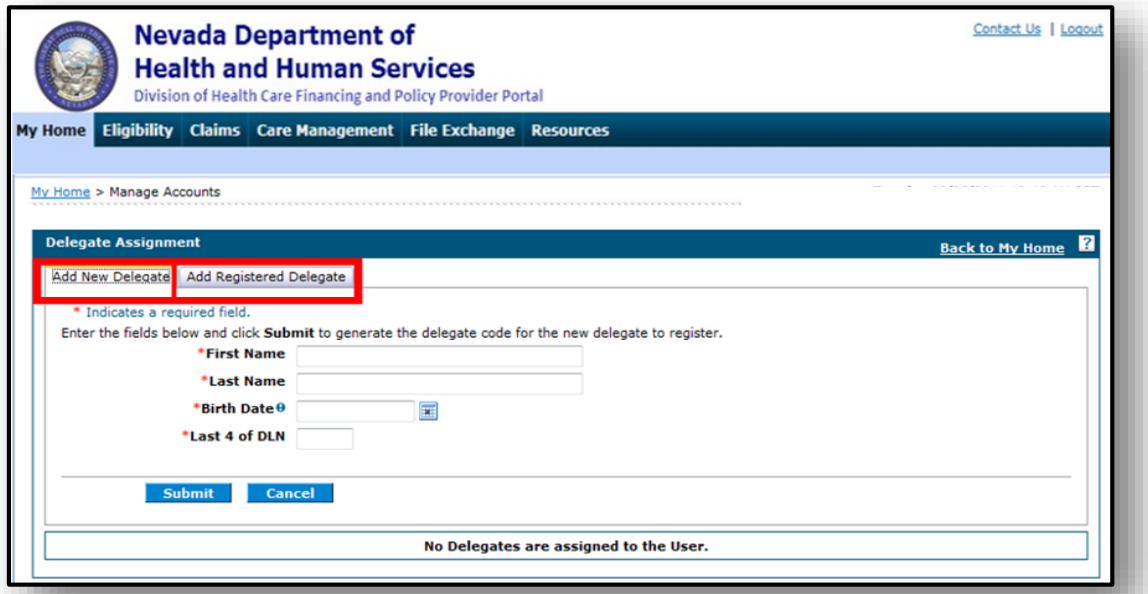
- Add New Delegate
- Add Registered Delegate

Required fields are marked with a red asterisk (*).



Delegate Assignment

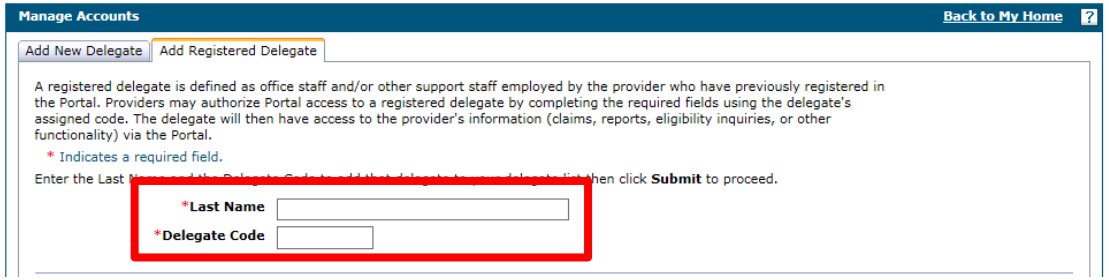
Add New Delegate



Enter the delegate's:

- First Name, Last Name, Date of Birth and Last four digits of the delegate's Driver's License Number
- Click "Submit"

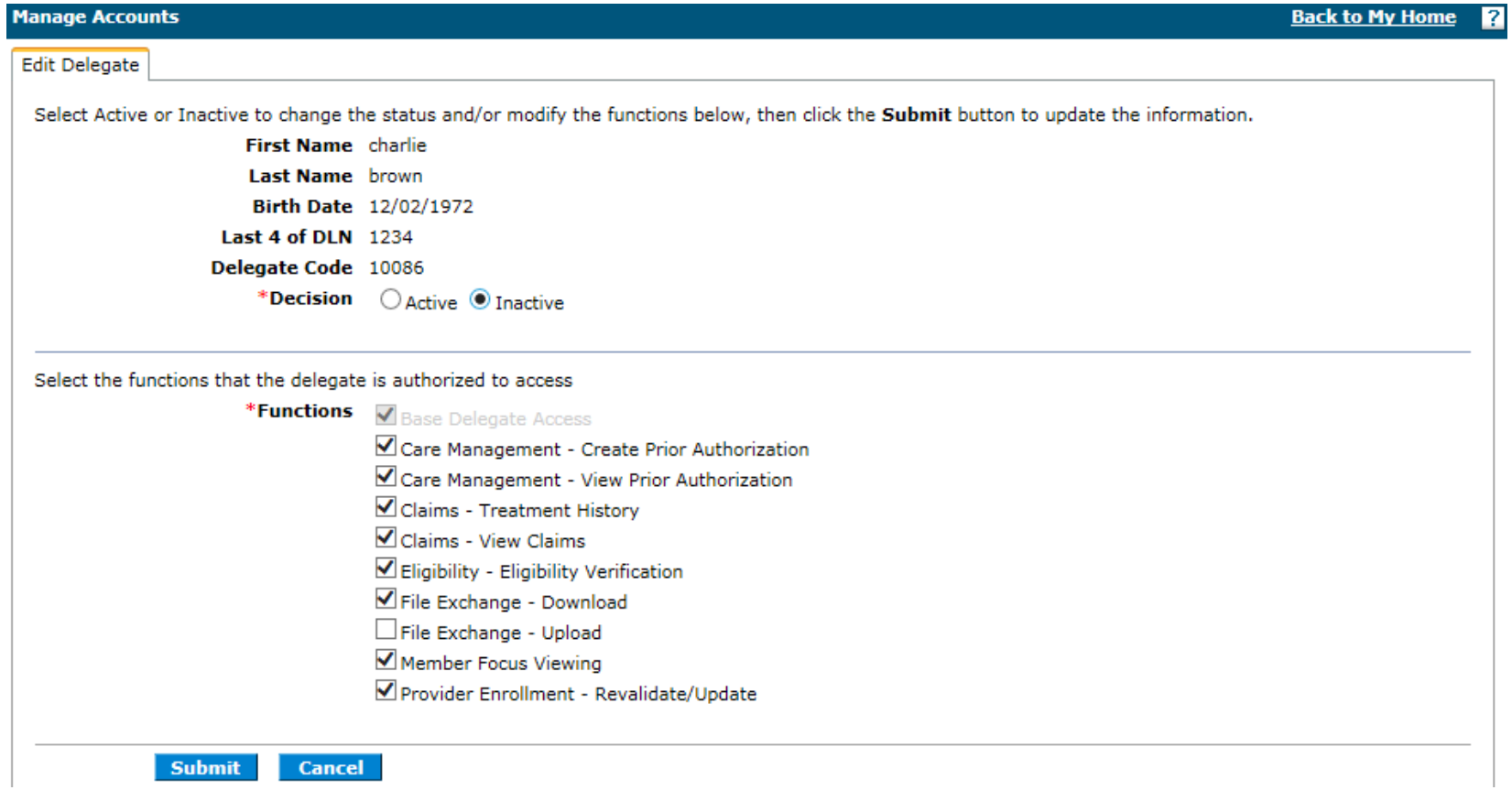
Add Registered Delegate



Enter the delegate's:

- Last Name and previously provided Delegate Code

Delegate Assignment, continued



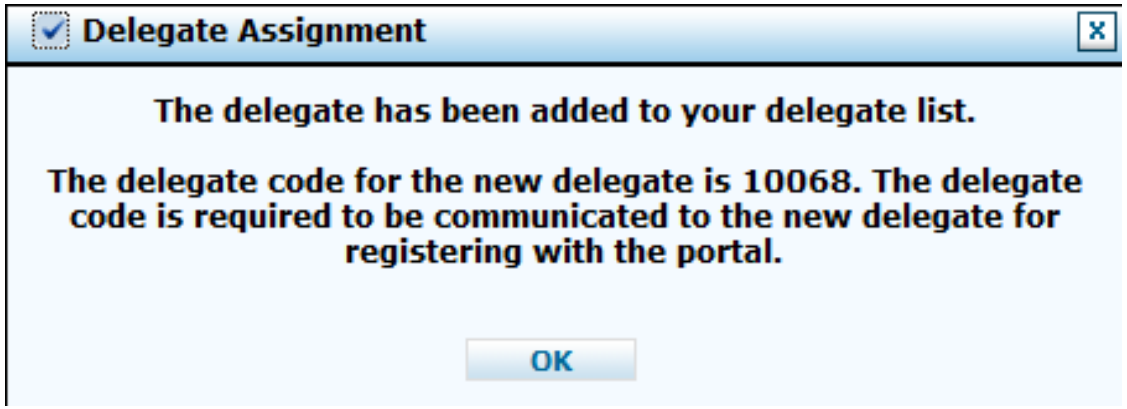
- Choose the Functions you want the delegate to be able to perform
- Click "Confirm"

Edit Delegate

- Make the appropriate changes to the functionality for the delegate
- To remove the delegate's ability to have access to your Portal chose **Inactive**
- When changes are complete, click "Submit"

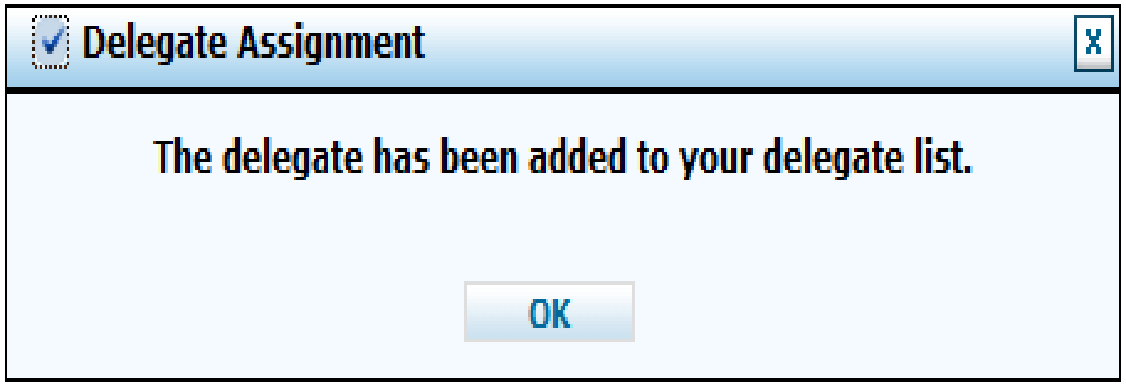
Delegate Assignment, continued

New Delegate



- The delegate needs a code to register for their own Provider Web Portal account. Once registered, they can access and switch between all providers who have assigned them as a delegate

Registered Delegate



- A Delegate Assignment box will be displayed to confirm that the delegate was added to the provider's delegate list.

