Psychiatric Hospital, Inpatient (Provider Type 13) Prior Authorization Training
Objectives
Objectives

- Recipient Eligibility
- Recipient Eligibility via the Electronic Verification System (EVS)
- Medicare Eligibility
- Submission Guidelines
- Prior Authorization (PA) Processes
- Prior Authorization (PA) Information
- Retrospective Authorizations and Documentation
- Clinical Documentation
- Skilled Days
- Submit a Prior Authorization via the EVS secure Provider Web Portal
- Discharge Planning
- Residential Treatment Center (RTC) Referrals and Psychiatric Evaluations
- Coverage and Limitations
- Resources
- Contact Nevada Medicaid
Recipient Eligibility
Recipient Eligibility Tips

- Verify recipient eligibility frequently and at least weekly during a hospital stay.
- Utilize the Electronic Verification System (EVS) to verify recipient eligibility.
- If a recipient's eligibility ends during the course of a hospital stay, a portion of the request will be denied. It is important to check recipient eligibility daily if the recipient remains in the hospital.
- **Provider type 13 may only provide services to recipients who are younger than 21 years of age or older than 64 years of age.**
- If an individual is admitted while being 20 years of age, then turns 21 during their stay, the recipient is eligible for services until they no longer meet medical necessity or until they turn 22 years of age.
- An approved authorization does not confirm recipient eligibility or guarantee claims payment.
Recipient Eligibility via the Electronic Verification System (EVS)
Once registered, users may access their accounts from the PWP “Home” page by:

1. Entering the **User ID**.
2. Clicking the **Log In** button.
Once the user has clicked the Log In button, they will need to provide identity verification as follows:

3. Type in their answer to the Challenge Question to verify identity.
4. Choose whether log in is on a personal computer or public computer.
5. Click the Continue button.
Navigating the PWP, continued

6. Confirm that the Site Key and Passphrase are correct.
7. Enter Password.
8. Click the Sign In button.

NOTE: If information is incorrect, contact the help desk by clicking the Customer help desk link.
Once the user has provided identity verification and entered their password, the “My Home” page will display.

From there, the user will need to:

9. Verify all provider information located on the left margin of the screen.

NOTE: If this provider information is incorrect, users should contact the Help Desk by clicking the **Contact Us** link on the right side of this page.
Navigating the PWP, continued

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 PWP, continued

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**: 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.
Searching for a Member’s Benefit Eligibility

1. Hover over Eligibility.
2. Select Eligibility Verification.
Searching for a Member’s Benefit Eligibility, continued

3. Enter a **Recipient ID**; **SSN** and **Birth Date**; or **First Name**, **Last Name**, and **Birth Date**
4. Select the **Effective From** and **To** date range (defaults to current date)
5. Select the **Service Type Code**
6. Click the **Submit** button

**NOTE:** Click the **Reset** button to clear the fields and start a new search.
Viewing a Member’s Benefit Details

The results display below the Eligibility Verification Request panel. Verify the recipient displayed matches the recipient being searched.

Information in this panel lists all eligible coverage from Managed Care Organizations (MCOs) and a link to other health coverage (OHC) and third-party insurance details.

NOTE: The system will display an error message if the member is not found or does not have eligible benefits during the given effective date range.
From the **Eligibility Verification Request** panel:

1. Select any of the **Coverage** links to view details about all available coverage benefits.

NOTE: The Effective and End Dates in the results panel match the range used in the search criteria. Users can also view the Date of Decision.
After clicking any of the coverage links, the “Coverage Details” page displays, listing details about each coverage benefit in sections.

The available sections will depend on the types of coverage the member has.

Most sections initially display as hidden. Click the (+) symbol to expand the section and view the details or click the Expand All link to expand all sections.

NOTE: Log the Verification Response ID for future reference. The ID identifies this specific eligibility verification instance.
A. The **Benefit Details** section will always be available. This section lists all active coverage for the date range and provides descriptions of each coverage type.

