Hospice Provider Training

Provider Types: 64 and 65

Objectives

Objectives

- Understand changes to the Nevada Medicaid Services Manual Chapter 3200
- Understand how to complete new Hospice Prior Authorization Request form (FA-95)
- Identify common mistakes of additional forms and successfully complete all forms
- Properly navigate EVS Web Portal
- Understand how to submit Prior Authorization requests via the Web Portal

Policy Changes

Policy Changes

New Policy effective February 23, 2017

- Reference Chapter 3200 of the Medicaid Services Manual (MSM)
  - Section 3206.6 for Prior Authorization Information
- Updated language to better coincide with the Code of Federal Regulations
- Conditions of Participation for Non-Cancer Terminal Illness
- Clarify criteria for pediatric hospice recipients

Policy Changes for Prior Authorization for Hospice Services

- The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the Quality Improvement Organization (QIO)-like vendor (DXC Technology, which is referred to as Nevada Medicaid) and prior authorization has been obtained. It is the responsibility of the hospice provider to ensure that prior authorization has been obtained for services unrelated to the hospice benefit. Authorization requests for admission to Hospice services must be submitted as soon as possible, but not more than eight business days following admission.

- Please note: if the authorization request is submitted after admission, the Hospice provider is assuming responsibility for program costs if the authorization request is denied. Prior authorization only approves the existence of medical necessity, not recipient eligibility.

Policy Changes for Prior Authorization for Extended Hospice Care

- Medicaid hospice benefits are reserved for terminally ill recipients who have a medical prognosis to live no more than six months if the illness runs its normal course.

- When an adult recipient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the recipient continues to receive extended hospice care. Hospice agencies should advise recipients of this requirement and provide the “Nevada Medicaid Independent Physician Review for Extended Care” form to take with them to each independent review.
  - Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the recipient does not continue to meet program eligibility requirements.

- The following medical professionals may conduct the Independent Physician Review:
  1. Physician (MD)
  2. Doctor of Osteopathic Medicine (D.O.)
  3. Physician’s Assistant (PA)
  4. Advanced Practice Registered Nurse (APRN)

Policy Changes for Prior Authorization for extended Hospice Care, continued

- The Independent Physician Review can occur at a physician's office or at the recipient's place of residence, whether it be a private home or a nursing facility.

- The review must be completed no sooner than 30 days before the end of the recipient's 12-month certification period.

- In cases when the independent physician reviewer claims the recipient should no longer be appropriate for hospice services, the hospice provider will be notified. The hospice physician has seven days to submit a narrative update on the recipient to staff at the DHCFP Long Term Services and Supports (LTSS) unit for further review.

- The Independent Physician review is not required for dual-eligible recipients.

- Due to concurrent care allowed for the pediatric recipient of hospice services, the Independent Physician Review is required for the pediatric hospice recipient who has elected not to pursue curative treatment.

Policy Changes for Non-Cancer Terminal Illness

Please review MSM Chapter 3200 Section 3209.1 (Non-Cancer Terminal Illnesses) for guidance on the following:

- Adult Failure to Thrive Syndrome
- Adult HIV Disease
- Adult Pulmonary Disease
- Adult Alzheimer’s disease, Dementia & Related Disorders
- Adult Stroke and/or Coma
- Adult Amyotrophic Lateral Sclerosis (ALS)
- Adult Heart Disease
- Adult Liver Disease
- Adult Renal Disease

Policy Changes for clarification of pediatric hospice recipients

- Pediatric hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with terminal illnesses and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth, planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center.

- Recipients under the age of 21 are entitled to concurrent care under the Affordable Care Act (ACA); that is curative care and palliative care at the same time while an eligible recipient of the Medicaid Hospice Program, and shall not constitute a waiver of any rights of the child to be provided with, or to have payment made for services that are related to the treatment of the child's terminal illness.

- Upon turning 21 years of age, the recipient will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care. Upon turning 21 years of age, the recipient must sign a Nevada Medicaid Hospice Program Election Notice -Adult (FA-93), continuing in the certification period currently in place.

New Hospice Prior Authorization Request Form (FA-95)

Hospice Prior Authorization Request Form (FA-95)

Reminders:

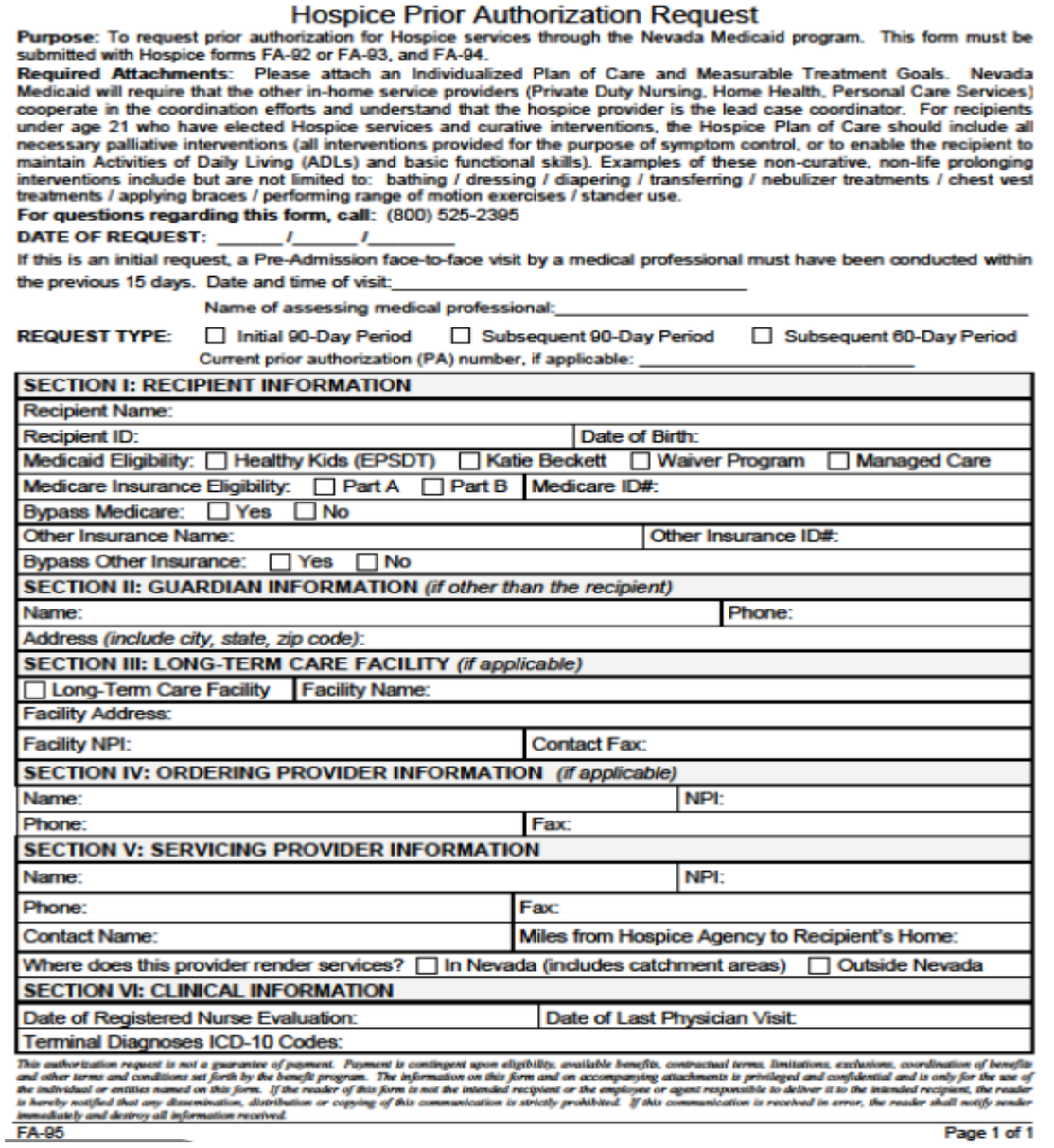
- Sections I, II, IV, V, VI, date of request and request type must be fully completed
- Section III should be completed only if the recipient is in a nursing facility

Required Attachments:

- Individualized Plan of Care and Measurable Treatment Goals
- FA-92 Hospice Program Election Notice (Adult) or FA-93 Hospice Program Election Notice (Pediatric)
- FA-94 Hospice Program Physician Certification of Terminal Illness (CTI)
- For subsequent benefit periods: Labs, assessments, documented decline (or improvement) of recipient health, mandating further hospice care.

Hospice Prior Authorization Request Form (FA-95)

If any information on the prior authorization request form is missing, the request will be pended back to the provider. The provider will need to update the information and resubmit within 5 days.



Hospice Prior Authorization Request

Purpose: To request prior authorization for Hospice services through the Nevada Medicaid program. This form must be submitted with Hospice forms FA-92 or FA-93, and FA-94.

Required Attachments: Please attach an Individualized Plan of Care and Measurable Treatment Goals. Nevada Medicaid will require that the other in-home service providers (Private Duty Nursing, Home Health, Personal Care Services) cooperate in the coordination efforts and understand that the hospice provider is the lead case coordinator. For recipients under age 21 who have elected Hospice services and curative interventions, the Hospice Plan of Care should include all necessary palliative interventions (all interventions provided for the purpose of symptom control, or to enable the recipient to maintain Activities of Daily Living (ADLs) and basic functional skills). Examples of these non-curative, non-life prolonging interventions include but are not limited to: bathing / dressing / diapering / transferring / nebulizer treatments / chest vest treatments / applying braces / performing range of motion exercises / stander use.

