Personal Care Services Provider Training

Provider Types 30 and 83

Nevada Medicaid Provider Training

2019

Objectives

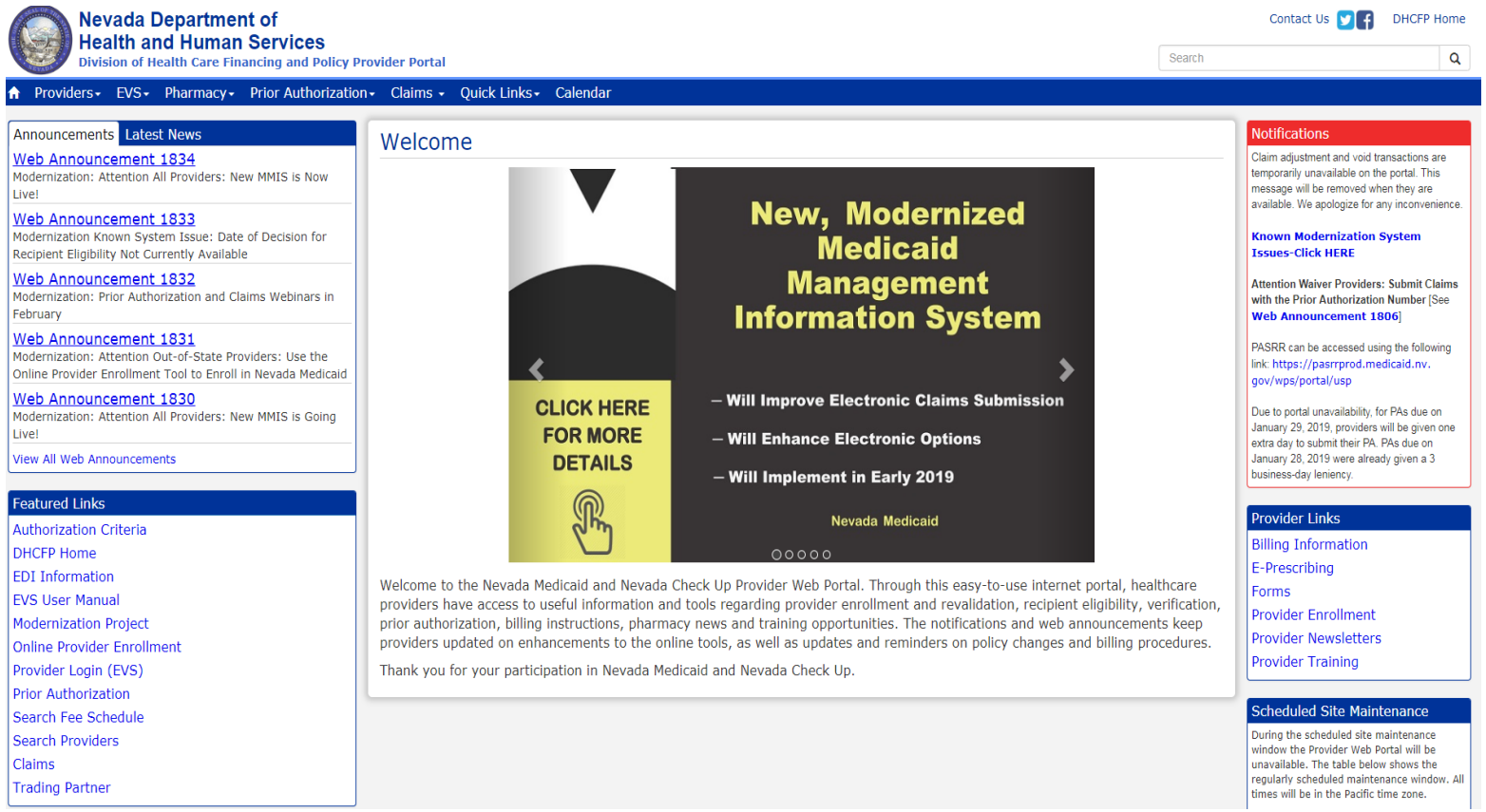
Objectives

- Locate Medicaid Policy
- Navigate to Web Announcements
- Locate Prior Authorization Forms
- Login to the Electronic Verification System (EVS) secure Provider Web Portal
- Successfully Submit a Prior Authorization
- View Prior Authorizations
- Locate Billing Information
- Access the Search Fee Schedule and DHCFP Rates Unit
- Submit Claims using Direct Data Entry via the EVS secure Provider Web Portal

Medicaid Website

Medicaid Website

www.medicaid.nv.gov



EVS

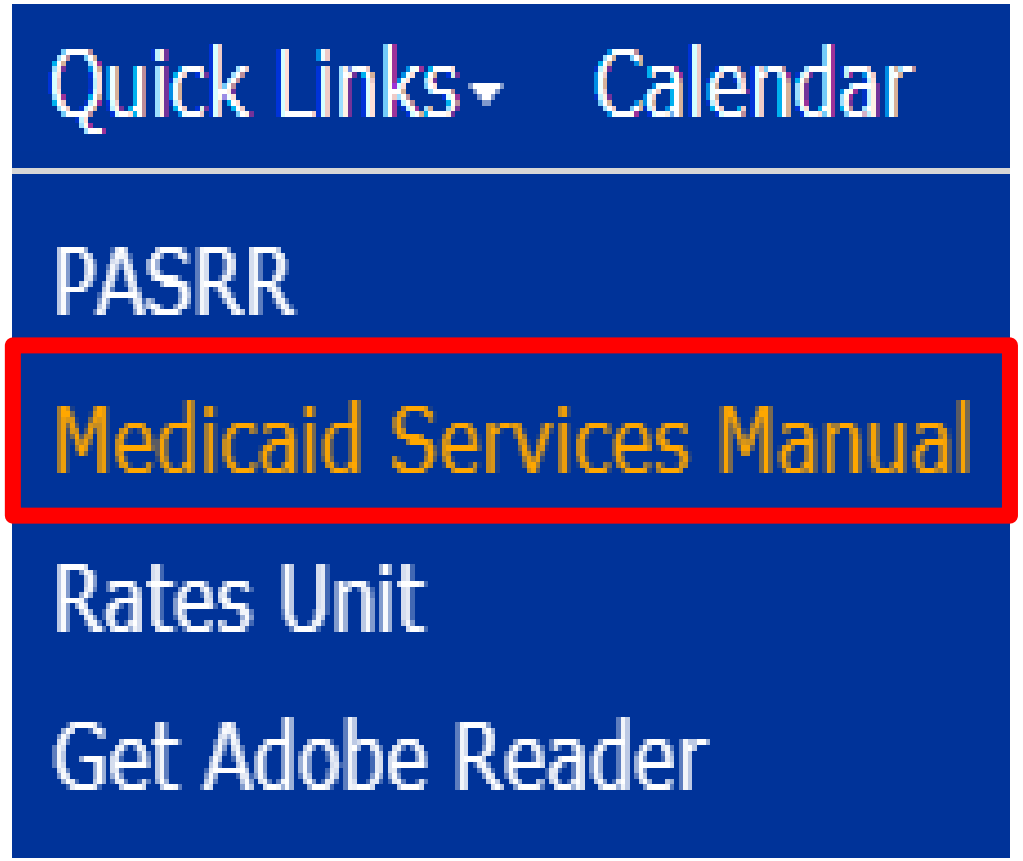
EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

System Requirements

To access EVS, user must have internet access and a computer with a web browser. (Microsoft Internet Explorer 9.0 or higher recommended)

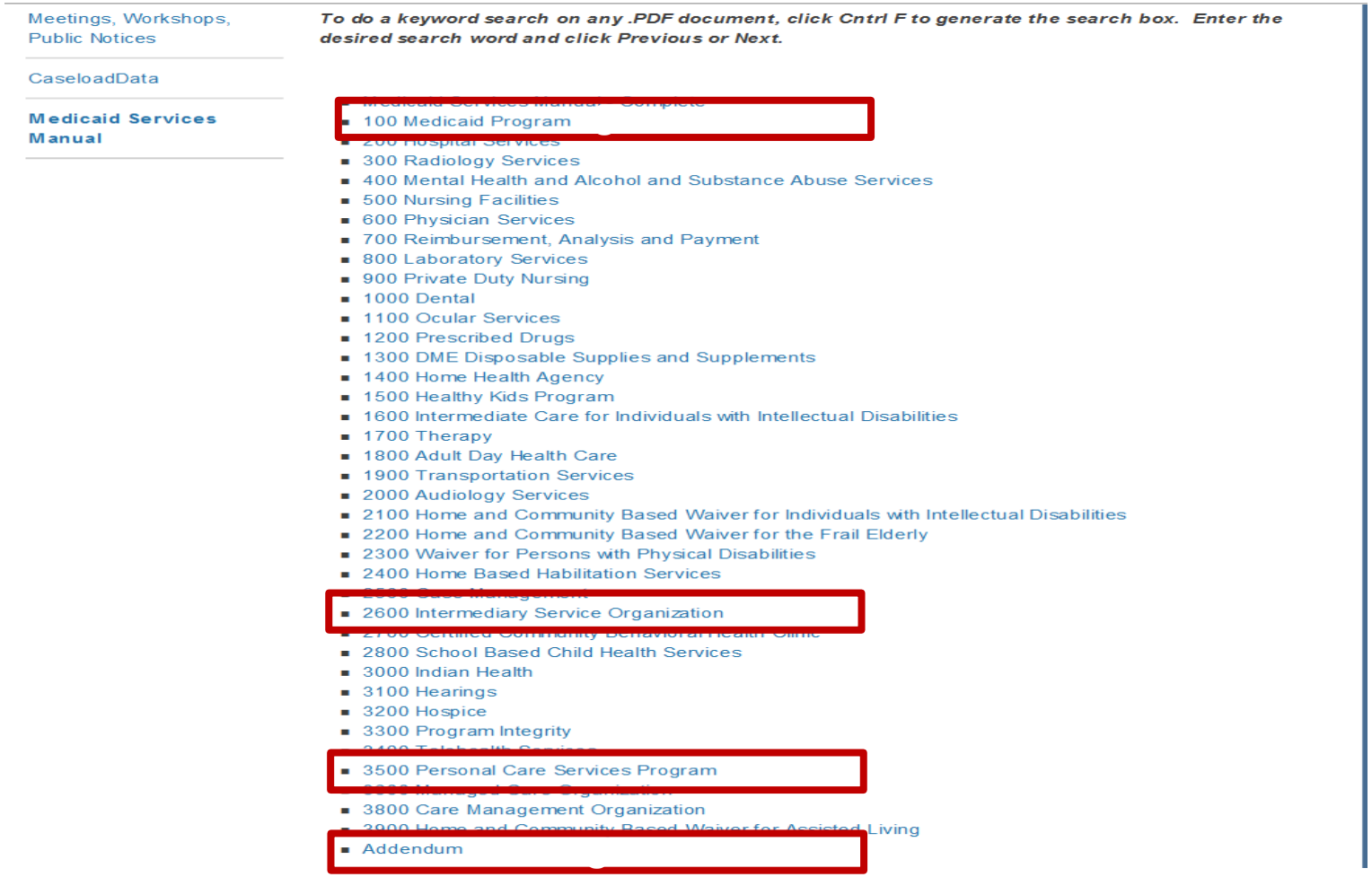
Medicaid Services Manual (MSM)

Locating Medicaid Services Manual (MSM)



- Step 1: Highlight “Quick Links” from top blue tool bar at www.medicaid.nv.gov.
- Step 2: Select “Medicaid Services Manual” from the drop-down menu.
- Note: MSM Chapters will open in new webpage through the DHCFP website.

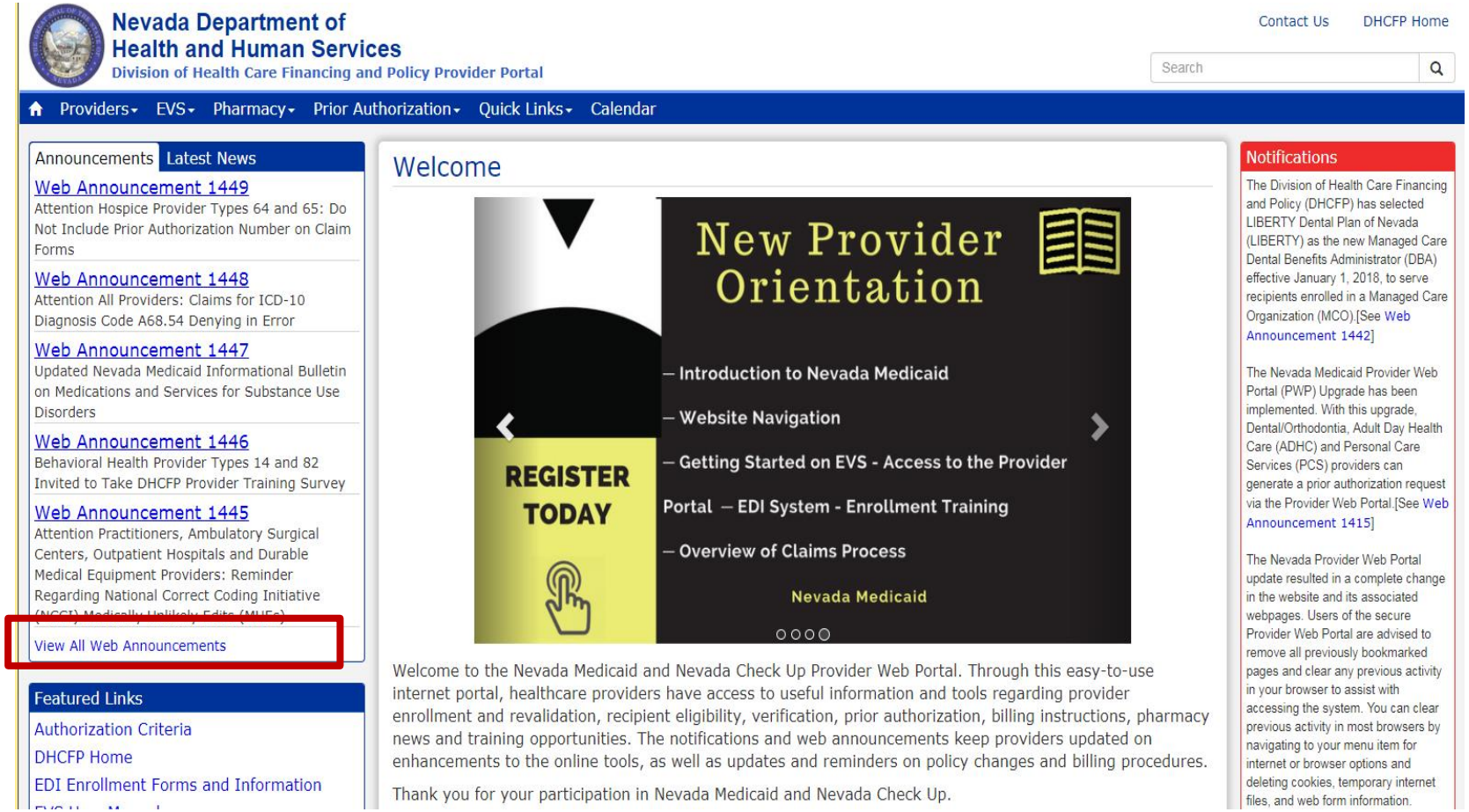
Locating Medicaid Services Manual, continued



- Select “2600 Intermediary Service Organization”
- Select “3500 Personal Care Services Program”
- All providers are responsible for knowing the information in Chapter 100 “Medicaid Program” and the Addendum
- From the next page, always make sure to select the “Current” policy

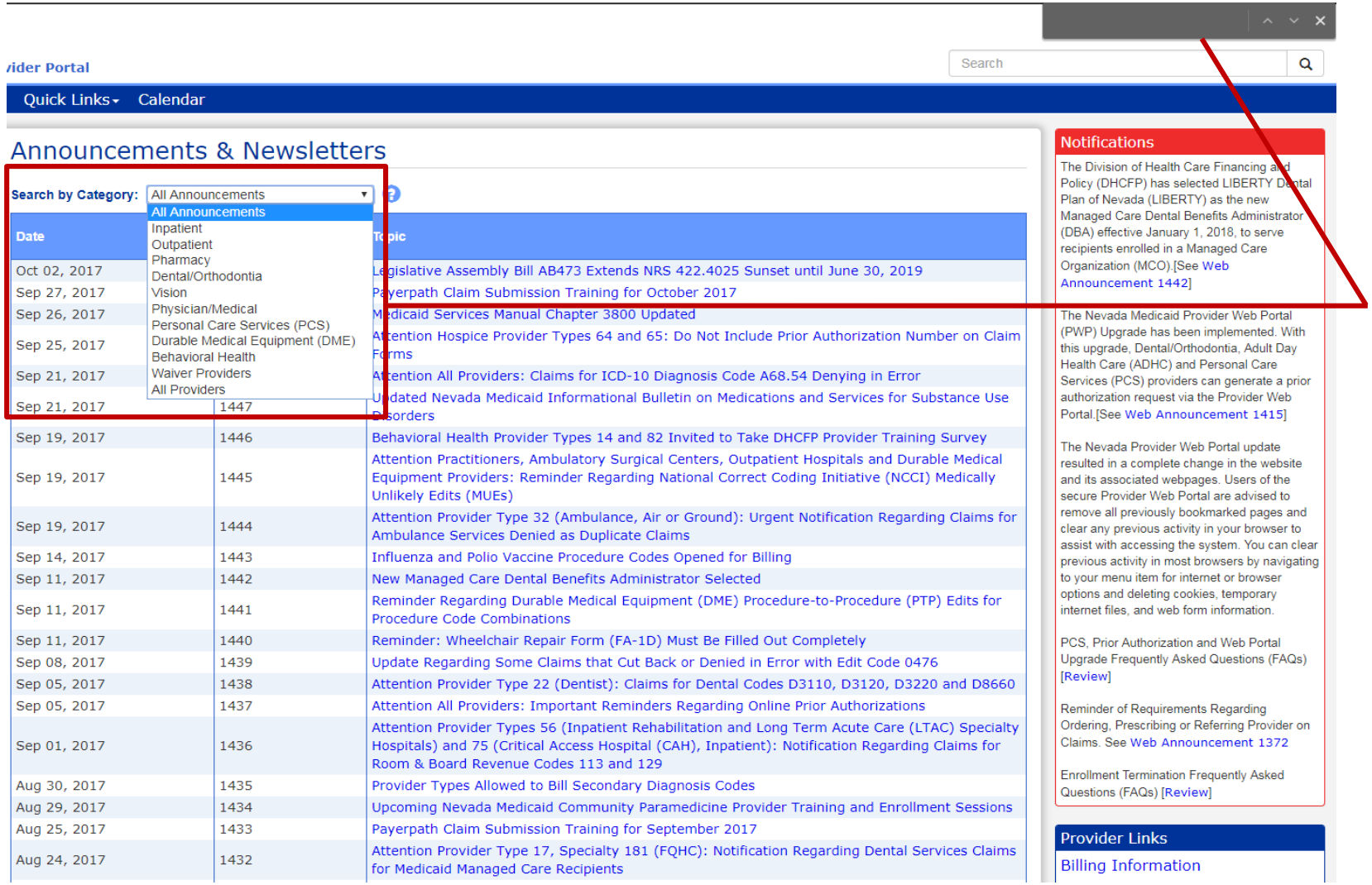
Viewing Web Announcements

Web Announcements



– Select “View All Web Announcements” to view Web Announcements

Web Announcements, continued



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

Web Announcements, continued

Web Announcement 1463

Recipient's Eligibility Changes from Managed Care Organization (MCO) to Fee-for-Service (FFS)

- Submit the most current authorization letter that specifies the dates of service and the number hours approved by the MCO.
- Submit an FA-24 marked as "Information Only" and on lines beneath state that this recipient's eligibility has now changed from an MCO to Medicaid FFS.

October 26, 2017
Web Announcement 1463

Attention Personal Care Services Provider Types 30 and 83:

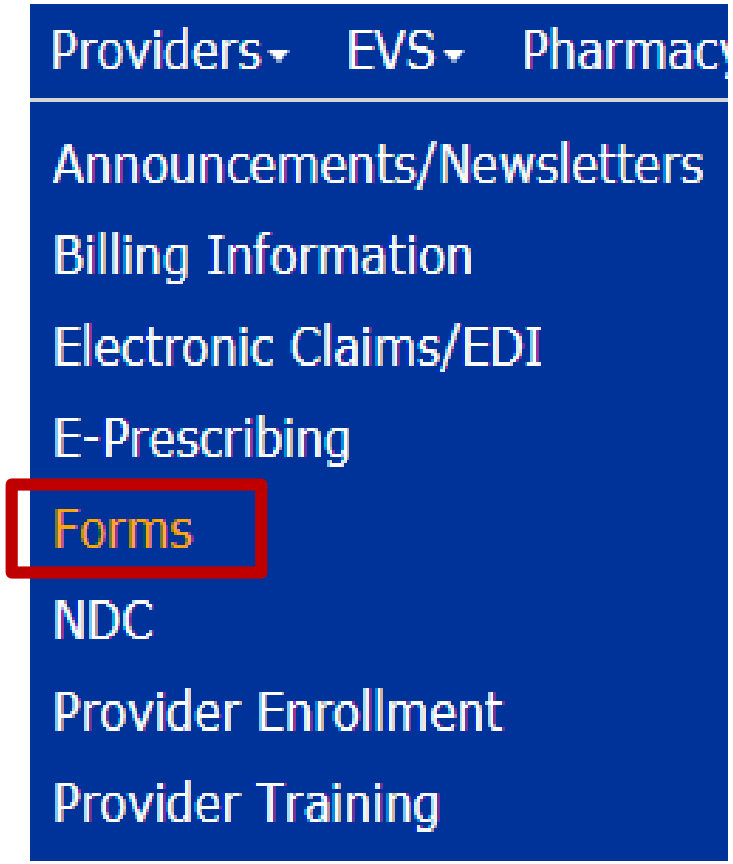
Instructions Regarding Recipient Eligibility Transfers from Managed Care Organization to Fee-for-Service

When a prior authorization (PA) request for Personal Care Services (PCS) has been approved by one of the Managed Care Organizations (MCOs) and the recipient's eligibility subsequently transfers to Fee-for-Service (FFS), Nevada Medicaid will authorize PCS services in order to ensure continuity of care while awaiting completion of an in-home functional assessment (FASP). PCS providers please upload or submit by fax an FA-24 (Authorization Request for Personal Care Services (PCS)) with the Significant Change in Condition checkbox selected, along with a copy of the approved authorization from the MCO. This MCO documentation must include the service type (PCS), approved dates of services and authorized units. The MCO documentation must be uploaded as a separate attachment from the FA-24 when submitted through the Provider Web Portal.

Upon receipt of the PA request and required documentation, Nevada Medicaid will issue a temporary authorization at the level of service provided by the MCO and obtain an in-home functional assessment. Once the in-home functional assessment has been completed, the provider will be notified of the outcome. Failure to include the required MCO authorization will result in a delay in processing the request for authorization of continued PCS services.

Prior Authorization Forms

Locating Prior Authorization Forms



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

Locating Prior Authorization Forms, continued

FA-24	Personal Care Services (PCS) Prior Authorization | PCS Assessment Forms
FA-24 Instructions	Personal Care Services (PCS) Prior Authorization Instructions
FA-24A	Coordination of Hospice and Waiver or Personal Care Services (PCS)
FA-24A Instructions	Coordination of Hospice and Waiver or Personal Care Services (PCS) Instructions
FA-24B	Legally Responsible Individual (LRI) Availability Determination for the Personal Care Services Program
FA-24C	Authorization Request for Self-Directed Skilled Services
FA-24C Instructions	Authorization Request for Self-Directed Skilled Services Instructions
FA-24T	Personal Care Services Recipient Request for Provider Transfer

- While on the “Forms” page, locate the appropriate FA-24 form and its instructions, if applicable.
- Make sure to follow the instructions for each required form.
- All active forms are fillable for easy uploading for PA submission online.
- Any form that is not legible will not be accepted.
- **Only Physical Therapists/Occupational Therapists (PT/OT) will use the “PCS Assessment Forms” which are also known as the Functional Assessment Service Plan (FASP).**

Authorization for Personal Care Services (PCS) – FA-24

- Indicate the Date of Request at the top of the form.
- Section 1: To be filled out by Nevada Medicaid Only.
- Section 2: Indicate the purpose of the request.
- Section 3: Contact information for the recipient and agency information.
- The Legally Responsible Individual (LRI) portion must be completed and marked Yes or No, and when Yes, submit form FA-24B.

When the recipient's Eligibility Changes from Managed Care Organization (MCO) to Fee-for-Service (FFS):

- Submit the most current authorization letter that specifies the dates of service and the number of hours approved by the MCO.
- Submit an FA-24 marked as "Information Only" and on lines beneath state that this recipient's eligibility has now changed from an MCO to Medicaid FFS.

Nevada Medicaid and Check Up

Authorization Request for Personal Care Services (PCS)

Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

For information on completing this form, see the instructions online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu, then click on Form Number FA-24-I).

DATE OF REQUEST: ____/____/_____

SECTION 1: FOR NEVADA MEDICAID USE ONLY

SECTION 2: PURPOSE OF REQUEST

☐ Update Visit (annual)
☐ Significant Change in Condition
☐ Temporary Service Authorization
☐ One-Time Service

☐ Information Only

☐ Cancel Authorization
Agency's last date of service: ____/____/_____
Reason: ☐ Recipient Ineligible ☐ Recipient Expired ☐ Other: _____

SECTION 3: CONTACT INFORMATION

RECIPIENT INFORMATION

Last Name:	First Name:
Recipient Medicaid ID:	Date of Birth:
Translator Required: ☐ Yes ☐ No	Language:
Address:	

City:	State:	Zip Code:	Phone:

PCS AGENCY INFORMATION

PCS Agency Name:		City:
NPI/API:	Phone:	Fax:

LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION *(if applicable*)*

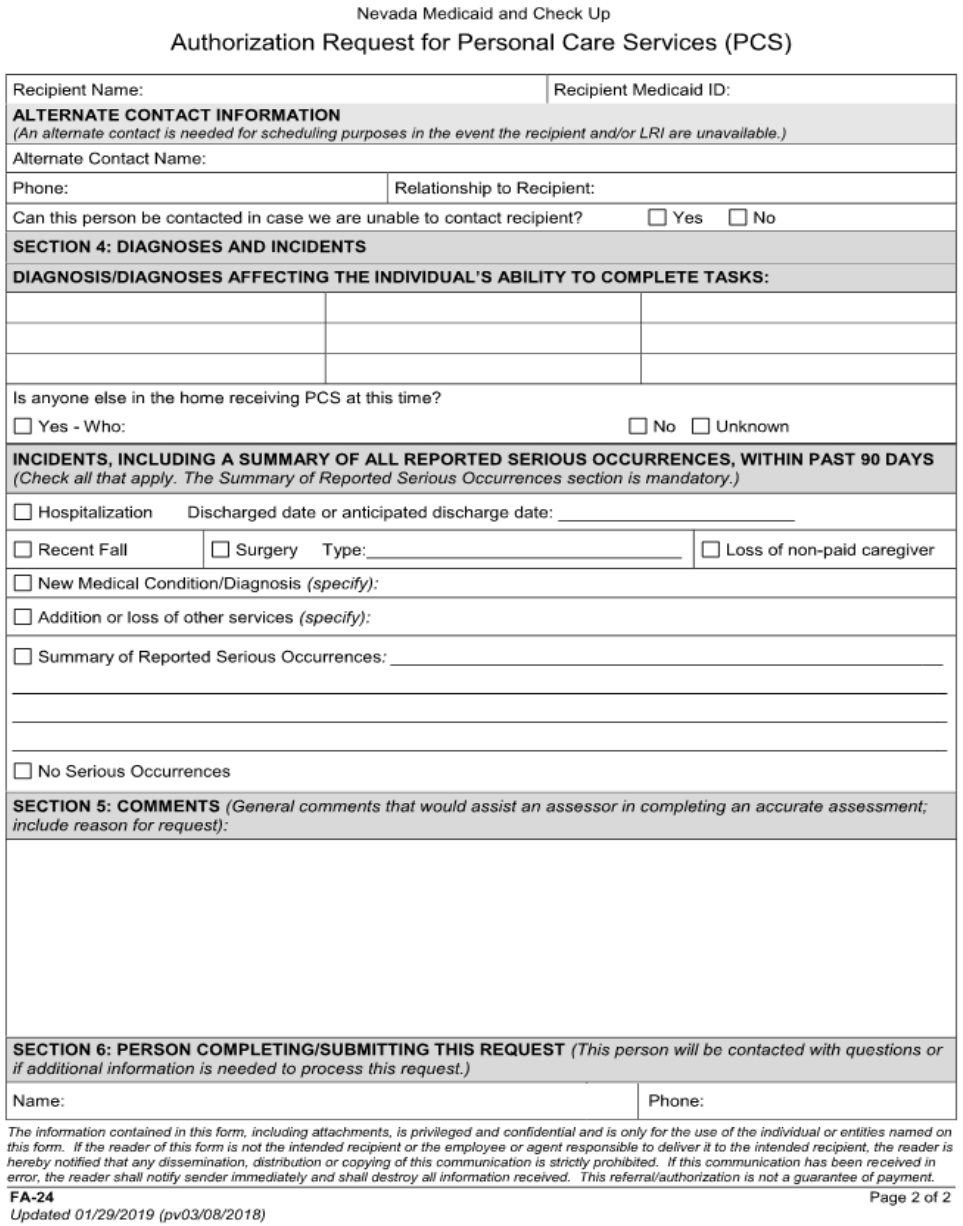
**Complete this section if the definition of LRI is met. Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents. Attach a completed copy of form FA-24B (LRI Availability Determination for the Personal Care Services Program) with any submitted request when the recipient resides with an LRI. It is the responsibility of the provider to attach a current work note (availability) or a copy of the permanent disability form or an updated disability form if the disability was/is temporary (capability). If this section is not addressed and appropriate paperwork not attached, this request will be denied and the form will be returned to the provider. See the FA-24 Instructions on the Forms webpage at www.medicaid.nv.gov for additional instructions regarding this section.*

Does recipient have an LRI? *(see definition above)* ☐ Yes ☐ No ☐ Unknown		
LRI Name:	Phone:	
Relationship to Recipient:	Does LRI reside with recipient? ☐ Yes ☐ No	
Is the LRI also on the PCS Program: ☐ Yes ☐ No	Receives_____ hrs/wk	
LRI Employment Status: ☐ Employed # Hrs/wk:_____ Days Off:_____ ☐ Unemployed ☐ Disabled ☐ Other		

FA-24 Page 1 of 2
Updated 01/29/2019 (*pv03/08/2018*)

Authorization for Personal Care Services (PCS) – FA-24, continued

- Fill out Recipient Information on top and provide any alternative contact information.
- Section 4: PCS provider will need to indicate only 1 Diagnosis Code.
- Section 5: Indicate any additional information that is not notated on the form. Information must be clear and specific as to why this service is being requested.
- Section 6: To be filled out by person requesting the services being rendered.



Nevada Medicaid and Check Up

Authorization Request for Personal Care Services (PCS)

Recipient Name:	Recipient Medicaid ID:

ALTERNATE CONTACT INFORMATION
(An alternate contact is needed for scheduling purposes in the event the recipient and/or LRI are unavailable.)

Alternate Contact Name:	
Phone:	Relationship to Recipient:

Can this person be contacted in case we are unable to contact recipient? ☐ Yes ☐ No

SECTION 4: DIAGNOSES AND INCIDENTS

DIAGNOSIS/DIAGNOSES AFFECTING THE INDIVIDUAL'S ABILITY TO COMPLETE TASKS:

Is anyone else in the home receiving PCS at this time?

☐ Yes - Who: ☐ No ☐ Unknown

INCIDENTS, INCLUDING A SUMMARY OF ALL REPORTED SERIOUS OCCURRENCES, WITHIN PAST 90 DAYS
(Check all that apply. The Summary of Reported Serious Occurrences section is mandatory.)

☐ Hospitalization Discharged date or anticipated discharge date: _____

☐ Recent Fall ☐ Surgery Type:_____ ☐ Loss of non-paid caregiver

☐ New Medical Condition/Diagnosis *(specify):*

☐ Addition or loss of other services *(specify):*

☐ Summary of Reported Serious Occurrences: _____

☐ No Serious Occurrences

SECTION 5: COMMENTS *(General comments that would assist an assessor in completing an accurate assessment; include reason for request):*

SECTION 6: PERSON COMPLETING/SUBMITTING THIS REQUEST *(This person will be contacted with questions or if additional information is needed to process this request.)*

Name:	Phone:

The information contained in this form, including 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 has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/authorization is not a guarantee of payment.

FA-24 Page 2 of 2

Updated 01/29/2019 (pv03/08/2018)

Legally Responsible Individual (LRI) – FA-24B

- Follow instructions located at the top of the form.
- As of December 1, 2017, this form is required when applicable.
- This form will be used to determine if an LRI is unavailable or incapable of providing PCS services.
- Not providing completed LRI information could delay authorization for the following year of PCS services.

LRI:

- A spouse.
- A parent, foster parent or step parent of a minor child and legal guardians who obtained such through a legal proceeding.
- A recipient's power of attorney (POA) is not a legally responsible individual.
- A legally responsible individual can never be the Personal Care Attendant (PCA).

Nevada Medicaid and Nevada Check Up

Legally Responsible Individual (LRI)

Availability Determination For the Personal Care Services Program

Please see page 2 of this form for LRI definition.

SECTION 1: DATE OF REQUEST: _____ /_____ /_____

SECTION 2: RECIPIENT REQUESTING TO BEGIN OR CONTINUE PERSONAL CARE SERVICES

Recipient Name:

Recipient ID: | Date of Birth:

SECTION 3: LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION (Submit one form for each LRI)

LRI Name: | Phone:

SECTION 4: LRI RELATIONSHIP

Check the relationship the LRI identified in Section 3 has to the recipient: (If this is a guardianship, attach a copy of the guardianship papers)

Recipients 18 years and older: A. ☐ Spouse B. ☐ Legal Guardian

Recipients under 18 years of age: C. ☐ Parent D. ☐ Step Parent E. ☐ Foster Parent F. ☐ Legal Guardian

SECTION 5: LRI UNAVAILABLE OR NOT CAPABLE OF PROVIDING CARE

Identify the reason the LRI identified in Section 3 is unavailable or not capable of providing care. (See page 2 for definitions and required documents)

☐ Unavailable to provide the recipient with necessary medical support due to the LRI's **work or school schedule**. Attach copy of proof of employment or school. If this option is checked, proceed to Section 7 to submit the form.

☐ Incapable to provide the recipient with necessary medical support due to LRI's own health condition. If this option is checked, complete section 6.

SECTION 6: LRI LIMITATIONS (A licensed healthcare professional must complete this section)

Enter the name of the LRI identified in Section 3:_____

Identify specific limitations of the LRI:

The LRI has: ☐ No limitations to provide care.

☐ Cognitive limitations (cannot learn care tasks, memory deficits)

☐ Physical limitations (cannot render care such as ability to lift recipient)

☐ Significant health or emotional issues that directly prevent or interfere with provision of care

Limitations: Describe in detail specific limitations and/or issues: _____

_____

_____

The limitations and/or issues described above are: ☐ Temporary through _____(date) ☐ Permanent

Date LRI was last seen in the healthcare professional's office: _____

LRI's Physician Name *(please print)*: _____ Contact Phone: _____

LRI's Physician Signature: _____ **Date:** _____

Credentials of healthcare provider signing the form:_____

SECTION 7: NOTES

SECTION 8: SUBMIT THIS FORM

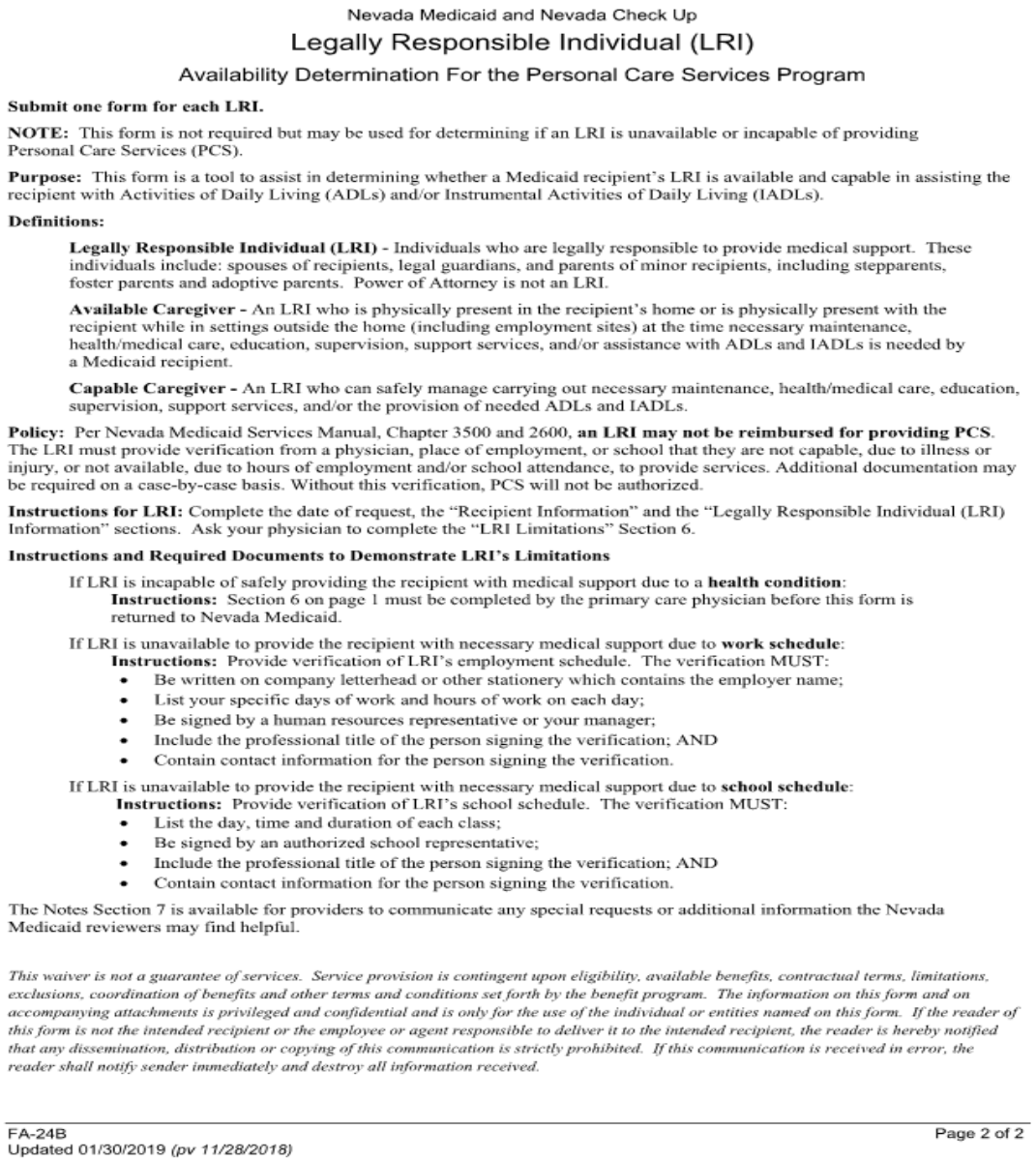
Submit this form through the Provider Web Portal using the prior authorization number referenced on the related Notice of Decision. For questions regarding this form, call: (800) 525-2395

FA-24B
Updated 01/30/2019 (*pv 11/28/2018*)

Page 1 of 2

Legally Responsible Individual (LRI) – FA-24B, continued

- Additional Information is listed on Page 2.



Nevada Medicaid and Nevada Check Up

Legally Responsible Individual (LRI)

Availability Determination For the Personal Care Services Program

Submit one form for each LRI.

NOTE: This form is not required but may be used for determining if an LRI is unavailable or incapable of providing Personal Care Services (PCS).

Purpose: This form is a tool to assist in determining whether a Medicaid recipient's LRI is available and capable in assisting the recipient with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs).

Definitions:

Legally Responsible Individual (LRI) - Individuals who are legally responsible to provide medical support. These individuals include: spouses of recipients, legal guardians, and parents of minor recipients, including stepparents, foster parents and adoptive parents. Power of Attorney is not an LRI.

Available Caregiver - An LRI who is physically present in the recipient's home or is physically present with the recipient while in settings outside the home (including employment sites) at the time necessary maintenance, health/medical care, education, supervision, support services, and/or assistance with ADLs and IADLs is needed by a Medicaid recipient.

Capable Caregiver - An LRI who can safely manage carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

Policy: Per Nevada Medicaid Services Manual, Chapter 3500 and 2600, **an LRI may not be reimbursed for providing PCS**. The LRI must provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or not available, due to hours of employment and/or school attendance, to provide services. Additional documentation may be required on a case-by-case basis. Without this verification, PCS will not be authorized.

Instructions for LRI: Complete the date of request, the "Recipient Information" and the "Legally Responsible Individual (LRI) Information" sections. Ask your physician to complete the "LRI Limitations" Section 6.

Instructions and Required Documents to Demonstrate LRI's Limitations

If LRI is incapable of safely providing the recipient with medical support due to a **health condition**:
Instructions: Section 6 on page 1 must be completed by the primary care physician before this form is returned to Nevada Medicaid.

If LRI is unavailable to provide the recipient with necessary medical support due to **work schedule**:
Instructions: Provide verification of LRI's employment schedule. The verification MUST:
- Be written on company letterhead or other stationery which contains the employer name;
- List your specific days of work and hours of work on each day;
- Be signed by a human resources representative or your manager;
- Include the professional title of the person signing the verification; AND
- Contain contact information for the person signing the verification.

If LRI is unavailable to provide the recipient with necessary medical support due to **school schedule**:
Instructions: Provide verification of LRI's school schedule. The verification MUST:
- List the day, time and duration of each class;
- Be signed by an authorized school representative;
- Include the professional title of the person signing the verification; AND
- Contain contact information for the person signing the verification.

The Notes Section 7 is available for providers to communicate any special requests or additional information the Nevada Medicaid reviewers may find helpful.

This waiver is not a guarantee of services. Service provision 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-24B Page 2 of 2
Updated 01/30/2019 *(pv 11/28/2018)*

Authorization Request for Self-Directed Skilled Services – FA-24C

- ***This form is to be used only by Provider Type 83.***
- Fill out form in its entirety.
- Indicate **Date** of Request.
- Section 1:
  - Initial – No current authorization for self-directed skilled services.
  - Reauthorization – previous request for Medically Necessary Skilled Services has changed within an authorized period or for annual request for authorization.
  - Indicate Date of Request.
- Personal Care Representative (PCR) cannot be the Personal Care Attendant (PCA).

Nevada Medicaid and Check Up

Authorization Request for Self-Directed Skilled Services
(For use only by Provider Type 83 – Intermediary Service Organization – ISO)

Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

DATE OF REQUEST: _____/_____/_____

NOTES:

SECTION 1: Contact Information

PURPOSE OF REQUEST

☐ Initial ☐ Reauthorization

RECIPIENT INFORMATION

Last Name, First Name, Middle Initial:

Recipient's Medicaid ID: | Date of Birth:

Address:

City: | State: | Zip Code: | Phone:

Check the appropriate box:

☐ The recipient has no Legally Responsible Individual (LRI) and is able to self-direct their own care. ***(If this option is checked, complete Section 4; do not complete Section 5)***

☐ The recipient is not able to direct their own care, and the LRI or Personal Care Representative understands that they must be present to direct the care while it occurs and cannot be the paid caregiver for the recipient. ***(If this option is checked, complete Section 5; do not complete Section 4)***

LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION

Complete this section if this definition of an LRI is met: Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents.

If LRI is not available or not capable, complete and attach form FA-24B (LRI Availability Determination for the Personal Care Services Program)

LRI Name *(if applicable)*: | Relationship to Recipient:

LRI Address:

City: | State: | Zip Code: | Phone:

PERSONAL CARE REPRESENTATIVE INFORMATION

Complete this section if recipient is unable to direct his/her own care and has no legally responsible individual available or capable to perform or direct the care. ***The Personal Care Representative cannot be the Personal Care Assistant.***

Contact Name (*other than recipient*): | Relationship to Recipient:

Contact Address:

City: | State: | Zip Code: | Phone:

ISO PROVIDER INFORMATION

ISO Provider Name:

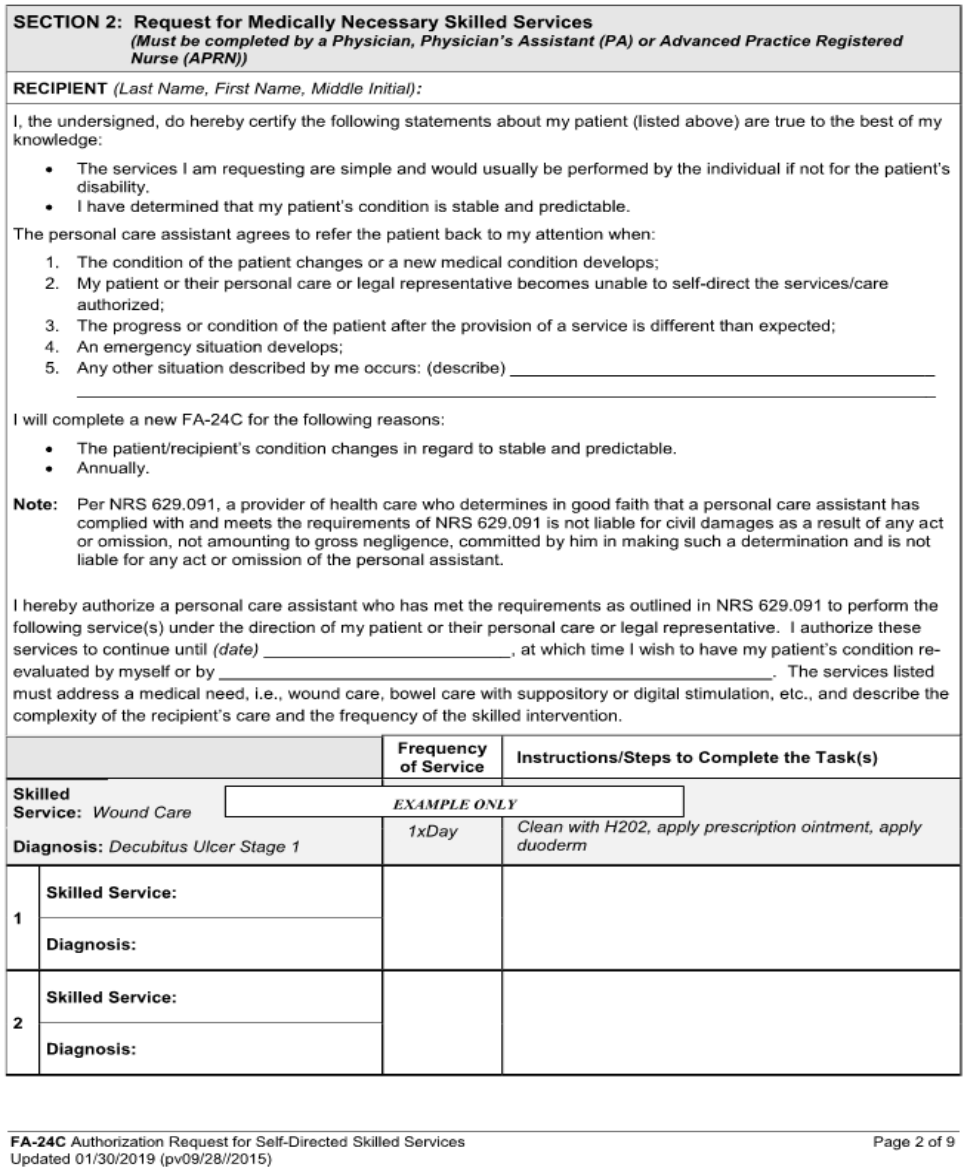
NPI/API:

Phone: | Fax:

FA-24C Authorization Request for Self-Directed Skilled Services Page 1 of 9
Updated 01/30/2019 *(pv09/28//2015)*

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 2 must be completed by the Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN).



SECTION 2: Request for Medically Necessary Skilled Services
(Must be completed by a Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN))

RECIPIENT *(Last Name, First Name, Middle Initial):*

I, the undersigned, do hereby certify the following statements about my patient (listed above) are true to the best of my knowledge:

- The services I am requesting are simple and would usually be performed by the individual if not for the patient's disability.
- I have determined that my patient's condition is stable and predictable.

The personal care assistant agrees to refer the patient back to my attention when:

1. The condition of the patient changes or a new medical condition develops;
2. My patient or their personal care or legal representative becomes unable to self-direct the services/care authorized;
3. The progress or condition of the patient after the provision of a service is different than expected;
4. An emergency situation develops;
5. Any other situation described by me occurs: (describe) _____

I will complete a new FA-24C for the following reasons:

- The patient/recipient's condition changes in regard to stable and predictable.
- Annually.

Note: Per NRS 629.091, a provider of health care who determines in good faith that a personal care assistant has complied with and meets the requirements of NRS 629.091 is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

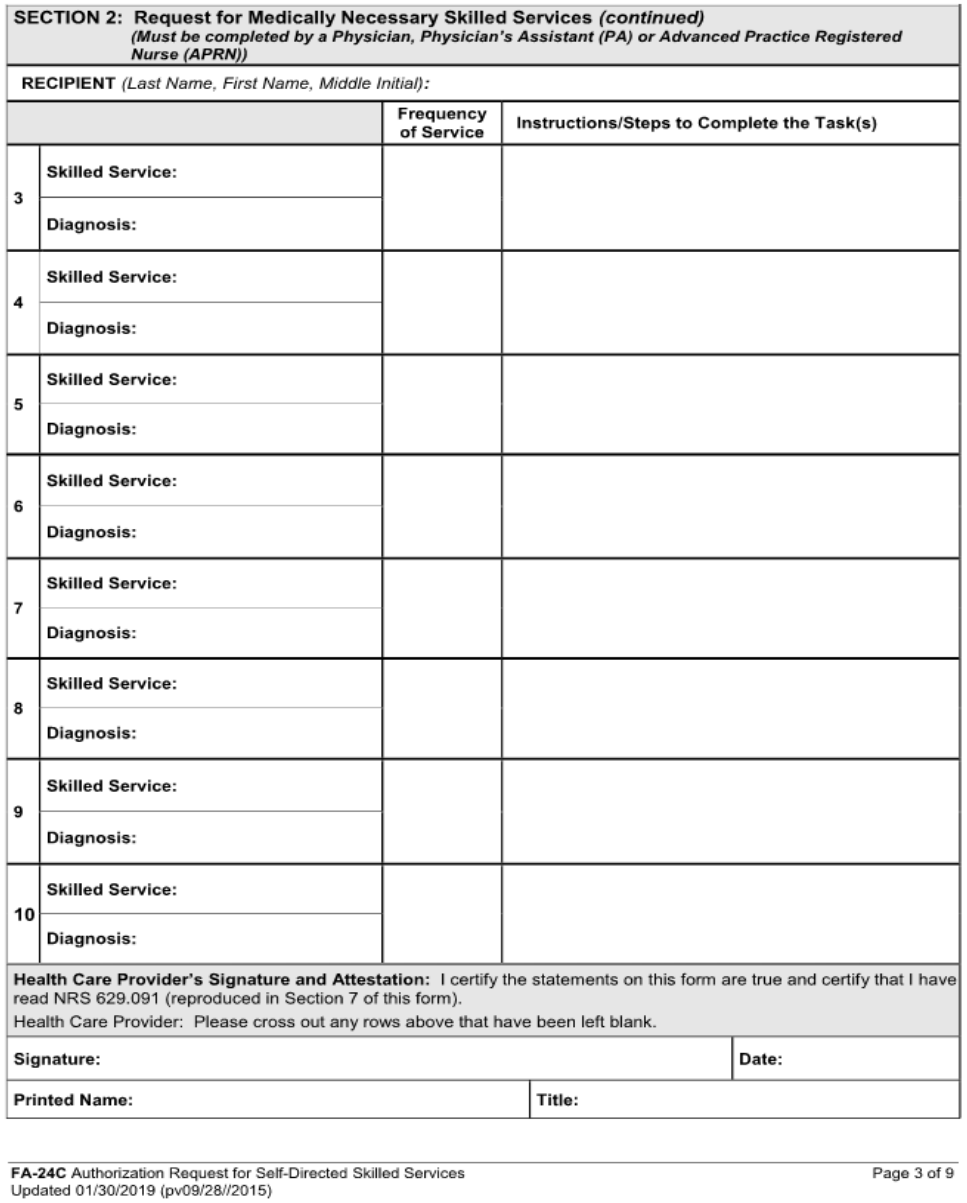
I hereby authorize a personal care assistant who has met the requirements as outlined in NRS 629.091 to perform the following service(s) under the direction of my patient or their personal care or legal representative. I authorize these services to continue until *(date)* _____, at which time I wish to have my patient's condition re-evaluated by myself or by _____. The services listed must address a medical need, i.e., wound care, bowel care with suppository or digital stimulation, etc., and describe the complexity of the recipient's care and the frequency of the skilled intervention.

		Frequency of Service	Instructions/Steps to Complete the Task(s)
Skilled Service: *Wound Care* **Diagnosis:** *Decubitus Ulcer Stage 1*	*EXAMPLE ONLY*	*1xDay*	*Clean with H202, apply prescription ointment, apply duoderm*
1	**Skilled Service:** / **Diagnosis:**		
2	**Skilled Service:** / **Diagnosis:**		

FA-24C Authorization Request for Self-Directed Skilled Services Page 2 of 9
Updated 01/30/2019 (pv09/28//2015)

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Fill out recipient information at the top of the page.
- If there are more than 10 skilled services needed, complete additional Section 2.
- Health care provider ***must*** sign to certify the statements are true.
- If any rows have been left blank, the health care provider who is signing the form must cross out the blank rows.



SECTION 2: Request for Medically Necessary Skilled Services *(continued)*
(Must be completed by a Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN))

RECIPIENT *(Last Name, First Name, Middle Initial)*:

		Frequency of Service	Instructions/Steps to Complete the Task(s)
3	**Skilled Service:** **Diagnosis:**		
4	**Skilled Service:** **Diagnosis:**		
5	**Skilled Service:** **Diagnosis:**		
6	**Skilled Service:** **Diagnosis:**		
7	**Skilled Service:** **Diagnosis:**		
8	**Skilled Service:** **Diagnosis:**		
9	**Skilled Service:** **Diagnosis:**		
10	**Skilled Service:** **Diagnosis:**		

Health Care Provider's Signature and Attestation: I certify the statements on this form are true and certify that I have read NRS 629.091 (reproduced in Section 7 of this form).
Health Care Provider: Please cross out any rows above that have been left blank.

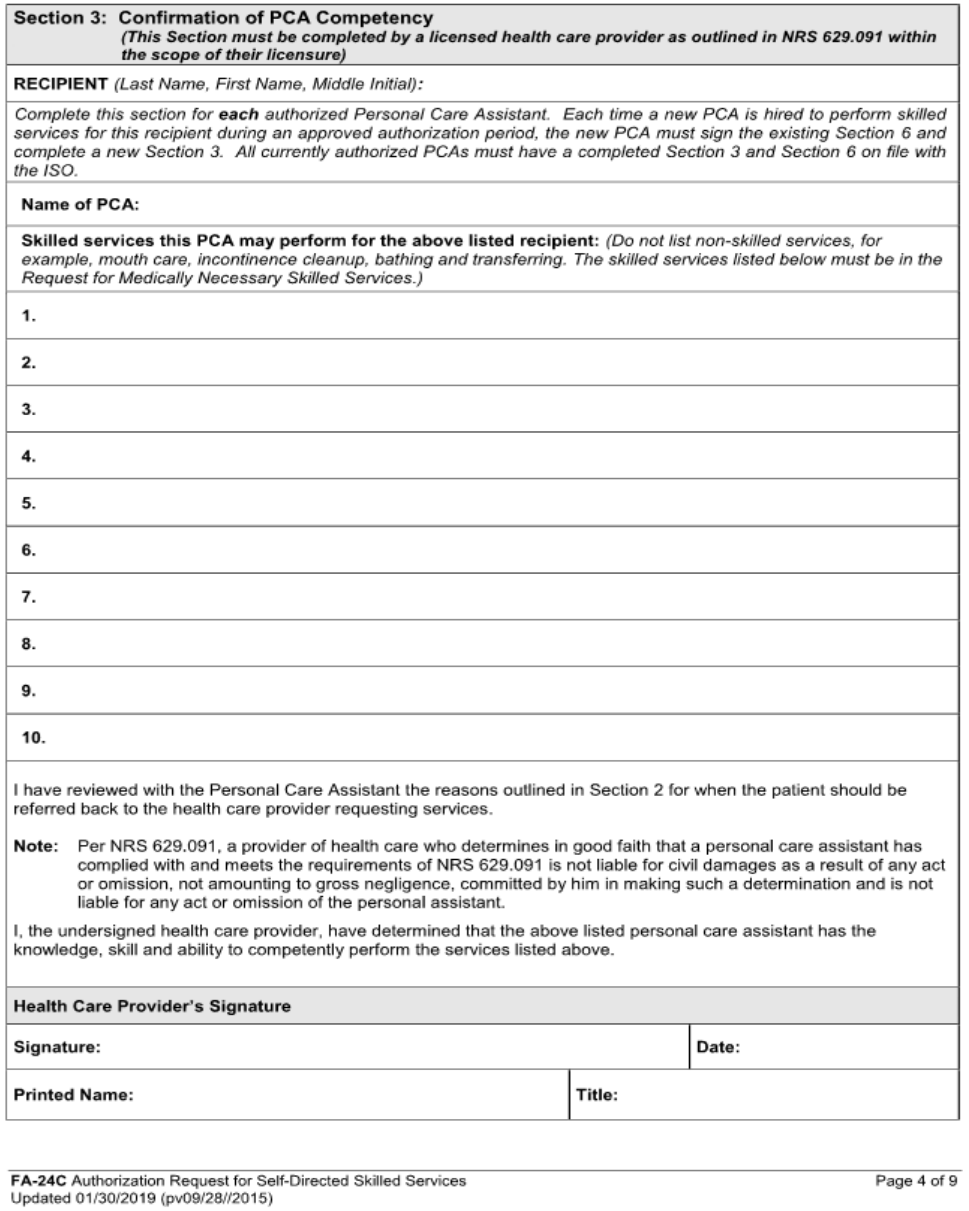
Signature:	**Date:**
Printed Name:	**Title:**

FA-24C Authorization Request for Self-Directed Skilled Services Page 3 of 9
Updated 01/30/2019 (pv09/28//2015)

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 3 must be completed by a licensed health care provider.
- The name of the PCA must be on the form.
- Skills that the PCA can perform must be listed.
- Page must be signed by a licensed health care provider acting within the scope of their licensure.