B. The **Copayment Details** section lists all copayments that a member could have for services during the date range.

NOTE: Most sections list all applicable service types and their associated amounts or percentages on separate lines. Only a few lines are shown in these examples.
C. The **Coinsurance Details** section lists all coinsurance payments that a member could have for services during the date range.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Service Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Fee For Service</td>
<td>Medical Care</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Dental Care</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Chiropractic</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Hospital</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Hospital - Inpatient</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Urgent Care</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Emergency Services</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Pharmacy</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Professional (Physician) Visit - Office</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Vision (Optometry)</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Mental Health</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Hospital - Outpatient</td>
<td>0%</td>
</tr>
</tbody>
</table>

D. The **Deductible Details** section lists all deductibles that a member could have for services during the date range.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Service Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Fee For Service</td>
<td>Medical Care</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid Fee For Service</td>
<td>Dental Care</td>
<td>$0.00</td>
</tr>
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<td>Medicaid Fee For Service</td>
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<td>Hospital</td>
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</tr>
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<td>Medicaid Fee For Service</td>
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<td>Medicaid Fee For Service</td>
<td>Hospital - Outpatient</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Viewing a Member’s Benefit Details, continued

E. The Managed Care Assignment Details section lists information about a member’s managed care providers and their contact details.

F. The Demographic Details will always be available. This section lists the member’s address.
When finished reviewing the member’s benefit details, the user has the option to print the page by clicking the **Print Preview** button at the top of the page.

The user may also click the **Back to Eligibility Verification Request** link to return to the results page and view third-party details for the member.
Viewing a Member’s Third-Party Coverage

From the results display below the Eligibility Verification Request panel, select the Other Insurance Detail Information link to view third-party coverage benefits.
Viewing a Member’s Third-Party Coverage, continued

After clicking the Other Insurance Detail Information link, the system will display any active third-party details available for the effective date range used in the search.

When finished reviewing the member’s third-party details, the user has the option to print the page by clicking the Print Preview button at the top of the page. Also click the Back to Eligibility Verification Request link to return to the results page and view coverage benefit details for the member.

NOTE: When there are no benefit records to display, the system provides a message indicating that there is no information available.
Medicare Eligibility
Medicare Eligibility

- When submitting a request for a recipient with Medicare Eligibility (Part A), include a copy of the Medicare Catastrophic Coverage Act (MECCA) form or other qualifying documentation that demonstrates that the recipient’s Medicare days have been exhausted.

- If Medicare Part A days have not been exhausted, a prior authorization is not needed as the provider would be instructed to bill Medicare Part A.

- If Medicare denies a stay due to exhausted benefits and no prior authorization was obtained, the provider may submit a retrospective request and mark that it is a retrospective review for Medicare.

- The retrospective review must be submitted within 30 days of receipt of the Medicare notification or the explanation of benefits (EOB).

- It is recommended that Medicare be billed as soon as possible after the recipient is discharged.
Submission Guidelines

- Authorization must be obtained prior to admission by submitting the initial request (form FA-12), with the exception of an emergency admission, in which case, Nevada Medicaid must be notified within one business day after admission.

- Concurrent requests (form FA-14) must be submitted by the anticipated date of discharge of the current/existing authorization period or the next business day if this falls on a non-business day.

- If a concurrent request is not received within the appropriate time frame, a second authorization period, if clinically appropriate, can begin on the date a concurrent authorization is received.

- Providers are advised not to wait to request a concurrent authorization based on a pending appeal or if the prior treatment period is pending information.

- Nevada Medicaid will not pay for unauthorized days between the end date of the first authorization period and the begin date of the second authorization period.
Prior Authorization (PA) Processes
Prior Authorization Process

- The admission must be certified by Nevada Medicaid for emergency and non-emergency inpatient psychiatric admissions based on:
  
  - Medical necessity.
  
  - Clear evidence of the physician’s admission order.
    
    - The date and time of the order and status of the recipient’s admission (i.e., inpatient, observation, same day surgery, transfer to observation, etc.).
  
  - Recipient meeting Level 6 on the intensity of needs grid (CASII for children/LOCUS for adults).

- The hospital must submit all required documentation, including:
  
  - Signed and dated physician order reflecting admit date and time.
  
  - Any other pertinent information requested by Nevada Medicaid.