For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____/_____/_____

If this is an initial request, a Pre-Admission face-to-face visit by a medical professional must have been conducted within the previous 15 days. Date and time of visit:_____

Name of assessing medical professional:_____

REQUEST TYPE: ☐ Initial 90-Day Period ☐ Subsequent 90-Day Period ☐ Subsequent 60-Day Period

Current prior authorization (PA) number, if applicable: _____

SECTION I: RECIPIENT INFORMATION
Recipient Name:
Recipient ID: | Date of Birth:
Medicaid Eligibility: ☐ Healthy Kids (EPSDT) ☐ Katie Beckett ☐ Waiver Program ☐ Managed Care
Medicare Insurance Eligibility: ☐ Part A ☐ Part B | Medicare ID#:
Bypass Medicare: ☐ Yes ☐ No
Other Insurance Name: | Other Insurance ID#:
Bypass Other Insurance: ☐ Yes ☐ No
SECTION II: GUARDIAN INFORMATION *(if other than the recipient)*
Name: | Phone:
Address *(include city, state, zip code)*:
SECTION III: LONG-TERM CARE FACILITY *(if applicable)*
☐ Long-Term Care Facility | Facility Name:
Facility Address:
Facility NPI: | Contact Fax:
SECTION IV: ORDERING PROVIDER INFORMATION *(if applicable)*
Name: | NPI:
Phone: | Fax:
SECTION V: SERVICING PROVIDER INFORMATION
Name: | NPI:
Phone: | Fax:
Contact Name: | Miles from Hospice Agency to Recipient's Home:
Where does this provider render services? ☐ In Nevada (includes catchment areas) ☐ Outside Nevada
SECTION VI: CLINICAL INFORMATION
Date of Registered Nurse Evaluation: | Date of Last Physician Visit:
Terminal Diagnoses ICD-10 Codes:

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

FA-95 Page 1 of 1

New Hospice Extended Care
Physician Review Form (FA-96)

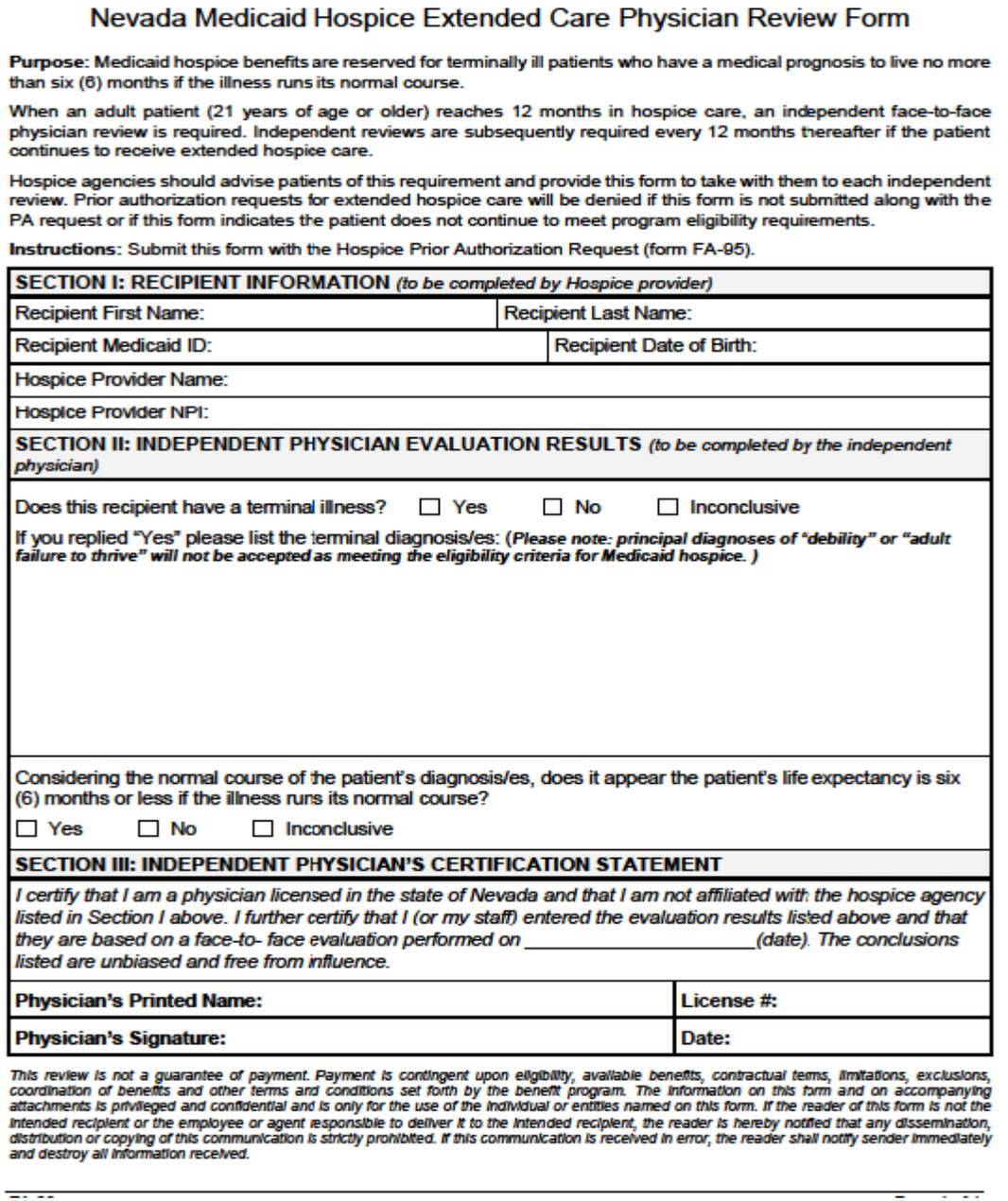
Hospice Extended Care Physician Review Form (FA-96)

- When an adult recipient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required.

- If any information on the form is missing, the request will be pended back to the provider. The provider will need to update the information and resubmit within 5 days.

Required Attachments:

- FA-95 Hospice Prior Authorization Request Form



Nevada Medicaid Hospice Extended Care Physician Review Form

Purpose: Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care.

Hospice agencies should advise patients of this requirement and provide this form to take with them to each independent review. Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

Instructions: Submit this form with the Hospice Prior Authorization Request (form FA-95).

SECTION I: RECIPIENT INFORMATION *(to be completed by Hospice provider)*	
Recipient First Name:	Recipient Last Name:
Recipient Medicaid ID:	Recipient Date of Birth:
Hospice Provider Name:	
Hospice Provider NPI:	

SECTION II: INDEPENDENT PHYSICIAN EVALUATION RESULTS *(to be completed by the independent physician)*

Does this recipient have a terminal illness? ☐ Yes ☐ No ☐ Inconclusive

If you replied "Yes" please list the terminal diagnosis/es: (***Please note: principal diagnoses of "debility" or "adult failure to thrive" will not be accepted as meeting the eligibility criteria for Medicaid hospice.)***

Considering the normal course of the patient's diagnosis/es, does it appear the patient's life expectancy is six (6) months or less if the illness runs its normal course?

☐ Yes ☐ No ☐ Inconclusive

SECTION III: INDEPENDENT PHYSICIAN'S CERTIFICATION STATEMENT

I certify that I am a physician licensed in the state of Nevada and that I am not affiliated with the hospice agency listed in Section I above. I further certify that I (or my staff) entered the evaluation results listed above and that they are based on a face-to- face evaluation performed on _____(date). The conclusions listed are unbiased and free from influence.

Physician's Printed Name:	**License #:**
Physician's Signature:	**Date:**

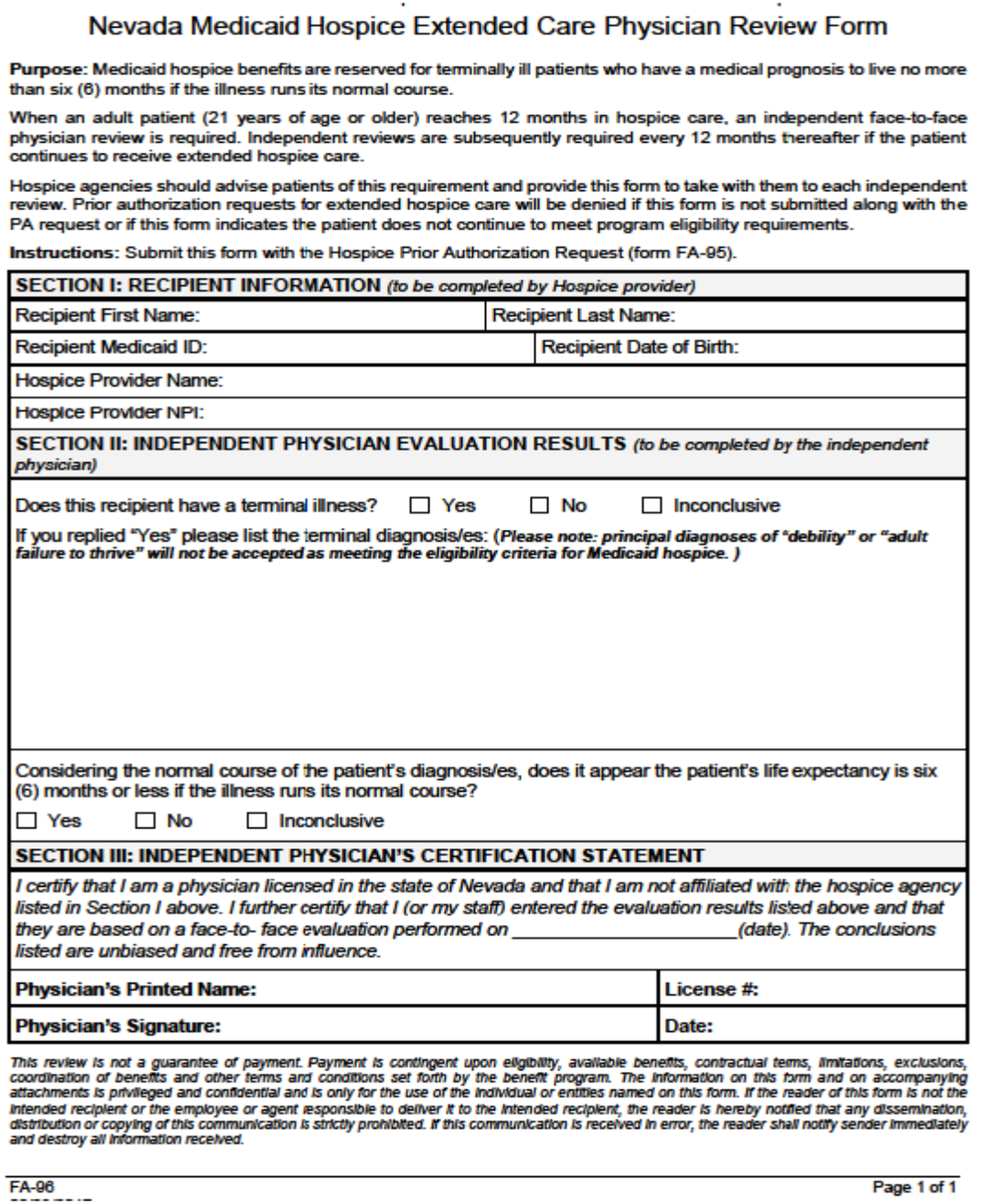
This review is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is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

Hospice Program Action Form
Nevada Medicaid
(FA-91)

Hospice Program Action Form (FA-91)

Reminders:

- Each section must be filled out according to the purpose of the form.
- Must indicate Purpose of Request: Discharge from Hospice Services (includes recipient death), Change of Hospice Provider or Revocation of Hospice Services
- This form must be signed and dated by the recipient or legal representative/DPOA
- The Hospice provider representative must also sign and date accordingly
- Please do not forget:
  - Discharge Date
  - Requesting provider NPI
  - Recipient/Responsible Party signature
  - Recipient ID number



Nevada Medicaid Hospice Extended Care Physician Review Form

Purpose: Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care.

