Hospice Provider Training: Provider Types 64 and 65
Objectives
Objectives:

- Locate Medicaid Policy
- Review Policy Updates
- Review Helpful Web Announcements
- Locate and properly fill out Hospice Prior Authorization Forms
- Submit a Prior Authorization via the Electronic Verification System (EVS) secure Provider Web Portal
- Locate Billing Manual
- Locate Hospice Billing Guidelines
- Submit Claims via the EVS secure Provider Web Portal
- Contact Nevada Medicaid
Locating the Medicaid Services Manual

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

- For Hospice policy, select Chapter 3200
  - PT 65 will also utilize Chapter 500

- From the next page, always make sure that the “Current” policy is selected
Policy Information
Policy Information

The information contained in this section is not all encompassing regarding policy. Providers will need to read and understand the entirety of the policy and policy information is subject to change.

- Reference Chapter 3200 of the Medicaid Services Manual (MSM)
- 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 Information, continued

— 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.
— 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 Information, 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 Support (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 Information, continued

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
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.
Web Announcements
Web Announcement 1841

Web Announcement 1841 provides hospice providers with information regarding reviewing recipient eligibility in the Electronic Verification System (EVS) secure Provider Web Portal.

Modernization: Instructions for Nursing Facilities, Intermediate Care Facilities and Hospice Providers Regarding Benefit Plan Details

The Division of Health Care Financing and Policy (DHCFP) implemented a new, modernized Medicaid Management Information System (MMIS) on February 1, 2019, that included updates to the Electronic Verification System (EVS) secure Provider Web Portal regarding checking recipient eligibility.

Please be advised some benefit plan details are located in different coverage sections as noted below:

- Nursing Facility (provider type 19) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (provider types 16 and 68) details are in the Living Arrangement Coverage section.
- Routine Hospice (provider type 64) details are in the Lock-In Detail Coverage section.
- Hospice Room and Board (provider type 65) details are now combined with Hospice, when applicable, and are in the Lock-In Detail Coverage section.

Another change was made where Routine Hospice and Hospice Room and Board are no longer separate eligibility lines. Prior authorizations should be obtained for both provider types. When submitting claims for either service, the National Provider Identifier (NPI) on the claim needs to match the NPI within the Lock-In Detail.

Should a provider or a delegate require additional information, please review Chapter 2 of the EVS User Manual or contact Nevada Medicaid.
Prior Authorization Requirements

- Effective with dates of service on or after March 1, 2017, prior authorization is required for hospice services.
  - The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to Nevada Medicaid and prior authorization has been obtained.
  - It is the responsibility of the hospice provider to ensure that prior authorization is 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 Requirements, continued

- Prior authorization only approves the existence of medical necessity, not recipient eligibility.
- Prior authorization for medical necessity is not required for dual-eligible (Medicare/Medicaid eligible) recipients.
- Hospice forms FA-92 (Hospice Program Election Notice – Adults) or FA-93 (Hospice Program Election Notice – Pediatric), and FA-94 (Hospice Program Physician Certification of Terminal Illness) must be submitted with FA-95 (Hospice Prior Authorization Request Form).
- For extended hospice services past 12 months, FA-96 (Hospice Extended Care Physician Review Form) must be submitted with FA-95.
Prior Authorization Forms
Hospice Prior Authorization Forms

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

Hospice Forms

The following forms are for the use of Nevada Medicaid Hospice providers.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-91</td>
<td>Nevada Medicaid Hospice Program Action Form</td>
</tr>
<tr>
<td>FA-92</td>
<td>Nevada Medicaid Hospice Program Election Notice - Adults</td>
</tr>
<tr>
<td>FA-93</td>
<td>Nevada Medicaid Hospice Program Election Notice - Pediatric</td>
</tr>
<tr>
<td>FA-94</td>
<td>Nevada Medicaid Hospice Program Physician Certification of Terminal Illness</td>
</tr>
<tr>
<td>FA-95</td>
<td>Nevada Medicaid Hospice Prior Authorization Request</td>
</tr>
<tr>
<td>FA-96</td>
<td>Nevada Medicaid Hospice Extended Care Physician Review Form</td>
</tr>
</tbody>
</table>

- While on the “Forms” page, locate the “Hospice Forms” section and choose appropriate forms.
- Make sure that all instructions are followed.
- All active forms are fillable forms for easy uploading into the Electronic Verification System (EVS) for PA submission online.
Nevada Medicaid Hospice Program
Action Form (FA-91)
Hospice Program Action Form (FA-91)

‒ 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/Durable Power of Attorney (DPOA).
  
  If there is no legal representative or DPOA available to sign, please explain the circumstances.

‒ The hospice provider representative must also sign and date accordingly.

‒ Please do not forget:
  
  – Discharge Date
  – Requesting provider National Provider Identifier (NPI)
  – Recipient/Responsible Party signature
  – Recipient ID number
Nevada Medicaid Hospice Program Election Notice – Adults (FA-92)
Hospice Program Election Notice – Adults (FA-92)

- This is a 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 prior authorization/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 and Check Up Nevada Medicaid Hospice Program Election Notice – Adults]

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 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 its normal course.

The goal of 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.

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.

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.

If I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medicaid benefit.

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.

SECTION III
Admitting Terminal Illness (ICD-10 Code(s)):

Recipient is currently admitted in a Nursing Facility:
- Yes
- No Facility:

Recipient is transferring from another Hospice Agency:
- Yes Agency:
- No

Certification Period:
- 1st 90 days
- 2nd 90 days
- 90 days Start date of current Certification Period:

Recipient has an attending physician separate from the hospice physician:
- Yes Physician:
- No 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.