Before creating a Prior Authorization

Before creating a Prior Authorization

- 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 that 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), Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT) Codes

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

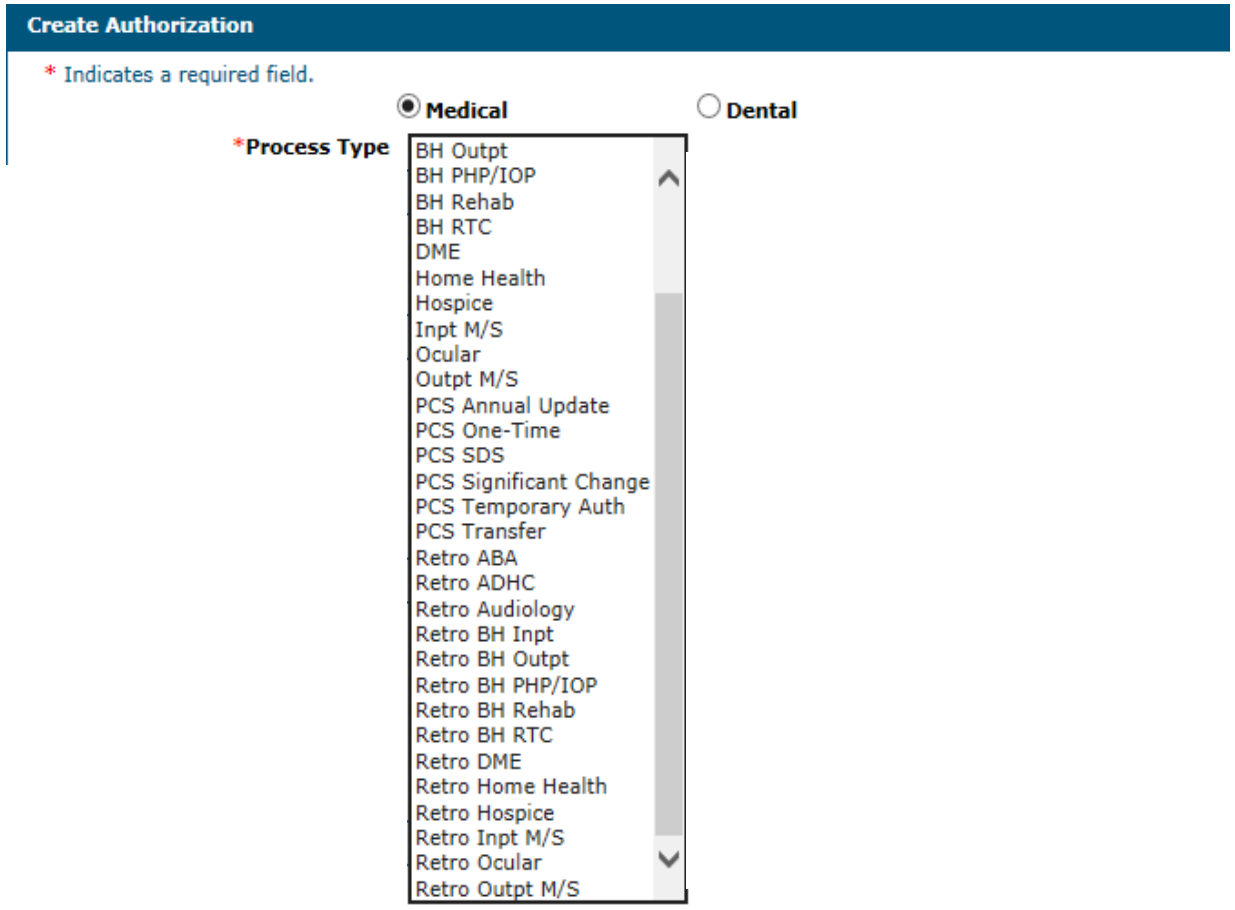
PA Attachments

– Attachments are required with all PA requests
– Attachments can be submitted electronically, by mail or by fax
– 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 cancelled

Create Authorization

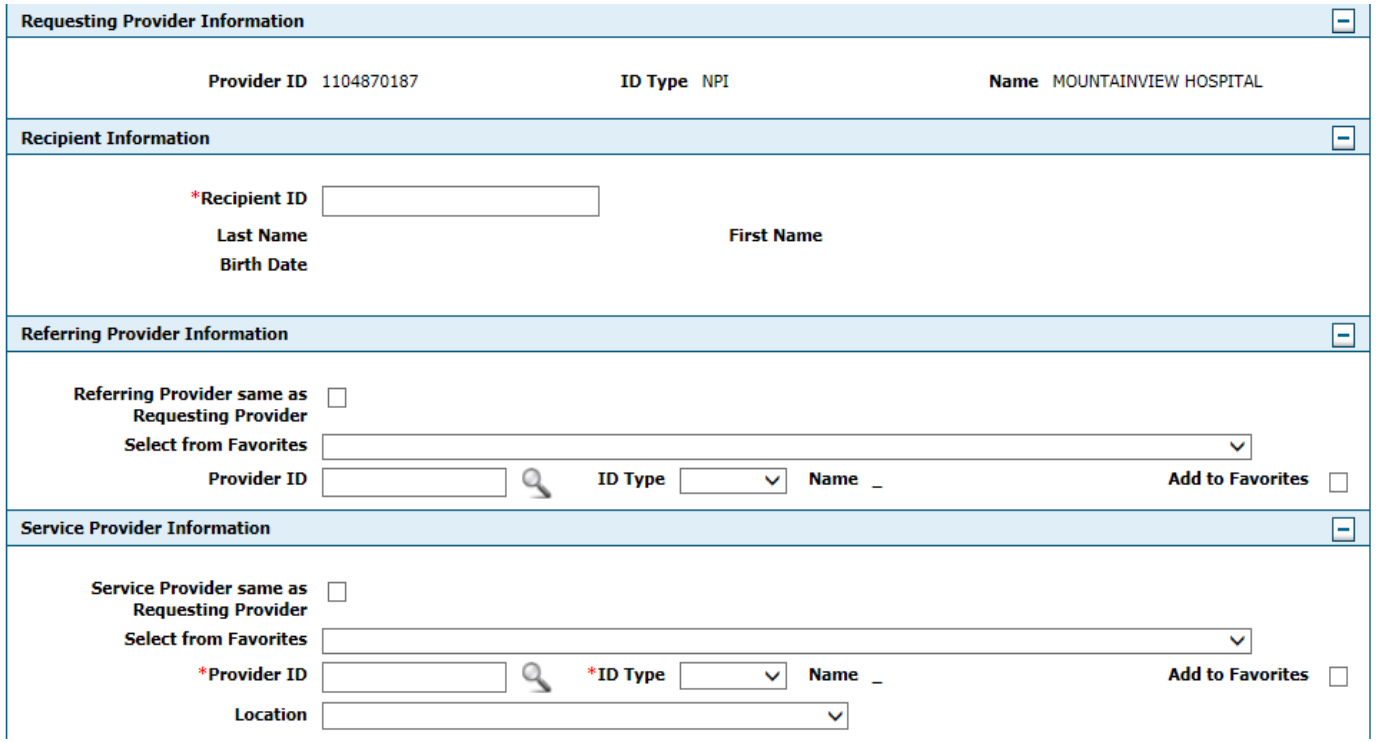
- Hover over the Care Management tab or select Care Management from the top tool bar
- Click “Create Authorization” from the sub-menu

One Page Process for Prior Authorization Requests



- Step 1: Select the radio button next to “Medical” or “Dental”
- Step 2: Select appropriate Process Type

Create Medical Prior Authorization
Provider, Recipient, Referring & Servicing Provider Information



The Last Name, First Name and Birth Date will be automatically populated based on the Recipient ID that is entered.