Hospice agencies should advise patients of this requirement and provide this form to take with them to each independent review. Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

Instructions: Submit this form with the Hospice Prior Authorization Request (form FA-95).

SECTION I: RECIPIENT INFORMATION *(to be completed by Hospice provider)*	
Recipient First Name:	Recipient Last Name:
Recipient Medicaid ID:	Recipient Date of Birth:
Hospice Provider Name:	
Hospice Provider NPI:	

SECTION II: INDEPENDENT PHYSICIAN EVALUATION RESULTS *(to be completed by the independent physician)*

Does this recipient have a terminal illness? ☐ Yes ☐ No ☐ Inconclusive

If you replied "Yes" please list the terminal diagnosis/es: (***Please note: principal diagnoses of "debility" or "adult failure to thrive" will not be accepted as meeting the eligibility criteria for Medicaid hospice.***)

Considering the normal course of the patient's diagnosis/es, does it appear the patient's life expectancy is six (6) months or less if the illness runs its normal course?

☐ Yes ☐ No ☐ Inconclusive

SECTION III: INDEPENDENT PHYSICIAN'S CERTIFICATION STATEMENT

I certify that I am a physician licensed in the state of Nevada and that I am not affiliated with the hospice agency listed in Section I above. I further certify that I (or my staff) entered the evaluation results listed above and that they are based on a face-to- face evaluation performed on _____(date). The conclusions listed are unbiased and free from influence.

Physician's Printed Name:	**License #:**
Physician's Signature:	**Date:**

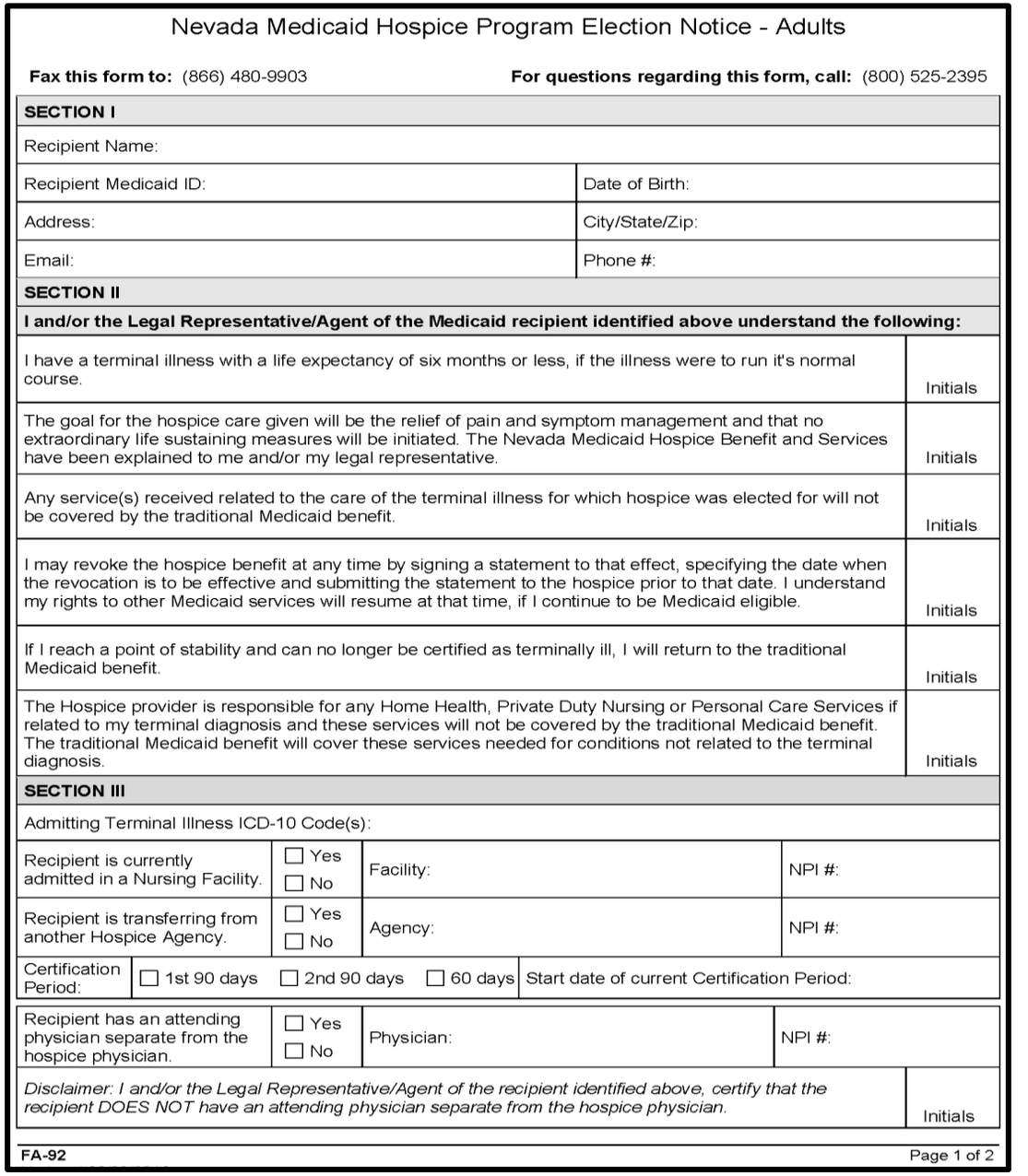
This review is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is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

FA-96 Page 1 of 1

Nevada Medicaid Hospice Program Election Notice – Adults (FA-92)

Hospice Program Election Notice –Adults (FA-92 Form)

- Be sure to use this required form. Nevada Medicaid will return requests to provider when old forms are submitted.
- Sections I, II, III and IV must be filled out completely.
- This form must be signed and dated by the recipient or legal representative/DPOA and Hospice representative.
- The original notice of election can be resubmitted for all subsequent PA/benefit periods. Recipient/responsible party/hospice representative does not need to sign a new FA-92 for each certification period. Be clear on the benefit period being requested.



Nevada Medicaid Hospice Program Election Notice - Adults

Fax this form to: (866) 480-9903 **For questions regarding this form, call:** (800) 525-2395

SECTION I	
Recipient Name:	
Recipient Medicaid ID:	Date of Birth:
Address:	City/State/Zip:
Email:	Phone #:

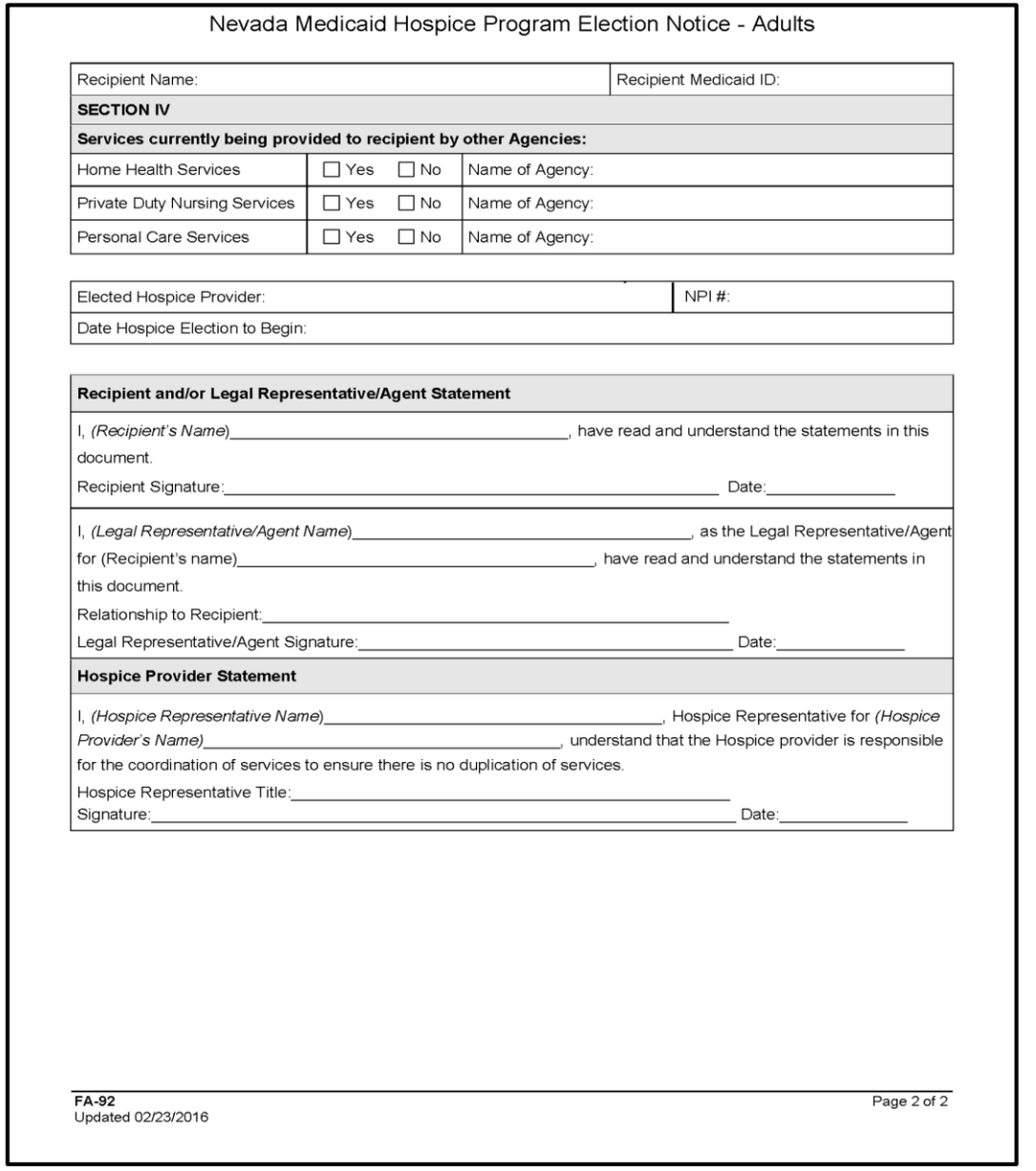
SECTION II	
I and/or the Legal Representative/Agent of the Medicaid recipient identified above understand the following:	
I have a terminal illness with a life expectancy of six months or less, if the illness were to run it's normal course.	Initials
The goal for the hospice care given will be the relief of pain and symptom management and that no extraordinary life sustaining measures will be initiated. The Nevada Medicaid Hospice Benefit and Services have been explained to me and/or my legal representative.	Initials
Any service(s) received related to the care of the terminal illness for which hospice was elected for will not be covered by the traditional Medicaid benefit.	Initials
I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date. I understand my rights to other Medicaid services will resume at that time, if I continue to be Medicaid eligible.	Initials
If I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medicaid benefit.	Initials
The Hospice provider is responsible for any Home Health, Private Duty Nursing or Personal Care Services if related to my terminal diagnosis and these services will not be covered by the traditional Medicaid benefit. The traditional Medicaid benefit will cover these services needed for conditions not related to the terminal diagnosis.	Initials