[Signature]

Nevada Medicaid Hospice Provider Training Updated 01/28/2019 (v5/02/2019) 25
Hospice Program Election Notice – Adults (FA-92)

- Section I: Recipient information (ID, name, date of birth)
- Section II: Initials
- Section III: Long Term Care (LTC) facility information (if the nursing facility box is checked, include LTC name and National Provider Identifier - 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 – Pediatric (FA-93)
Hospice Program Election Notice - Pediatric (FA-93)

- This is a 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.
Physician Certification of Terminal Illness (FA-94)

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 support a life expectancy of six months or less as part of the certification and recertification.
- **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 the attending provider’s signature and date; please include license number if available. If no attending provider, then Exclusion Statement must be signed and dated by the hospice medical director and the hospice representative.
Physician Certification of Terminal Illness (FA-94)

- **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 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 Certification of Terminal Illness (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 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 time frame 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 the agency CTI is signed/authenticated timely, but the provider did not sign FA-94 timely, the prior authorization will be pended for five business days requesting additional information.
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 five business days.
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**

– When requesting a PA for Room & Board, whether for initial or concurrent stays, only one FA-95 will need to be submitted

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

– For subsequent benefit periods:
  – Labs
  – Assessments
  – Documented decline (or improvement) of recipient health
Nevada Medicaid 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 or for recipients under the age of 21 who are **not** receiving curative care) 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 business days.

**Required Attachments:**

- Hospice Prior Authorization Request Form (FA-95)

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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 requested 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 FA 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 Medical 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 select "Yes," please list the terminal diagnostic(s). (Please note: principal diagnosis of "unlife" or "admit future to thrive" will not be accepted as meeting the eligibility criteria for Medicaid hospice.)

Considering the normal course of the patient's diagnosis/rate, 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 were 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, contract terms, benefits exclusions, authorization of services, and other terms and conditions set forth in this benefit program. The information on this form and its attachments is privileged and confidential and is only for use of the individual or entity named on this form. If the reader of this form is not 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 must notify the sender immediately and destroy all information received.

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Submitting a Prior Authorization via the EVS Secure Provider Web Portal
Once registered, users may access their accounts from the Provider Web Portal (PWP) “Home” page by:

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

Once the user has clicked the Log In button, the user will need to provide identity verification as follows:

- Answer the Challenge Question to verify identity.
- Choose whether log in is on a personal computer or public computer.
- Click the Continue button.
Logging in to the Provider Web Portal, continued

The user will continue providing identity verification as follows:
- Confirm that the **Site Key** and **Passphrase** are correct.
- Enter **Password**.
- Click the **Sign In** button.

**NOTE:** If this information is incorrect, users should not enter their password. Instead, they should contact the help desk by clicking the **Customer help desk** link.
Welcome Screen

Once the provider information has been verified, the user may explore the features of the PWP, including:

A. Additional tabs for users to research eligibility, submit claims and PAs, access additional resources, and more.
B. Important broadcast messages.
C. Links to contact customer support services.
D. Links to manage user account settings, such as passwords and delegate access.
E. Links to additional information regarding Medicaid programs and services.
F. Links to additional PWP resources.
Navigating the Provider Web Portal

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

A. **My Home**: Confirm and update provider information and check messages.
B. **Eligibility**: Search for recipient eligibility information.
C. **Claims**: Submit claims, search claims, view claims and search payment history.
D. **Care Management**: Request PAs, view PA statuses, and maintain favorite providers.
E. **File Exchange**: Upload forms online.
F. **Resources**: Download forms and documents.
G. **Switch Providers**: **Delegates** can switch between providers to whom they are assigned. The tab is only present when the user is logged in as a delegate.
Create Authorization

— Create authorizations for eligible recipients

View Authorization Status

— Prospective authorizations that identify the requesting or servicing provider

Maintain Favorite Providers

— Create a list of frequently used providers
— Select the facility or servicing provider from the providers on the list when creating an authorization
— Maintain a favorites list of up to 20 providers
Before Creating an Authorization Request
Before Creating a Prior Authorization Request

1. Verify eligibility to ensure that the recipient is eligible on the date of service for the requested services.

2. Use the Provider Web Portal’s PA search function to see if a request for the dates of service, units and service(s) already exist and is associated with your individual, state or local agency, or corporate or business entity.

3. Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.

4. Use the Provider Web Portal to check PAs in pending status for additional information.
Create a Prior Authorization Request
Key Information

Recipient Demographics
— First Name, Last Name and Birth Date will be auto-populated based on the recipient ID entered.

Diagnosis Codes
— All PAs will require at least one valid diagnosis code.

Searchable Diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)
— Enter the first three letters or the first three numbers of the code to use the predictive search.

PA Attachments
— Attachments are required with all PA requests. Attachments can only be submitted electronically.
— PA requests received without an attachment will remain in pended status for 30 days.
— If no attachment is received within 30 days, the PA request will automatically be canceled.
Submitting a PA Request

1. Hover over the Care Management tab.
2. Click Create Authorization from the sub-menu.
3. Select the authorization type (Medical).
4. Choose an appropriate Process Type from the drop-down list.
5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.
6. Enter the **Recipient ID**. The Last Name, First Name and Birth Date will populate automatically.
7. Enter **Referring Provider Information** using one of three ways.
Submitting a PA Request, continued

A. Check the **Referring Provider Same as Requesting Provider** box.
B. Choose an option from the **Select from Favorites** drop-down. This drop-down displays a list of providers that the user has indicated as favorites.
C. Enter the **Provider ID** and **ID Type**. Both fields must be completed when using this option.
D. Click the **Add to Favorites** check box. Use this after entering a provider ID to add it to the **Select from Favorites** drop-down.
8. Enter Service Provider Information.
9. Select a **Diagnosis Type** from the drop-down list.