Note: Complete Section 3 for each competent Personal Care Attendant. Each time a new PCA is hired to perform skilled services for this recipient during an approved authorization period, the new PCA must sign the existing Section 6 and complete a new Section 3. All currently authorized PCAs must have a completed Section 3 and Section 6 on file with the ISO.



Section 3: Confirmation of PCA Competency
(This Section must be completed by a licensed health care provider as outlined in NRS 629.091 within the scope of their licensure)

RECIPIENT *(Last Name, First Name, Middle Initial):*

*Complete this section for **each** authorized Personal Care Assistant. Each time a new PCA is hired to perform skilled services for this recipient during an approved authorization period, the new PCA must sign the existing Section 6 and complete a new Section 3. All currently authorized PCAs must have a completed Section 3 and Section 6 on file with the ISO.*

Name of PCA:

Skilled services this PCA may perform for the above listed recipient: *(Do not list non-skilled services, for example, mouth care, incontinence cleanup, bathing and transferring. The skilled services listed below must be in the Request for Medically Necessary Skilled Services.)*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

I have reviewed with the Personal Care Assistant the reasons outlined in Section 2 for when the patient should be referred back to the health care provider requesting services.

Note: Per NRS 629.091, a provider of health care who determines in good faith that a personal care assistant has complied with and meets the requirements of NRS 629.091 is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

I, the undersigned health care provider, have determined that the above listed personal care assistant has the knowledge, skill and ability to competently perform the services listed above.

Health Care Provider's Signature

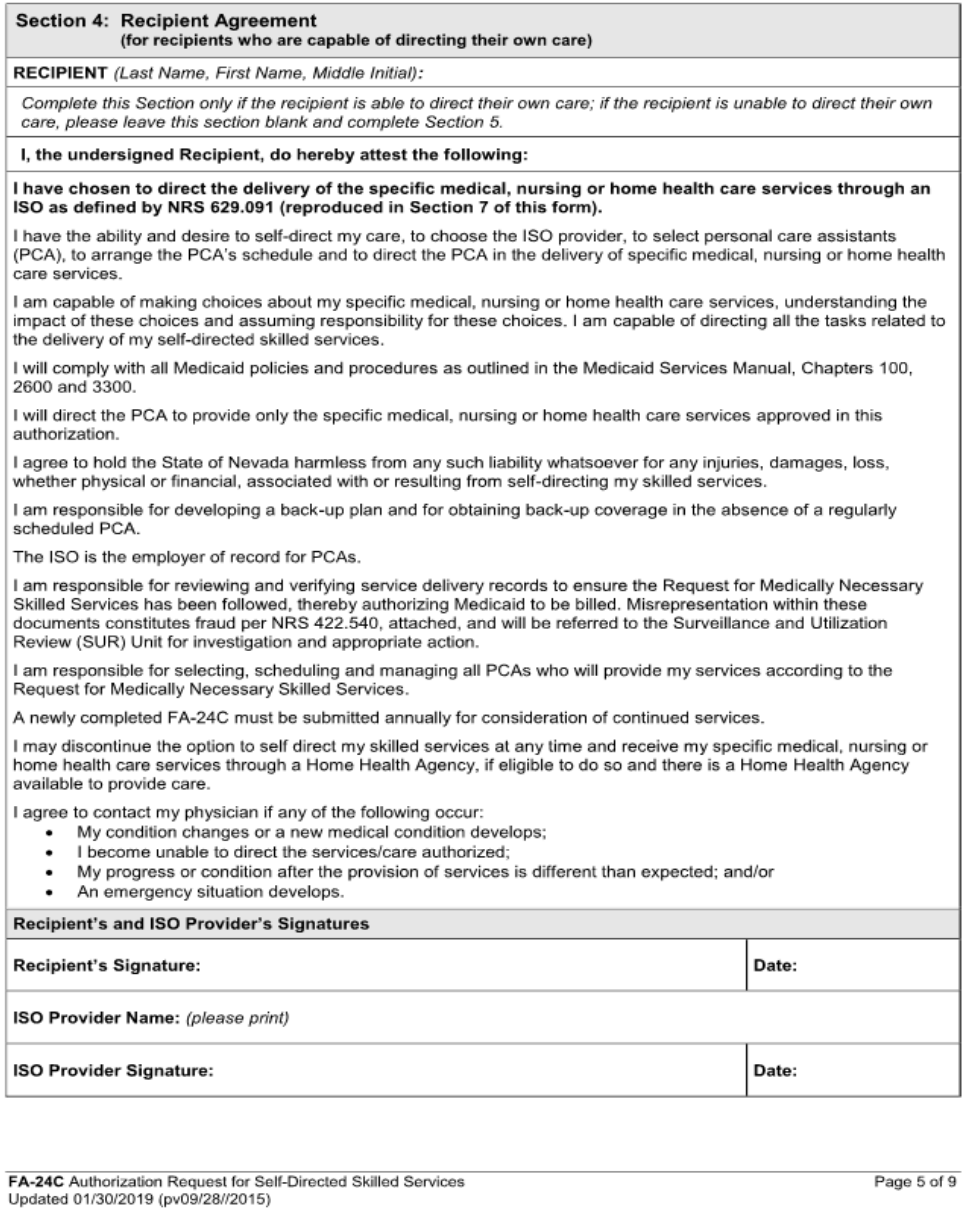
Signature:	**Date:**
Printed Name:	**Title:**

FA-24C Authorization Request for Self-Directed Skilled Services Page 4 of 9
Updated 01/30/2019 (pv09/28//2015)

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- If the recipient is able to self-direct their own care, complete Section 4. Section 4 must be read and understood by the recipient.
  - If the recipient is unable to self-direct their own care, do not complete Section 4, and move to Section 5.

- ISO provider must sign and date the section.



Section 4: Recipient Agreement
(for recipients who are capable of directing their own care)

RECIPIENT *(Last Name, First Name, Middle Initial):*

Complete this Section only if the recipient is able to direct their own care; if the recipient is unable to direct their own care, please leave this section blank and complete Section 5.

I, the undersigned Recipient, do hereby attest the following:

I have chosen to direct the delivery of the specific medical, nursing or home health care services through an ISO as defined by NRS 629.091 (reproduced in Section 7 of this form).

I have the ability and desire to self-direct my care, to choose the ISO provider, to select personal care assistants (PCA), to arrange the PCA's schedule and to direct the PCA in the delivery of specific medical, nursing or home health care services.

I am capable of making choices about my specific medical, nursing or home health care services, understanding the impact of these choices and assuming responsibility for these choices. I am capable of directing all the tasks related to the delivery of my self-directed skilled services.

I will comply with all Medicaid policies and procedures as outlined in the Medicaid Services Manual, Chapters 100, 2600 and 3300.

I will direct the PCA to provide only the specific medical, nursing or home health care services approved in this authorization.

I agree to hold the State of Nevada harmless from any such liability whatsoever for any injuries, damages, loss, whether physical or financial, associated with or resulting from self-directing my skilled services.

I am responsible for developing a back-up plan and for obtaining back-up coverage in the absence of a regularly scheduled PCA.

The ISO is the employer of record for PCAs.

I am responsible for reviewing and verifying service delivery records to ensure the Request for Medically Necessary Skilled Services has been followed, thereby authorizing Medicaid to be billed. Misrepresentation within these documents constitutes fraud per NRS 422.540, attached, and will be referred to the Surveillance and Utilization Review (SUR) Unit for investigation and appropriate action.

I am responsible for selecting, scheduling and managing all PCAs who will provide my services according to the Request for Medically Necessary Skilled Services.

A newly completed FA-24C must be submitted annually for consideration of continued services.

I may discontinue the option to self direct my skilled services at any time and receive my specific medical, nursing or home health care services through a Home Health Agency, if eligible to do so and there is a Home Health Agency available to provide care.

I agree to contact my physician if any of the following occur:
- My condition changes or a new medical condition develops;
- I become unable to direct the services/care authorized;
- My progress or condition after the provision of services is different than expected; and/or
- An emergency situation develops.

Recipient's and ISO Provider's Signatures

Recipient's Signature:	**Date:**
ISO Provider Name: *(please print)*	
ISO Provider Signature:	**Date:**

FA-24C Authorization Request for Self-Directed Skilled Services Page 5 of 9
Updated 01/30/2019 (pv09/28//2015)

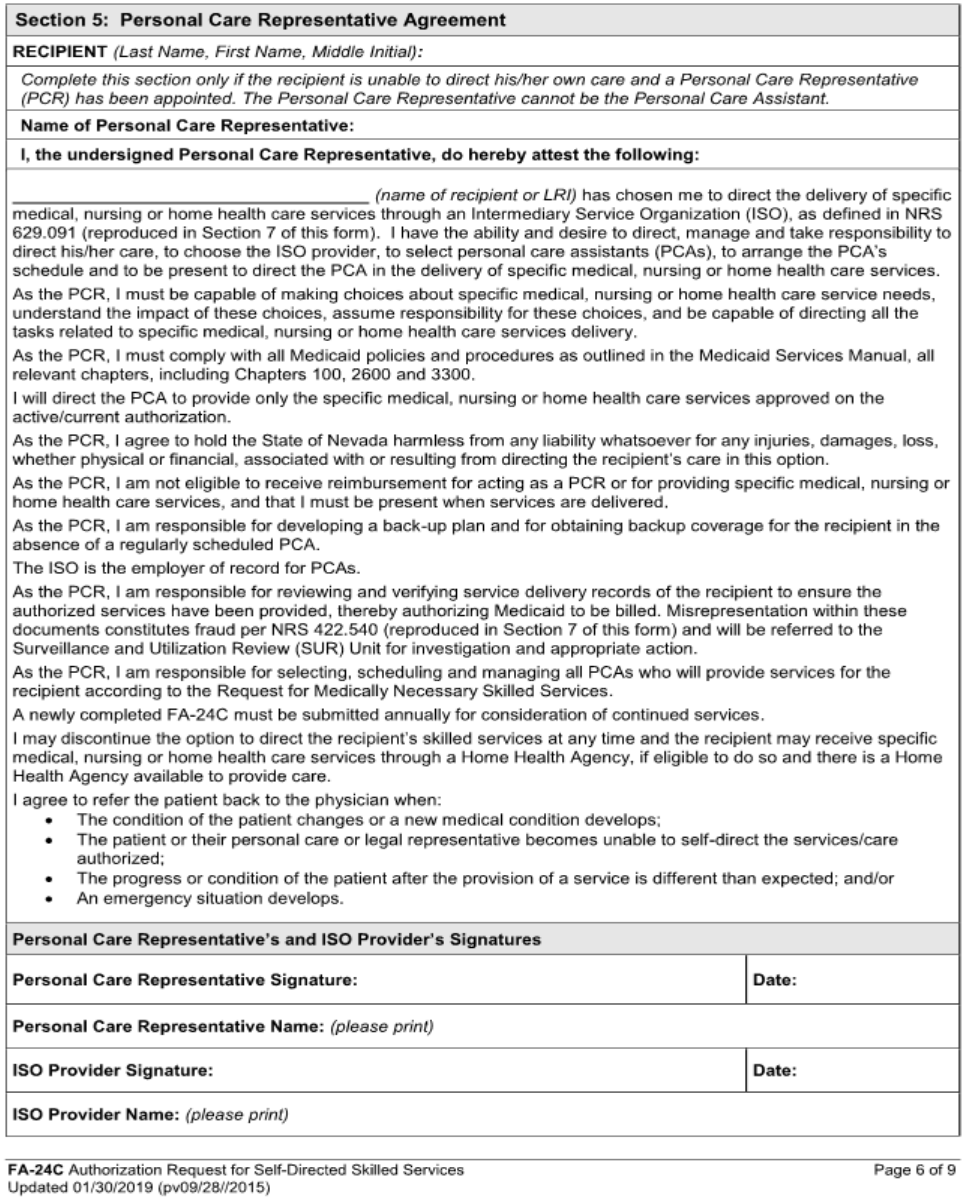
Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 5 is to be filled out only if the recipient is unable to direct their own care.
  - Do not complete Section 4.

- The Personal Care Representative (PCR) cannot be the PCA.

- This section must be completed by:
  - LRI & directing care, but unable to perform the care and FA-24B is on file or
  - PCR designated due to no LRI or
  - PCR designated by the LRI due to the LRI being unavailable and FA-24B is on file

- ISO provider must sign and date the section.



Section 5: Personal Care Representative Agreement

RECIPIENT *(Last Name, First Name, Middle Initial):*

Complete this section only if the recipient is unable to direct his/her own care and a Personal Care Representative (PCR) has been appointed. The Personal Care Representative cannot be the Personal Care Assistant.

Name of Personal Care Representative:

I, the undersigned Personal Care Representative, do hereby attest the following:

_____ *(name of recipient or LRI)* has chosen me to direct the delivery of specific medical, nursing or home health care services through an Intermediary Service Organization (ISO), as defined in NRS 629.091 (reproduced in Section 7 of this form). I have the ability and desire to direct, manage and take responsibility to direct his/her care, to choose the ISO provider, to select personal care assistants (PCAs), to arrange the PCA's schedule and to be present to direct the PCA in the delivery of specific medical, nursing or home health care services.

As the PCR, I must be capable of making choices about specific medical, nursing or home health care service needs, understand the impact of these choices, assume responsibility for these choices, and be capable of directing all the tasks related to specific medical, nursing or home health care services delivery.

As the PCR, I must comply with all Medicaid policies and procedures as outlined in the Medicaid Services Manual, all relevant chapters, including Chapters 100, 2600 and 3300.

I will direct the PCA to provide only the specific medical, nursing or home health care services approved on the active/current authorization.

As the PCR, I agree to hold the State of Nevada harmless from any liability whatsoever for any injuries, damages, loss, whether physical or financial, associated with or resulting from directing the recipient's care in this option.

As the PCR, I am not eligible to receive reimbursement for acting as a PCR or for providing specific medical, nursing or home health care services, and that I must be present when services are delivered.

As the PCR, I am responsible for developing a back-up plan and for obtaining backup coverage for the recipient in the absence of a regularly scheduled PCA.

The ISO is the employer of record for PCAs.

As the PCR, I am responsible for reviewing and verifying service delivery records of the recipient to ensure the authorized services have been provided, thereby authorizing Medicaid to be billed. Misrepresentation within these documents constitutes fraud per NRS 422.540 (reproduced in Section 7 of this form) and will be referred to the Surveillance and Utilization Review (SUR) Unit for investigation and appropriate action.

As the PCR, I am responsible for selecting, scheduling and managing all PCAs who will provide services for the recipient according to the Request for Medically Necessary Skilled Services.

A newly completed FA-24C must be submitted annually for consideration of continued services.

I may discontinue the option to direct the recipient's skilled services at any time and the recipient may receive specific medical, nursing or home health care services through a Home Health Agency, if eligible to do so and there is a Home Health Agency available to provide care.

I agree to refer the patient back to the physician when:

- The condition of the patient changes or a new medical condition develops;
- The patient or their personal care or legal representative becomes unable to self-direct the services/care authorized;
- The progress or condition of the patient after the provision of a service is different than expected; and/or
- An emergency situation develops.

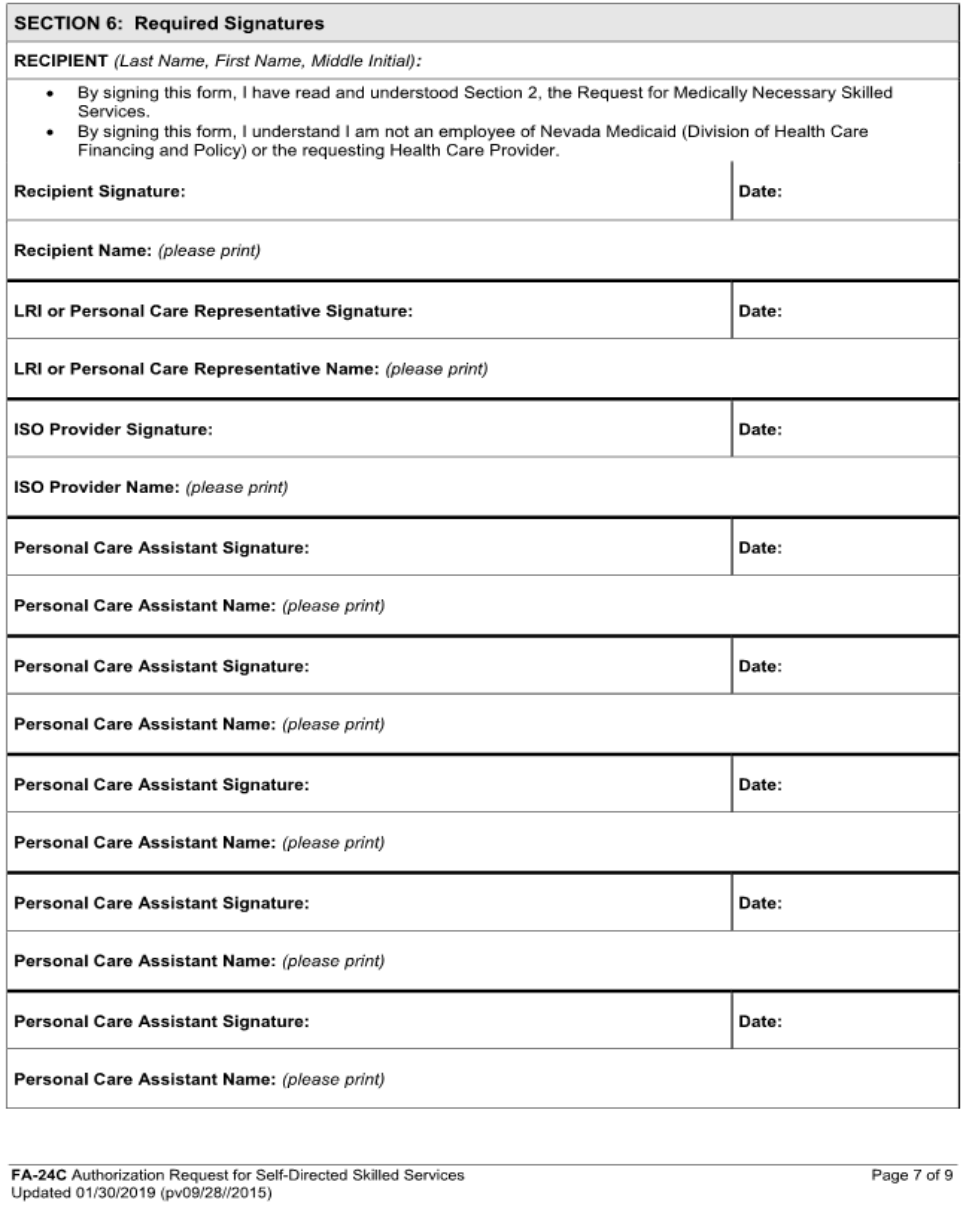
Personal Care Representative's and ISO Provider's Signatures

Personal Care Representative Signature:	**Date:**
Personal Care Representative Name: *(please print)*	
ISO Provider Signature:	**Date:**
ISO Provider Name: *(please print)*	

FA-24C Authorization Request for Self-Directed Skilled Services Page 6 of 9
Updated 01/30/2019 (pv09/28//2015)

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 6 must be signed by the following:
  - Recipient
  - Legally Responsible Individual/Personal Care Representative *(if the recipient is not able to self-direct the care)*
  - ISO Provider
  - PCA(s)



SECTION 6: Required Signatures	
RECIPIENT *(Last Name, First Name, Middle Initial):*	
• By signing this form, I have read and understood Section 2, the Request for Medically Necessary Skilled Services. • By signing this form, I understand I am not an employee of Nevada Medicaid (Division of Health Care Financing and Policy) or the requesting Health Care Provider.	
Recipient Signature:	**Date:**
Recipient Name: *(please print)*	
LRI or Personal Care Representative Signature:	**Date:**
LRI or Personal Care Representative Name: *(please print)*	
ISO Provider Signature:	**Date:**
ISO Provider Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	

FA-24C Authorization Request for Self-Directed Skilled Services Page 7 of 9
Updated 01/30/2019 (pv09/28//2015)

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 7 must be read and understood by all parties involved.

Section 7: Applicable Nevada Revised Statutes (NRS)

RECIPIENT *(Last Name, First Name, Middle Initial):*

NRS 422.540 Offenses regarding false claims, statements or representations; penalties.

1. A person, with the intent to defraud, commits an offense if with respect to the Plan the person:
   (a) Makes a claim or causes it to be made, knowing the claim to be false, in whole or in part, by commission or omission;
   (b) Makes or causes to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission;
   (c) Makes or causes to be made a statement or representation for use by another in obtaining goods or services or services pursuant to the plan, knowing the statement or representation to be false, in whole or in part, by commission or omission; or
   (d) Makes or causes to be made a statement or representation for use in qualifying as a provider, knowing the statement or representation to be false, in whole or in part, by commission or omission.
2. A person who commits an offense described in subsection 1 shall be punished for a:
   (a) Category D felony, as provided in NRS 193.130, if the amount of the claim or the value of the goods or services obtained or sought to be obtained was greater than or equal to $650.00.
   (b) Misdemeanor if the amount of the claim or the value of the goods or services obtained or sought to be obtained was less than $650.00.
   Amounts involved in separate violations of this section committed pursuant to a scheme or continuing course of conduct may be aggregated in determining the punishment.
3. In addition to any other penalty for a violation of the commission of an offense described in subsection 1, the court shall order the person to pay restitution.

(Added to NRS by 1991, 1049; A 1997, 457, 2011, 174)

NRS 629.091 Personal assistant authorized to perform certain services for person with disability if approved by provider of health care; requirements.

1. Except as otherwise provided in subsection 4, a provider of health care may authorize a person to act as a personal assistant to perform specific medical, nursing or home health care services for a person with a disability without obtaining any license required for a provider of health care or his assistant to perform the service if:
   (a) The services to be performed are services that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;
   (b) The provider of health care determines that the personal assistant has the knowledge, skill and ability to perform the services competently;
   (c) The provider of health care determines that the procedures involved in providing the services are simple and the performance of such procedures by the personal assistant does not pose a substantial risk to the person with a disability;
   (d) The provider of health care determines that the condition of the person with a disability is stable and predictable; and
   (e) The personal assistant agrees with the provider of health care to refer the person with a disability to the provider of health care if:
      (1) The condition of the person with a disability changes or a new medical condition develops;
      (2) The progress or condition of the person with a disability after the provision of the service is different than expected;
      (3) An emergency situation develops; or
      (4) Any other situation described by the provider of health care develops.
2. A provider of health care that authorizes a personal assistant to perform certain services shall note in the medical records of the person with a disability who receives such services:
   (a) The specific services that he has authorized the personal assistant to perform; and
   (b) That the requirements of this section have been satisfied.
3. After a provider of health care has authorized a personal assistant to perform specific services for a person with a

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 8 must be read and understood by all parties involved.

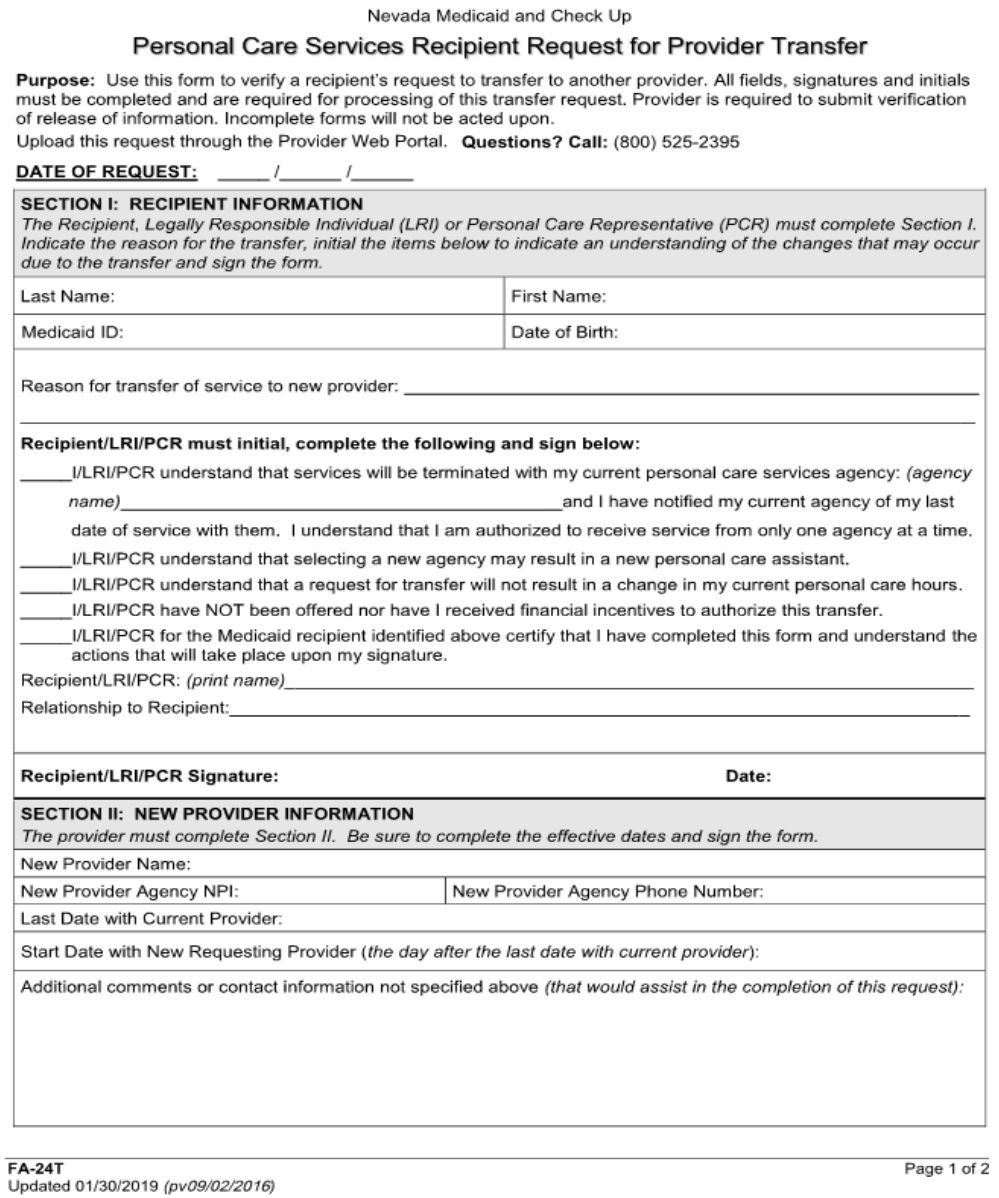
disability, no further authorization or supervision by the provider is required for the continued provision of those services.

4. A personal assistant shall not:
   (a) Perform services pursuant to this section for a person with a disability who resides in a medical facility.
   (b) Perform any medical, nursing or home health care service for a person with a disability which is not specifically authorized by a provider of health care pursuant to subsection 1.
   (c) Except if the services are provided in an educational setting, perform services for a person with a disability in the absence of the parent or guardian of, or any other person legally responsible for, the person with a disability, if the person with a disability is not able to direct his own services.
5. A provider of health care who determines in good faith that a personal assistant has complied with and meets the requirements of this section is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.
6. As used in this section:
   (a) "Guardian" means a person who has qualified as the guardian of a minor or an adult pursuant to testamentary or judicial appointment, but does not include a guardian ad litem.
   (b) "Parent" means a natural or adoptive parent whose paternal rights have not been terminated.
   (c) "Personal assistant" means a person who, for compensation and under the direction of:
      (1) A person with a disability;
      (2) A parent or guardian of, or any other person legally responsible for, a person with a disability who is under the age of 18 years; or
      (3) A parent, spouse, guardian or adult child of a person with a disability who suffers from a cognitive impairment, performs services for the person with a disability to help him maintain his independence, personal hygiene and safety.
   (d) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.

(Added to NRS by 1995, 749; A 2005, 69)

PCS Recipient Request for Provider Transfer – FA-24T

- This form is to be used when a recipient is requesting to transfer from one provider to another.
- Fill out the form in its entirety.
- Recipient, LRI or PCR must complete Section 1, indicate the reason for the transfer and initial where applicable.
- Section 2 is the new provider information.
  - The new provider must ensure that there will be no lapse in services when a recipient is transferring.
  - Start Date with New Requesting Provider: This is the date the authorization will begin. The agency must be in the home providing services on this date.



Nevada Medicaid and Check Up

Personal Care Services Recipient Request for Provider Transfer

Purpose: Use this form to verify a recipient's request to transfer to another provider. All fields, signatures and initials must be completed and are required for processing of this transfer request. Provider is required to submit verification of release of information. Incomplete forms will not be acted upon.

Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

SECTION I: RECIPIENT INFORMATION

The Recipient, Legally Responsible Individual (LRI) or Personal Care Representative (PCR) must complete Section I. Indicate the reason for the transfer, initial the items below to indicate an understanding of the changes that may occur due to the transfer and sign the form.

Last Name:	First Name:
Medicaid ID:	Date of Birth:

Reason for transfer of service to new provider: _____

_____

Recipient/LRI/PCR must initial, complete the following and sign below:

_____I/LRI/PCR understand that services will be terminated with my current personal care services agency: *(agency name)*_____and I have notified my current agency of my last date of service with them. I understand that I am authorized to receive service from only one agency at a time.

_____I/LRI/PCR understand that selecting a new agency may result in a new personal care assistant.

_____I/LRI/PCR understand that a request for transfer will not result in a change in my current personal care hours.

_____I/LRI/PCR have NOT been offered nor have I received financial incentives to authorize this transfer.

_____I/LRI/PCR for the Medicaid recipient identified above certify that I have completed this form and understand the actions that will take place upon my signature.

Recipient/LRI/PCR: *(print name)*_____

Relationship to Recipient:_____

Recipient/LRI/PCR Signature: **Date:**

SECTION II: NEW PROVIDER INFORMATION

The provider must complete Section II. Be sure to complete the effective dates and sign the form.

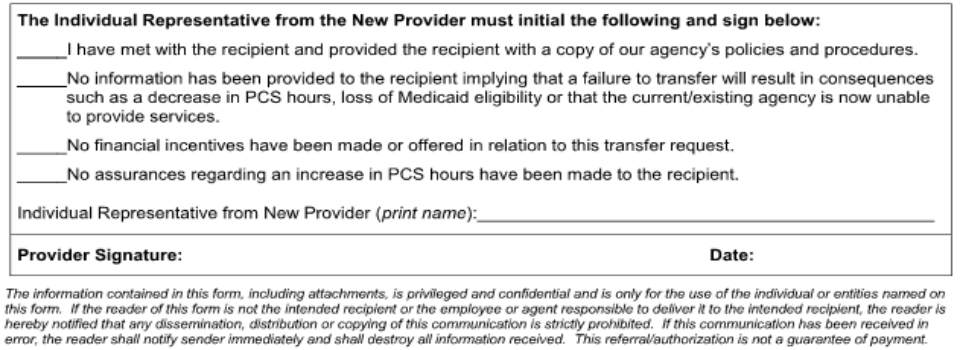
New Provider Name:	
New Provider Agency NPI:	New Provider Agency Phone Number:
Last Date with Current Provider:	
Start Date with New Requesting Provider (*the day after the last date with current provider*):	
Additional comments or contact information not specified above *(that would assist in the completion of this request):*	

FA-24T Page 1 of 2

Updated 01/30/2019 *(pv09/02/2016)*

PCS Recipient Request for Provider Transfer – FA-24T, continued

- An individual representative from the new provider must initial and sign page 2.



The Individual Representative from the New Provider must initial the following and sign below:

_____I have met with the recipient and provided the recipient with a copy of our agency's policies and procedures.

_____No information has been provided to the recipient implying that a failure to transfer will result in consequences such as a decrease in PCS hours, loss of Medicaid eligibility or that the current/existing agency is now unable to provide services.

_____No financial incentives have been made or offered in relation to this transfer request.

_____No assurances regarding an increase in PCS hours have been made to the recipient.

Individual Representative from New Provider (*print name*):_____

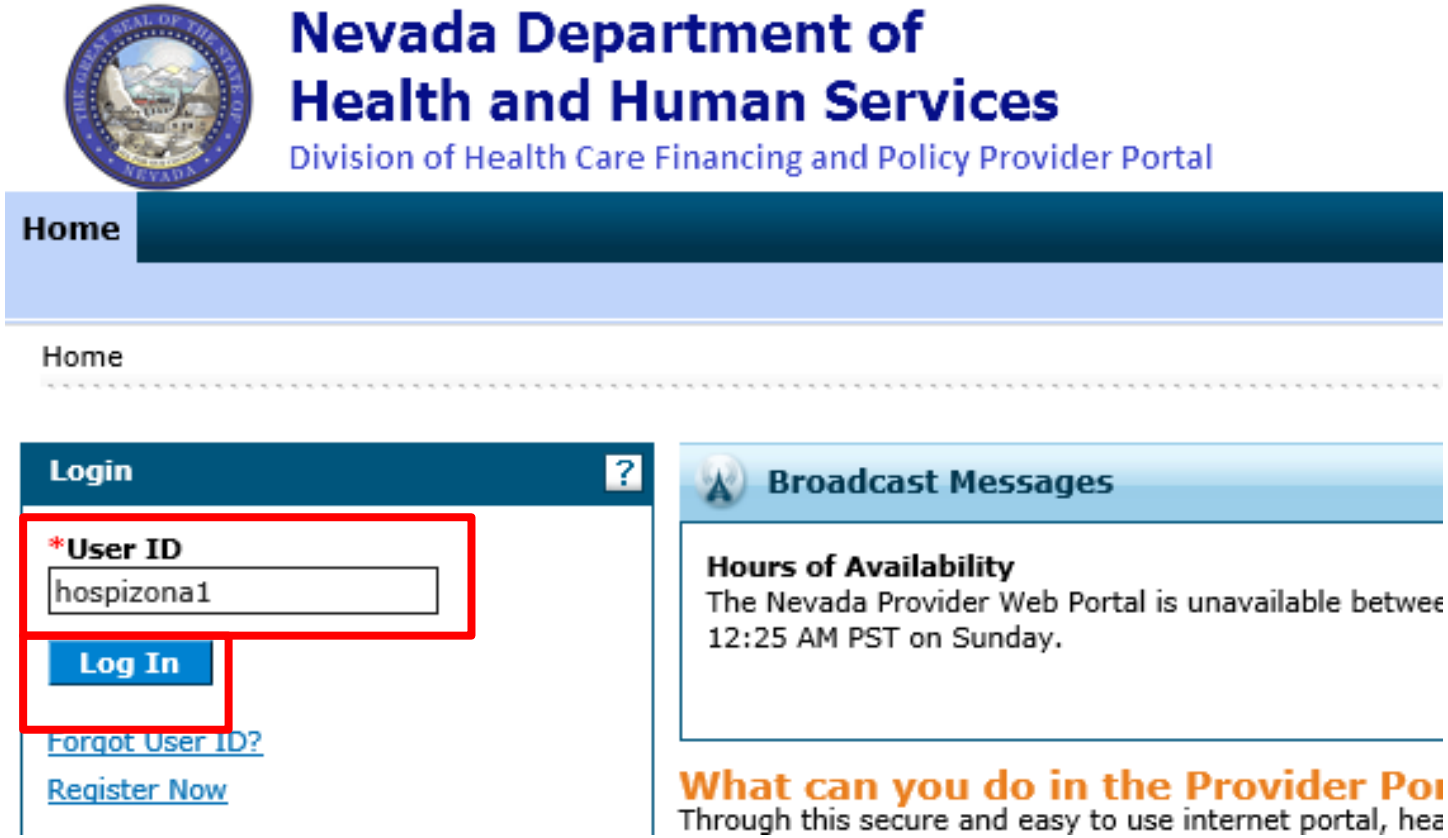
Provider Signature: **Date:**

The information contained in this form, including 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 has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/authorization is not a guarantee of payment.

FA-24T Page 2 of 2
Updated 01/30/2019 *(pv09/02/2016)*

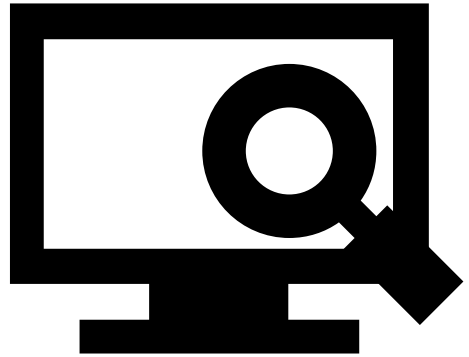
Submitting a Prior Authorization via the EVS Secure Provider Web Portal

Logging into the Provider Web Portal

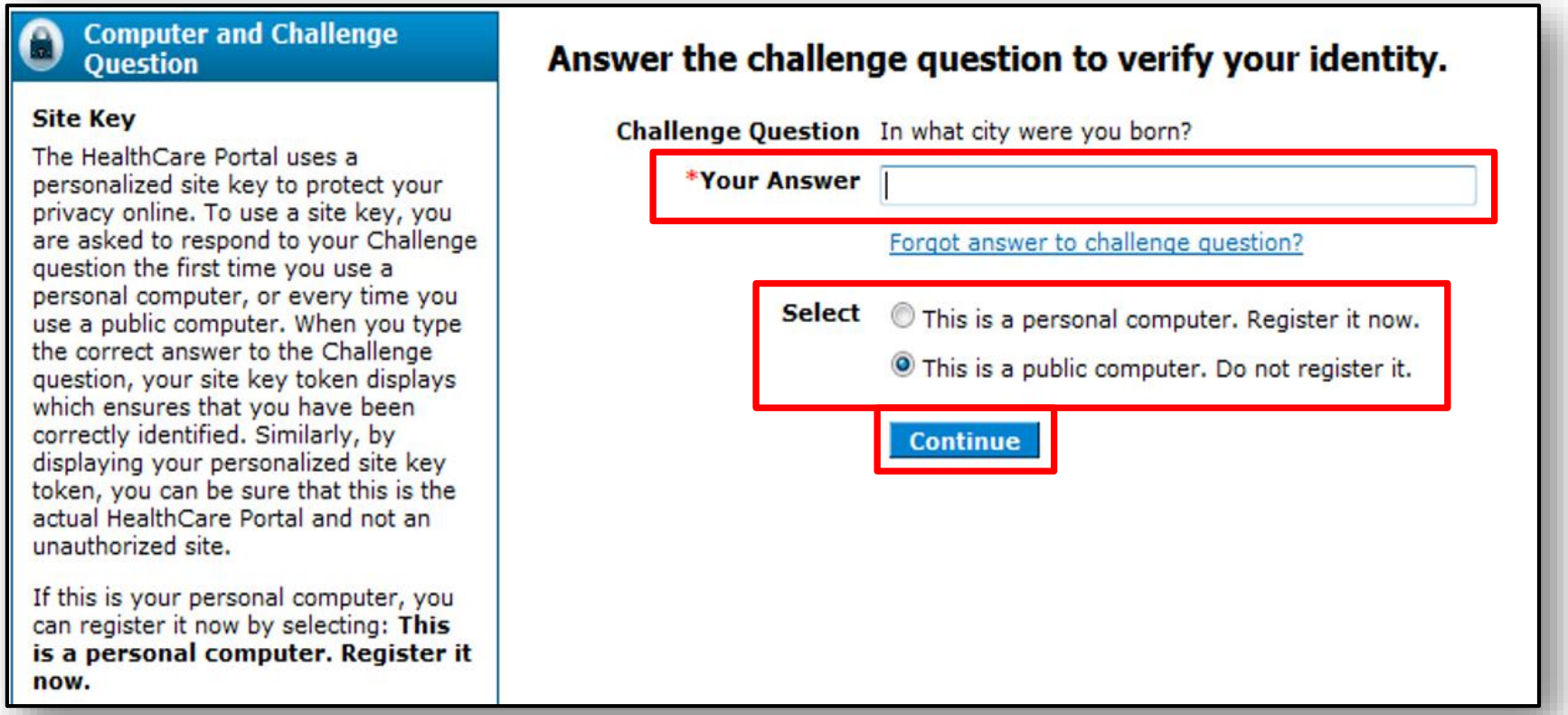


Once registered, users may access their accounts from the PWP "Home" page by:

- Entering the **User ID.**
- Clicking the **Log In** button.



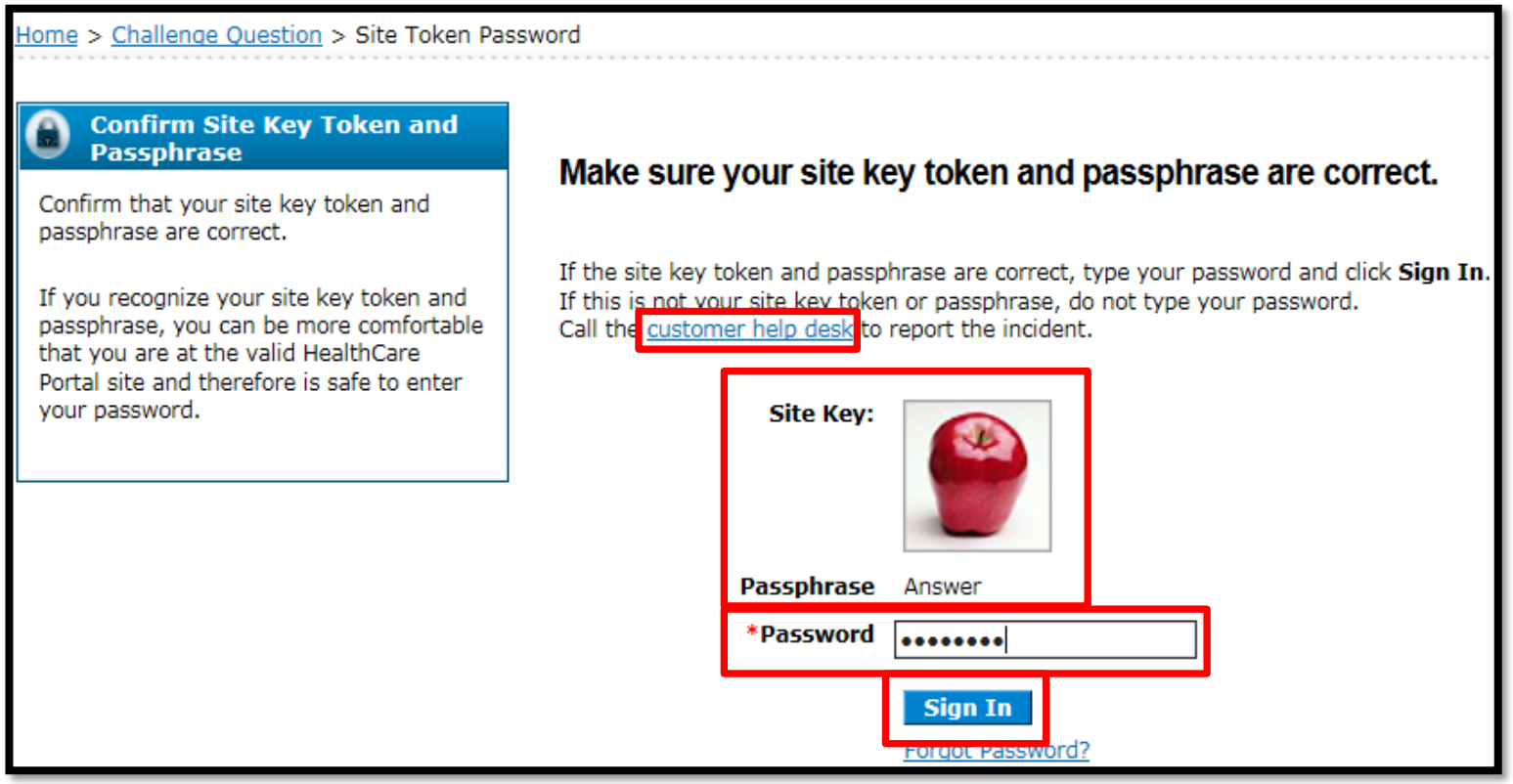
Logging in to the Provider Web Portal, continued



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

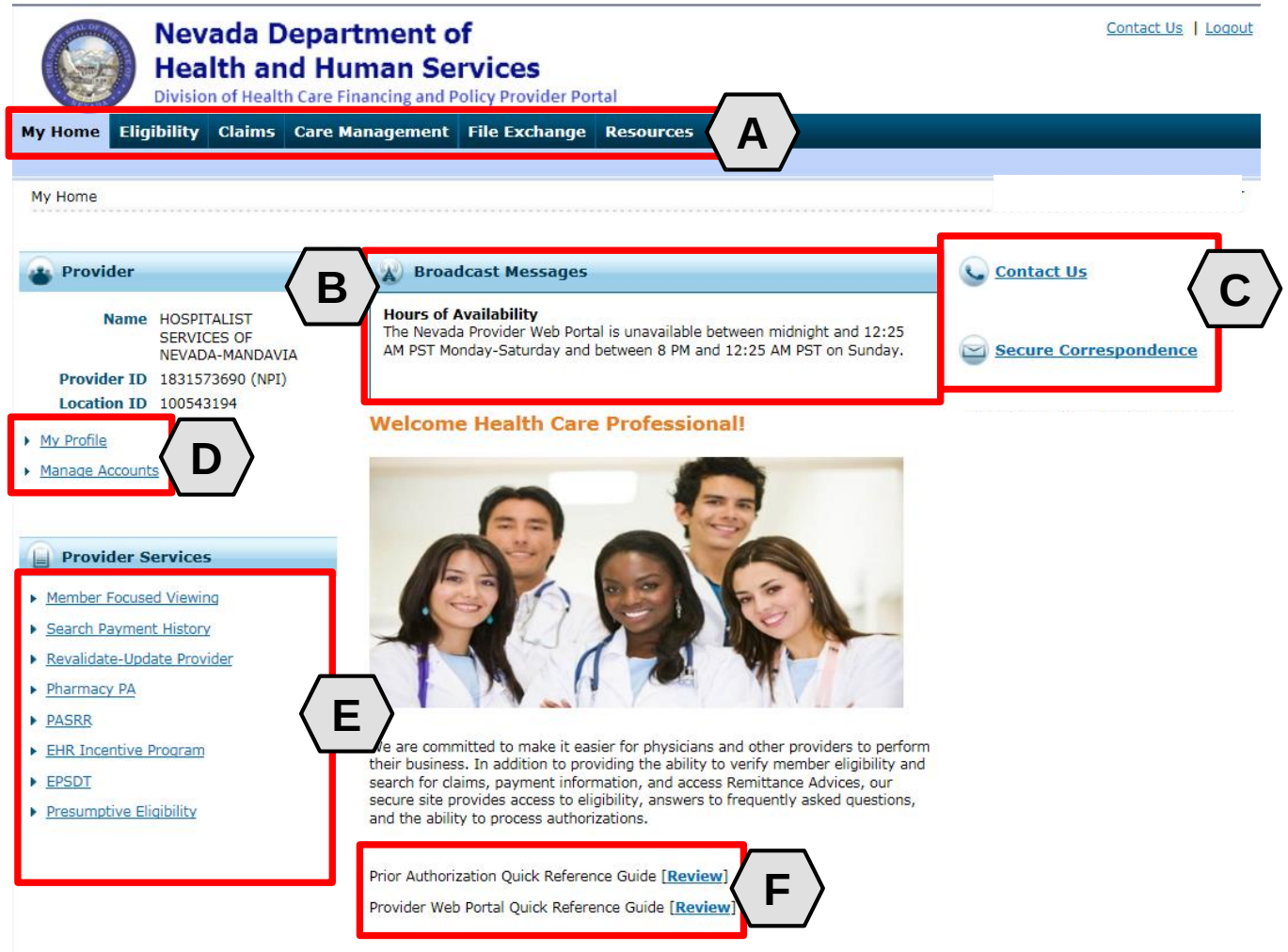


The user will continue providing identity verification as follows:

- Confirming that the **Site Key** and **Passphrase** are correct.
- Entering **Password.**
- Clicking the **Sign In** button.

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

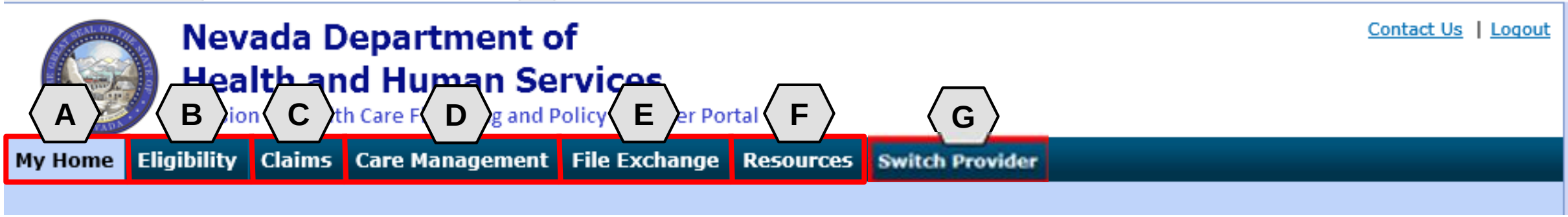
Welcome Screen



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.

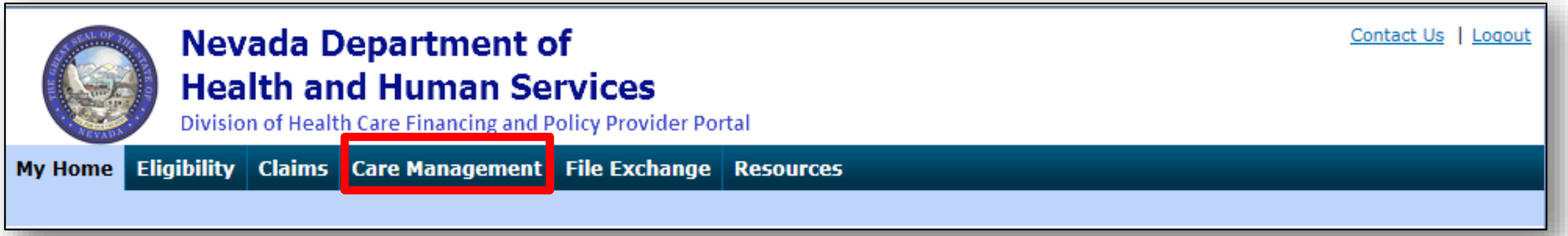
Navigating the Provider Web Portal



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**: This is where **delegates** can switch between providers to whom they are assigned. The tab is only present when the user is logged in as a delegate.

Care Management Tab



Create Authorization

- Create authorizations for eligible recipients

View Authorization Status

- Prospective authorizations that identify the requesting or servicing provider

Maintain Favorite Providers

- Create a list of frequently used providers
- Select the facility or servicing provider from the providers on the list when creating an authorization
- Maintain a favorites list of up to 20 providers

Before You Create a Web Portal Prior Authorization Request

Before Creating a Prior Authorization Request

- Verify eligibility to ensure that the recipient is eligible on the date of service for the requested services.
- Use the Provider Web Portal's PA search function to see if a request for the dates of service, units and service(s) already exists.
- Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.
- Use the Provider Web Portal to check PAs in pending status for additional information.

Create a Prior Authorization Request

Key Information

Recipient Demographics

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

Diagnosis Codes

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

Searchable Diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)

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

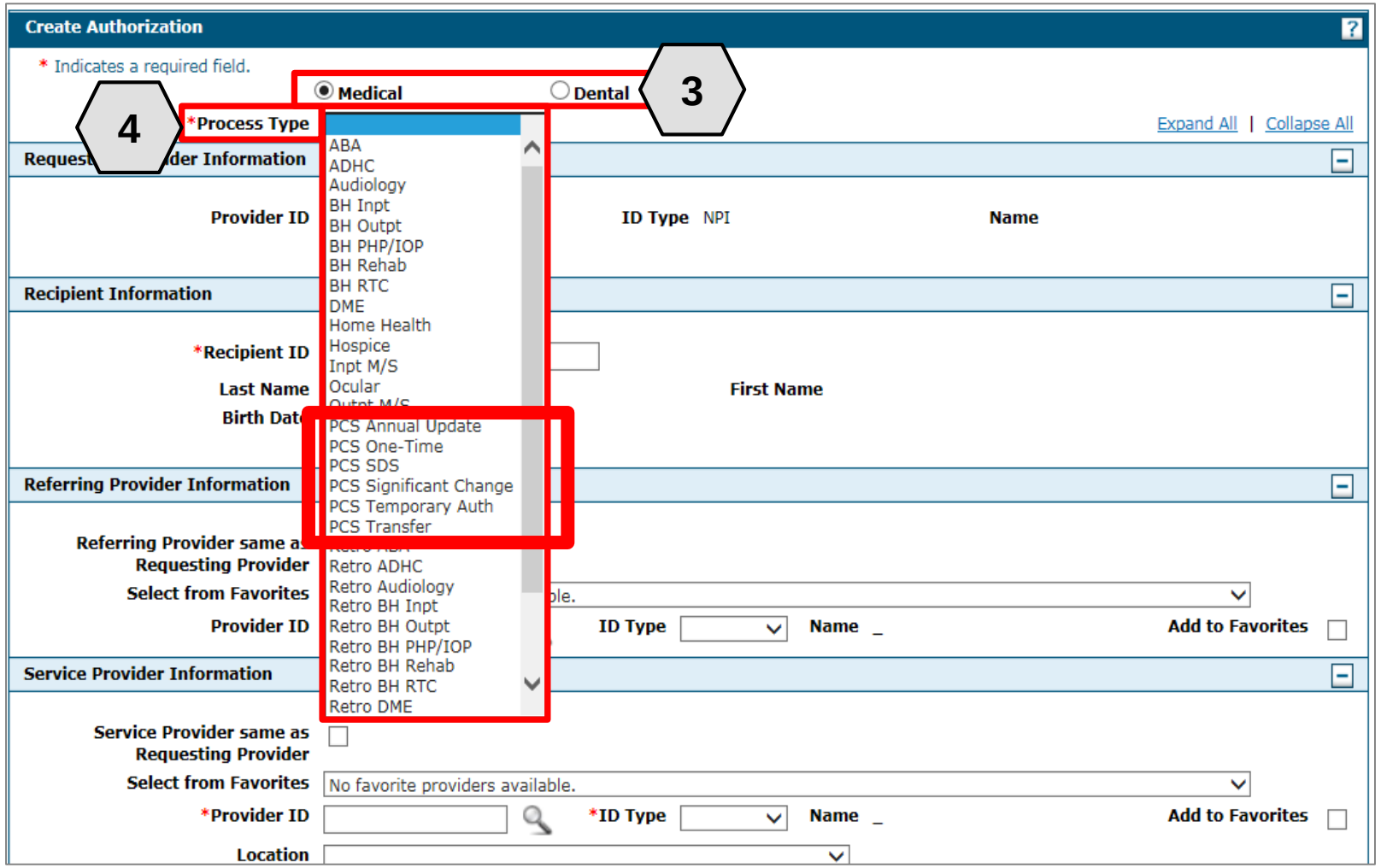
PA Attachments

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

Submitting a PA Request

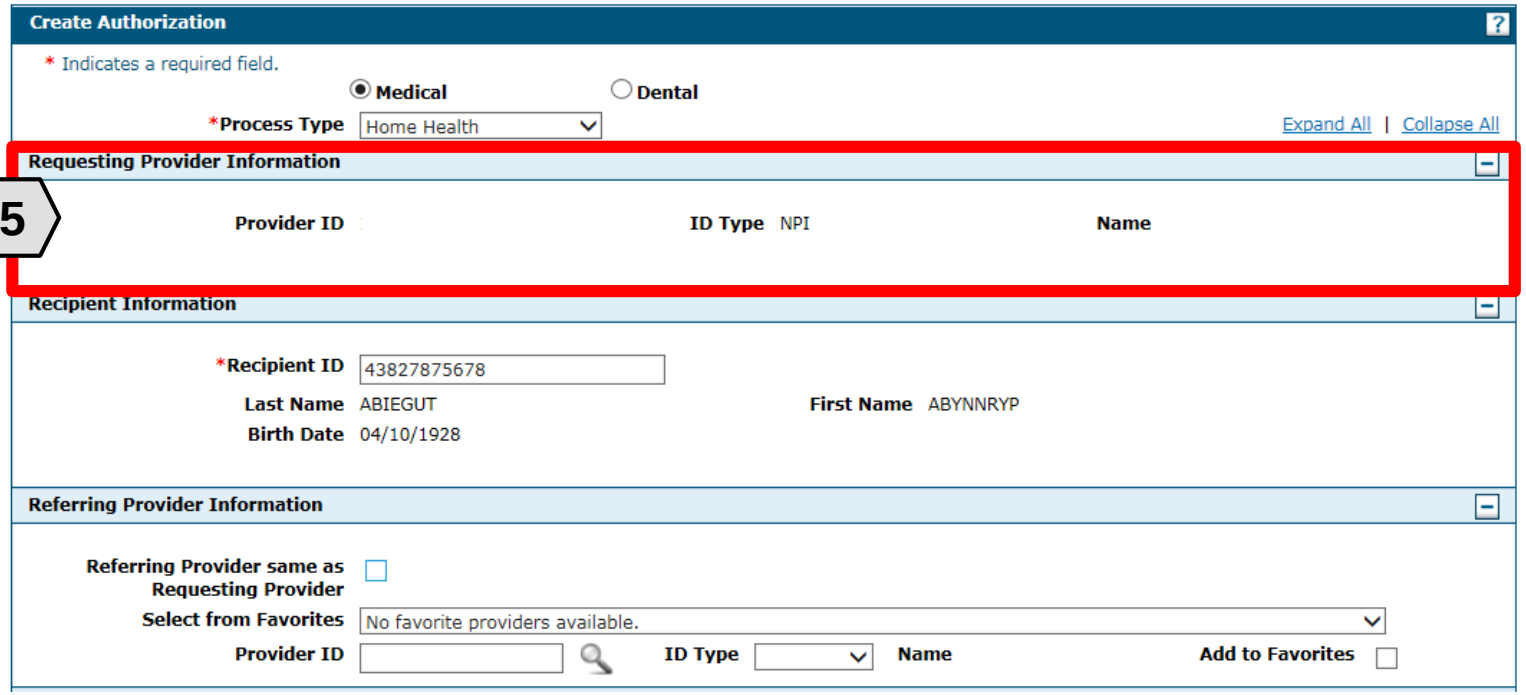
1. Hover over the **Care Management** tab.
2. Click **Create Authorization** from the sub-menu.