SECTION III			
Admitting Terminal Illness ICD-10 Code(s):			
Recipient is currently admitted in a Nursing Facility.	☐ Yes ☐ No	Facility:	NPI #:
Recipient is transferring from another Hospice Agency.	☐ Yes ☐ No	Agency:	NPI #:
Certification Period:	☐ 1st 90 days ☐ 2nd 90 days ☐ 60 days	Start date of current Certification Period:	
Recipient has an attending physician separate from the hospice physician.	☐ Yes ☐ No	Physician:	NPI #:
Disclaimer: I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician.			Initials

FA-92 Page 1 of 2

Hospice Program Election Notice – Adults (FA-92)

- Section I: Recipient information (ID, name, date of birth)
- Section II: Initials
- Section III: LTC information (if the nursing facility box is checked, include LTC name and NPI)
- Section III: Transfer from another agency information
- Section III: Certification period designation or start date of hospice service
- Section IV: Elected hospice provider and NPI, date to begin
- Section IV: Names and signatures



Nevada Medicaid Hospice Program Election Notice - Adults

Recipient Name:		Recipient Medicaid ID:
SECTION IV		
Services currently being provided to recipient by other Agencies:		
Home Health Services	☐ Yes ☐ No	Name of Agency:
Private Duty Nursing Services	☐ Yes ☐ No	Name of Agency:
Personal Care Services	☐ Yes ☐ No	Name of Agency:

Elected Hospice Provider:	NPI #:
Date Hospice Election to Begin:	

Recipient and/or Legal Representative/Agent Statement

I, *(Recipient's Name)*_____, have read and understand the statements in this document.

Recipient Signature:_____ Date:_____

I, *(Legal Representative/Agent Name)*_____, as the Legal Representative/Agent for (Recipient's name)_____, have read and understand the statements in this document.

Relationship to Recipient:_____

Legal Representative/Agent Signature:_____ Date:_____

Hospice Provider Statement

I, *(Hospice Representative Name)*_____, Hospice Representative for *(Hospice Provider's Name)*_____, understand that the Hospice provider is responsible for the coordination of services to ensure there is no duplication of services.

Hospice Representative Title:_____

Signature:_____ Date:_____

FA-92
Updated 02/23/2016

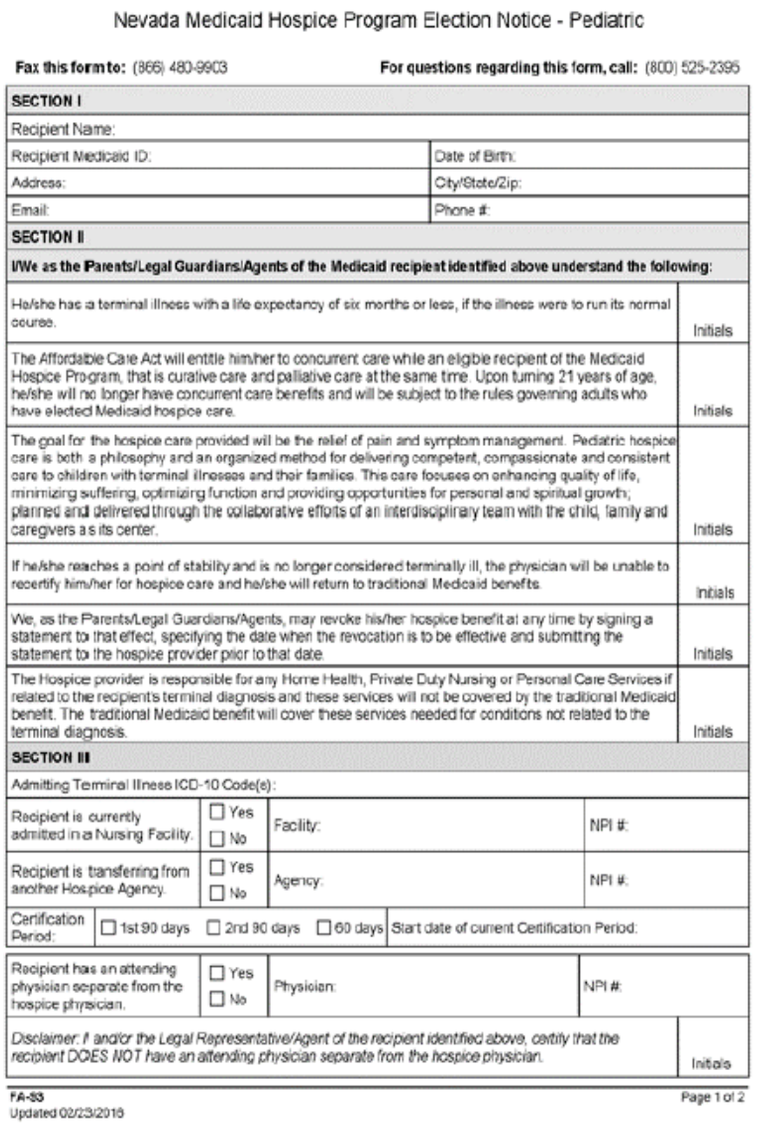
Page 2 of 2

Nevada Medicaid Hospice Program Election Notice – Pediatric (FA-93)

Hospice Program Election Notice -Pediatric (FA-93)

Reminders:

- Be sure to use this required form. Nevada Medicaid will cancel requests back to provider when old forms are submitted
- Sections I, II, III and IV must be filled out completely.
- This form *must* be signed and dated by the recipient or legal representative/DPOA and Hospice Representative
- Section IV: Services currently being provided to recipient by other agencies must be entered



Nevada Medicaid Hospice Program Election Notice - Pediatric

Fax this form to: (866) 480-9903 **For questions regarding this form, call:** (800) 525-2395

SECTION I	
Recipient Name:	
Recipient Medicaid ID:	Date of Birth:
Address:	City/State/Zip:
Email:	Phone #:

SECTION II	
I/We as the Parents/Legal Guardians/Agents of the Medicaid recipient identified above understand the following:	
He/she has a terminal illness with a life expectancy of six months or less, if the illness were to run its normal course.	Initials
The Affordable Care Act will entitle him/her to concurrent care while an eligible recipient of the Medicaid Hospice Program, that is curative care and palliative care at the same time. Upon turning 21 years of age, he/she will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care.	Initials
The goal for the hospice care provided will be the relief of pain and symptom management. Pediatric hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with terminal illnesses and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth; planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center.	Initials
If he/she reaches a point of stability and is no longer considered terminally ill, the physician will be unable to recertify him/her for hospice care and he/she will return to traditional Medicaid benefits.	Initials
We, as the Parents/Legal Guardians/Agents, may revoke his/her hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice provider prior to that date.	Initials
The Hospice provider is responsible for any Home Health, Private Duty Nursing or Personal Care Services if related to the recipient's terminal diagnosis and these services will not be covered by the traditional Medicaid benefit. The traditional Medicaid benefit will cover these services needed for conditions not related to the terminal diagnosis.	Initials

SECTION III			
Admitting Terminal Illness ICD-10 Code(s):			
Recipient is currently admitted in a Nursing Facility.	☐ Yes ☐ No	Facility:	NPI #:
Recipient is transferring from another Hospice Agency.	☐ Yes ☐ No	Agency:	NPI #:
Certification Period:	☐ 1st 90 days ☐ 2nd 90 days ☐ 60 days	Start date of current Certification Period:	
Recipient has an attending physician separate from the hospice physician.	☐ Yes ☐ No	Physician:	NPI #:
Disclaimer: I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician.			Initials

FA-93
Updated 02/23/2016
Page 1 of 2

Nevada Medicaid Hospice Program Election Notice - Pediatric

Recipient Name:	Recipient Medicaid ID:

SECTION IV			
Services currently being provided to recipient by other Agencies:			
Home Health Services	☐ Yes ☐ No	Name of Agency:	
Private Duty Nursing Services	☐ Yes ☐ No	Name of Agency:	
Personal Care Services	☐ Yes ☐ No	Name of Agency:	

Elected Hospice Provider:	NPI #:
Date Hospice Election to Begin:	

Recipient and/or Legal Representative/Agent Statement

I, *(Recipient's Name)*_____ have read and understand the statements in this document.

Recipient Signature:_____ Date:_____

I, *(Legal Representative/Agent Name)*_____, as the Legal Representative/Agent for (Recipient's name)_____, have read and understand the statements in this document.

Relationship to Recipient:_____

Legal Representative/Agent Signature:_____ Date:_____

Hospice Provider Statement

I, *(Hospice Representative Name)*_____, Hospice Representative for *(Hospice Provider's Name)*_____, understand that the Hospice provider is responsible for the coordination of services to ensure there is no duplication of services.

