Durable Medical Equipment

Provider Type 33 Training
Objectives
Objectives

- Review Durable Medical Equipment (DME) Program Information
- Locate Medicaid Policy
- Locate Public Notice/Hearings Information
- Review Web Announcements
- Locate CMS-1500 Claim Form Instructions, Billing Manual and Billing Guidelines
- Utilize the Search Fee Schedule
- Use the Authorization Criteria
- Locate and Review Prior Authorization Forms
- Login to the Electronic Verification System (EVS) Secure Web Portal
- Review Delegate Access
- Utilize the Treatment History Function
- Successfully Submit a Prior Authorization
- View Prior Authorizations
- Learn about the Benefits of Electronic Data Interchange (EDI)
- Edit Codes and Resolutions
Provider Web Portal
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.
Locating Program Information

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

- Highlight “Programs” and select “Durable Medical Equipment” from the sub-menu
Medicaid Services Manual (MSM)
Locating the Medicaid Services Manual (MSM)

- Step 1: Highlight “Quick Links” from top blue tool bar
- Step 2: Select “Medicaid Services Manual” from the drop-down menu
- Note: MSM Chapters will open in new webpage through the DHCFP website
Locating MSM Chapter 1300

- Select “1300 DME Disposable Suppliers and Supplements”
- All providers are responsible for knowing the information in Chapter 100 “Medicaid Program” and the Addendum
- From the next page, always make sure to select the “Current” policy
Division of Health Care Financing and Policy (DHCFP) 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 highlight “Public Notices”
- Select “Meetings/Public Notices”
- The webpage that opens will provide information pertaining to upcoming meetings
Viewing Web Announcements
Web Announcements

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.

– 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.
Web Announcements, continued

- **Web Announcement 1466** – Contains information regarding procedure code A5500 and possible denials of claims. Any claims submitted with a date of service between October 1, 2015, and November 6, 2017, that have denied with only edit code 0967 will be automatically reprocessed.

- **Web Announcement 1469** – Contains information that as of November 6, 2017, Healthcare Common Procedure Coding System (HCPCS) codes billed by DME providers have been updated. This includes codes that are no longer billable.

- **Web Announcement 1496** – Contains information regarding new rates and prior authorization requirements for 2018.
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

**Paper Claim Form Instructions**

<table>
<thead>
<tr>
<th>Title</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA (Version 2012) Claim Form Instructions</td>
<td>01/28/16</td>
</tr>
<tr>
<td>CMS-1500 (02-12) Claim Form Instructions</td>
<td>07/27/17</td>
</tr>
<tr>
<td>UB Claim Form Instructions</td>
<td>05/30/17</td>
</tr>
</tbody>
</table>

**Billing Manual**

For Archives Click here

<table>
<thead>
<tr>
<th>Title</th>
<th>File Size</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Manual</td>
<td>2 MB</td>
<td>09/01/2017</td>
</tr>
</tbody>
</table>

**Billing Guidelines (by Provider Type)**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME), Disposable, Prosthetics</td>
<td>07/24/17</td>
</tr>
</tbody>
</table>

- Utilize the CMS-1500 Claim Form Instructions to properly submit claims
- Utilize the Billing Manual for general billing information
- Utilize the Billing Guidelines for specific information for PT 33, including prior authorization information, and covered and non-covered services
Utilize the Search Fee Schedule to determine the rate of reimbursement for a procedure code.
Fee Schedule, continued

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

- Step 1: Select Code Type from the drop-down menu
- Step 2: Input Procedure Code of Description
- Step 3: Input appropriate Provider Type
- Step 4: Click “Search” to populate results
Note: Make sure that the “Effective Date” ends in 9999 for current rates of reimbursement.
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.

Provider Type 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies

Select the appropriate title to open the PDF pertaining to the reimbursement schedule you would like to review.
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 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 your service type at dhcfp.nv.gov and the Billing Guide for your provider type 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

- Make sure that the effective date ends in “9999” to verify that the user is viewing the most accurate information.
Prior Authorization Forms
Locating DME Prior Authorization Forms

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

<table>
<thead>
<tr>
<th>FA-1</th>
<th>Durable Medical Equipment Prior Authorization Request</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

- While on the “Forms” page, locate the appropriate FA-1 Form and its instructions, if applicable
- All active forms are fillable for easy uploading for PA submission online
- Any form that is not legible will not be accepted
Prior Authorization Forms, continued

- FA-1 (Durable Medical Equipment Prior Authorization Request)
  - This form is not required when submitting the prior authorization request online

- FA-1A (Usage Evaluation for Continuing Use of BIPAP and CPAP Devices)