Submitting a PA Request, continued



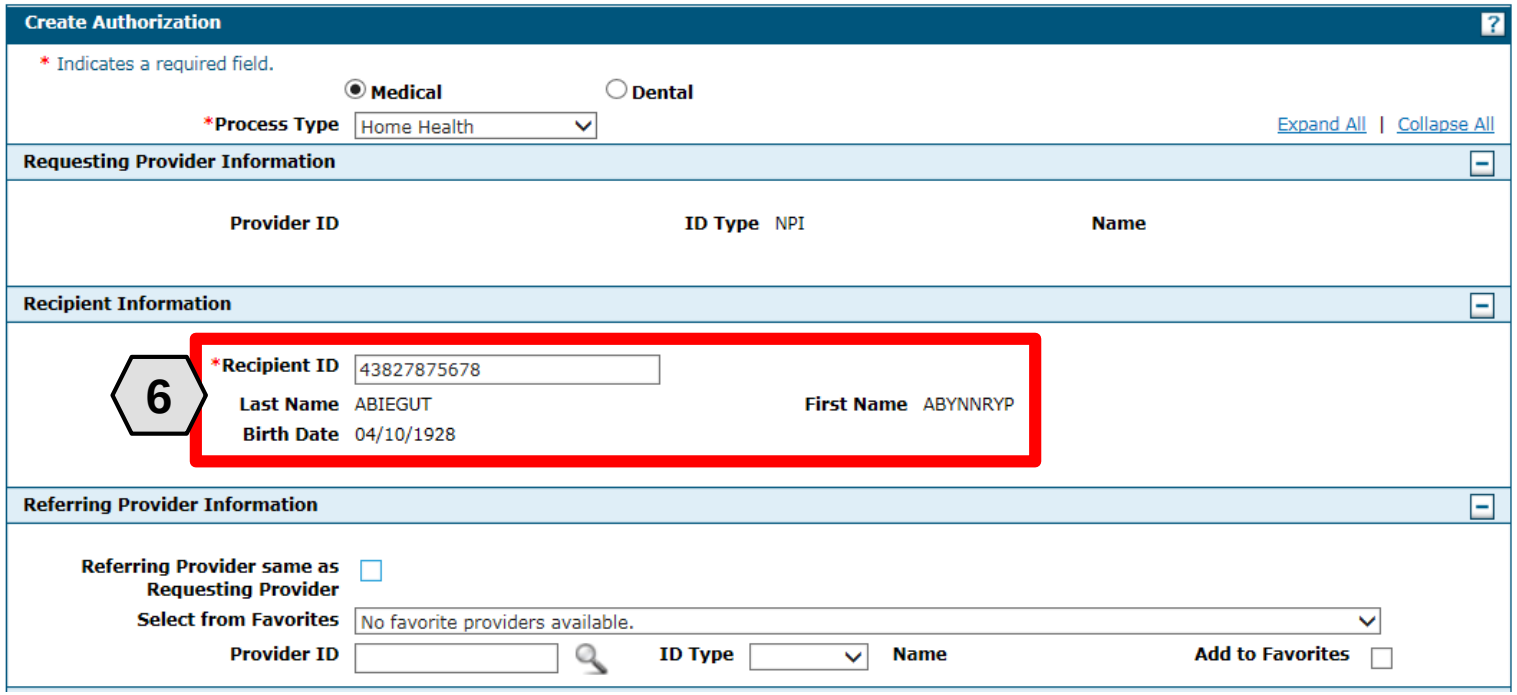
3. Select the authorization type (**Medical**).
4. Choose the correct **Process Type** from the drop-down list. If the wrong type is selected, the PA request will be canceled.

Submitting a PA Request, continued



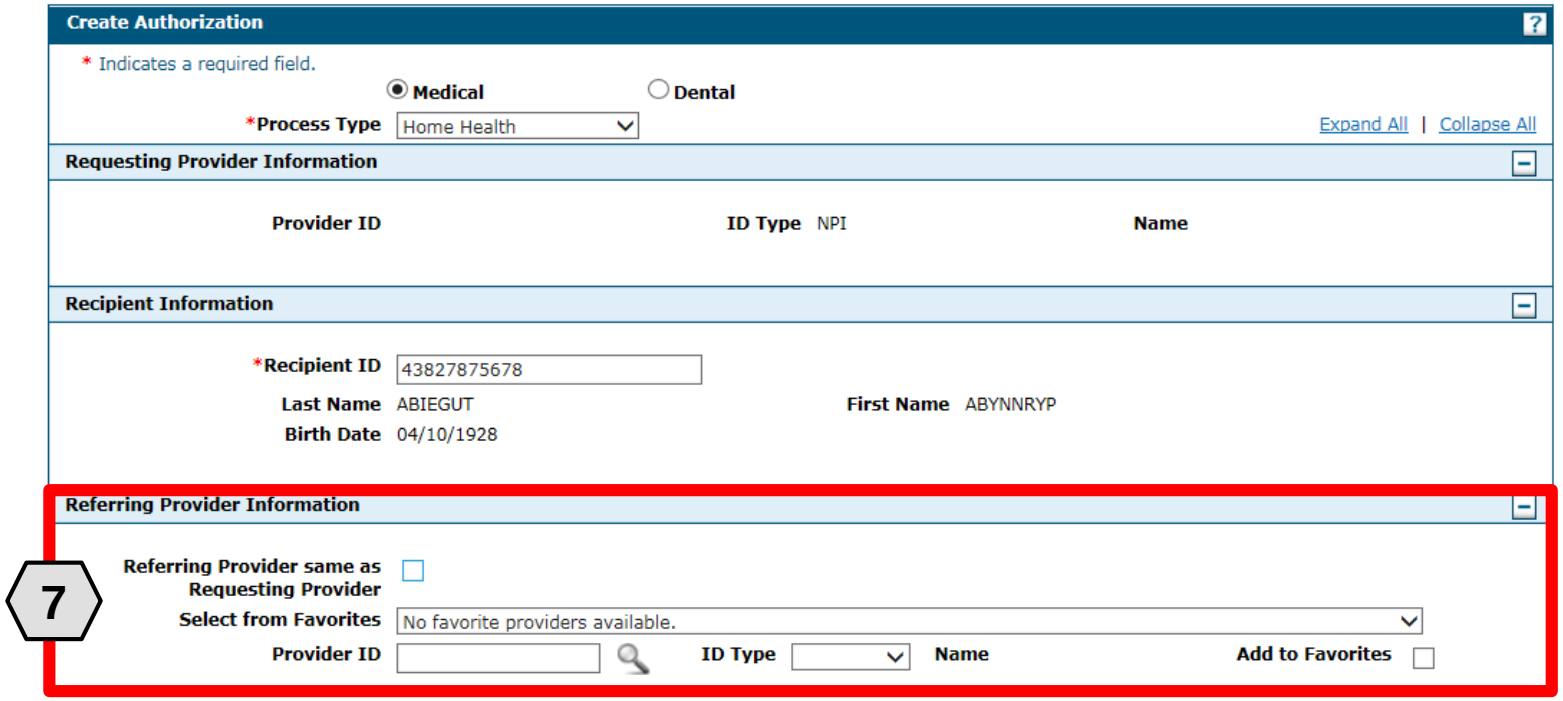
5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.

Submitting a PA Request, continued



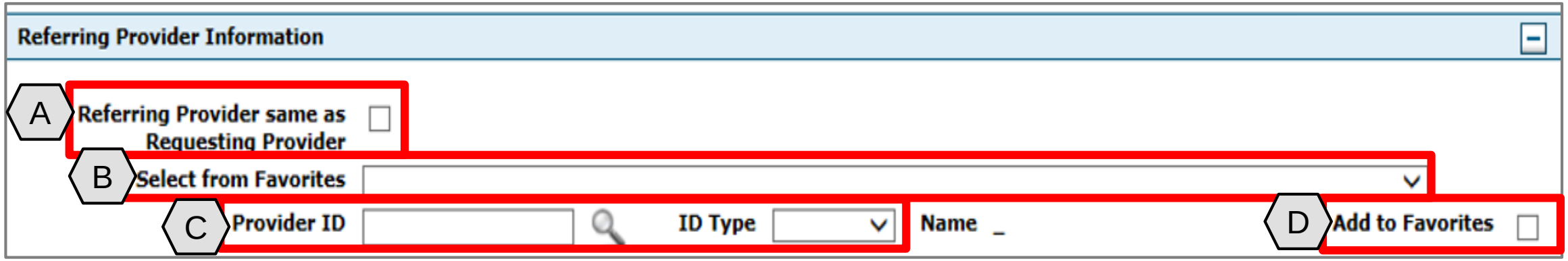
6. Enter the **Recipient ID.** The Last Name, First Name and Birth Date will populate automatically**.**

Submitting a PA Request, continued



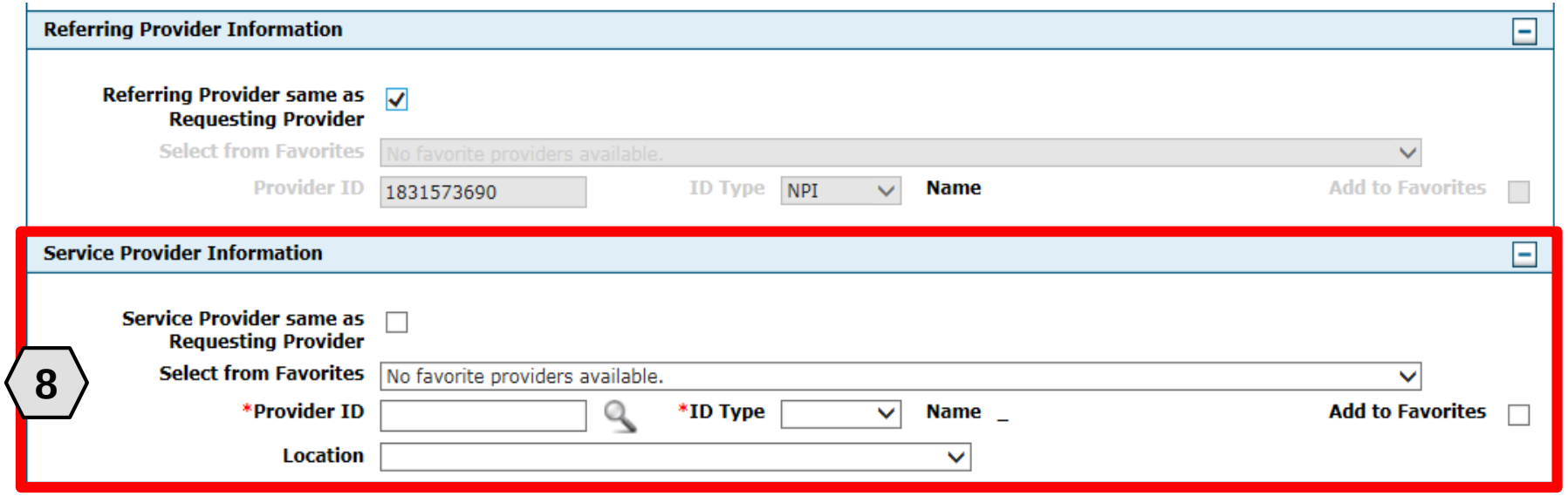
7. Enter **Referring Provider Information** using one of three ways.

Submitting a PA Request, continued



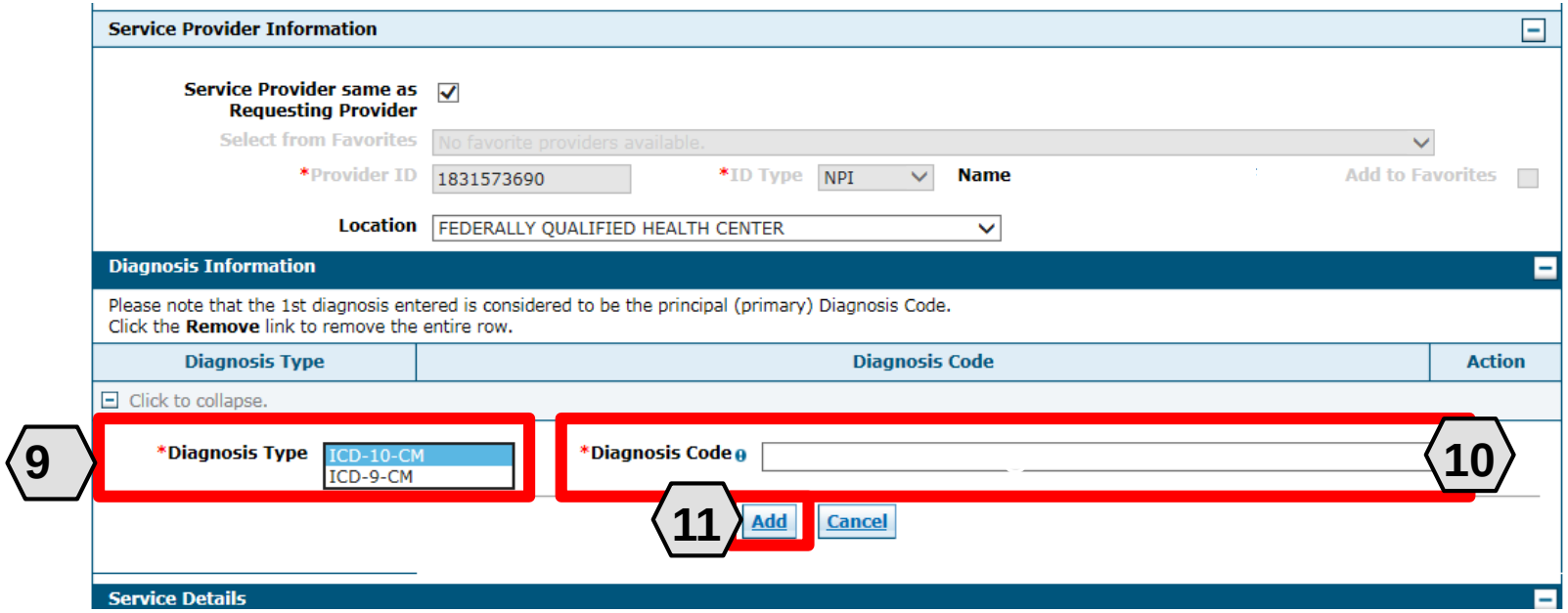
A. Check the **Referring Provider Same as Requesting Provider** box.
B. Choose an option from the **Select from Favorites** drop-down. This drop-down displays a list of providers that the user has indicated as favorites.
C. Enter the **Provider ID** and **ID Type**. Both fields must be completed when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

Submitting a PA Request, continued



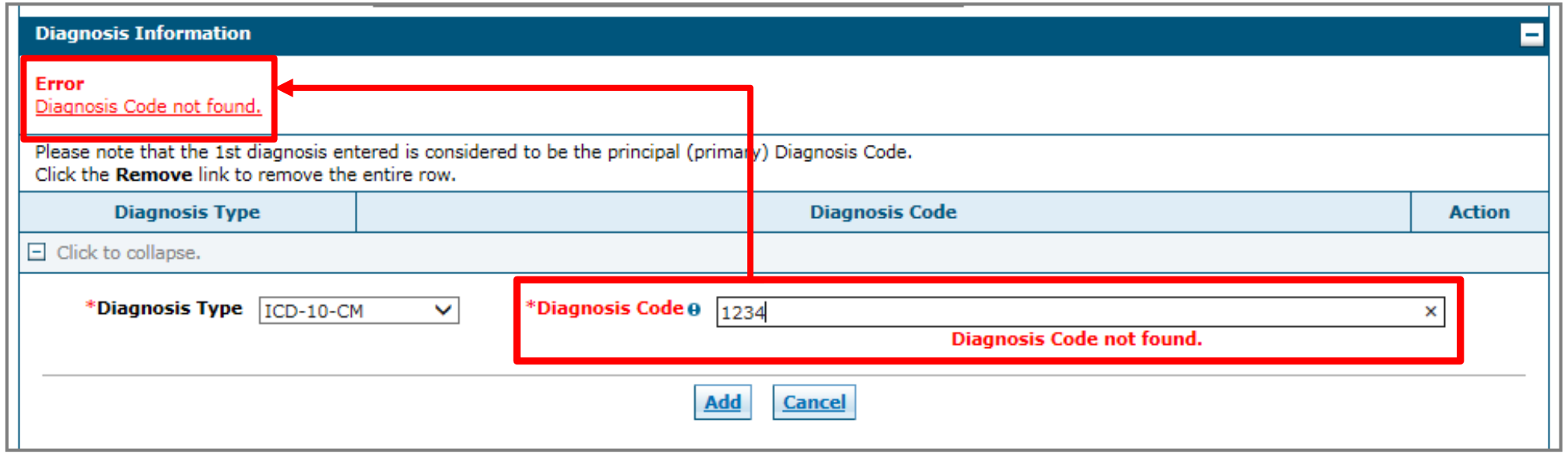
8. Enter **Service Provider Information.**

Submitting a PA Request, continued



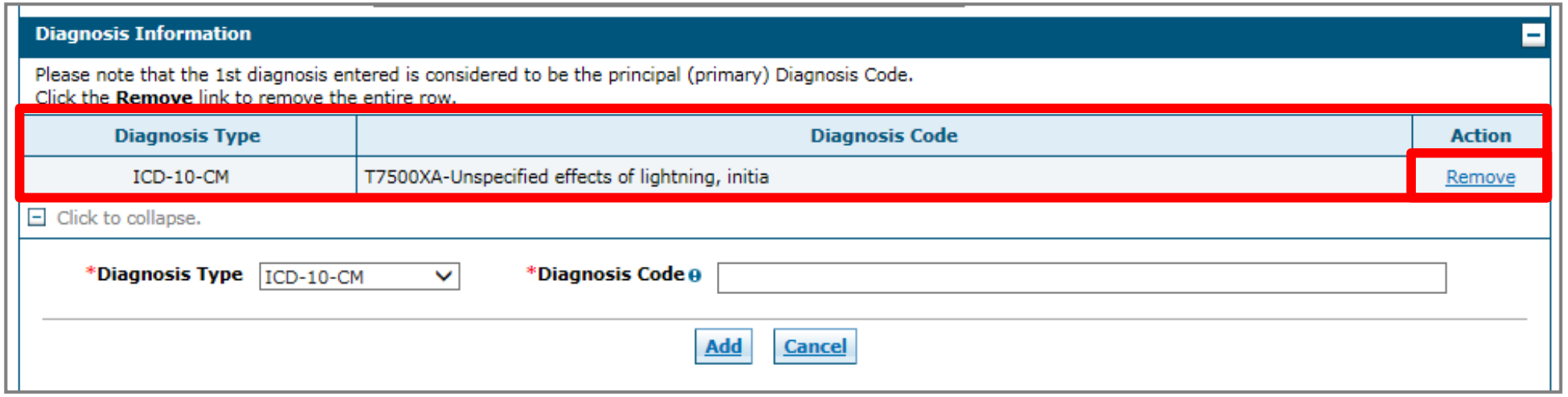
9. Select a **Diagnosis Type** from the drop-down list.
10. Enter the **Diagnosis Code**. Enter only one diagnosis code. Once the user begins typing, the field will automatically search for matching codes.
11. Click the **Add** button.

Submitting a PA Request, continued



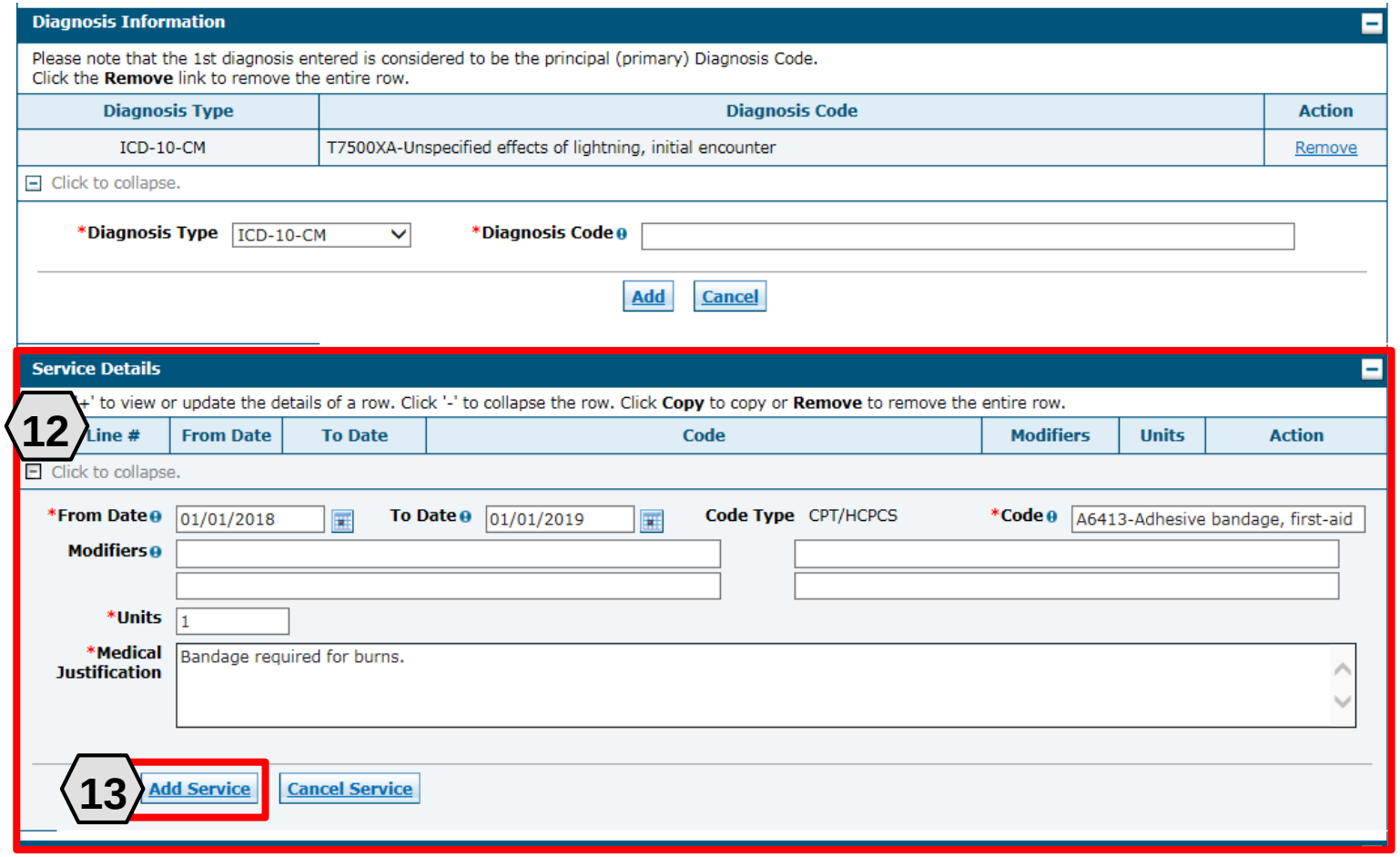
If you click the **Add** button with an invalid diagnosis code, an error will display. You must ensure the diagnosis code is correct, up-to-date with the selected **Diagnosis Type**, and does not include decimals.

Submitting a PA Request, continued



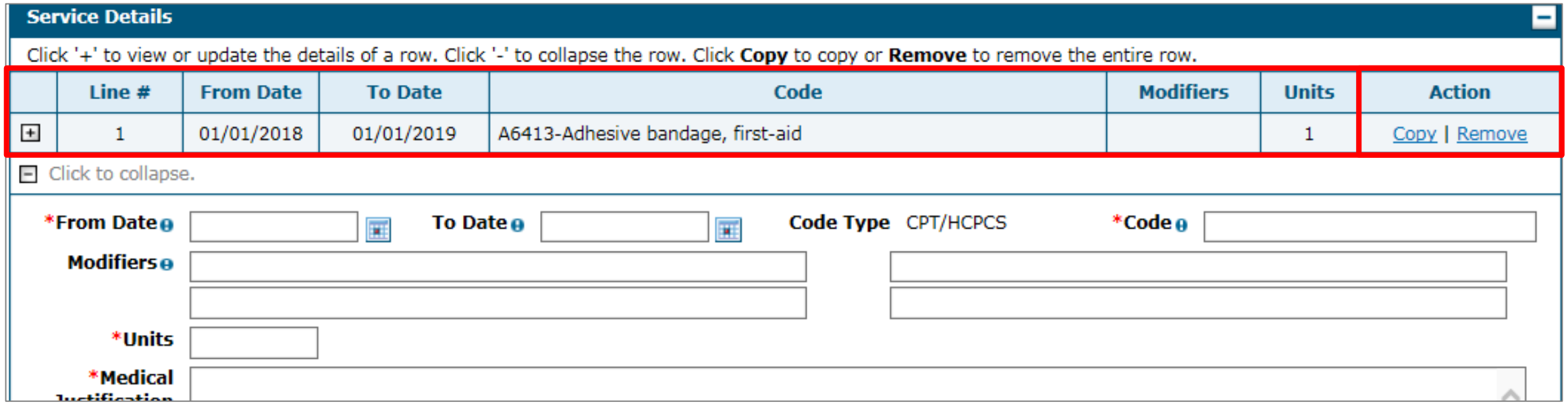
Once a diagnosis code has been entered accurately, and the **Add** button has been clicked, the diagnosis code will display under the **Diagnosis Information section**. If a code needs to be removed from the PA request, click **Remove** located in the **Action** column.

Submitting a PA Request, continued



12. Enter detail regarding the service(s) provided into the **Service Details** section.
13. Click the **Add Service** button.

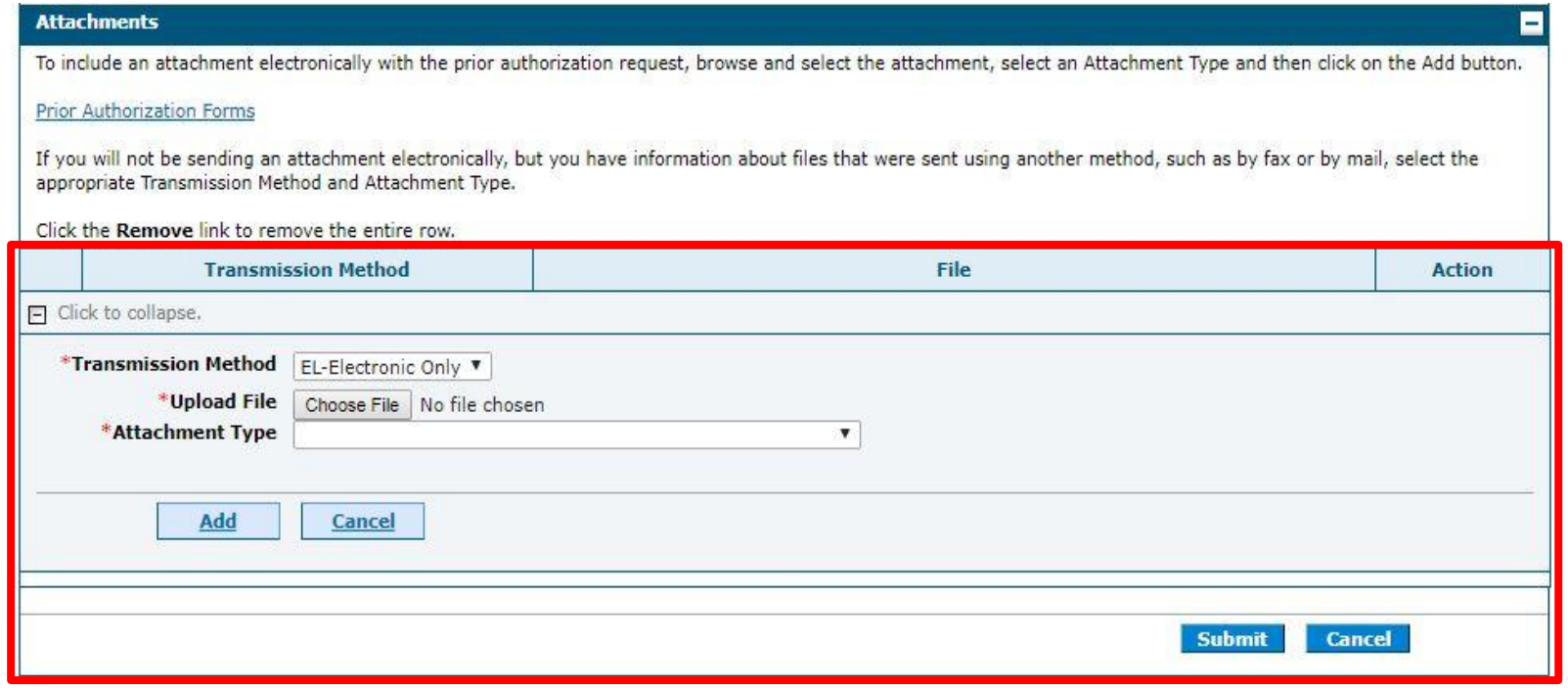
Submitting a PA Request, continued



After clicking the **Add Service** button, the service details will display in the list.

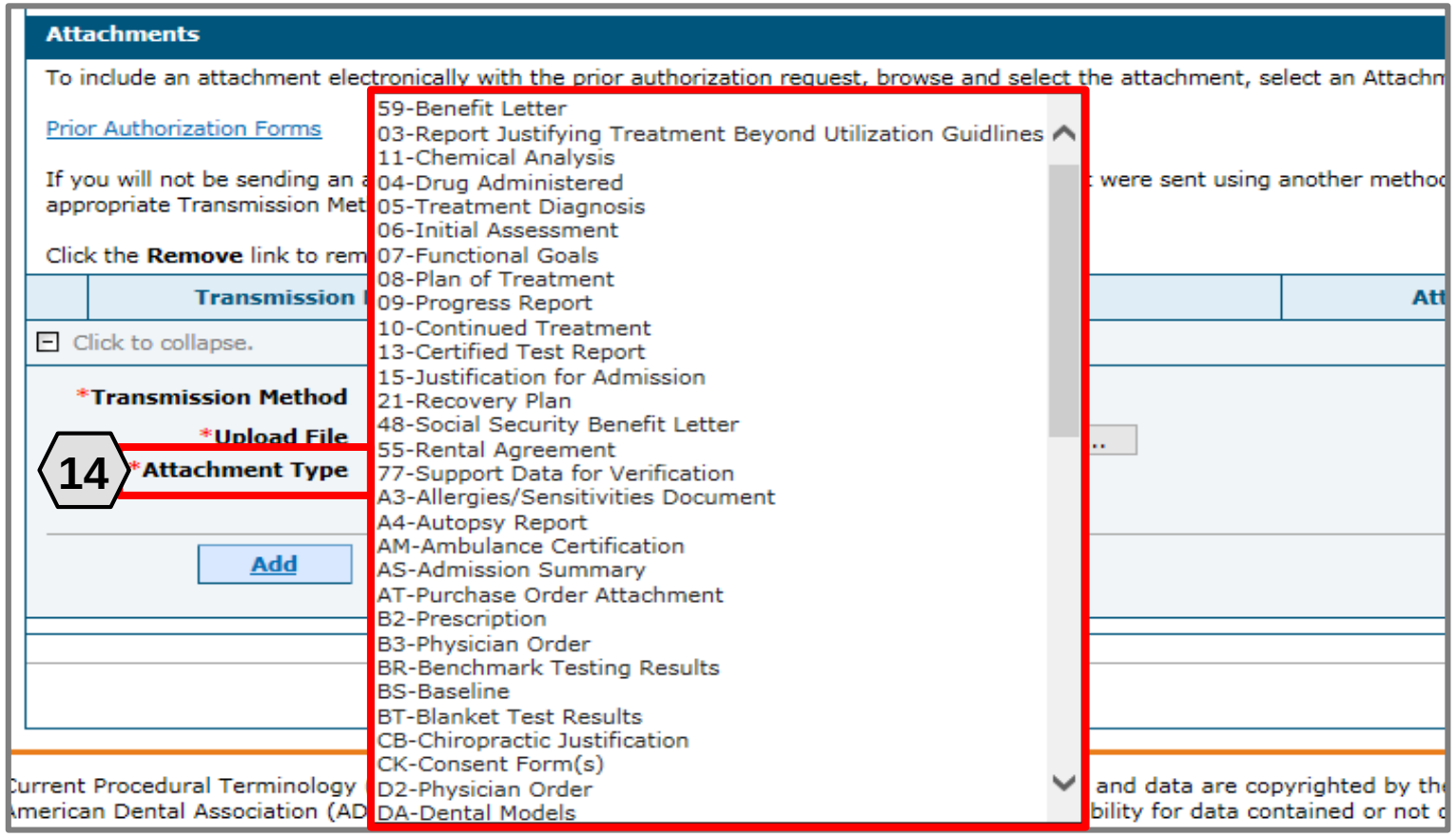
NOTE: Manage additional details as needed. If a user wishes to copy a service detail, click **Copy** located in the **Action** column. To remove the detail, click **Remove**.

Submitting a PA Request, continued



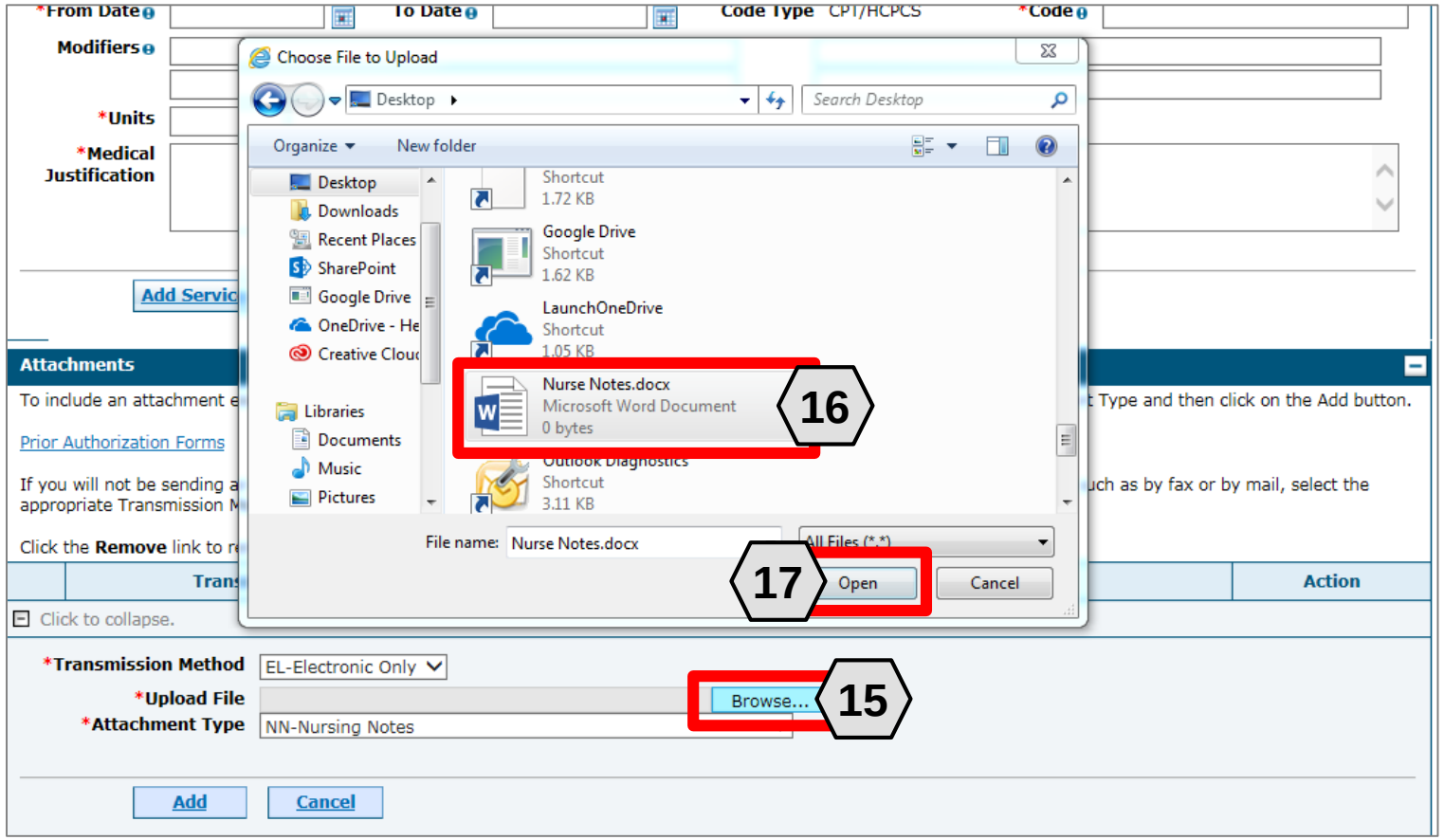
The **Transmission Method** will default to EL-Electronic Only as attachments must be sent via the Provider Web Portal.

Submitting a PA Request, continued



14. Choose the type of attachment being submitted from the **Attachment Type** drop-down list.

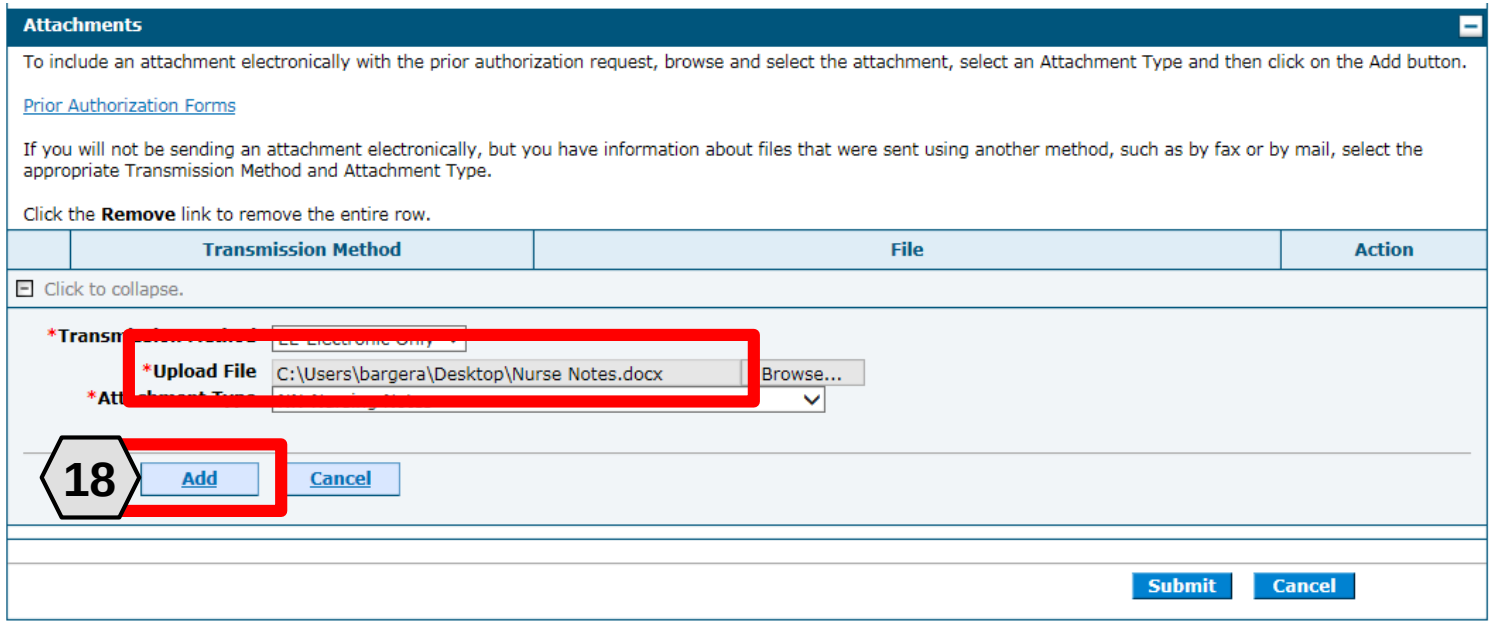
Submitting a PA Request, continued



15. Click the **Browse** button.
16. Select the desired attachment.
17. Click the **Open** button.

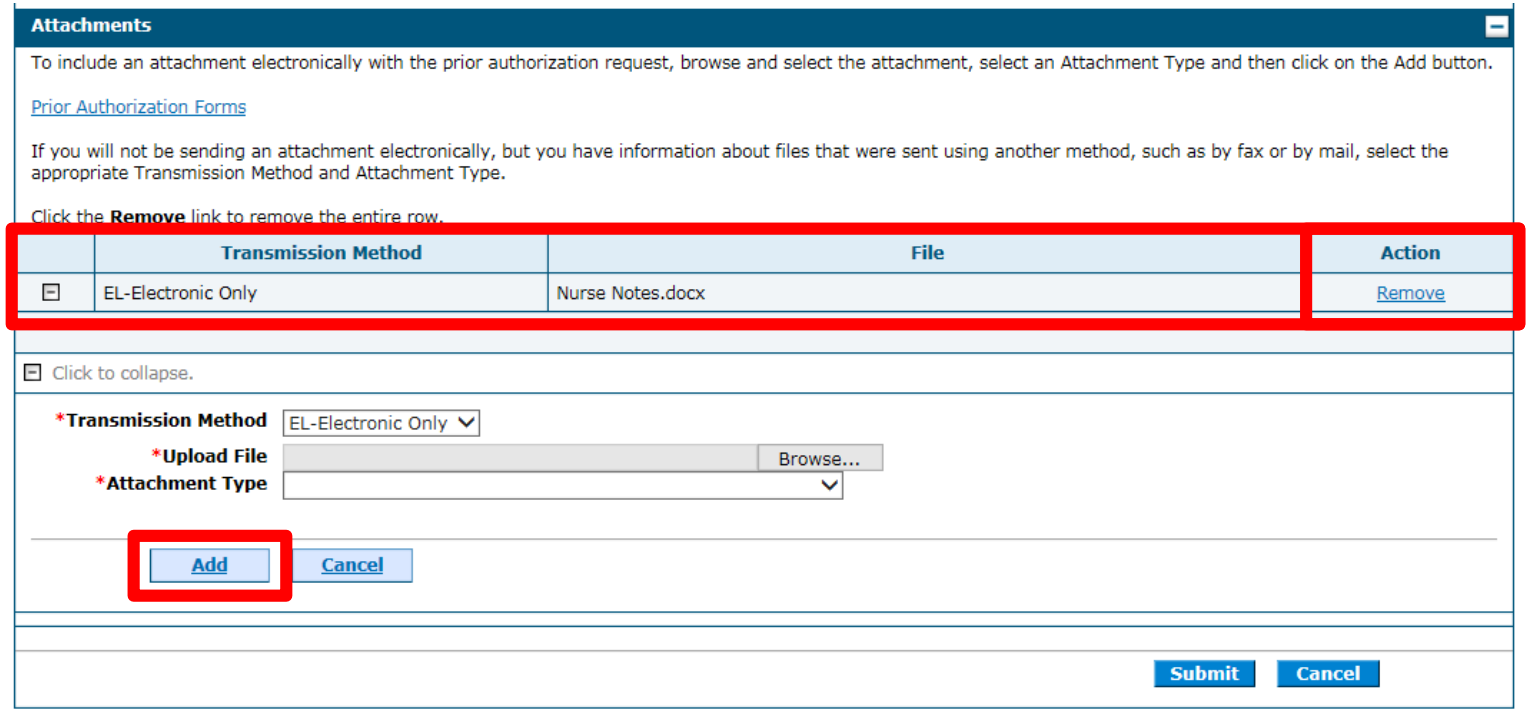
Allowable file types include:
.doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.

Submitting a PA Request, continued



18. Click the **Add** button.

Submitting a PA Request, continued



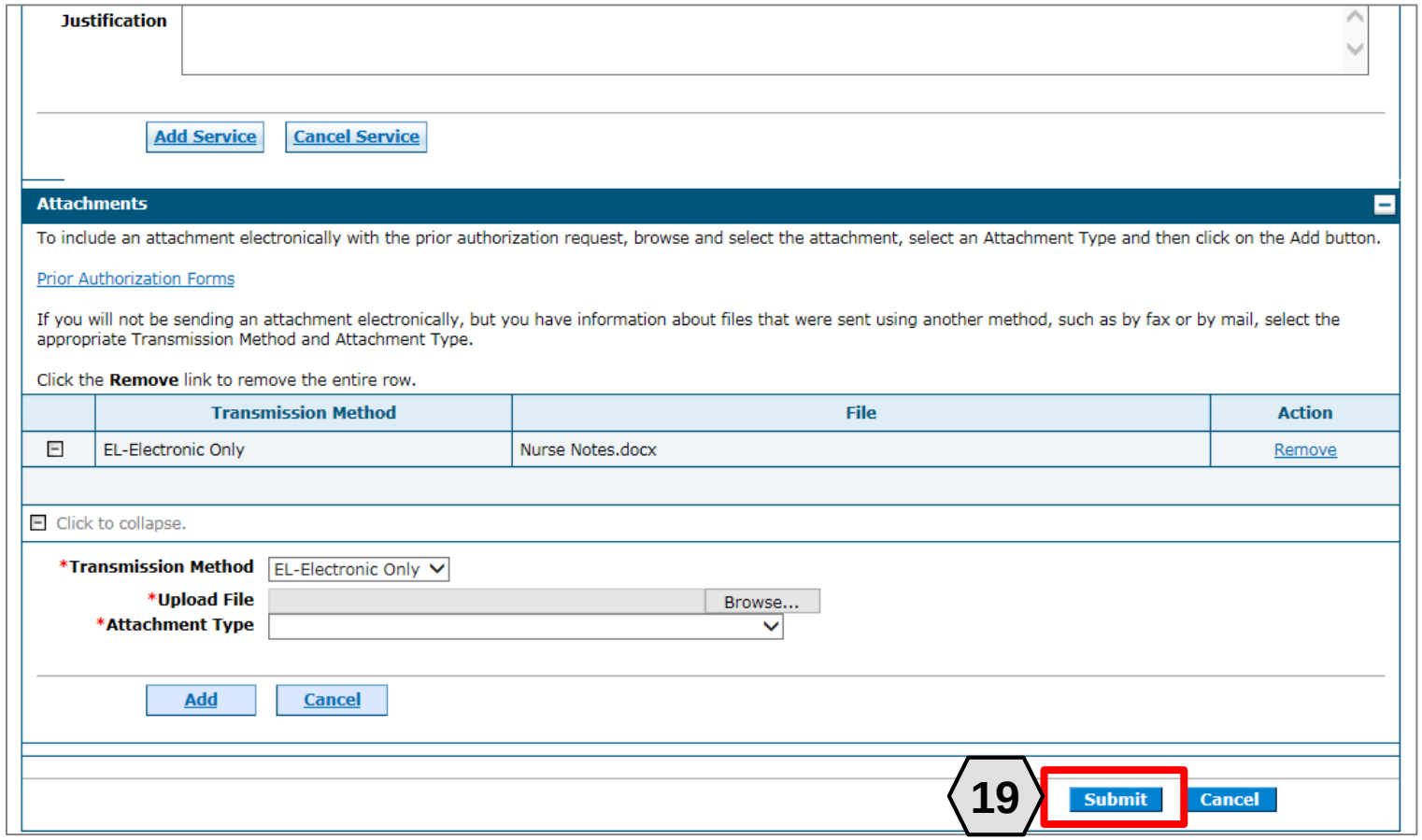
The added attachment displays in the list.

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

Add additional attachments by repeating steps 14-18.

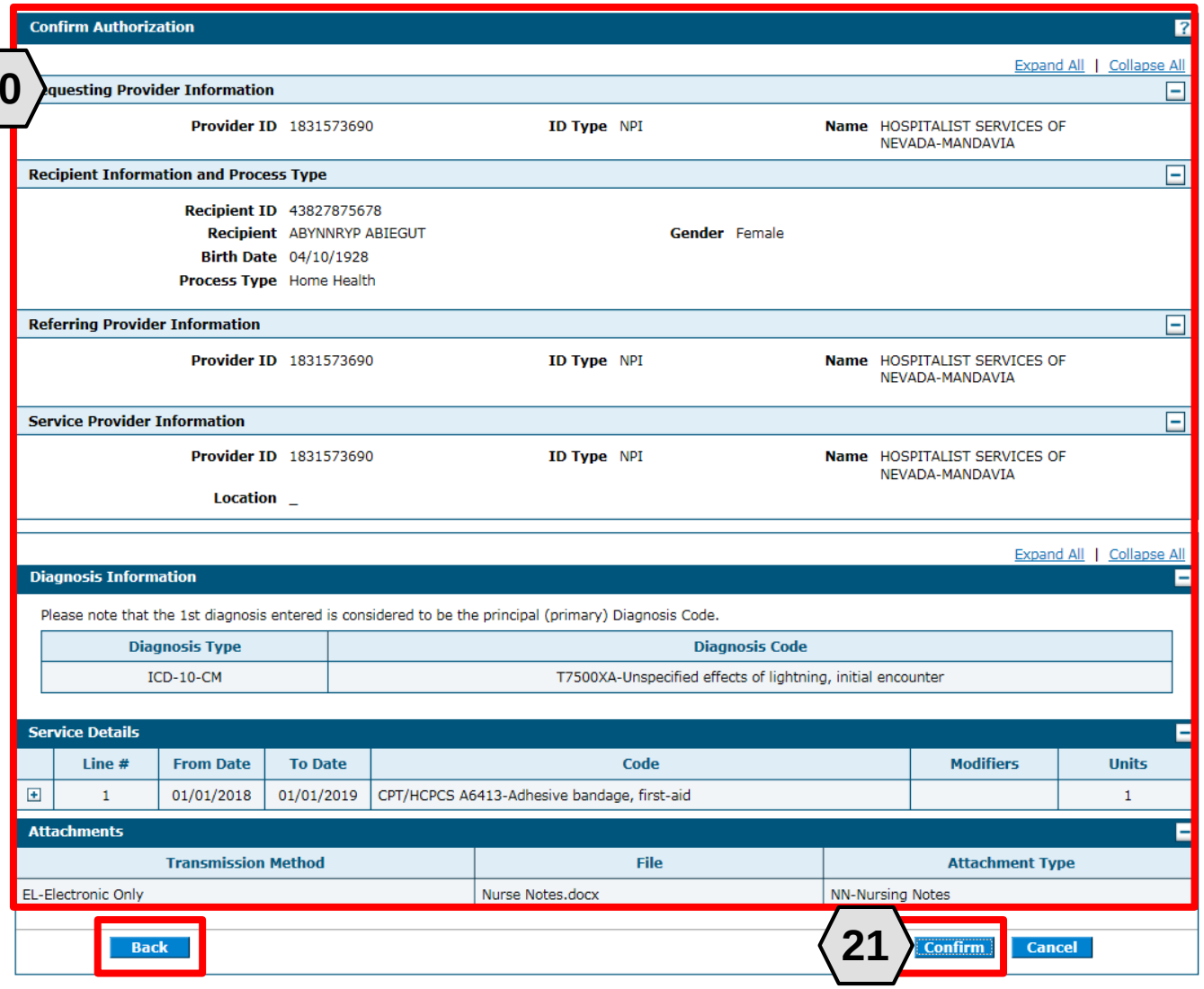
NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards, go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.

Submitting a PA Request, continued



19. Click the **Submit** button.

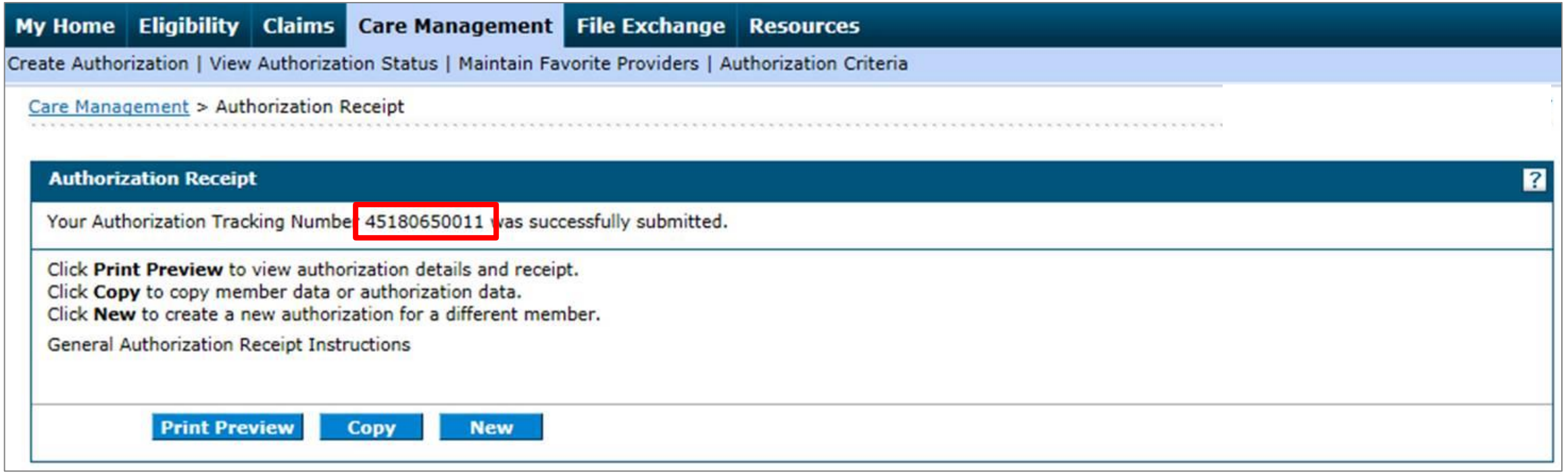
Submitting a PA Request, continued



20. Review the information on the PA request.
21. Click the **Confirm** button to submit the PA for processing. Only click the Confirm button once. If a user clicks Confirm multiple times, multiple PA's will be submitted and denied due to multiple submissions.

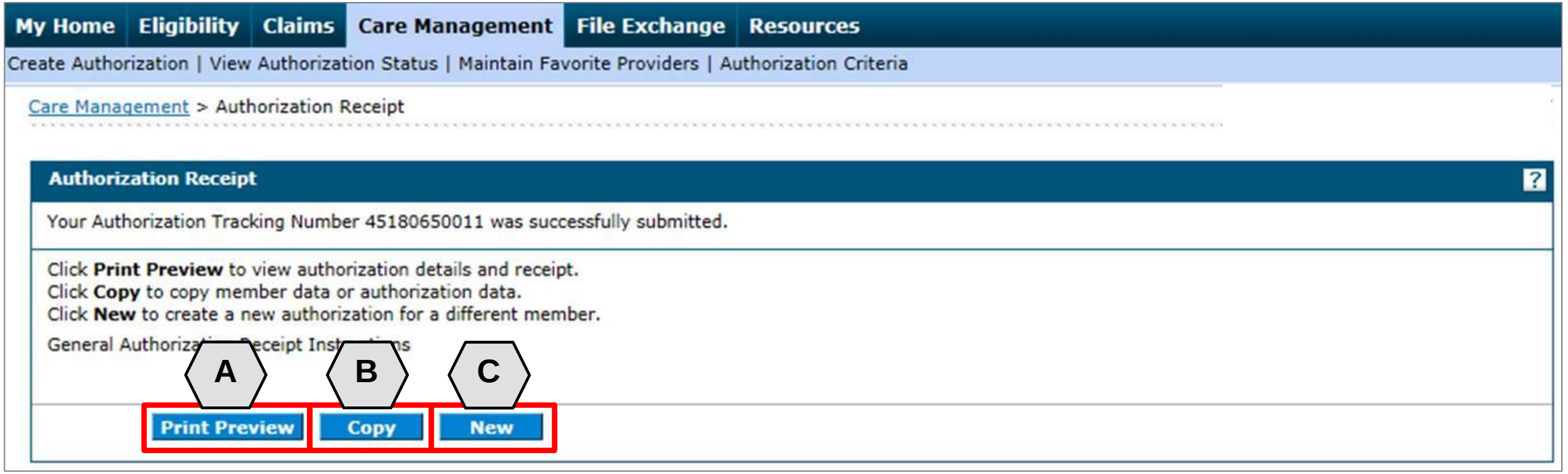
NOTE: If updates are needed prior to clicking the **Confirm** button, click the **Back** button to return to the "Create Authorization" page.

Submitting a PA Request, continued



After the **Confirm** button has clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.

