Psychiatric Hospital, Inpatient - Provider Type 13

Nevada Medicaid Provider Training

2020

Objectives

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- Recipient Eligibility
- Recipient Eligibility via the Electronic Verification System (EVS)
- Medicare Eligibility
- Prior Authorization Submission Guidelines
- Prior Authorization (PA) Processes
- Prior Authorization (PA) Information
- Retrospective Authorizations and Documentation
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- 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
- Submit a Claim to Nevada Medicaid via Direct Data Entry (DDE)
- Resources
- Contact Nevada Medicaid

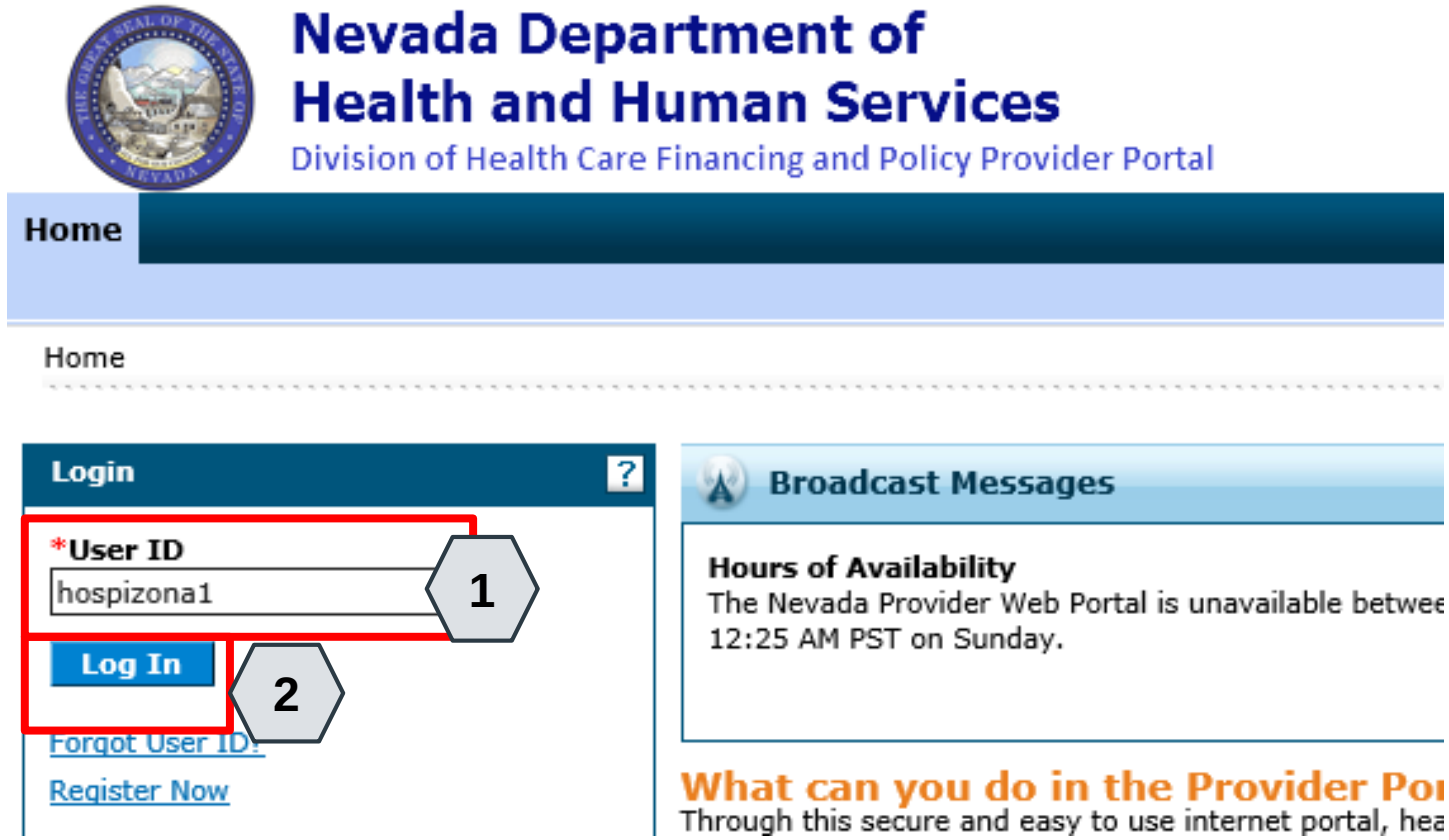
Recipient Eligibility

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 Fee-for Service (FFS) recipients who are younger than 21 years of age or older than 64 years of age, and Qualified Medicare Beneficiaries (QMB) of any age. Medicare crossover claims involving recipients ages 21 to 64 in freestanding psychiatric hospitals are reimbursable only if the recipient is a QMB.
- 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)

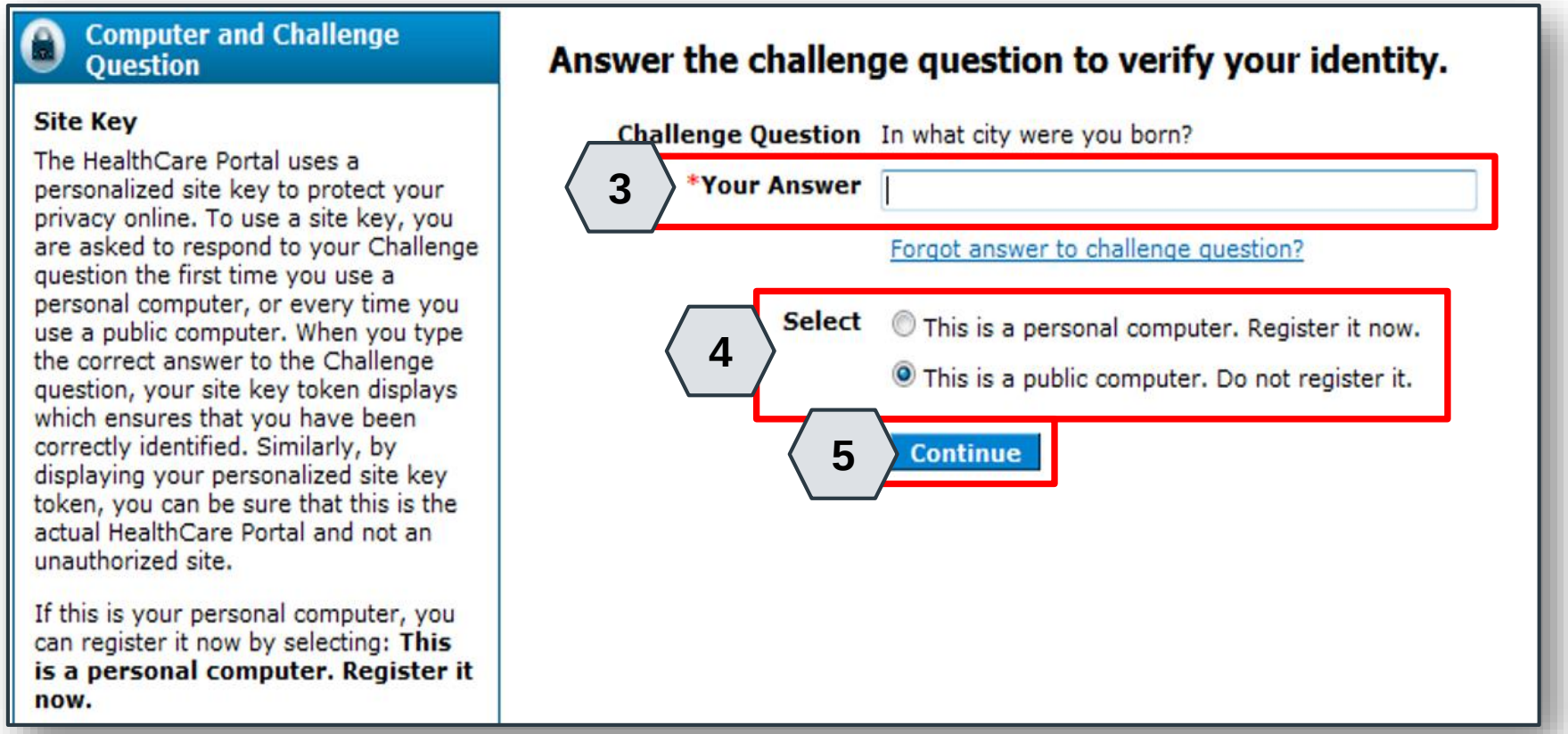
Navigating the Provider Web Portal (PWP)



- Once registered, users may access their accounts from the PWP “Home” page by:

1. Entering the User ID.
2. Clicking the Log In button.

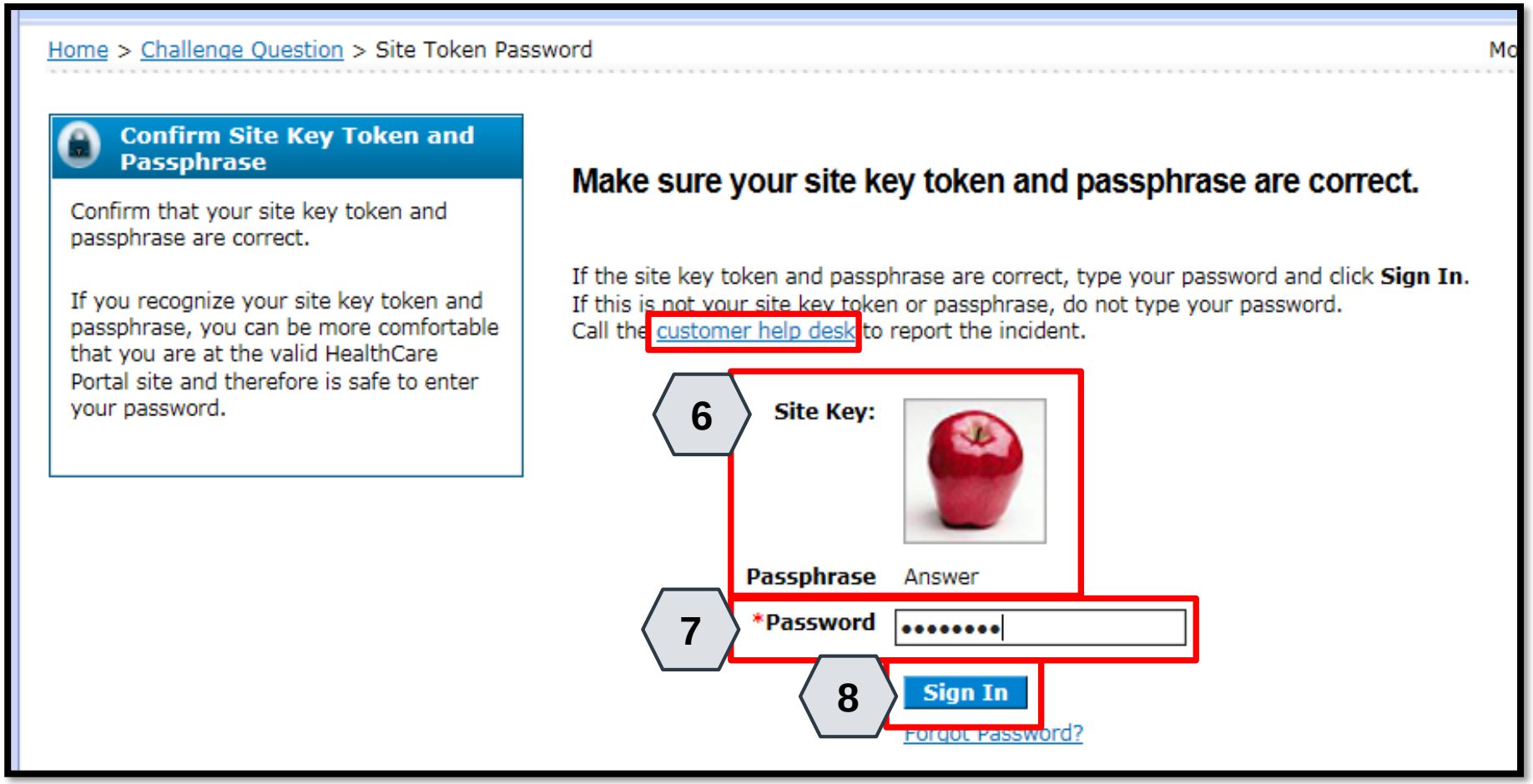
Navigating the PWP, continued



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



The user will continue providing identity verification:

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.

