Personal Care Services Provider Training

Provider Types 30 and 83
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
EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

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

Welcome to the Nevada Medicaid and Nevada Check Up Provider Web Portal. Through this easy-to-use internet portal, healthcare providers have access to useful information and tools regarding provider enrollment and revalidation, recipient eligibility, verification, prior authorization, billing instructions, pharmacy news and training opportunities. The notifications and web announcements keep providers updated on enhancements to the online tools, as well as updates and reminders on policy changes and billing procedures. Thank you for your participation in Nevada Medicaid and Nevada Check Up.
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.

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

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

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

– Additional Information is listed on Page 2.
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).

### Section 1: Contact Information

<table>
<thead>
<tr>
<th>PERSONAL CARE REPRESENTATIVE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name (other than recipient):</td>
</tr>
<tr>
<td>Relationship to Recipient:</td>
</tr>
</tbody>
</table>

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<tr>
<th>ISO PROVIDER INFORMATION</th>
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<tbody>
<tr>
<td>ISO Provider Name:</td>
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<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>Phone:</td>
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<tr>
<td>Fax:</td>
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This form is to be used only by Provider Type 83. Fill out form in its entirety. Indicate Date of Request. 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)

**LEGALY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION**

Complete this section if the LRI is not present. Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians and 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).
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.

<table>
<thead>
<tr>
<th>Skilled Service</th>
<th>Frequency of Service</th>
<th>Instructions/Steps to Complete the Task(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound Care</td>
<td></td>
<td>EXAMPLE ONLY</td>
</tr>
<tr>
<td>Diagnosis: Decubitus Ulcer Stage 7</td>
<td>1xDay</td>
<td>Close with H242, apply prescription ointment, apply dressing</td>
</tr>
</tbody>
</table>

Skilled Service:
1. Diagnosis:

2. Skilled Service:
   Diagnosis:
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.

<table>
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<th>Skilled Service:</th>
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Health Care Provider’s Signature and Attestation: I certify the statements on this form are true and certify that I have read NRS 429.091 (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: ______________
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.
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.
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.
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)

<table>
<thead>
<tr>
<th>SECTION 6: Required Signatures</th>
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<tbody>
<tr>
<td>RECIPIENT (Last Name, First Name, Middle Initial):</td>
</tr>
<tr>
<td>- By signing this form, I have read and understood Section 2, the Request for Medically Necessary Skilled Services.</td>
</tr>
<tr>
<td>- 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.</td>
</tr>
<tr>
<td>Recipient Signature:</td>
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<tr>
<td>Recipient Name: (please print)</td>
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<tr>
<td>LRI or Personal Care Representative Signature:</td>
</tr>
<tr>
<td>LRI or Personal Care Representative Name: (please print)</td>
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<tr>
<td>ISO Provider Signature:</td>
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<td>ISO Provider Name: (please print)</td>
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<td>Personal Care Assistant Signature:</td>
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Authorization Request for Self-Directed Skilled Services – FA-24C, continued

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 claim 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;
   (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) Category D felony, as provided in NRS 200.302, 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 $100,000.
   (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 $100,000.
   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.


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 personal assistant 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 services 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:
      (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 services is different than anticipated;
      (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.

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 recipient of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is forewarned 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 destroy all information received. This authorization is not a guarantee of payment.

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 parental 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 patient, 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, 631A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.

(Added to NRS by 636, 749, A 2065, 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.
PCS Recipient Request for Provider Transfer – FA-24T, continued

- An individual representative from the new provider must initial and sign page 2.
Submitting a Prior Authorization via the EVS Secure 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.
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.
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

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

2. Use the Provider Web Portal’s PA search function to see if a request for the dates of service, units and service(s) already exists.

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

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

Recipient Demographics

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

Diagnosis Codes

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

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

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

PA Attachments

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

1. Hover over the Care Management tab.
2. Click Create Authorization from the sub-menu.
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.
5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.
6. Enter the **Recipient ID**. The Last Name, First Name and Birth Date will populate automatically.
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.
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.
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.
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.
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**.