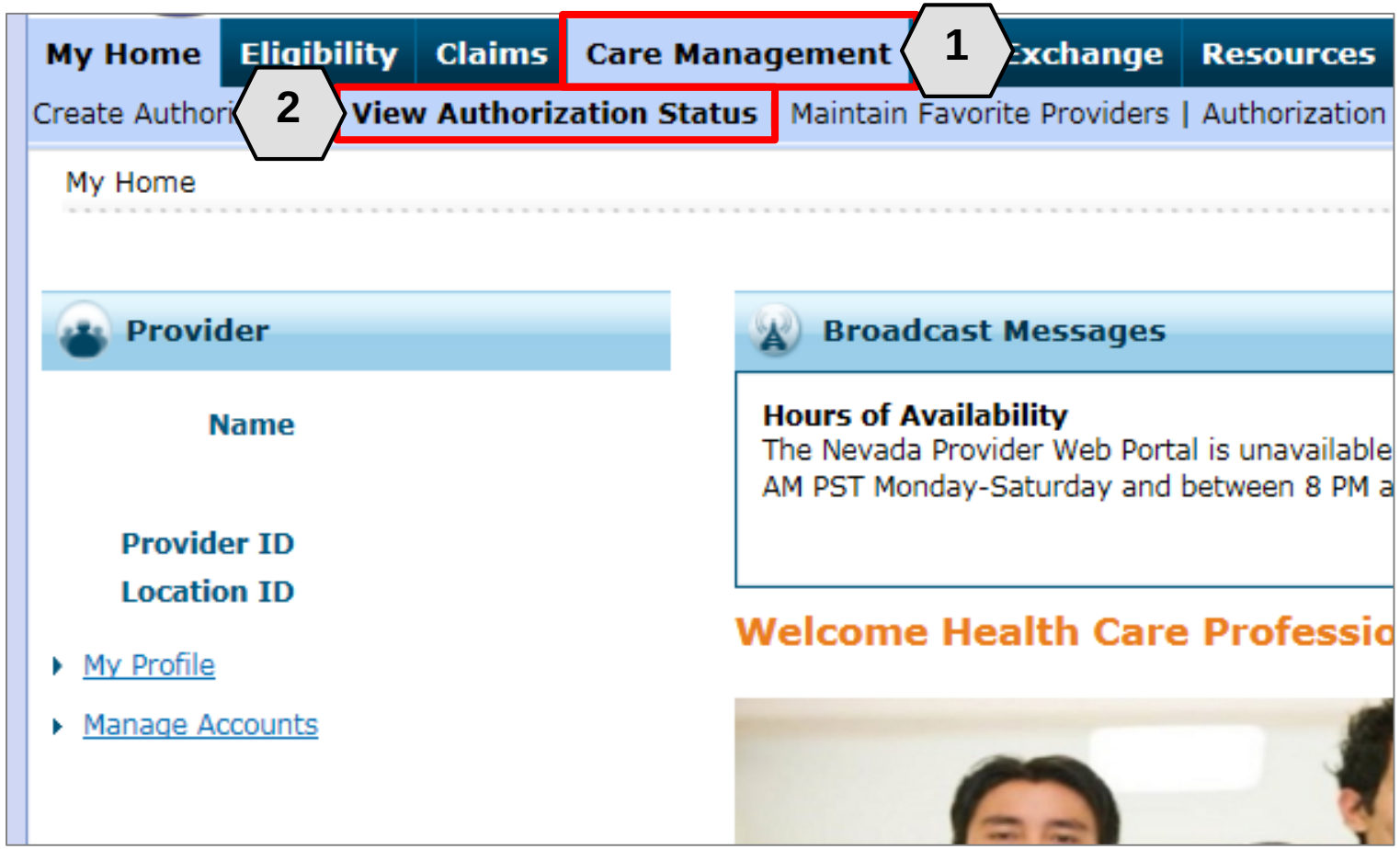
Submitting a PA Request, continued



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

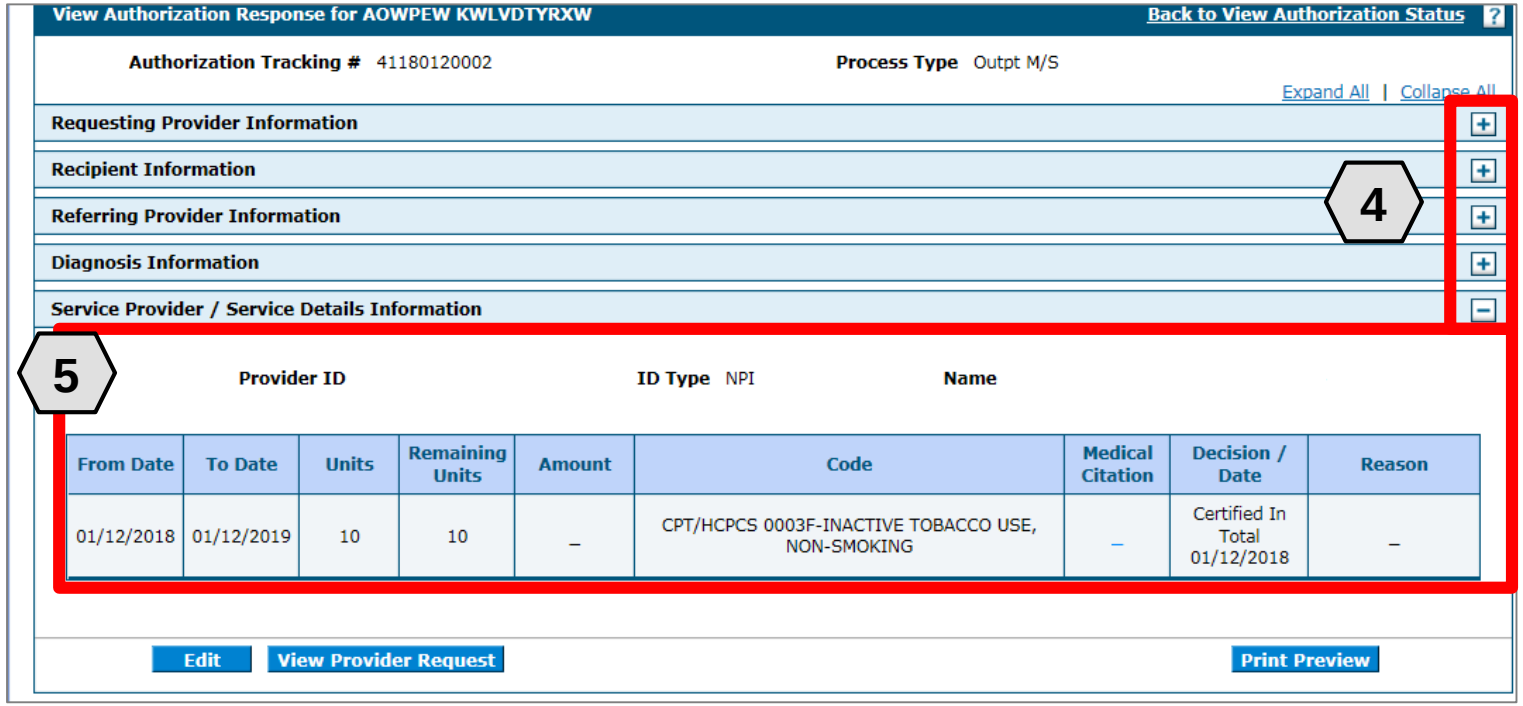


1. Hover over the **Care Management** tab.
2. Click **View Authorization Status**.

Viewing the Status of PAs, continued

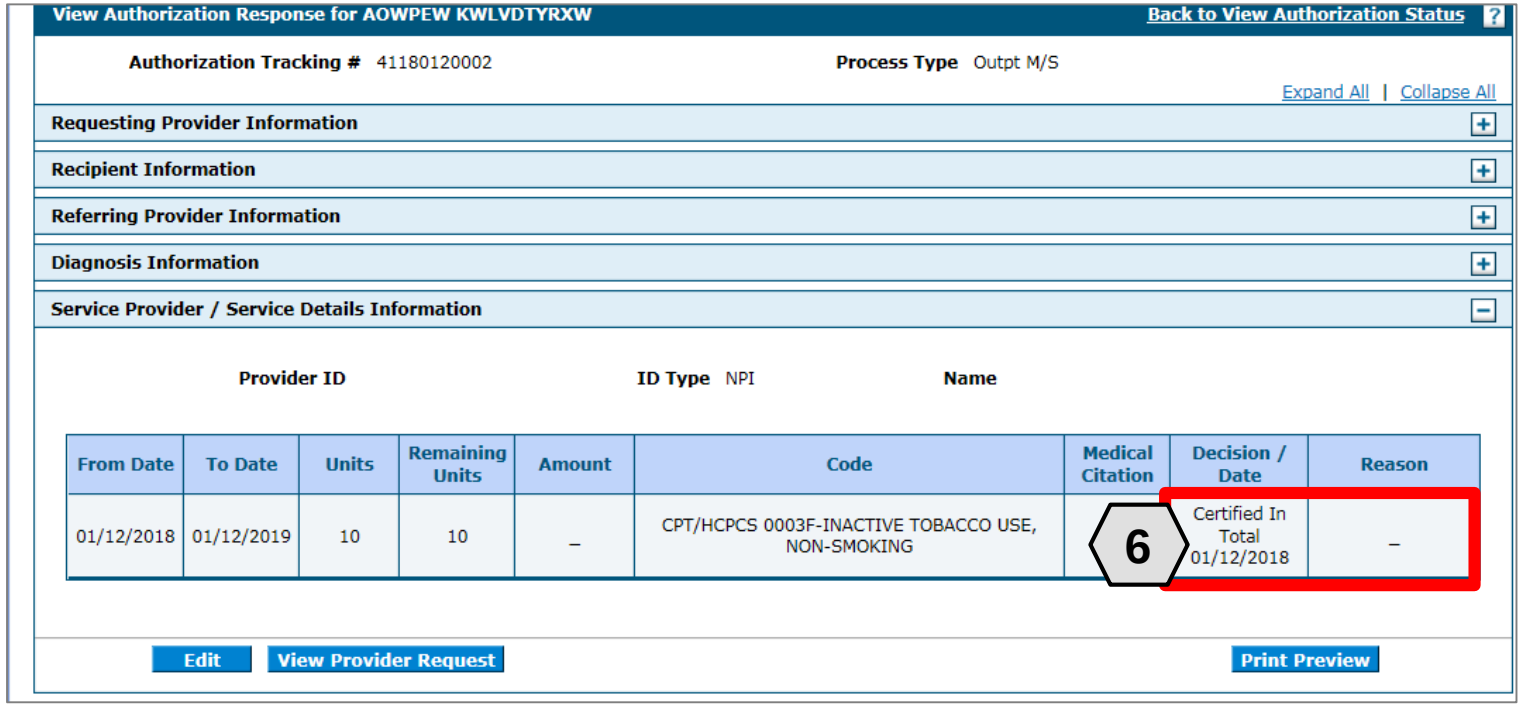
3. Click the **ATN** hyperlink of the PA to be viewed.

Viewing the Status of PAs, continued



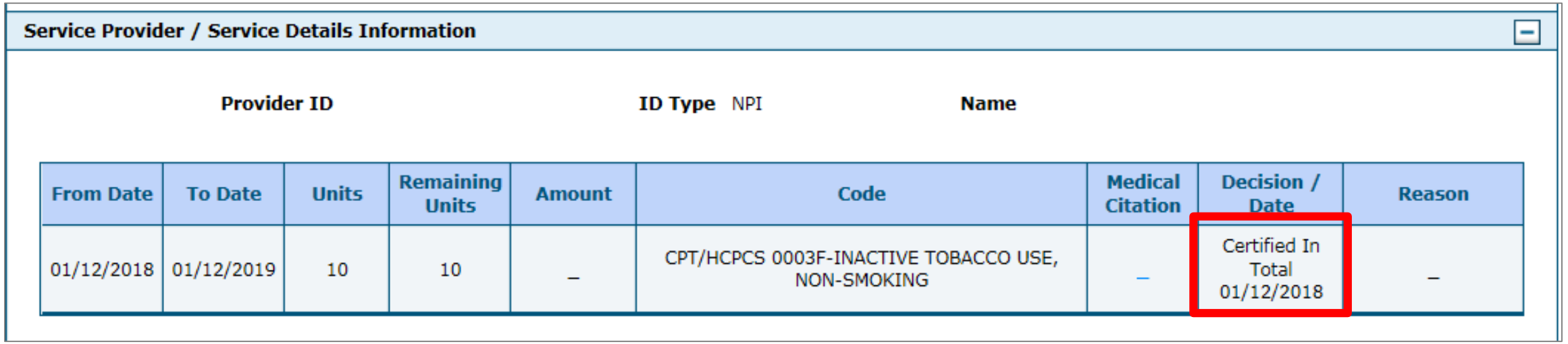
4. Click the **plus** ⊞ symbol to the right of a section to display its information.
5. Review the information as needed.

Viewing the Status of PAs, continued



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

Viewing the Status of PAs, continued



Service Provider / Service Details Information

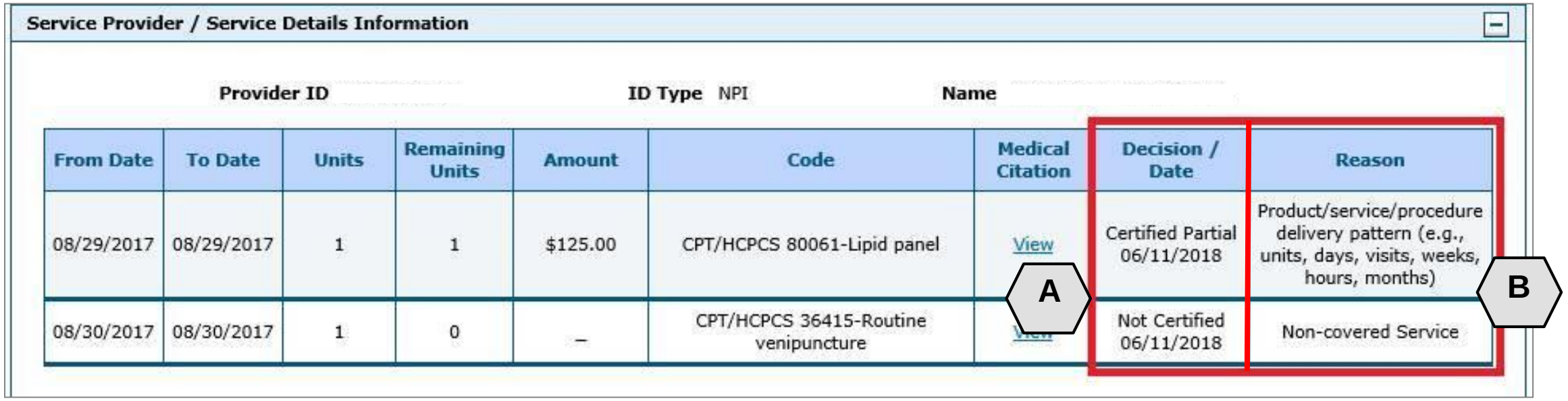
Provider ID **ID Type** NPI **Name**

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	–	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	–	Certified In Total 01/12/2018	–

In the **Decision / Date** column, you may see one of the following decisions:

- **Certified in Total:** The PA request is approved for exactly as requested.
- **Certified Partial:** The PA request has been approved, but not as requested.
- **Not Certified:** The PA request is not approved.
- **Pended:** The PA request is pending approval.
- **Cancel:** The PA request has been canceled.

Viewing the Status of PAs, continued



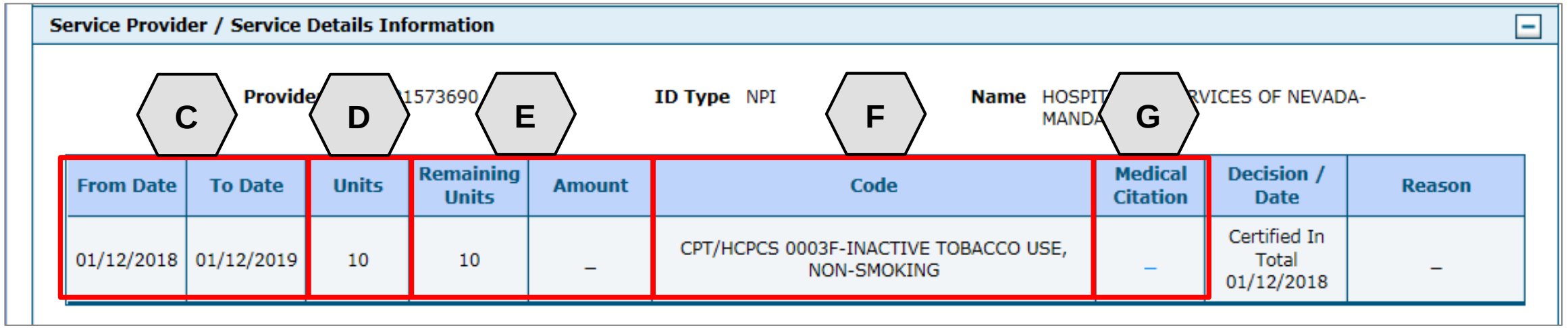
Service Provider / Service Details Information

Provider ID **ID Type** NPI **Name**

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
08/29/2017	08/29/2017	1	1	$125.00	CPT/HCPCS 80061-Lipid panel	View	Certified Partial 06/11/2018	Product/service/procedure delivery pattern (e.g., units, days, visits, weeks, hours, months)
08/30/2017	08/30/2017	1	0	–	CPT/HCPCS 36415-Routine venipuncture	View	Not Certified 06/11/2018	Non-covered Service

When the **Decision / Date** column is not “Certified in Total” information will be provided in the **Reason** column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).

Viewing the Status of PAs, continued



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

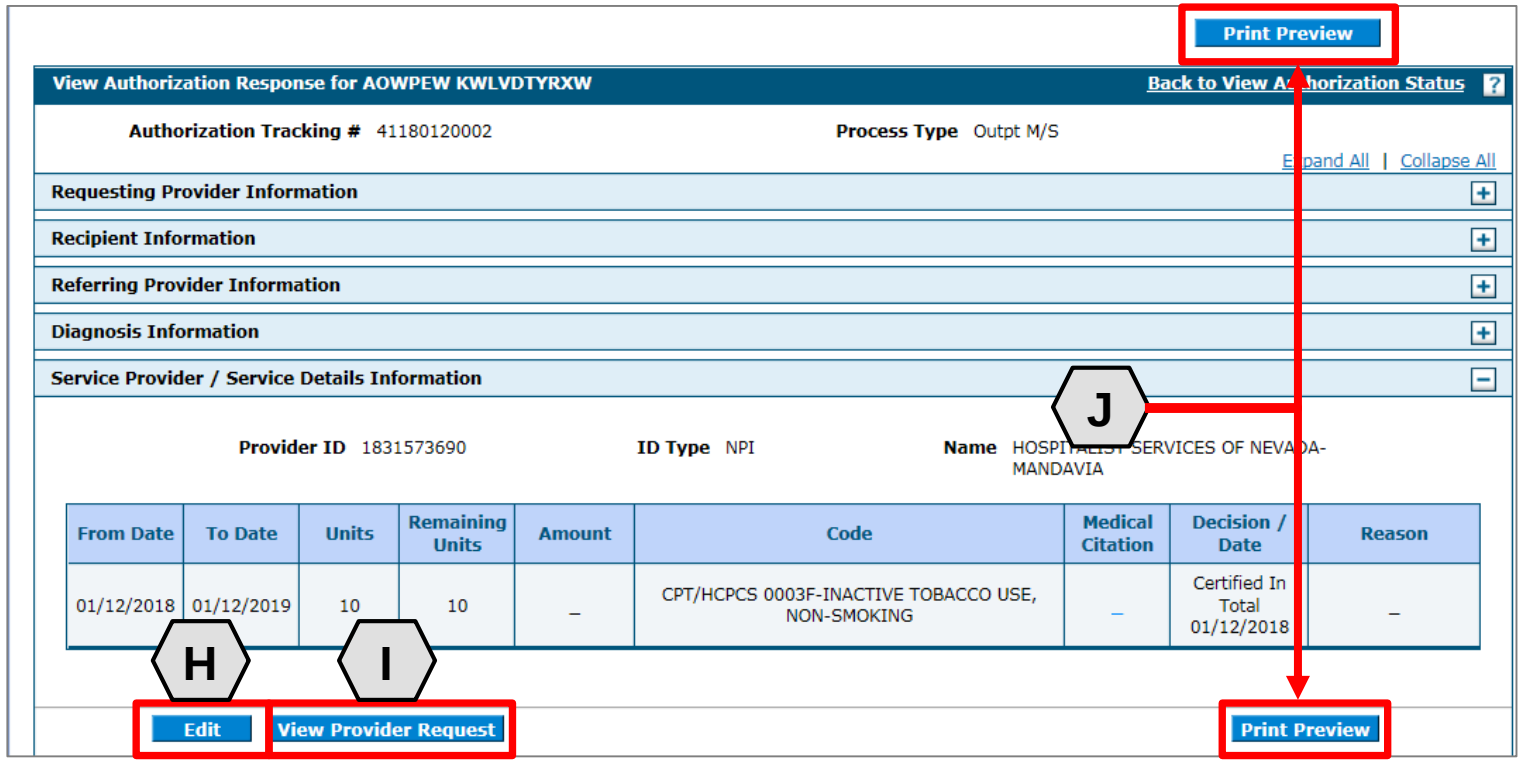
Viewing the Status of PAs, continued

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
02/17/2013	02/17/2013	3	0	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	Hide	Not Certified 02/21/2013	–
Medical Citation 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid. **Notes To Provider** Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted.								
02/20/2031	02/20/2031	2	0	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	View	Not Certified 02/22/2013	–
02/17/2013	02/20/2013	3	3	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	–	Certified In Total 02/24/2013	–

Edit | View Provider Request | Print Preview

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

Viewing the Status of PAs, continued



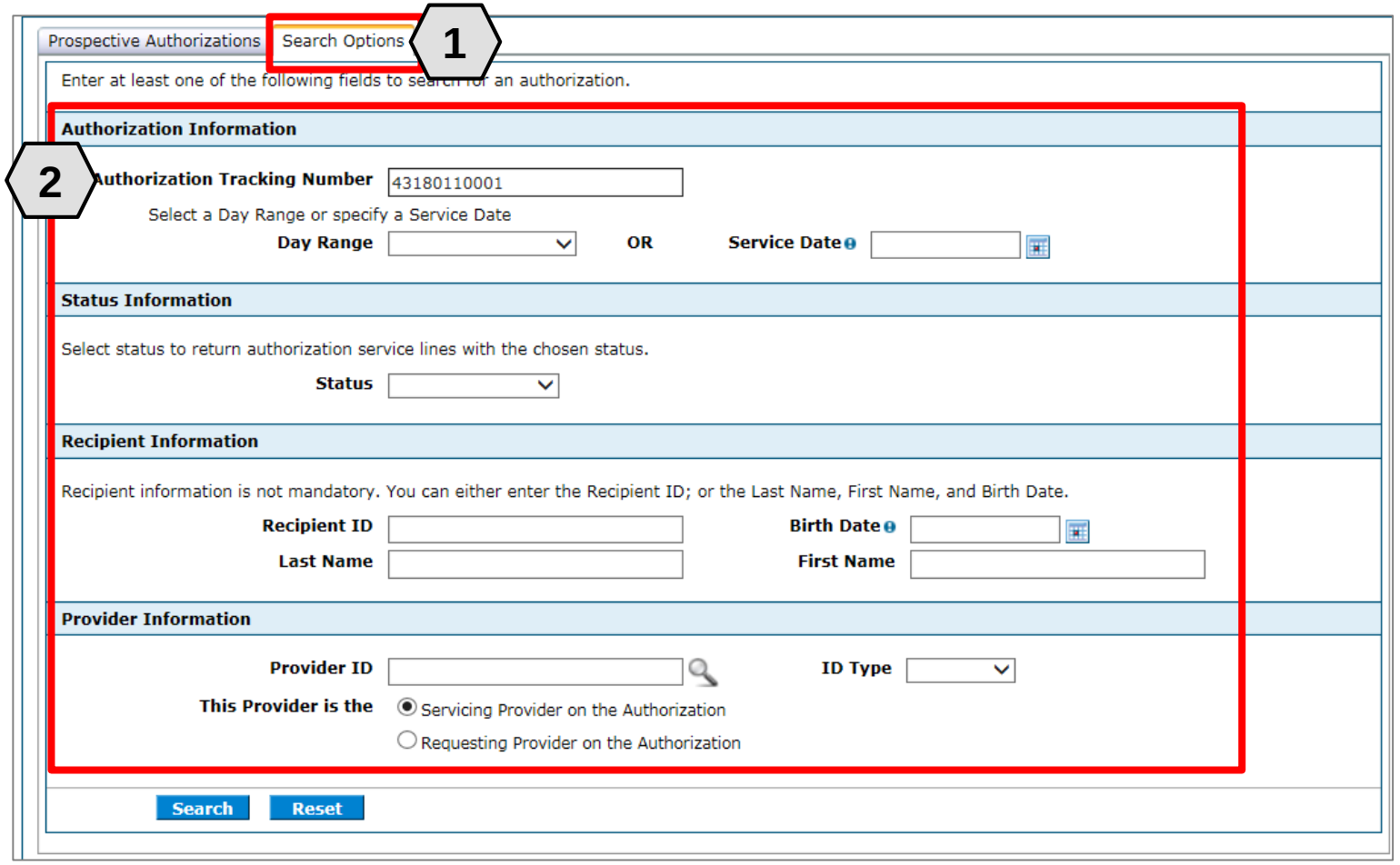
H. **Edit:** Edit the PA.

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

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

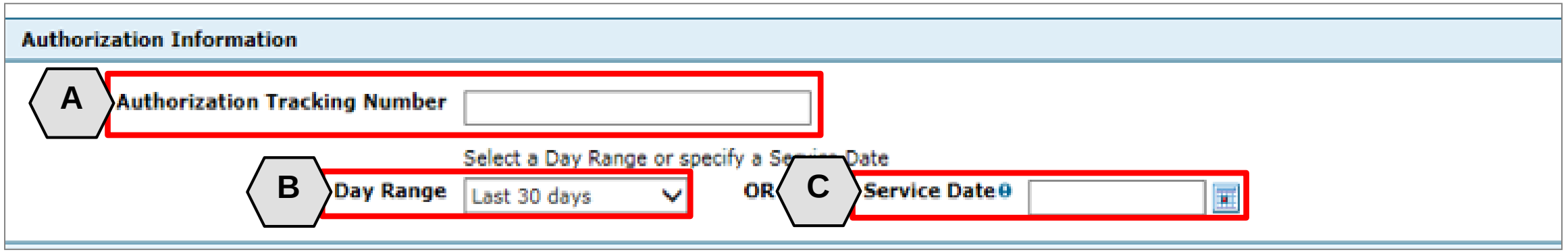
Searching for PAs

Searching for PAs



1. Click the **Search Options** tab.
2. Enter search criteria into the search fields.

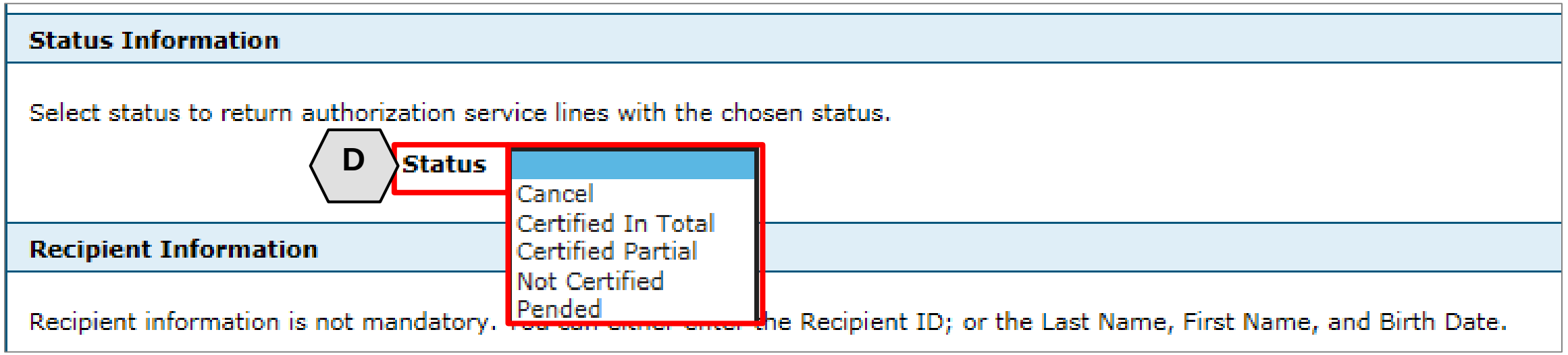
Searching for PAs, continued



A. **Authorization Tracking Number:** Enter the ATN to locate a specific PA.
B. **Day Range:** Select an option from this list to view PA results within the selected time period.
C. **Service Date:** Enter the date of service to display PA with that service date.

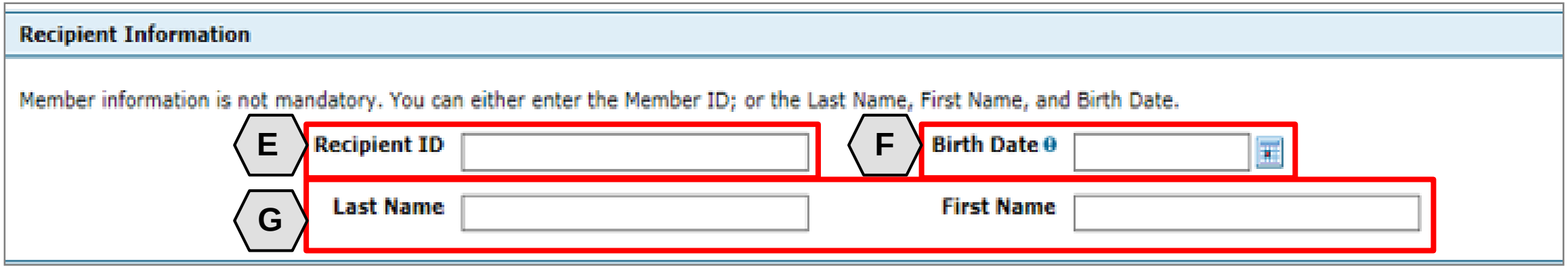
NOTE: Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.

Searching for PAs, continued



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

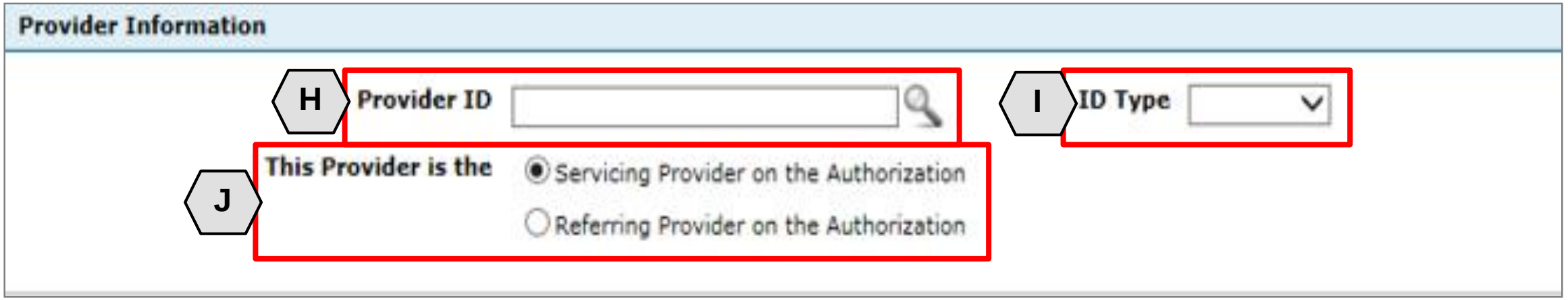
Searching for PAs, continued



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.

Searching for PAs, continued

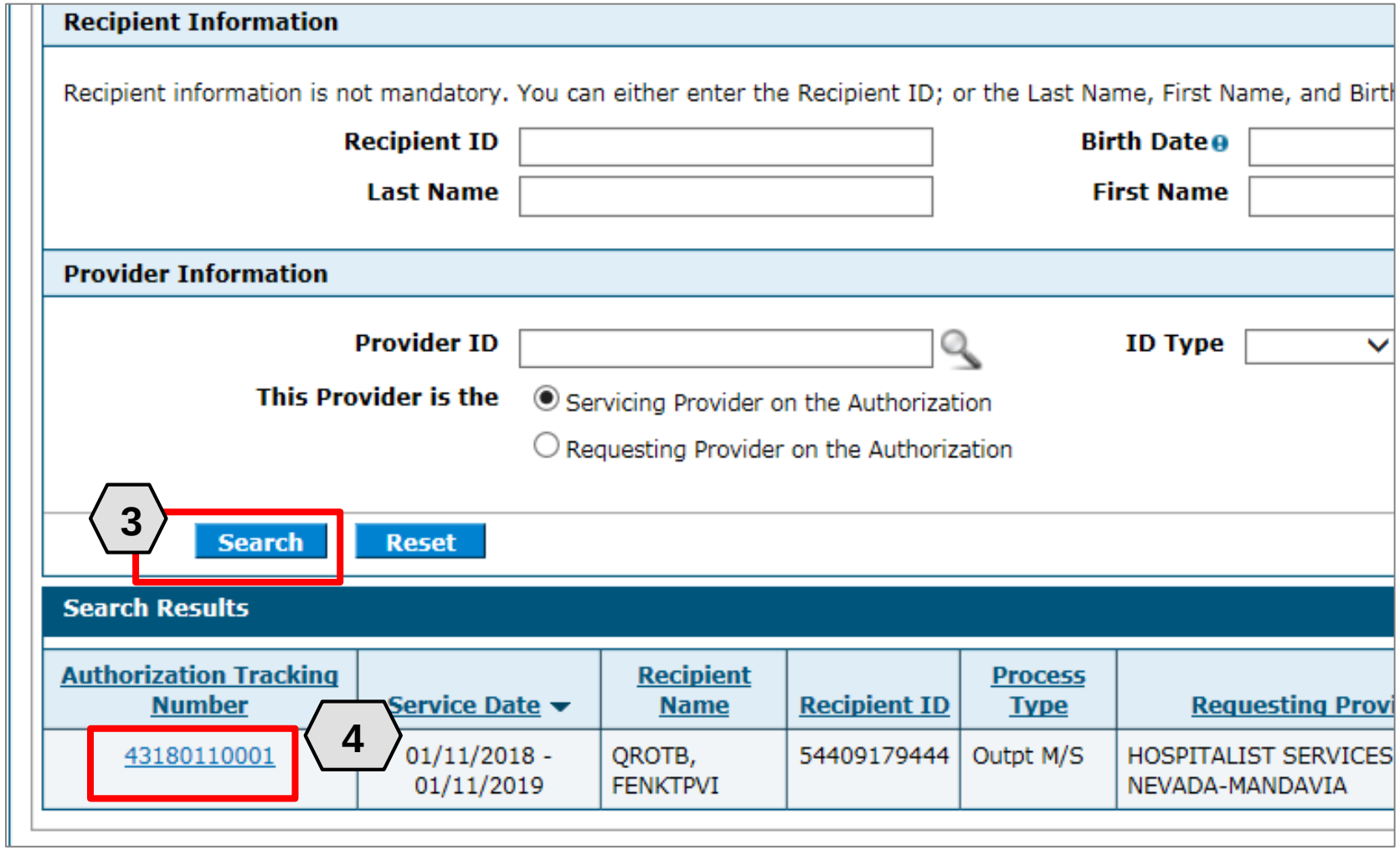


H. **Provider ID:** Enter the provider's unique National Provider Identifier (NPI).

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

J. **This Provider is the:** Select whether the provider is the servicing or referring provider on the PA request.

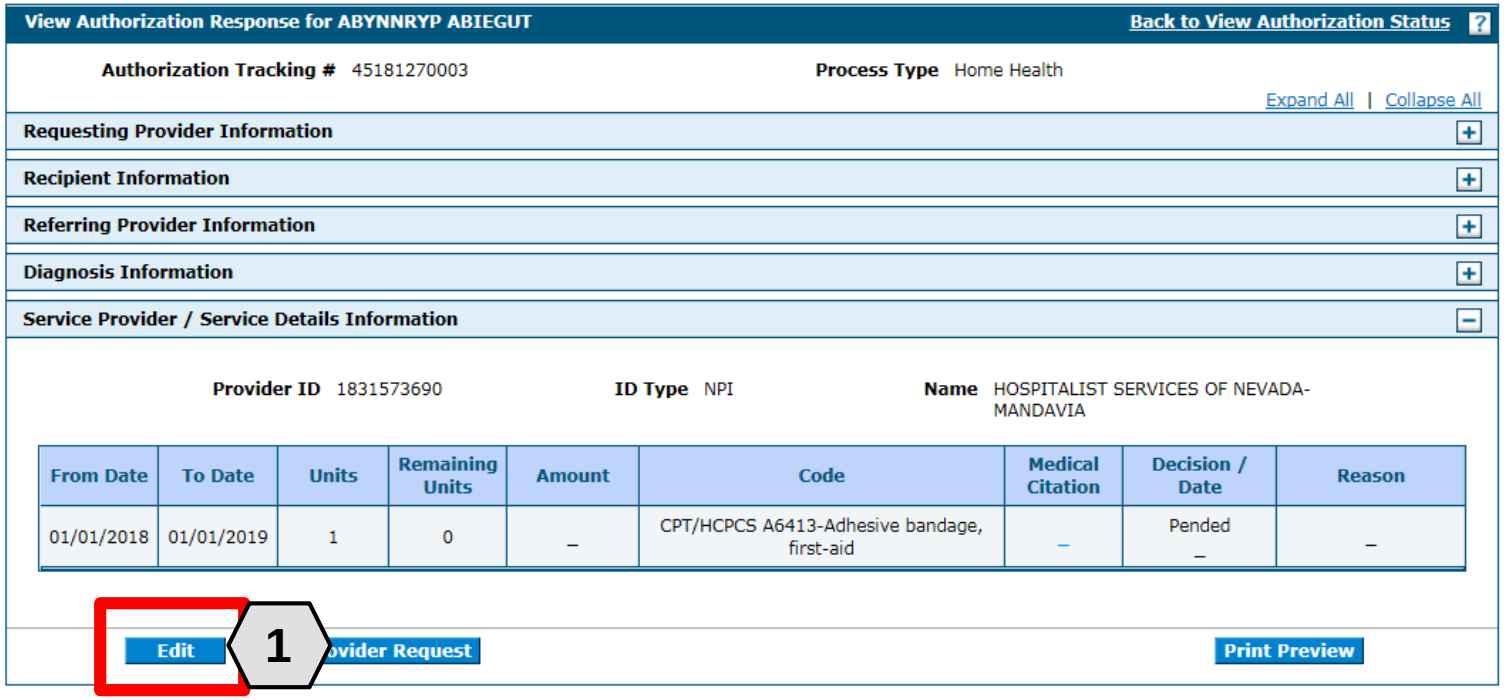
Searching for PAs, continued



3. Click the **Search** button.
4. Select an **ATN** hyperlink to review the PA.

Submitting Additional Information

Submitting Additional Information

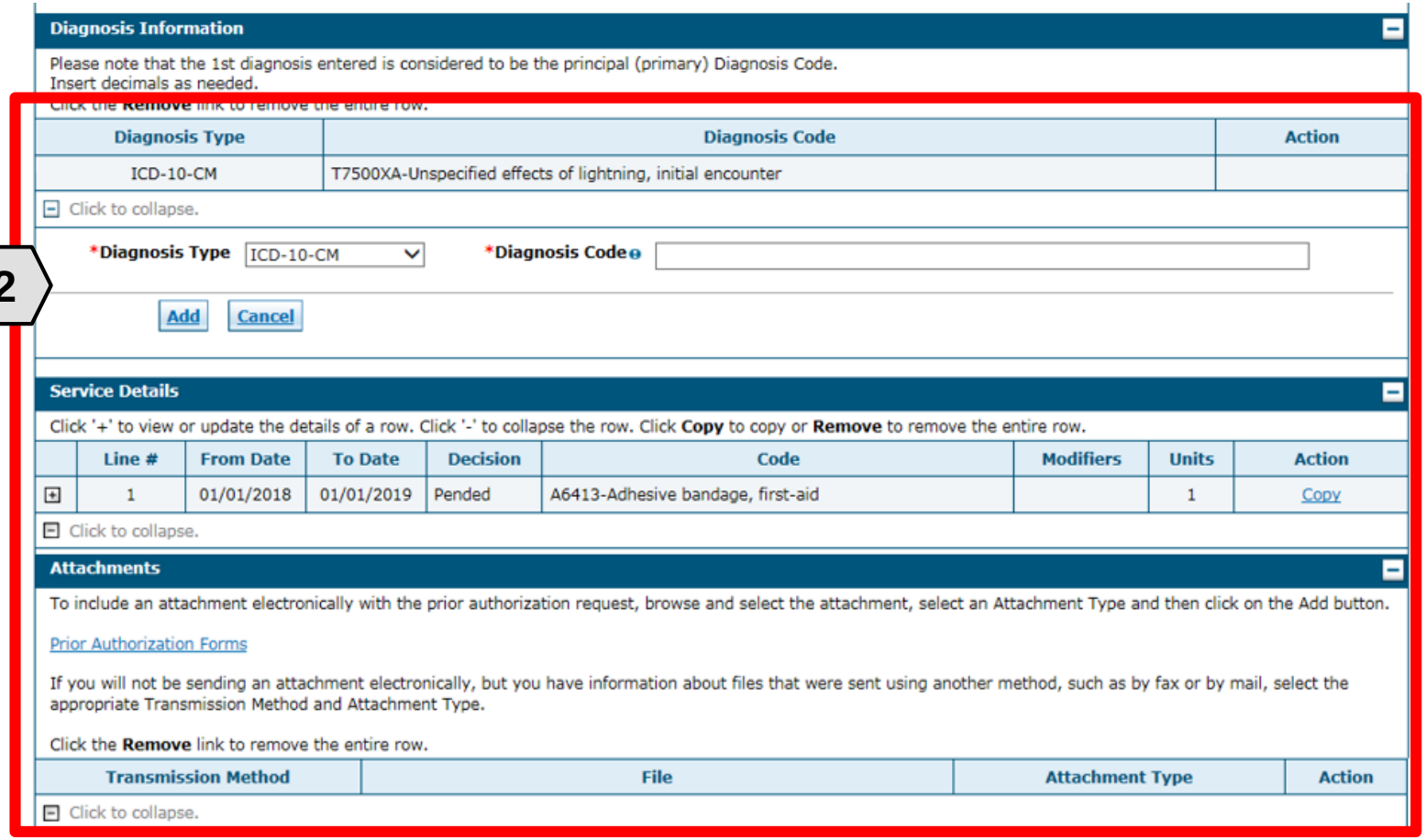


1. Click the **Edit** button to edit a submitted PA request.

Additional information may include:

- Requests for additional services
- Attachments
- “FA-29 Prior Authorization Data Correction” form
- “FA-29A Request for Termination of Service” form

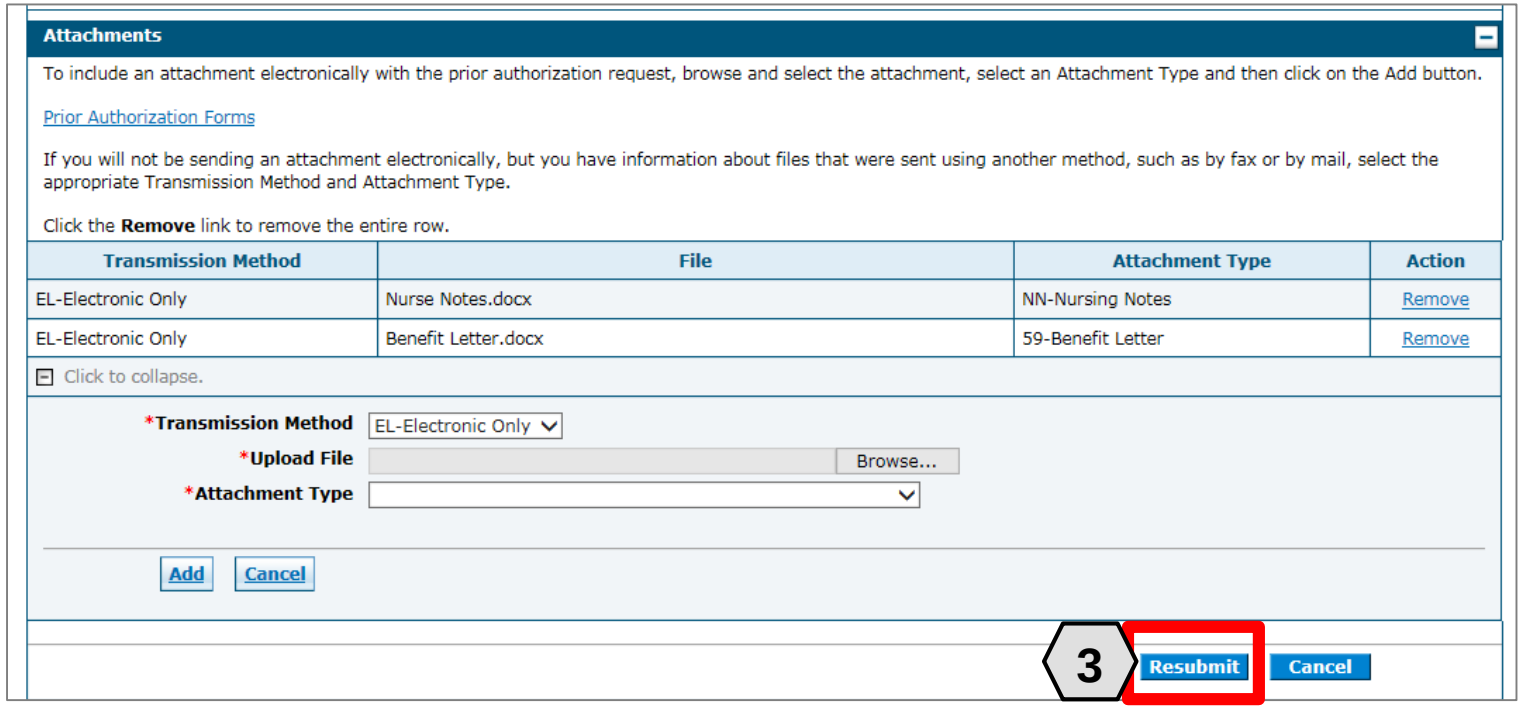
Submitting Additional Information, continued



2

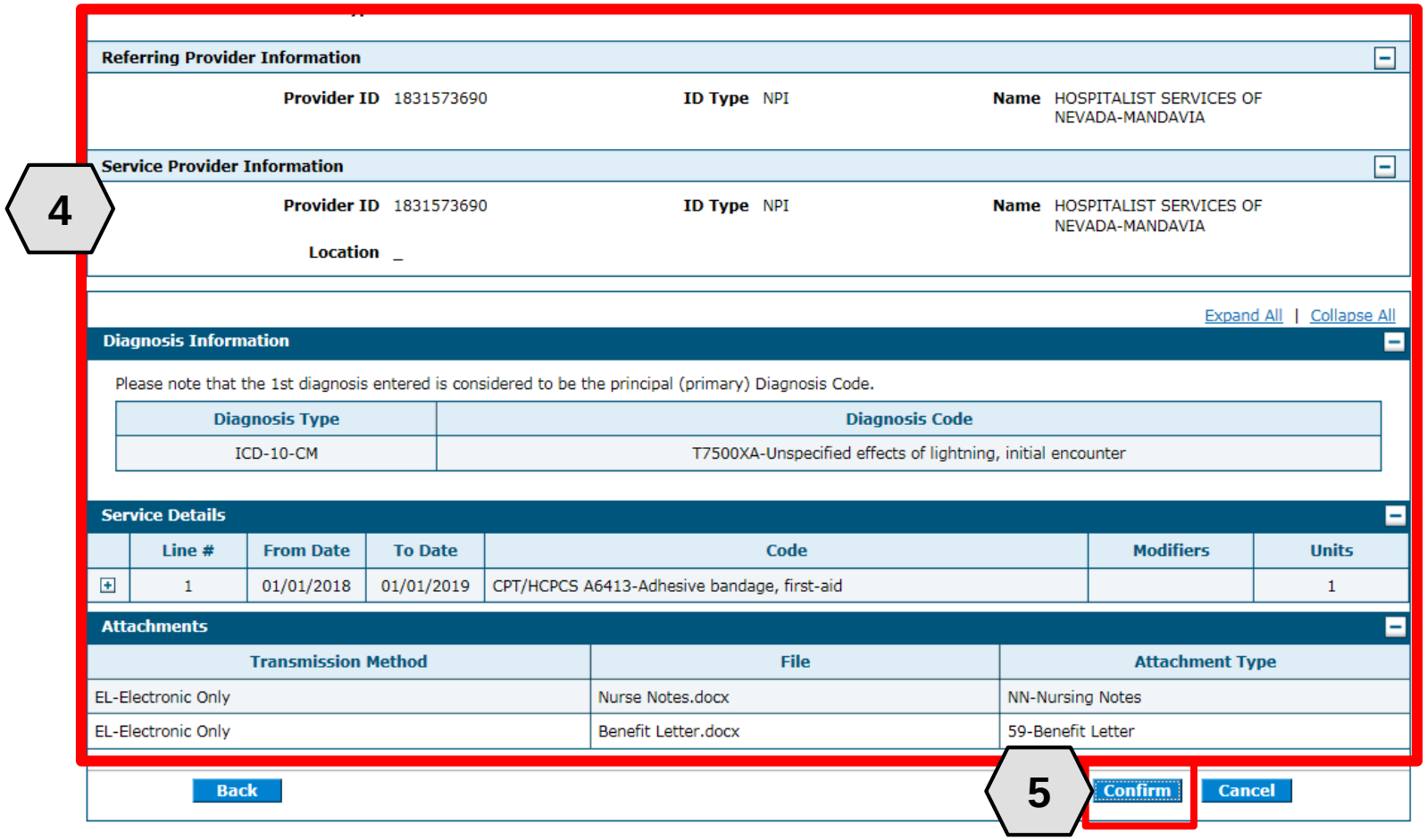
2. Add additional diagnosis codes, service details and/or attachments.

Submitting Additional Information, continued



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.

How to Submit Additional Information, continued

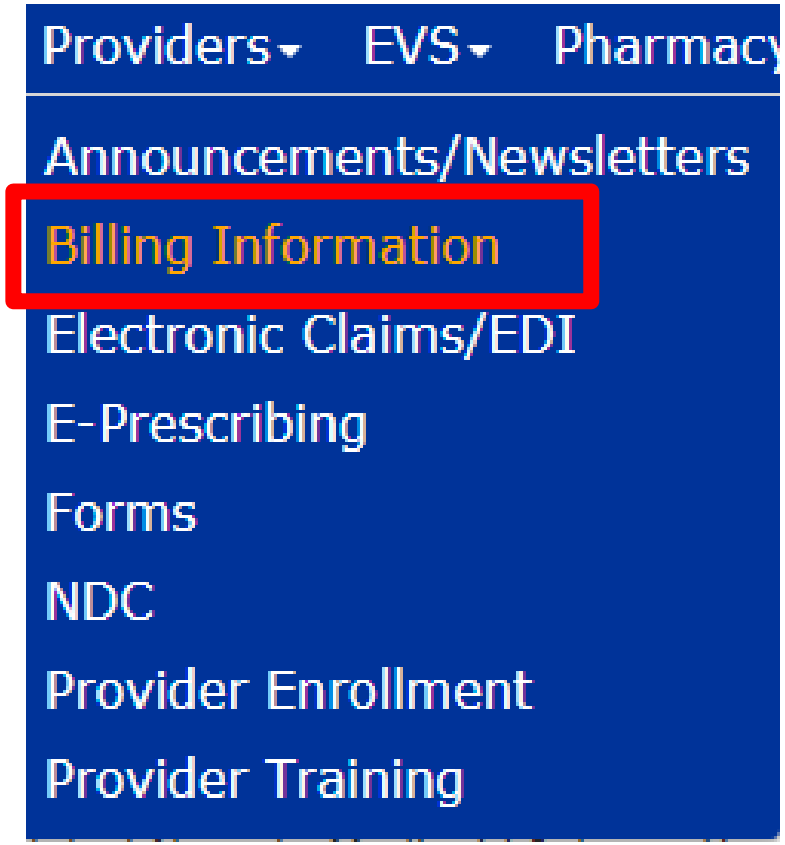
FA-29	Prior Authorization Data Correction Form
FA-29A	Request for Termination of Service
FA-29B	Prior Authorization Reconsideration Request

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

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

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

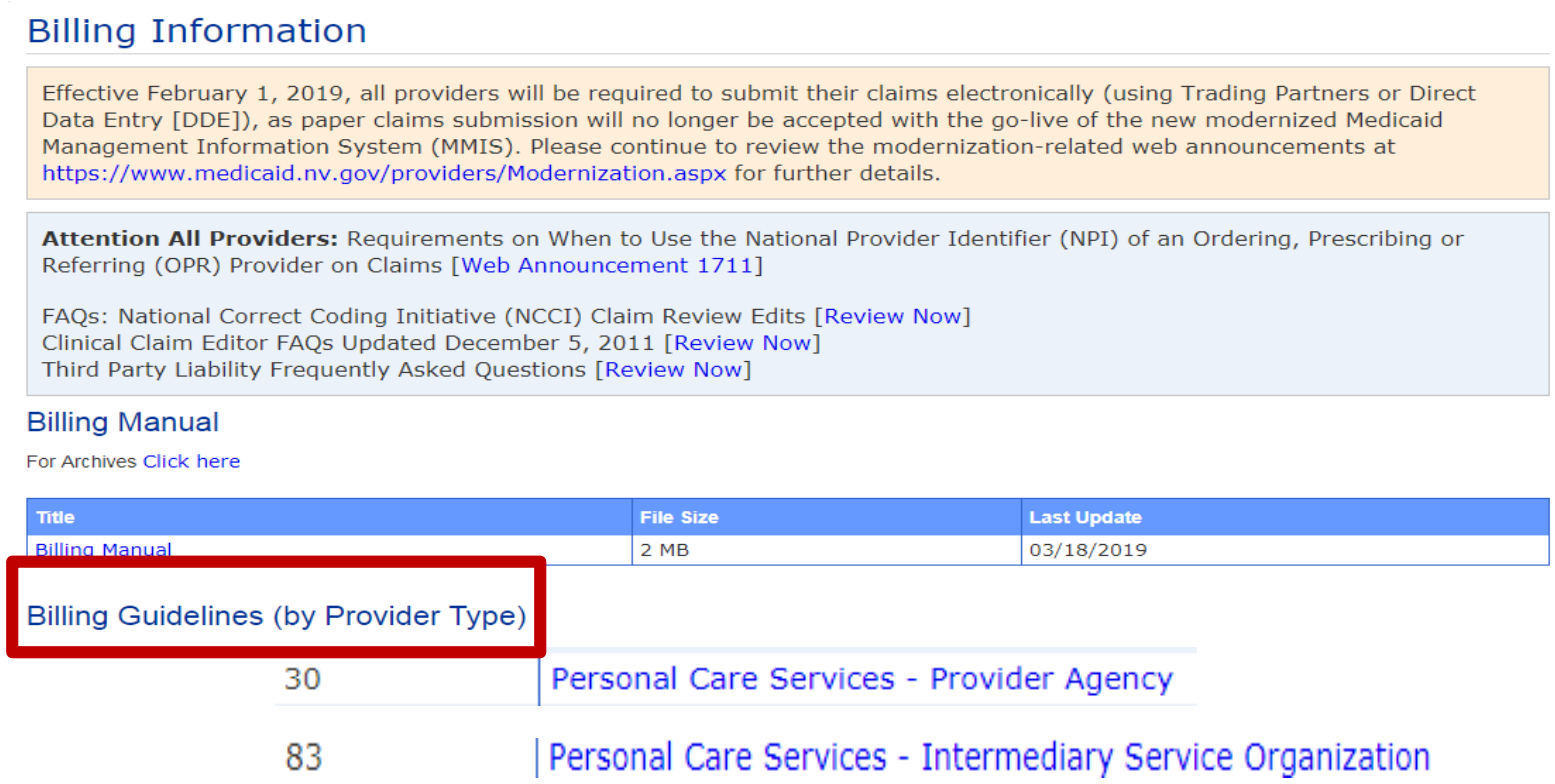
For Archives Click here

Title	File Size	Last Update
Billing Manual	1 MB	02/01/2019

Review the Billing Manual for more information regarding:

- Introduction to Medicaid
- Contact Information
- Recipient Eligibility
- PA
- Third Party Liability (TPL)
- Electronic Billing
- Frequently Asked Questions
- Claims Processing and Beyond

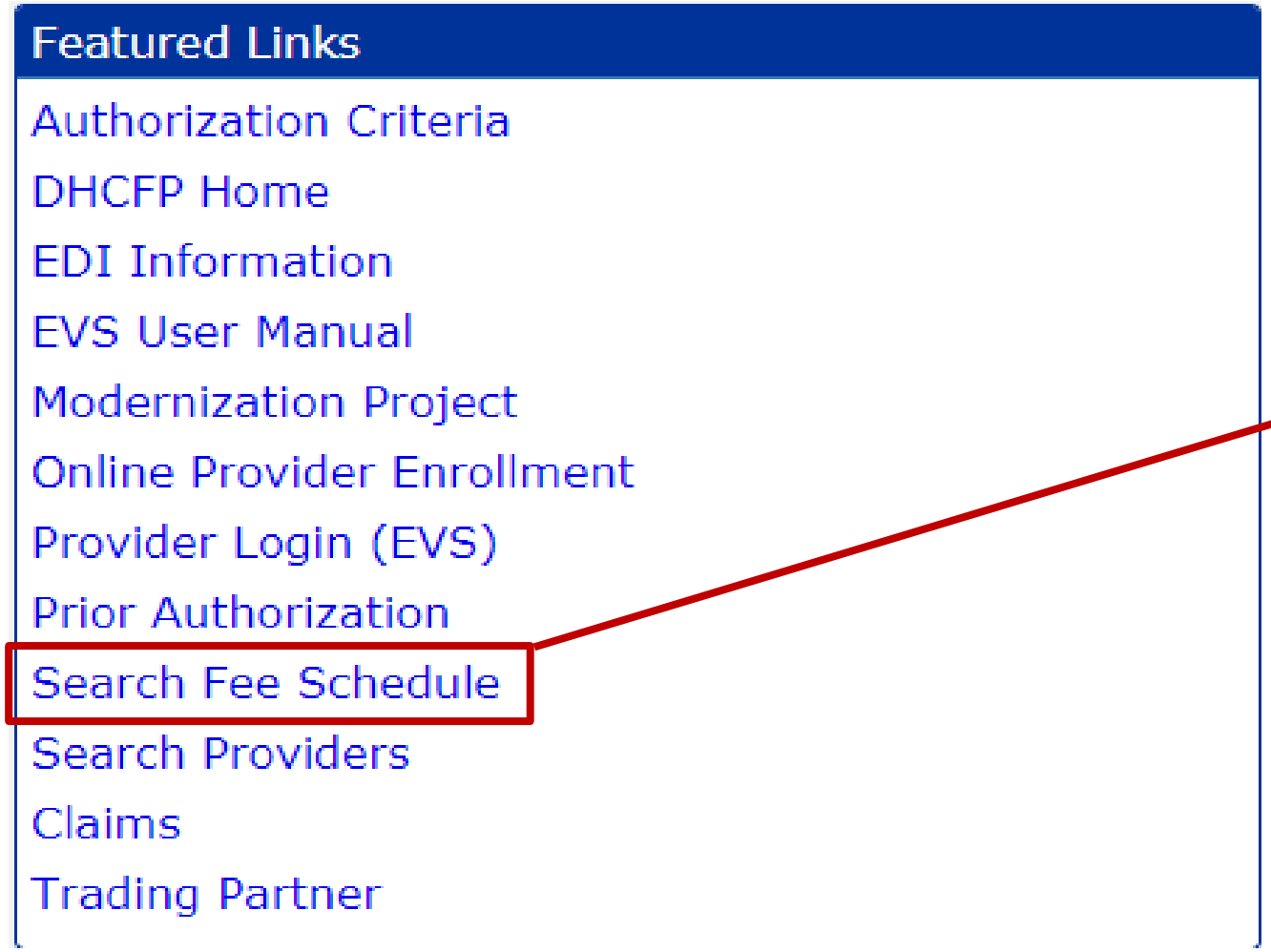
Locating Medicaid Billing Information, continued



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

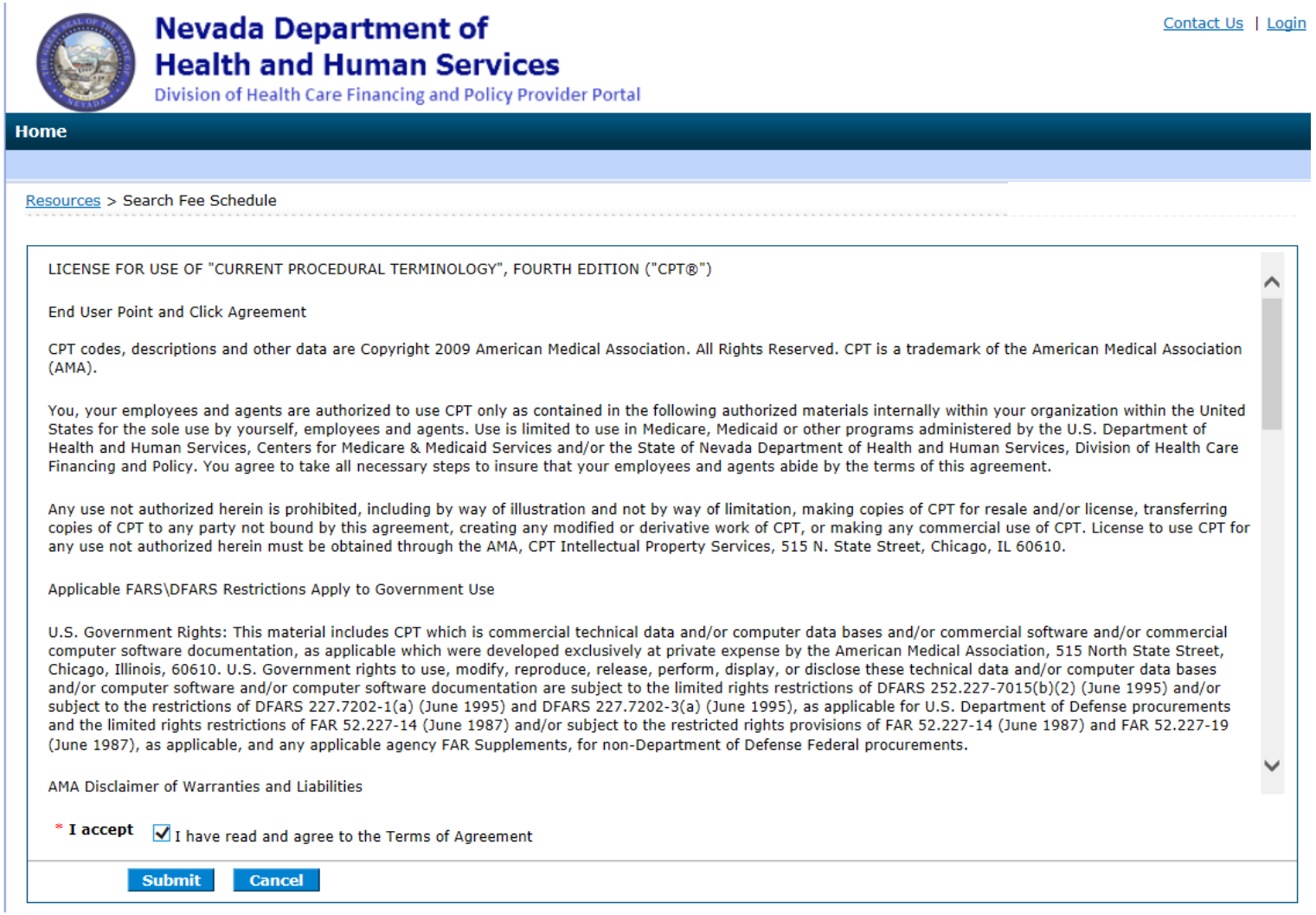
Search Fee Schedule and DHCFP Rates Unit

Fee Schedule



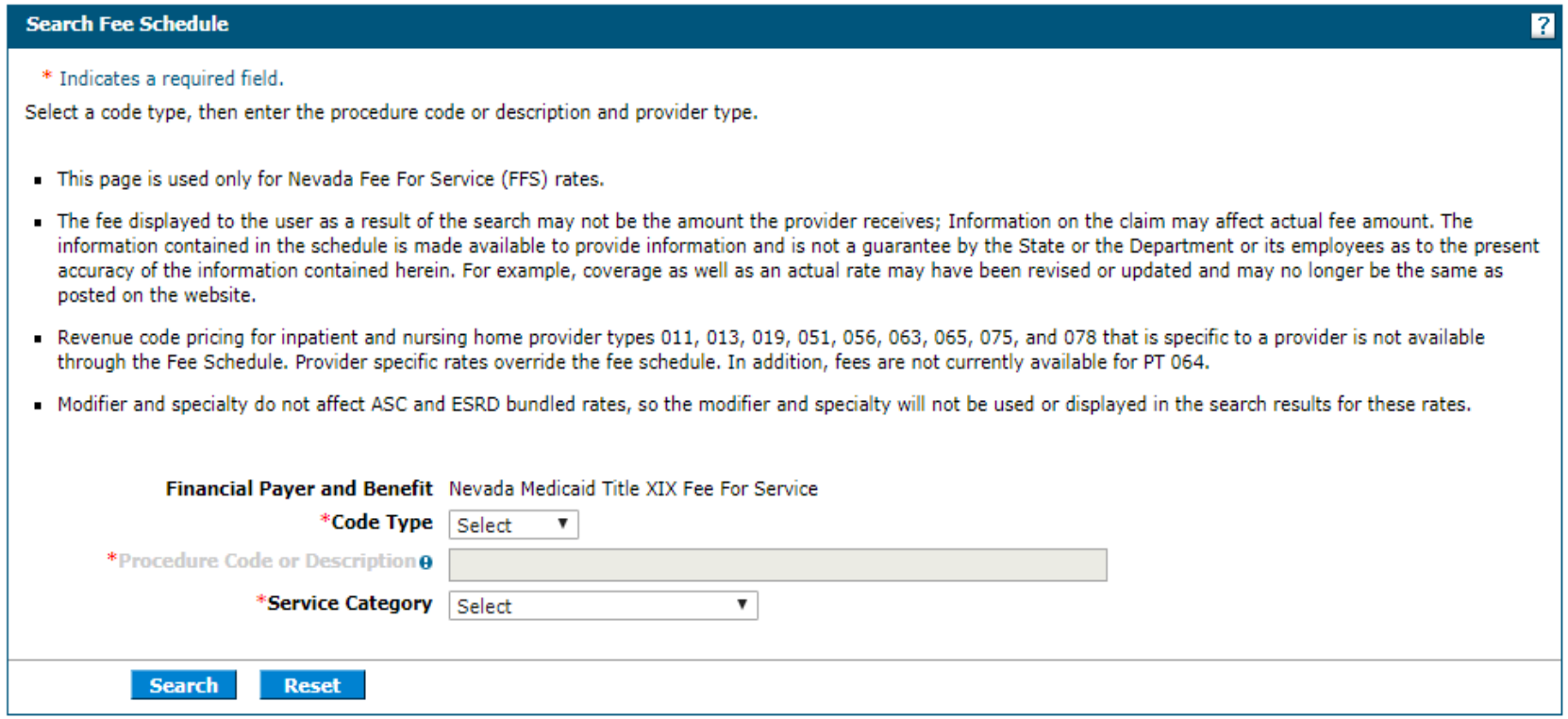
- Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a procedure code.