Navigating the PWP, continued

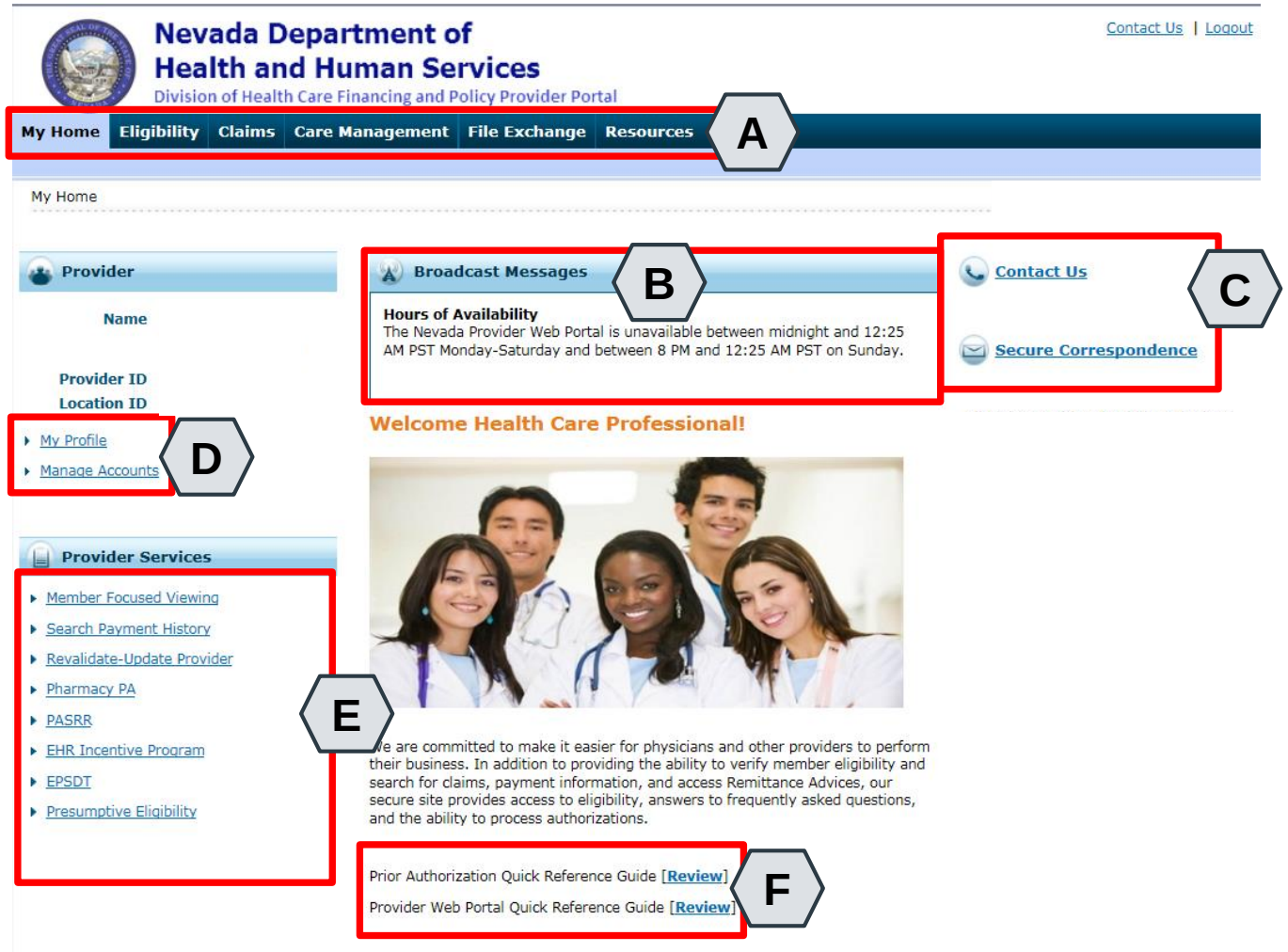
Once the user has provided identity verification and entered their password, the “My Home” page will display.

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.

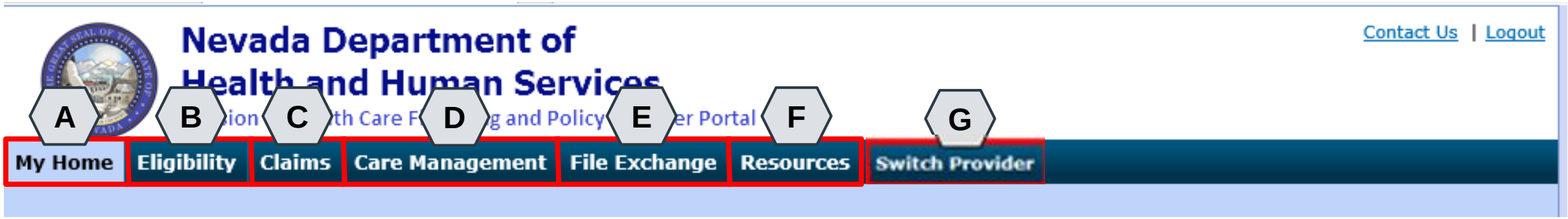
Navigating the PWP, continued



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



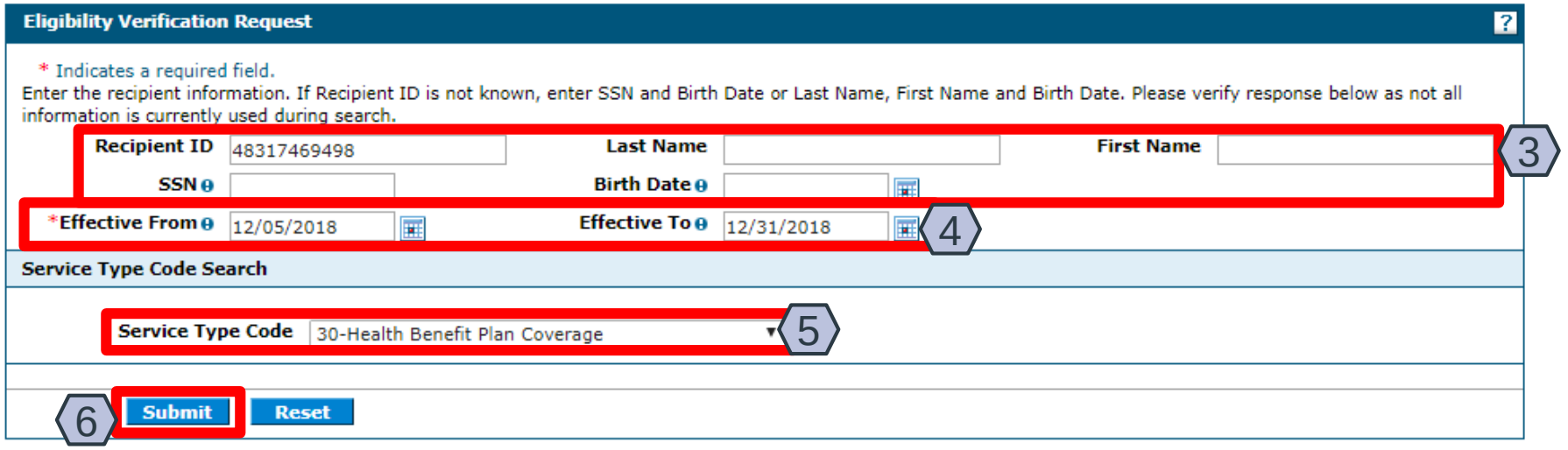
The tabs at the top of the page provide users quick access to helpful pages and information:

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.**

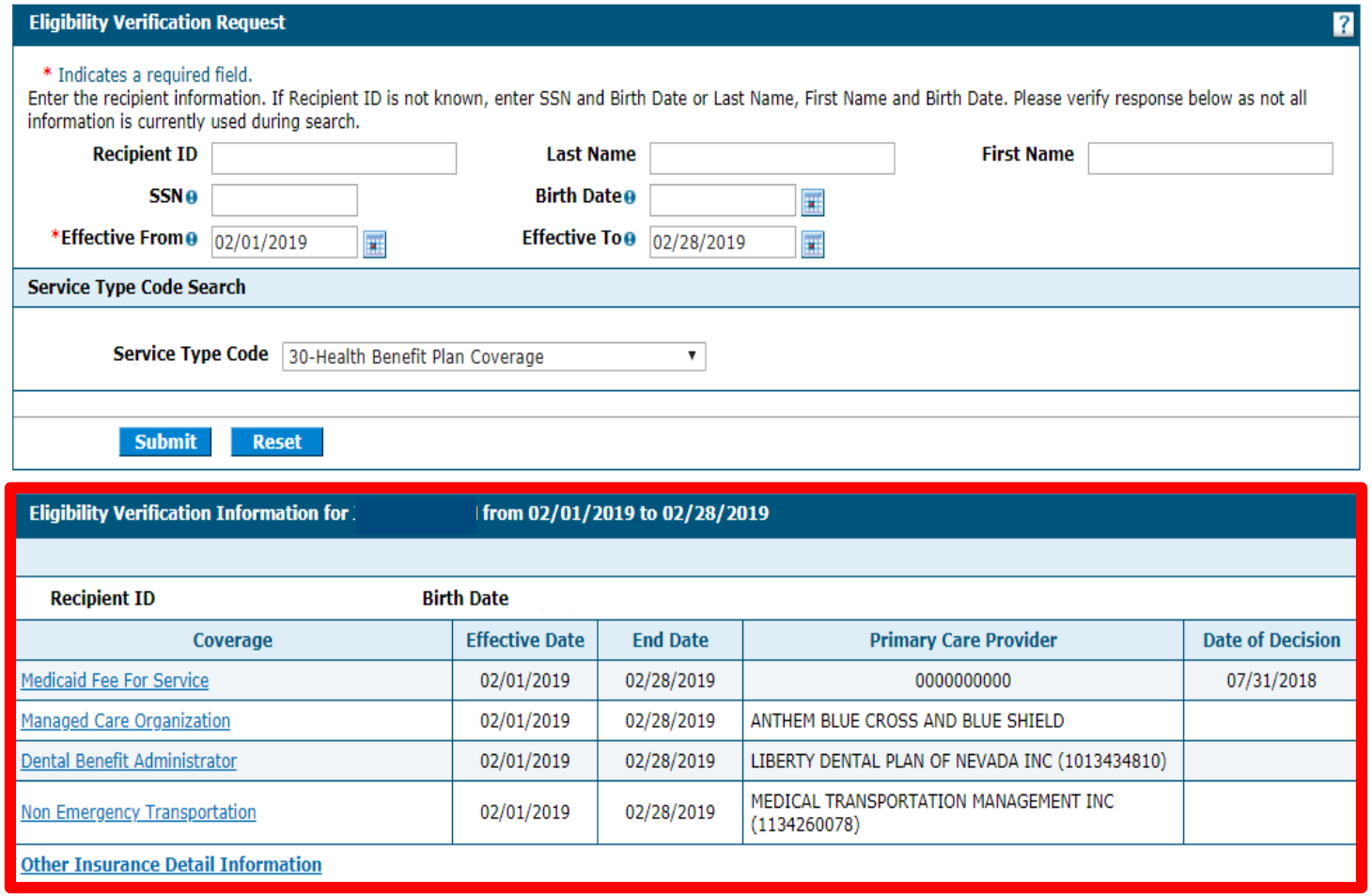
Searching for a Member's Benefit Eligibility, continued



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



Eligibility Verification Request

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date or Last Name, First Name and Birth Date. Please verify response below as not all information is currently used during search.

Recipient ID | Last Name | First Name
SSN | Birth Date
*Effective From 02/01/2019 | Effective To 02/28/2019

Service Type Code Search

Service Type Code: 30-Health Benefit Plan Coverage

Submit | Reset

Eligibility Verification Information for from 02/01/2019 to 02/28/2019

Recipient ID | Birth Date

Coverage	Effective Date	End Date	Primary Care Provider	Date of Decision
Medicaid Fee For Service	02/01/2019	02/28/2019	0000000000	07/31/2018
Managed Care Organization	02/01/2019	02/28/2019	ANTHEM BLUE CROSS AND BLUE SHIELD	
Dental Benefit Administrator	02/01/2019	02/28/2019	LIBERTY DENTAL PLAN OF NEVADA INC (1013434810)	
Non Emergency Transportation	02/01/2019	02/28/2019	MEDICAL TRANSPORTATION MANAGEMENT INC (1134260078)	