Hospice Representative Title:_____

Signature:_____ Date:_____

FA-93
Updated 02/23/2016
Page 2 of 2

Nevada Medicaid Hospice Program
Physician Certification of Terminal Illness
(FA-94)

FA-94 - Physician Certification of Illness

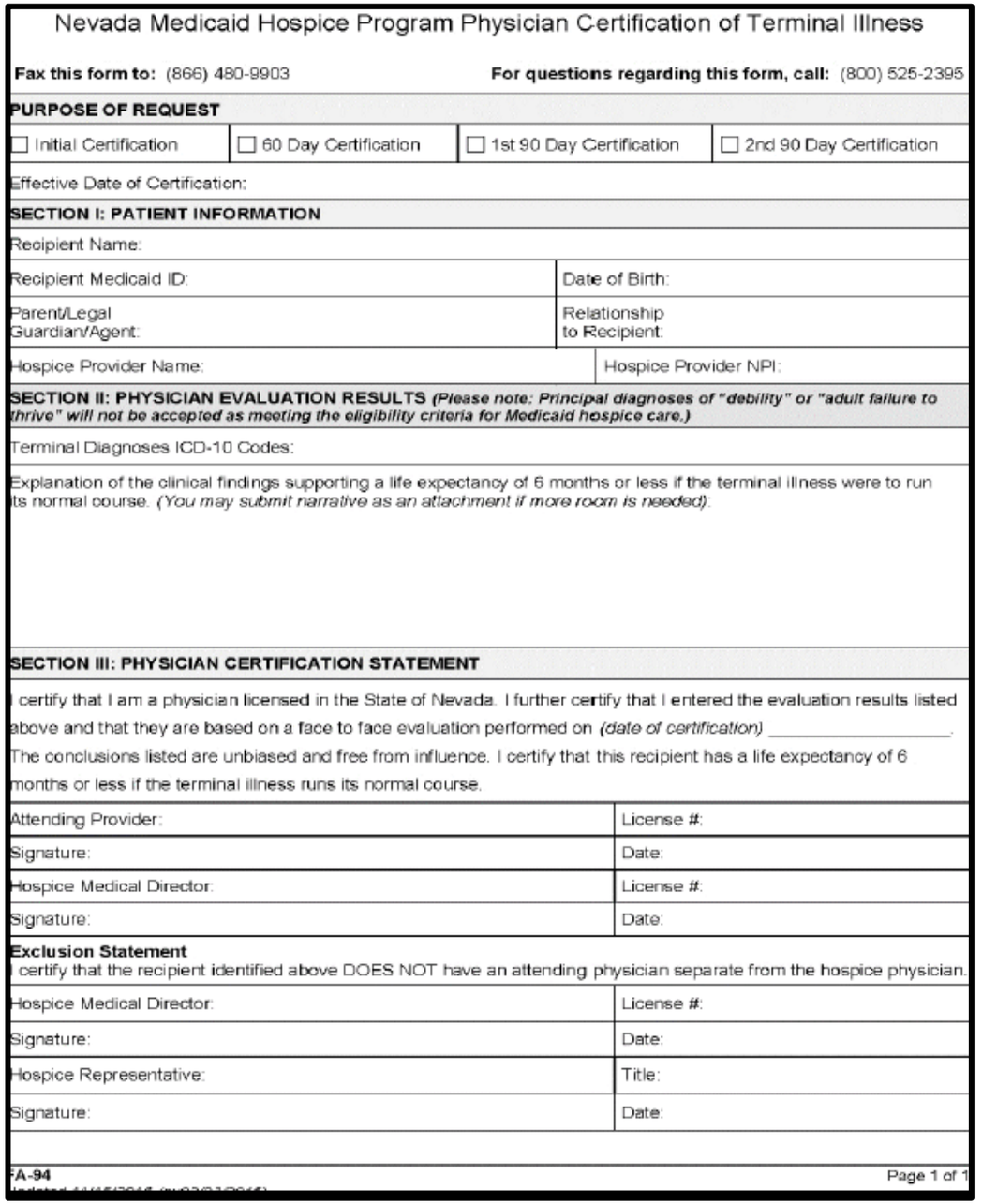
This form must indicate the Purpose of Request (Initial Certification, 60 Day Certification, 1st 90 Day Certification or 2nd 90 day or Subsequent Certification) and the Effective Date of Certification

- **Sections I, II and III:** Must be filled out completely if not completed the prior authorization will be pended for five business days requesting additional information.

- **Section II, PHYSICIAN EVALUATION RESULTS:** Must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and re-certification.

- **Section III PHYSICIAN CERTIFICATION STATEMENT:** The face-to-face encounter must occur no more than 30 calendar days prior to the 180th day benefit period recertification and no more than 30 calendar days prior to every subsequent recertification thereafter.

- Must include Attending Provider license #, signature and date. If no attending provider, then Exclusion Statement must be signed and dated by Hospice Medical Director and Hospice Representative.



Nevada Medicaid Hospice Program Physician Certification of Terminal Illness

Fax this form to: (866) 480-9903 **For questions regarding this form, call:** (800) 525-2395

PURPOSE OF REQUEST

☐ Initial Certification ☐ 60 Day Certification ☐ 1st 90 Day Certification ☐ 2nd 90 Day Certification

Effective Date of Certification:

SECTION I: PATIENT INFORMATION

Recipient Name:

Recipient Medicaid ID: | Date of Birth:

Parent/Legal Guardian/Agent: | Relationship to Recipient:

Hospice Provider Name: | Hospice Provider NPI:

SECTION II: PHYSICIAN EVALUATION RESULTS ***(Please note: Principal diagnoses of "debility" or "adult failure to thrive" will not be accepted as meeting the eligibility criteria for Medicaid hospice care.)***

Terminal Diagnoses ICD-10 Codes:

Explanation of the clinical findings supporting a life expectancy of 6 months or less if the terminal illness were to run its normal course. *(You may submit narrative as an attachment if more room is needed).*

SECTION III: PHYSICIAN CERTIFICATION STATEMENT

I certify that I am a physician licensed in the State of Nevada. I further certify that I entered the evaluation results listed above and that they are based on a face to face evaluation performed on *(date of certification)* _____. The conclusions listed are unbiased and free from influence. I certify that this recipient has a life expectancy of 6 months or less if the terminal illness runs its normal course.

Attending Provider: | License #:

Signature: | Date:

Hospice Medical Director: | License #:

Signature: | Date:

Exclusion Statement

I certify that the recipient identified above DOES NOT have an attending physician separate from the hospice physician.

Hospice Medical Director: | License #:

Signature: | Date:

Hospice Representative: | Title:

Signature: | Date:

FA-94 Page 1 of 1

FA-94 Physician Certification of Illness, continued

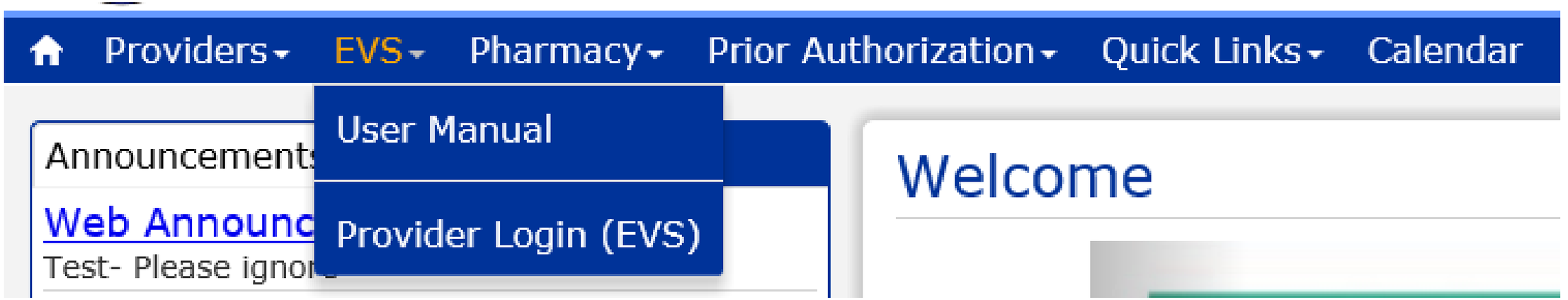
- **Purpose of recertification and start date**
  - Needs to be checked and date listed. If certification period requested does not correspond with Medicaid service history (recipient has already received hospice and new provider is asking for 1st 90 days), prior authorization will be pended for five business days requesting additional information.
- **Section I Patient Information**
  - If the request is missing information, such as hospice name and National Provider Identifier (NPI), prior authorization will be pended for five business days requesting additional information.
- **Section II Physician Evaluation Results**
  - If FA-94 is not completed as required, and agency CTI with detailed information NOT attached, prior authorization request will be pended for five business days requesting additional information.
- **Section III Physician Certification Statement**
  - One of the two physicians (attending or hospice medical director) have to timely sign and date the FA-94 within two calendar days of initiation of care. If a signature cannot be obtained, a verbal order must be obtained within this two calendar day timeframe and a written order obtained no later than eight calendar days after care is initiated. If not signed within eight calendar days, only the signature date forward will be considered allowable days.
  - If agency CTI is signed/authenticated timely, but provider did not sign FA-94 timely, the prior authorization will be pended for five business days requesting additional information.