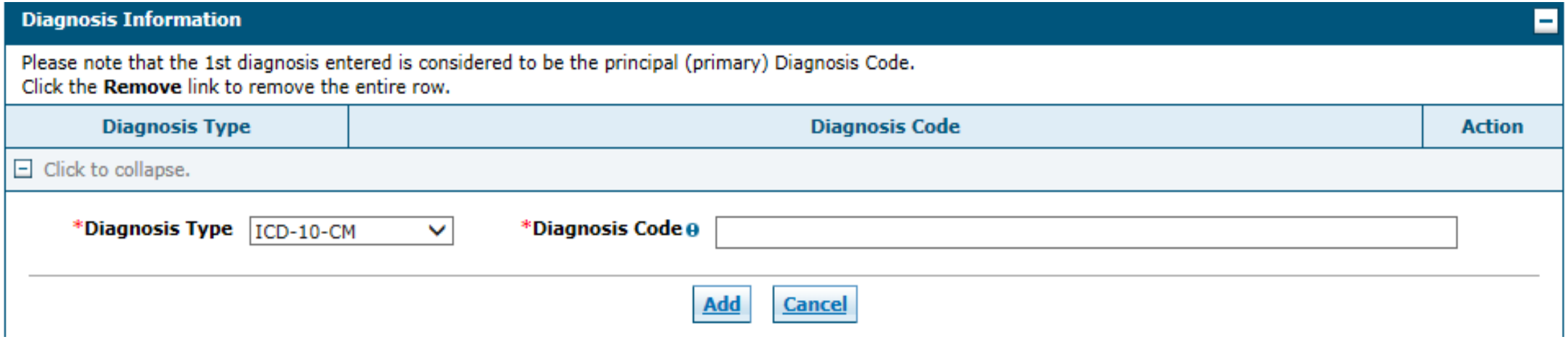
Requesting Provider Information
The information in this section is automatically populated

Recipient Information
Enter the Recipient ID

Referring Provider Information
If there is a referring provider, complete one of the following options:
- Check the Referring Provider same as Requesting Provider box
- Use the Select from Favorites drop-down list to select a provider from the favorites list
- Enter the Provider ID and select the ID Type from the drop-down list

Service Provider Information
- Check the Service Provider same as Requesting Provider box
- Use the Select from Favorites drop-down list to select a provider from the favorites list
- Enter the Provider ID and select the ID Type from the drop-down list
- Select Service Location (optional)

Diagnosis Information

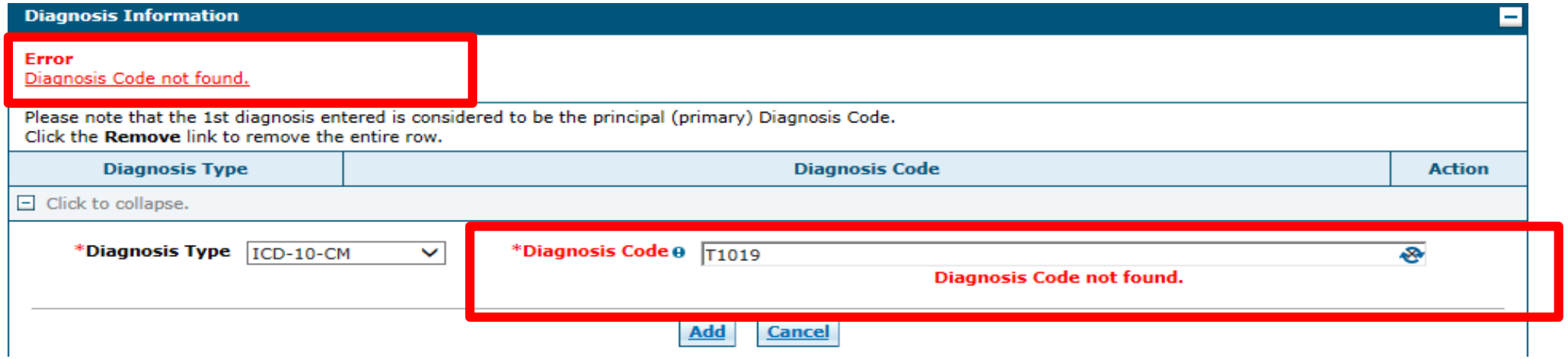


- The first diagnosis code entered is considered to be the principal or primary diagnosis code
- Portal allows up to nine diagnosis codes; only one valid diagnosis code is required for the PA
- Click “Add” to add each diagnosis code

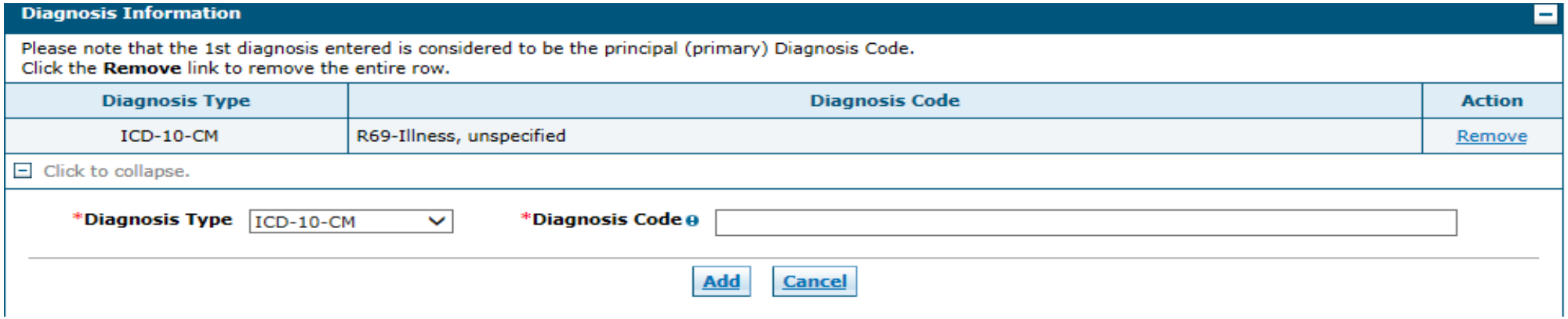
Do **not** key any decimals into the diagnosis code fields.

Diagnosis Information, continued

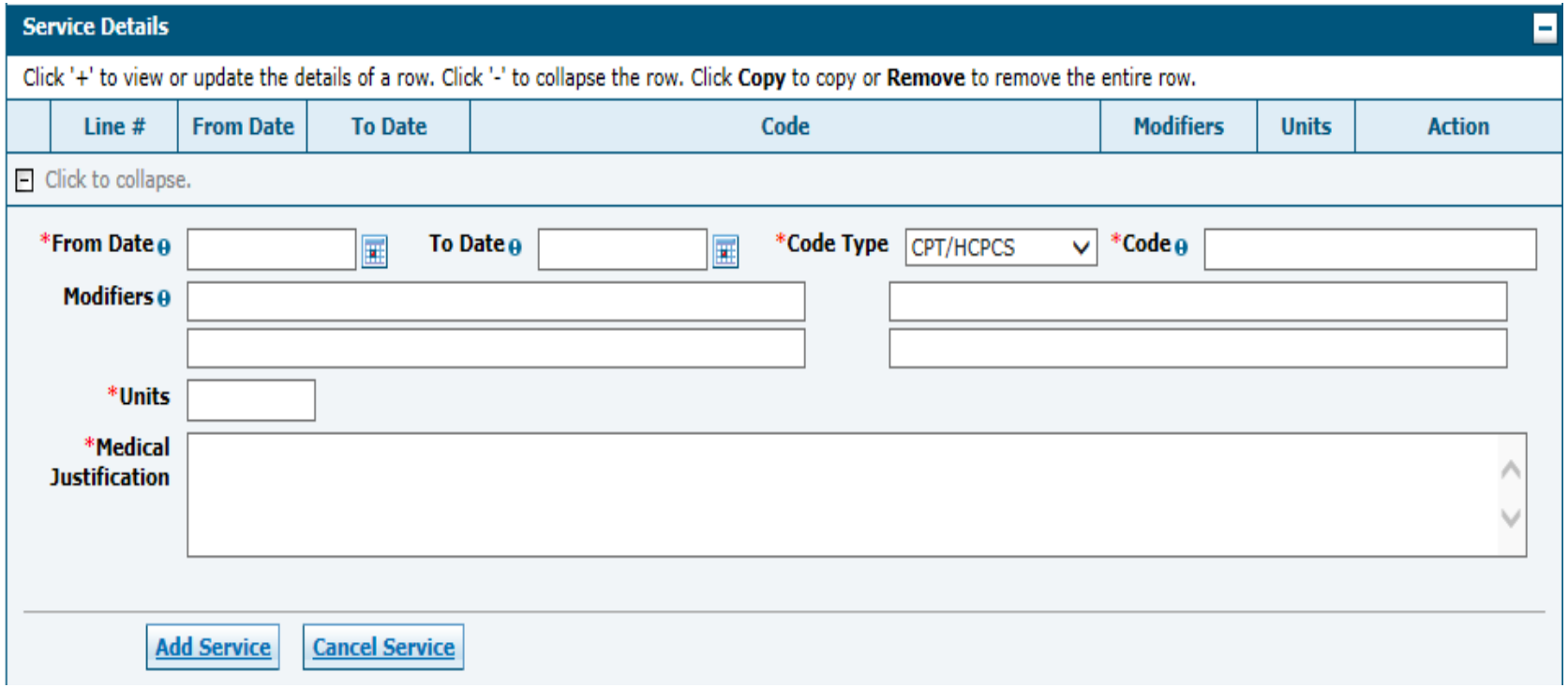
Invalid diagnosis code:



Valid diagnosis code:



Service Details



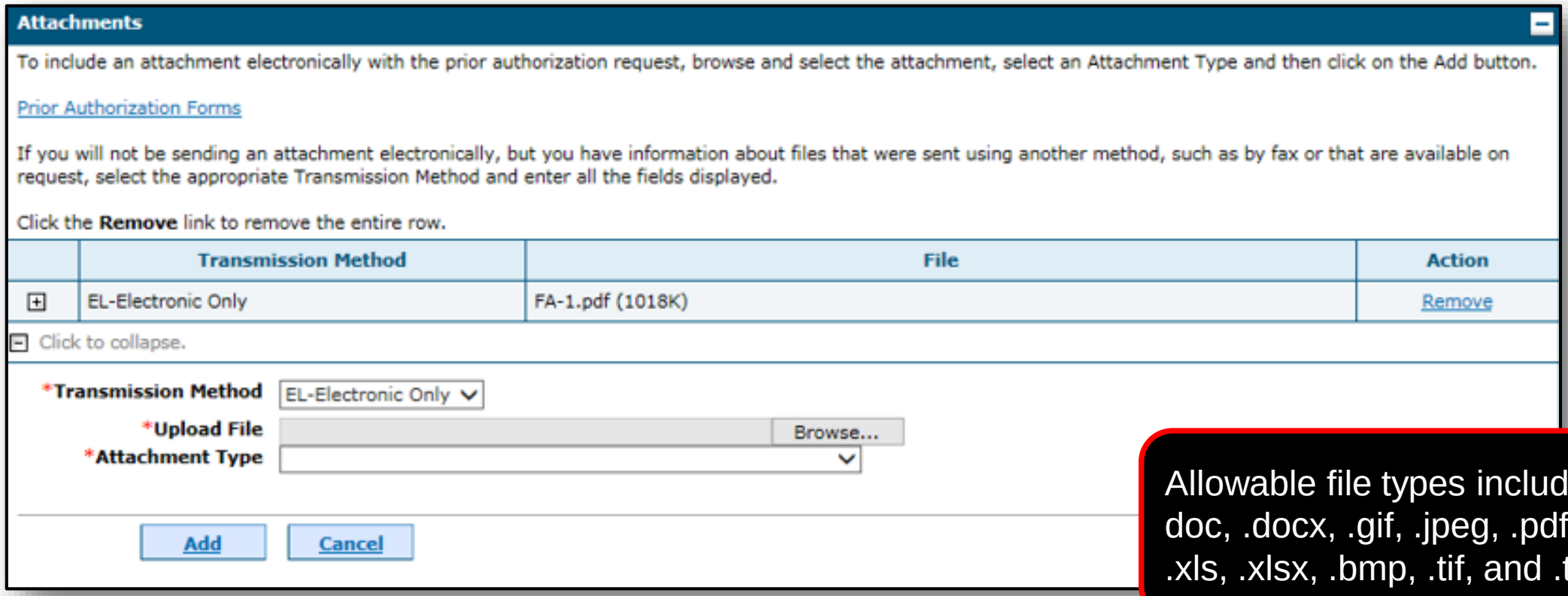
- Indicate a “From” or start date
- Select a Code Type from the drop-down menu
- Input Code
- Input amounts of units being requested
- In the Medical Justification field, indicate details as to why the PA is being requested
- Select “Add Service”

Unsaved Data Warning

– If you have entered information on the PA and have not clicked the “Add” button, you will get the message below when you click the “Submit” button

Attachments

Attachment Requirements

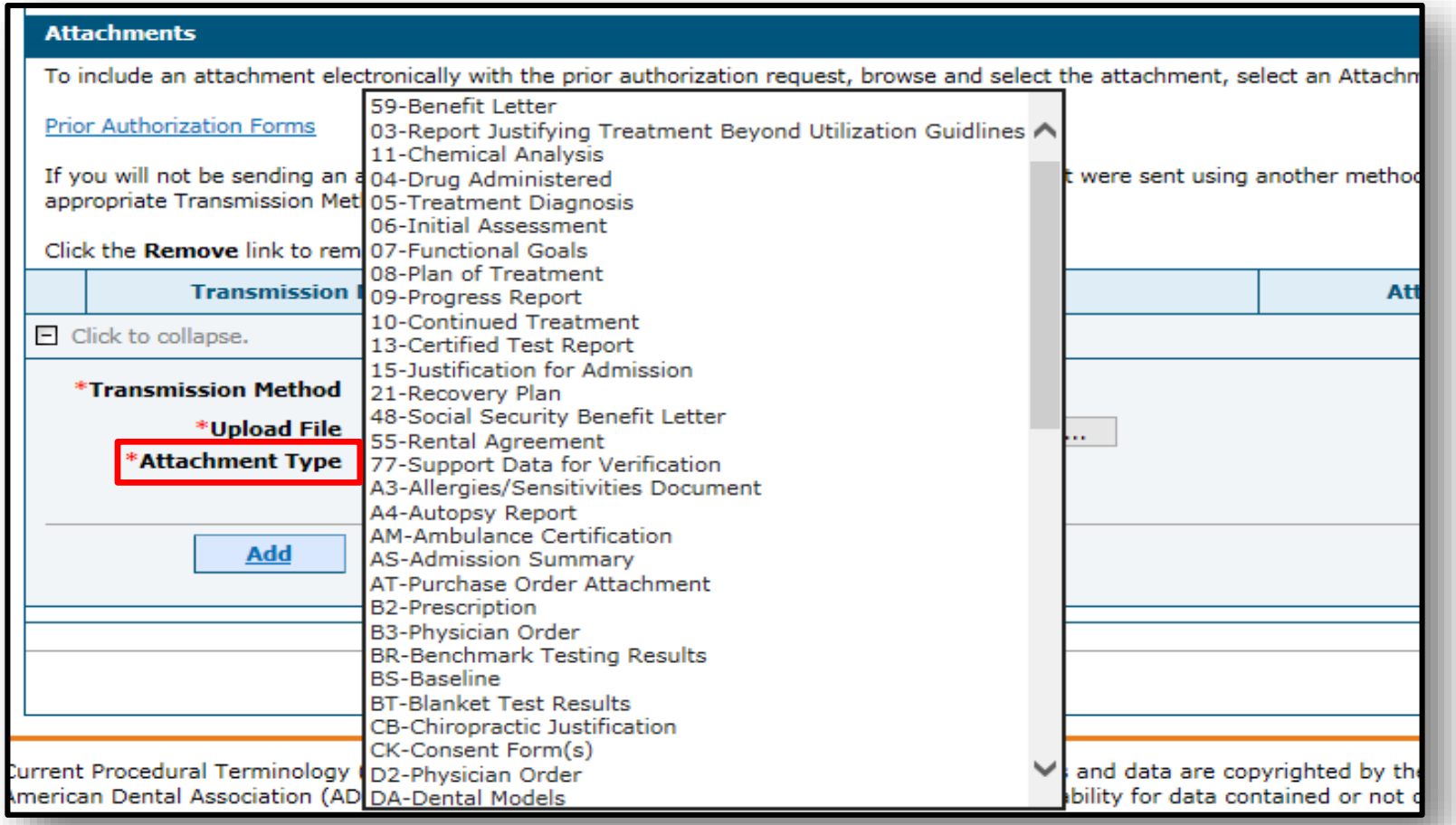


Allowable file types include: doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.

All PA requests require an attachment and any PA request that does not have an attachment submitted within 30 days will be automatically cancelled.