10. Enter the **Diagnosis Code**. Once the user begins typing, the field will automatically search for matching codes.

11. Click the **Add** button.

**NOTE:** Repeat steps 9-11 to enter up to nine codes. The first code entered will be considered the primary.
If you click the Add button with an invalid diagnosis code, an error will display. Ensure the diagnosis code is correct, up-to-date with the selected Diagnosis Type, and does not include decimals.
Once a diagnosis code has been entered accurately, and the Add button has been clicked, the diagnosis code will display under the Diagnosis Information section. If a code needs to be removed from the PA request, click Remove located in the Action column.
Submitting a PA Request, continued

12. Enter detail regarding the service(s) provided into the Service Details section.
13. Click the Add Service button.
After clicking the Add Service button, the service details will display in the list.

NOTE: Add additional details as needed. If a user wishes to copy a service detail, click Copy located in the Action column. To remove the detail, click Remove.
The **Transmission Method** will default to EL-Electronic Only as attachments must be sent via the portal.
14. Choose the type of attachment being submitted from the **Attachment Type** drop-down list.
15. Click the **Browse** button.
16. Select the desired attachment.
17. Click the **Open** button.

Allowable file types include: .doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.
18. Click the **Add** button.
Submitting a PA Request, continued

The added attachment displays in the list.

To remove the attachment, click Remove in the Action column.

Add additional attachments by repeating steps 14-18.

NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards, go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.
Submitting a PA Request, continued

19. Click the Submit button.
20. Review the information on the PA request.

21. Click the Confirm button to submit the PA for processing. Only click the Confirm button once. If a user clicks Confirm multiple times, multiple PA requests will be submitted and denied due to multiple submissions.

NOTE: If updates are needed prior to clicking the Confirm button, click the Back button to return to the “Create Authorization” page.
After the **Confirm** button has been clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.
A. **Print Preview:** Allows a user to view the PA details and receipt for printing.

B. **Copy:** Allows a user to copy member or authorization data for another authorization.

C. **New:** Allows a user to begin a new PA request for a different member.
Viewing Status
Viewing the Status of PAs

1. Hover over the Care Management tab.
2. Click View Authorization Status.
Viewing the Status of PAs, continued

3. Click the ATN hyperlink of the PA to be viewed.
4. Click the plus symbol to the right of a section to display its information.

5. Review the information as needed.
Viewing the Status of PAs, continued

6. Review the details listed in the **Decision / Date** and **Reason** columns.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>ID Type</th>
<th>NPI</th>
<th>Name</th>
<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>1831573690</td>
<td></td>
<td></td>
<td>HOSPITALIST SERVICES OF NEVADA-MANDAVIA</td>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td></td>
<td>CPT/HCPCS 0033F-INACTIVE TOBACCO USE, NON-SMOKING</td>
<td>01/12/2018</td>
<td>6 Certified In Total 01/12/2018</td>
<td></td>
</tr>
</tbody>
</table>
In the Decision / Date column, users may see one of the following decisions:

- **Certified in Total**: The PA request is approved for exactly as requested.
- **Certified Partial**: The PA request has been approved, but not as requested.
- **Not Certified**: The PA request is not approved.
- **Pended**: The PA request is pending approval.
- **Cancel**: The PA request has been canceled.
When the Decision / Date column is not “Certified in Total”, information will be provided in the Reason column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).
### Viewing the Status of PAs, continued

<table>
<thead>
<tr>
<th>C. From Date and To Date:</th>
<th>Display the start and end dates for the PA.</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Units:</td>
<td>Displays the number of units originally on the PA.</td>
</tr>
<tr>
<td>E. Remaining Units or Amount:</td>
<td>Display the units or amount left on the PA as claims are processed.</td>
</tr>
<tr>
<td>F. Code:</td>
<td>Displays the procedure code on the PA.</td>
</tr>
<tr>
<td>G. Medical Citation:</td>
<td>Indicates when additional information is needed for authorizations (including denied).</td>
</tr>
</tbody>
</table>

#### Service Provider / Service Details Information

<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>
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<tbody>
<tr>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td>–</td>
<td>CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING</td>
<td>Certified In Total 01/12/2018</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>
Viewing the Status of PAs, continued

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.

<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>Hide</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>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified 02/22/2013</td>
<td>-</td>
</tr>
<tr>
<td>02/17/2013</td>
<td>02/20/2013</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td></td>
<td>Certified In Total 02/24/2013</td>
<td>-</td>
</tr>
</tbody>
</table>

Medical Citation
7002 - Information provided does not support medical necessity as defined by Nevada Medicaid.
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.

The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.
Viewing the Status of PAs, continued

H. **Edit**: Edit the PA.

I. **View Provider Request**: Expand all sections to view the information.

J. **Print Preview**: Display a printable version of the PA with options to print.
Searching for PAs
Searching for PAs

1. Click the **Search Options** tab.
2. Enter search criteria into the search fields.
A. **Authorization Tracking Number**: Enter the ATN to locate a specific PA.
B. **Day Range**: Select an option from this list to view PA results within the selected time period.
C. **Service Date**: Enter the date of service to display PA with that service date.