- Non-emergency admissions not prior authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.
Prior Authorization Process, continued

- Transfers and Planned Admissions:
  - For those instances when a physician's order was issued for a planned admission and before the recipient arrives at the hospital:
    - The order must be signed by the physician and indicate the anticipated date of admission.
    - A physician order must also be issued for transfers from another acute care hospital.
  - Observations:
    - Observation status cannot exceed a maximum of 48 hours.
    - Begins when the physician issues an observation status order and ends when the recipient is discharged from the hospital.
    - A new Admission order must be issued and signed by a physician when a recipient is admitted to inpatient status after discharge from observation status.
Emergency Authorization Process

- Authorization must be obtained prior to admission, with the exception of an emergency admission, in which case Nevada Medicaid must be notified within one business day.

- Emergency inpatient psychiatric admission is defined as meeting at least one of the following:
  - Active suicidal ideation accompanied by a documented suicide attempt or a documented history of a suicide attempt(s) within the past 30 days.
  - Active suicidal ideation within the past 30 days accompanied by physical evidence (ex: a note) or means to carry out the suicide threat (ex: gun, knife, etc.).
  - Documented aggression within the 72-hour period before admission which:
    - Resulted in harm to self, others or property.
    - Manifests as requiring control that cannot be maintained outside an inpatient hospitalization.
    - Is expected to continue without treatment.
During Initial Authorization Period

- The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement.

- In addition, when a recipient remains hospitalized longer than seven days the attending physician must document the medical necessity of each additional inpatient day.

- Note: Acute inpatient admissions authorized by Nevada Medicaid don't require any additional authorizations for physician-ordered psychological evaluations and testing:

  - The psychologist must list the “Inpatient Authorization Number” on the claim form when billing for services.
Prior Authorization (PA) Information
Prior Authorization (PA) Information, Initial Review

- Requests must be submitted using form FA-12 and uploaded to the Provider Web Portal. The Certificate of Need (CON) is included within this and must be signed by the physician with a current date.
- Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days, except for retrospective reviews.
- A CASII/LOCUS acuity level of at least 6 is required for hospital admission.
- FA-12 must include an individualized treatment plan with active participation by the recipient and their family (when applicable).
- Documentation must include all outpatient services that have been attempted prior to admission (include name of the provider, specific services and dates of service).
Prior Authorization Information, FA-12

- FA-12 Form is to be used when requesting an Initial Review
- **Section I (Recipient Information)**
  - Fill out all information pertaining to the recipient.
- **Section II (Responsible Party Information)**
  - Fill out if the responsible party is not the recipient.
- **Section III (Admitting Facility Information)**
  - Fill out all information pertaining to the Admitting Facility.
- **Section IV (Treatment History)**
  - This section must filled out completely and is continued on Page 2.
Prior Authorization Information, FA-12, continued

- **Section IV, continued (Treatment History)**
  - Fill out all information pertaining to the recipient.

- **Section V (ICD-10 Diagnosis)**
  - Input appropriate and active ICD-10 diagnosis codes.

- **Section VI (Symptoms and Medications)**
  - List all symptoms that the recipient is experiencing and medications currently and previously being prescribed to the recipient.

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Length of Stay</th>
<th>Facility Name</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>to 4.</td>
<td>2.</td>
<td>to 5.</td>
</tr>
<tr>
<td>3.</td>
<td>to 6.</td>
<td>4.</td>
<td>to 7.</td>
</tr>
</tbody>
</table>

Has the recipient had prior outpatient treatment? □ No □ Yes (if yes, complete the following lines.)

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Dates of Service</th>
<th>Frequency of Service</th>
<th>Outcome of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Other Placements (Foster Care, Group Home, Shelter, Detention, Training School, Boot Camp, etc.)*

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Length of Stay</th>
<th>Facility Name</th>
<th>Length of Stay</th>
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<tr>
<td>1.</td>
<td>to 4.</td>
<td>2.</td>
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<tr>
<td>3.</td>
<td>to 6.</td>
<td>4.</td>
<td>to 7.</td>
</tr>
</tbody>
</table>

**V. ICD-10 DIAGNOSIS**

Primary Code: Disorder
Secondary Code: Disorder
Tertiary Code: Disorder

**VI. SYMPTOMS AND MEDICATIONS**

Current symptoms requiring inpatient care. (Include clinical rationale for number of days being requested for review and evaluation of risk)