Prior Authorization (PA) Submission

How to submit a PA via the Web Portal

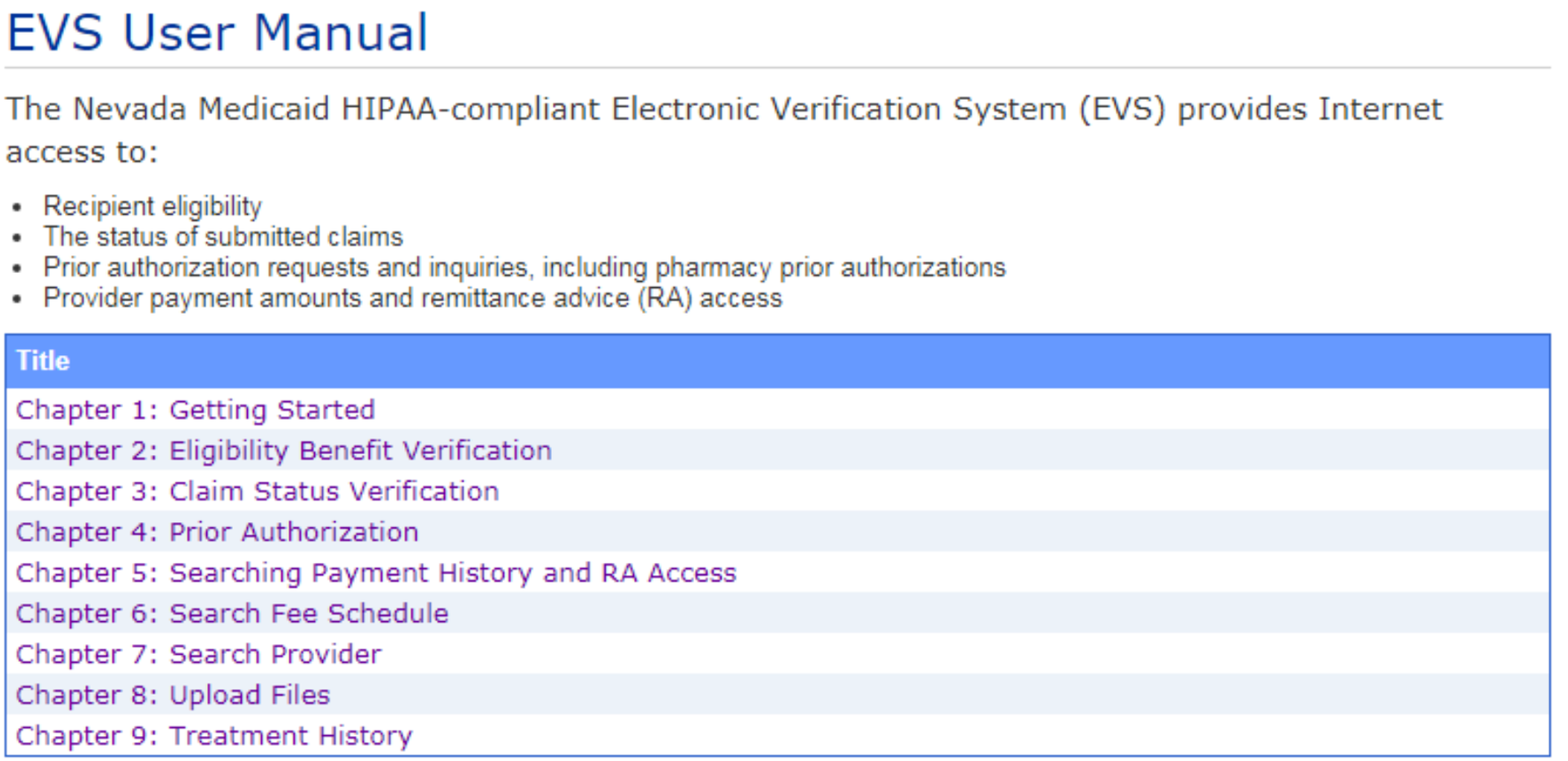
Accessing the Provider Web Portal EVS System

- Navigate to Provider Web Portal at www.medicaid.nv.gov
- Select “EVS” tab from blue tool bar at top
- Highlight and select either User Manual or Provider Login (EVS)



Accessing the provider web portal EVS System

Select “User Manual” to access step-by-step instructions concerning the use of the EVS and its benefits



EVS User Manual

The Nevada Medicaid HIPAA-compliant Electronic Verification System (EVS) provides Internet access to:

- Recipient eligibility
- The status of submitted claims
- Prior authorization requests and inquiries, including pharmacy prior authorizations
- Provider payment amounts and remittance advice (RA) access

Title
Chapter 1: Getting Started
Chapter 2: Eligibility Benefit Verification
Chapter 3: Claim Status Verification
Chapter 4: Prior Authorization
Chapter 5: Searching Payment History and RA Access
Chapter 6: Search Fee Schedule
Chapter 7: Search Provider
Chapter 8: Upload Files
Chapter 9: Treatment History

Accessing the provider web portal EVS System

Select “Provider Login (EVS)” to bring up *secure* web portal for providers

Tips Before You Begin

- When submitting the Prior Authorization via the secure web portal, fill out all necessary forms and save them to your computer in a folder that is easily accessible so that the forms can be attached onto the Prior Authorization
- Be sure that you save the forms with the required signatures.

Remember the forms to submit are:

- FA-92 or FA 93 Hospice Program Election Notice – Adult or Pediatric
- FA-94 – Hospice Program Physician Certification of Terminal Illness
- FA-95 – Hospice Prior Authorization Request Form
- FA-96 – Extended Care Physician Review Form

Please note, your current paperwork submission for prior authorization will no longer be accepted via fax as of April 1, 2017.

Secure Web Portal

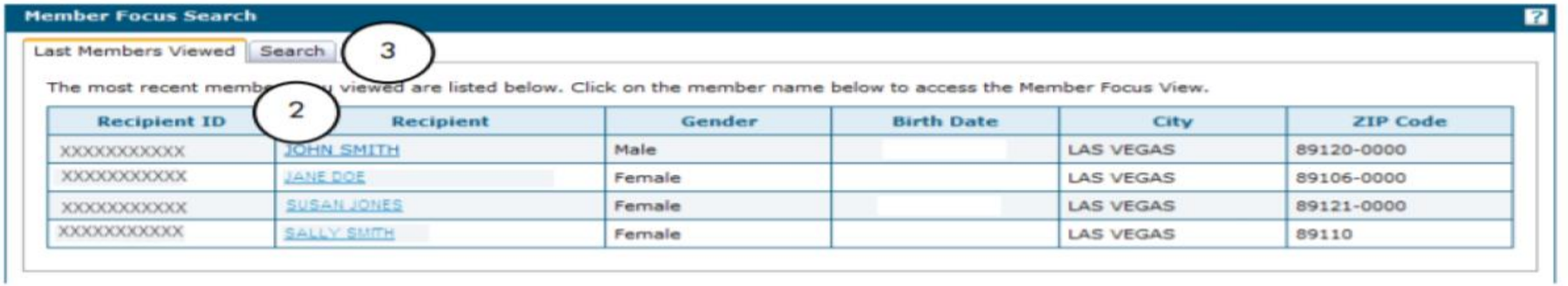
Secure Web Portal – Eligibility Information

The **Member Focus Search** page displays two tabs. If you have previously viewed members, the **Last Member Viewed** tab displays up to the last 10 searches. If no members have been previously viewed, then only the **Search** tab displays. Selection of an individual member from either tab displays the Member In Focus bar at the top of the page, and summary information below, including their recent activity.

2. Click the name that is listed on the **Member Focus Search** screen.

-OR-

3. Click the **Search** tab and enter in required information.

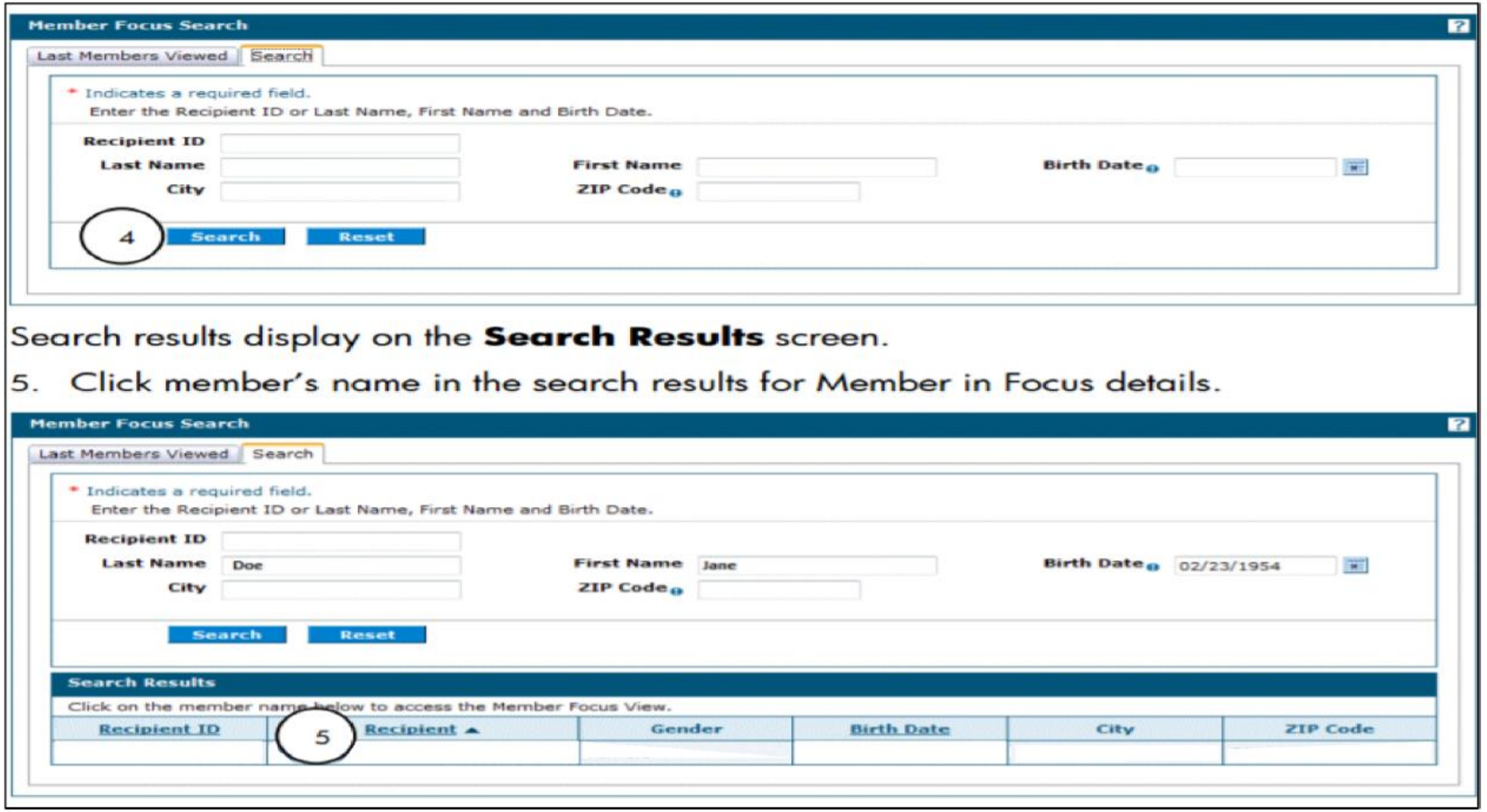


Recipient ID	Recipient	Gender	Birth Date	City	ZIP Code
XXXXXXXXXX	JOHN SMITH	Male		LAS VEGAS	89120-0000
XXXXXXXXXX	JANE DOE	Female		LAS VEGAS	89106-0000
XXXXXXXXXX	SUSAN JONES	Female		LAS VEGAS	89121-0000
XXXXXXXXXX	SALLY SMITH	Female		LAS VEGAS	89110

The **Search** tab allows you to search for members and select a member to view. When searching for members, you must enter complete information. Partial information will not generate a search.

✍ *To avoid generating a large number of search results, you should enter as much information as possible to limit your searches.*

Secure Web Portal – Eligibility Information, continued



Search results display on the **Search Results** screen.