NOTE: Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.
Searching for PAs, continued

D. **Status**: Select a status from this list to narrow search results to include only the selected status.

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

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient information is not mandatory. You can either enter the Recipient ID; or the Last Name, First Name, and Birth Date.</td>
</tr>
</tbody>
</table>

D. **Status**:
- Cancel
- Certified In Total
- Certified Partial
- Not Certified
- Pended
E. **Recipient ID:** Enter the unique Medicaid ID of the client.

F. **Birth Date:** Enter the date of birth for the client.

G. **Last Name** and **First Name:** Enter the client’s first and last name.

NOTE: Enter only the **Recipient ID** number or the client’s last name, first name and date of birth.
H. **Provider ID**: Enter the provider’s unique NPI.

I. **ID Type**: Select the provider’s ID type from the drop-down list.

J. **This Provider is the**: Select whether the provider is the servicing or referring provider on the PA request.
Searching for PAs, continued

3. Click the **Search** button.
4. Select an **ATN** hyperlink to review the PA.
Submitting Additional Information
1. Click the **Edit** button to edit a submitted PA request.

Additional information may include:
- Requests for additional services
- Attachments
- “FA-29 Prior Authorization Data Correction” form
- “FA-29A Request for Termination of Service” form
Submitting Additional Information, continued

2. Add additional diagnosis codes, service details and/or attachments.
3. Click the **Resubmit** button to review the PA information.
Submitting Additional Information, continued

4. Review the information.
5. Click the **Confirm** button.

NOTE: The PA number remains the same as the original PA request when resubmitting the PA request.
Options if a PA is not approved
Denied Prior Authorization

If a prior authorization is denied by Nevada Medicaid, the provider has the following options:

– Request 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 nvpeer_to_peer@dxc.com.
- Only available for denials related to the medical necessity of the service.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
Reconsideration Request

- Reconsiderations can be uploaded via the Provider Web Portal by completing an FA-29B form and uploading the form to the “File Exchange” on the Provider Web Portal.
- Additional medical documentation is reviewed to support the medical necessity.
- The information is reviewed by a different clinician than reviewed the original documentation.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
Reconsideration Request, continued

- A reconsideration must be requested within 30 calendar days from the date of the denial, except for Residential Treatment Center (RTC) services, which must be requested within 90 calendar days.

- The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review.

- Give a synopsis of the medical necessity not presented previously. Include only the medical records that support the issues identified in the synopsis. Voluminous documentation will not be reviewed. It is the provider’s responsibility to identify the pertinent information in the synopsis.

- Only available for denials related to the medical necessity of the service.
Medicaid Provider Hearing

- Review Chapter 3100 (Hearings) of the Medicaid Services Manual located on the DHCFP website for further information regarding the Hearing Process.
Medicaid Billing Information
Locating Medicaid Billing Information

- Step 1: Highlight Providers from top blue tool bar.
- Step 2: Select Billing Information from the drop-down menu.
Locating Medicaid Billing Information, continued

Billing Information

Effective February 1, 2019, all providers will be required to submit their claims electronically (using Trading Partners or Direct Data Entry [DDE]), as paper claims submission will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at https://www.medicaid.nv.gov/providers/Modernization.aspx for further details.

Attention All Providers: Requirements on When to Use the National Provider Identifier (NPI) of an Ordering, Prescribing or Referring (OPR) Provider on Claims [Web Announcement 1711]

FAQs: National Correct Coding Initiative (NCCI) Claim Review Edits [Review Now]
Clinical Claim Editor FAQs Updated December 5, 2011 [Review Now]
Third Party Liability Frequently Asked Questions [Review Now]

Billing Manual
For Archives Click here

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

Review the Billing Manual for more information regarding:
- nvpeer_to_peer@dx.com
Locating Medicaid Billing Information, continued

- Locate the section header “Billing Guidelines (by Provider Type)"
- Select appropriate Provider Type Guideline
Medicaid Billing Information, continued

Provider Type 64
- Must bill only using Revenue Codes.
- As of October 2, 2017, do not bill with procedure codes.
- All claims are to be billed monthly.
- Claims should be submitted during the first week of the month following the month of service.
- Do not include a prior authorization number on the claim but retain the PA number.

Provider Type 65
- Use this provider type to receive Room and Board reimbursement.
- All claims are to be billed monthly.
- Claims should be submitted during the first week of the month following the month of service.
- The NPI of the Nursing Facility from which the recipient was transferred, if applicable, must be provided in Loop 2310B NM109 of the 837I electronic transaction.
- Do not include a prior authorization number on the claim but retain the PA number.
- All hospice-enrolled recipients must have a Pre-Admission Screening Resident Review (PASRR) and Level of Care (LOC) prior to admission.
DHCFP Rates Unit
DHCFP Rates Unit

• Step 1: Highlight Quick Links from tool bar at www.medicaid.nv.gov.

• Step 2: Select Rates Unit.

• Step 3: From new window, select Accept.
DHCFP Rates Unit, continued

• Locate the “Fee-for-Service PDF Fee Schedules” from the Fee Schedules section.
DHCFP Rates Unit, continued

• Select Appropriate Title to open the PDF pertaining to the Reimbursement Schedule.