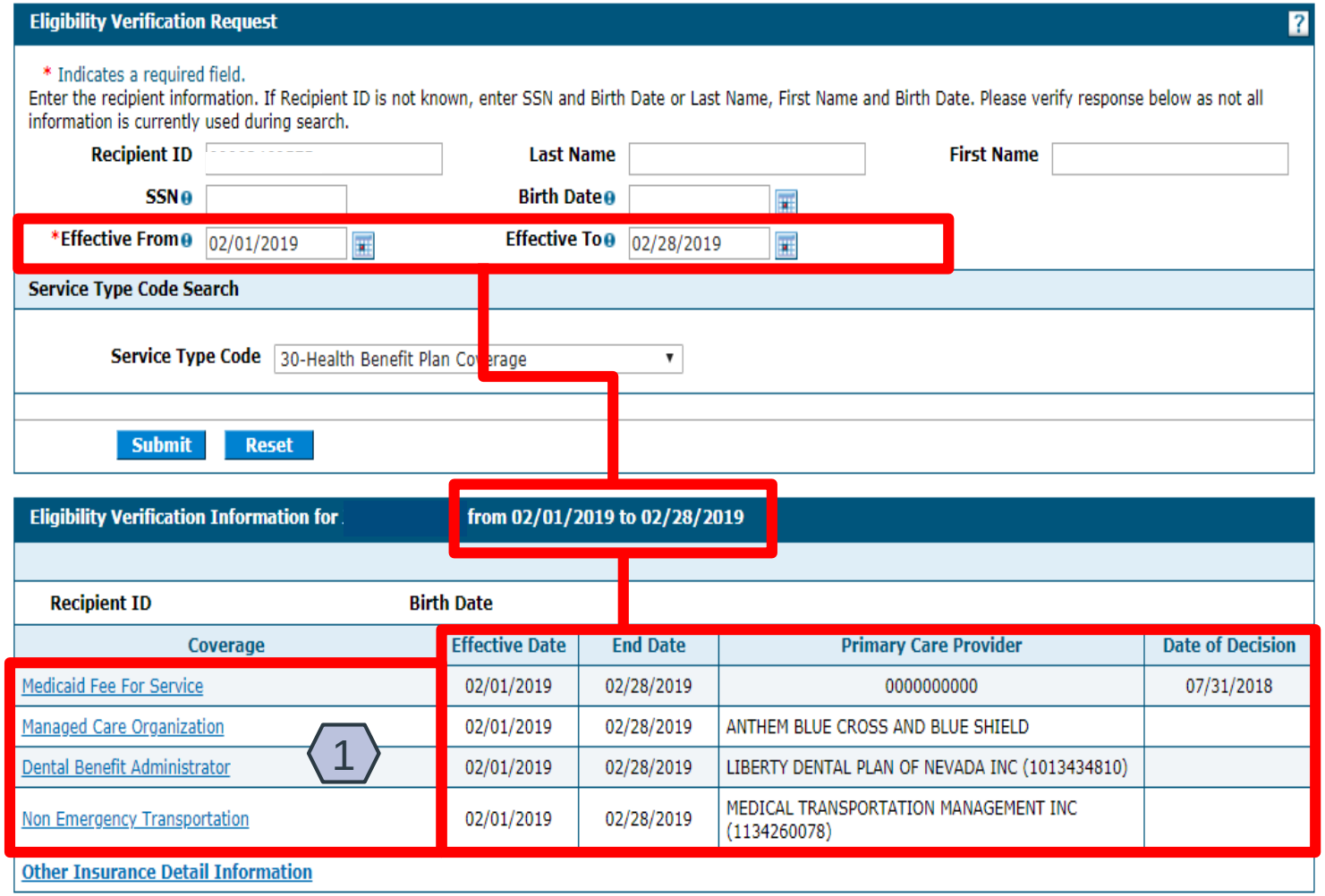
Other Insurance Detail Information

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 with links 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.

Viewing a Member's Benefit Details, continued

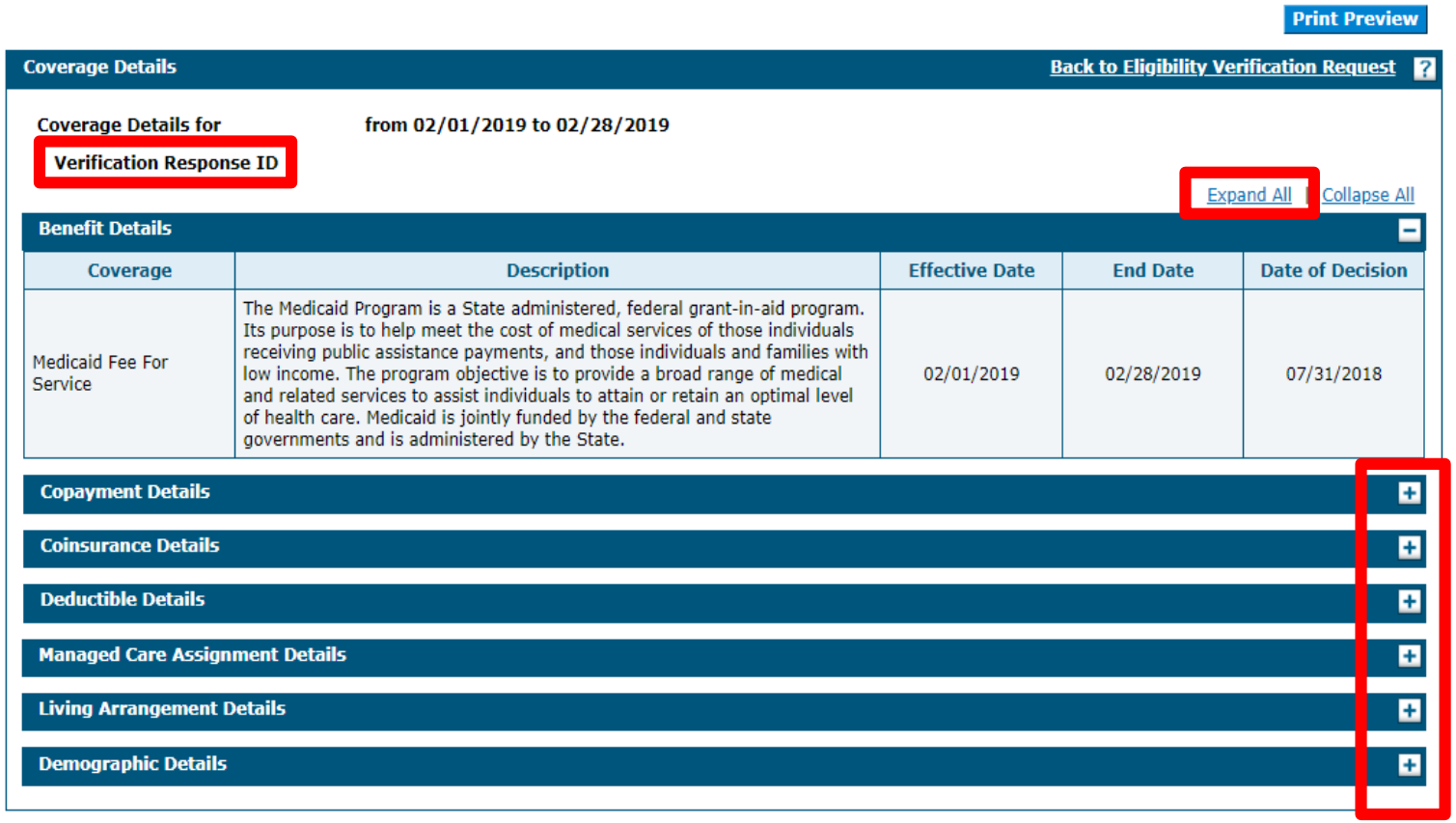


From the **Eligibility Verification Request** panel:

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.

Viewing a Member's Benefit Details, continued



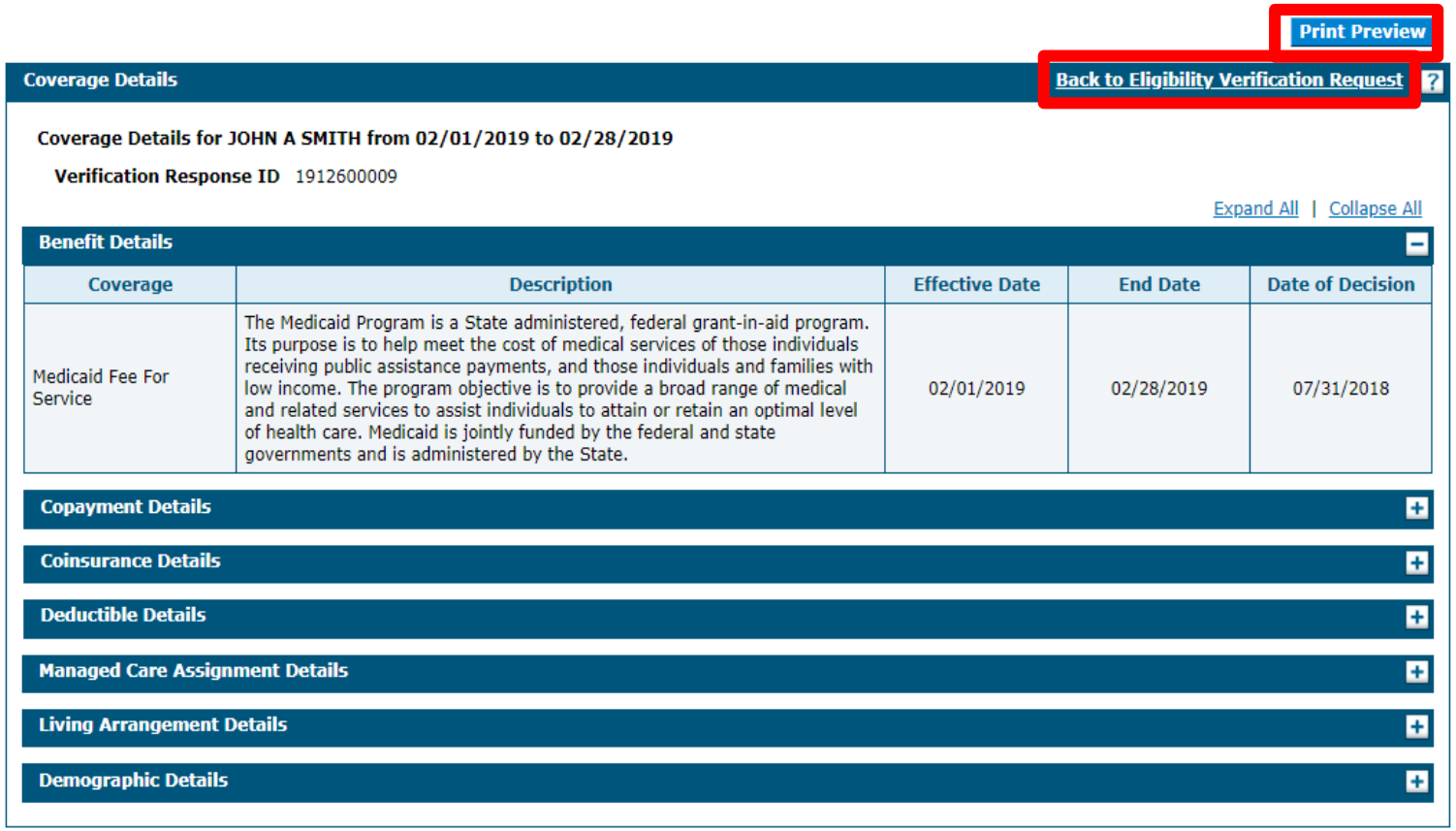
NOTE: Log the **Verification Response ID** for future reference. The ID identifies this specific eligibility verification instance.

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.

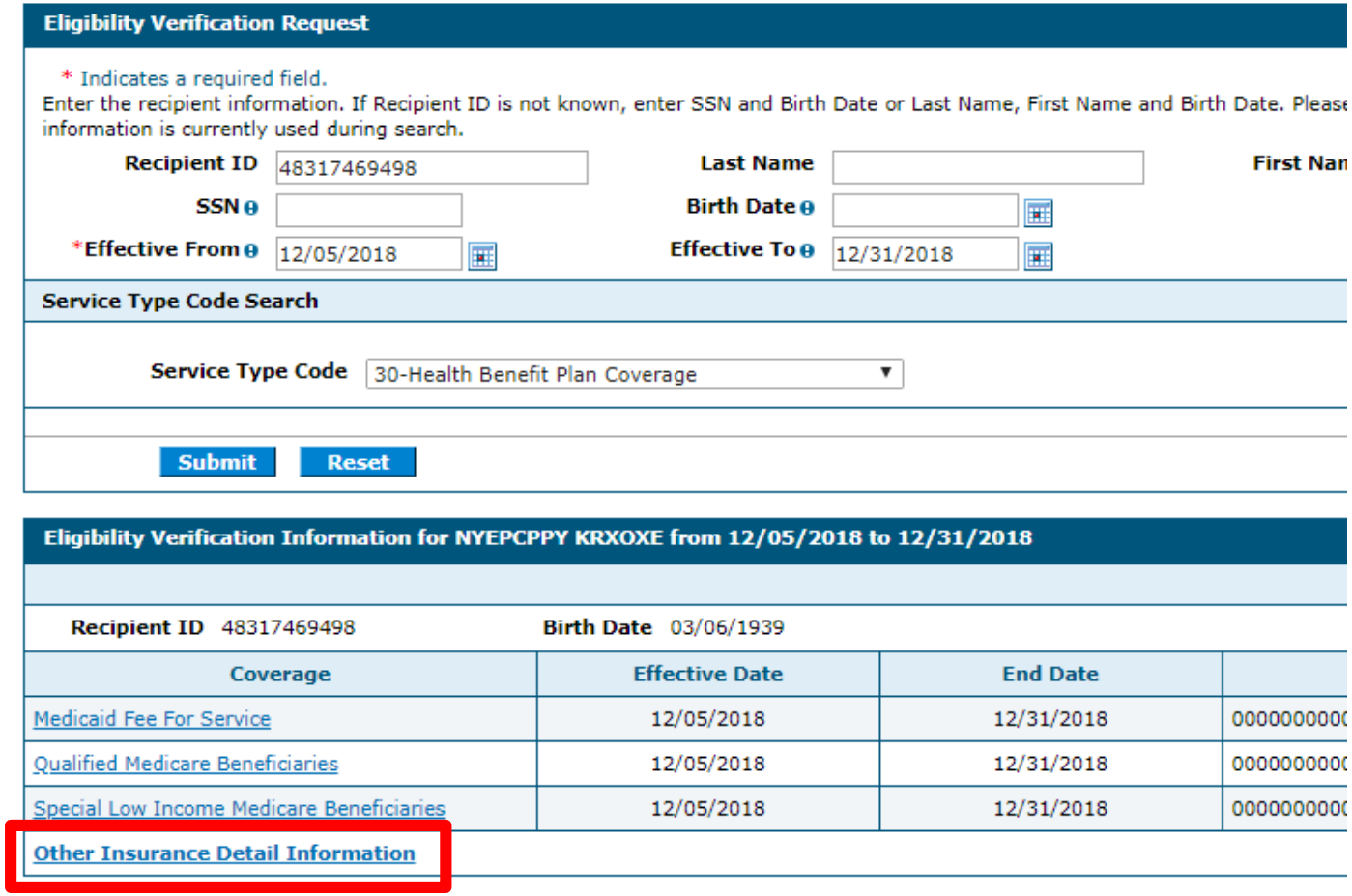
Viewing a Member's Benefit Details, continued



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.