Chronic behaviors:
Prior Authorization Information, FA-12, continued

- **Section VI, continued (Symptoms and Medications)**
- **Section VII (Requested Treatment)**
  - Select the requested treatment and provide additional details, such as, admission information, length of stay and discharge plan
Prior Authorization Information, FA-12, continued

- The last page contains information regarding the Certificate of Need (CON).
- This page must be signed and dated by the physician.
- Must be accompanied by an individualized plan of treatment with active participation by the recipient and their family, when applicable.
Prior Authorization Information, Concurrent Review

- All requests are to be made using form FA-14 and uploaded to the Provider Web Portal.
- Requests for concurrent stay may not exceed seven days, except for retrospective reviews.
- Each prior authorization must stand on its own; therefore, two to three sentences regarding why the recipient was initially admitted is recommended. Generally this is documented under justification for continued services.
- As the recipient’s acuity level is a 6, after the initial dates of service there should not be any unspecified diagnoses or remaining rule out diagnoses.
Prior Authorization Information, FA-14

- The FA-14 is used when requesting Concurrent Reviews, Reconsiderations or Retro Authorizations.

- Section I (Recipient Information)
- Section II (Facility Information)
- Section III (ICD-10 Diagnosis)
- Section IV (Clinical Information)

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II. FACILITY INFORMATION

III. ICD-10 DIAGNOSIS

IV. CLINICAL INFORMATION

- Requested Start Date
- Number of days requested
- Date of Admission
- Service: Acute □ Skilled □
- Date of physician’s initial admission assessment:
- Special precautions for this recipient: □ SP □ Aggression □ Elopement □ Other:
- Intervals: □ q15 □ q30 □ q 1 hour □ Routine □ Other:
- Current Medication(s)
- Dosage
- Start Date
- 1. 
- 2. 
- 3.
- If applicable, list the most recent lab levels for the above medications: 
- Describe the recipient’s current mental status.

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Nevada Medicaid Psychiatric Hospital (Inpatient) Provider Training
Prior Authorization Information, FA-14, continued

- Section IV, continued
  - Input recipient’s activities.
  - Provide the recipient’s individualized treatment plan.
  - Provide medical justification.
  - Indicate the recipient’s date of discharge.

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Nevada Medicaid Psychiatric Hospital (Inpatient) Provider Training
Retrospective Authorizations
Retrospective Authorizations

- Nevada Medicaid authorizes only Medicaid eligible clients, not pending eligibility.
- If the recipient becomes eligible during their stay, providers must request a retrospective authorization utilizing the Inpatient Mental Health Prior Authorization Request (FA-12) or the Inpatient Mental Health Concurrent Review Request (FA-14). Check “Retrospective Authorization” at the top of the form.
- If a recipient is currently a patient at the hospital, the provider has 10 business days from the eligibility date of decision to submit the retrospective review.
- If the recipient has discharged prior to the eligibility date of decision, the provider has 90 calendar days to submit their retrospective review.
- If a recipient loses eligibility and it is later reinstated, submit a retrospective authorization for any prior dates. The retrospective authorization request must be attached to the original prior authorization number which included specific dates of service that were denied for loss of eligibility.
Retrospective Authorizations, continued

– Use FA-12 or FA-14. With either form, select “Retrospective Authorization” and fill out all other necessary fields.

– The forms can be located on the Providers Forms webpage at https://www.medicaid.nv.gov/providers/forms/forms.aspx

– All forms are fillable forms.

– All forms can be saved to a desktop for convenient uploading into the Provider Web Portal.
Retrospective Documentation
Retrospective Documentation

- When submitting for a retrospective review, please only provide pertinent clinical information that would substantiate medical necessity.
- Voluminous clinical data will not be reviewed and will cause delays in the processing of a request.
- Level of Care (LOC) and dates of service must be clearly documented. Note that Nevada Medicaid will not reimburse for date of discharge.
- Admission and discharge summaries by the physician are recommended along with a concise summary of symptoms, behaviors and treatment interventions that have occurred every 5-7 days.
Clinical Documentation
Clinical Documentation

- All information on the appropriate FA form, including start dates and number of days requested, must be consistent with the information entered into the Provider Web Portal. If any of the information is not consistent, there will be a delay in the processing of the request.

- Type all information into the appropriate form as illegible forms will not be processed.