• Provider Type 65 rates are reimbursed at a rate of 95% of Nursing Facilities. For information regarding Nursing Facility Rates, see next slide.
DHCFP Rates Unit, continued

Nursing Facilities
Rates are acuity-adjusted on a quarterly basis. Reimbursement methodology may be found in the State Plan, Attachment 4.19-D.

If you need information regarding Nursing Facility rates other than what is provided below, you may contact our office and our staff may assist you; 775-684-7972.

- PDF Nursing Facility Rates

NURSING FACILITIES

2019 Nursing Facility Rates
- January 2019 Nursing Facility Rates
- October 2018 Nursing Facility Rates
- July 2018 Nursing Facility Rates

- While on the Rates Unit Page, locate the Nursing Facilities section and select PDF Nursing Facility Rates.

- From the next page, select the most recent Rate schedule. Please note that these rates are updated and posted each quarter.
Submitting an Institutional Claim via the EVS Secure Provider Web Portal (Direct Data Entry / DDE)
Understanding Claims Sub Menus
Understanding Claim Sub Menus

1. Hover over **Claims**.
2. Select the appropriate sub menu from the options.
Understanding Claim Sub Menus, continued

The page displays a listing of Claim activities for the user to choose.
Submitting an Inpatient Claim for Provider Type 65
Submitting an Inpatient Claim

The Institutional Claim submission process is broken out into three main steps:

- **Step 1** - Provider, Patient and Claim Information plus an option to add Other Insurance details
- **Step 2** - Diagnosis Codes
- **Step 3** - Service Details and Attachments
Submitting an Inpatient Claim, continued

1. Hover over the **Claims** tab.
2. Select **Submit Claim Inst.**
Submitting an Inpatient Claim, continued

When selecting the **Claim Type**, each claim form will vary. Each hospice provider will need to determine the correct type and some basic guidelines should be followed, which is outlined below:

**Provider Type 65. Long Term Care should be selected.**

The information above is not all inclusive and is based on a case-by-case basis.
Submitting an Inpatient Claim – Step 1

Once the user clicks on the Submit Claim Inst tab, this “Submit Institutional Claim: Step 1” page is displayed, with all three subsections included:

A. Provider Information
B. Patient Information
C. Claim Information

NOTE: All of the fields marked with a red asterisk (*) are required.

To begin Step 1, the user will:
• Select Inpatient from the Claims Type drop-down.
Submitting an Inpatient Claim – Step 1, continued

Provider Information

If the Billing Provider has multiple locations, as in this example of an Institutional Inpatient claim associated with a hospital, the Billing Provider Service Location field does not pre-populate.

For this type of claim, the user will:

3. Select the appropriate Billing Provider Service Location from the drop-down option.
4. Enter the Attending Provider ID.

NOTE: For PT 65, the Nursing Facility NPI should be entered in the Operating Provider ID field.
Submitting an Inpatient Claim – Step 1, continued

Provider Information

5. Select the desired search method.
6. Enter Provider ID and Provider ID Type.
7. Click the Search button, and the search results populate at the bottom.
8. Click the hyperlink in the Provider ID column with correct Provider ID.

NOTE: The user can also search by the Search By Name or Search By Organization tabs.
Submitting an Inpatient Claim – Step 1, continued

Provider Information

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
<td>ID Type NPI</td>
</tr>
<tr>
<td>1285360160</td>
<td></td>
</tr>
<tr>
<td>Billing Provider Service Location</td>
<td></td>
</tr>
<tr>
<td>VIC-001</td>
<td></td>
</tr>
<tr>
<td>Institutional Provider ID</td>
<td>ID Type NPI</td>
</tr>
<tr>
<td>1952455032</td>
<td>NPI</td>
</tr>
<tr>
<td>Attending Provider ID</td>
<td>ID Type NPI</td>
</tr>
<tr>
<td>1952455032</td>
<td>NPI</td>
</tr>
<tr>
<td>Operating Provider ID</td>
<td>ID Type NPI</td>
</tr>
<tr>
<td>Other Operating Provider ID</td>
<td>ID Type NPI</td>
</tr>
<tr>
<td>Referring Provider ID</td>
<td>ID Type NPI</td>
</tr>
</tbody>
</table>

Once the user clicks the Provider ID, it will populate into the Attending Provider ID field.
Submitting an Inpatient Claim – Step 1, continued

Patient Information

<table>
<thead>
<tr>
<th>Patient Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient ID 96536412536</td>
<td></td>
</tr>
<tr>
<td>Last Name VOLWNSF</td>
<td></td>
</tr>
<tr>
<td>Birth Date 10/03/1983</td>
<td></td>
</tr>
<tr>
<td>First Name QPRB</td>
<td></td>
</tr>
</tbody>
</table>

9. Enter the 11-digit recipient ID into the Recipient ID field and click outside the field to populate Last Name, First Name and Birth Date.
Submitting an Inpatient Claim – Step 1, continued

10. The following required fields (*) must be completed:
   - Covered Dates
   - Admission Date/Hour
   - Admission Type
   - Admitting Diagnosis Type
   - Patient Status
   - Patient Number
   - Admission Source
   - Admitting Diagnosis
   - Facility Type Code
   - When selecting a Facility Type Code, Hospice providers should select a code that begins with 66_

11. Click the **Continue** button

NOTE: For this example, the user has checked the **Include Other Insurance** field to indicate that additional insurance will be added in subsequent steps.
Once the user clicks the **Continue** button, the “Submit Institutional Claim: Step 2” page is displayed with all the panels expanded.