Fee Schedule, continued



- Step 1: Click “I Accept”
- Step 2: Click “Submit”

Fee Schedule, continued



- Step 1: Select Code Type from drop-down menu.
- Step 2: Input Procedure Code or Description.
- Step 3: Select Service Category from drop-down menu.
- Step 4: Click “Search” to populate results.

Fee Schedule, continued

Search Fee Schedule

* Indicates a required field.

Select a code type, then enter the procedure code or description and provider type.

- This page is used only for Nevada Fee For Service (FFS) rates.
- The fee displayed to the user as a result of the search may not be the amount the provider receives; Information on the claim may affect actual fee amount. The information contained in the schedule is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.
- Revenue code pricing for inpatient and nursing home provider types 011, 013, 019, 051, 056, 063, 065, 075, and 078 that is specific to a provider is not available through the Fee Schedule. Provider specific rates override the fee schedule. In addition, fees are not currently available for PT 064.
- Modifier and specialty do not affect ASC and ESRD bundled rates, so the modifier and specialty will not be used or displayed in the search results for these rates.

Financial Payer and Benefit Nevada Medicaid Title XIX Fee For Service

***Code Type** Procedure

***Procedure Code or Description** 0362T-BHV ID SUPRT ASSMT EA 15 MIN

***Service Category** Behavioral Treatment

Search Reset

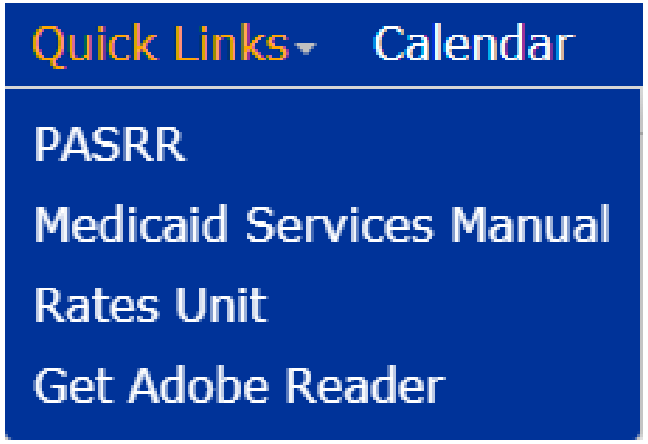
Search Results

Total Records: 6

Procedure	Provider Type	Provider Specialty	Modifier	Fee Amount	Age Restrictions	Effective Date
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	312-Lic. Board Certified Assist Behavior Analyst			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	312-Lic. Board Certified Assist Behavior Analyst	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	310-Lic. Board Certified Behavior Analyst			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	310-Lic. Board Certified Behavior Analyst	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	311-Psychologist			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	311-Psychologist	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299

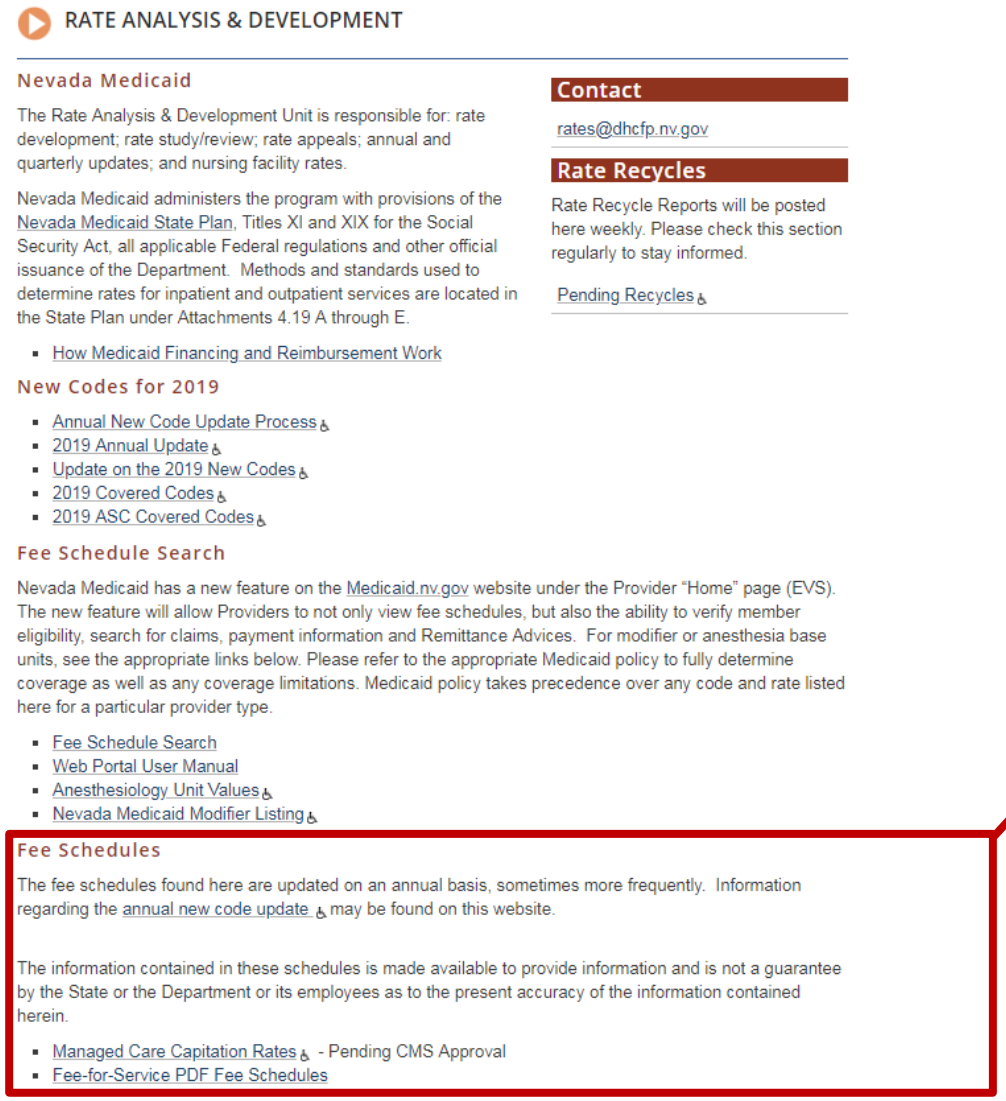
Note: Make sure that the Effective Date ends in 2299.

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



RATE ANALYSIS & DEVELOPMENT

Nevada Medicaid

The Rate Analysis & Development Unit is responsible for: rate development; rate study/review; rate appeals; annual and quarterly updates; and nursing facility rates.

Nevada Medicaid administers the program with provisions of the Nevada Medicaid State Plan, Titles XI and XIX for the Social Security Act, all applicable Federal regulations and other official issuance of the Department. Methods and standards used to determine rates for inpatient and outpatient services are located in the State Plan under Attachments 4.19 A through E.

- How Medicaid Financing and Reimbursement Work

Contact

rates@dhcfp.nv.gov

Rate Recycles

Rate Recycle Reports will be posted here weekly. Please check this section regularly to stay informed.

Pending Recycles

New Codes for 2019

- Annual New Code Update Process
- 2019 Annual Update
- Update on the 2019 New Codes
- 2019 Covered Codes
- 2019 ASC Covered Codes

Fee Schedule Search

Nevada Medicaid has a new feature on the Medicaid.nv.gov website under the Provider "Home" page (EVS). The new feature will allow Providers to not only view fee schedules, but also the ability to verify member eligibility, search for claims, payment information and Remittance Advices. For modifier or anesthesia base units, see the appropriate links below. Please refer to the appropriate Medicaid policy to fully determine coverage as well as any coverage limitations. Medicaid policy takes precedence over any code and rate listed here for a particular provider type.

- Fee Schedule Search
- Web Portal User Manual
- Anesthesiology Unit Values
- Nevada Medicaid Modifier Listing

Fee Schedules

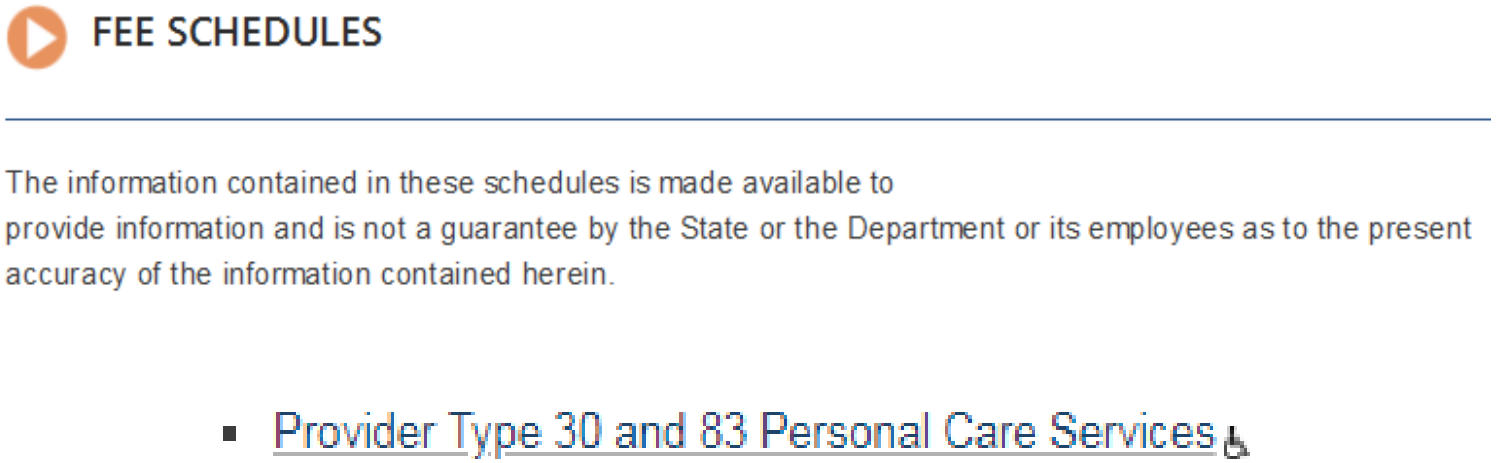
The fee schedules found here are updated on an annual basis, sometimes more frequently. Information regarding the annual new code update may be found on this website.

The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- Managed Care Capitation Rates - Pending CMS Approval
- Fee-for-Service PDF Fee Schedules

- Locate the "Fee-for-Service PDF Fee Schedules" from the Fee Schedules section.

DHCFP Rates Unit, continued

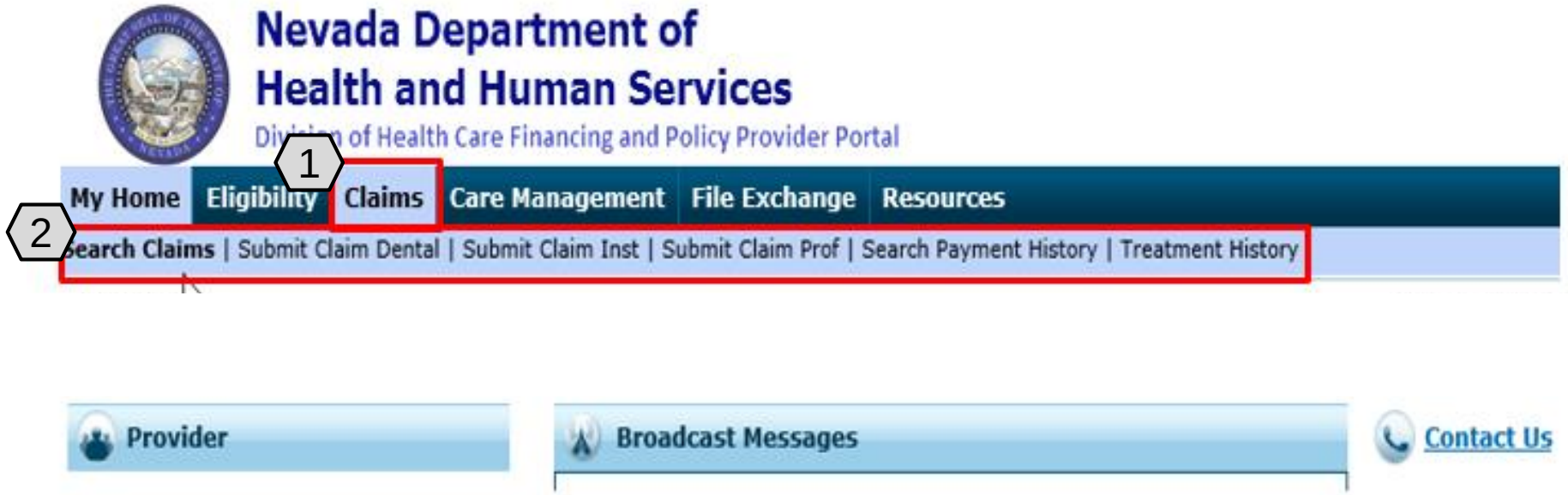


- Select Appropriate Title to open the PDF pertaining to the reimbursement schedule.

Submitting a Professional Claim via the EVS Secure Provider Web Portal (DDE)

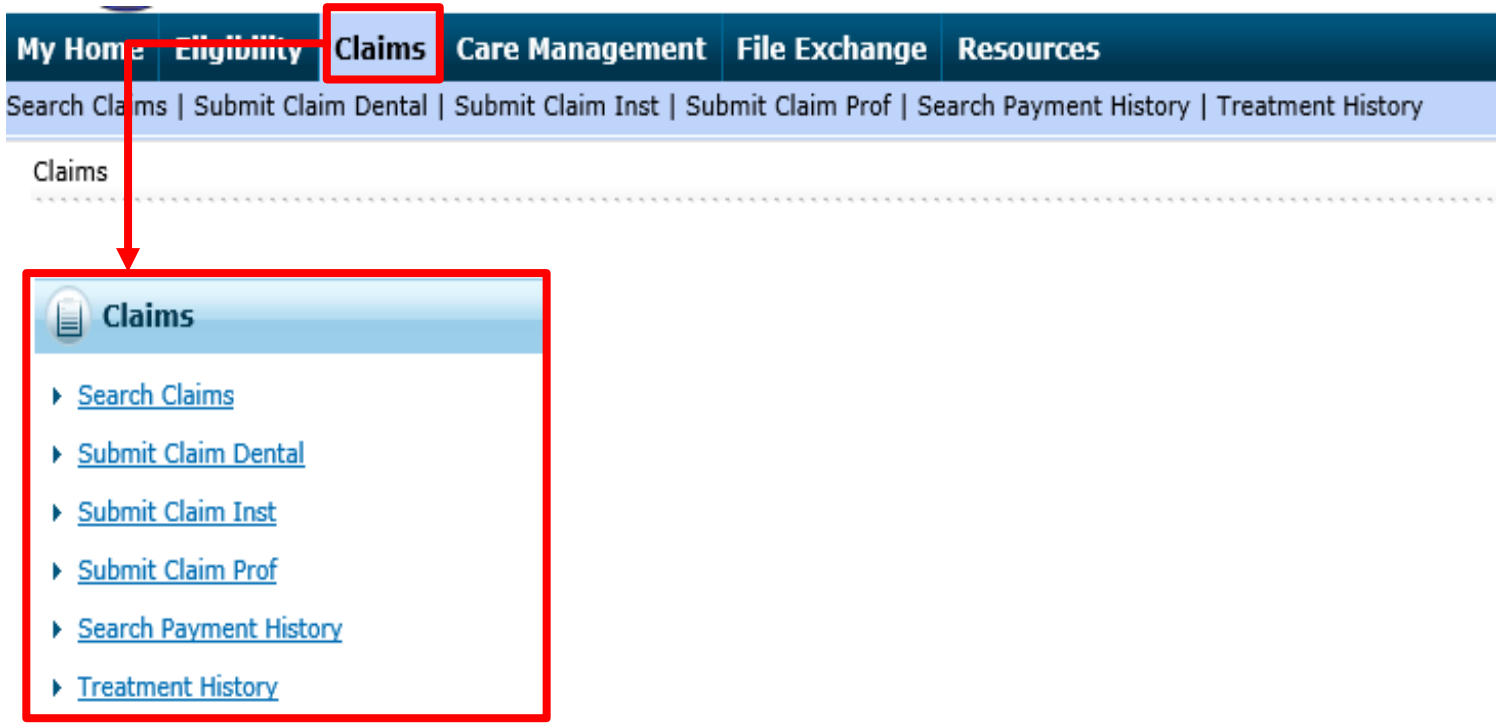
Understanding Claim Sub Menus

Understanding Claims Sub Menus

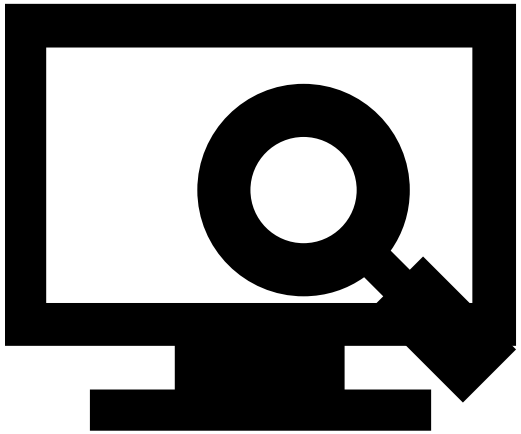


1. Hover over **Claims.**
2. Select the appropriate sub menu from the options.

Understanding Claims Sub Menus, continued



The page will display a list of Claims activities for the user to choose from.



Submitting a Professional Claim

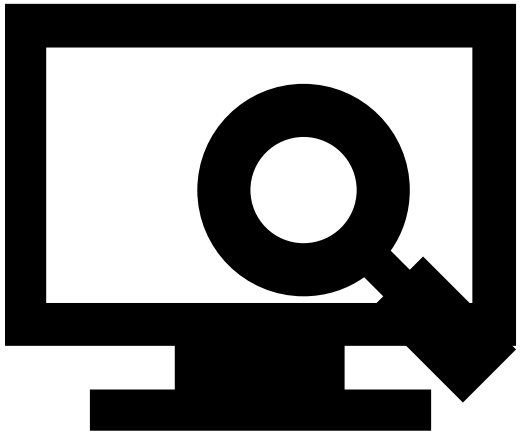
Submitting a Claim

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

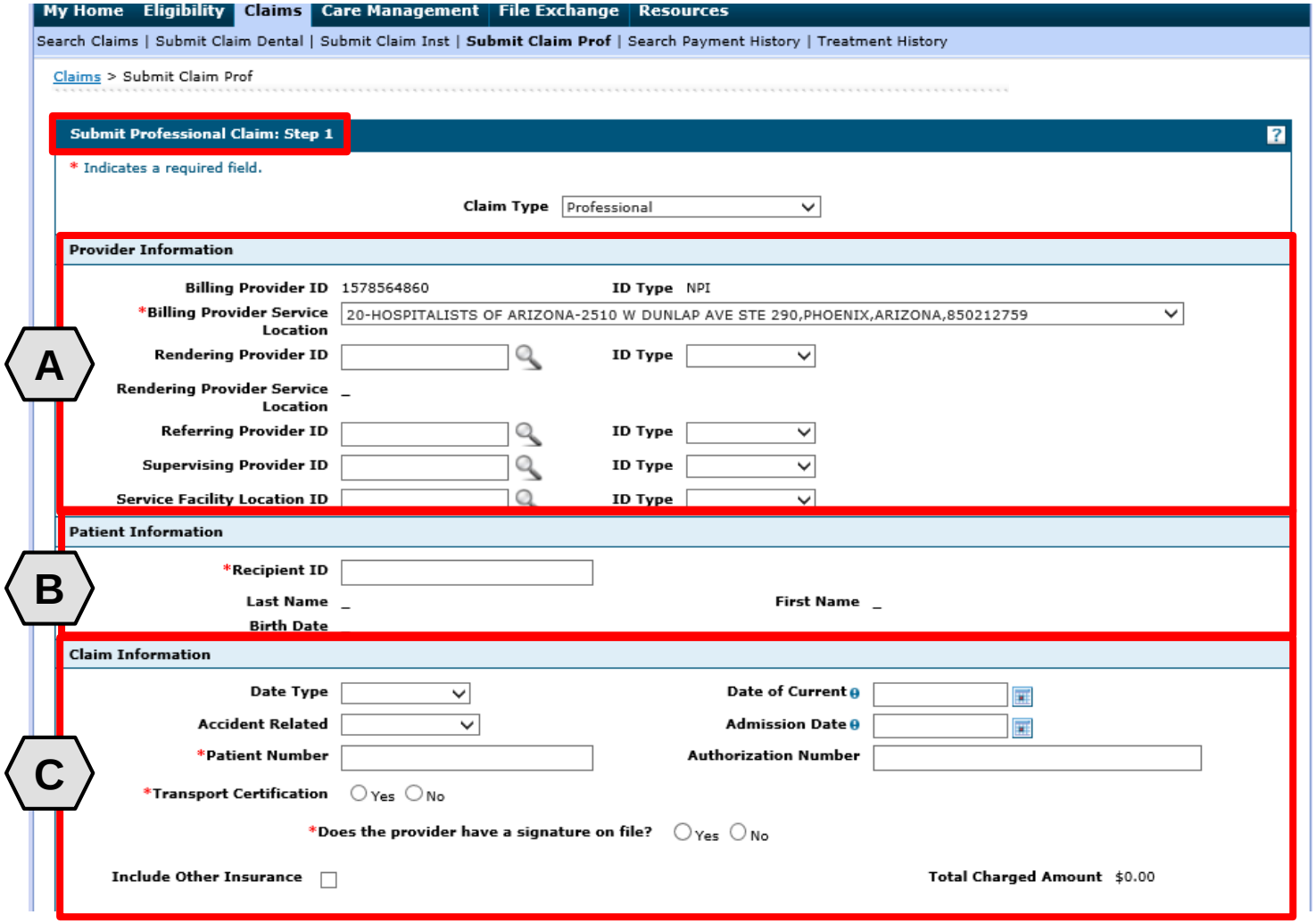
- **Step 1** - Provider, Patient, and Claim Information
- **Step 2** - Diagnosis Codes
- **Step 3** - Service Details and Attachments

Submitting a Claim: Step 1

1. Hover over the **Claims** tab.
2. Select **Submit Claim Prof.**



Submitting a Claim: Step 1



"Submit Professional Claim: Step 1" page sub-sections to complete:

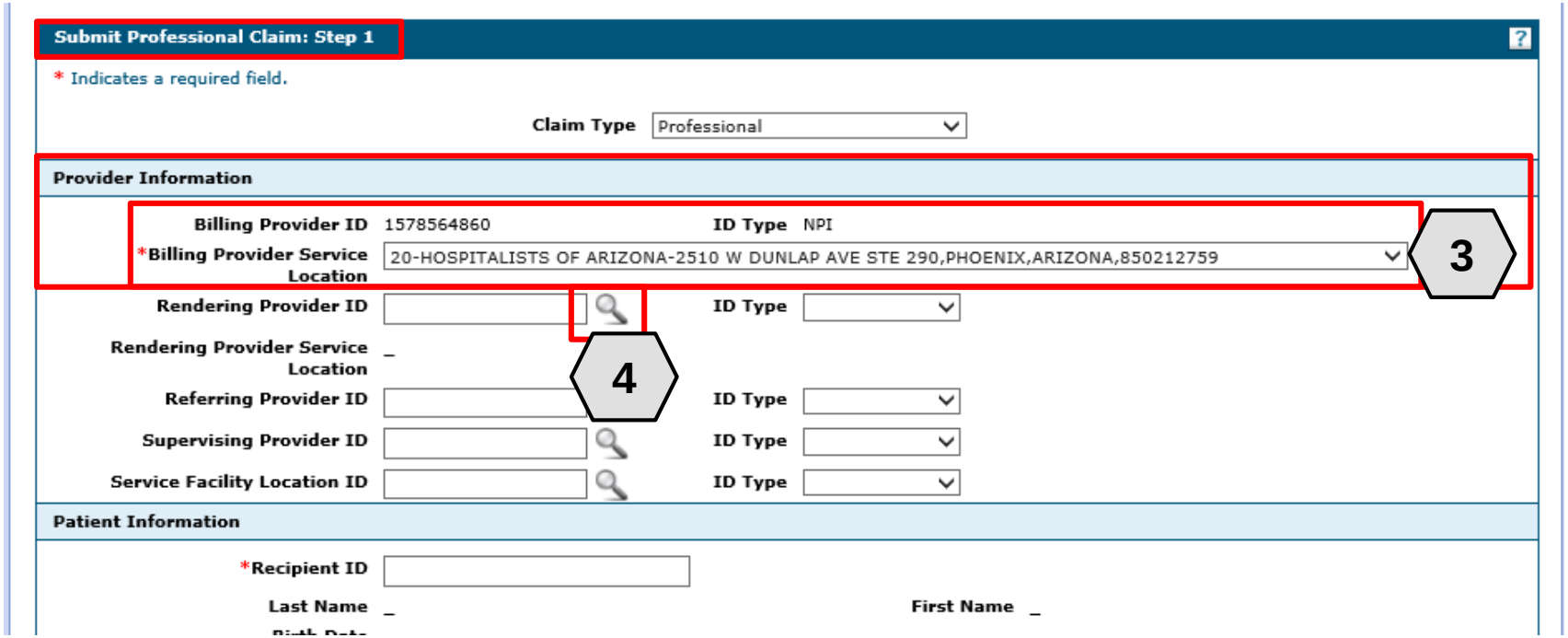
A. Provider Information

B. Patient Information

C. Claim Information

Submitting a Claim: Step 1, continued

Provider Information



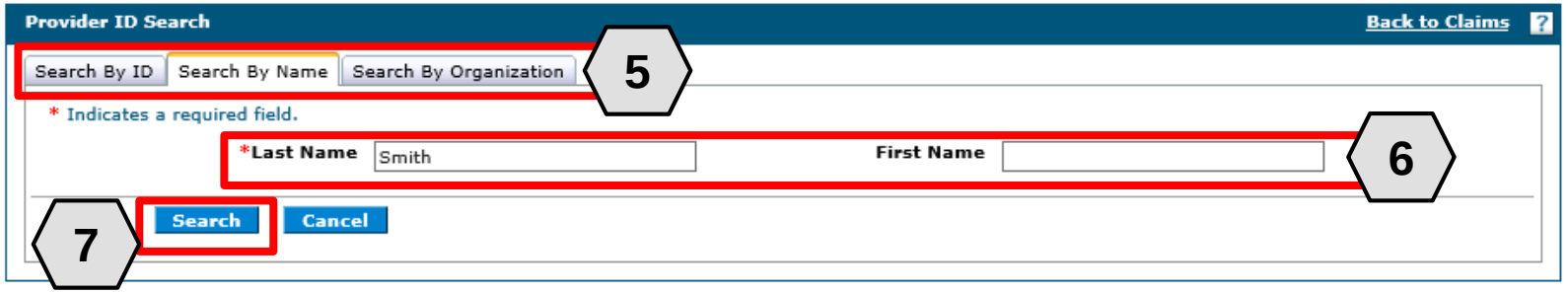
3. Select the appropriate provider type/service location being billed from the **Billing Provider Service Location** drop-down option.

4. Enter the Rendering ID and ID Type. If the Rendering ID is unknown, click the  button adjacent to the **Rendering Provider ID** field.

NOTE: If the Billing Provider has multiple locations, the user will use the drop-down option to locate and select the correct location for the claim.

Submitting a Claim: Step 1, continued

Provider Information



Search Results: Smith

Duplicate providers may appear in the results since a unique row is created for each specialty.

Total Records: 174

Provider ID	Provider Name	Provider Type	Address	City	State	Zip Code
1003195538 (NPI)	CHAEL A SMITH	Mental Health Outpatient Services	6130 ELTON AVE	LAS VEGAS	NEVADA	89107-2538
1013228659 (NPI)	GWEN M SMITHSON	Mental Health Outpatient Services	224 E WINNIE LN STE 222	CARSON CITY	NEVADA	89706-2251
1013901529 (NPI)	WILLIAM R SMITH	Nurse, Anesthetist	1050 E SOUTH TEMPLE	SALT LAKE CITY	UTAH	84102-1507
1013905793 (NPI)	JEFFERY D SMITH	Physician Assistant	520 S EAGLE RD STE 2209	MERIDIAN	IDAHO	83642-6354
1013907096 (NPI)	AMY P SMITH	Nurse, APRN	2201 SOUTH AVE	S LAKE TAHOE	CALIFORNIA	96150-7025
1023298254 (NPI)	COURTNEY M SMITH	Audiologist	3150 N TENAYA WAY STE 112	LAS VEGAS	NEVADA	89128-0446

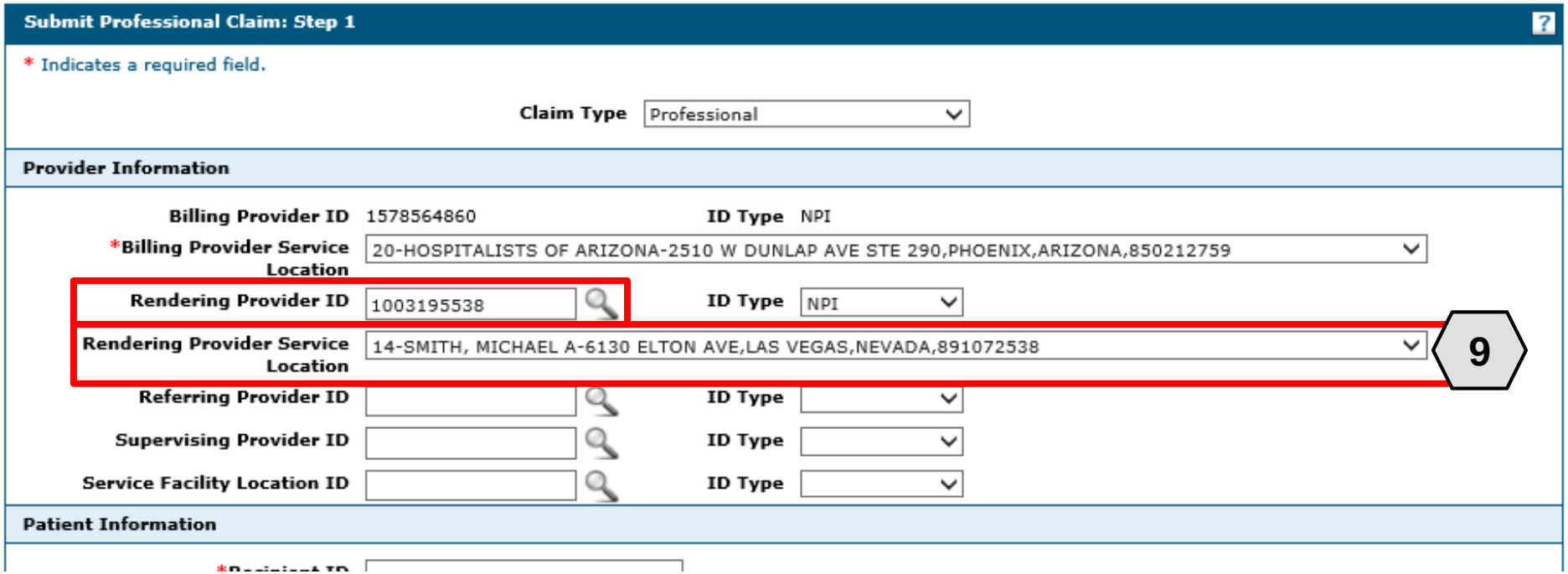
8

5. Select the desired search method.
6. Enter the provider's last name.
7. Click the **Search** button**,** and the search results populate at the bottom.
8. Click the blue link in the **Provider ID** column with correct Provider ID.

NOTE: The user can also search by the **Search By ID** or **Search By Organization** tabs.

Submitting a Claim: Step 1, continued

Provider Information

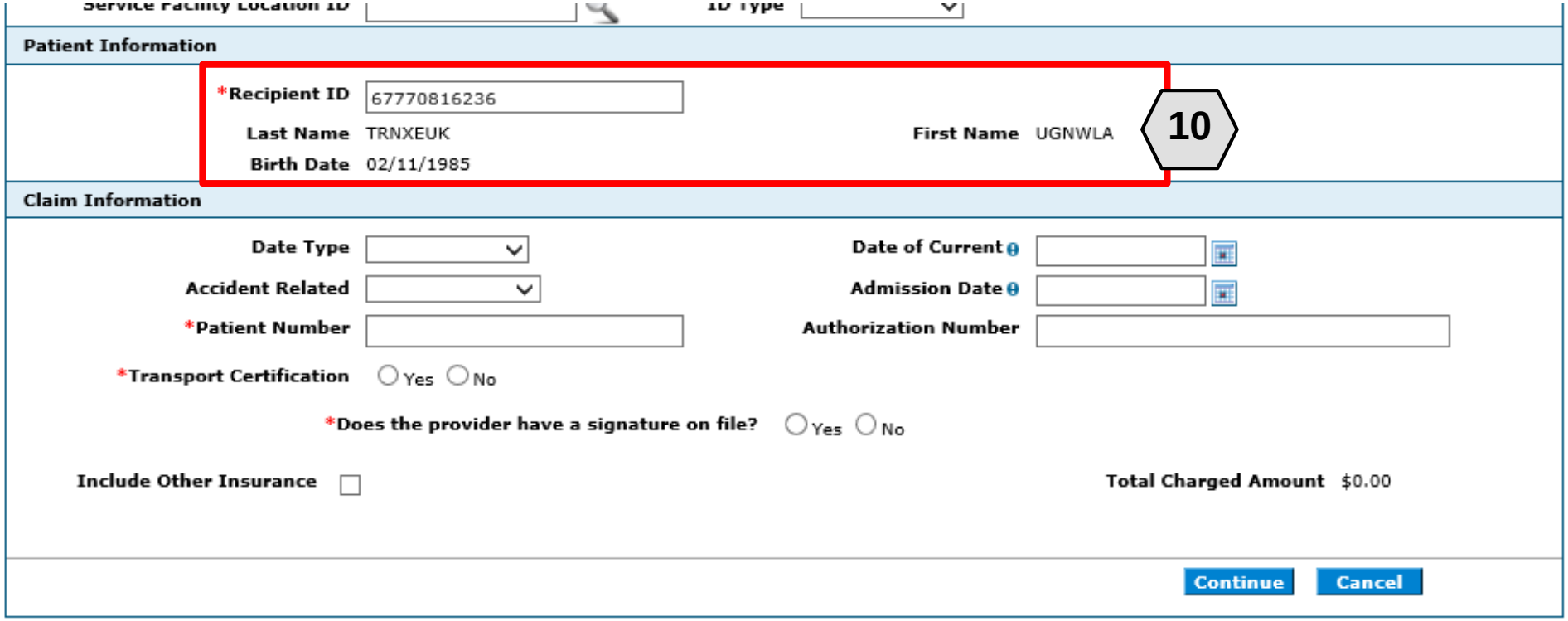


9. Select a **Rendering Provider Service Location** from the drop-down.

NOTE: If needed, the user may enter a **Referring Provider**, **Supervising Provider**, or **Service Facility Location ID** the same way the **Rendering Provider ID** was entered.

Submitting a Claim: Step 1, continued

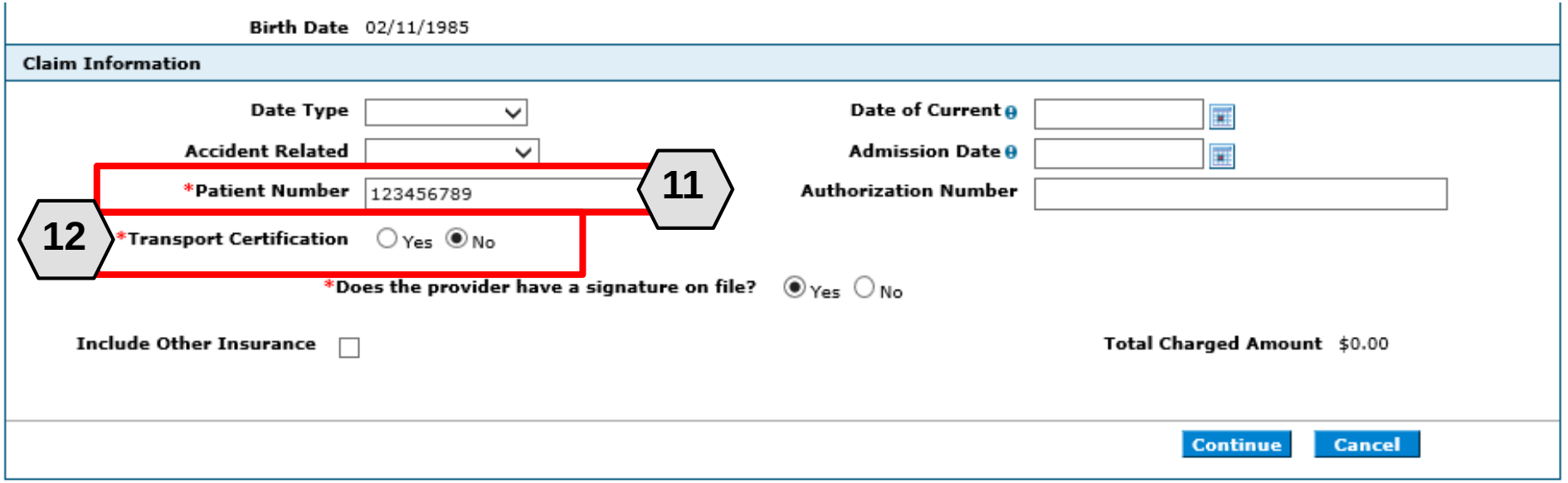
Patient Information



10. Enter the 11-digit **Recipient ID** and click outside of the field to populate **Last Name**, **First Name** and **Birth Date.**

Submitting a Claim: Step 1, continued

Claim Information



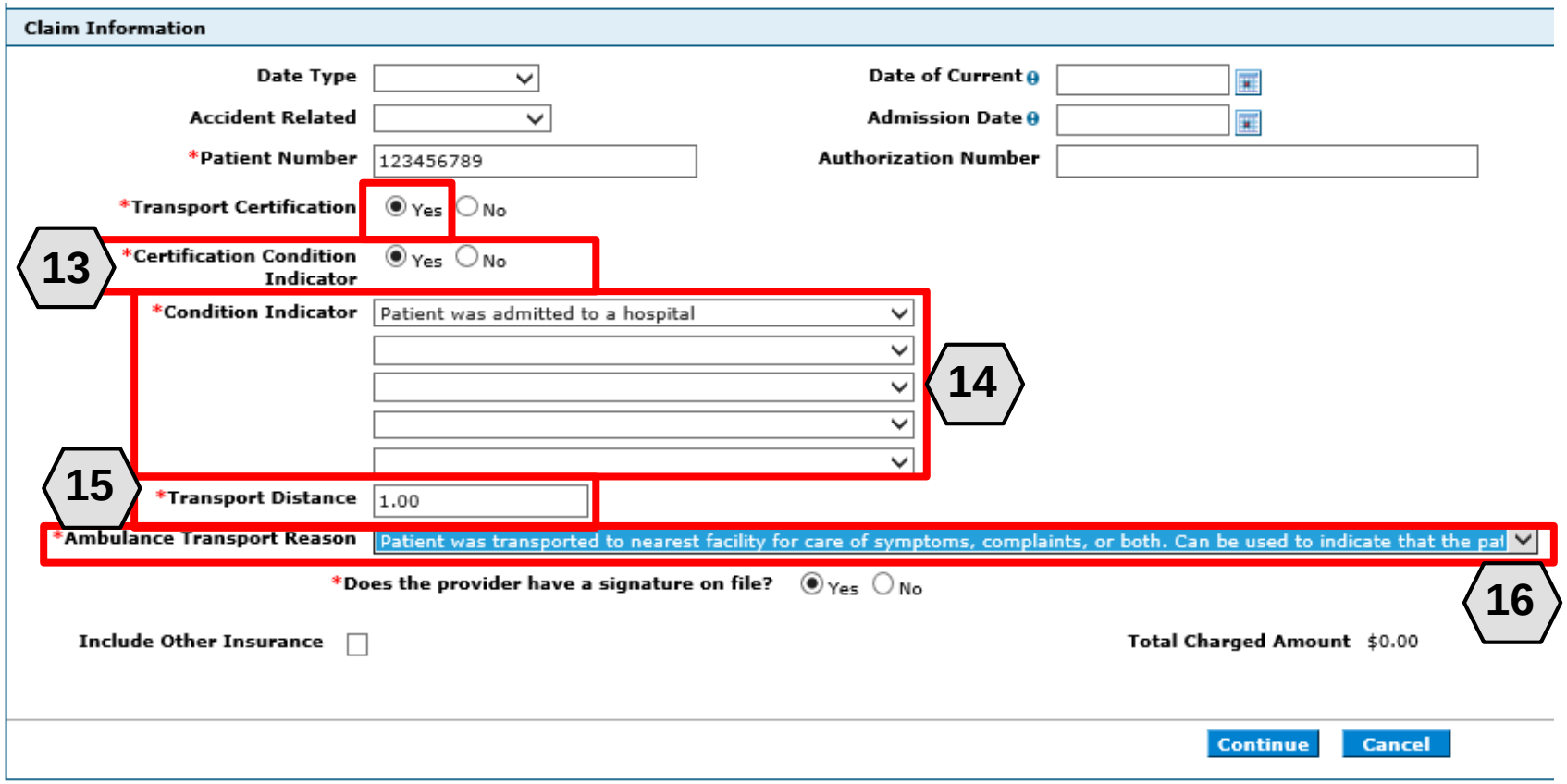
NOTE: Other fields can be completed based on additional details known about the claim.

The following fields with an (*) must be completed as follows:

11. Enter the **Patient Number.**
12. Choose “Yes” or “No” to indicate a **Transport Certification** (If “Yes,” additional details will be required. These are illustrated on the next slide).

Submitting a Claim: Step 1, continued

Claim Information

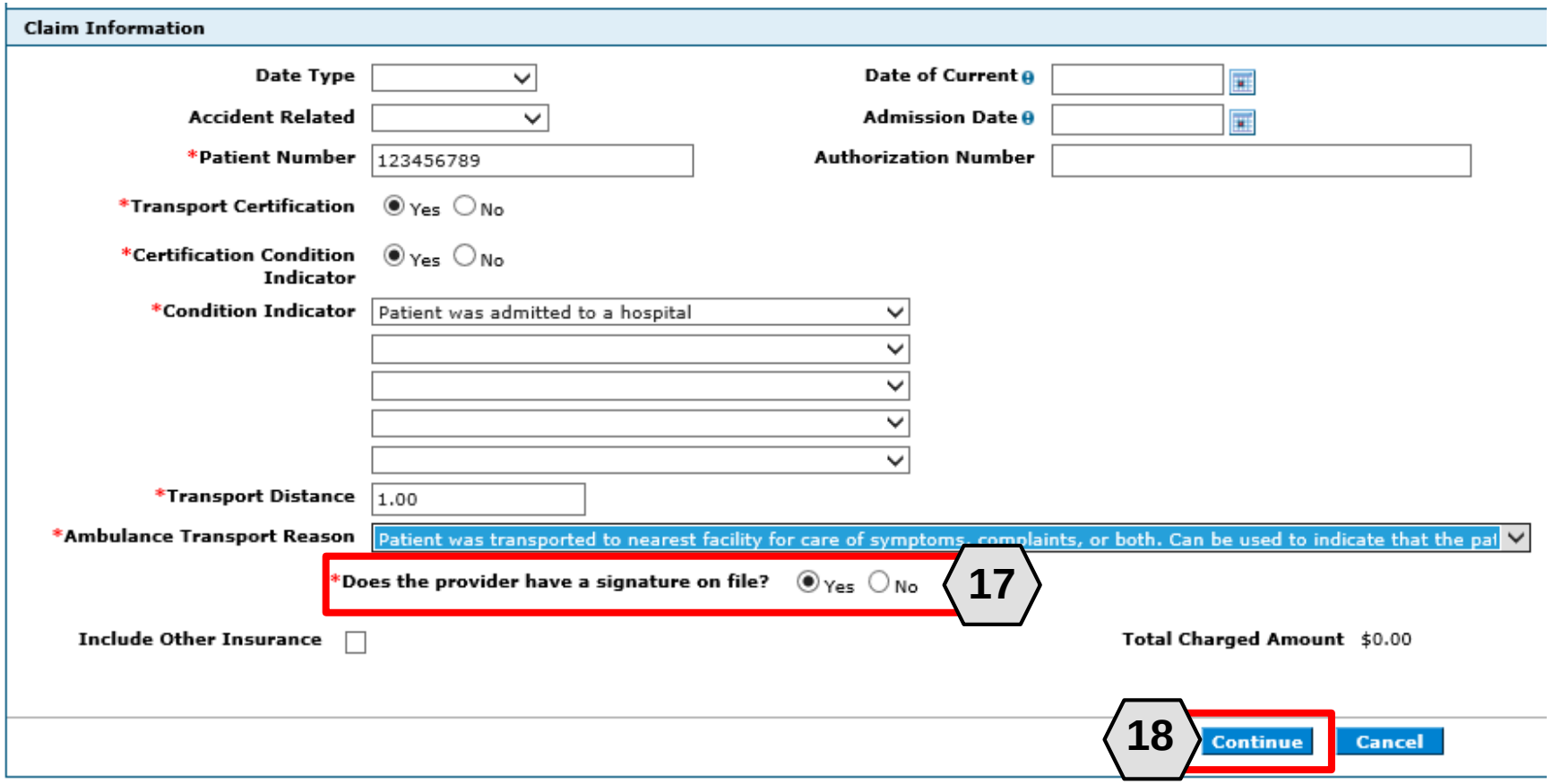


If the user selects “Yes” in the **Transport Certification** field, additional details must be entered.

13. Choose “Yes” or “No” as the **Certification Condition Indicator.**
14. Indicate the patient’s condition from the **Condition Indicator** drop-downs (up to five options may be selected).
15. Enter the distance (in miles) that the patient traveled into the **Transport Distance** field.
16. Select the **Ambulance Transport Reason.**

Submitting a Claim: Step 1, continued

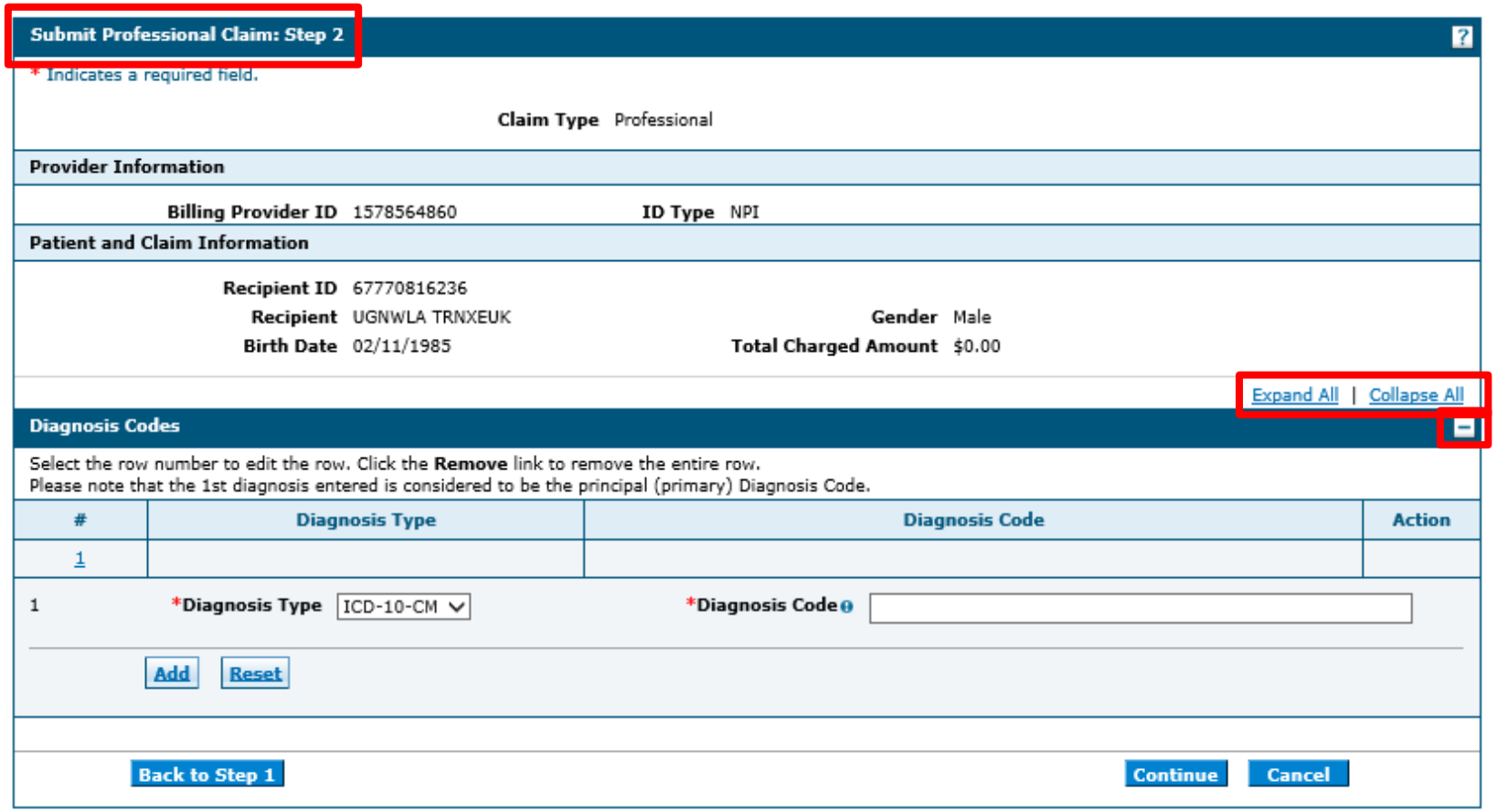
Claim Information



17. Indicate whether the provider has a signature on file.
18. Click the **Continue** button.

Submitting a Claim: Step 2

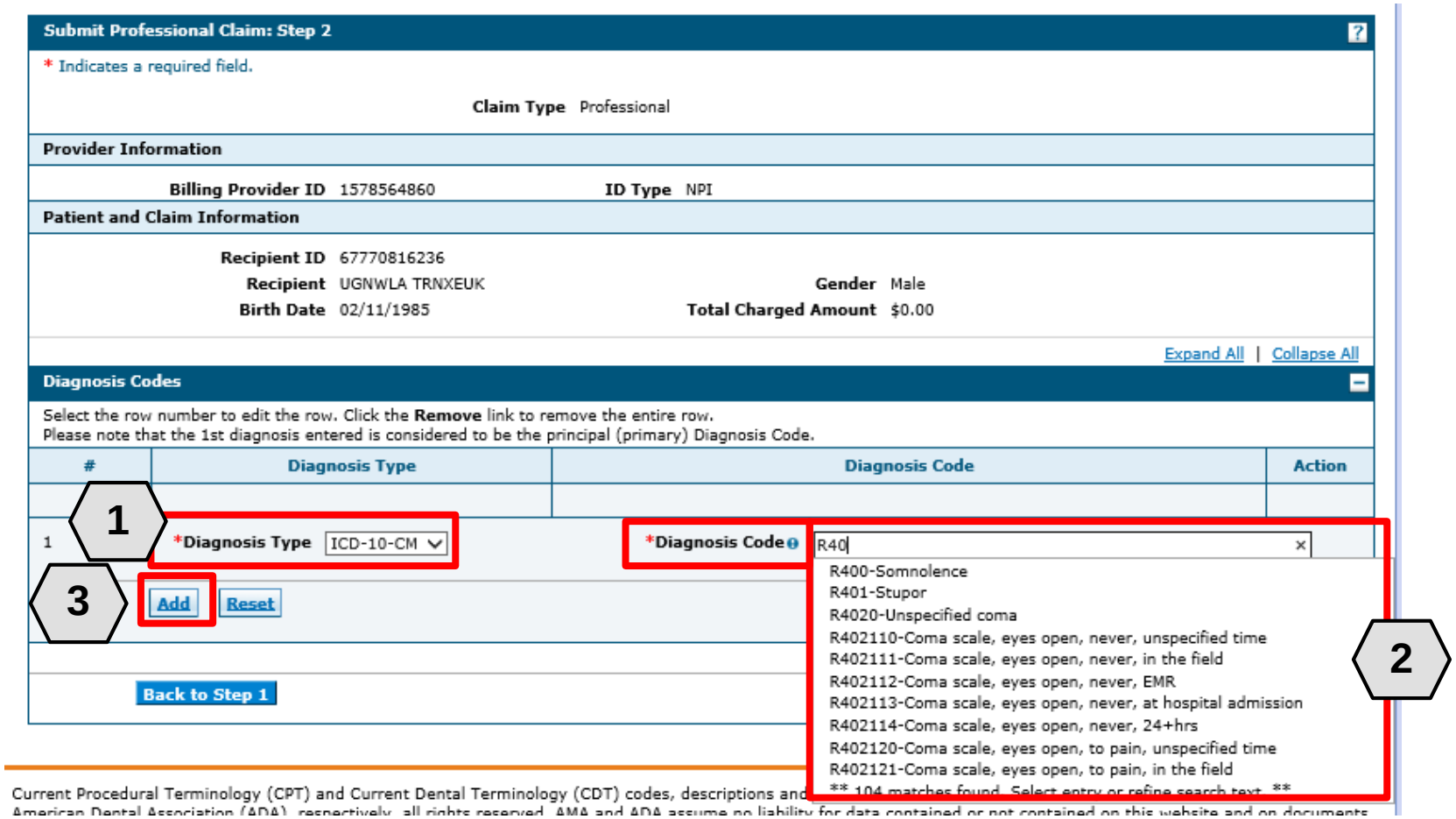
Diagnosis Codes



Once the user clicks the **Continue** button, the "Submit Professional Claim: Step 2" page is displayed with all the panels expanded.