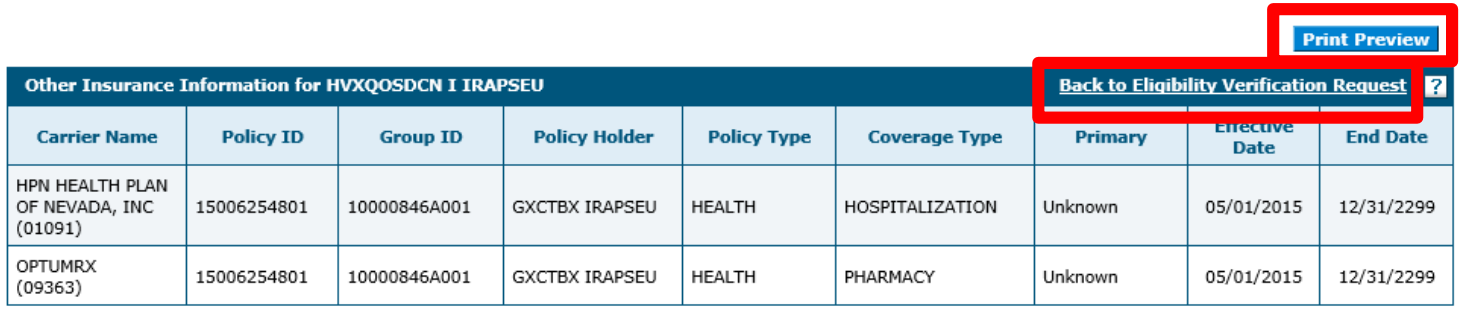
The user may also click the **Back to Eligibility Verification Request** link to return to the results page and view third-party details for the member.

Viewing a Member's Third-Party Coverage

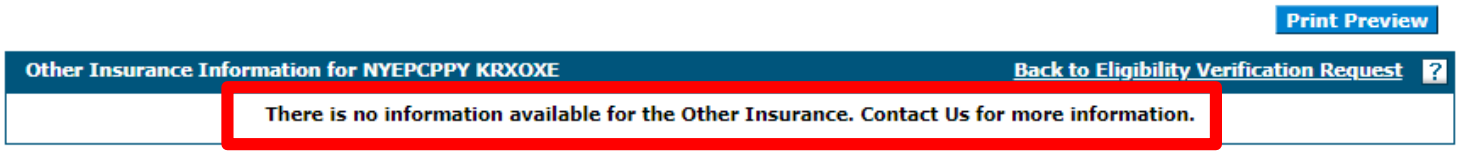


From the results display below the **Eligibility Verification Request** panel, select the **Other Insurance Detail Information** link to view third-party coverage benefits.

Viewing a Member's Third-Party Coverage, continued



Carrier Name	Policy ID	Group ID	Policy Holder	Policy Type	Coverage Type	Primary	Effective Date	End Date
HPN HEALTH PLAN OF NEVADA, INC (01091)	15006254801	10000846A001	GXCTBX IRAPSEU	HEALTH	HOSPITALIZATION	Unknown	05/01/2015	12/31/2299
OPTUMRX (09363)	15006254801	10000846A001	GXCTBX IRAPSEU	HEALTH	PHARMACY	Unknown	05/01/2015	12/31/2299



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

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.

Medicare Eligibility

Medicare Eligibility

- When submitting a prior authorization 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.

Prior Authorization Submission Guidelines

Prior Authorization 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 five business days after admission.
- Requests for the initial stay may not exceed seven (7) days, except for retrospective reviews.
- Concurrent requests (form FA-14) must be received within five business days of the last day of the current/existing authorization period.
- 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 and Additional Information

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.
- Per Medicaid Services Manual Chapter 200, section 203:
  - The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, long-term acute care (LTAC) specialty, inpatient rehabilitation specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor must make a determination regarding the availability of such services at the referring hospital or within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being available at the transferring facility.
  - It is always the receiving hospital’s responsibility to confirm with the QIO-like vendor whether the transferring physician/hospital obtained authorization for a non-emergent transfer from the QIO-like vendor prior to the transfer and prior to the receiving hospital’s agreeing to accept/admit the recipient.

Prior Authorization Process, continued

- 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 five business days after the admission.
- 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

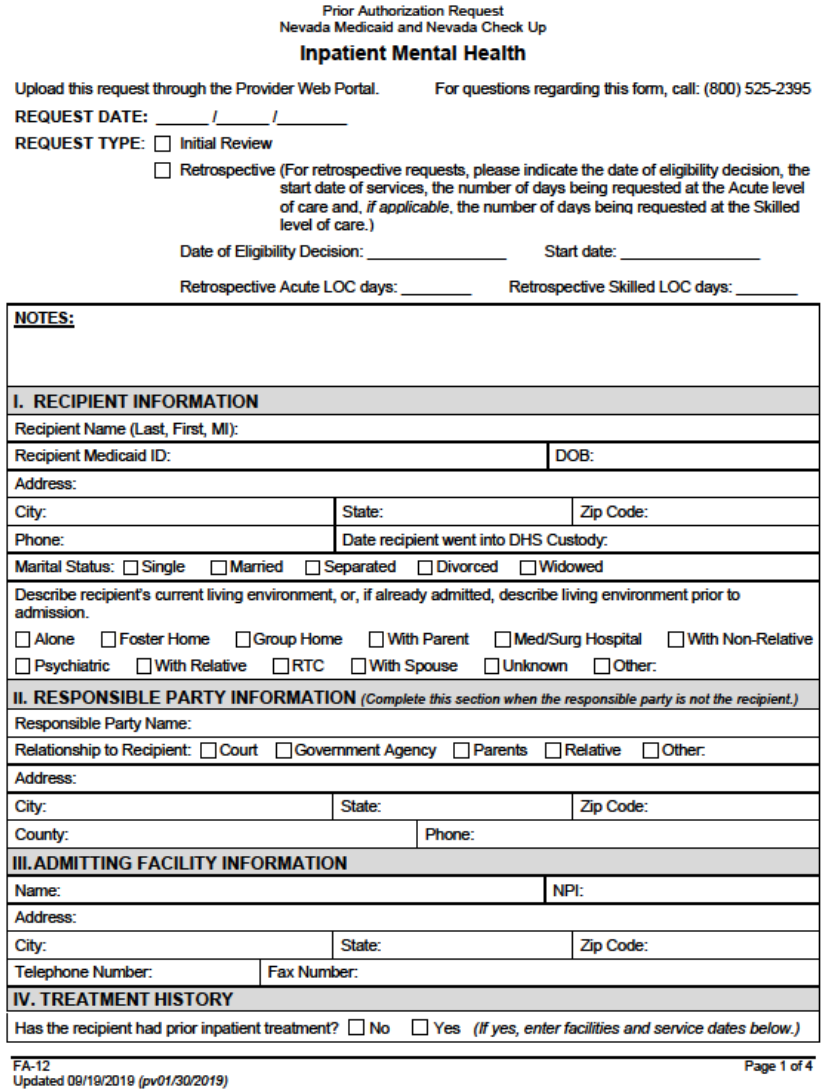
- The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement.
- In addition, when a recipient remains hospitalized longer than seven days the attending physician must document the medical necessity of each additional inpatient day.
- 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, 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

- Form FA-12 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 be filled out completely and is continued on Page 2.



Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Inpatient Mental Health

Upload this request through the Provider Web Portal. For questions regarding this form, call: (800) 525-2395

REQUEST DATE: _____/_____/_____

REQUEST TYPE: ☐ Initial Review

☐ Retrospective (For retrospective requests, please indicate the date of eligibility decision, the start date of services, the number of days being requested at the Acute level of care and, *if applicable*, the number of days being requested at the Skilled level of care.)

Date of Eligibility Decision: _____ Start date: _____

Retrospective Acute LOC days: _____ Retrospective Skilled LOC days: _____

NOTES:

I. RECIPIENT INFORMATION

Recipient Name (Last, First, MI):

Recipient Medicaid ID: | DOB:

Address:

City: | State: | Zip Code:

Phone: | Date recipient went into DHS Custody:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Describe recipient's current living environment, or, if already admitted, describe living environment prior to admission.

☐ Alone ☐ Foster Home ☐ Group Home ☐ With Parent ☐ Med/Surg Hospital ☐ With Non-Relative
☐ Psychiatric ☐ With Relative ☐ RTC ☐ With Spouse ☐ Unknown ☐ Other:

II. RESPONSIBLE PARTY INFORMATION *(Complete this section when the responsible party is not the recipient.)*

Responsible Party Name:

Relationship to Recipient: ☐ Court ☐ Government Agency ☐ Parents ☐ Relative ☐ Other:

Address:

City: | State: | Zip Code:

County: | Phone:

III. ADMITTING FACILITY INFORMATION

Name: | NPI:

Address:

City: | State: | Zip Code:

Telephone Number: | Fax Number:

IV. TREATMENT HISTORY

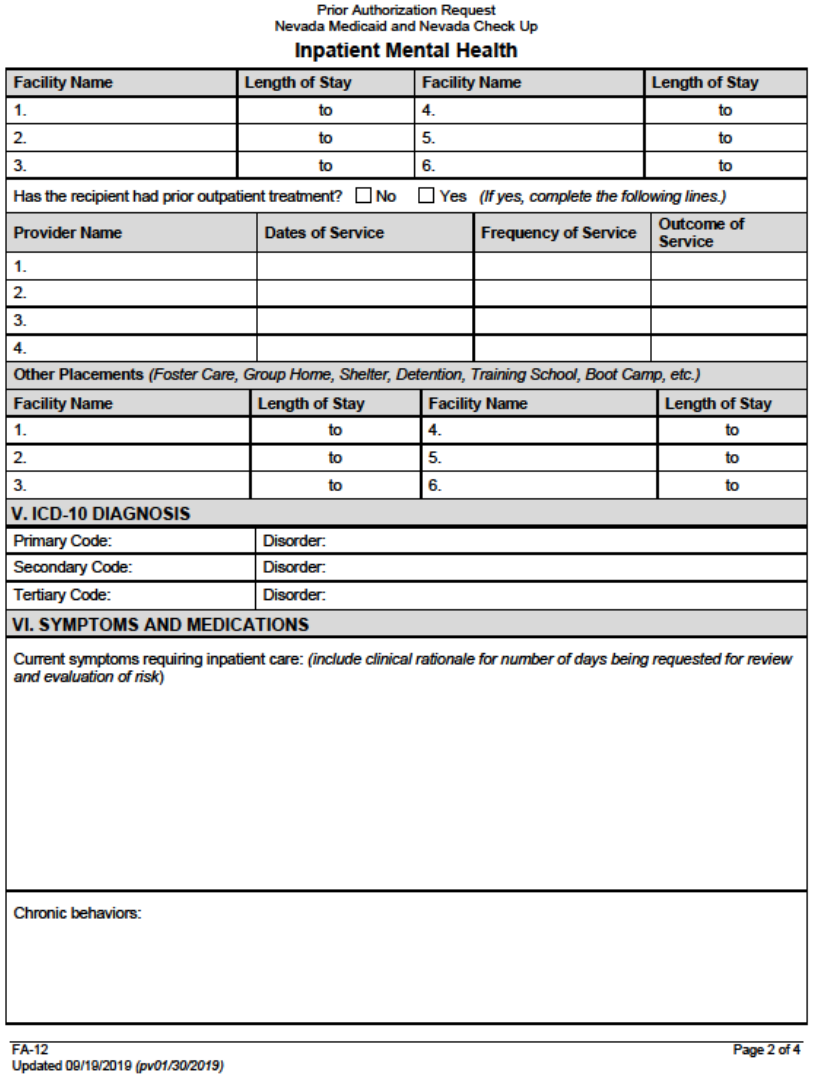
Has the recipient had prior inpatient treatment? ☐ No ☐ Yes *(If yes, enter facilities and service dates below.)*

FA-12
Updated 09/19/2019 *(pv01/30/2019)*

Page 1 of 4

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

Facility Name	Length of Stay	Facility Name	Length of Stay
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

Has the recipient had prior outpatient treatment? ☐ No ☐ Yes *(If yes, complete the following lines.)*

Provider Name	Dates of Service	Frequency of Service	Outcome of Service
1.			
2.			
3.			
4.			