Attachment Requirements, continued

– Choose the type of attachment being submitted from the drop-down list

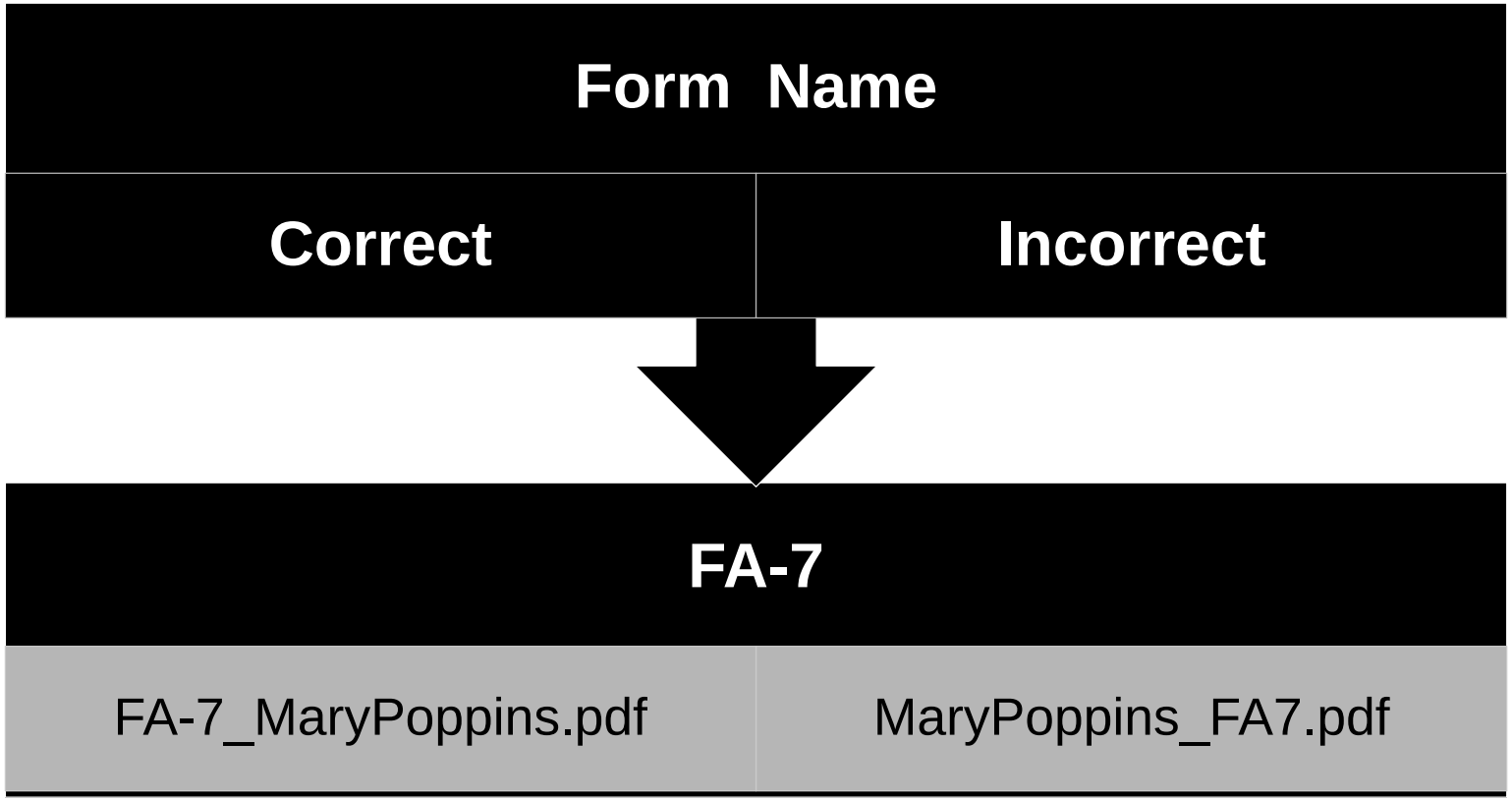


Uploading Attachments, continued

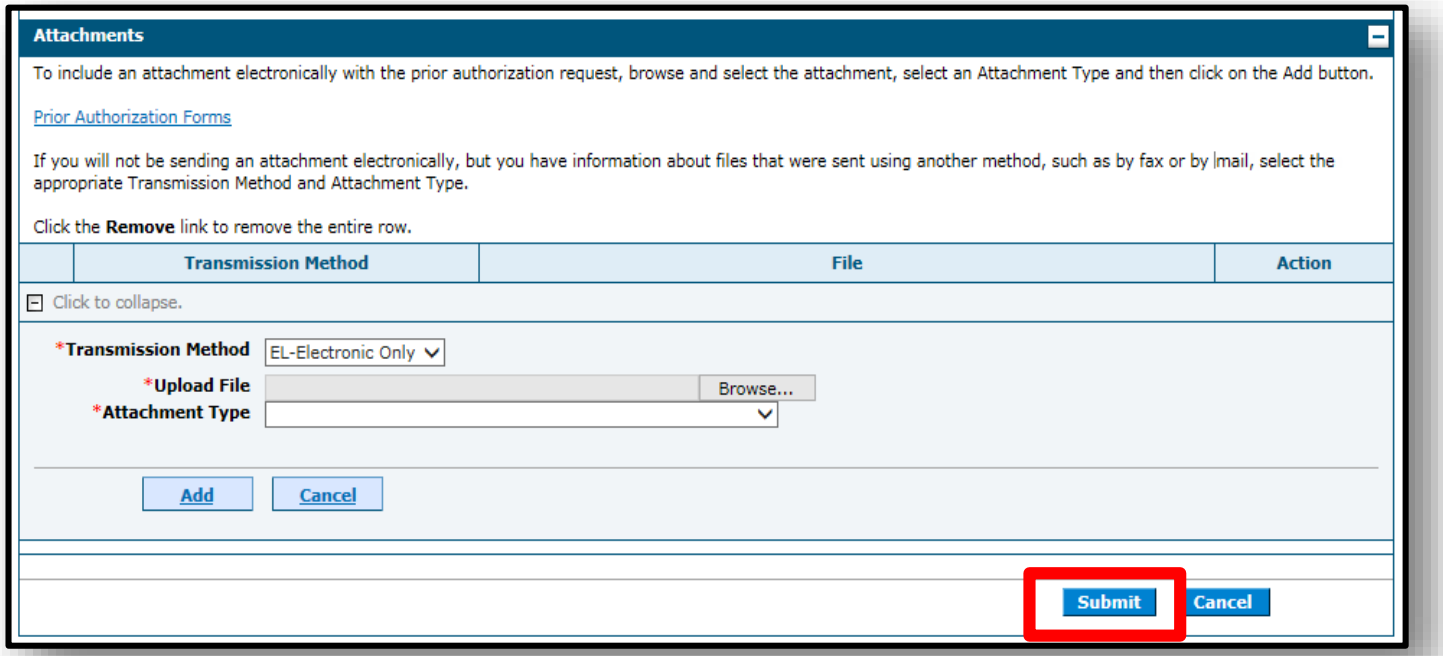
File Upload Naming Convention Guidelines

- Forms being uploaded must be in an approved format
- Files should be saved using the form name as the prefix
- Non-compliant files may cause a delay in processing the request

File Upload Naming Convention Examples

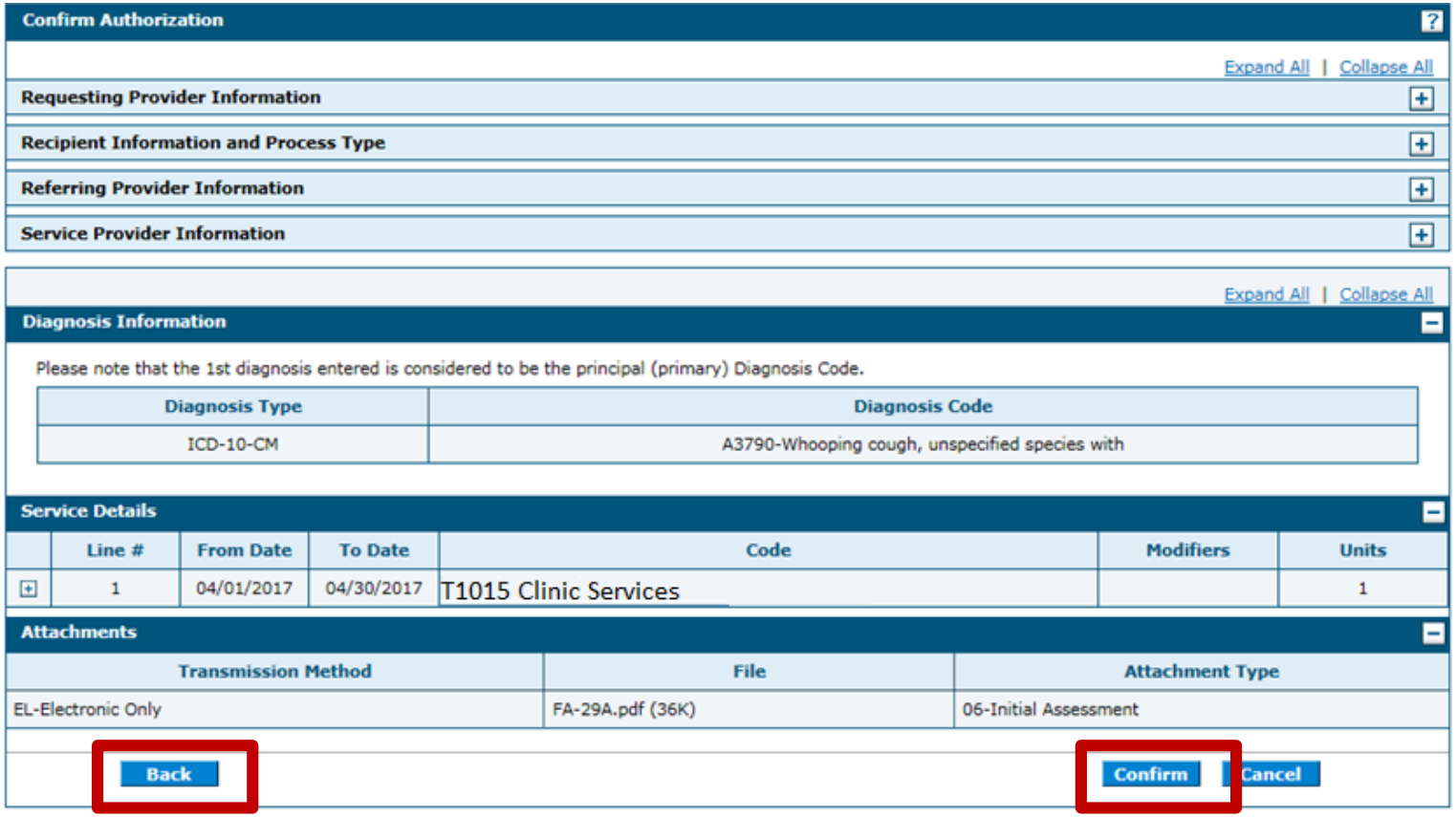


Submitting a Prior Authorization



– Once all of the required information, service details lines and attachment information has been added, click “Submit” to go to the Confirm Authorization page

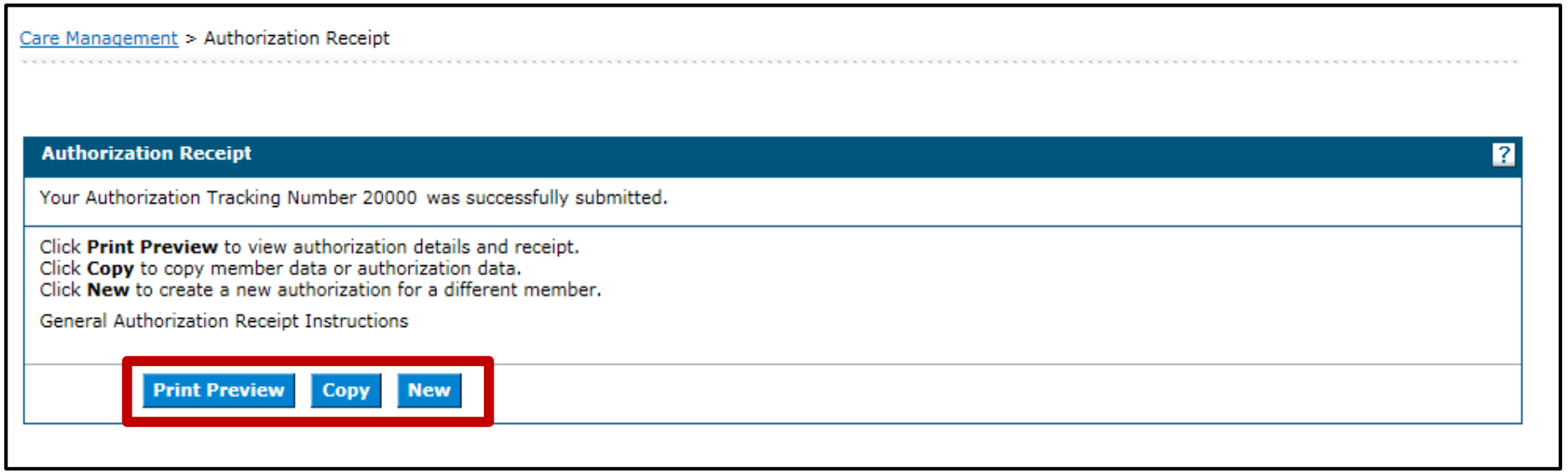
Finalizing a Prior Authorization



Review the information for accuracy:

- If errors are present, click “Back” to return to the Create Authorization page
- After all of the information has been reviewed, click “Confirm” to submit the PA for processing
- When confirming the PA, only click on “Confirm” once and wait for confirmation page to load. Clicking multiple times will create multiple PA requests in the system.