Submitting a Claim: Step 2, continued

Diagnosis Codes

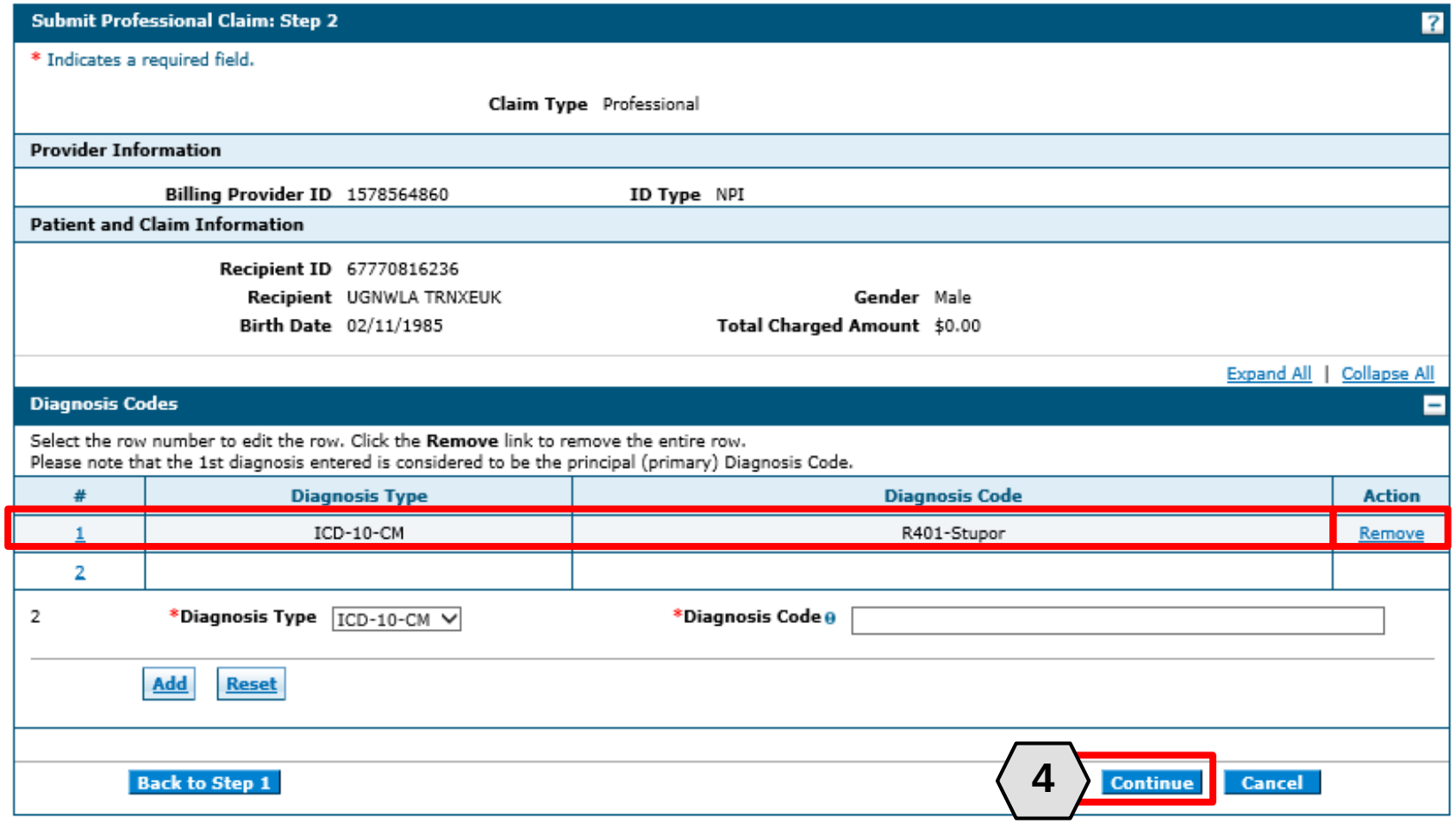


1. Choose a **Diagnosis Type.**
2. Enter the **Diagnosis Code.**
3. Click the **Add** button.

NOTE: The **Diagnosis Code** field contains a predictive search feature using the first three characters of the code or code description.

Submitting a Claim: Step 2, continued

Diagnosis Codes



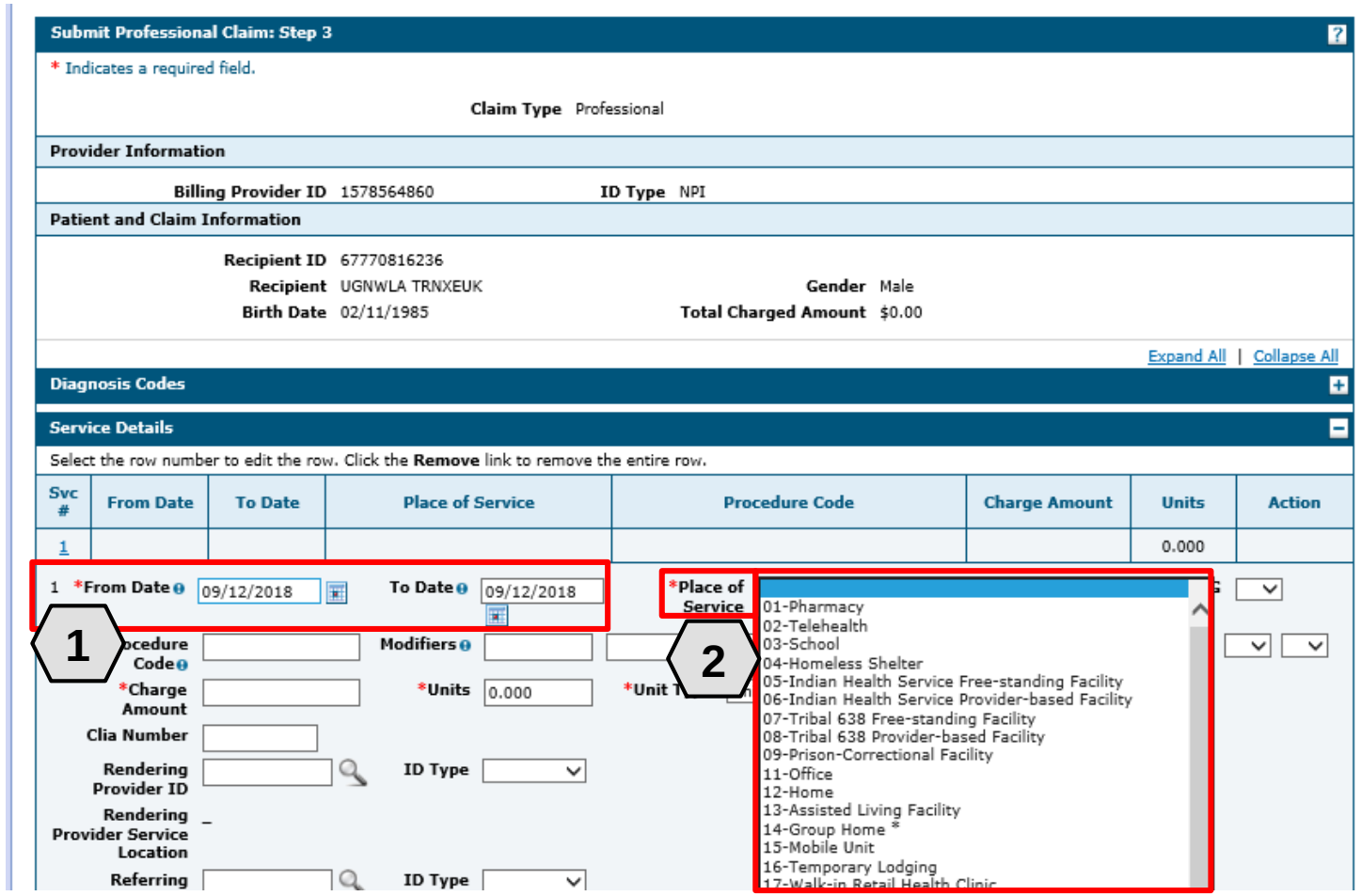
Click the **Remove** link to remove a diagnosis code from the claim.

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

4. Click the **Continue** button.

Submitting a Claim: Step 3

Service Details

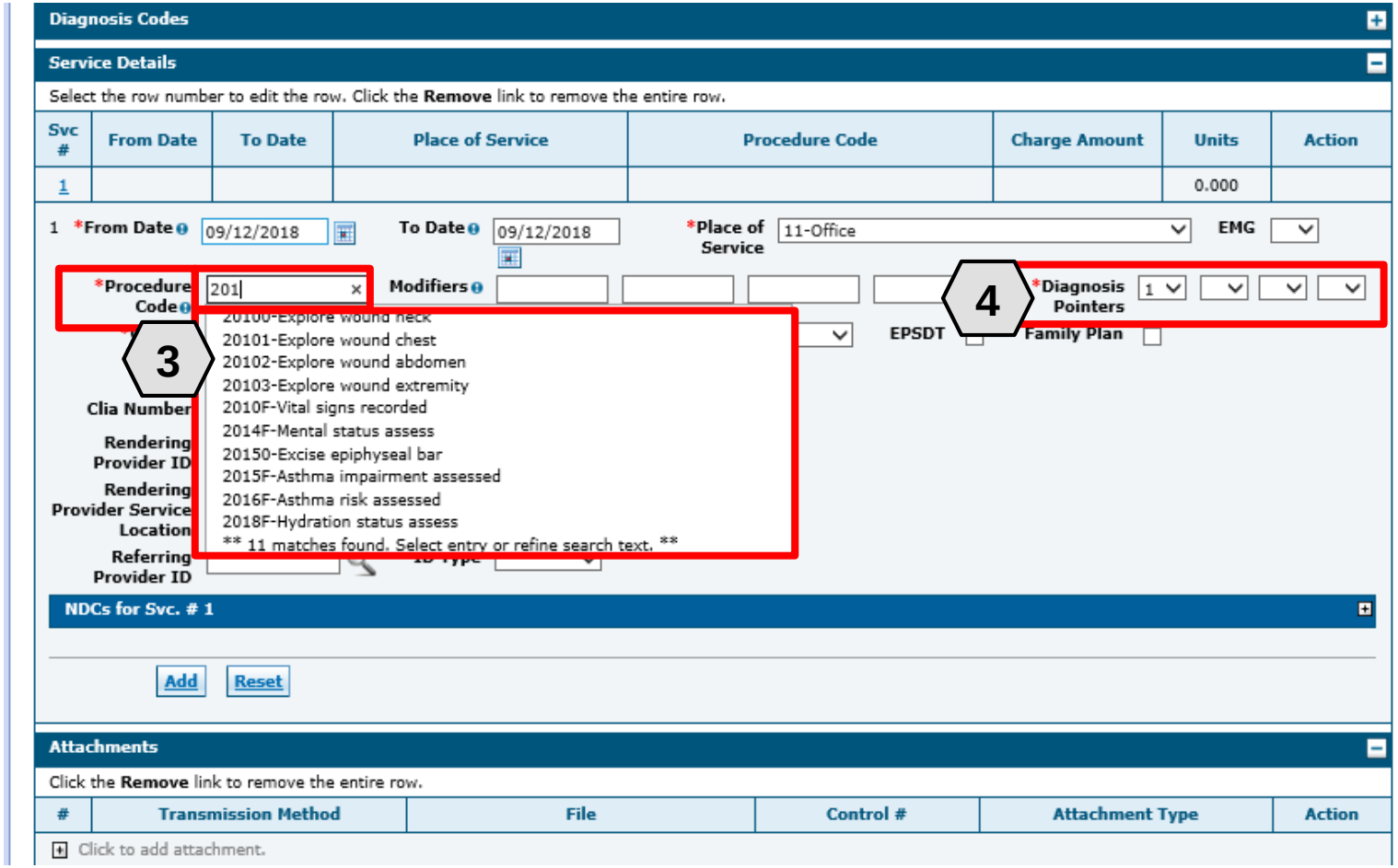


Enter the following service details for the claim:

1. Enter the **From Date** and **To Date** that services were rendered.
2. Select the **Place of Service** from the drop-down.

Submitting a Claim: Step 3, continued

Service Details



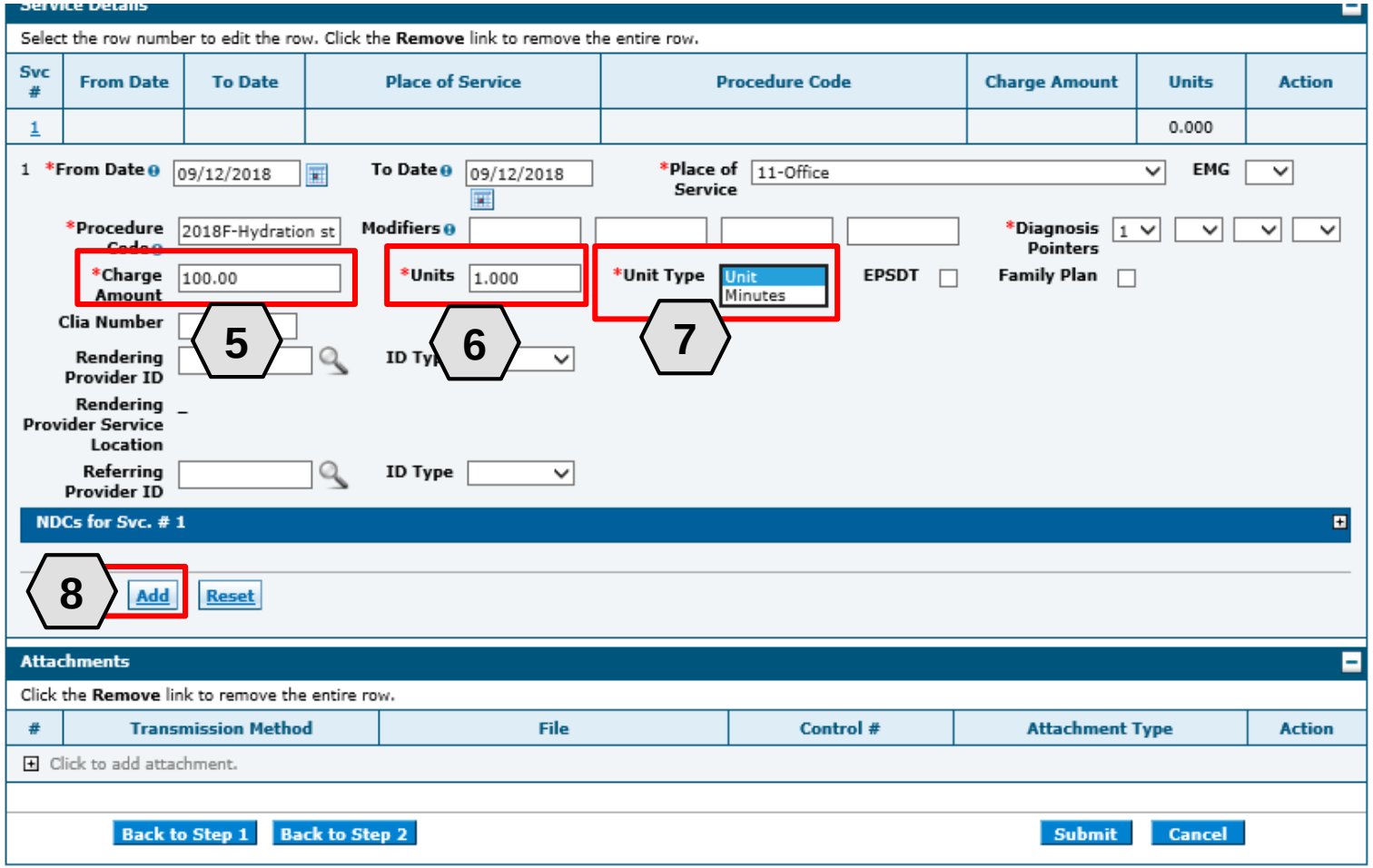
3. Enter the **Procedure Code**, which is searchable by entering at least the first three letters or numbers of the code description.

4. Enter at least one **Diagnosis Pointer.**

NOTE: **Diagnosis Pointers** are used to show what diagnosis is applicable to a service detail.

Submitting a Claim: Step 3

Service Details



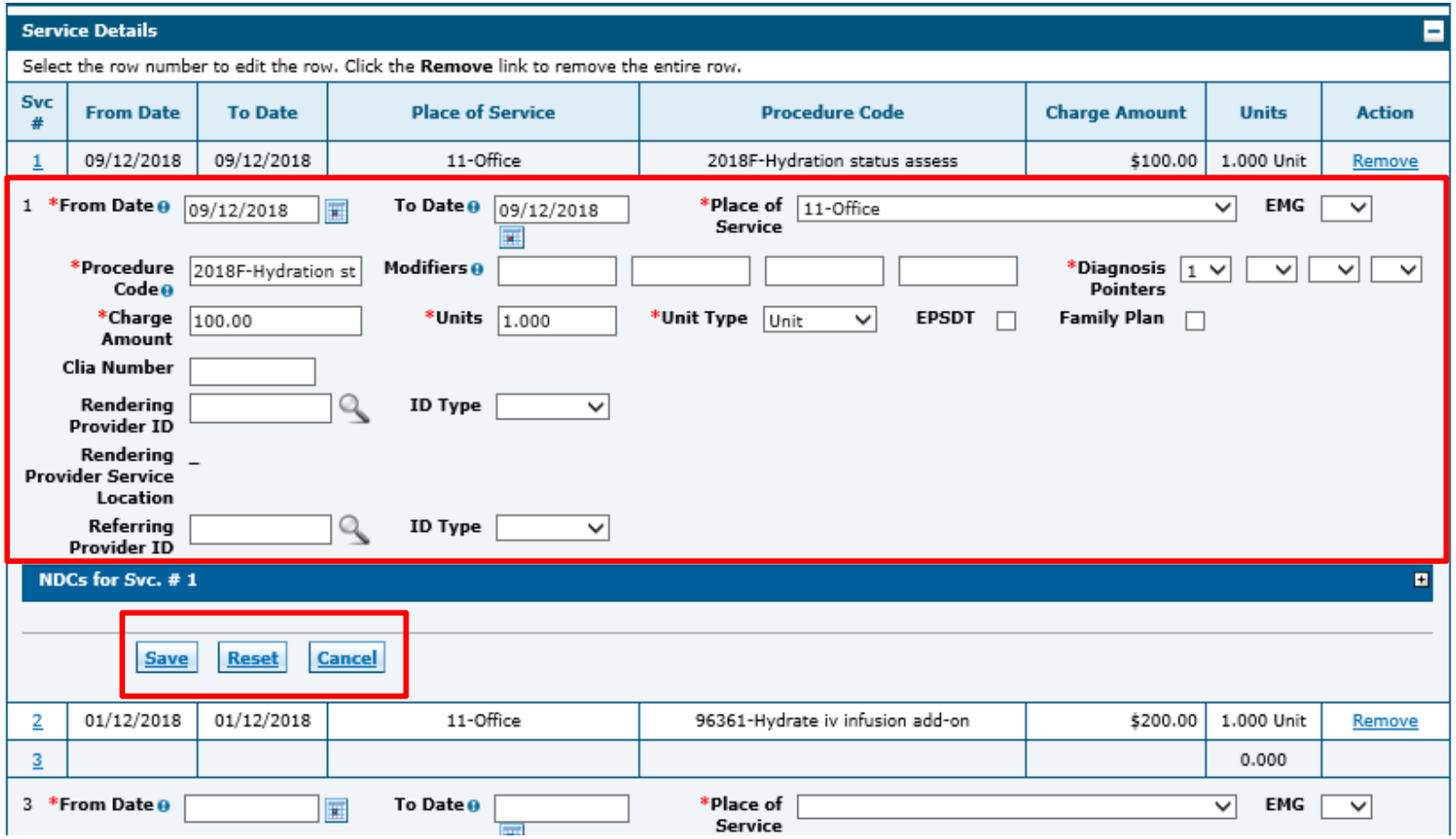
With the **Procedure Code** and **Diagnosis Pointers** entered, the user will need to:

5. Enter a **Charge Amount.**
6. Enter the number of **Units.**
7. Select a **Unit Type** from the drop-down.
8. Click the **Add** button to add the procedure to the claim.

NOTE: The user may enter any additional details, such as **Modifiers**, prior to clicking **Add**. Repeat Steps 1-8 in this section for each additional procedure.

Submitting a Claim: Step 3, continued

Service Details



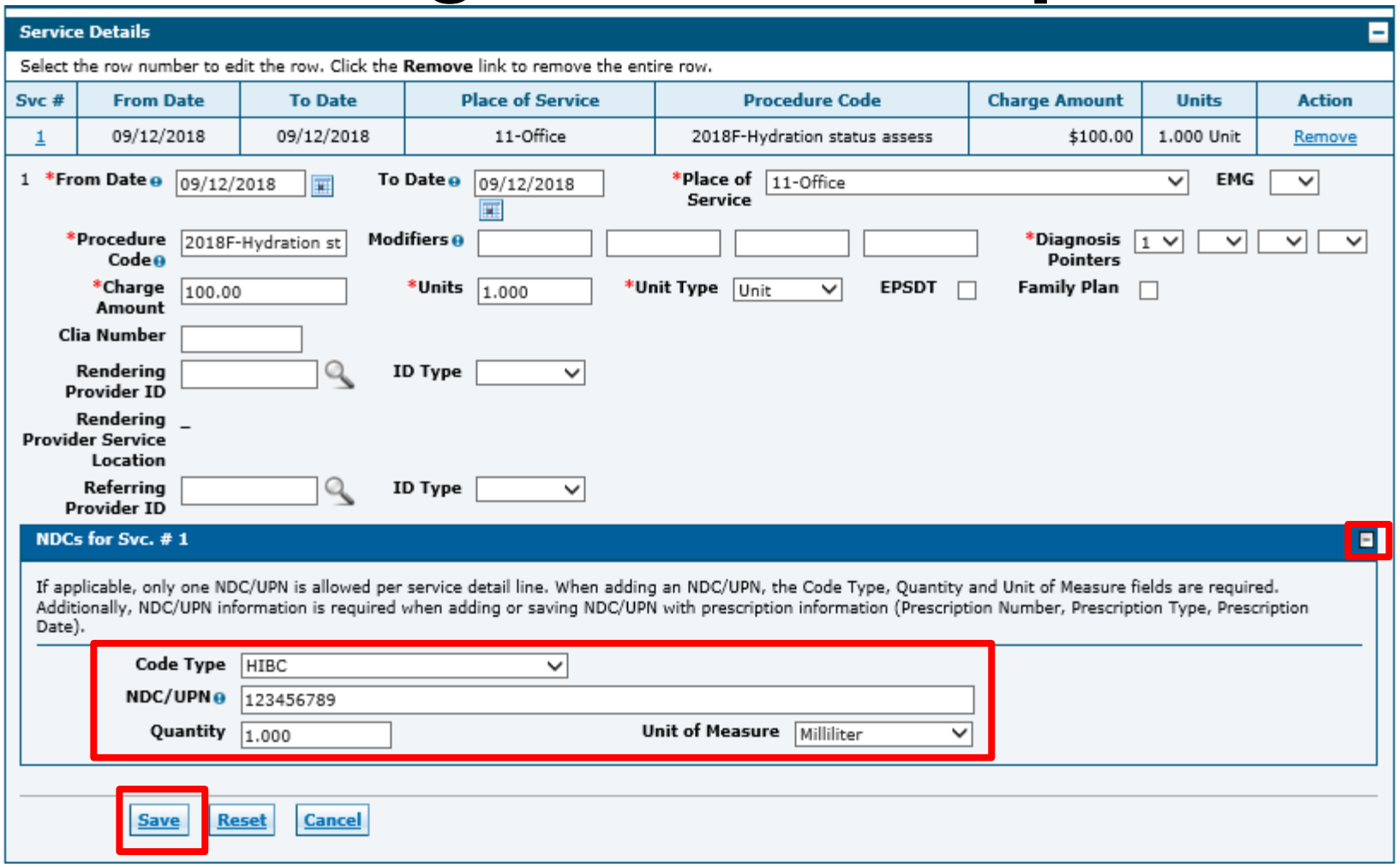
When editing a Service Detail, three buttons are available:

Save: Saves any changes made to the detail.

Reset: Clears all fields in the selected service detail.

Cancel: Cancels any updates and closes the service detail.

Submitting a Claim: Step 3, continued



Optionally, if the user needs to enter a National Drug Code for a Service Detail, the user will click the + symbol to expand the **NDC for Svc.** panel.

From here, the user may enter and save NDC information to the service detail. To close this panel, the user will click the – symbol.

Submitting a Claim: Step 3, continued

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	$100.00	1.000 Unit	Remove
2	01/12/2018	01/12/2018	11-Office	96361-Hydrate iv infusion add-on	$200.00	1.000 Unit	Remove
3						0.000	

3 *From Date | To Date | *Place of Service | EMG

*Procedure Code | Modifiers | *Diagnosis Pointers

*Charge Amount | *Units 0.000 | *Unit Type Unit | EPSDT | Family Plan

Clia Number

Rendering Provider ID | ID Type

Rendering Provider Service Location

Referring Provider ID | ID Type

NDCs for Svc. # 3

Add Reset

Attachments

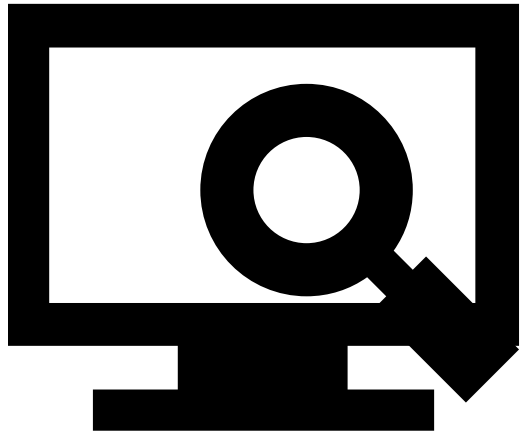
Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action

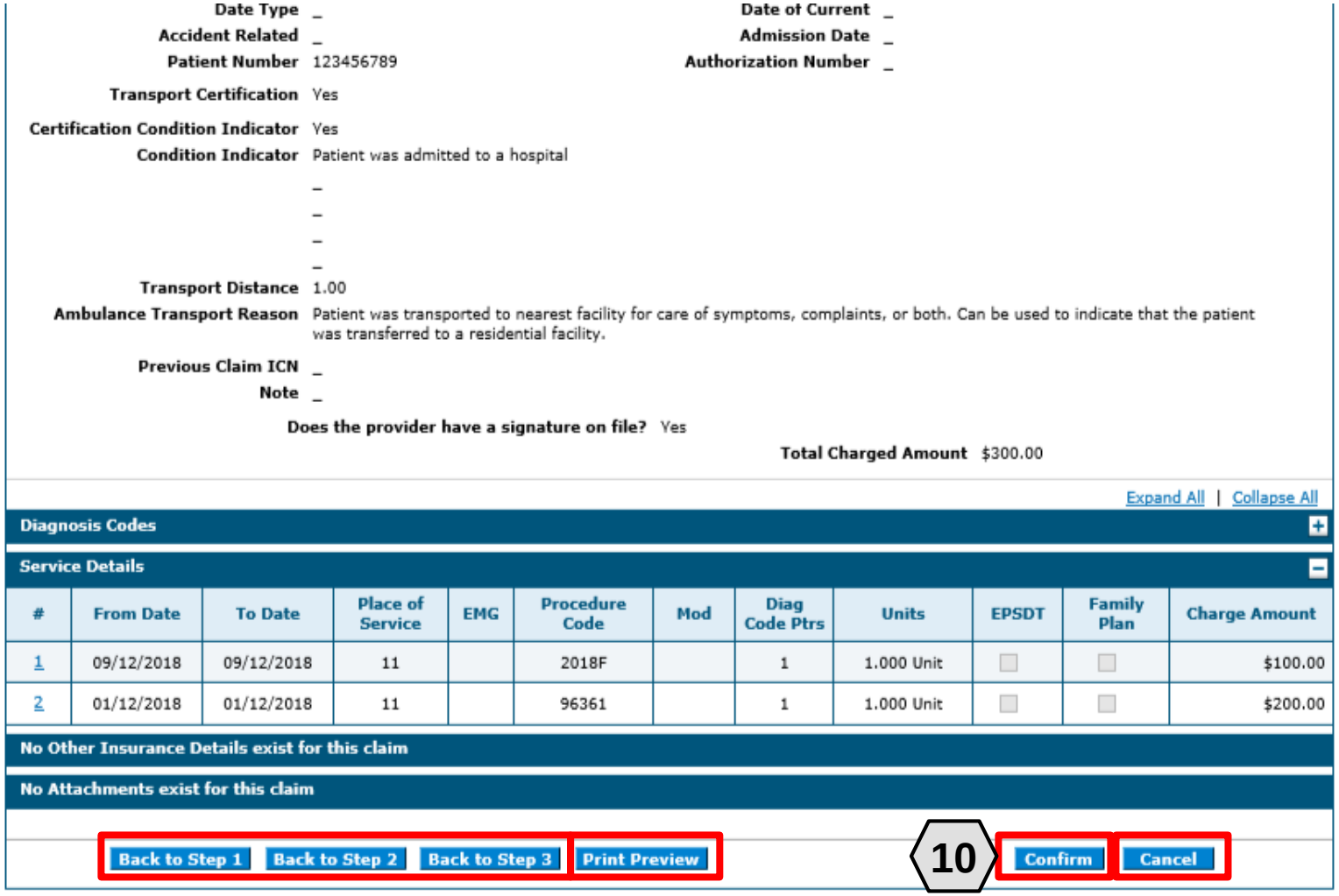
Click to add attachment.

Back to Step 1 | Back to Step 2 | 9 | Submit | Cancel

9. Click the **Submit** button.



Submitting a Claim: Step 3, continued



Date Type _
Accident Related _
Patient Number 123456789
Transport Certification Yes
Certification Condition Indicator Yes
Condition Indicator Patient was admitted to a hospital
_
_
_
_
Transport Distance 1.00
Ambulance Transport Reason Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility.
Previous Claim ICN _
Note _

Date of Current _
Admission Date _
Authorization Number _

Does the provider have a signature on file? Yes

Total Charged Amount $300.00

Expand All | Collapse All

Diagnosis Codes

Service Details

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
1	09/12/2018	09/12/2018	11		2018F		1	1.000 Unit			$100.00
2	01/12/2018	01/12/2018	11		96361		1	1.000 Unit			$200.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

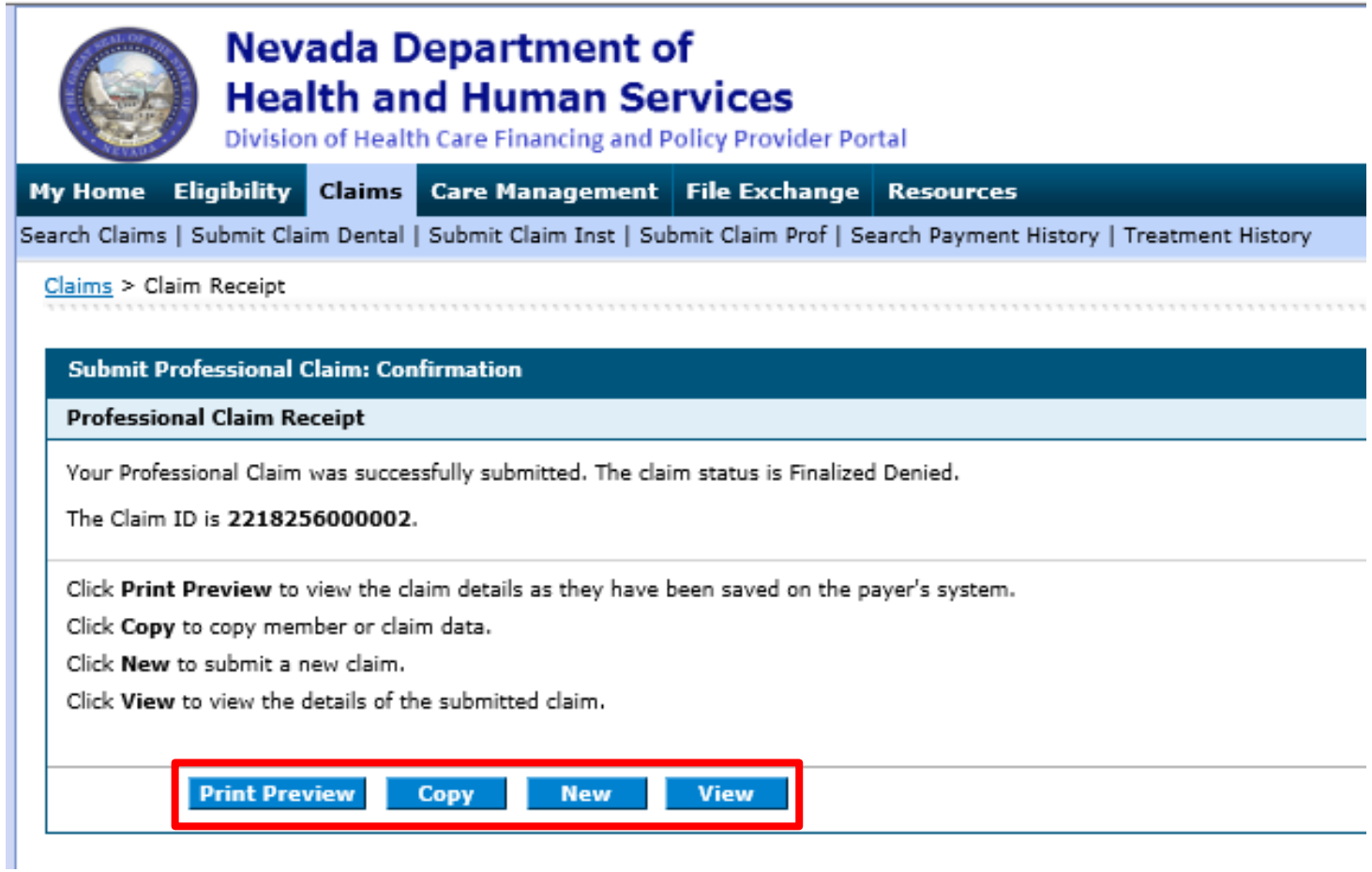
Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview

10

Confirm | Cancel

10. Click the **Confirm** button.

Submitting a Claim: Step 3, continued



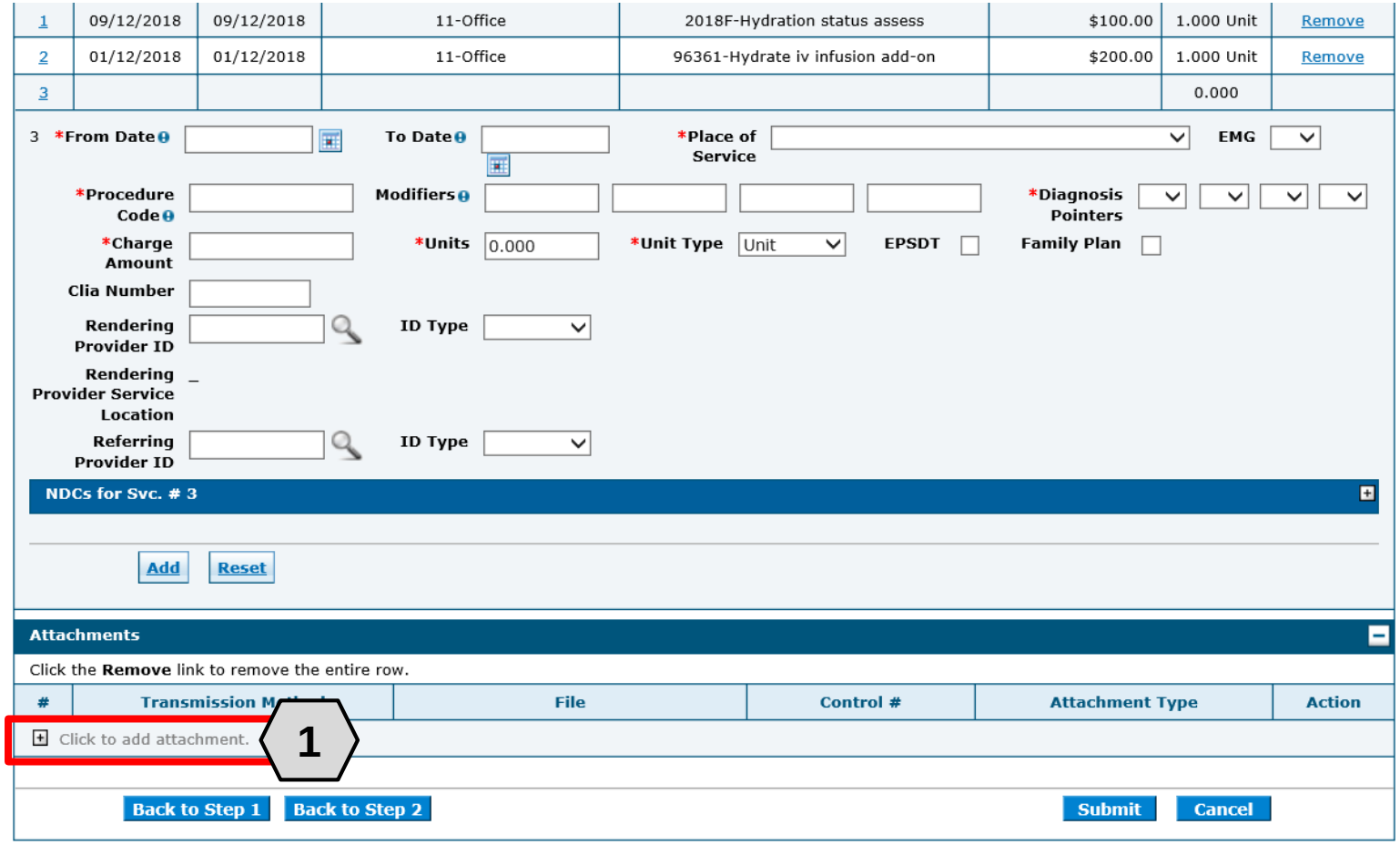
The **Submit Professional Claim: Confirmation** will appear after the claim has been submitted. It will display the claim status and **Claim ID**.

The user may then:

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

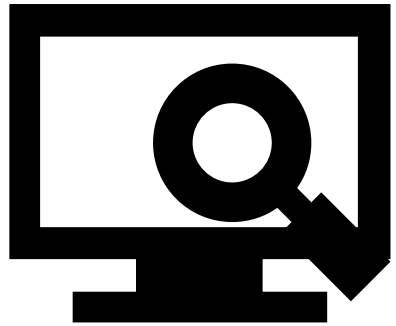
Submitting a Claim: Attachments

Submitting a Claim: Attachments

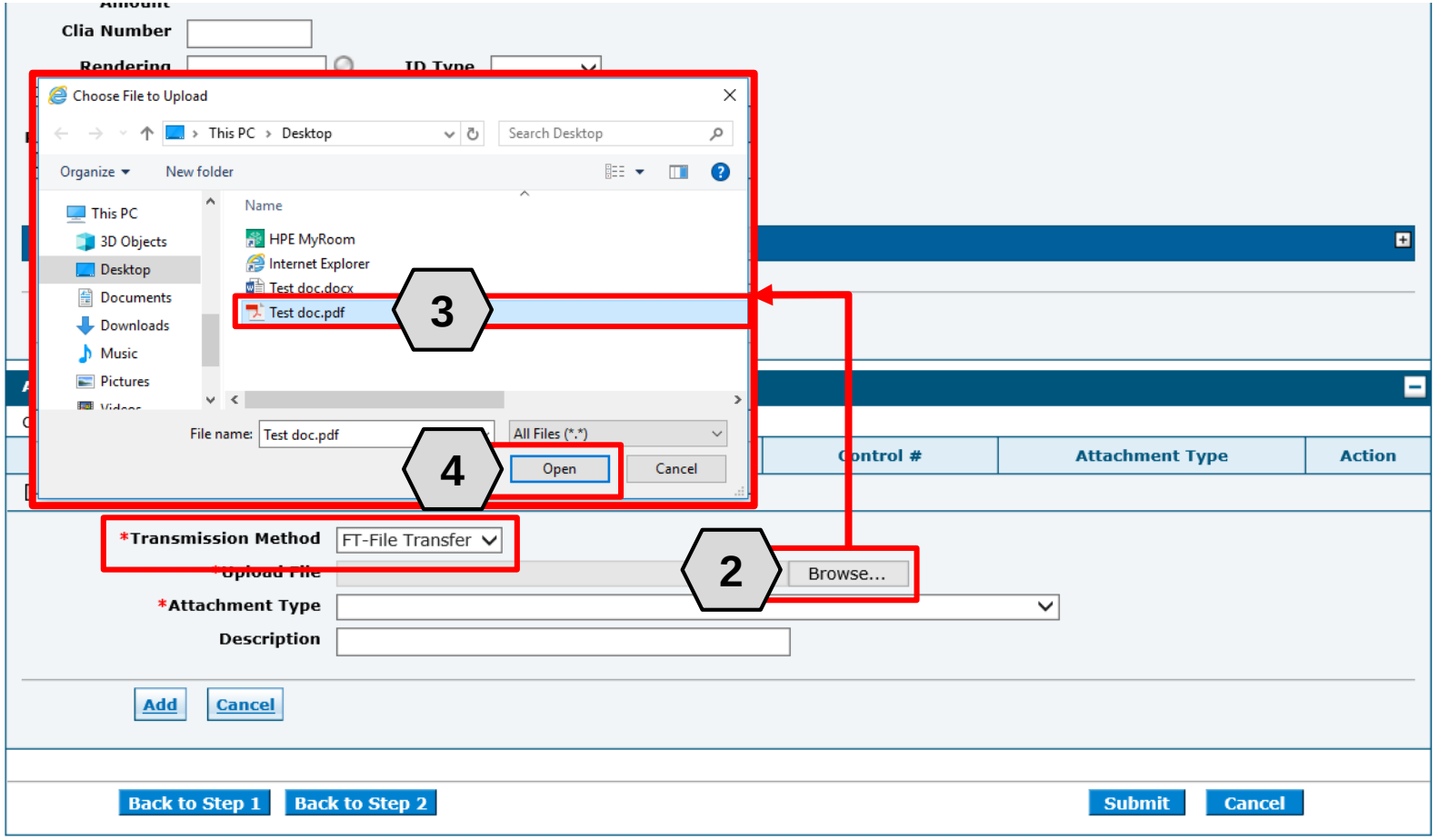


To upload attachments to a professional claim:

1. Click the (+) sign on the **Attachments** panel.



Submitting a Claim: Attachments, continued



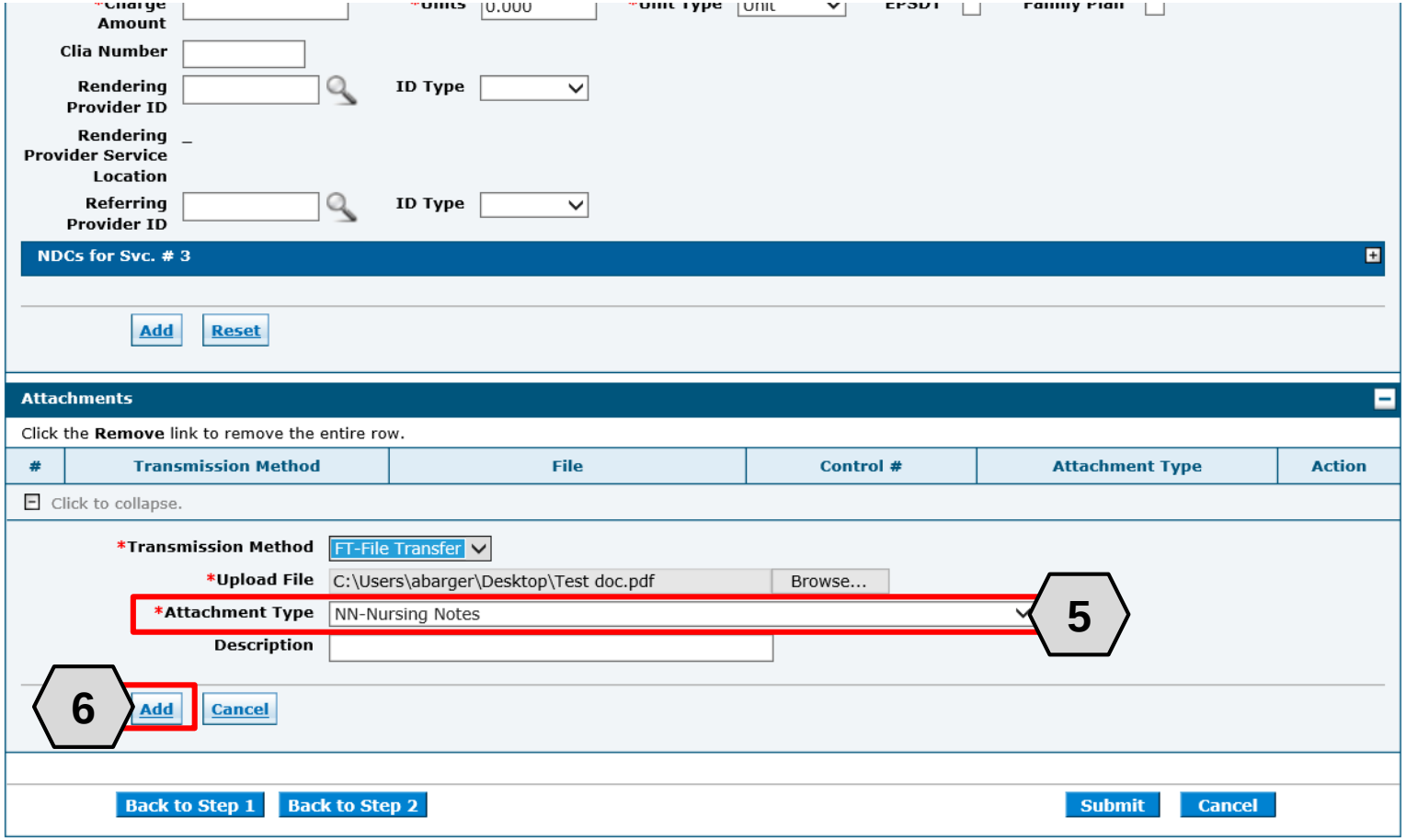
2. Click **Browse** button and locate the file on your computer to be attached.

A window will then pop up. From there:

3. Locate and select the file.
4. Click the **Open** button.

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

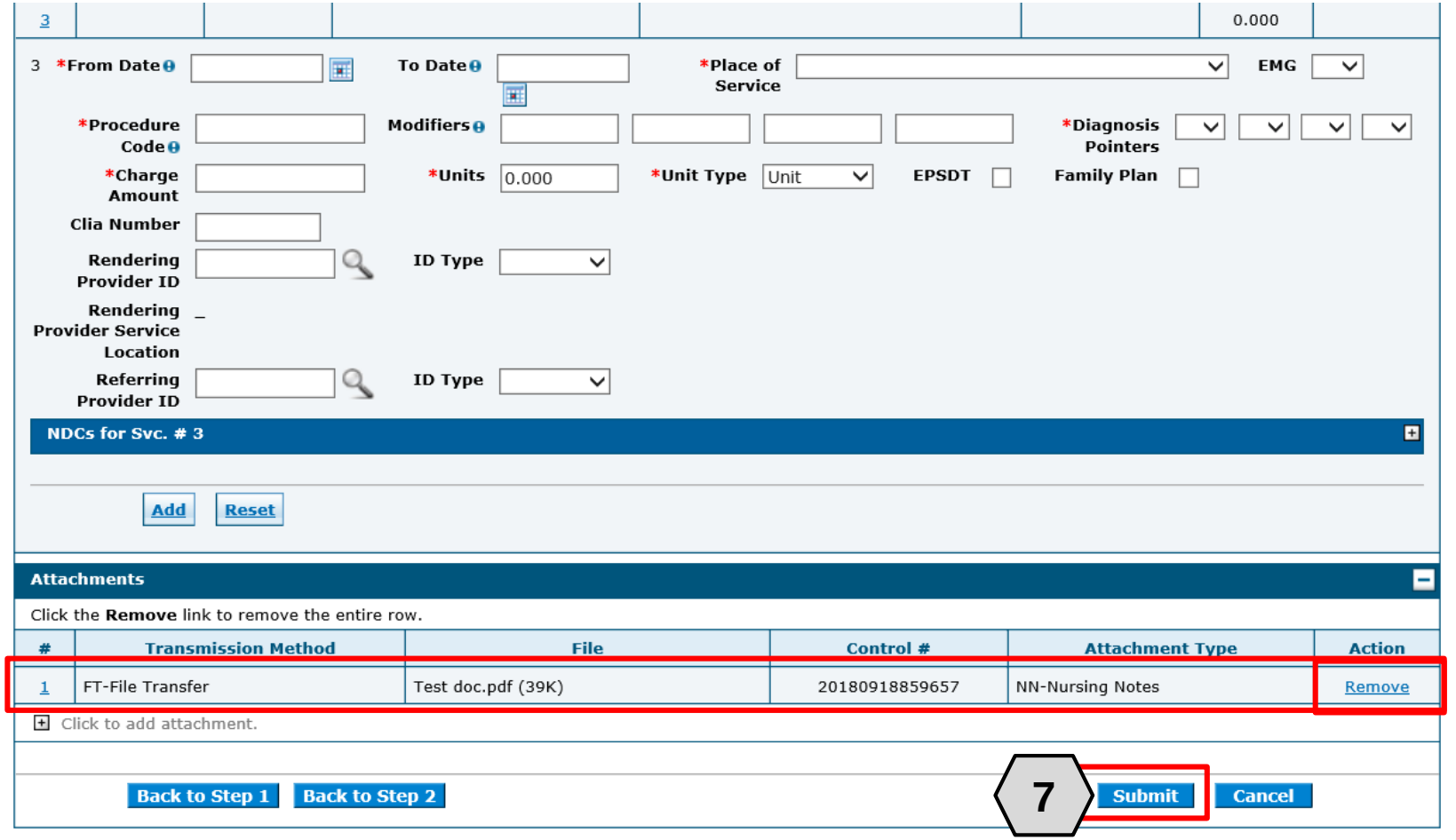
Submitting a Claim: Attachments, continued



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: Attachments, continued

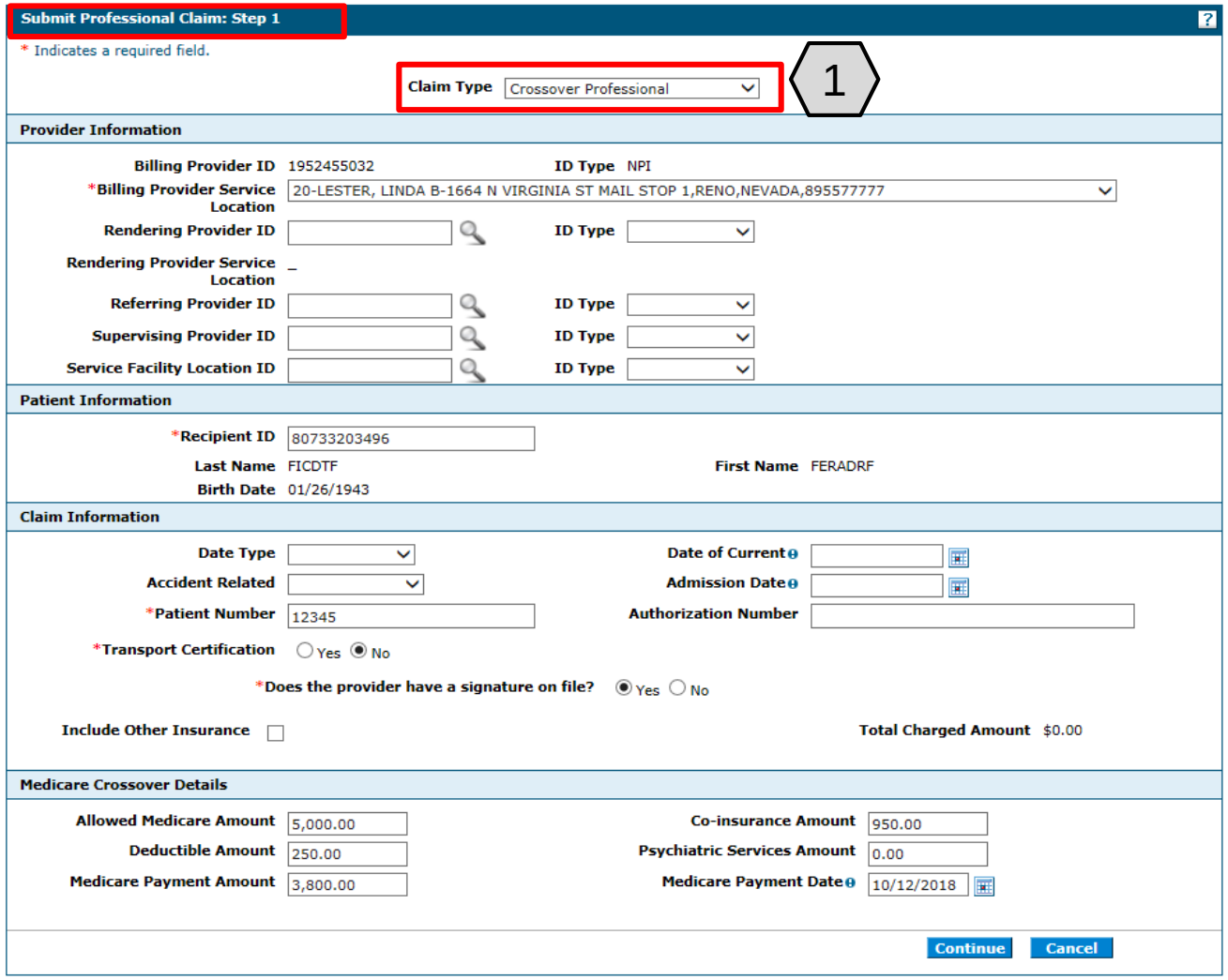


7. Click the **Submit** button to proceed.

NOTE: To remove any attachments, click the **Remove** link.

Submitting a Crossover Claim

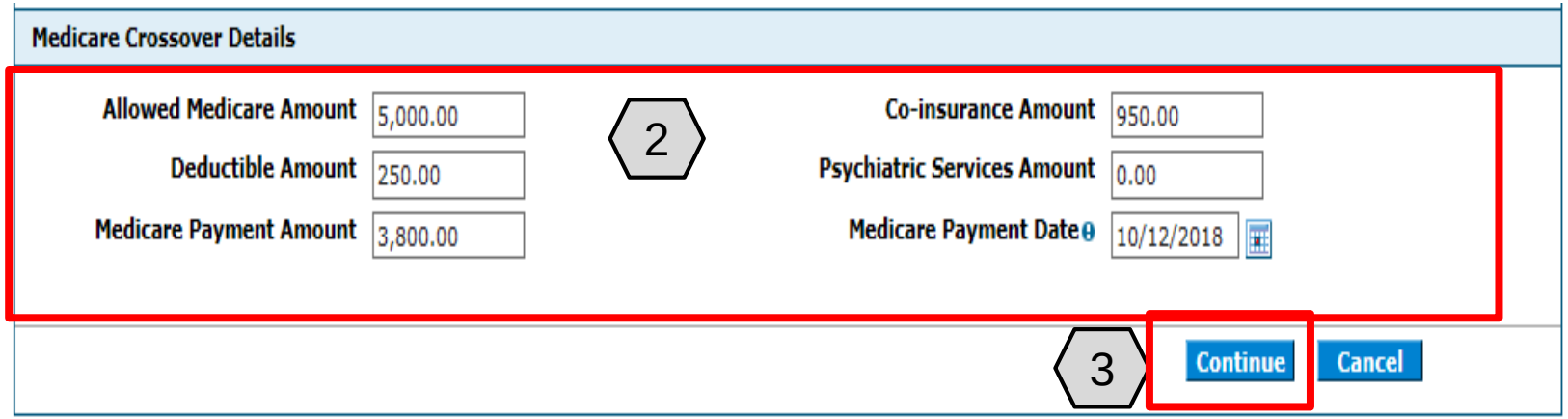
Submitting a Crossover Claim



1. Select the **Claim Type: Crossover Professional.**

NOTE: The user will follow the same steps as previously shown in the “Submitting a Professional Claim” section.