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

Facility Name	Length of Stay	Facility Name	Length of Stay
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

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)*

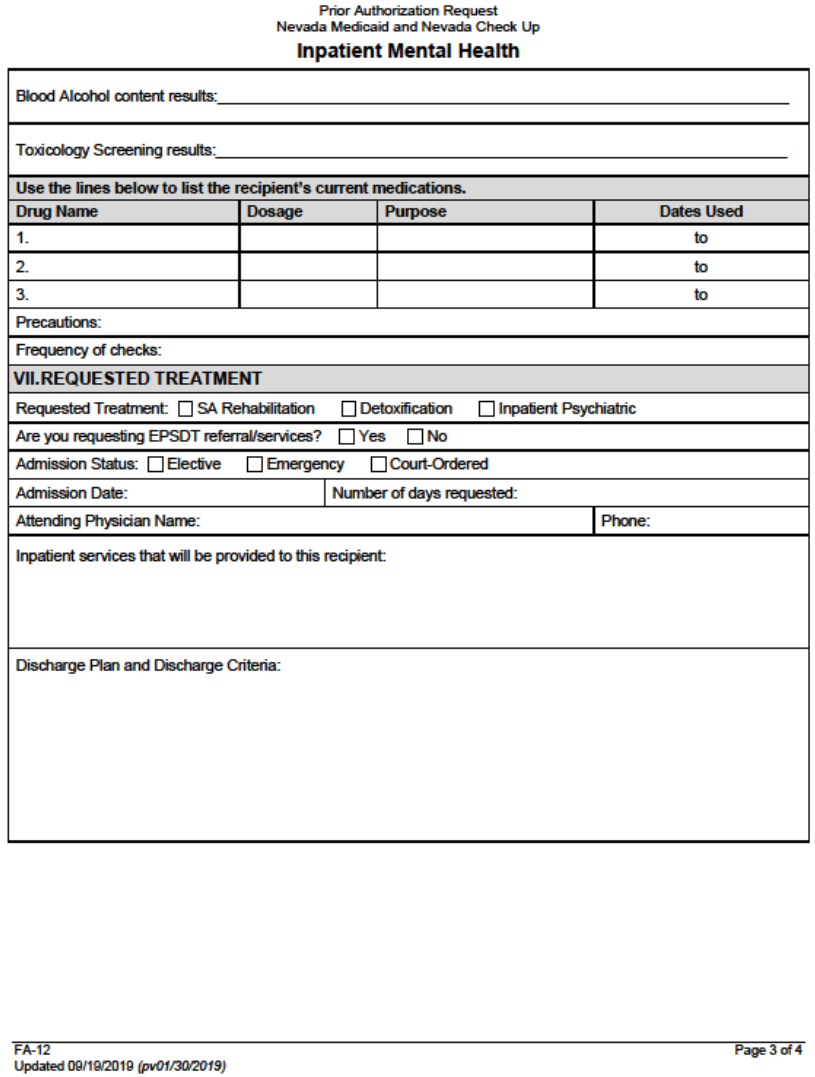
Chronic behaviors:

FA-12
Updated 09/19/2019 *(pv01/30/2019)*

Page 2 of 4

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 Request
Nevada Medicaid and Nevada Check Up

Inpatient Mental Health

Blood Alcohol content results:_____

Toxicology Screening results:_____

Use the lines below to list the recipient's current medications.

Drug Name	Dosage	Purpose	Dates Used
1.			to
2.			to
3.			to

Precautions:

Frequency of checks:

VII. REQUESTED TREATMENT

Requested Treatment: ☐ SA Rehabilitation ☐ Detoxification ☐ Inpatient Psychiatric

Are you requesting EPSDT referral/services? ☐ Yes ☐ No

Admission Status: ☐ Elective ☐ Emergency ☐ Court-Ordered

Admission Date: | Number of days requested:

Attending Physician Name: | Phone:

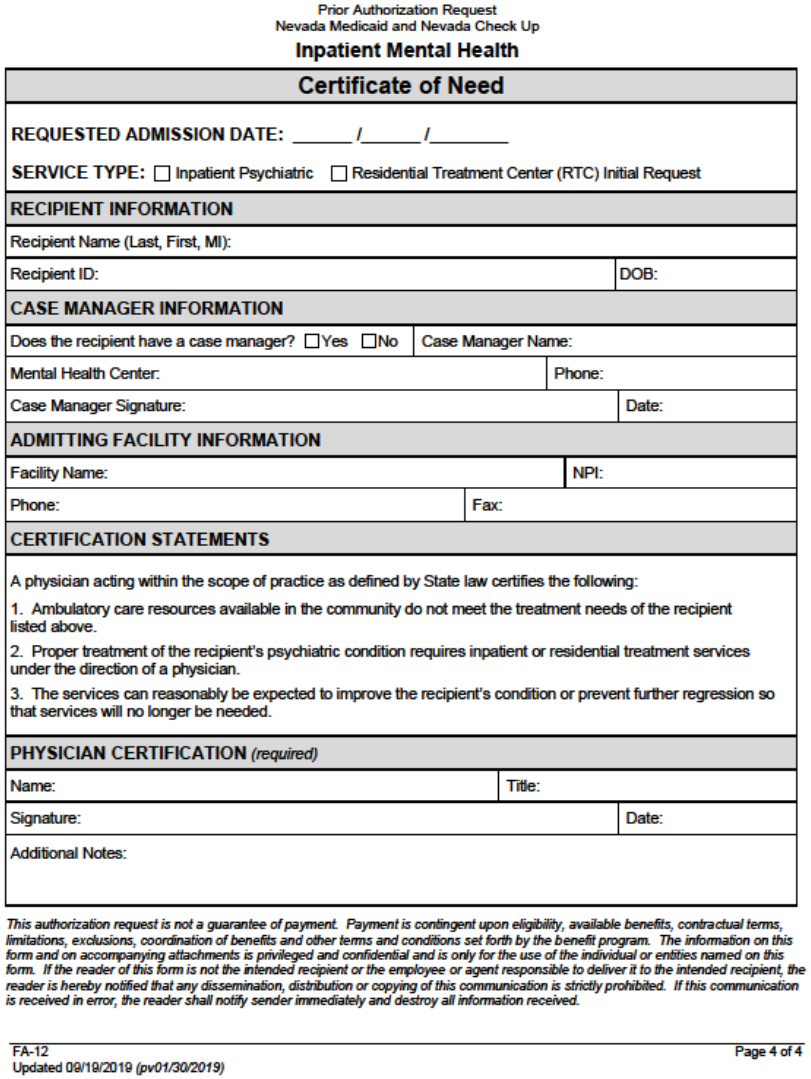
Inpatient services that will be provided to this recipient:

Discharge Plan and Discharge Criteria:

FA-12 Page 3 of 4
Updated 09/19/2019 *(pv01/30/2019)*

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 Request
Nevada Medicaid and Nevada Check Up

Inpatient Mental Health

Certificate of Need

REQUESTED ADMISSION DATE: _____/_____/_____

SERVICE TYPE: ☐ Inpatient Psychiatric ☐ Residential Treatment Center (RTC) Initial Request

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):	
Recipient ID:	DOB:

CASE MANAGER INFORMATION

Does the recipient have a case manager? ☐Yes ☐No	Case Manager Name:
Mental Health Center:	Phone:
Case Manager Signature:	Date:

ADMITTING FACILITY INFORMATION

Facility Name:	NPI:
Phone:	Fax:

CERTIFICATION STATEMENTS

A physician acting within the scope of practice as defined by State law certifies the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient listed above.
2. Proper treatment of the recipient's psychiatric condition requires inpatient or residential treatment services under the direction of a physician.
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

PHYSICIAN CERTIFICATION *(required)*

Name:	Title:
Signature:	Date:
Additional Notes:	

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

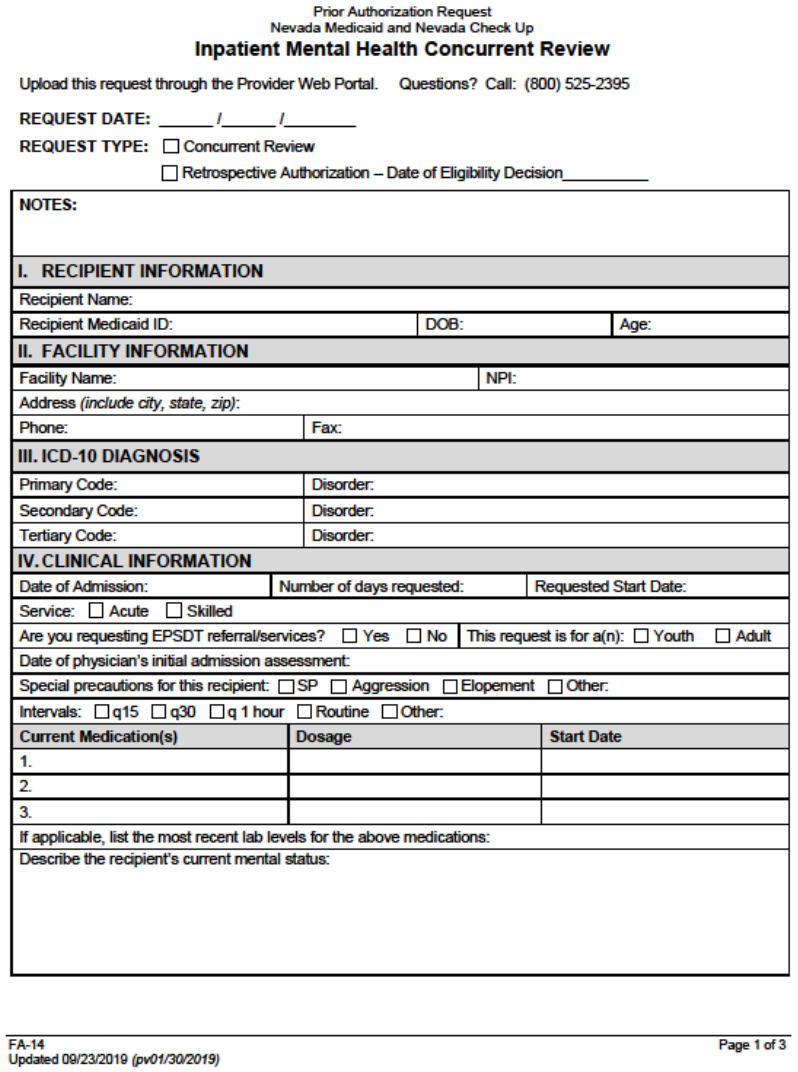
FA-12 Page 4 of 4
Updated 09/19/2019 *(pv01/30/2019)*

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 are 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)**



Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Inpatient Mental Health Concurrent Review

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

REQUEST DATE: _____ /_____ /_____

REQUEST TYPE: ☐ Concurrent Review
☐ Retrospective Authorization – Date of Eligibility Decision_____

NOTES:		
I. RECIPIENT INFORMATION		
Recipient Name:		
Recipient Medicaid ID:	DOB:	Age:
II. FACILITY INFORMATION		
Facility Name:	NPI:	
Address *(include city, state, zip)*:		
Phone:	Fax:	
III. ICD-10 DIAGNOSIS		
Primary Code:	Disorder:	
Secondary Code:	Disorder:	
Tertiary Code:	Disorder:	
IV. CLINICAL INFORMATION		
Date of Admission:	Number of days requested:	Requested Start Date:
Service: ☐ Acute ☐ Skilled		
Are you requesting EPSDT referral/services? ☐ Yes ☐ No	This request is for a(n): ☐ Youth ☐ Adult	
Date of physician's initial admission assessment:		
Special precautions for this recipient: ☐ SP ☐ Aggression ☐ Elopement ☐ Other:		
Intervals: ☐ q15 ☐ q30 ☐ q 1 hour ☐ Routine ☐ Other:		

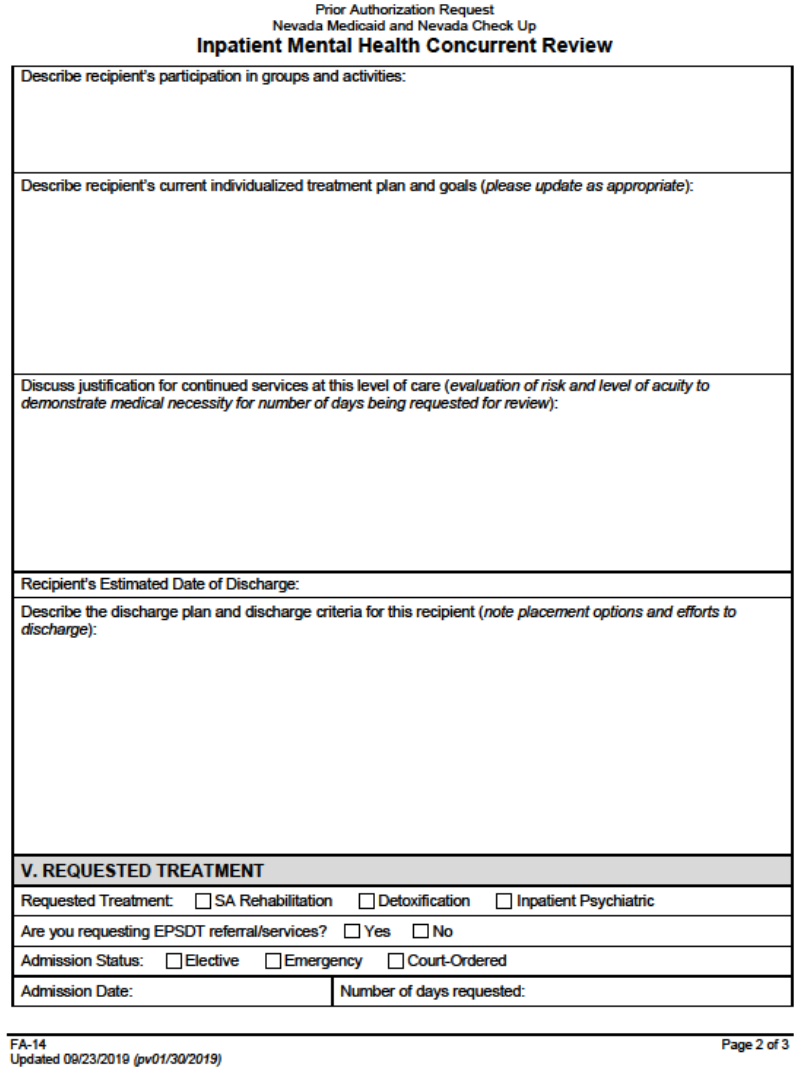
Current Medication(s)	Dosage	Start Date
1.		
2.		
3.		