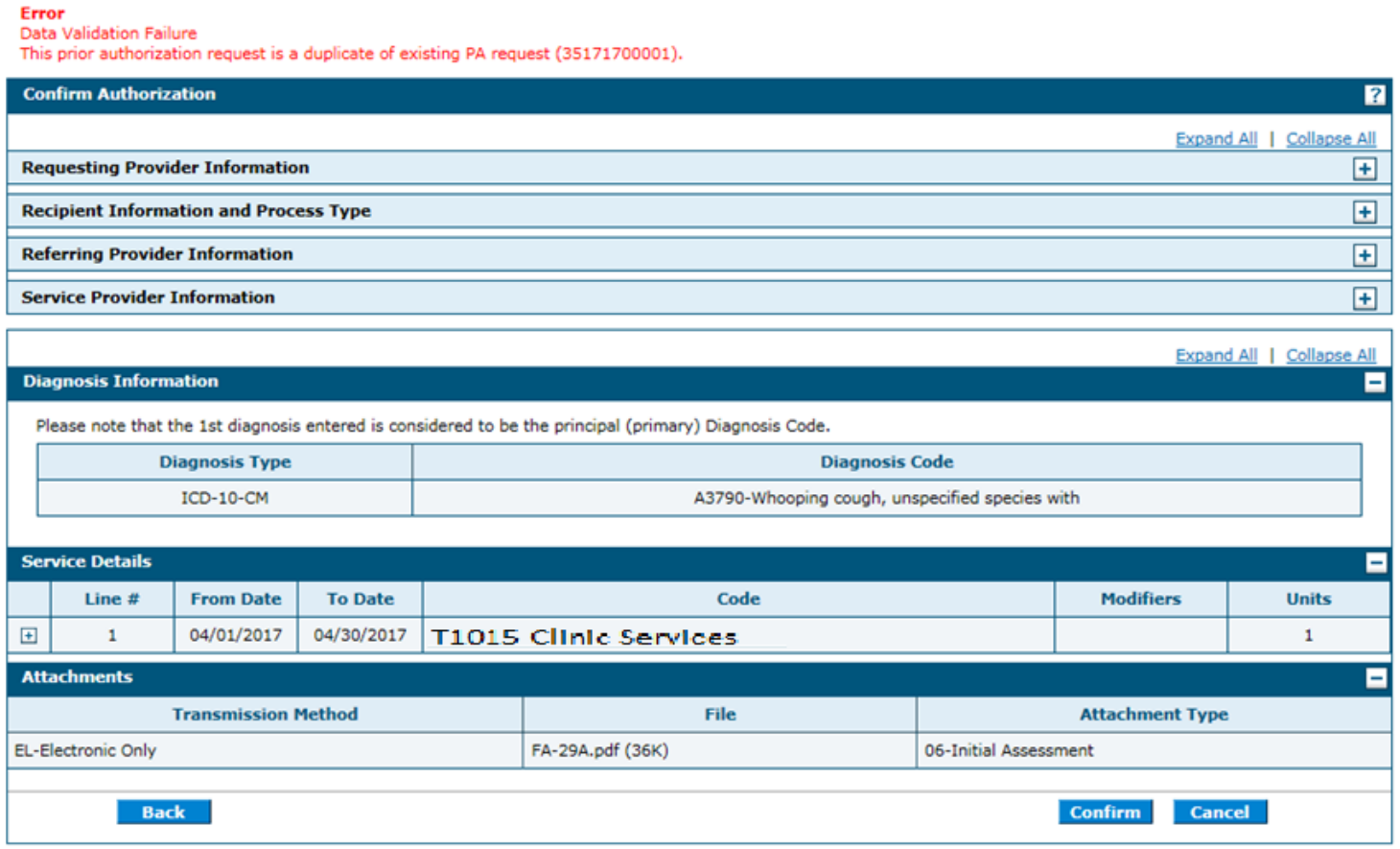
Authorization Successfully Submitted



- An authorization tracking number (ATN) receipt is generated upon successfully submitting the PA request
- Click “Print Preview” to view the PA details and receipt
- Click “Copy” to copy member data or authorization data
- Click “New” to create a new PA request for a different recipient

Example of an Unsuccessful Authorization

– Duplicate service lines that already exist on another PA for the same recipient



Error
Data Validation Failure
This prior authorization request is a duplicate of existing PA request (35171700001).

Confirm Authorization

Expand All | Collapse All

Requesting Provider Information

Recipient Information and Process Type

Referring Provider Information

Service Provider Information

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	A3790-Whooping cough, unspecified species with

Service Details

	Line #	From Date	To Date	Code	Modifiers	Units
⊞	1	04/01/2017	04/30/2017	T1015 Clinic Services		1

Attachments

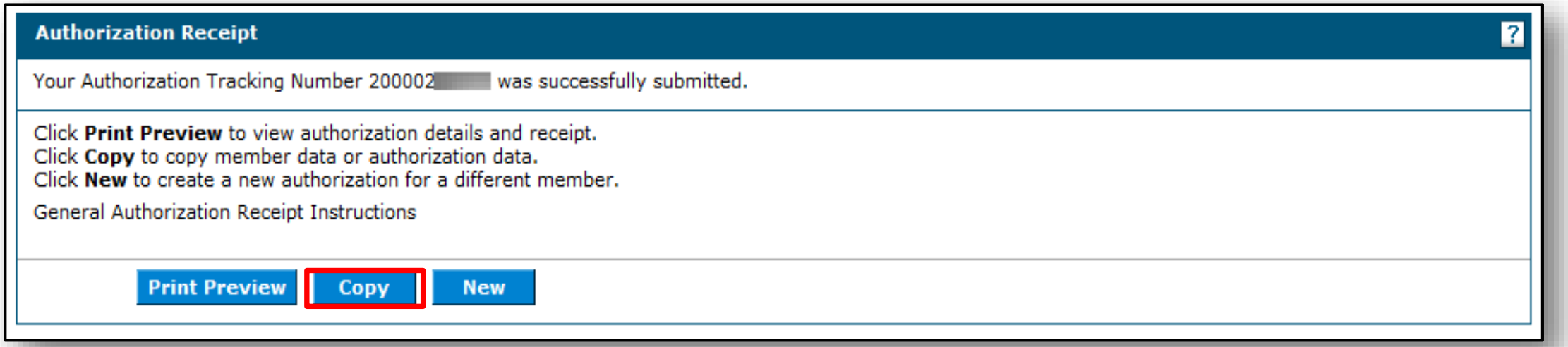
Transmission Method	File	Attachment Type
EL-Electronic Only	FA-29A.pdf (36K)	06-Initial Assessment

Back Confirm Cancel

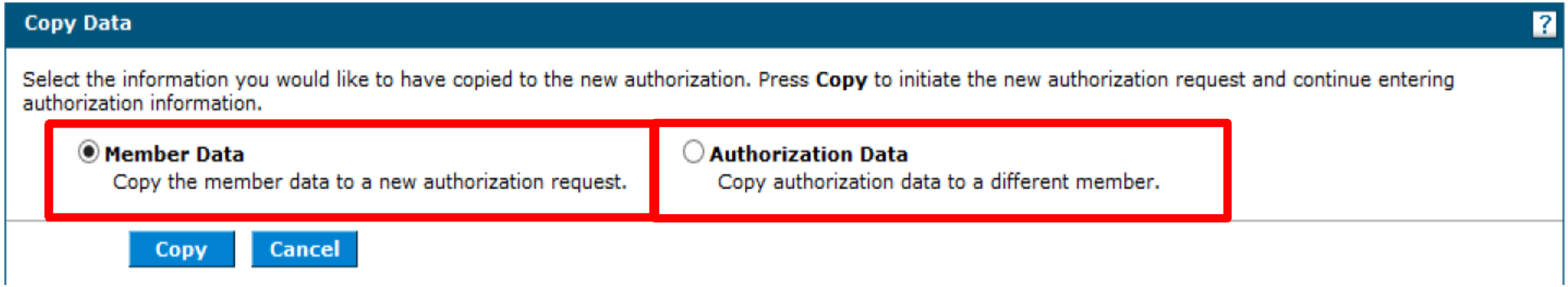
Copying an Authorization

Copying an Authorization

– A PA request can be copied, either for the same recipient or the same service, from the Authorization Receipt screen once the original PA request has been successfully submitted



Copying an Authorization, continued
Member or Authorization Data



- Copy a PA request for an existing recipient when requesting a new service
- Only the recipient data is copied