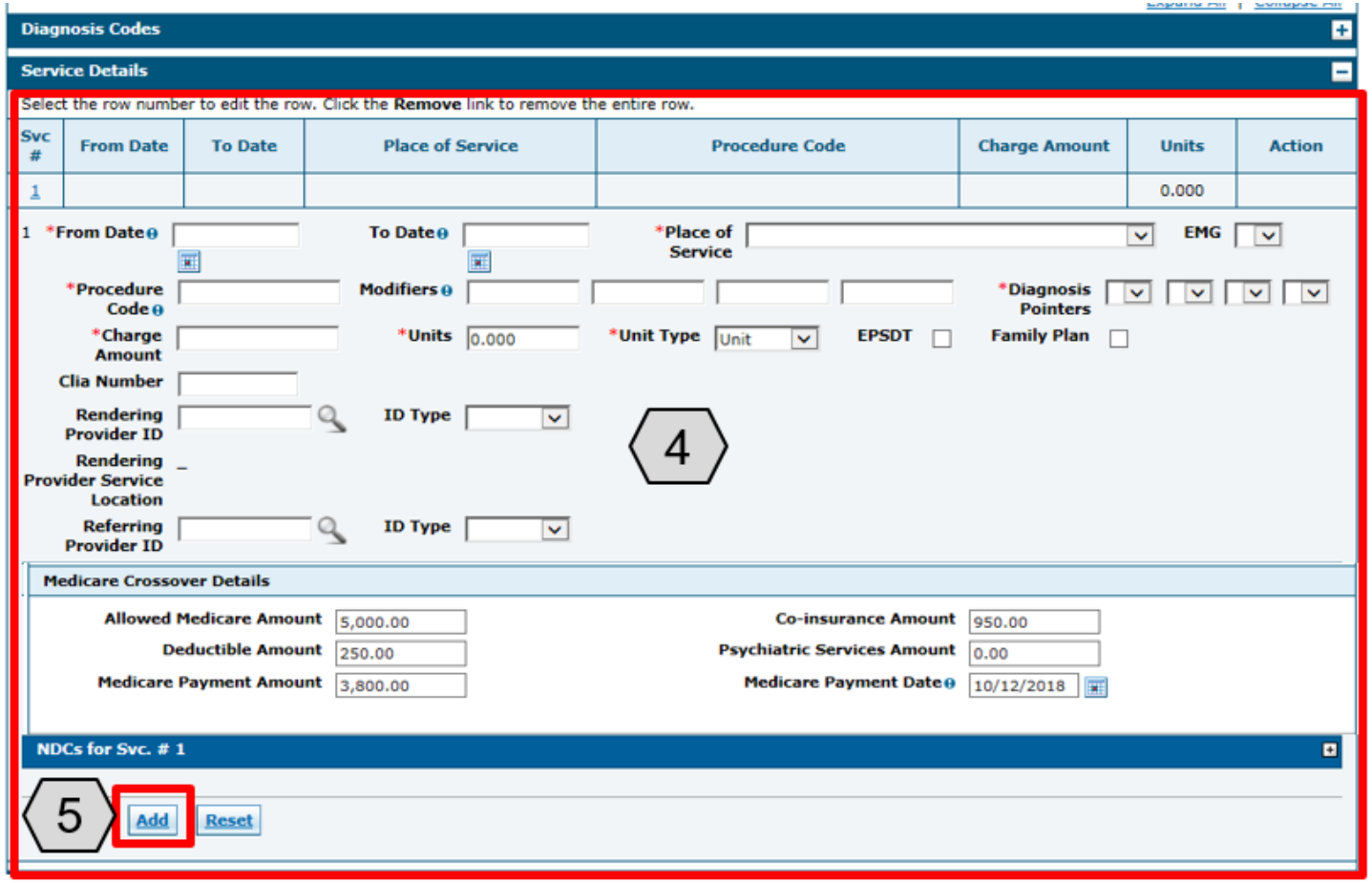
Submitting a Crossover Claim, continued



2. Enter the **Medicare Crossover Details:**
   - **Allowed Medicare Amount**
   - **Deductible Amount**
   - **Medicare Payment Amount**
   - **Medicare Payment Date**

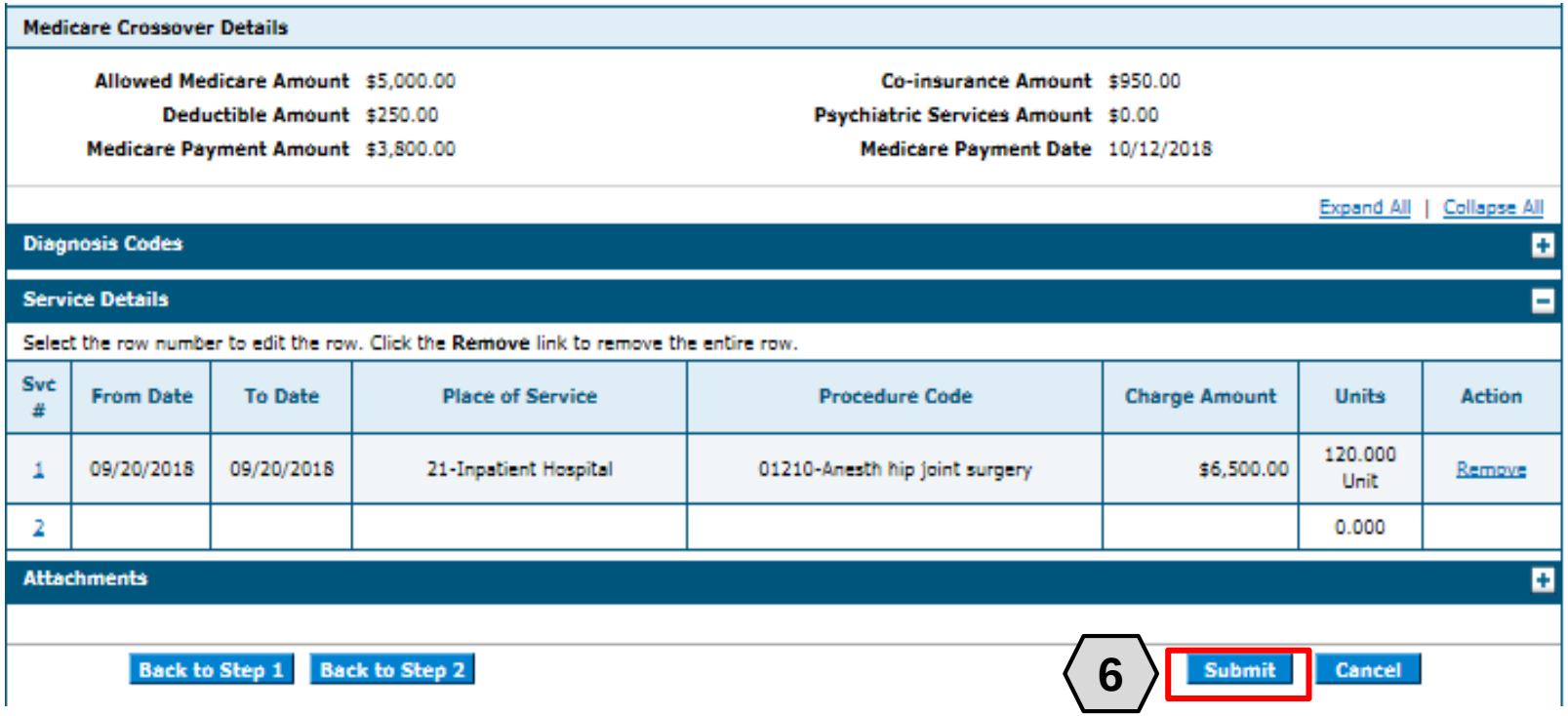
3. Click the **Continue** button.

Submitting a Crossover Claim, continued



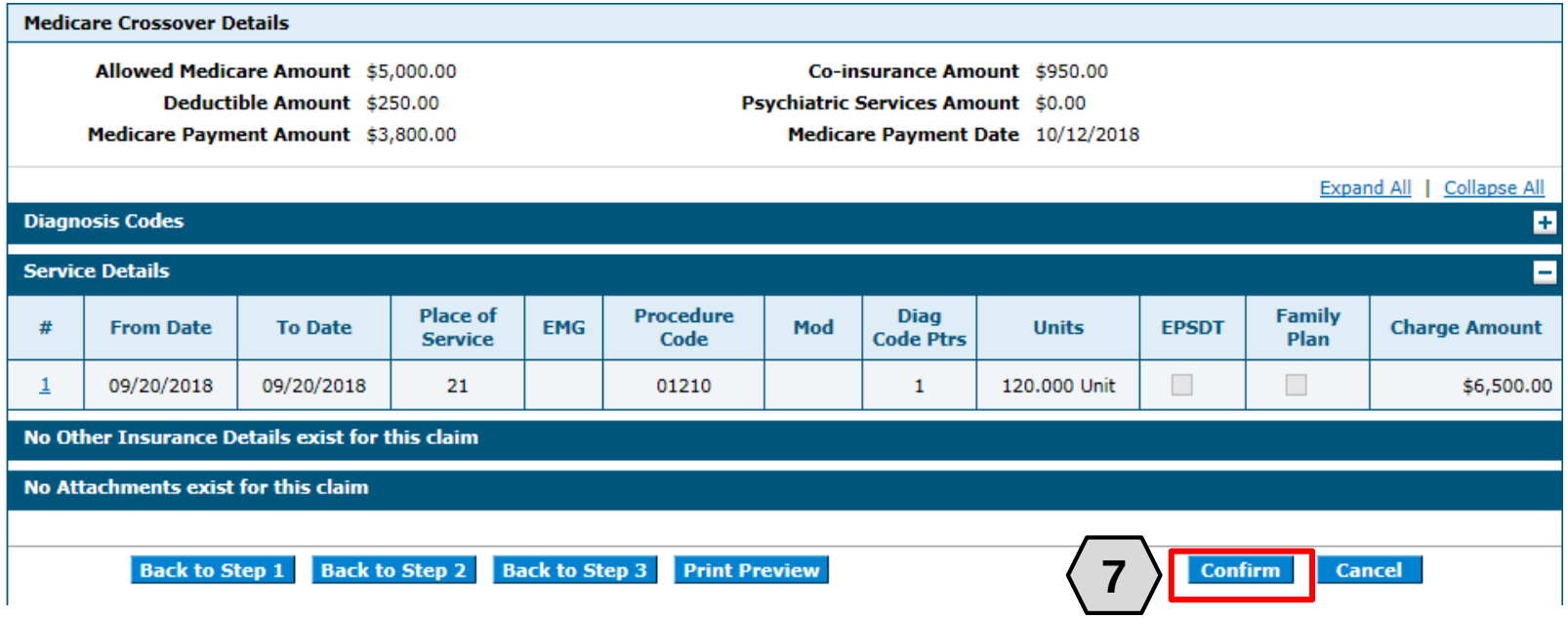
4. Enter applicable service detail information. Required fields are marked with a red asterisk (*).
5. Click the **Add** button.

Submitting a Crossover Claim, continued



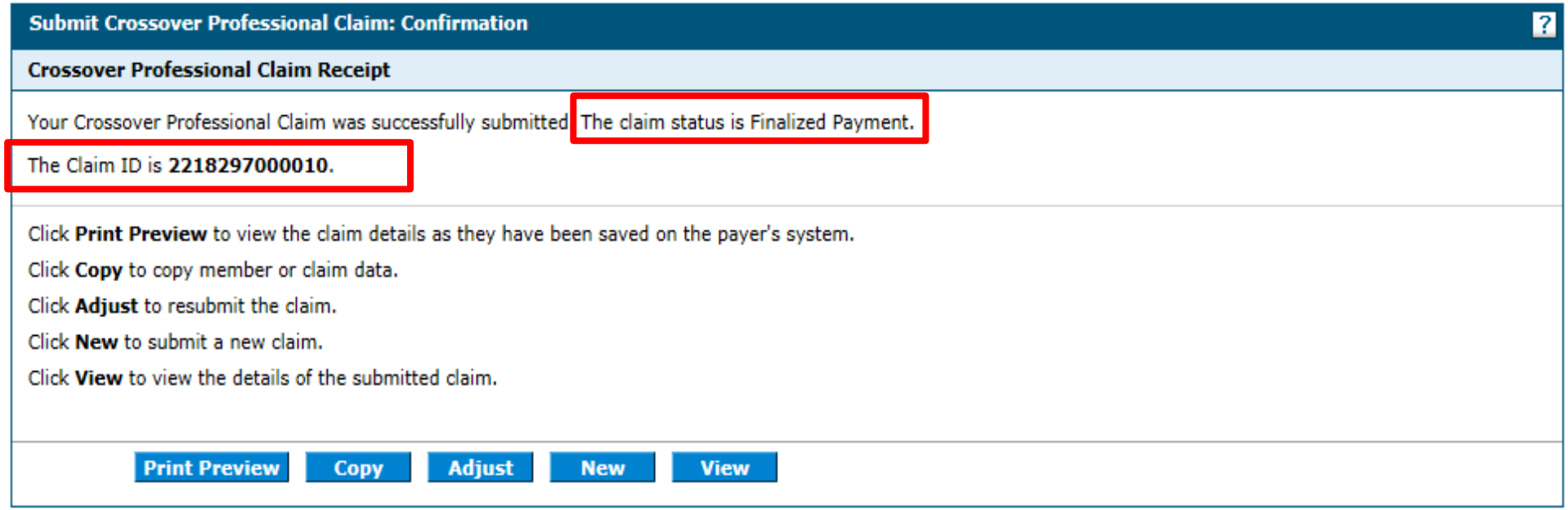
6. Click the **Submit** button.

Submitting a Crossover Claim, continued



7. Click the **Confirm** button.

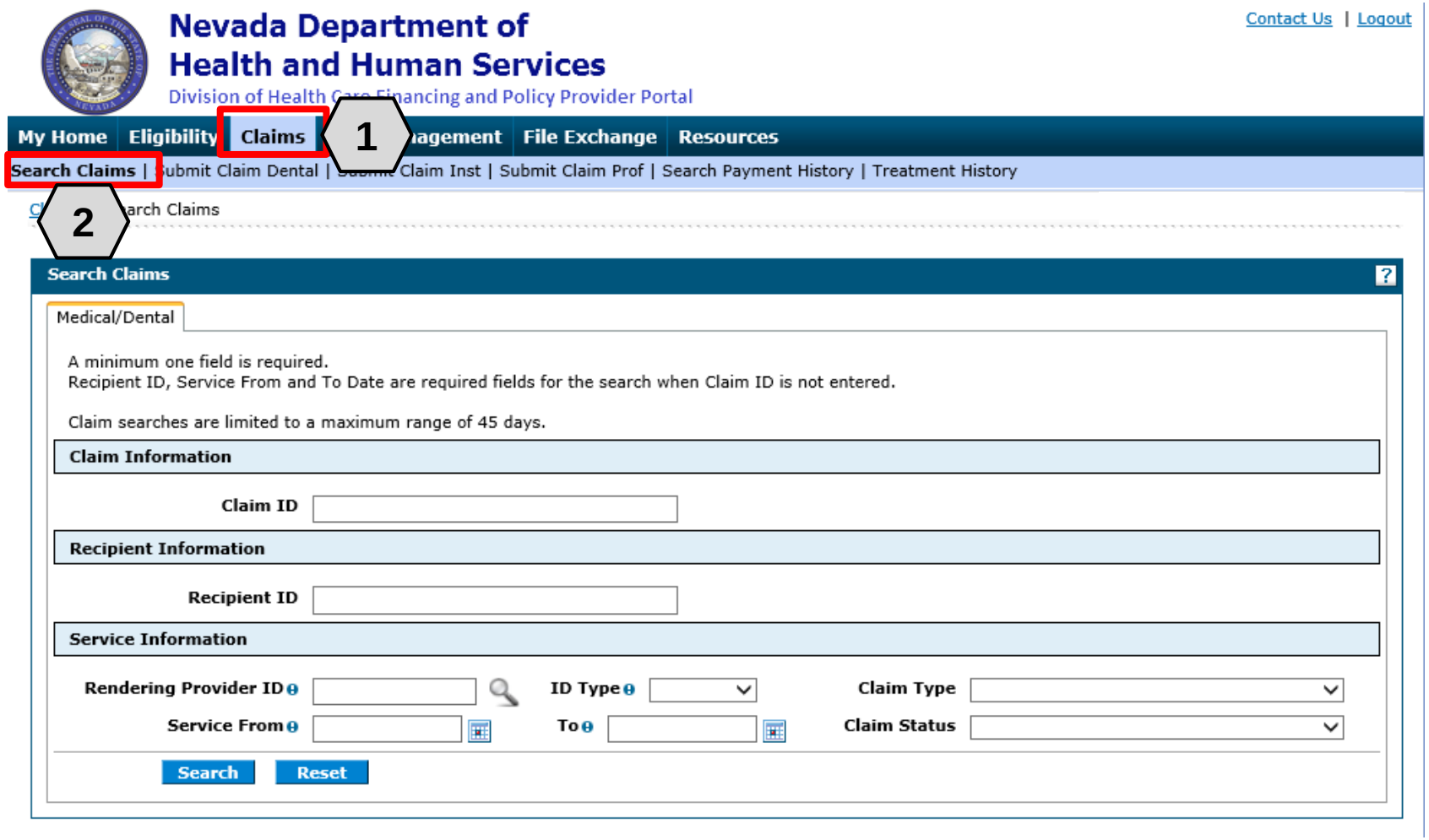
Submitting a Crossover Claim, continued



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

Searching for a Professional Claim

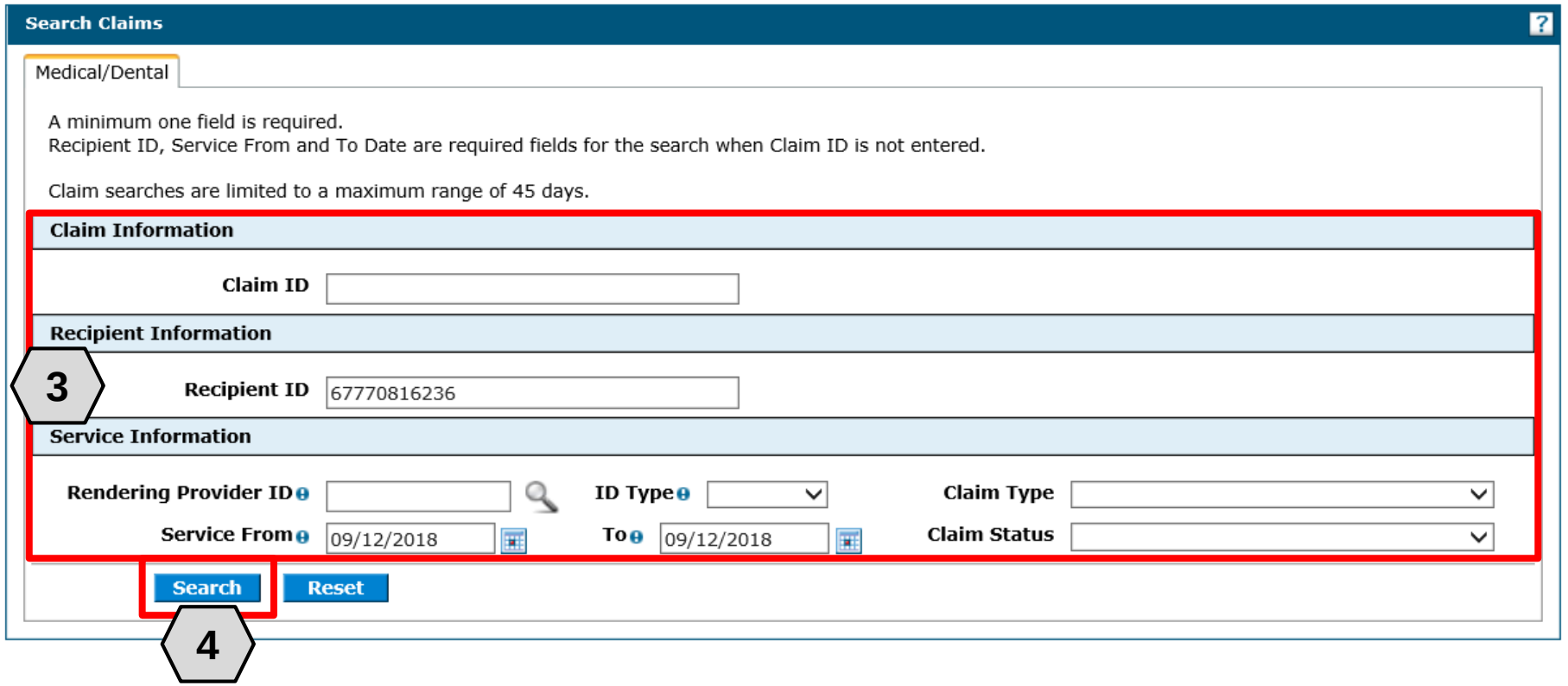
Searching for a Claim



To search for a claim the user will need to:

1. Hover over **Claims.**
2. Select **Search Claims.**

Searching for a Claim, continued



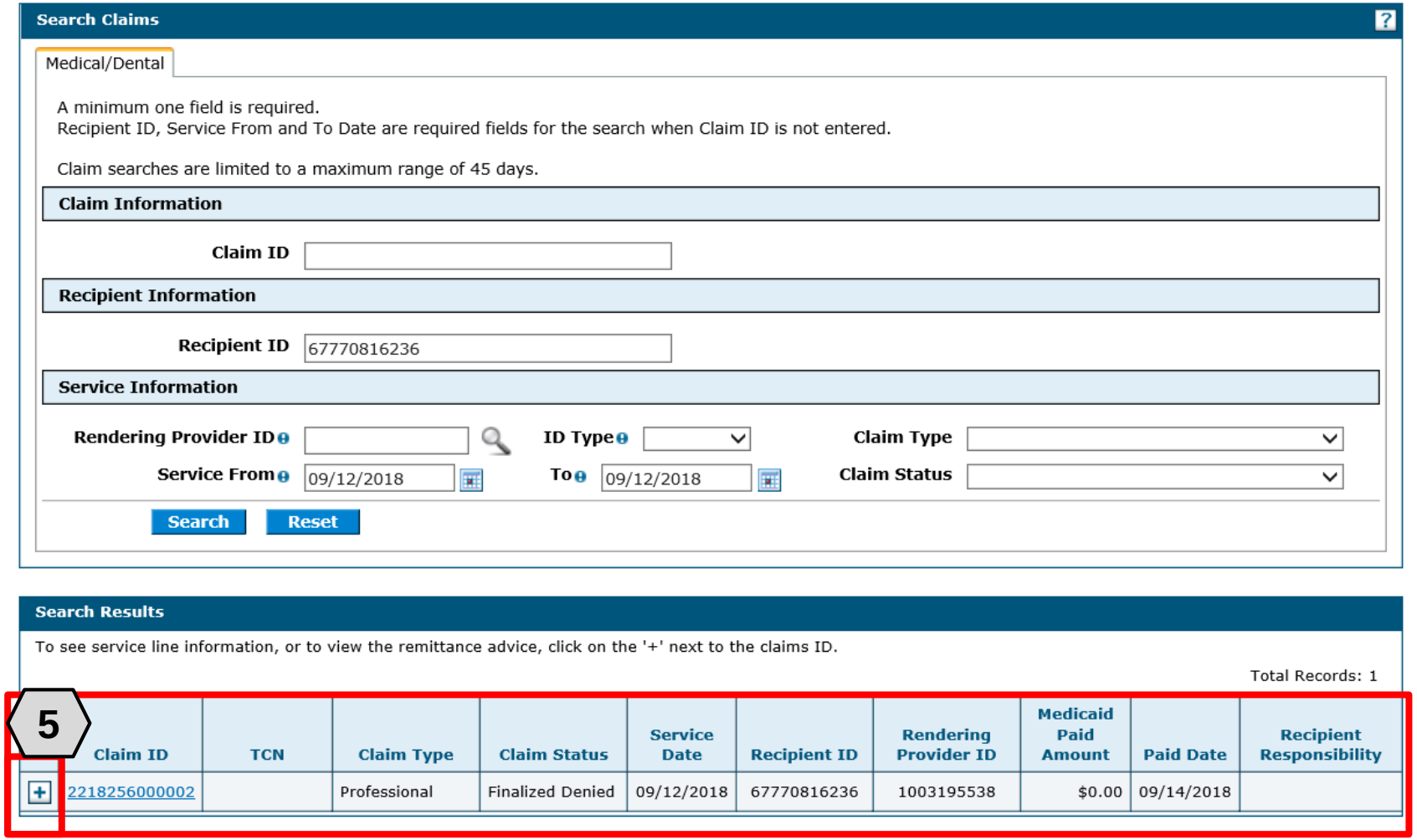
The fastest way to locate a claim is by entering the **Claim ID.**

To search without using the **Claim ID**:

3. Enter the search parameters.
4. Click the **Search** button.

NOTE: When searching for a claim without using the **Claim ID**, the user must enter the **Recipient ID** along with the **Service From** and **To** date range as shown in this example.

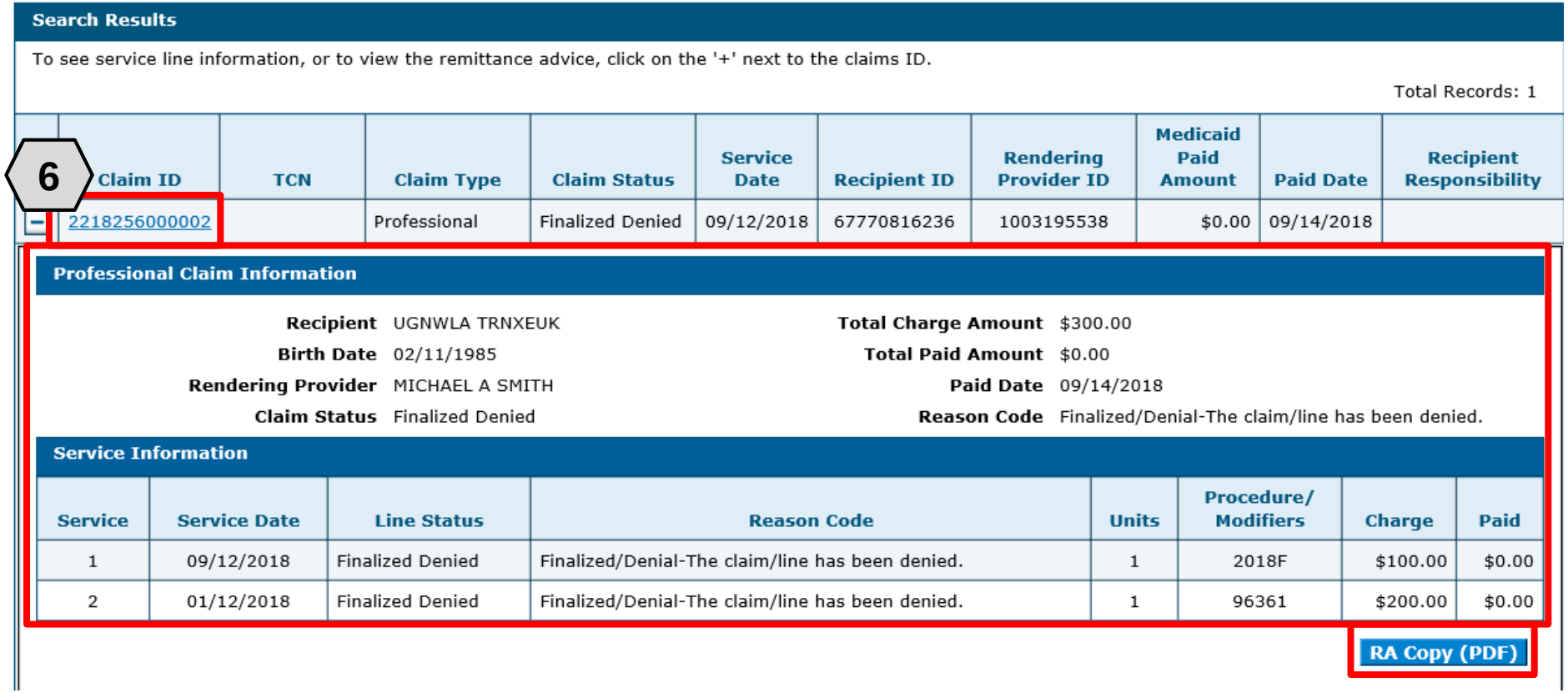
Searching for a Claim, continued



Once the user has clicked the **Search** button, the results will display below. From there, the user may:

5. Click the **(+)** symbol to expand the claim details.

Searching for a Claim, continued



Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID.

Total Records: 1

6

Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
2218256000002		Professional	Finalized Denied	09/12/2018	67770816236	1003195538	$0.00	09/14/2018	

Professional Claim Information

Recipient	UGNWLA TRNXEUK	**Total Charge Amount**	$300.00
Birth Date	02/11/1985	**Total Paid Amount**	$0.00
Rendering Provider	MICHAEL A SMITH	**Paid Date**	09/14/2018
Claim Status	Finalized Denied	**Reason Code**	Finalized/Denial-The claim/line has been denied.

Service Information

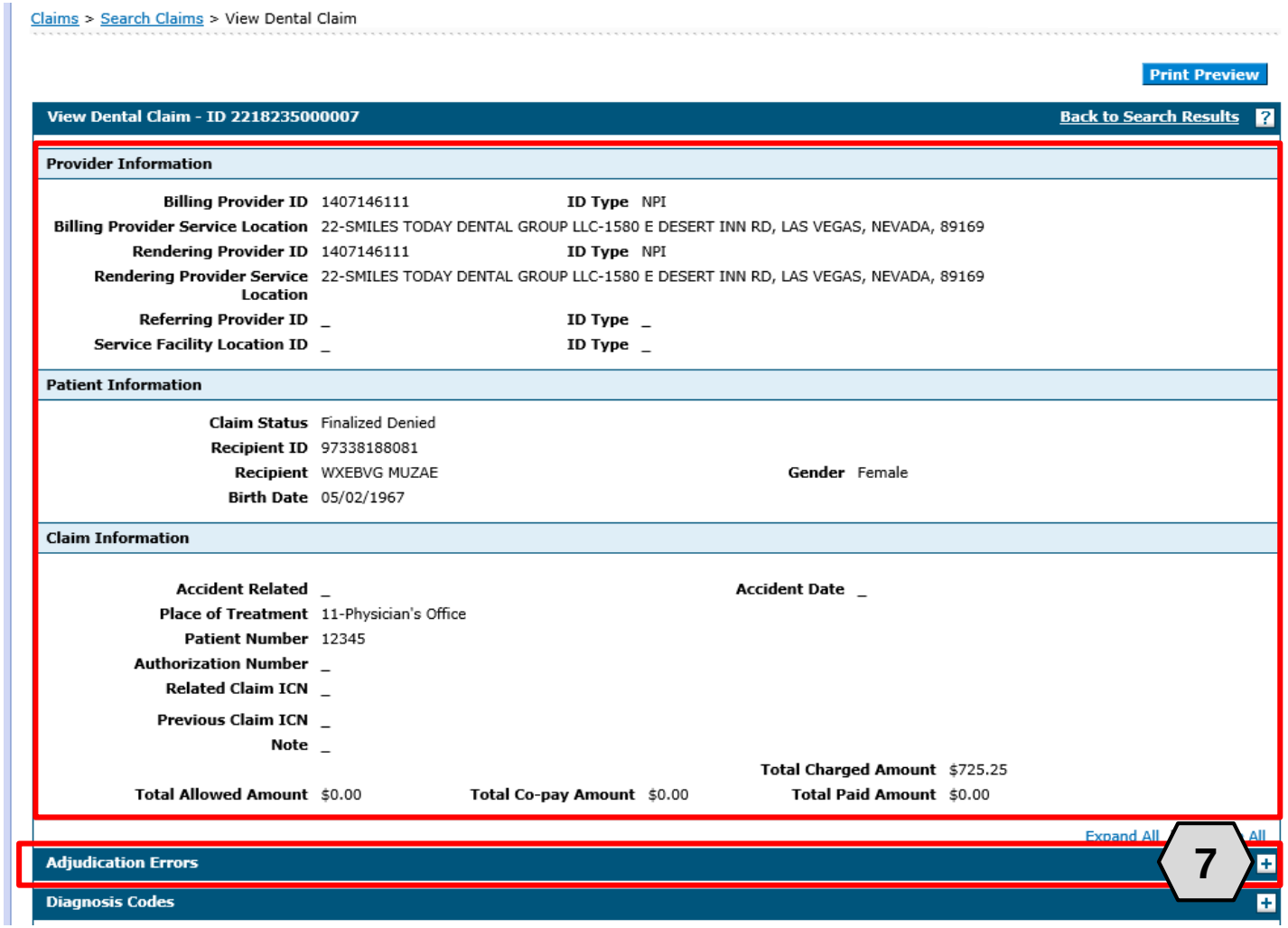
Service	Service Date	Line Status	Reason Code	Units	Procedure/ Modifiers	Charge	Paid
1	09/12/2018	Finalized Denied	Finalized/Denial-The claim/line has been denied.	1	2018F	$100.00	$0.00
2	01/12/2018	Finalized Denied	Finalized/Denial-The claim/line has been denied.	1	96361	$200.00	$0.00

RA Copy (PDF)

6. Click the blue **Claim ID** link to open a specific claim

NOTE: The user may view the RA by clicking the **RA Copy (PDF)** button. Searching for RAs will be covered later in the training.

Searching for a Claim, continued



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

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

Searching for a Claim, continued

Certification Condition Indicator Yes
Condition Indicator Patient was admitted to a hospital
–
–
–
–
Transport Distance 1.00
Ambulance Transport Reason Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility.
Previous Claim ICN –
Note –
Does the provider have a signature on file? Yes

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

Expand All | Collapse All

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	EOB
Service # 1	1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110
Service # 2	1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110

Diagnosis Codes

Service Details

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	09/12/2018	09/12/2018	11	N	2018F		1	1.000 Unit	$100.00	$0.00	$0.00	$0.00
2	01/12/2018	01/12/2018	11	N	96361		1	1.000 Unit	$200.00	$0.00	$0.00	$0.00

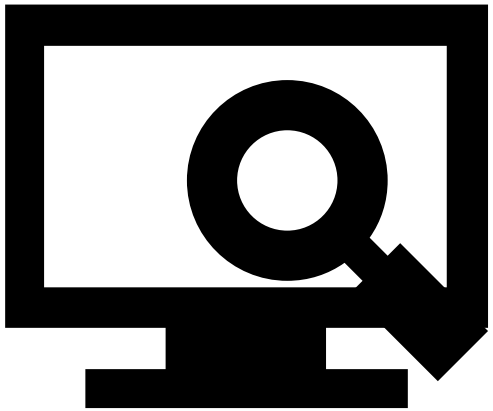
No Other Insurance Details exist for this claim

No Attachments exist for this claim

Copy | Print Preview | RA Copy (PDF)

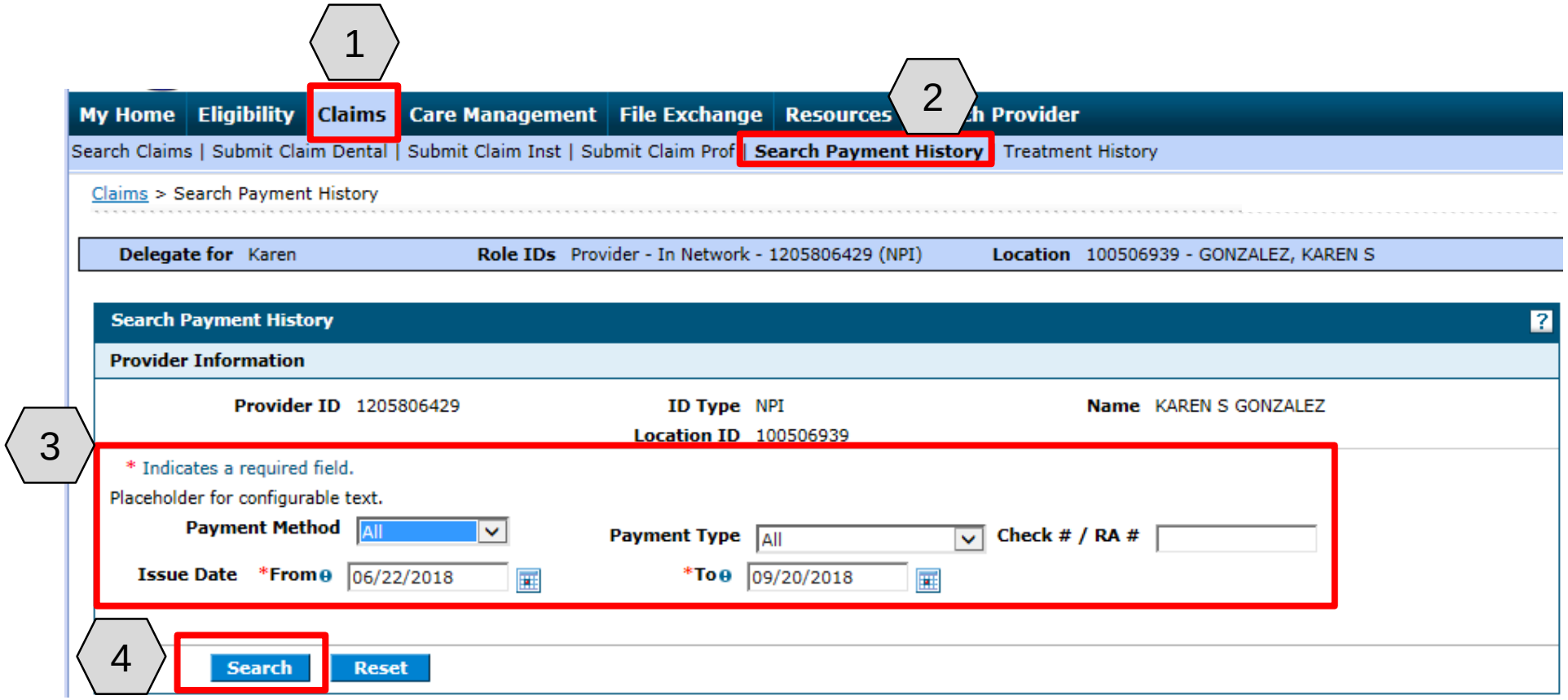
With the **Adjudication Errors** panel expanded, the user may review the errors associated with the claim's denial.

NOTE: User will be shown how to adjust a claim later in the training.



Viewing a Remittance Advice (RA)

Viewing a Remittance Advice



To begin locating an RA, the user will:

1. Hover over **Claims.**
2. Select **Search Payment History.**
3. Enter search criteria to refine the search results.
4. Click the **Search** button.

NOTE: Users can only search for RAs on the Provider Web Portal for the past 6 months. The default search range is for the past 90 days.

Viewing a Remittance Advice, continued

Search Results

To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.

If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assista

5

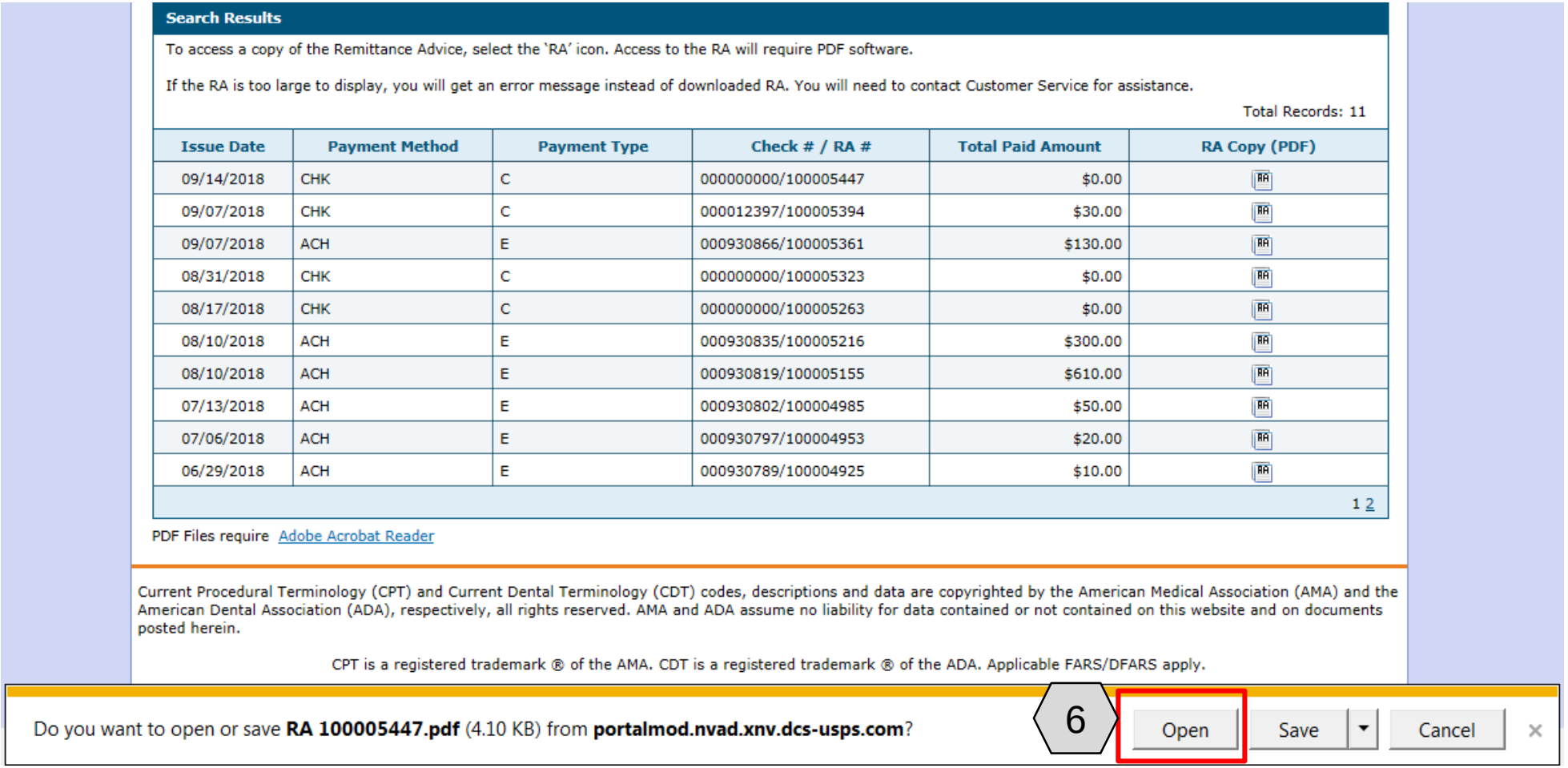
Total Records: 11

Issue Date	Payment Method	Payment Type	Check # / RA #	Total Paid Amount	RA Copy (PDF)
09/14/2018	CHK	C	000000000/100005447	$0.00	
09/07/2018	CHK	C	000012397/100005394	$30.00	
09/07/2018	ACH	E	000930866/100005361	$130.00	
08/31/2018	CHK	C	000000000/100005323	$0.00	
08/17/2018	CHK	C	000000000/100005263	$0.00	
08/10/2018	ACH	E	000930835/100005216	$300.00	
08/10/2018	ACH	E	000930819/100005155	$610.00	
07/13/2018	ACH	E	000930802/100004985	$50.00	
07/06/2018	ACH	E	000930797/100004953	$20.00	
06/29/2018	ACH	E	000930789/100004925	$10.00	

1 2

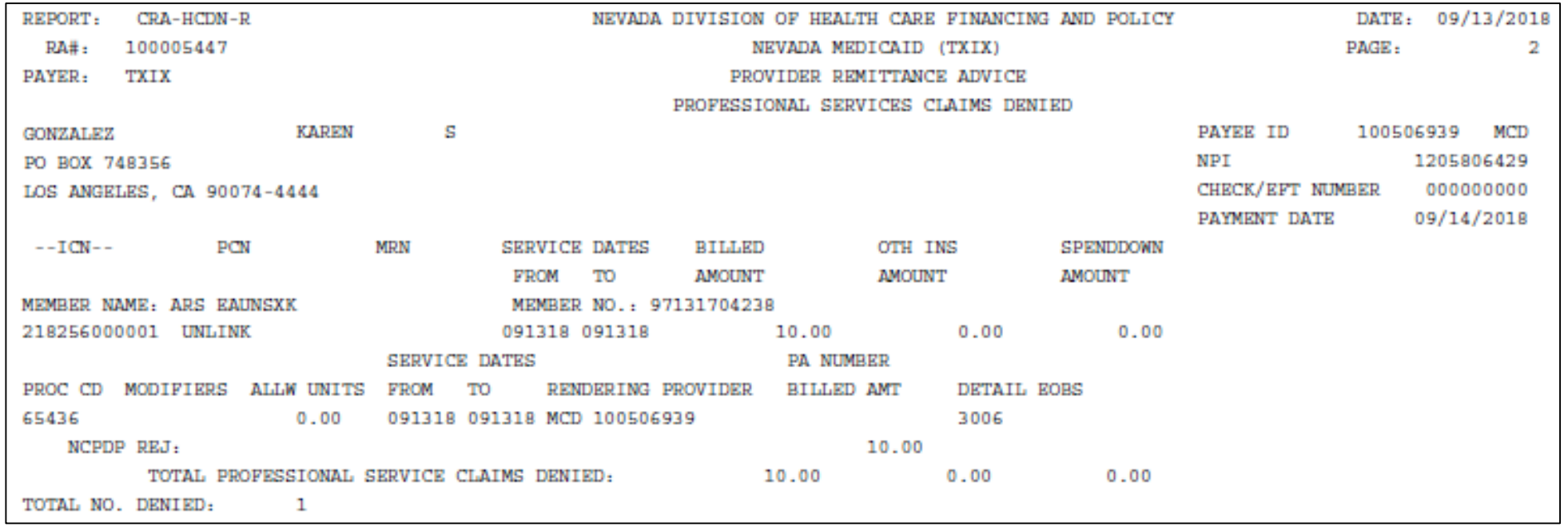
5. Click on the **RA Copy (PDF)** icon.

Viewing a Remittance Advice, continued



6. User will click the **Open** button.

Viewing a Remittance Advice, continued

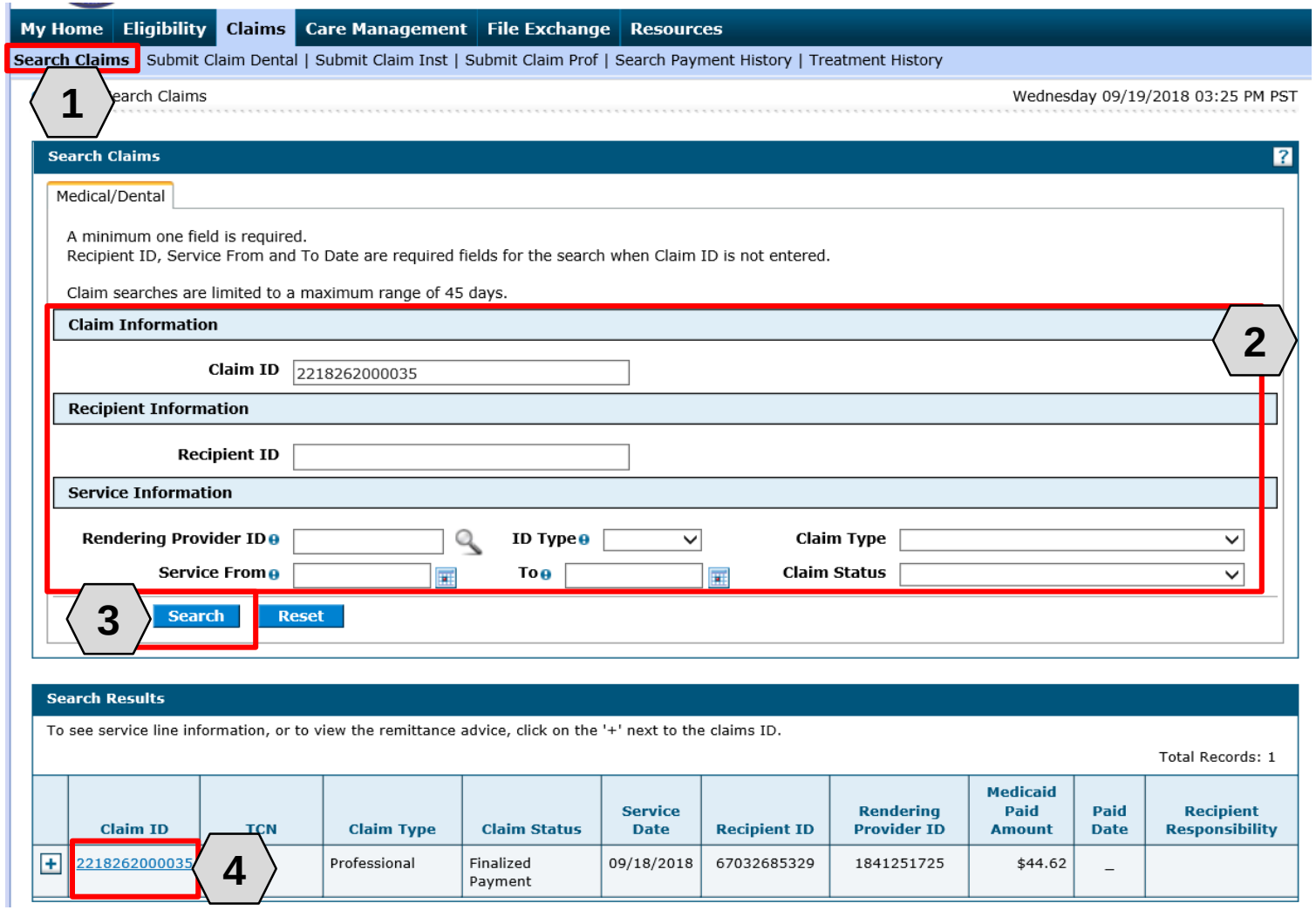


```
REPORT:   CRA-HCDN-R                    NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY          DATE:  09/13/2018
  RA#:   100005447                                  NEVADA MEDICAID (TXIX)                           PAGE:          2
PAYER:   TXIX                                    PROVIDER REMITTANCE ADVICE
                                              PROFESSIONAL SERVICES CLAIMS DENIED

GONZALEZ              KAREN       S                                                  PAYEE ID      100506939   MCD
PO BOX 748356                                                                        NPI                1205806429
LOS ANGELES, CA 90074-4444                                                           CHECK/EFT NUMBER    000000000
                                                                                     PAYMENT DATE       09/14/2018

 --ICN--         PCN          MRN       SERVICE DATES    BILLED         OTH INS         SPENDDOWN
                                         FROM   TO       AMOUNT         AMOUNT          AMOUNT
MEMBER NAME: ARS EAUNSXK                 MEMBER NO.: 97131704238
218256000001  UNLINK                     091318 091318          10.00          0.00          0.00
                            SERVICE DATES                    PA NUMBER
PROC CD  MODIFIERS  ALLW UNITS  FROM   TO     RENDERING PROVIDER   BILLED AMT     DETAIL EOBS
65436                  0.00     091318 091318 MCD 100506939                       3006
    NCPDP REJ:                                                        10.00
          TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:          10.00          0.00          0.00
TOTAL NO. DENIED:      1
```

After clicking **Open**, the user can review the RA.

Copying Claims

Copying a Claim



To copy a claim, the user will:

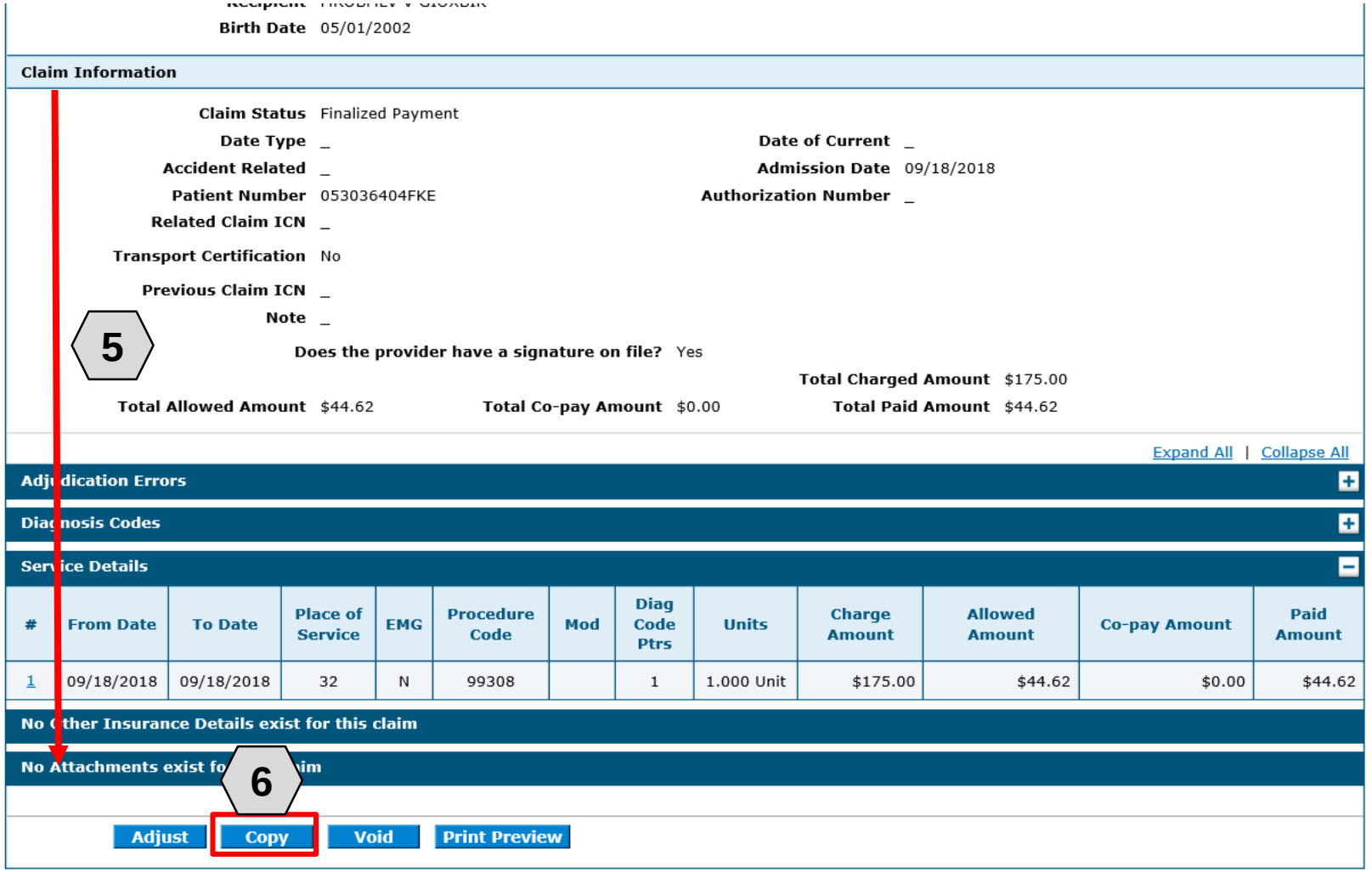
1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the **Search** button.

Search results will populate at the bottom of the screen.