If applicable, list the most recent lab levels for the above medications:
Describe the recipient's current mental status:

FA-14
Updated 09/23/2019 *(pv01/30/2019)*
Page 1 of 3

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.
- **Section V**
  - Input the treatment you are requesting for the recipient on pages 2 and 3 of the form.



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

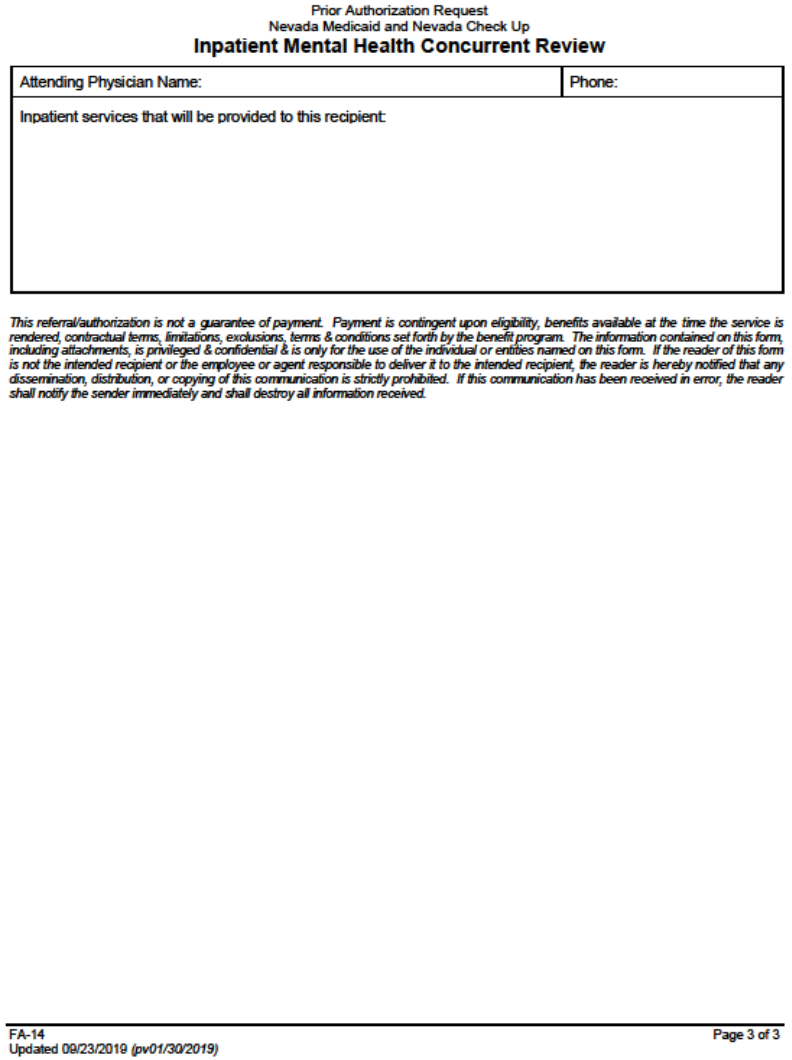
Describe recipient's participation in groups and activities:
Describe recipient's current individualized treatment plan and goals (*please update as appropriate*):
Discuss justification for continued services at this level of care (*evaluation of risk and level of acuity to demonstrate medical necessity for number of days being requested for review*):
Recipient's Estimated Date of Discharge:
Describe the discharge plan and discharge criteria for this recipient (*note placement options and efforts to discharge*):

V. REQUESTED TREATMENT	
Requested Treatment: ☐ SA Rehabilitation ☐ Detoxification ☐ Inpatient Psychiatric	
Are you requesting EPSDT referral/services? ☐ Yes ☐ No	
Admission Status: ☐ Elective ☐ Emergency ☐ Court-Ordered	
Admission Date:	Number of days requested:

FA-14 Page 2 of 3
Updated 09/23/2019 *(pv01/30/2019)*

Prior Authorization Information, FA-14, continued

- **Section V, continued**
  - List/describe the inpatient services that you are requesting for the recipient.



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

Attending Physician Name:	Phone:
Inpatient services that will be provided to this recipient:	

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

FA-14 Page 3 of 3
Updated 09/23/2019 *(pv01/30/2019)*

Retrospective Authorizations

Retrospective Authorizations

- Nevada Medicaid authorizes only Medicaid-eligible recipients, 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.

Prior Authorization Forms

All prior authorization forms are for completion and submission by current Medicaid providers only.

Form Number	Title
FA-1	Durable Medical Equipment Prior Authorization Request
FA-1A	Usage Evaluation for Continuing Use of BIPAP and CPAP Devices
FA-1B	Mobility Assessment and Prior Authorization (PA), Revised 12/29/10
FA-1B Instructions	Mobility Assessment and Prior Authorization (PA) Instructions
FA-1C	Oxygen Equipment and Supplies Prior Authorization Request
FA-1D	Wheelchair Repair Form
FA-3	Inpatient Rehabilitation Referral/Assignment
FA-4	Long Term Acute Care Prior Authorization
FA-6	Outpatient Medical/Surgical Services Prior Authorization Request
FA-7	Outpatient Rehabilitation and Therapy Services Prior Authorization Request
FA-8	Inpatient Medical/Surgical Prior Authorization Request
FA-8A	Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections
FA-9	Ocular Services or Medical Nutrition Therapy Services Prior Authorization Request
FA-10A	Psychological Testing
FA-10B	Neuropsychological Testing
FA-10C	Developmental Testing
FA-10D	Neurobehavioral Status Exam
FA-11	Outpatient Mental Health Request
FA-11A	Behavioral Health Authorization
FA-11D	Substance Abuse/Behavioral Health Authorization Request
FA-11E	Applied Behavior Analysis (ABA) Authorization Request
FA-11F	Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services
FA-12	Inpatient Mental Health Prior Authorization
FA-13	Residential Treatment Center Concurrent Review
FA-13A	RTC Therapeutic Home Pass Form
FA-14	Inpatient Mental Health Services Concurrent Review Request
FA-15	Residential Treatment Center Prior Authorization

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.

Clinical Documentation, continued

– 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.

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

Edit | View Provider Request | Print Preview

Skilled Days

Skilled Days

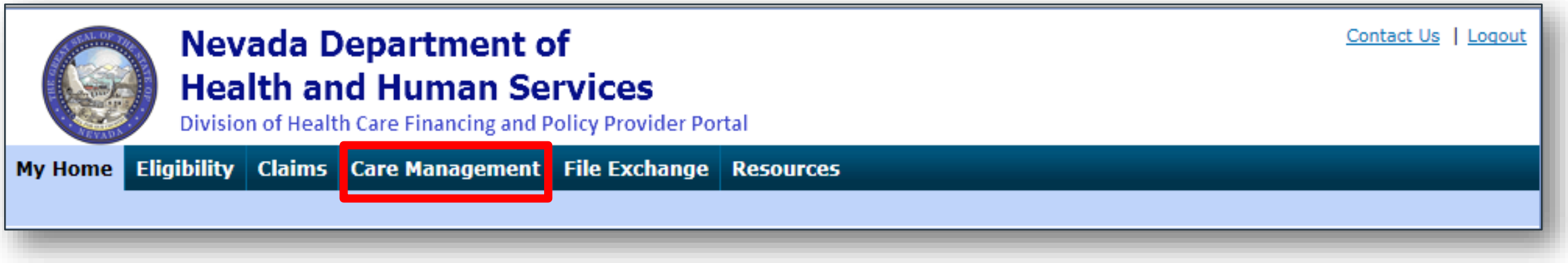
- Skilled Days do not need to be denied first at the acute level of care, but can be submitted as concurrent days.
- If the provider does not appeal an adverse decision, a request can be made for the denied dates of service at a lower level of care.
- When submitting a reconsideration review, additional 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

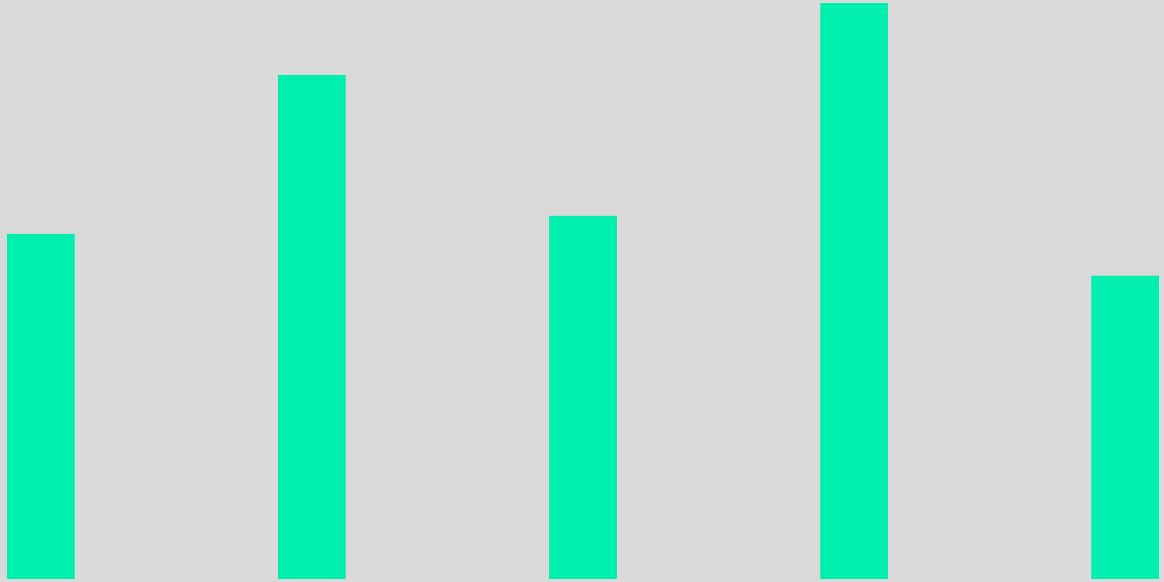
View Authorization Status

- 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

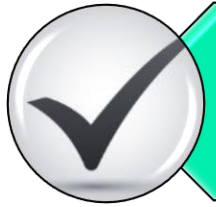
Before Creating an Authorization Request



Before Creating a Prior Authorization Request

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

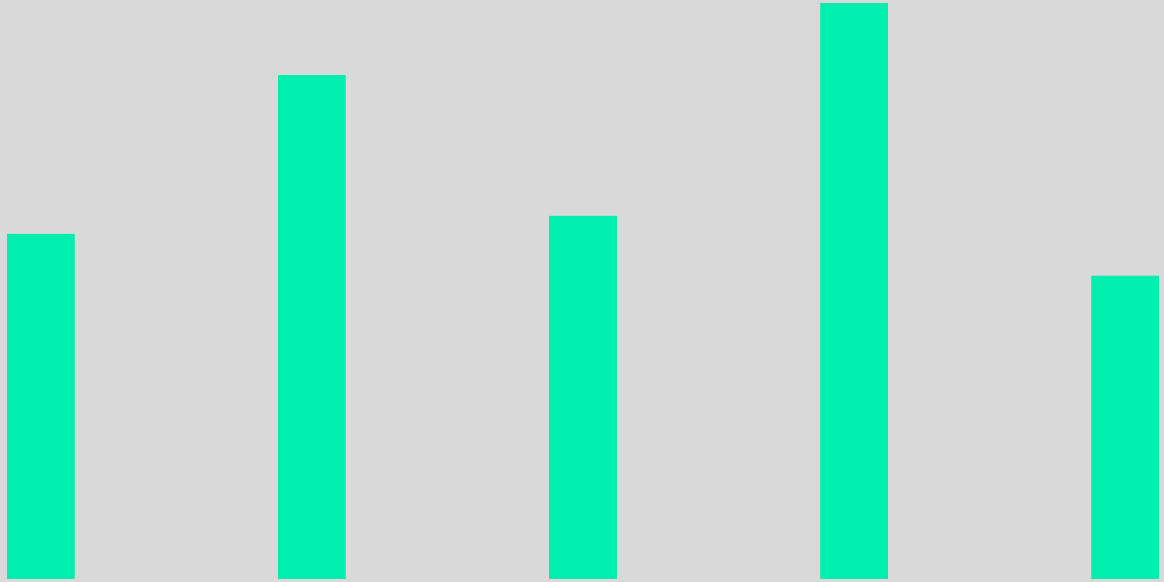
Use the Provider Web Portal's PA search function to see if a request for the dates of service, units and service(s) already exists and is associated with your individual, state or local agency, or corporate or business entity.