5. Click member's name in the search results for Member in Focus details.

Secure Web Portal – Recipient Information

Member in Focus: MaryPoppins Change ID: 00001234567 Close Member Focus

Other Details

Secure Cnrresaaodeace
Review previously sent messages or send new secure messages.

Member Details

Recipient ID
Name
Birth Date
City
state
Gender
P,ima,y Language

Coverage Details

Eligibility Verification Information for MARY POPPINS from 06/01/2016 to 06/30/2016

Recipient ID 00001234567 Birth Date 01/01/1900

Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS	06/01/11,)16	06/30/2016	0000000000
XIX NF	06/01/11,)16	06/30/2016	12345000000

Other Insurance Detail Information

Your Member Claims

Medical/Dental

There are no claims for this member.

View more claims for this member

Your Member Authorizations

Submit an Authorization

Secure Web Portal – Recipient Information after PA Submission

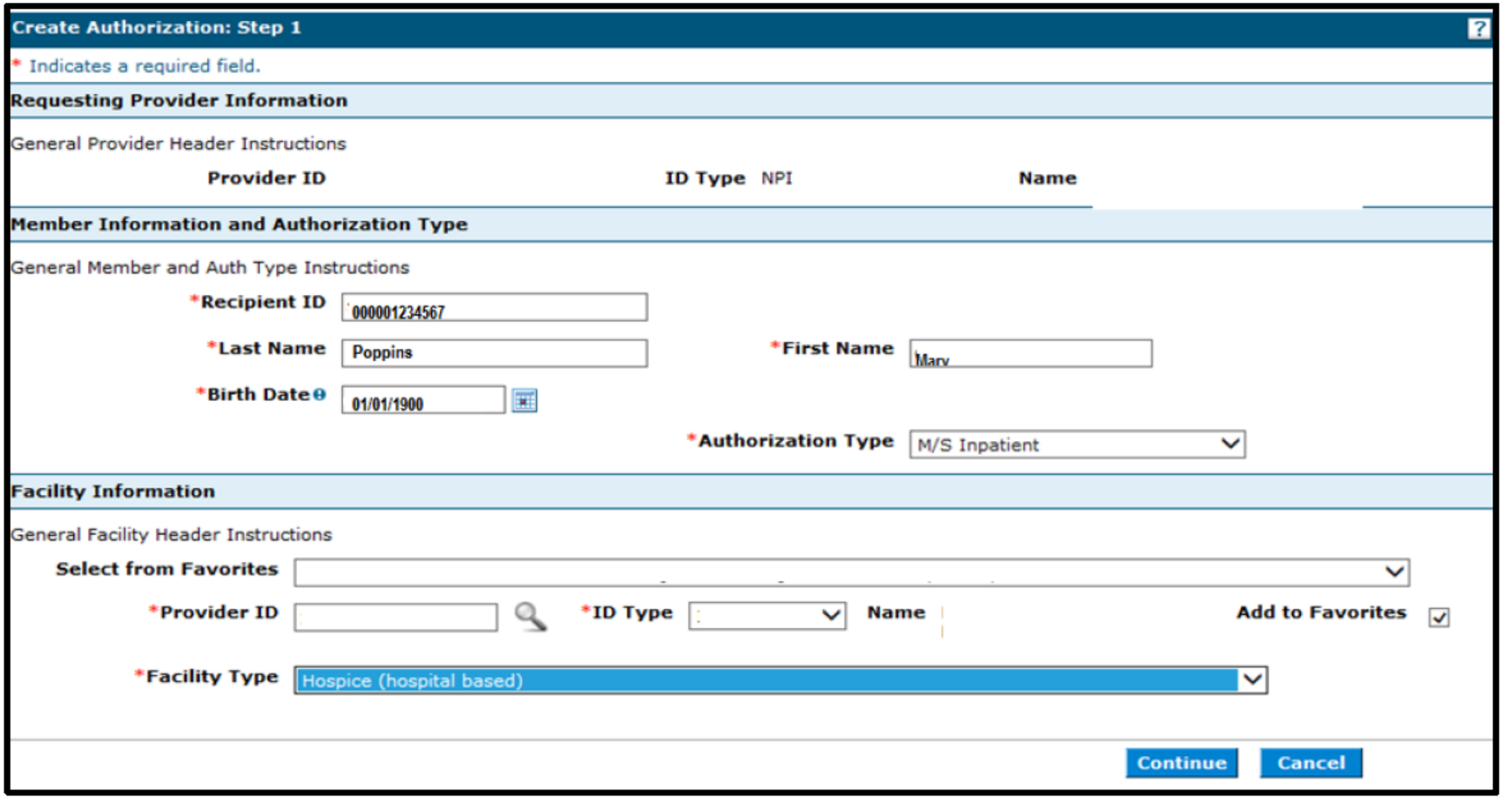
Eligibility Verification Information for Mary Poppins from 09/01/2016 to 09/30/2016

Recipient ID 00001234567 Birth Date 01/01/1900

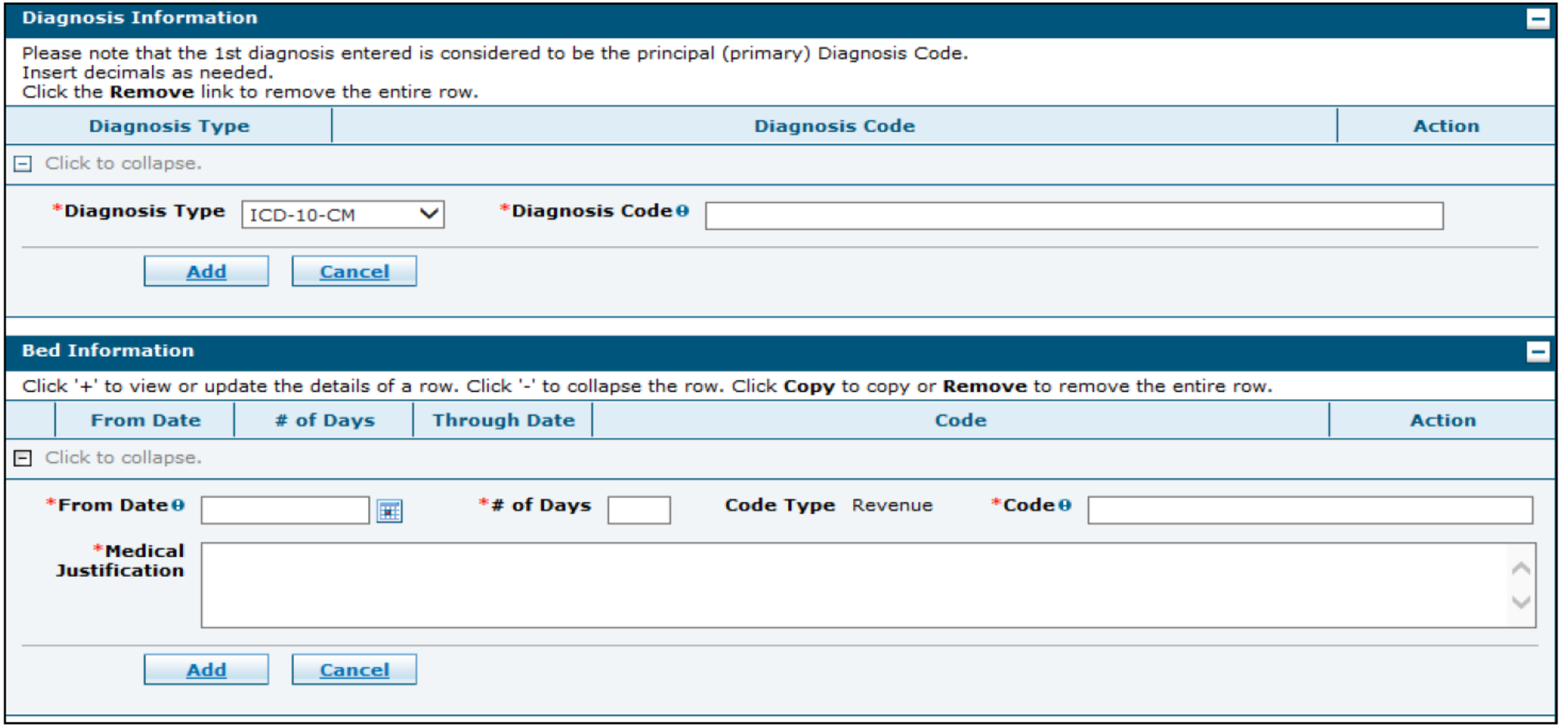
Coverage	Effective Date	End Date	Primary Care Provider
Medicaid FFS	09/01/2016	09/30/2016	0000000000
XIX HOSP SVC	09/15/2016	09/30/2016	0000000000
XIX HOSP R&B	09/15/2016	09/30/2016	0000000000
XIX NF	09/01/2016	09/15/2016	0000000000