From the search results:

4. Click the blue **Claim ID** link.

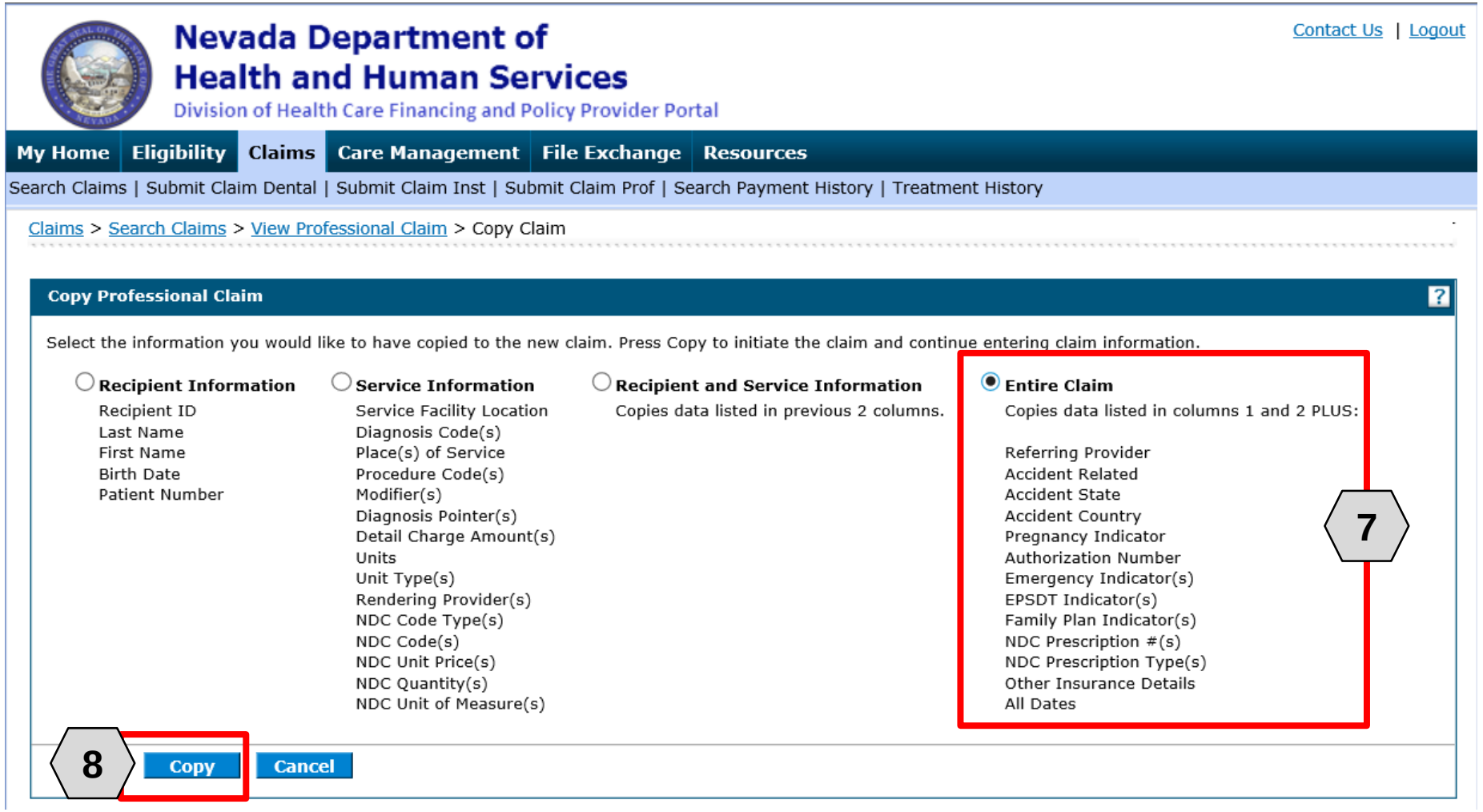
Copying a Claim, continued



After the user has viewed the claim, user will:

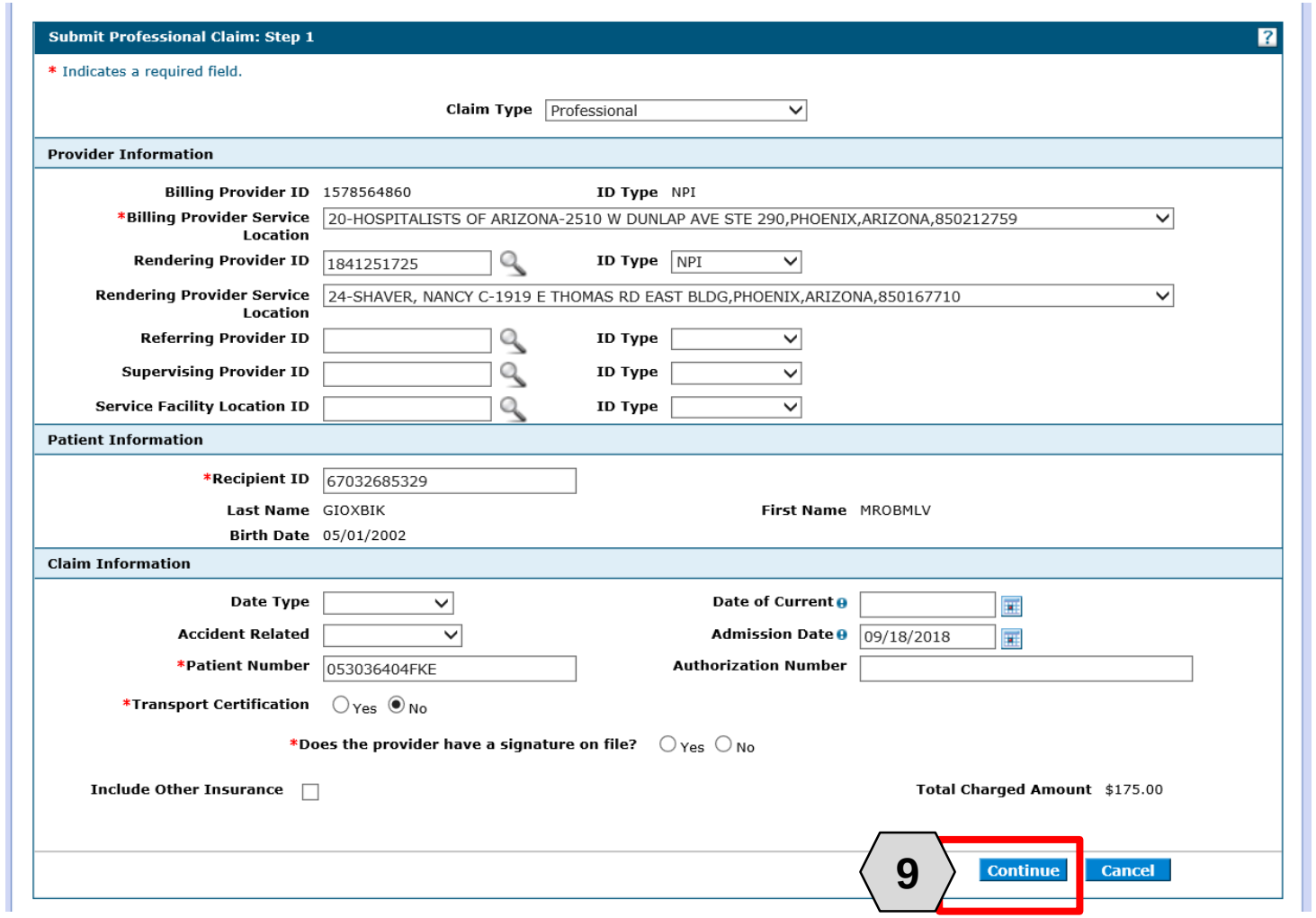
5. Scroll down to the bottom of the “Claim Information” page.
6. Click the **Copy** button.

Copying a Professional Claim, continued



7. Select what portion of the claim to copy (for this example, the user has selected **Entire Claim**).
8. Click the **Copy** button.

Copying a Claim, continued

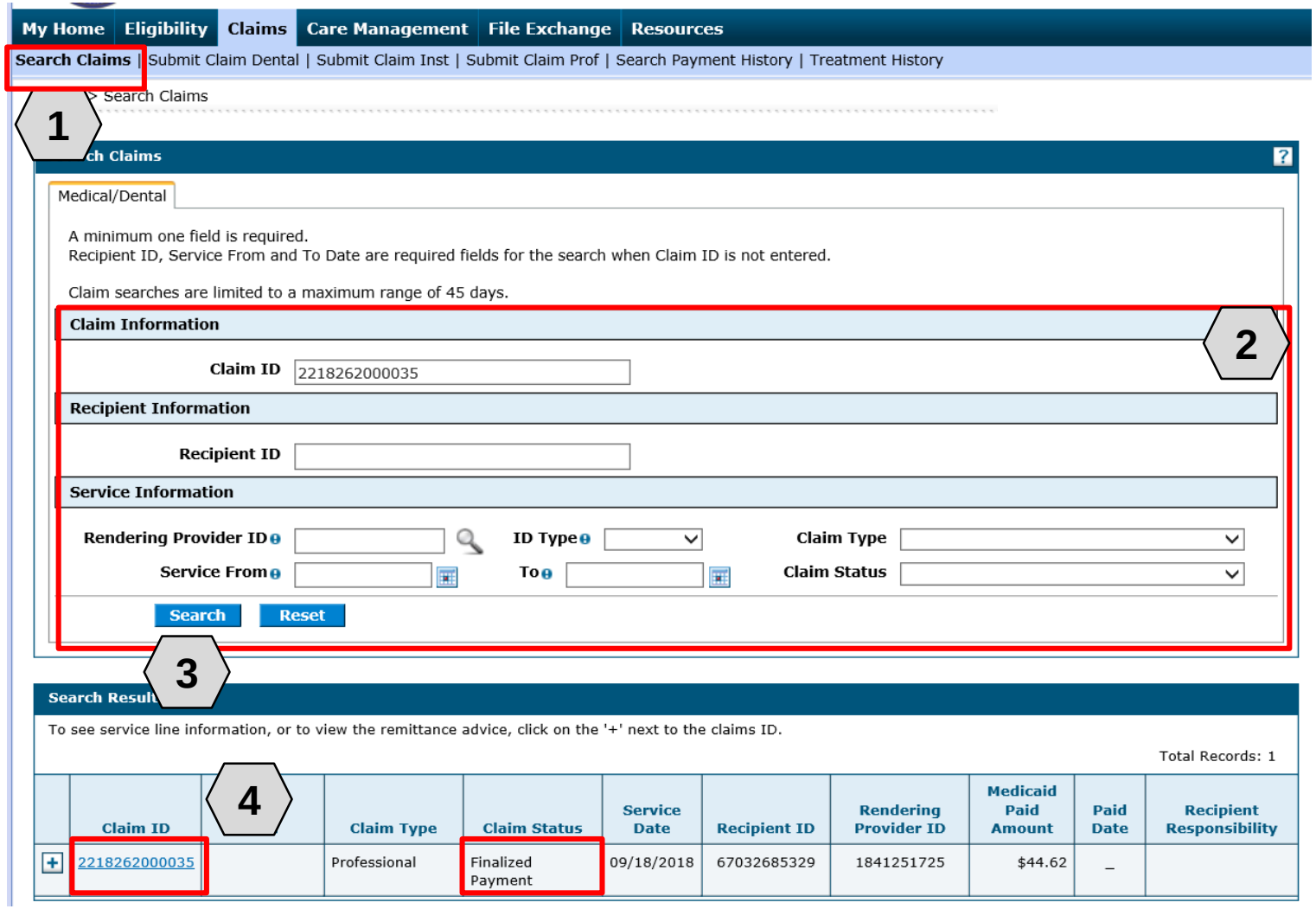


As the user goes through Steps 1-3, the user may make updates.

9. Click the **Continue** button.

Adjusting a Claim

Adjusting a Claim

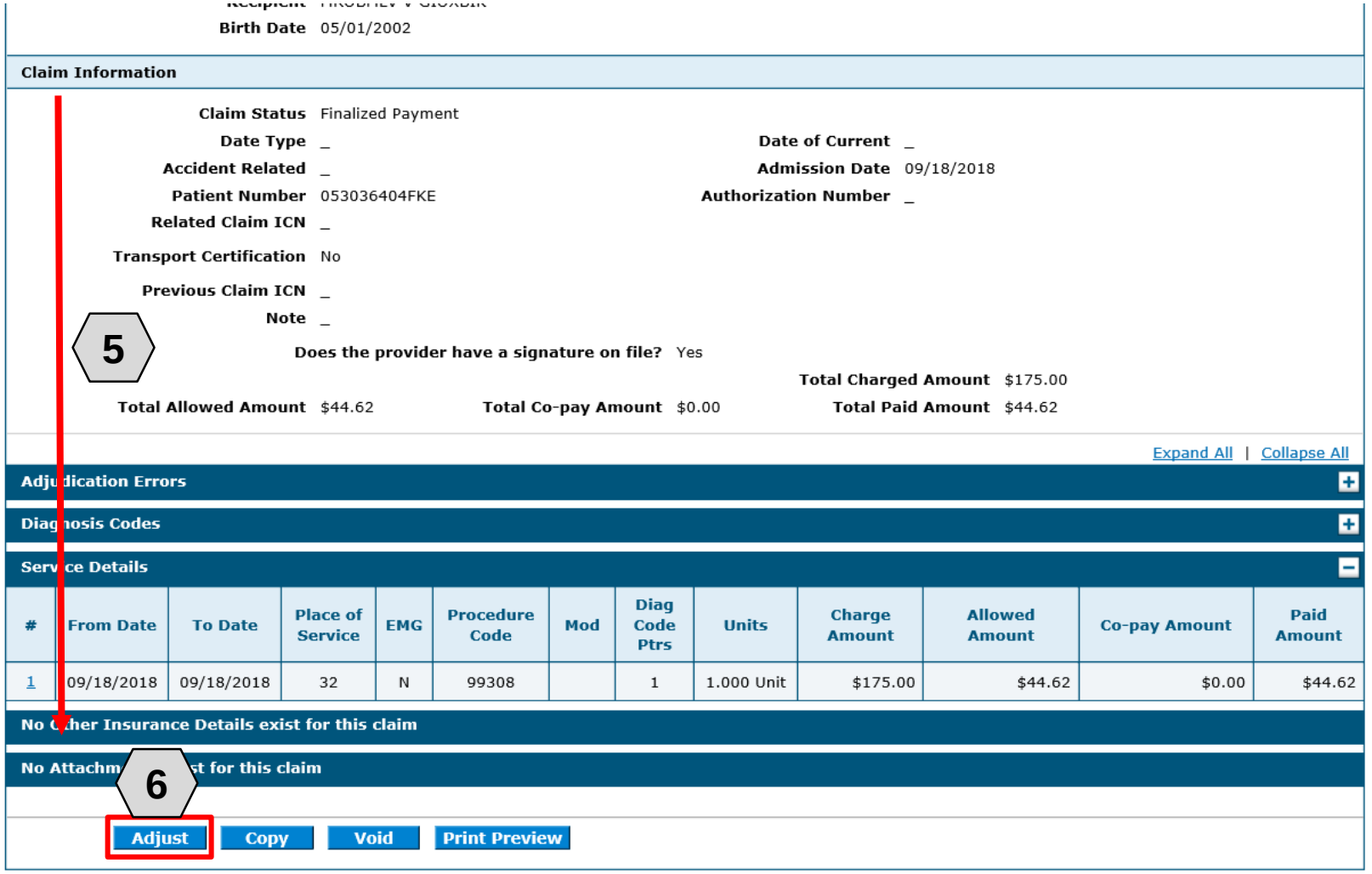


To begin the claim adjustment process:

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

NOTE: Denied Claims cannot be adjusted. The **Claim Status** column will indicate “Finalized Payment” if a claim is paid.

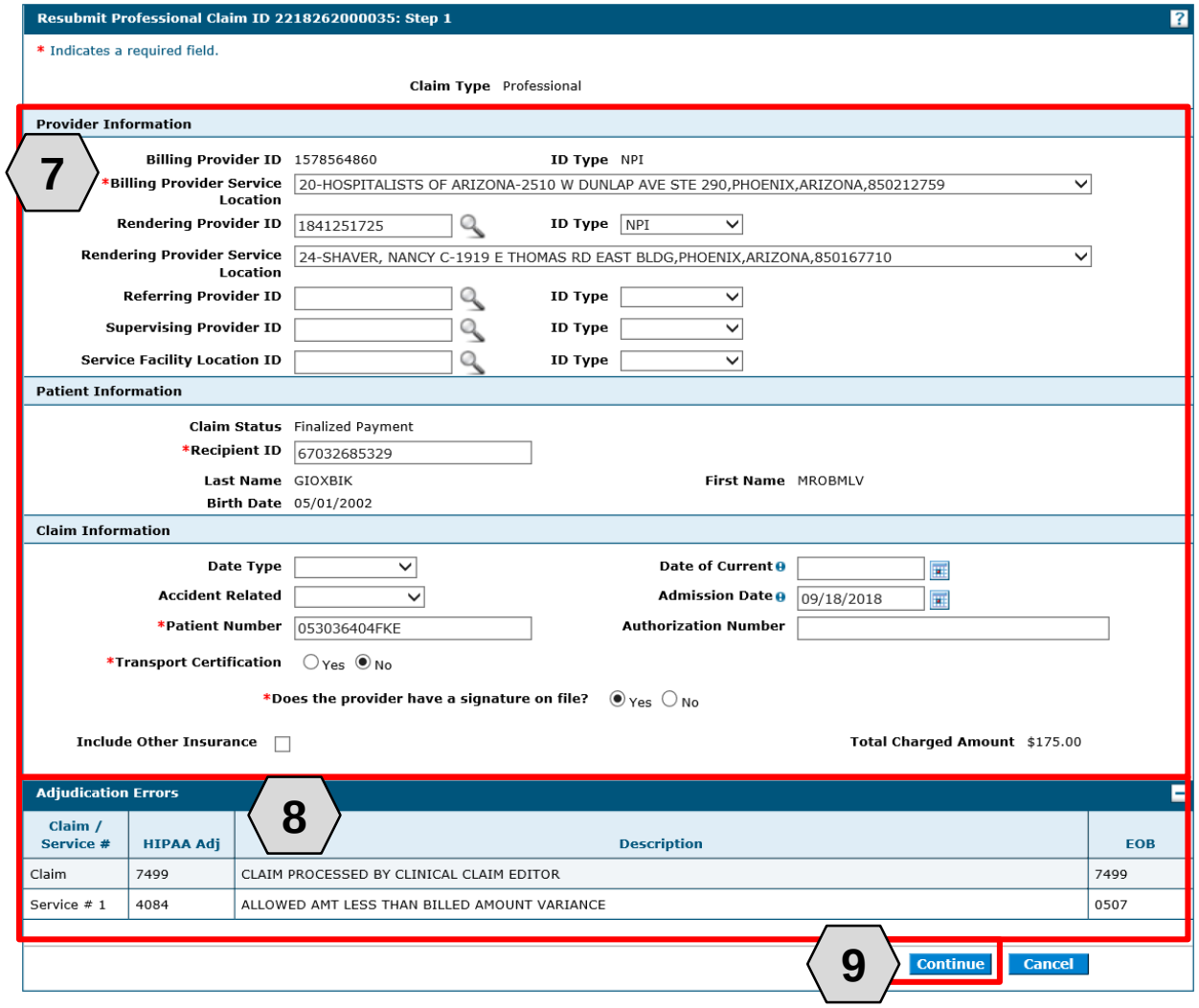
Adjusting a Claim, continued



On the “View Professional Claim” page, the user will:

5. Scroll down to the bottom of the page.
6. Click the **Adjust** button.

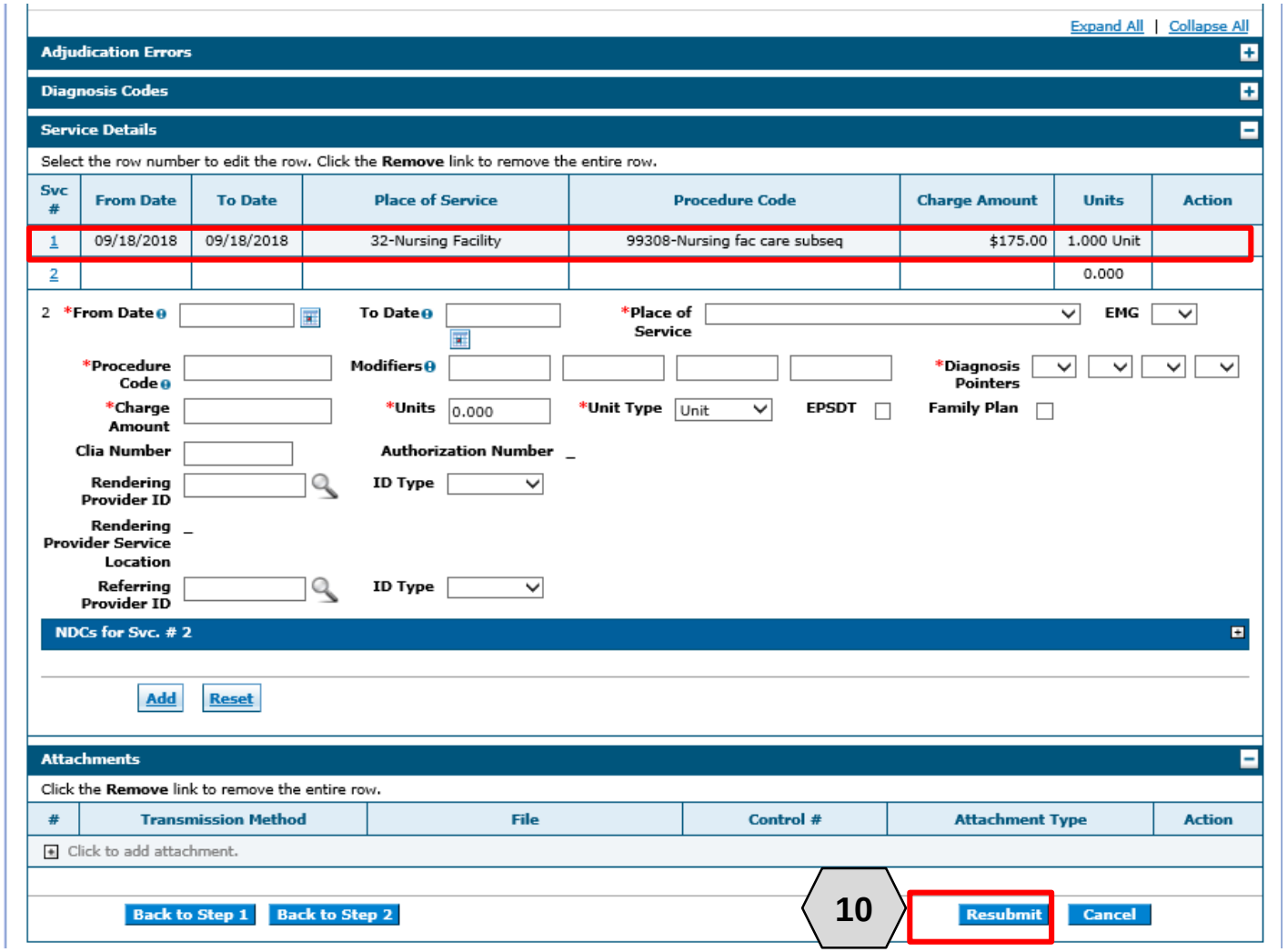
Adjusting a Claim, continued



From here, the user may:

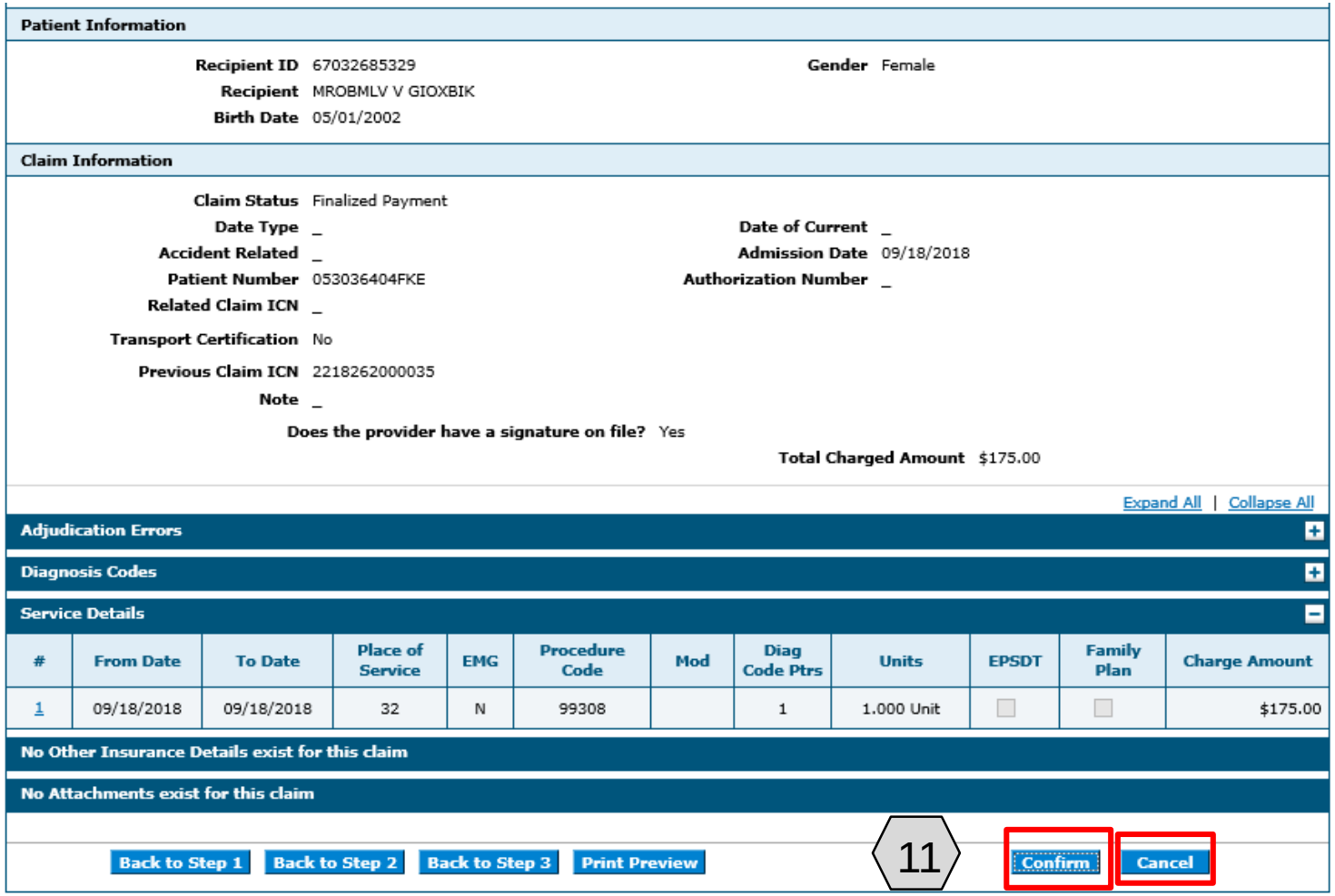
7. Review and make any necessary edits to the provider, patient or claim information.
8. Review the **Adjudication Errors** panel to identify any issues that may need to be resolved.
9. Click on the **Continue** button at the bottom of the page to proceed to the next step.

Adjusting a Claim, continued



10. Click the **Resubmit** button.

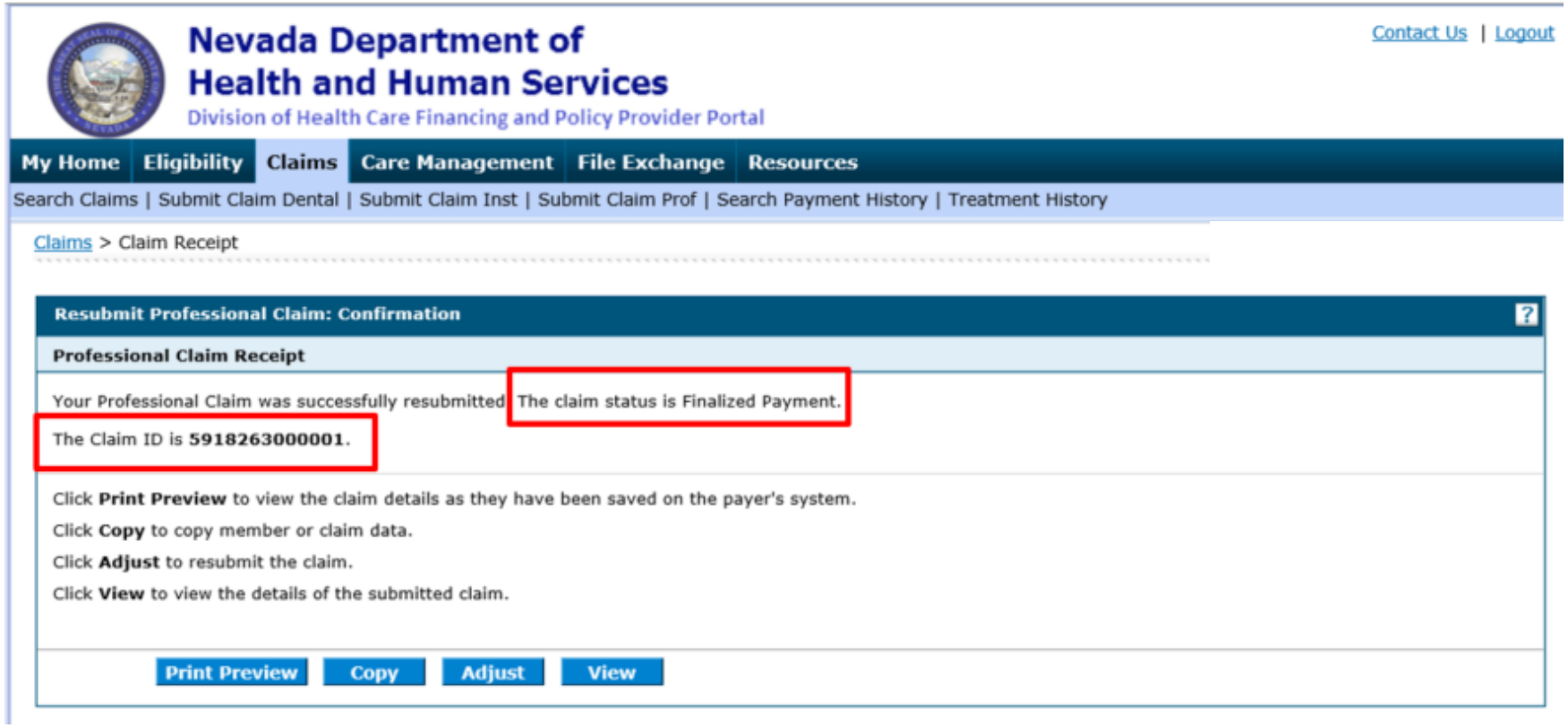
Adjusting a Claim, continued



11. Click the **Confirm** button.

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

Adjusting a Claim, continued



The “Resubmit Professional Claim: Confirmation” page will appear after the claim has been submitted.

It will display the claim status and adjusted Claim ID.

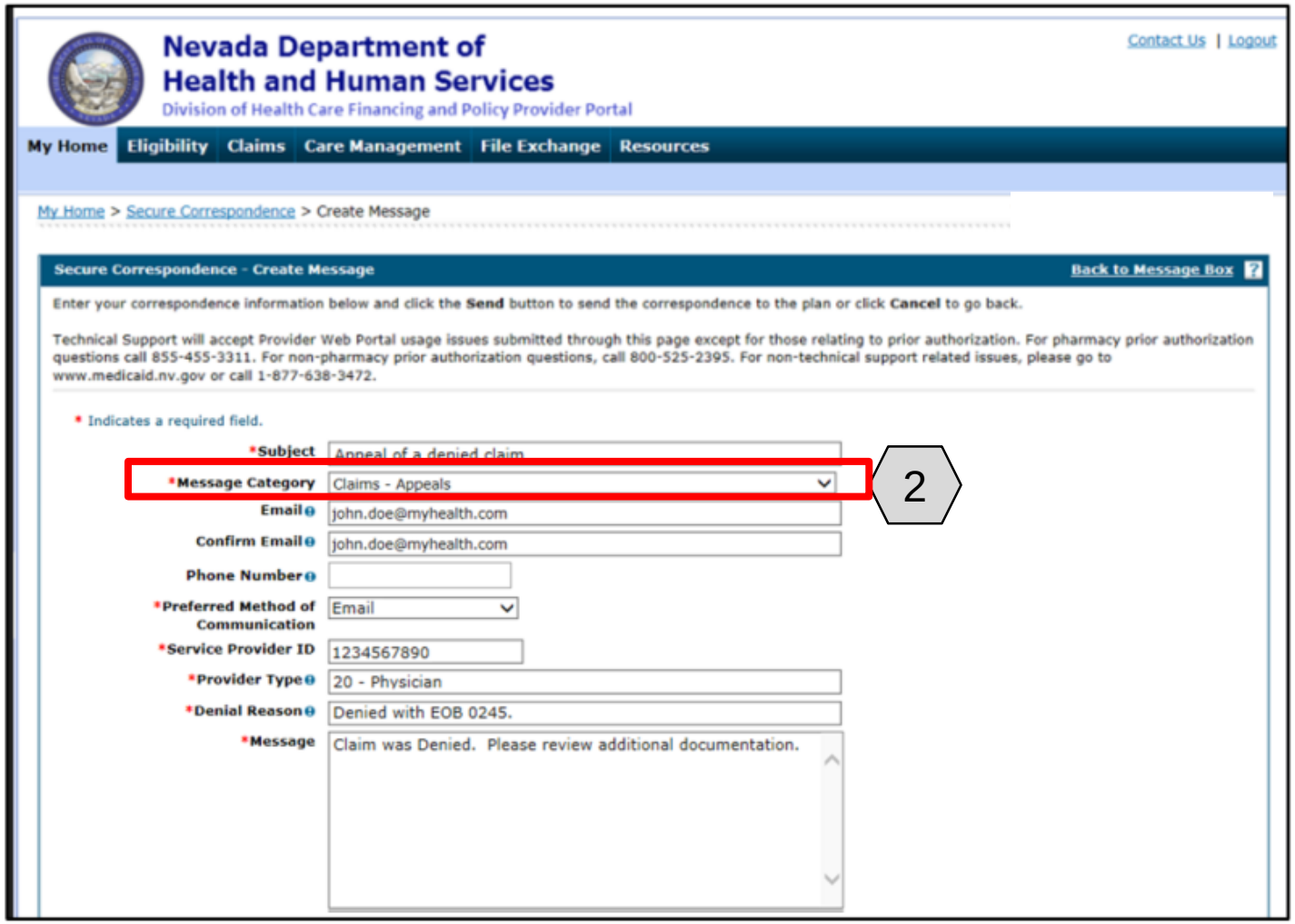
Submitting an Appeal for a Claim

Submitting an Appeal for a Claim

From the home page, the user will:

1. Select **Secure Correspondence** to start the Appeal process.

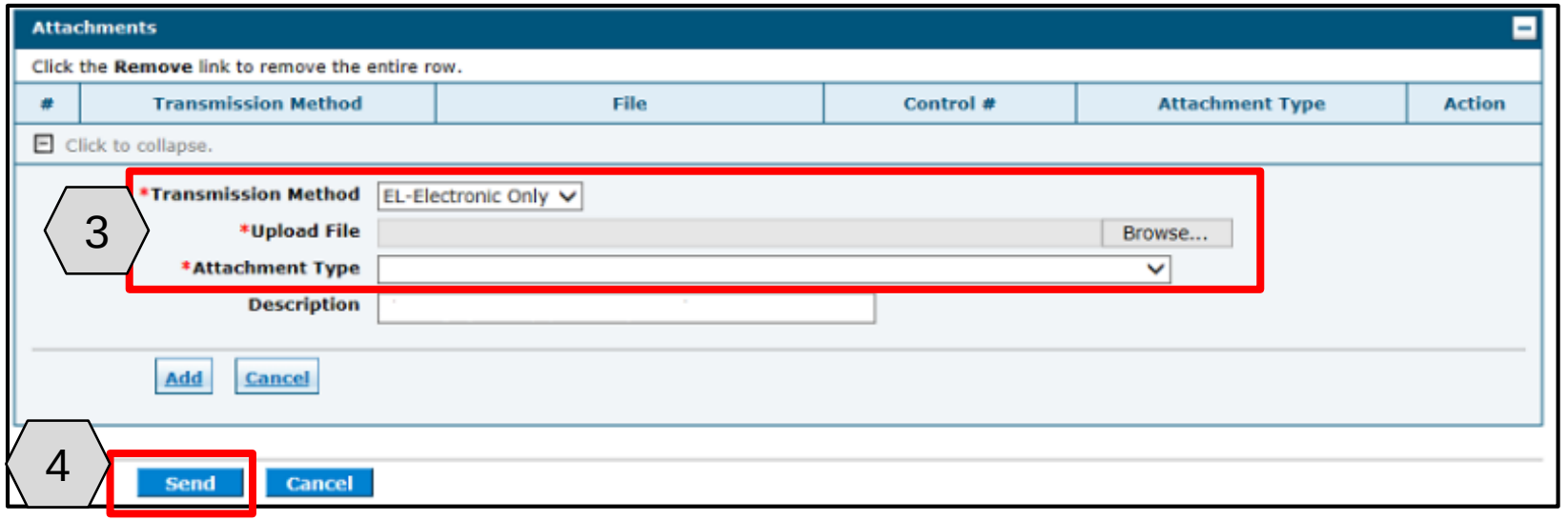
Submitting an Appeal for a Claim, continued



The user will then:

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

Submitting an Appeal for a Claim, continued



Next, the user will need to:

3. Click the **Browse** button and locate the file supporting the appeal request.

4. Click the **Send** button.

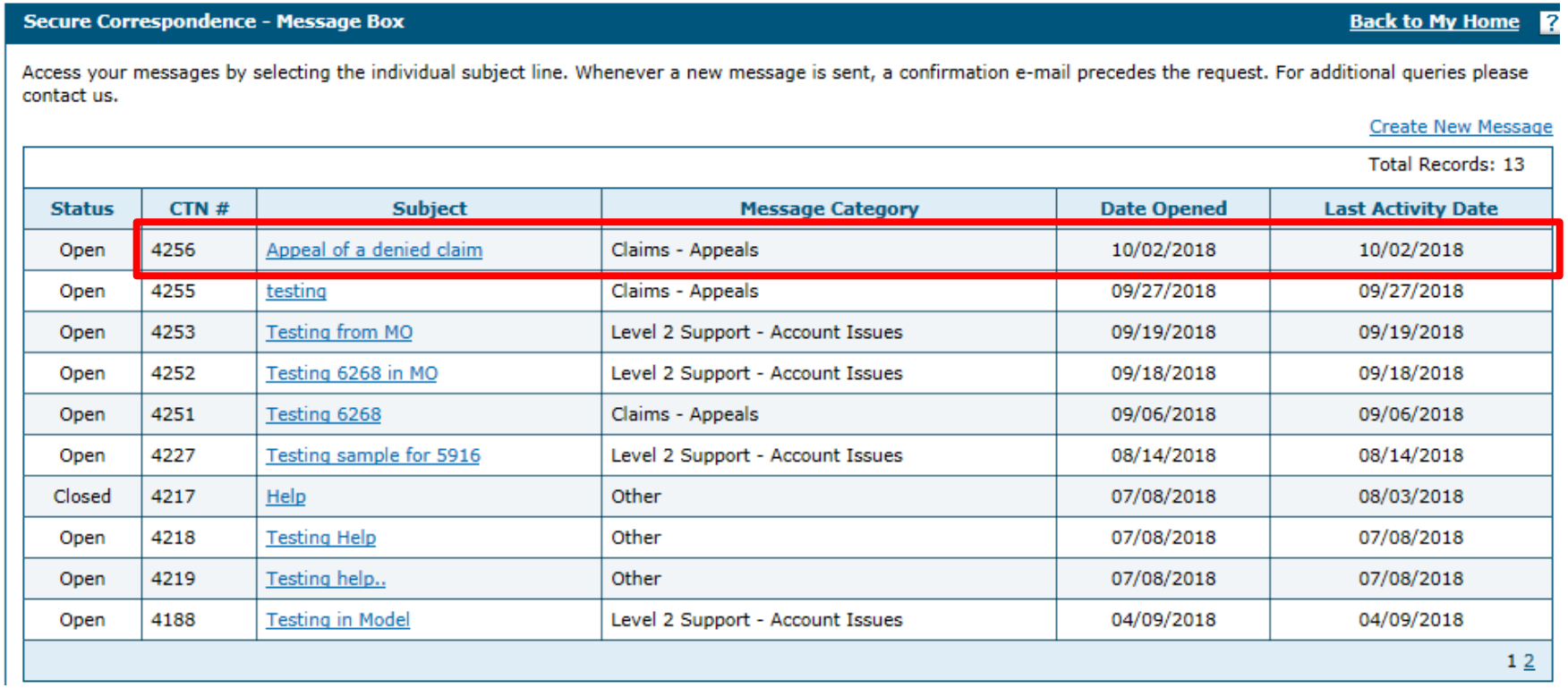
NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.

Submitting an Appeal for a Claim, continued

After the user clicks the **Send** button, a confirmation message will populate with "Your secure message was successfully sent"

User will then need to:
5. Click the **OK** button.

Submitting an Appeal for a Claim, continued



Secure Correspondence - Message Box Back to My Home ?

Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional queries please contact us.

Create New Message

Total Records: 13

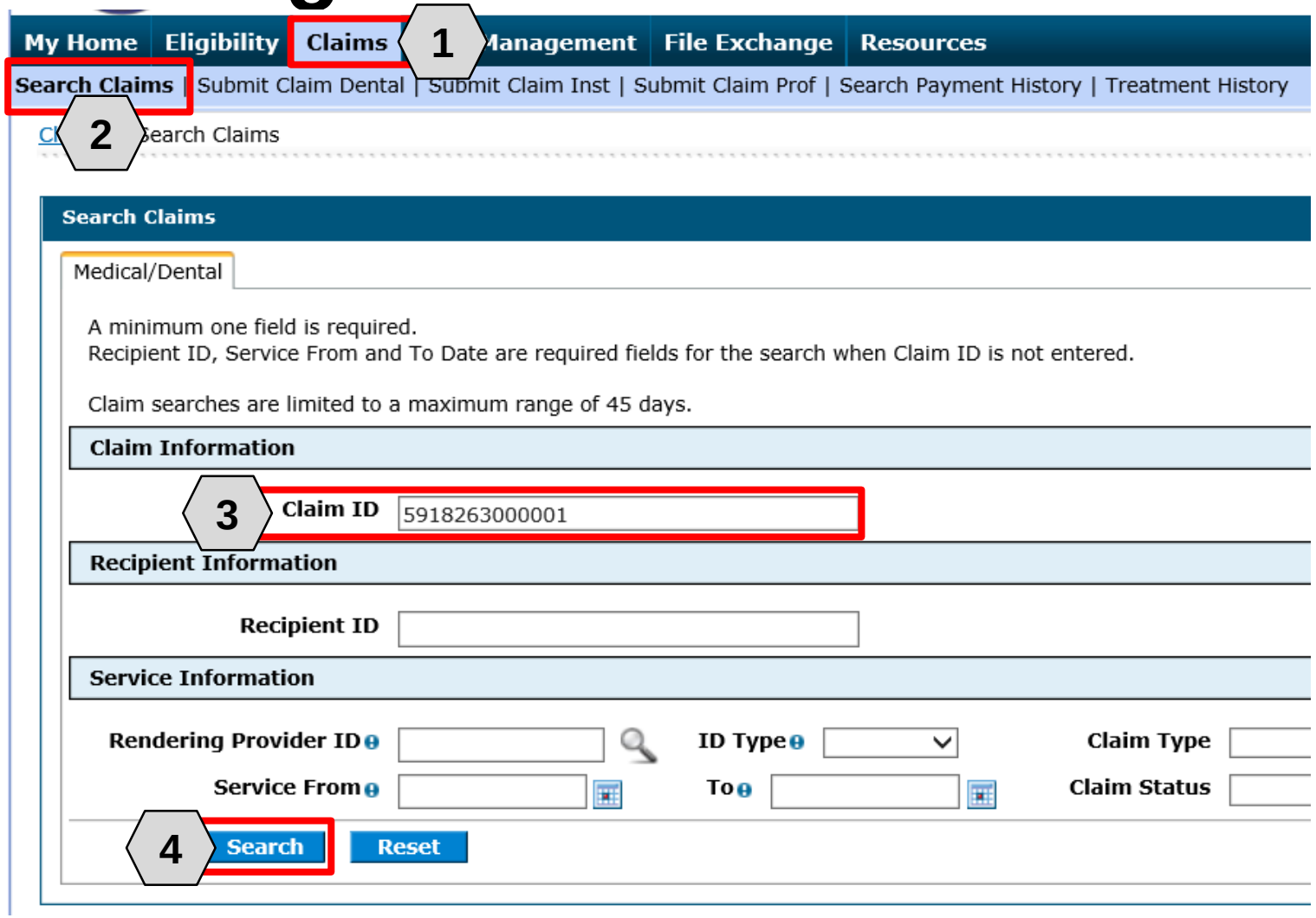
Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4256	Appeal of a denied claim	Claims - Appeals	10/02/2018	10/02/2018
Open	4255	testing	Claims - Appeals	09/27/2018	09/27/2018
Open	4253	Testing from MO	Level 2 Support - Account Issues	09/19/2018	09/19/2018
Open	4252	Testing 6268 in MO	Level 2 Support - Account Issues	09/18/2018	09/18/2018
Open	4251	Testing 6268	Claims - Appeals	09/06/2018	09/06/2018
Open	4227	Testing sample for 5916	Level 2 Support - Account Issues	08/14/2018	08/14/2018
Closed	4217	Help	Other	07/08/2018	08/03/2018
Open	4218	Testing Help	Other	07/08/2018	07/08/2018
Open	4219	Testing help..	Other	07/08/2018	07/08/2018
Open	4188	Testing in Model	Level 2 Support - Account Issues	04/09/2018	04/09/2018

1 2

After the user clicks the **OK** button, they will be directed to the **Secure Correspondence - Message Box**, where the new CTN can be seen.

Voiding a Claim

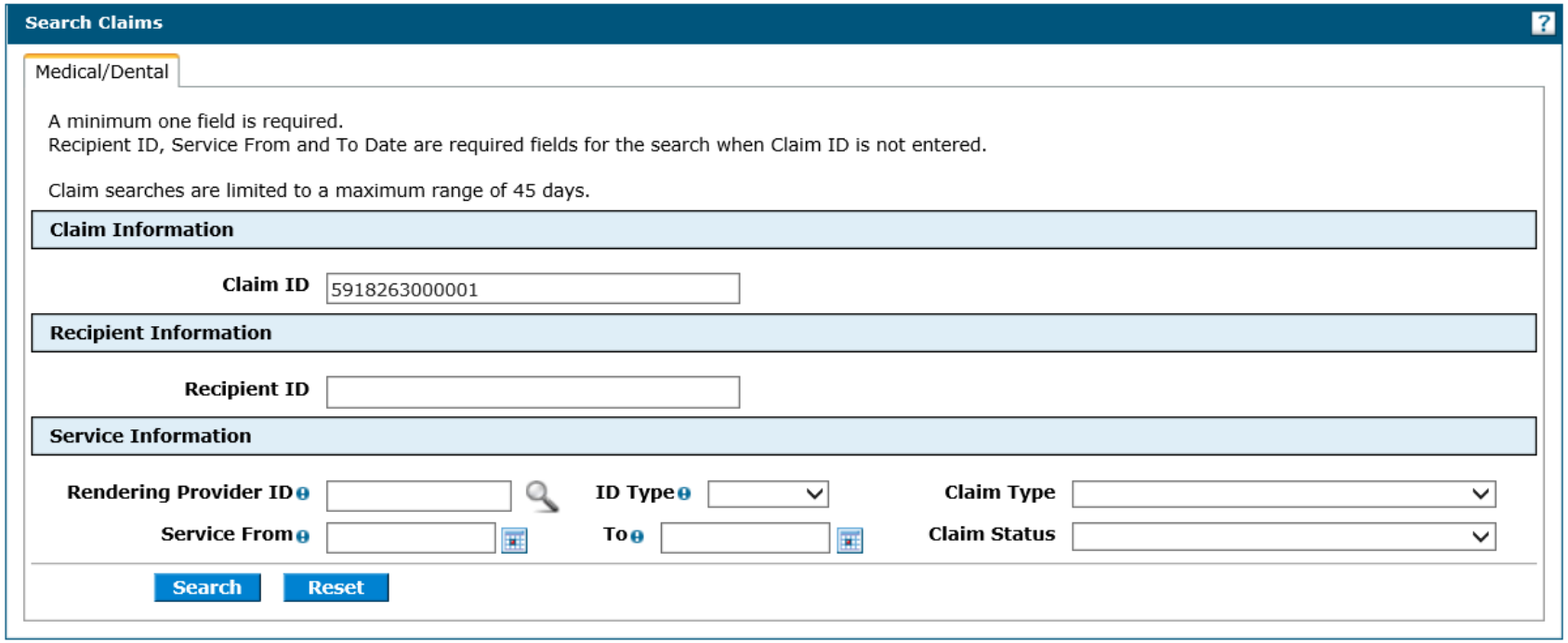
Voiding a Claim

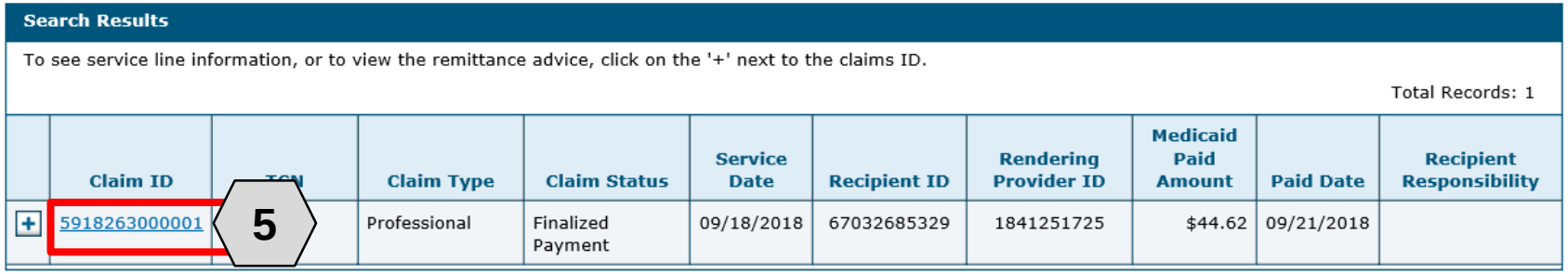


To search for a claim the user will need to:

1. Hover over **Claims.**
2. Select **Search Claims.**
3. Enter **Claim ID.**
4. Click the **Search** button.

Voiding a Claim, continued





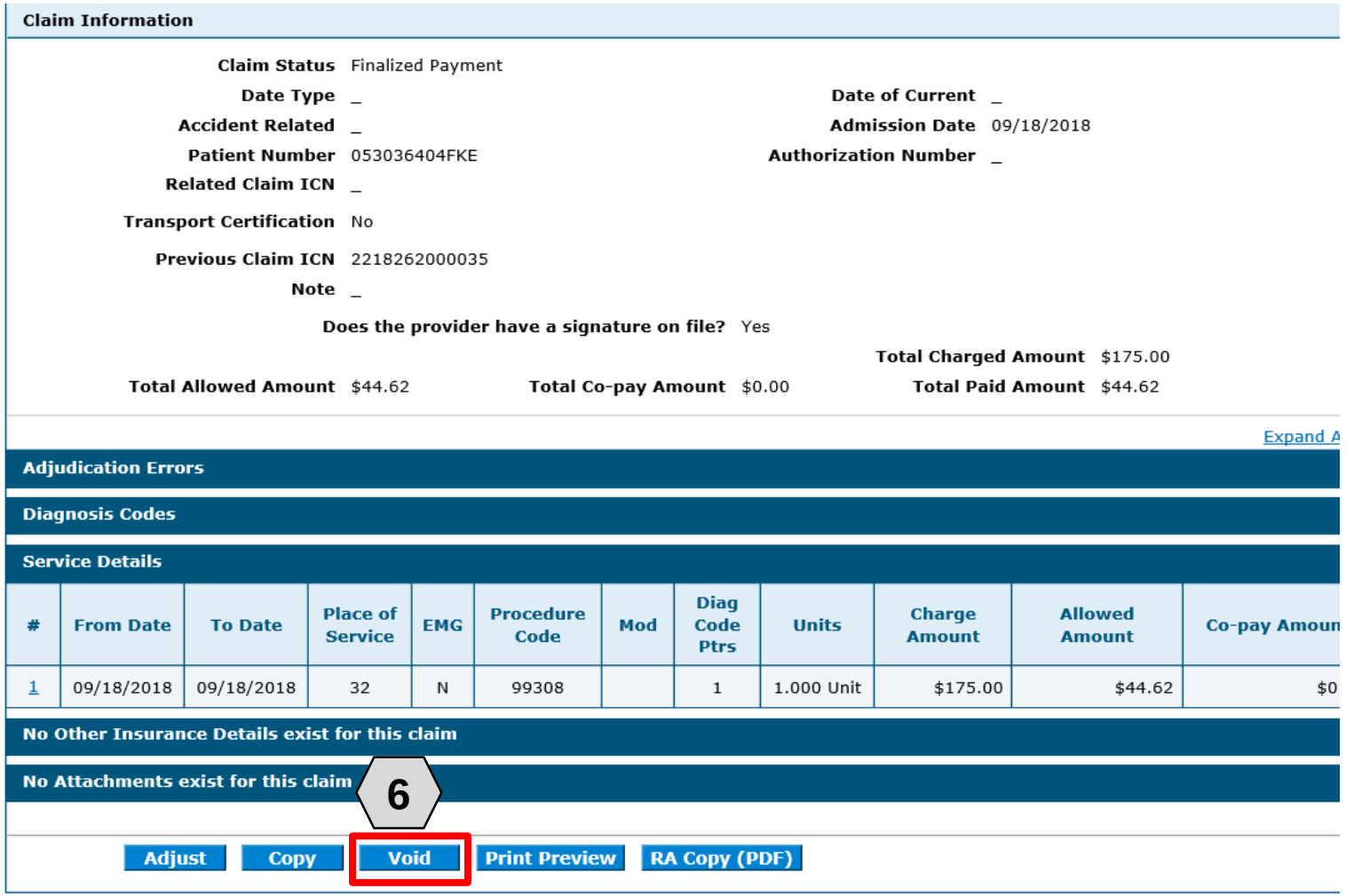
Once the user has clicked the **Search** button, the results will display below.

To open the claim, the user will:

5. Click the blue **Claim ID** link to open the claim.

NOTE: Denied Claims cannot be voided. The **Claim Status** column will indicate "Finalized Payment" if a claim is paid.

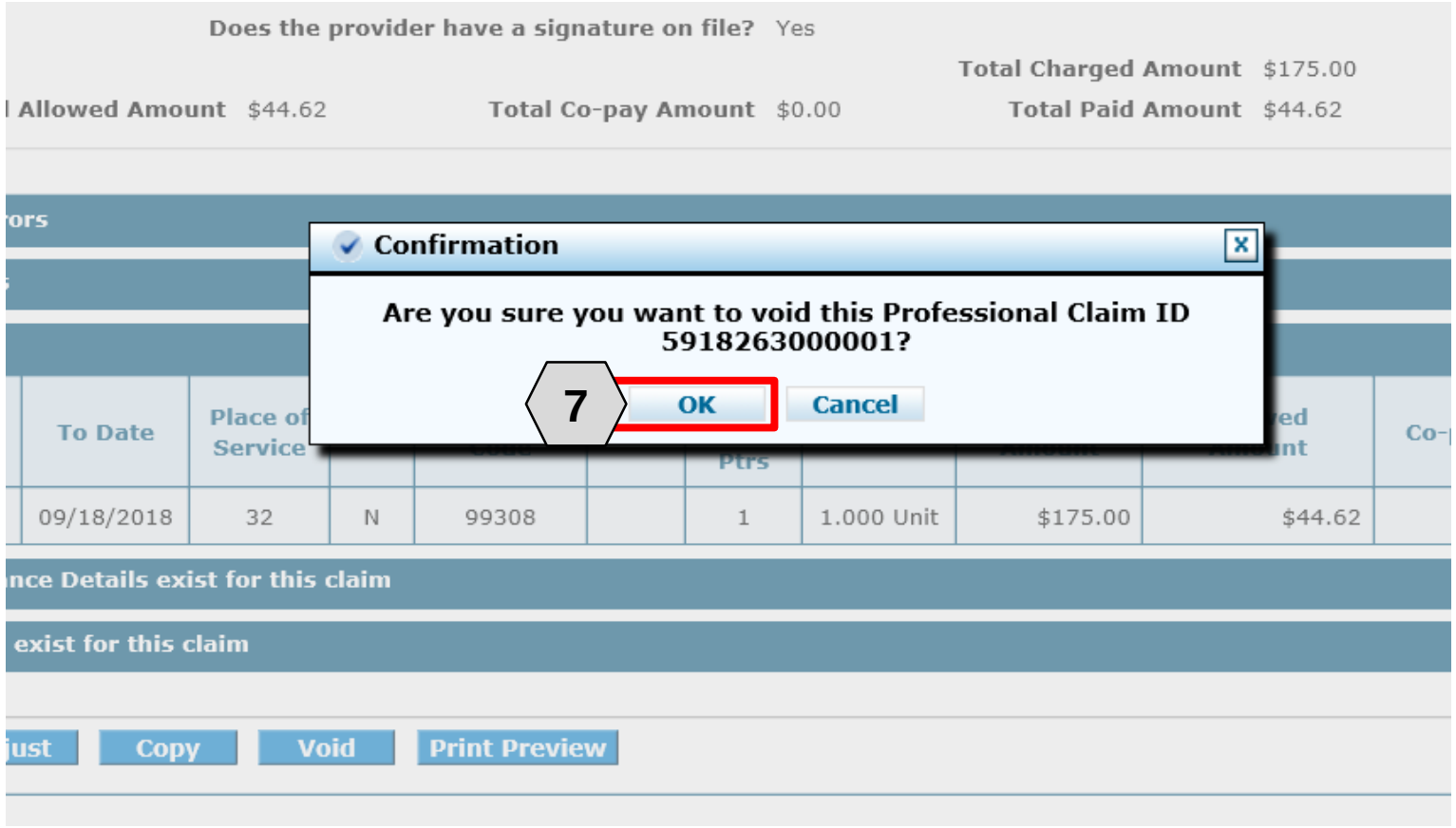
Voiding a Claim, continued



To void the claim, the user will:

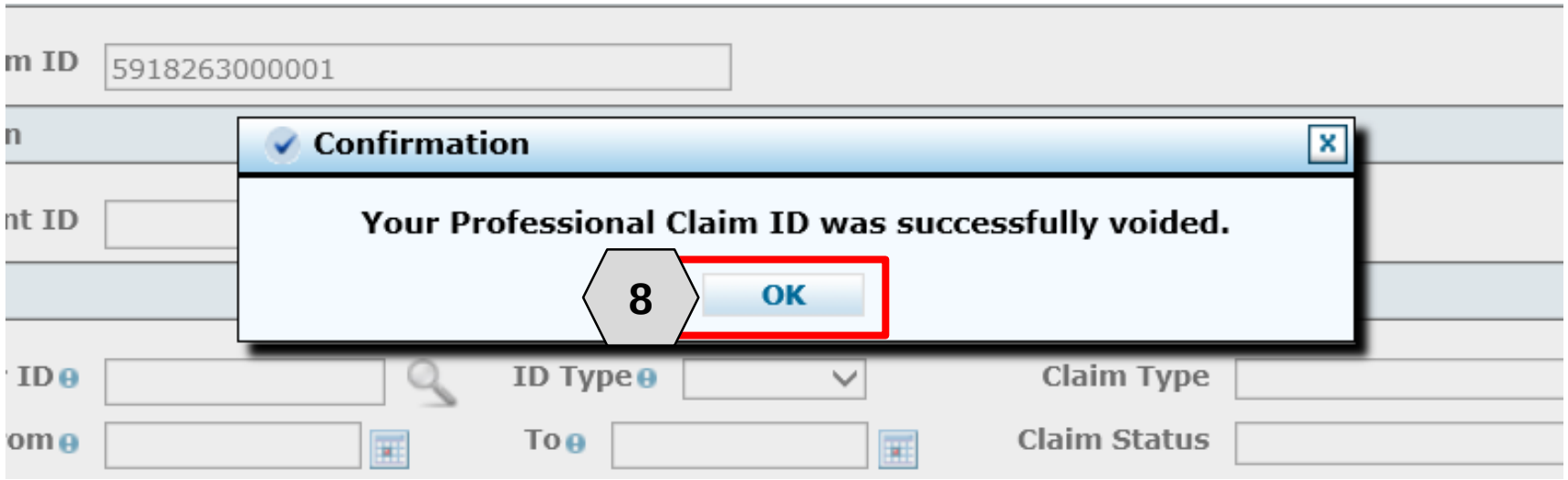
6. Click the **Void** button.

Voiding a Claim, continued



7. Click the **OK** button.

Voiding a Claim, continued



8. Click the **OK** button.

Resources

Additional Resources

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

DHCFP Contact Information:

E-Mail: pcsprogram@dhcfp.nv.gov

Contact Nevada Medicaid

Contact Nevada Medicaid

Prior Authorization Department: 800-525-2395

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

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

Thank You