<table>
<thead>
<tr>
<th>Line #</th>
<th>From Date</th>
<th>To Date</th>
<th>Code</th>
<th>Modifiers</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>01/01/2018</td>
<td>01/01/2019</td>
<td>A6413-Adhesive bandage, first-aid</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*From Date* ✔️  
*To Date* ✔️  
*Code* ✔️  
*Modifiers* ✔️  
*Units* ✔️  
*Medical* ✔️
Submitting a PA Request, continued

The Transmission Method will default to EL-Electronic Only as attachments must be sent via the Provider Web Portal.
14. Choose the type of attachment being submitted from the Attachment Type drop-down list.
15. Click the **Browse** button.
16. Select the desired attachment.
17. Click the **Open** button.

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

The added attachment displays in the list.

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

Add additional attachments by repeating steps 14-18.

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

21. Click the Confirm button to submit the PA for processing. Only click the Confirm button once. If a user clicks Confirm multiple times, multiple PA’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.
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.

<table>
<thead>
<tr>
<th>Authorization Tracking Number</th>
<th>Service Date</th>
<th>Recipient Name</th>
<th>Recipient ID</th>
<th>Process Type</th>
<th>Requesting Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>4518127003</td>
<td>01/01/2018 - 01/01/2019</td>
<td>ABIEGUT, ABYNRYP</td>
<td>43827875678</td>
<td>Home Health</td>
<td>HOSPITALIST SERV NEVADA-MANDAVi</td>
</tr>
<tr>
<td>43180110001</td>
<td>01/11/2018 - 01/11/2019</td>
<td>QROTB, FENKTPVI</td>
<td>54409179444</td>
<td>Outpt M/S</td>
<td>HOSPITALIST SERV NEVADA-MANDAVi</td>
</tr>
<tr>
<td>41180120002</td>
<td>01/12/2018 - 01/12/2019</td>
<td>KWLVOTYRXW, AOWPEW H</td>
<td>80335695037</td>
<td>Outpt M/S</td>
<td>HOSPITALIST SERV NEVADA-MANDAVi</td>
</tr>
</tbody>
</table>
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.
6. Review the details listed in the **Decision / Date** and **Reason** columns.

### Viewing the Status of PAs, continued

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>ID Type</th>
<th>NPI</th>
<th>Name</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CPT/HCPCS 0031P-INACTIVE TOBACCO USE, NO=SMOKING</td>
<td>01/12/2018</td>
<td></td>
</tr>
</tbody>
</table>

![Table Image]
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.
When the **Decision / Date** column is not “Certified in Total” information will be provided in the **Reason** column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).
### Viewing the Status of PAs, continued

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

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td>-</td>
<td>CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING</td>
<td>Certified In Total 01/12/2018</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
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. |

#### Table Example:

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td>-</td>
<td>CPT/HCPCS 0093F-INACTIVE TOBACCO USE, NON-SMOKING</td>
<td>-</td>
<td>Certified In Total 01/12/2018</td>
<td>-</td>
</tr>
</tbody>
</table>
Searching for PAs
Searching for PAs

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

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

D. **Status**: Select a status from this list to narrow search results to include only the selected status.
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. Add additional diagnosis codes, service details and/or attachments.
Submitting Additional Information, continued

3. Click the Resubmit button to review the PA information.
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

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

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

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

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

Billing Information

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

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

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

Billing Manual
For Archives Click here

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

Review the Billing Manual for more information regarding:
- 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
• Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a procedure code.
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

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Modifier</th>
<th>Fee Amount</th>
<th>App Restrictions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>0362T-BHV ID SUPRT ASMT EA 15 MIN</td>
<td>85-Applied Behavior Analysis (ABA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/1/2019 - 12/31/2299</td>
</tr>
<tr>
<td>0362T-BHV ID SUPRT ASMT EA 15 MIN</td>
<td>85-Applied Behavior Analysis (ABA)</td>
<td>312-Lic. Board Certified Assist Behavior Analyst</td>
<td></td>
<td></td>
<td></td>
<td>1/1/2019 - 12/31/2299</td>
</tr>
<tr>
<td>0362T-BHV ID SUPRT ASMT EA 15 MIN</td>
<td>85-Applied Behavior Analysis (ABA)</td>
<td>311-Psychologist</td>
<td></td>
<td></td>
<td></td>
<td>1/1/2019 - 12/31/2299</td>
</tr>
<tr>
<td>0362T-BHV ID SUPRT ASMT EA 15 MIN</td>
<td>85-Applied Behavior Analysis (ABA)</td>
<td>311-Psychologist</td>
<td>UD-M/cad care lev 13 state</td>
<td></td>
<td></td>
<td>1/1/2019 - 12/31/2299</td>
</tr>
</tbody>
</table>
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

Slide from a presentation:

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

FEE SCHEDULES

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

- Provider Type 30 and 83 Personal Care Services

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

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).