- Any information that must be brought to the reviewer’s attention should be placed prominently at the beginning or the front of the request; for example, this information can be placed on a cover sheet or the top of the FA form.

- ICD-10 diagnosis codes must be utilized to include the correct code and narrative disorder.

- Failure to provide all pertinent medical information as required by Nevada Medicaid will result in authorization denial.

- Inpatient days not authorized by Nevada Medicaid are not covered.
While viewing a prior authorization in the Provider Web Portal, review the Medical Citation field as additional information may be requested from Nevada Medicaid. This will also allow the user to view the status of the prior authorization.

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

### Notes To Provider
Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted.

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

- Skilled Days do not need to be denied first at the acute level of care, but can be submitted as concurrent days.

- If the provider does not appeal an adverse decision, a request can be made for the denied dates of service at a lower level of care.

- When submitting a reconsideration review, additional days cannot be added at a lower level of care as they were not part of the original denial. Requests for additional days must be submitted separately.
Skilled Days, continued

- Skilled Days will be denied if the recipient was not at an acute inpatient level of care facility at least 1 day immediately preceding the request for skilled days.

- Skilled Days will be denied if a recipient, family member or physician refuse to cooperate with the discharge plan or refuse appropriate placement.

- Skilled Days will be denied if the provider fails to submit evidence of comprehensive discharge planning.
Submitting a Prior Authorization via the EVS Secure Provider Web Portal
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 Creating an 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 and is associated with your individual, state or local agency, or corporate or business entity.
- Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.
- Use the Provider Web Portal to check PAs in pending status for additional information.
Create a Prior Authorization Request
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 an appropriate Process Type from the drop-down list.
5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.
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 list. 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**. Once the user begins typing, the field will automatically search for matching codes.

11. Click the **Add** button.

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

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

**NOTE:** 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**.
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.
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.
18. Click the Add button.
Submitting a PA Request, continued

The added attachment displays in the list.

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

Add additional attachments by repeating steps 14-18.

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

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

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

**NOTE:** If updates are needed prior to clicking the **Confirm** button, click the **Back** button to return to the “Create Authorization” page.
After the **Confirm** button has been clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.
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.
6. Review the details listed in the Decision / Date and Reason columns.
In the **Decision / Date** column, users may see one of the following decisions:

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

---

### Service Provider / Service Details Information

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>ID Type</th>
<th>Name</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1831573690</td>
<td>NPI</td>
<td>HOSPITALIST SERVICES OF NEVADA-MANDAVIA</td>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td>_</td>
<td>CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING</td>
<td>_</td>
<td>Certified In Total</td>
<td>01/12/2018</td>
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</tbody>
</table>
Viewing the Status of PAs, continued

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).

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>ID Type</th>
<th>Name</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1306097878</td>
<td>NPI</td>
<td>KHOSROW HAKIMPOUR</td>
<td>08/29/2017</td>
<td>08/29/2017</td>
<td>1</td>
<td>1</td>
<td>$125.00</td>
<td>CPT/HCPCS 80061-Lipid panel</td>
<td>View</td>
<td>Certified Partial 06/11/2018</td>
<td>Product/service/procedure delivery pattern (e.g., units, days, visits, weeks, hours, months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>08/30/2017</td>
<td>08/30/2017</td>
<td>1</td>
<td>0</td>
<td>–</td>
<td>CPT/HCPCS 36415-Routine venipuncture</td>
<td>View</td>
<td>Not Certified 06/11/2018</td>
<td>Non-covered Service</td>
</tr>
</tbody>
</table>
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

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

**Medical Citation**

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

**Notes To Provider**

Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted.

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<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/20/2013</td>
<td>02/20/2013</td>
<td>2</td>
<td>0</td>
<td>-</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-</td>
<td>View</td>
<td>Not Certified</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SURG-GYN</td>
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<td>-</td>
<td>Certified In Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SURG-GYN</td>
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<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.
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.
D. **Status:** Select a status from this list to narrow search results to include only the selected status.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Cancel</td>
</tr>
<tr>
<td>Certified In Total</td>
</tr>
<tr>
<td>Certified Partial</td>
</tr>
<tr>
<td>Not Certified</td>
</tr>
<tr>
<td>Pended</td>
</tr>
</tbody>
</table>

Recipient information is not mandatory. You can enter the Recipient ID; or the Last Name, First Name, and Birth Date.
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** 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.