### Diagnosis Codes

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>POA</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Diagnosis Type</em> ICD-10-CM</td>
<td><em>Diagnosis Code</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Submitting an Inpatient Claim – Step 2, continued

**Diagnosis Codes**

To add a code, the user will:

1. Choose a **Diagnosis Type** (Auto-populates as “ICD-10-CM”, but “ICD-9-CM” is also available).
2. Enter the **Diagnosis Code**.
3. Click the **Add** button.

NOTE: The **Diagnosis Code** field contains a predictive search feature using the first three characters of the code or code description.
Submitting an Inpatient Claim – Step 2, continued

**Diagnosis Codes**

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Code</th>
<th>Description</th>
<th>Present on Admission</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E00-01 OM</td>
<td>D00-09</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>E00-01 OM</td>
<td>D01-09</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>E00-01 OM</td>
<td>D02-09</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Click the **Remove** link to remove a diagnosis code from the claim.

Once all the diagnosis codes have been entered, the user will:

4. Click the **Continue** button to proceed to Step 3.
Submitting an Inpatient Claim – Step 3

The user will enter the Service Details using the same process below:

1. Enter the required fields.
2. Click the Add button.
3. Click the Submit button.
At this point, the user has the option to:

- Go back to any previous step if needed by clicking one of the Back to Step... buttons.
- Print a copy of the page by clicking the Print Preview button.
- Cancel the claim submission by clicking the Cancel button.

To continue, the user must:

4. Click the Confirm button.
Submitting an Inpatient Claim, continued

The Submit Inpatient Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

The user may then:

- Click the **Print Preview** button to view the claim details.
- Click the **Copy** button to copy claim data and start a new claim using identical details.
- Click the **Adjust** button to adjust a submitted claim.
- Click the **New** button to submit a new claim.
- Click the **View** button to view the details of the submitted claim, including adjudication errors.

NOTE: The Claim ID is the same as ICN
Submitting an Outpatient Claim for Provider Type 64
Submitting an Outpatient Claim – Step 1

To submit an Outpatient Institutional Claim, the user will proceed with the same steps as shown on the previous slides.

To complete Step 1, the user will:

1. Select the Claim Type.
2. Complete all three sub-sections:
   A. Provider Information
   B. Patient Information
   C. Claim Information
3. Click the Continue button.
Submitting an Outpatient Claim – Step 2

To complete Step 2, the user will need to enter diagnosis codes.

To add a code, the user will:

4. Choose a **Diagnosis Type** (Auto-populates as “ICD-10-CM”, but “ICD-9-CM” is also available).
5. Enter the **Diagnosis Code**.
6. Click the **Add** button.
7. Click the **Continue** button.
Submitting an Outpatient Claim – Step 3

To complete Step 3, the user will enter the Service Details, using the process below:

8. Enter the required fields.
9. Click the **Add** button.
10. Click the **Submit** button.
At this point the user has the option to:

- Go back to any previous step if needed by clicking one of the **Back to Step** buttons.
- Print a copy of the page by clicking the **Print Preview** button.
- Cancel the claim submission by clicking the **Cancel** button.

To continue, the user must:

11. Click the **Confirm** button.
Submitting an Outpatient Claim, continued

The **Submit Outpatient Claim: Confirmation** will appear after the claim has been submitted. It will display the claim status and Claim ID.

The user may then:

- Click the **Print Preview** button to view claim details.
- Click the **Copy** button to copy claim data and start a new claim using identical details.
- Click the **Adjust** button to adjust the claim.
- Click the **New** button to submit a new claim.
- Click the **View** button to view the details of the submitted claim, including adjudication errors.
Submitting a Claim with Attachments
Submitting a Claim with Attachments

To upload attachments to an institutional claim:

1. Click the (+) sign on the Attachments panel.
Submitting a Claim with Attachments, continued

2. Click the **Browse** button and locate the file on the user’s computer to attach.

A window will then pop up. From there, the user will:

3. Locate and select the file.

4. Click the **Open** button.

**NOTE:** The **Transmission Method** field will populate with “FT - File Transfer” by default and does not need to be changed.
Submitting a Claim with Attachments, continued

Once the Attachment has been uploaded, the user will:

5. Select the type of attachment from the **Attachment Type** drop-down list.

6. Click the **Add** button to attach the file or click on the **Cancel** button to cancel and close the attachment line.

**NOTE:** A description of the attachment may be entered into the **Description** field, but it is not required.
Submitting a Claim with Attachments, continued

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

NOTE: To remove any attachments, click the **Remove** link.
Submitting a Claim: Other Insurance Details
Submitting a Claim: Other Insurance Details

1. Check the Include Other Insurance checkbox located at the bottom of the page.

2. Click the Continue button.
Submitting a Claim: Other Insurance Details, continued

To add a policy or new other insurance, the user will:

3. Click the (+) in the Other Insurance Details panel at the bottom of the page.

NOTE: If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto-populate in the Other Insurance Details panel. If not, no policy information will display.
Submitting a Claim: Other Insurance Details, continued

After clicking the (+), the user must:

4. Complete all required fields (*).

5. Click the **Add Insurance** button to add the Other Insurance details to the claim.

NOTE: Click the **Cancel Insurance** button to cancel addition of a new other health insurance detail.
Submitting a Claim: Other Insurance Details, continued

After the user clicks the Add Insurance button, the new insurance will populate.
Submitting a Claim: Other Insurance Details, continued

Click the Remove link to remove any other insurance details unrelated to the claim.