Other Insurance Detail Information

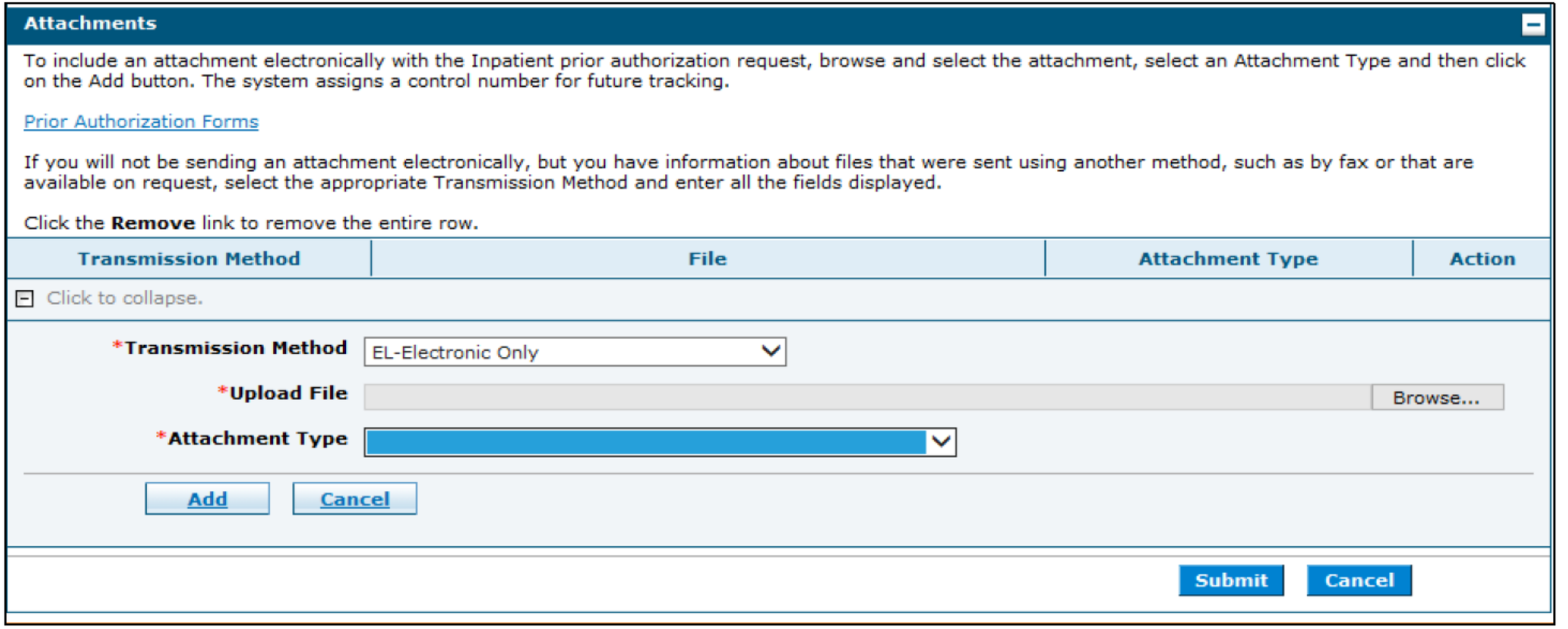
Secure Web Portal – Creating a Prior Authorization



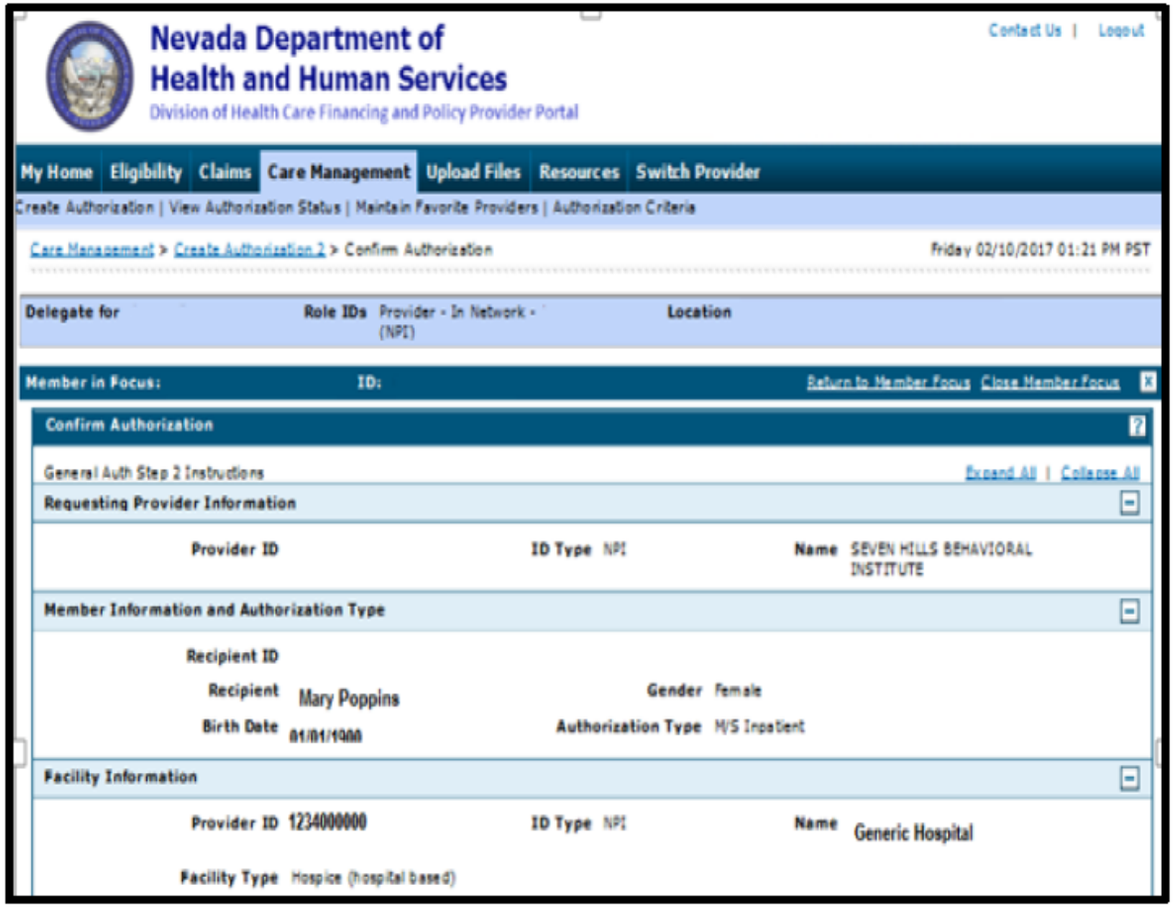
Secure Web Portal – Recipient Diagnosis Information

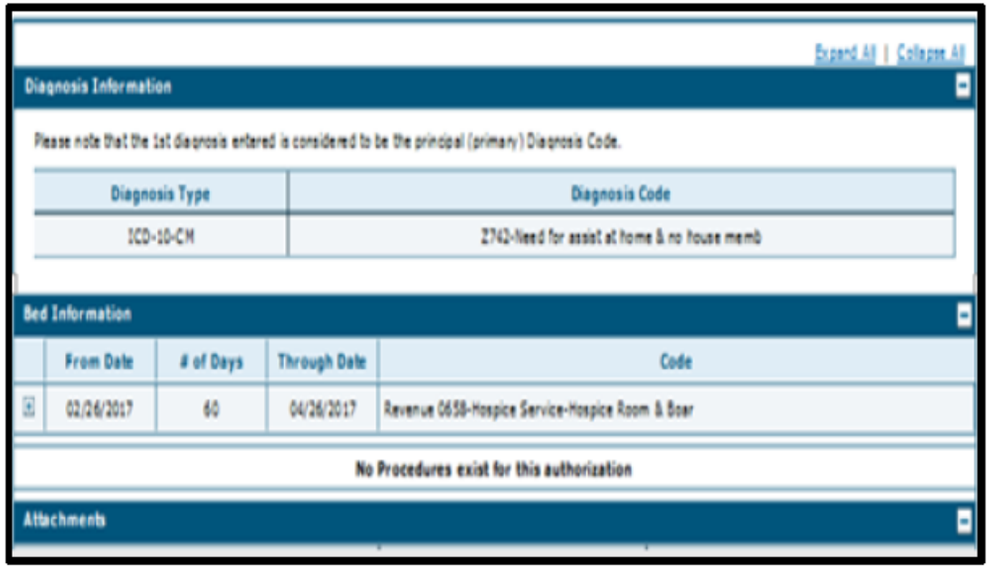


Secure Web Portal – Adding Attachments (Forms)



Secure Web Portal – Confirmation Page

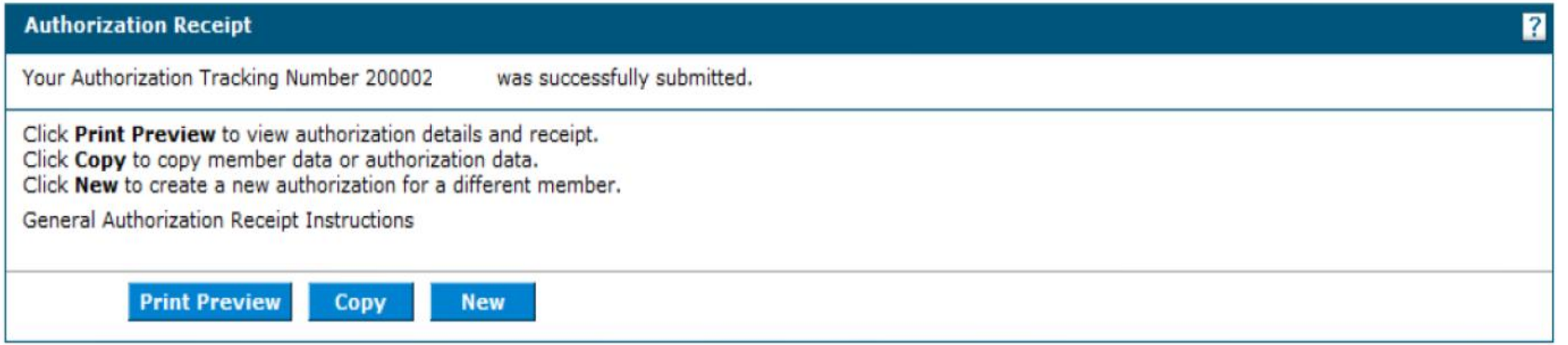




Prior Authorization – Tracking Number

Authorization Receipt Page

The Authorization Receipt page will display the Authorization Tracking number; this number is used to track your authorization in the portal.



Resources

Additional Resources

- For forms, including the new FA-95 form: https://www.medicaid.nv.gov/providers/forms/forms.aspx
- For EVS General Information: https://www.medicaid.nv.gov/providers/evsusermanual.aspx
- For secure EVS Web Portal: https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx
- Chapter 3200 of the Medicaid Services Manual and Fee Schedules located on the DHFCP website: dhcfp.nv.gov
- DHCFP CONTACT INFORMATION:

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Division of Health Care Financing and Policy | Long Term Services & Supports
1100 E. William Street, Suite 222 | Carson City, NV 89701
T: (775) 684-3757 |F: (775) 687-8724 | E: rhoff@dhcfp.nv.gov

Contact Nevada Medicaid

Customer Service

Customer Service Center
Telephone: 877-638-3472

EDI Help Desk
877-638-3472

EDI, option 2, then select option 0 and then select option 3 to speak with an EDI Coordinator

Contact Us — Nevada Medicaid

Prior Authorization

Customer Service Telephone:
877-638-3472

Prior Authorization Telephone:
800-525-2395

Contact Nevada Medicaid

Provider Training — Field Service Representatives

Contact the Provider Training Unit
Team Territories

Upcoming Training Events
2017 Provider Training Registration Website

Provider Services Email Us
NevadaProviderTraining@dxc.com

Onsite training

Virtual instructor-led

Self-paced Web-based course

Thank You