---

<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>
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</thead>
<tbody>
<tr>
<td>43180110001</td>
<td>01/11/2018 - 01/11/2019</td>
<td>QROTB, FENKTPV1</td>
<td>54409179444</td>
<td>Outpt M/S</td>
<td>HOSPITALIST SERVICES NEVADA-MANDAVIA</td>
</tr>
</tbody>
</table>
Submitting Additional Information
Data Correction Form (FA-29) Submission

- When submitting a Prior Authorization Data Correction Form (FA-29), please be sure to reference the prior authorization number to which the information should be attached.

- Please understand that if a user is requesting to change a date of service (add or delete), Nevada Medicaid is unable to process this request if the units on that specific line of service have already been adjudicated by claims.

- Please ensure that you submit the FA-29 with the correct NPI.

- Always include detailed information, a contact name and direct telephone number of a person who can answer questions regarding submission of the FA-29.
Submitting Additional Information

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

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

2. Add additional diagnosis codes, service details and/or attachments.
3. Click the Resubmit button to review the PA information.
4. Review the information.
5. Click the **Confirm** button.

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

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

– Request for a peer-to-peer review (avenue used in order to clarify why the request was denied or approved with modifications)

– Submit a reconsideration request (avenue used when the provider has additional information that was not included in the original request)

– Request a Medicaid provider hearing
Peer-to-Peer Review

- The intent of a peer-to-peer review is to clarify the reason the PA request was denied or approved but modified.
- This is a verbal discussion between the requesting clinician and the clinician that reviewed the request for medical necessity.
- The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the peer-to-peer review.
- Additional information is not allowed to be presented because all medical information must be in writing and attached to the case.
- Must be requested within 10 business days of the denial.
- Peer-to-peer reviews can be requested by emailing nvpeer_to_peer@dxc.com.
- Only available for denials related to the medical necessity of the service.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
- Denied dates of service cannot be requested as a concurrent review. Those dates of service may only be appealed.
Reconsideration Request

- If the provider attempts to introduce new or additional clinical information, the peer-to-peer will be terminated and the provider will be advised to submit a reconsideration review.

- A reconsideration review is a one-time review of denied/modified services.

- Reconsiderations can be uploaded via the provider portal by completing an FA-29B form and uploading to the “File Exchange” on the Provider Web Portal.

- Change the start date and number of days requested to reflect only those days that were denied by the physician.

- Additional medical documentation is reviewed to support the medical necessity.

- The information is reviewed by a different clinician than the clinician who reviewed the original documentation.

- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
A reconsideration must be requested within 30 calendar days from the date of the denial, except for Residential Treatment Center (RTC) services, which must be requested within 90 calendar days.

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

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

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

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

- Discharge planning should begin on the date of admission.
- As the hospital stay continues, there should be evidence of comprehensive discharge planning. This would include where the recipient is going to be discharged and the services that will be recommended for the recipient after discharge. Please be specific regarding the type of locations and the types of service.
- There must be a legible and comprehensive psychiatric evaluation completed prior to the recipient’s discharge to facilitate coordination of care between the hospital and other agencies.
Residential Treatment Center (RTC) Referrals
Residential Treatment Center (RTC) Referrals

- A legible and comprehensive psychiatric evaluation is required prior to RTC admission.
- Prior to making an out-of-state RTC referral, please ensure that all in-state resources have been exhausted, including outpatient (OP) services and in-state RTCs.
- If there is a plan for the recipient to “transfer” to another RTC, the accepting RTC must document the services they can provide that the current RTC cannot provide.
- Recipients transferring to an out-of-state RTC must have a caseworker/case manager from the State of Nevada for oversight of services.
- Should the recipient have developmental delays that would prohibit them from rehabilitative services, those delays must be documented and include the most recent psychological or neuropsychological testing completed.
RTC Referrals, continued

- If referring a recipient to an RTC, document and provide explanations regarding any unspecified diagnosis codes.
- If the recipient is too violent to be placed in an enclosed and locked area with their peers, this is considered an exclusion to RTC placement.
- If the recipient has a developmental delay, including intellectual delays, this may be exclusionary to RTC placement based on the fact that the RTC level of care is rehabilitative.
- The recipient must have the ability to benefit from the rehabilitative RTC milieu.
- Review the Medicaid Services Manual Chapter 400 Section 403.8A.5: Criteria for Exclusion from RTC Admission, in order to see if the recipient meets criteria for placement.
Coverage and Limitations
Absences

– In special circumstances, Nevada Medicaid may allow up to an eight-hour pass from the acute hospital without denial of payment.