The user will:

6. Click the Continue button.
After the user clicks the **Continue** button, the user will:

7. Click the **Submit** button.
At this point, the user has the option to:

- Go back to any previous step if needed by clicking one of the **Back to Step...** buttons.
- Print a copy of the page by clicking the **Print Preview** button.
- Cancel the claim submission by clicking the **Cancel** button.

To continue, the user must:

8. Click the **Confirm** button.
Submitting a Claim: Other Insurance Details, continued

The **Submit Inpatient Claim: Confirmation** will appear after the claim has been submitted. It will display the claim status and adjusted Claim ID.

The user may then:

- Click the **Print Preview** button to view claim details.
- Click the **Copy** button to copy claim data.
- Click the **Adjust** button to adjust the claim.
- Click the **New** button to submit a new claim.
- Click the **View** button to view the details of the submitted claim.
Submitting an Institutional Crossover Claim
Submitting an Institutional Crossover Claim

Step 1

To start the process for a Crossover Institutional claim, the user will:

1. Select the Claim Type.

NOTE: The user will follow the same steps as previously shown in the Submitting an Institutional Inpatient Claim section.
Submitting an Institutional Crossover Claim, continued

Step 1

2. Enter the Medicare Crossover Details:
   - Deductible Amount
   - Blood Deductible Amount
   - Medicare Payment Amount
   - Co-insurance Amount
   - Medicare Payment Date

3. Click the Continue button.

NOTE: After adding the Medicare Crossover Details, the claims submission process is the same for Steps 2 and 3 as detailed in earlier sections.
Submitting an Institutional Crossover Claim, continued

Step 3

The user will:

4. Enter information in all of the required fields (*).
5. Click the **Add** button.
Submitting an Institutional Crossover Claim, continued

Then the user will:
6. Click the Confirm button.
Submitting an Institutional Crossover Claim, continued

The user will receive a Confirmation with the **Crossover Inpatient Claim Receipt**.

![Submit Crossover Inpatient Claim Confirmation](image-url)

- Your Crossover Inpatient Claim was successfully submitted.
- The Claim ID is 2218276000022.
- The claim status is Finalized Payment.

- Click **Print Preview** to view the claim details as they have been saved on the payer’s system.
- Click **Copy** to copy member or claim data.
- Click **Adjust** to resubmit the claim.
- Click **New** to submit a new claim.
- Click **View** to view the details of the submitted claim.
Searching for Claims
Searching for a Claim

To search for a claim, the user will need to:

1. Hover over Claims.
2. Select Search Claims.
Searching for a Claim, continued

The fastest way to locate a claim is by entering the **Claim ID**.

To search without using the Claim ID:

3. Enter the **Recipient ID**.
4. Enter the **Service From** and **To**.
5. Click the **Search** button.

NOTE: To clear the screen and access claim status on another claim, click the **Reset** button found at the bottom of the “Search Claims” page.
Searching for a Claim, continued

Once the user has clicked the Search button, the results will display at the bottom of the page.

From there, the user may:

6. Click the (+) symbol to expand the claim details.

To see service line information, or to view the remittance advice, click on the (+) next to the claims ID.
Searching for a Claim, continued

Once the user has clicked the + symbol, the **Inpatient Claim Information** and **Service Information** panels will populate.

### Inpatient Claim Information

<table>
<thead>
<tr>
<th>Recipient</th>
<th>QPRB VBLWIBF</th>
<th>Total Charge Amount</th>
<th>$2,575.00</th>
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<tbody>
<tr>
<td>Birth Date</td>
<td>10/03/1983</td>
<td>Total Paid Amount</td>
<td>$0.00</td>
</tr>
<tr>
<td>Rendering Provider</td>
<td>CARSON TAHOE REGIONAL HEALTHCARE</td>
<td>Paid Date</td>
<td>-</td>
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</table>

### Service Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Date</th>
<th>Line Status</th>
<th>Reason Code</th>
<th>Units</th>
<th>Revenue</th>
<th>Procedure/Modifiers</th>
<th>Charge</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/24/2018 - 09/28/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>4</td>
<td>120</td>
<td></td>
<td>$1,300.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>09/24/2018 - 09/28/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>4</td>
<td>250</td>
<td></td>
<td>$500.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>3</td>
<td>09/24/2018 - 09/28/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>1</td>
<td>320</td>
<td></td>
<td>$300.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>4</td>
<td>09/24/2018 - 09/28/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>2</td>
<td>300</td>
<td></td>
<td>$275.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Searching for a Claim, continued

7. Click the Claim ID hyperlink to open the claim.
If the claim is denied, the user may review the errors as follows:

8. Click the (+) symbol adjacent to the **Adjudication Errors** panel.
With the **Adjudication Errors** panel expanded, the user may review the errors associated with the claim's denial.
Viewing a Remittance Advice (RA)
Viewing a RA

To begin locating an RA, the user will:
1. Hover over Claims.
2. Select Search Payment History.
3. Enter search criteria to refine the search results.
4. Click the Search button.

NOTE: RAs can only be searched in the Provider Web Portal. The default search range is for the past 90 days.
The user will:

5. Click on the image in the RA Copy column to view the RA.
Viewing a RA, continued

6. User will click the **Open** button.
After clicking the **Open** button, the user can review the RA.
Copying a Claim
To copy a claim, the user will need to:

1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the **Search** button.

Search results will populate at the bottom of the screen.