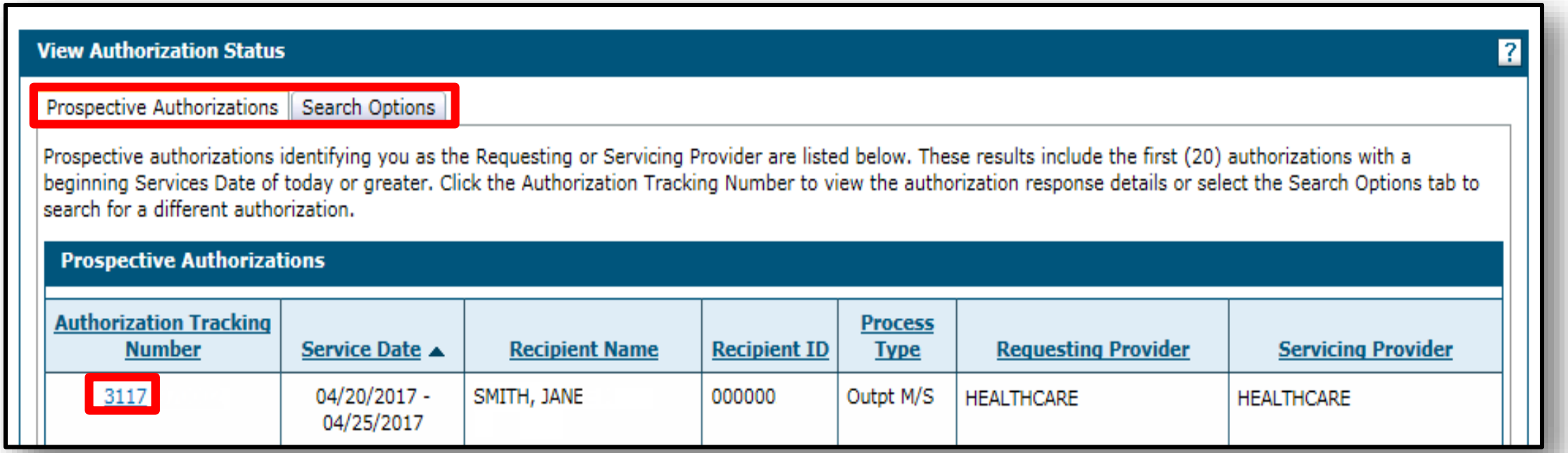
- Copy a PA request by service in order to submit a PA request for similar services but for a different recipient

Viewing Authorizations

View Status of Authorization

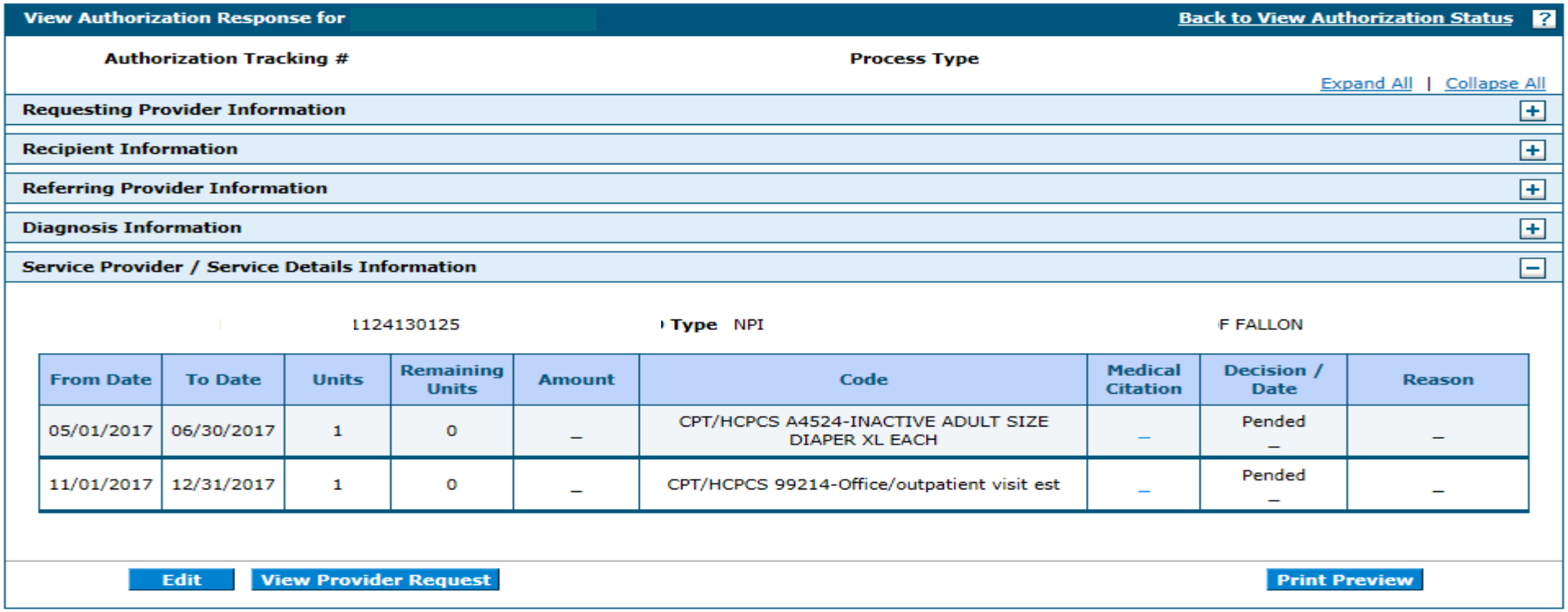
– Hover over the Care Management tab from the top tool bar and select “View Authorization Status” from the sub-menu or select Care Management from the top tool bar and click “View Status of Authorizations” from the Authorizations menu

Viewing Authorizations, continued



- Prospective Authorizations and Search Options tabs will be displayed
- Prospective Authorizations displays PAs by either the requesting or servicing provider
- Search Options allows a search by either recipient or provider information
- To view the details of an authorization, click the blue, underlined “ATN” link

Viewing Authorizations, continued


View Authorization Response for

Back to View Authorization Status

Authorization Tracking #

Process Type

Expand All | Collapse All

Requesting Provider Information

Recipient Information

Referring Provider Information

Diagnosis Information

Service Provider / Service Details Information

1124130125 Type NPI F FALLON

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
05/01/2017	06/30/2017	1	0	–	CPT/HCPCS A4524-INACTIVE ADULT SIZE DIAPER XL EACH	–	Pended –	–
11/01/2017	12/31/2017	1	0	–	CPT/HCPCS 99214-Office/outpatient visit est	–	Pended –	–

Edit View Provider Request Print Preview

- The ATN is the same as the PA number
- If a claim is submitted before the PA is approved, the claim will deny
- The PA status always defaults to “Pended” until a determination is complete

Viewing Authorizations, 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	View	Not Certified 02/21/2013	–
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

- Under the Decision/Date field:
  - Certified in Total – The PA request was approved
  - *Not* Certified – The PA was not approved
  - Certified in Partial – The PA was approved but only for a specific amount that is different than what was requested
- Under the Reason field:
  - Disposition pending review – The PA request is still in process, which appears when the PA request is in "Pended" status

Viewing Authorizations, continued

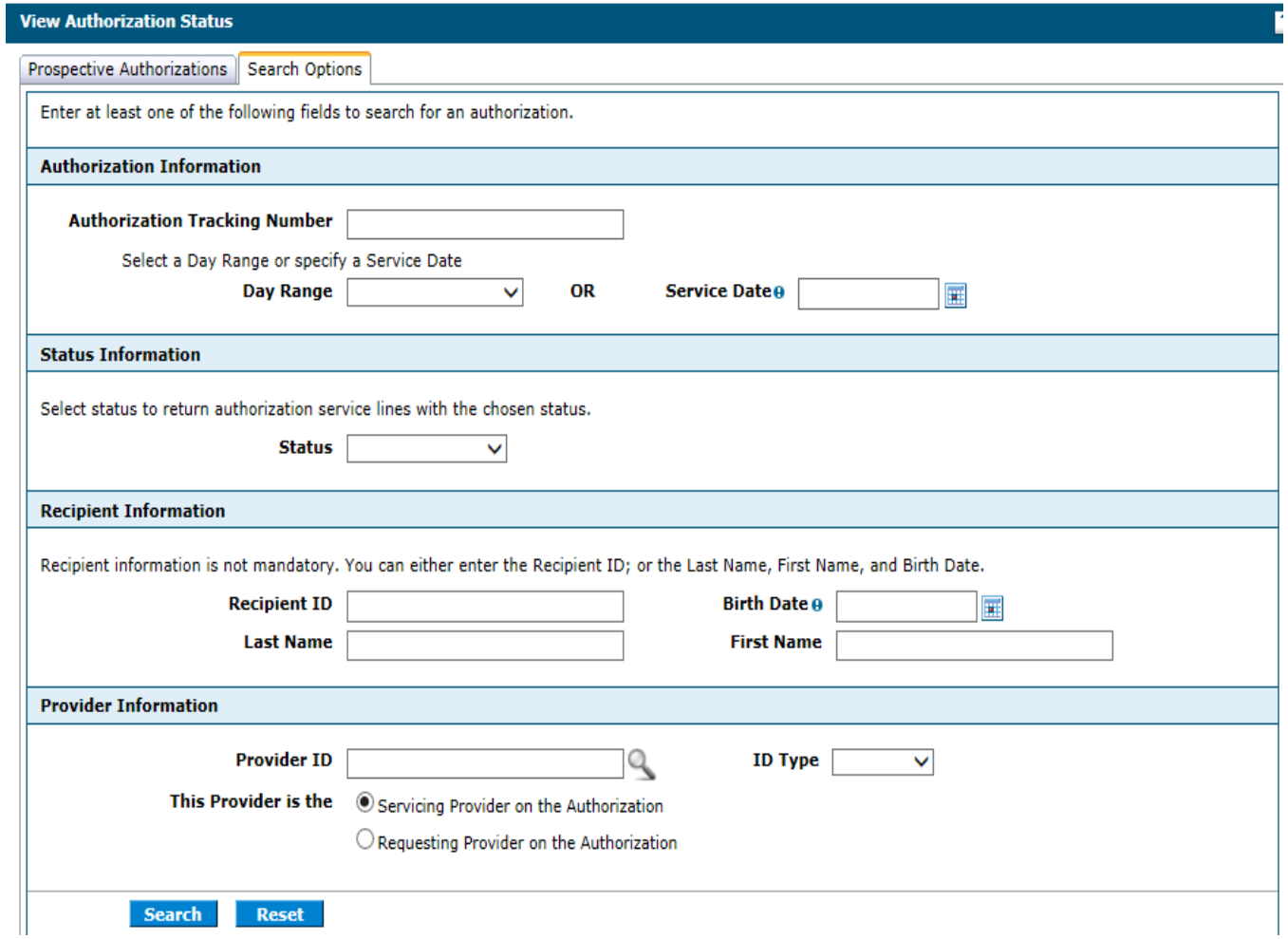
From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
02/17/2013	02/17/2013	3	0	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	Hide	Not Certified 02/21/2013	–
Medical Citation 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid. **Notes 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

- Remaining Units/Days – The amount counts down as claims are processed. A dash indicates that a claim is not processed for the authorization.
- 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.
- PA requests submitted through the Provider Web Portal are viewable. Faxed authorizations may limit the amount of information that is viewable (summary, status of request).