– Absences may include, but are not limited to:
  – A trial home visit
  – A respite visit with parents (in the case of a child)
  – A death in the immediate family

– The hospital must request prior authorization from Nevada Medicaid for an absence expected to last longer than eight hours.

– There must be a physician's order that a recipient is medically appropriate to leave on the pass and the therapeutic reason for the pass must be clearly documented in the chart prior to the issuance of the pass.

– Upon the recipient's return, the pass must be evaluated for therapeutic effect and the results clearly documented in the recipient’s chart.
Provider Responsibilities

Medicaid Form NMO-3058 (Admit/Discharge/Death Notice)

- All hospitals are required to submit Form NMO-3058 to their local Welfare District Office whenever a hospital admission, discharge or death occurs.

- Failure to submit this form could result in payment delay or denial.

- To obtain copies of Form 3058-SM, please contact the Welfare District Office or visit their website at https://dwss.nv.gov/uploadedFiles/dwssnv.gov/content/Home/Features/Forms_3058-SM.pdf
Reimbursement

- Nevada Medicaid reimburses for admissions certified by Nevada Medicaid to a:
  - Psychiatric unit of a general hospital, regardless of age; or
  - Psychiatric hospital (Institution for Mental Diseases) for recipients under age 21 or 65 or older.
- For recipients under age 21 who are in the custody of the public child welfare agency, Nevada Medicaid reimburses for inpatient mental health services only when:
  - The child welfare agency also approves the admission/placement (this does not apply to placements at State-owned and operated facilities); and
  - The admission is certified by the QIO-like vendor.
Reimbursement, continued

- Institutions for Mental Disease (IMD) — In accordance with 42 CFR 435.1009(2), Federal Financial Participation (FFP) is not available for individuals under the age of 65, unless they are under age 22 (or under 21 if they haven’t met the following):
  - Coverage of services for ages 21 up to 22 years – If a recipient is receiving services immediately prior to turning age 21, the services continue until:
    - The individual no longer requires the services or
    - The date the individual reaches 22.
  - In this extenuating circumstance, IMD service may continue until age 22. The regulation requires that the recipient must be receiving services immediately prior to age 21 and continuously up to age 22. Services cannot begin during the 21st year.
Reimbursement, continued

- Nevada Medicaid FFS shall not reimburse for any service for individuals who are ages 22-64 that are in an IMD which is defined as:
  - A hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.
  - Whether an institution is an IMD is determined by its overall character being that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.
- Medicare crossover claims involving recipients ages 22-64 (or 21-64), in free-standing psychiatric hospitals, or IMDs, are reimbursable only if the recipient is a QMB — in these instances Medicaid may reimburse for copays and/or deductibles for Qualified Medicare Beneficiaries (QMB) while in an IMD up to the Medicaid allowable amount.
- However, QMB claims denied by Medicare are also denied by Nevada Medicaid.
Reimbursement if Prior Resources Involved

- Pursuant to federal law, Medicaid is the payer of last resort whenever any other resources may be responsible for payment.

- Prior resources include but are not limited to:
  - Medicare
  - Labor Unions
  - Worker’s Compensation Insurance carriers
  - Private/group insurances
  - CHAMPUS

- Exceptions where Medicaid is primary instead are:
  - Bureau of Family Health Services
  - Indian Health Services
  - Ryan White Act and Victims of Crime
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
Contact Nevada Medicaid
Contact Nevada Medicaid

- Nevada Medicaid Prior Authorization Department: 800-525-2395
- Customer Service Call Center: 877-638-3472 (Monday through Friday 8 a.m. to 5 p.m. Pacific Time)
- Nevada Provider Training: NevadaProviderTraining@dxc.com
Thank You