- FA-1B (Mobility Assessment and Prior Authorization (PA))
  - Use this form if the equipment is greater than $500.00

- FA-1C (Oxygen Equipment and Supplies Prior Authorization Request)
  - Use this form when requesting Oxygen Equipment (Example: E1390, E1392, E0431, E0433 & K0738)

- FA-1D (Wheelchair Repair Form)
Prior Authorization Forms: Tips

‒ All PA forms must be submitted at least 3 business days prior to the start date unless recipient is being discharged from a hospital.
‒ Retro dates are only accepted if recipient has retro eligibility coverage and holidays and weekends are not considered business days.
‒ Use the Search Fee Schedule to determine appropriate modifier. Note that some procedure codes can be overridden per Nevada Medicaid Policy. Some modifiers, i.e., rental, will be paid up to the purchase amount.
‒ Divide the NU modifier purchase amount by the RR Modifier rental amount to find the months of rental needed to meet the purchase price.
‒ Repairs to equipment must have an RB Modifier along with the appropriate code to prevent claim denials. See Web Announcement 661 at www.medicaid.nv.gov.
‒ Rental codes cannot use the NU modifier.
‒ Some codes are 1 unit per day.
EVS Secure Web Portal
EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period, Monday through Friday 12:00–12:30 a.m. Pacific Time (PT) and Sunday 8:00 p.m.–12:30 a.m. PT

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 can be accessed by highlighting EVS from the top tool and select “Provider Login” or “Provider Login” 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.
Answer the challenge question to verify your identity the first time you log in from a personal computer or every time you use a public computer.

- Select personal computer or a public computer.
- Click “Continue”
Confirm that your **site key token** and **passphrase** are correct. If you recognize your site key token and passphrase, you can be assured that you are at the valid Provider Web Portal website and it is safe to enter your password.

Enter your ***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

<table>
<thead>
<tr>
<th>My Home</th>
<th>Eligibility</th>
<th>Claims</th>
<th>Care Management</th>
<th>File Exchange</th>
<th>Resources</th>
<th>Switch Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm provider information and contact information and check messages.</td>
<td>Search recipient eligibility information.</td>
<td>Search claims and payment history.</td>
<td>Create authorizations, view authorization status, and maintain favorite providers.</td>
<td>Upload forms online.</td>
<td>Download forms and documents.</td>
<td></td>
</tr>
</tbody>
</table>
Role-Based Security and 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 “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, choose Inactive
- When changes are complete, click “Submit”
Delegate Assignment, continued

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

- A Delegate Assignment box will be displayed to confirm that the delegate was added to the provider’s delegate list.
Before You Create 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.
Treatment History
Treatment History

- Utilize the “Treatment History” sub-menu from the Claims menu
- Treatment History allows a user to indicate a Recipient ID and additional information to determine the recipient’s previous treatments
- All fields marked with a red asterisk are required
- Select “Search” to populate results
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”
- Step 2: Select appropriate DME Process Type
Create Medical Prior Authorization
Provider, Recipient, Referring and Servicing Provider Information

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 your 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 your favorites list
- Enter the Provider ID and select the ID Type from the drop-down list
- Select Service Location (optional)

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

The first diagnosis code entered is considered to be the principal (primary) Diagnosis Code.
Portal allows up to nine diagnosis codes; 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 the Code
- Input amounts of Units being requested
- In the Medical Justification field, indicate “See attached form”
- 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.

![Unsaved Data Warning]

The prior page contained unsaved Service Detail changes. If changes needed to be saved, navigate back to the page, reapply the changes to the table, and save.
Attachments
Attachment Requirements

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

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

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

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Correct</th>
<th>Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-1</td>
<td>FA-1_MaryPoppins.pdf</td>
<td>MaryPoppins_FA1.pdf</td>
</tr>
<tr>
<td>FA-1B</td>
<td>FA-1B_MaryPoppins.pdf</td>
<td>MaryPoppins_FA-1B.pdf</td>
</tr>
</tbody>
</table>
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 PAs 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
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

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Select the information you would like to have copied to the new authorization. Press **Copy** to initiate the new authorization request and continue entering authorization information.

- **Member Data**
  - Copy the member data to a new authorization request.
- **Authorization Data**
  - Copy authorization data to a different member.

[Image of the Copy Data interface]
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

- 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

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/17/2013</td>
<td>02/17/2013</td>
<td>3</td>
<td>0</td>
<td>_</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified 02/21/2013</td>
<td>_</td>
</tr>
<tr>
<td>02/20/2031</td>
<td>02/20/2031</td>
<td>2</td>
<td>0</td>
<td>_</td>
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<td>View</td>
<td>Certified in Total 02/24/2013</td>
<td>_</td>
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− 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

- 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).