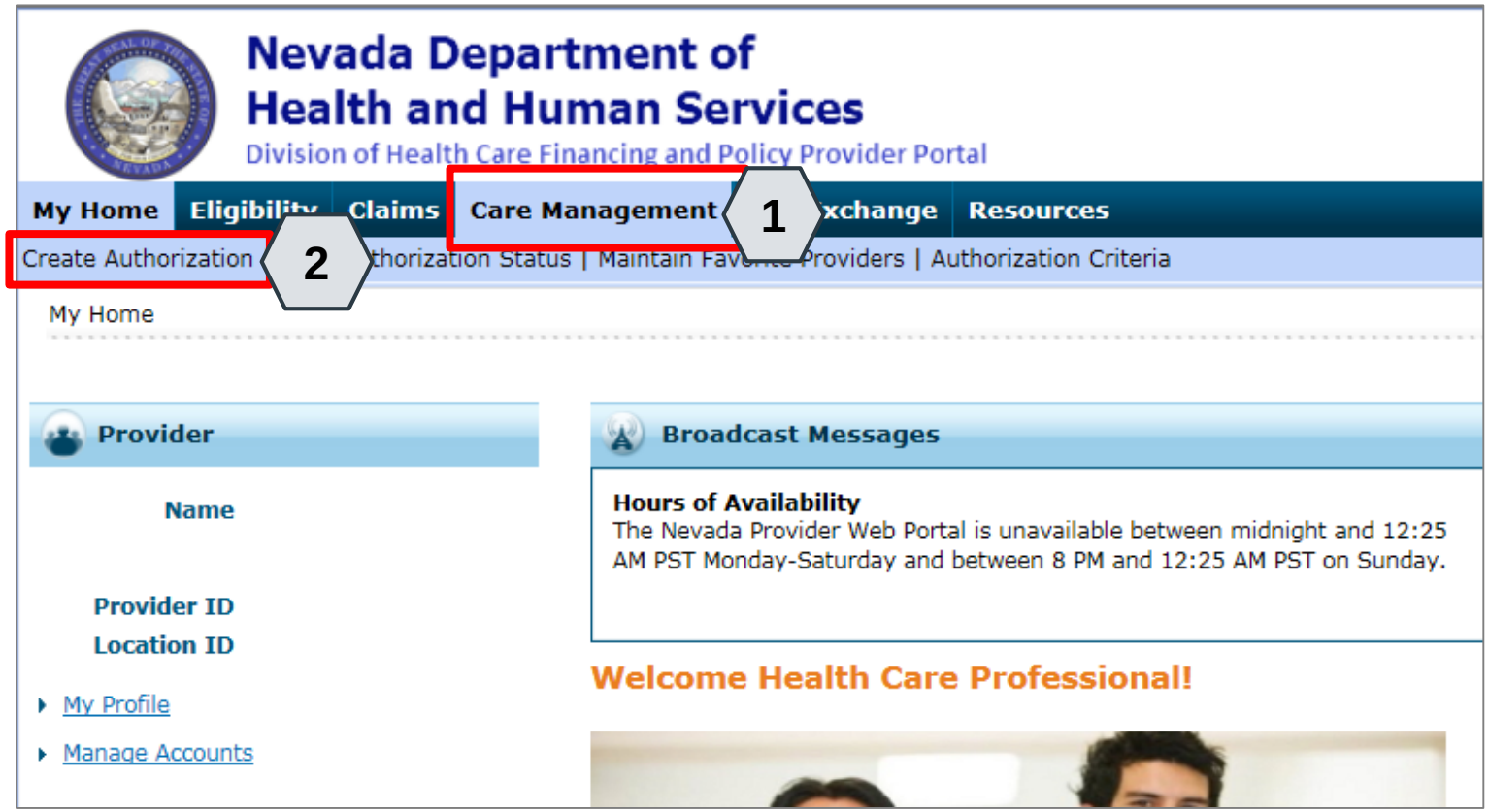
Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.

Use the Provider Web Portal to check PAs in pending status for additional information.

Create a Prior Authorization Request

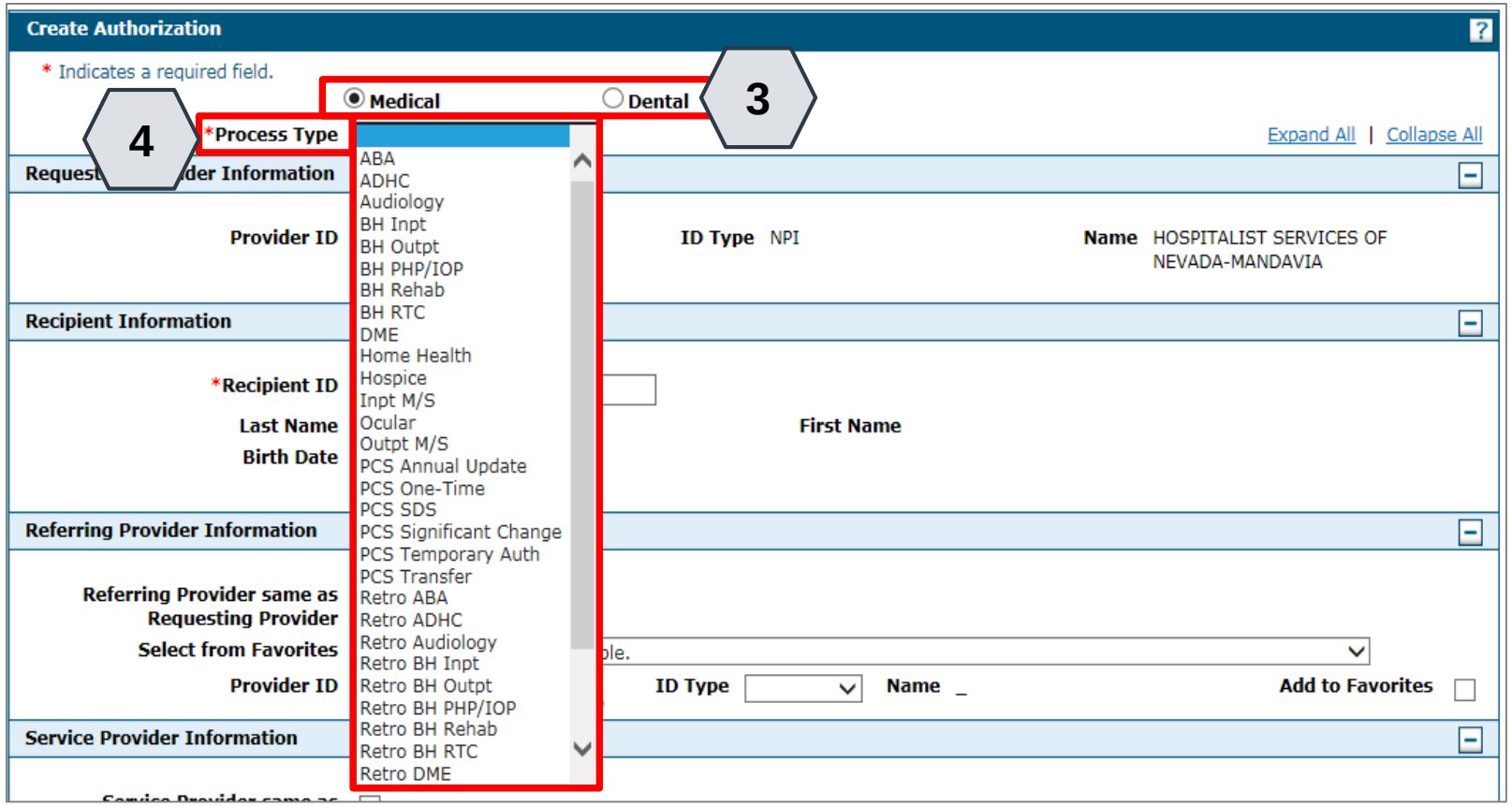


Submitting a PA Request



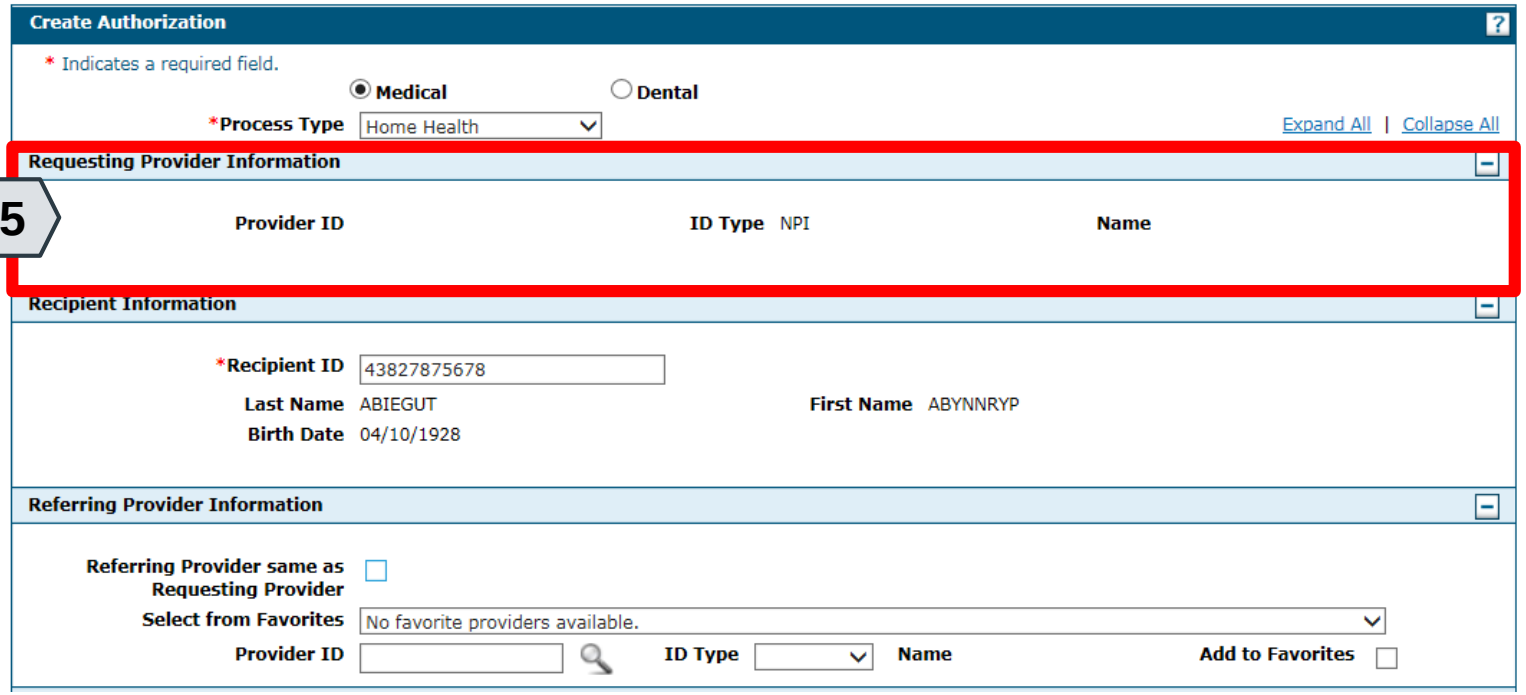
1. Hover over the Care Management tab.
2. Click Create Authorization from the sub-menu.