From the search results:

4. Click the **Claim ID** link.
After the user has viewed the claim, user will:

5. Scroll down to the bottom of the page.

6. Click the **Copy** button, that opens the copied claim.
Copying a Claim, continued

7. Select the portion of the claim to copy (for this example, the user has selected Entire Claim).
8. Click the Copy button.
The user may edit and submit the claim as covered in prior sections.
Adjusting a Claim
Adjusting a Claim

To begin the claim adjustment process:

1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the **Search** button.
4. Click the **Claim ID** hyperlink.

**NOTE:** Denied claims cannot be adjusted. The **Claim Status** column will indicate Finalized Payment if a claim is paid.
On the “View Institutional Claim: Step 1” page, the user will:

5. Scroll down to the bottom of the page.
6. Click the Adjust button.
Adjusting a Claim, continued

Step 1

From here, the user may:

7. Review and make any necessary edits to the Step 1 Provider, Recipient or Claim information.

8. For this example, the user will change the Medicare **Deductible Amount** field.

9. Click on the **Continue** button at the bottom of the page to proceed to the next step.
Adjusting a Claim, continued

For this example, the user has removed the Medicare Deductible Amount (step 10) from the adjusted claim.

To continue, the user will:
11. Click the Continue button to proceed to Step 2.
Once the user has clicked the **Continue** button, Step 2 will populate and the user will:

12. Click the **Continue** button again at the bottom of the page and Step 3 will populate.

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

**NOTE:** Click the **Cancel** button to cancel the adjustment.
Adjusting a Claim, continued

14. Click the **Confirm** button.

**NOTE:** Click the **Cancel** button to cancel the adjustment.
Once the user clicks the **Confirm** button, the “Resubmit Crossover Inpatient Claim: Confirmation” page will appear.

It will display the claim status and adjusted Claim ID.
Submitting an Appeal for a Claim
Submitting an Appeal for a Claim

From the home page, the user will:

1. Select Secure Correspondence to start the Appeal process.
Submitting an Appeal for a Claim, continued

2. The user will select from the **Message Category** drop-down “Claims – Appeals” and fill out all of the required fields.

NOTE: If a different Message Category is selected, the Appeal will not be reviewed.
Submitting an Appeal for a Claim, continued

Next, the user will:

3. Click the **Browse** button and locate the file supporting the appeal request on their computer to attach.

4. Click the **Send** button.

NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.
Submitting an Appeal for a Claim, continued

After clicking **Send**, a confirmation message will populate with “Your secure message was successfully sent”

User will then need to:

5. Click the **OK** button.

NOTE: A confirmation email will be sent preceding the request.
After the user clicks the OK button, they will be directed to the Secure Correspondence - Message Box, where the new CTN can be seen.

NOTE: After initial email confirmation, subsequent notifications of correspondence will not be sent.
Voiding a Claim
Voiding a Claim

Should a claim need to be voided immediately after submitting for payment, the user will

1. Click the **View** button to begin the void process.

NOTE: Additionally, a claim can be voided by searching for a previously submitted claim, as shown in the Searching for an Institutional Claim section.
Voiding a Claim, continued

Once the user has clicked the View button, the claim will display.

![Claim Information Table]

- Claim Type: Crossover Inpatient
- Provider Information:
  - Billing Provider ID: 180115266
  - ID Type: NP
  - Billing Provider Service Location: 11-Saint Mary's Regional Medical Center-235 W 6TH ST, RENO, NEVADA, 89503-4548
  - Institutional Provider ID: 180115266
  - ID Type: NP
  - Attending Provider ID: 155243502
  - ID Type: NP
  - Operating Provider ID: 1
  - ID Type: _
  - Other Operating Provider ID: 1
  - ID Type: _
  - Referring Provider ID: 1
  - ID Type: _
- Patient Information:
  - Recipient ID: 0732203446
  - Recipient Name: Ferrand Fichier
  - Birth Date: 01/29/1943
- Claim Information:
  - Claim Status: Finalized Payment
  - Admission Date/Time: 09/25/2018 - 08:00
  - Admission Source: 2-Clinic or Physician's Office
  - Discharge Date: 10:00
  - Facility Type Code: 111-Hospital Inpatient (Including Medicare Part A)-Admit through Discharge Claim
  - Authorization Number: _
  - Related Claim ICN: _
  - Total Allowed Amount: $4,500.00
  - Total Co-pay Amount: $0.00
  - Total Charged Amount: $11,771.22
  - Total Paid Amount: $0.00
To void the claim, the user will:

2. Click the **Void** button at the bottom of the page.
Voiding a Claim, continued

The system will ask if the user is sure and will list the Crossover Inpatient Claim ID that will be voided.

The user will then:

3. Click the OK button.
Voiding a Claim, continued

The system will send a confirmation message that the claim has been successfully voided.

The user will:

4. Click the **OK** button.
Resources

- For Forms: www.medicaid.nv.gov/providers/forms/forms.aspx
- For Electronic Verification System (EVS) General Information: www.medicaid.nv.gov/providers/evsusermanual.aspx
- Billing Information: www.medicaid.nv.gov/providers/BillingInfo.aspx

DHCFP Contact Information:
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy / Long Term Support Services (Facilities Unit)
E-Mail: LTSS@dhcfp.nv.gov / Telephone: (775) 684-3757
Contact Nevada Medicaid
Contact Nevada Medicaid

Prior Authorization Department: 800-525-2395

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

Provider Relations Field Services Representatives:
E-mail: NevadaProviderTraining@dxc.com
Thank You