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

If the user selects “Yes” in the Transport Certification field, additional details must be entered.
Submitting a Claim: Step 1, continued

Claim Information

| Claim Information          |  
|----------------------------|---|
| Date Type                  |  
| Accident Related           |  
| Patient Number             |  
| Transport Certification    | Yes No  
| Certification Condition Indicator | Yes No  
| Condition Indicator        |  
| Transport Distance         |  
| Ambulance Transport Reason |  
| Does the provider have a signature on file? | Yes No  
| Include Other Insurance    |  
| Total Charged Amount       | $0.00  

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.

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>*Diagnosis Type</td>
<td>ICD-10-CM</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>*Diagnosis Code</td>
<td>Rx</td>
<td>&lt;</td>
</tr>
<tr>
<td>3</td>
<td>Add</td>
<td>Reset</td>
<td></td>
</tr>
</tbody>
</table>

Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes, descriptions and diagnosis codes are the exclusive copyright of the American Medical Association (AMA). All rights reserved. 2002 and 2012. Unless as otherwise noted, the data contained herein are represented on this website and on document.
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

<table>
<thead>
<tr>
<th>Service Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From Date</strong></td>
<td>09/12/2018</td>
</tr>
<tr>
<td><strong>To Date</strong></td>
<td>09/12/2018</td>
</tr>
</tbody>
</table>

**2. Select the Place of Service from the drop-down.**

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.
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.
9. Click the Submit button.
Submitting a Claim: Step 3, continued

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.
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.
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.
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
   - Psychiatric Services 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.

---

### Medicare Crossover Details

<table>
<thead>
<tr>
<th>Allowed Medicare Amount</th>
<th>Co-insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000.00</td>
<td>$550.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Amount</th>
<th>Psychiatric Services Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Payment Amount</th>
<th>Medicare Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,800.00</td>
<td>10/12/2018</td>
</tr>
</tbody>
</table>

---

### Diagnois Codes

---

### Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/10/2018</td>
<td>09/20/2018</td>
<td>21-Inpatient Hospital</td>
<td>01210-Arth-de hip joint surgery</td>
<td>$6,500.00</td>
<td>120.000 Unit</td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td>00/00/2018</td>
<td>00/00/2018</td>
<td></td>
<td></td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Attachments

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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**.
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

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>TCN</th>
<th>Claim Type</th>
<th>Claim Status</th>
<th>Service Date</th>
<th>Recipient ID</th>
<th>Rendering Provider ID</th>
<th>Medicaid Paid Amount</th>
<th>Paid Date</th>
<th>Recipient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>221825500002</td>
<td>Professional</td>
<td>Finalized Denied</td>
<td>09/12/2018</td>
<td>67770816236</td>
<td>1003195530</td>
<td>$0.00</td>
<td>09/14/2018</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Professional Claim Information**

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

**Service Information**

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Date</th>
<th>Line Status</th>
<th>Reason Code</th>
<th>Units</th>
<th>Procedure/Modifiers</th>
<th>Charge</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/12/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>1</td>
<td>2018F</td>
<td>$100.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>01/12/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>1</td>
<td>06361</td>
<td>$200.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

7. Click the (+) symbol adjacent to the **Adjudication Errors** panel.
With the **Adjudication Errors** panel expanded, the user may review the errors associated with the claim’s denial.

**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.
5. Click on the RA Copy (PDF) icon.
Viewing a Remittance Advice, continued

6. User will click the Open button.
After clicking Open, the user can review the RA.
Copying Claims
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.
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.
7. Select what portion of the claim to copy (for this example, the user has selected **Entire Claim**).

8. Click the **Copy** button.
9. Click the Continue button.

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

---

<table>
<thead>
<tr>
<th>#</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Ptn</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/18/2018</td>
<td>09/18/2018</td>
<td>32</td>
<td>N</td>
<td>99206</td>
<td>1</td>
<td>1.000 Unit</td>
<td>$175.00</td>
<td>$44.62</td>
<td>$0.00</td>
<td>$44.62</td>
<td></td>
</tr>
</tbody>
</table>
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.
10. Click the **Resubmit** button.
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

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
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.
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.
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
- Billing Information: https://www.medicaid.nv.gov/providers/BillingInfo.aspx

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