Searching Authorization Status

Searching Authorization Status, continued



To search for a PA, enter at least one of the following:

– Enter the Authorization Tracking Number
– Select the Day Range from the drop-down list
– Enter the Service Date

Or

Recipient's ID number **or** the recipient's Last Name, First Name and Date of Birth

Or

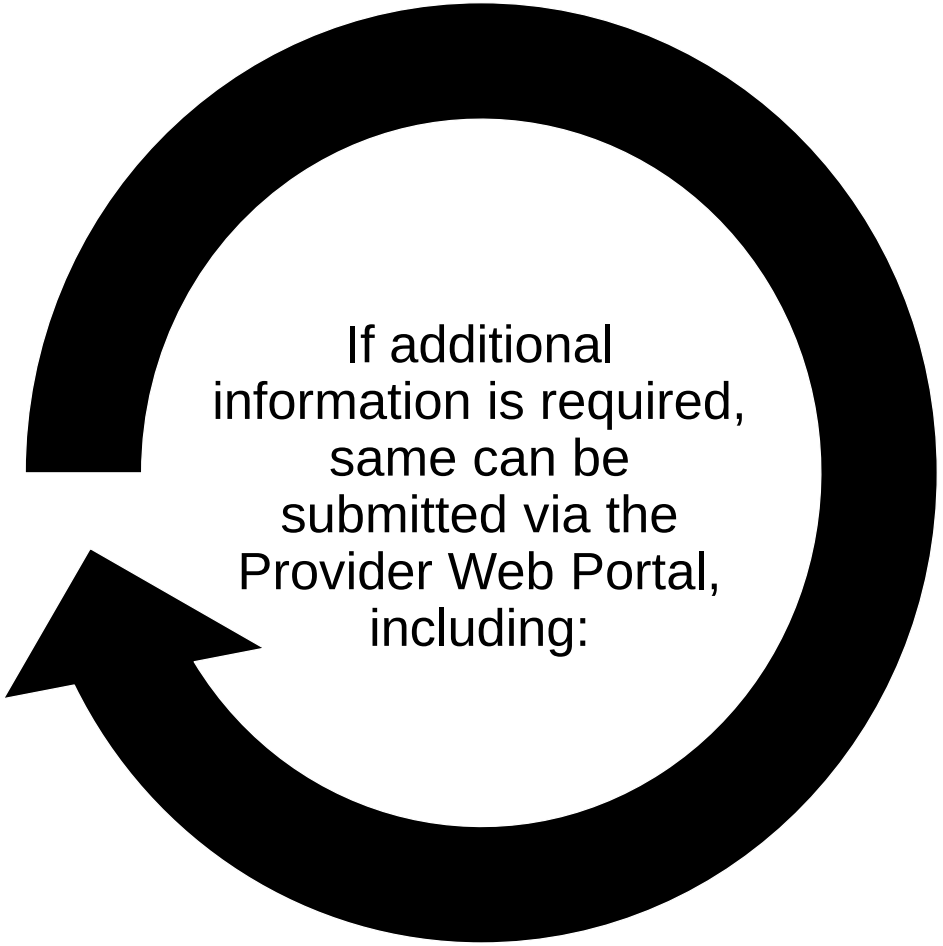
– Provider's NPI and ID Type
– Indicate Servicing or Referring Provider

Click "Search"

– Search results will display at the bottom of the screen

Submitting Additional Information

How to Submit Additional Information



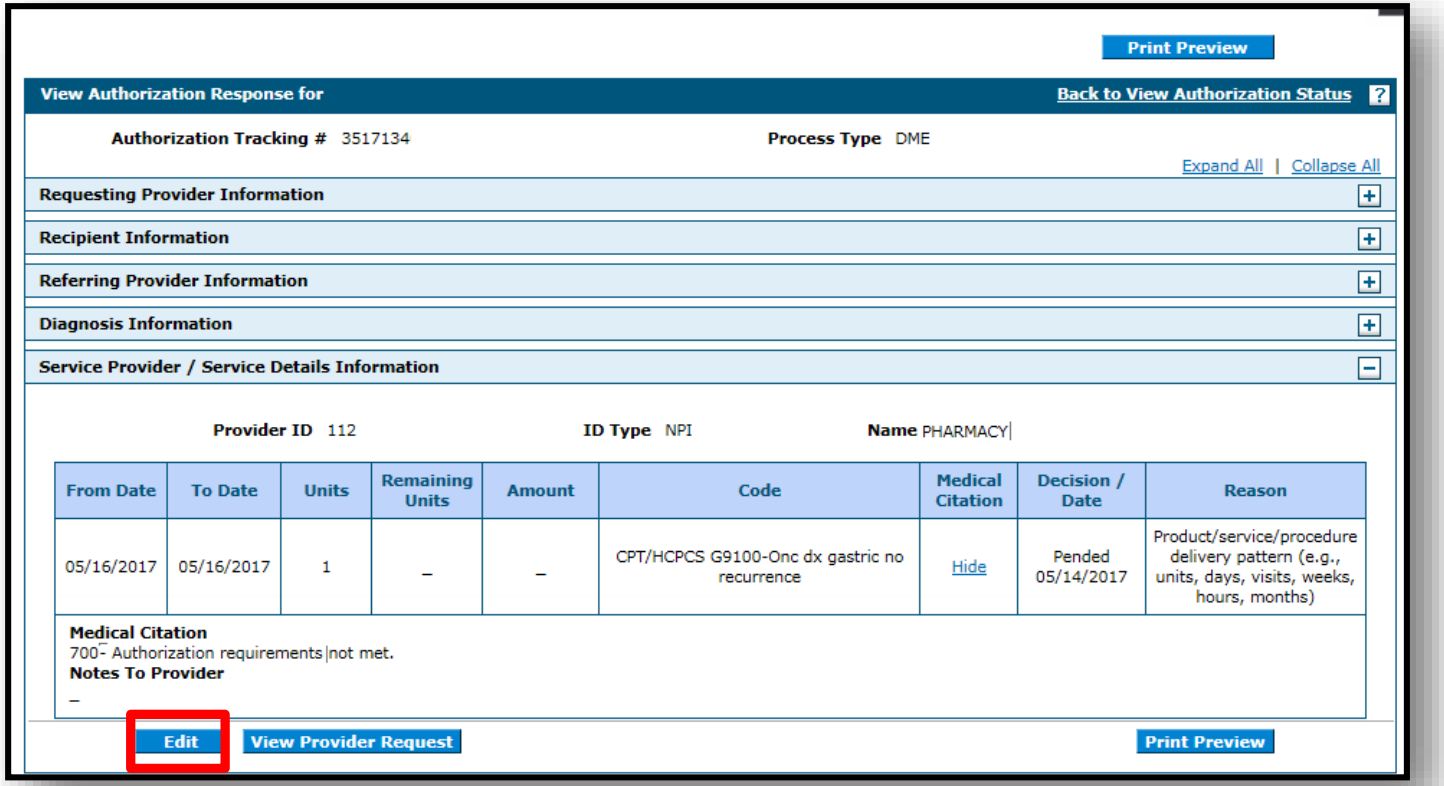
- Requests for additional services
- Attachments that were not submitted with the original PA submission
- An FA-29 Prior Authorization Data Correction Form

Use the approved naming convention when uploading attachments. For instance, “Form Name” as the prefix, FA-XX.

How to Submit Additional Information, continued

Resubmission Process

- Search for the PA using the View Authorization Status search page
- Click the “ATN” in the Search Results grid
- Click “Edit” on the View Authorization Response page
- The PA is re-opened, and new diagnosis codes, service details, and/or attachments can be added



Changes cannot be made to previously submitted information. If a user needs to update previously submitted information, attach the FA-29 Prior Authorization Data Correction Form to the PA request that needs to be updated.

How to Submit Additional Information, continued

FA-29	Prior Authorization Data Correction Form
FA-29A	Request for Termination of Service
FA-29B	Prior Authorization Reconsideration Request

- Locate necessary forms on the Forms Page after the completion of a PA
- Once the new information has been added to the PA request, click “Resubmit” to review the PA information
- Click “Confirm” to resubmit the PA
- The ATN will remain the same

PA requests with a status of Not Certified or Cancel cannot be resubmitted. The **Edit** button will not appear on the View Authorization Response page.

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 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

Resources

Additional Resources

- Forms: https://www.medicaid.nv.gov/providers/forms/forms.aspx
- EVS General Information: https://www.medicaid.nv.gov/providers/evsusermanual.aspx
- Secure EVS Web Portal: https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx
- Billing Manual and Guides: https://www.medicaid.nv.gov/providers/BillingInfo.aspx
- Medicaid Services Manual: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

DHCFP Contact Information:

Contact Form: http://dhcfp.nv.gov/Contact/ContactUsForm/

Contact Nevada Medicaid

Contact Us — Nevada Medicaid Customer Service

Prior Authorization Department: 800-525-2395

Customer Service Call Center: 877-638-3472 (Monday through Friday 8 am to 5 pm Pacific Time)

Provider Field Representatives:
E-mail: NevadaProviderTraining@dxc.com

Thank You