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<td></td>
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</table>

**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.

<table>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>02/22/2013</td>
<td></td>
</tr>
</tbody>
</table>
Searching Authorization Status
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

If you have submitted a PA request via the Provider Web Portal but need to submit additional information such as:

- 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, use “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 you need 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

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<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-29</td>
<td>Prior Authorization Data Correction Form</td>
</tr>
<tr>
<td>FA-29A</td>
<td>Request for Termination of Service</td>
</tr>
<tr>
<td>FA-29B</td>
<td>Prior Authorization Reconsideration Request</td>
</tr>
</tbody>
</table>

- 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.
EDI Information
Locating the EDI Page

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

EDI enrollment forms are for completion and submission by active or enrolling Nevada Medicaid and Nevada Check Up providers only.

<table>
<thead>
<tr>
<th>Form Number</th>
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</tr>
</thead>
<tbody>
<tr>
<td>FA-35</td>
<td>Electronic Transaction Agreement for Service Centers</td>
</tr>
<tr>
<td>FA-36</td>
<td>Service Center Operational Information</td>
</tr>
<tr>
<td>FA-37</td>
<td>Service Center Authorization</td>
</tr>
<tr>
<td>FA-39</td>
<td>Payerpath Enrollment</td>
</tr>
</tbody>
</table>

- Fill out necessary forms completely:
  - The Allscripts-Payerpath Program is a free program for all Nevada Medicaid providers
- Send completed enrollment forms to Nevada Medicaid:
  - By uploading into the Provider Web Portal
  - Mail to the address listed on the form
  - E-mail to: NVMMISEDISupport@dxc.com
- Training opportunities are hosted every month for Payerpath Trainings. Please review EDI Announcements on the EDI webpage for training sessions.
Locating the EDI Companion Guides

- Step 1: Highlight “Providers” from top blue tool bar
- Step 2: Select “Electronic Claims/EDI” from the drop-down menu
Locating the EDI Companion Guides, continued

EDI Companion Guides

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction 270/271 - Health Care Eligibility Inquiry and Response</td>
<td>February 2015</td>
</tr>
<tr>
<td>Transaction 271U - Unsolicited Transaction – HIPAA Version 5010</td>
<td>February 2013</td>
</tr>
<tr>
<td>Transaction 820 - Health Care Premium Payment – HIPAA Version 5010</td>
<td>October 2012</td>
</tr>
<tr>
<td>Transaction 834 - Benefit Enrollment and Maintenance – HIPAA Version 5010</td>
<td>October 2012</td>
</tr>
<tr>
<td>Transaction 835 - Health Care Payment/Advice</td>
<td>February 2015</td>
</tr>
<tr>
<td>Transaction 837D - Dental Health Care Claim – HIPAA Version 5010</td>
<td>October 2015</td>
</tr>
<tr>
<td>Transaction 837P - Professional Health Care Claim – HIPAA Version 5010</td>
<td>October 2015</td>
</tr>
</tbody>
</table>

The Companion Guides contain our HIPAA-compliant technical specifications for each transaction.

EDI Companion Guides are located at the bottom of the webpage.
Common DME Claim Denial Codes and Resolutions
Edit 0157: Approved Authorization Not on File

This Edit Code sets when a claim is submitted to Nevada Medicaid and the code requires a prior authorization.

Verify that a prior authorization has been requested from and approved by Nevada Medicaid. Do not submit a claim before the prior authorization has been approved.

If the Claim is still being denied, verify that all claim fields are filled out properly with the use of the CMS-1500 Claim Form Instructions located on the Billing Information webpage. If you believe the claim was submitted correctly with valid information and the claim was denied in error, you may appeal the denied claim.
Edit 0967: Procedure Code not Payable with Diagnosis Entered

This Edit Code sets when a claim is submitted to Nevada Medicaid with a HCPCS Code in the T series/range and the Diagnosis Code is not valid. If billing with a HCPCS Code in the T series/range, Diagnosis Codes should be 30011, 307.6, 307.7, 599.84, 625.6, 787.6 or in the range of 788.00-788.99.

If the claim is still being denied, verify that all claim fields are filled out properly with the use of the CMS-1500 Claim Form Instructions located on the Billing Information webpage. If you believe the claim was submitted correctly with valid information and the claim was denied in error, you may appeal the denied claim.
Resources
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:
Contact Form: http://dhcfp.nv.gov/Contact/ContactUsForm/
Contact Nevada Medicaid
Contact Us — Nevada Medicaid Customer Service

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

Prior Authorization Department: 800-525-2395

Provider Field Representative:
E-mail: NevadaProviderTraining@dxc.com
Thank You