Submitting a PA Request, continued



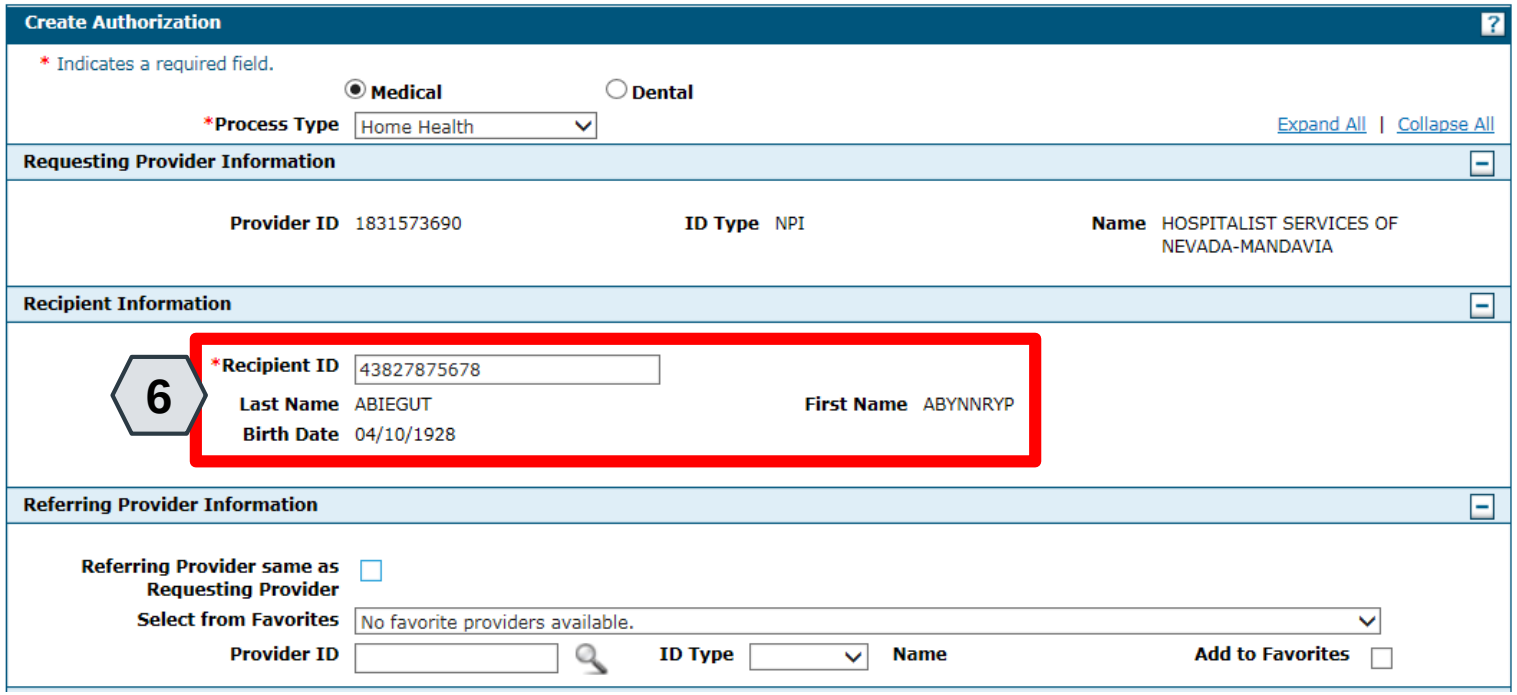
3. Select the authorization type (Medical).
4. Choose an appropriate Process Type from the drop-down list.

Submitting a PA Request, continued



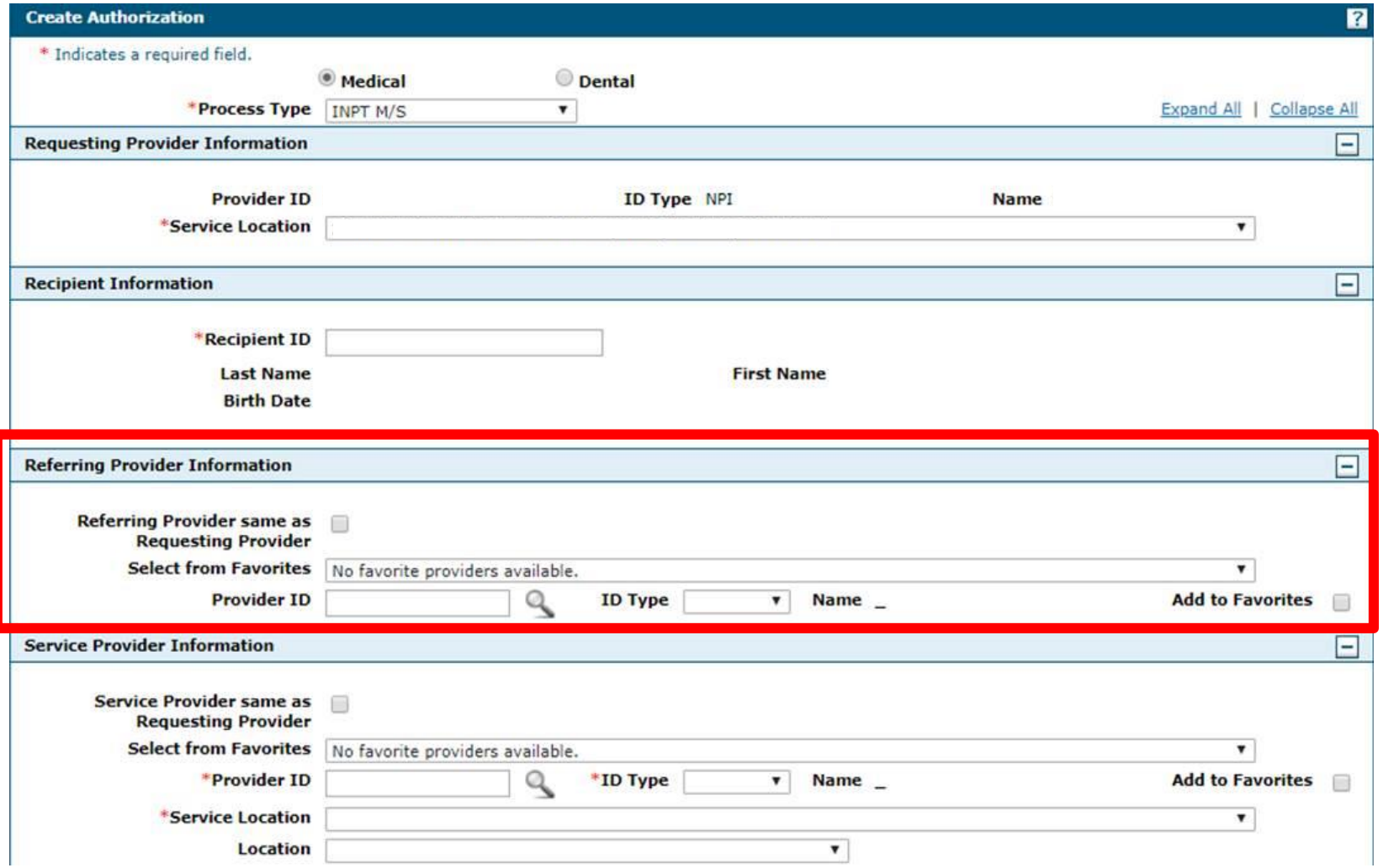
5. The Requesting Provider Information is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.

Submitting a PA Request, continued



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

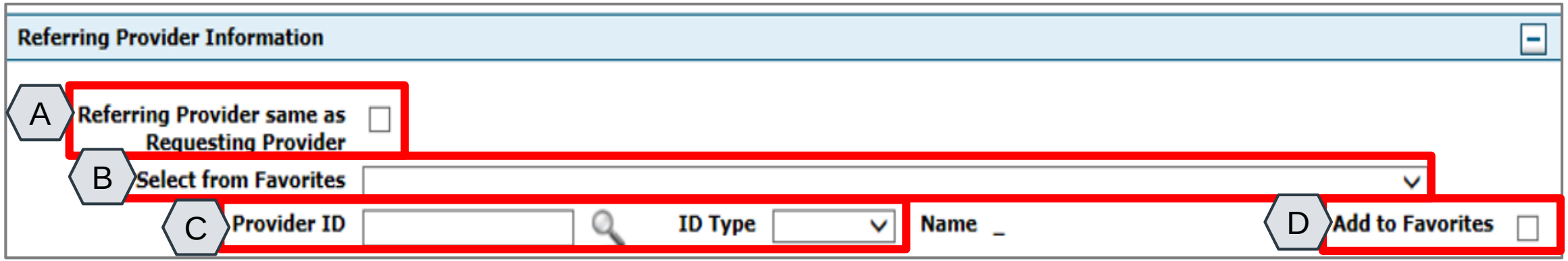
Submitting a PA Request, continued



7

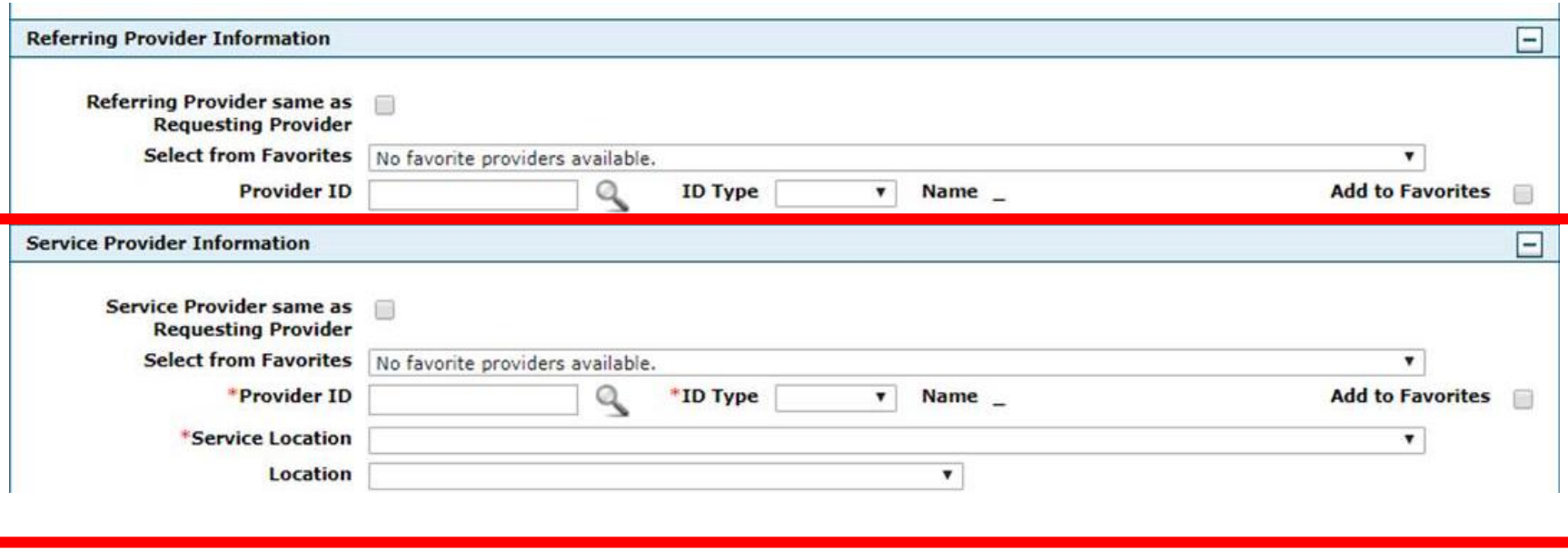
7. Enter Referring Provider Information using one of three ways.

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.

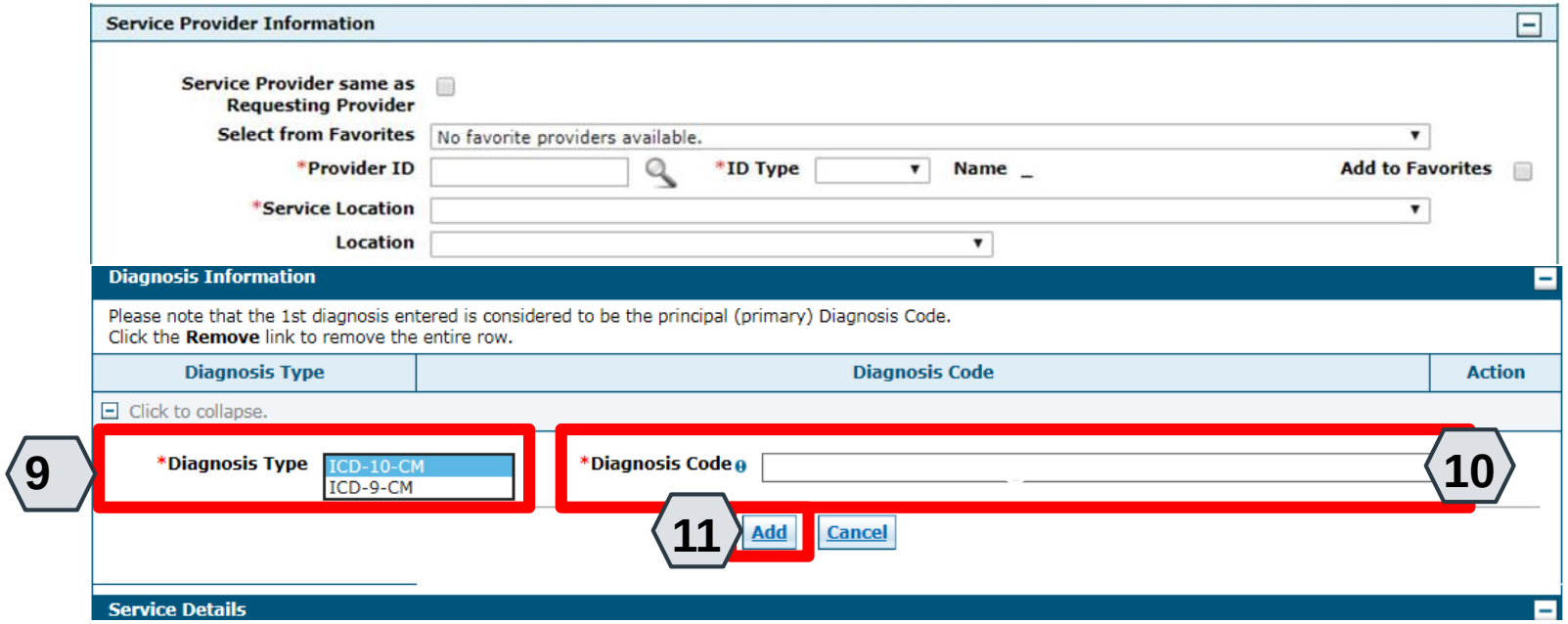
Submitting a PA Request, continued



8

8. Enter Service Provider Information.

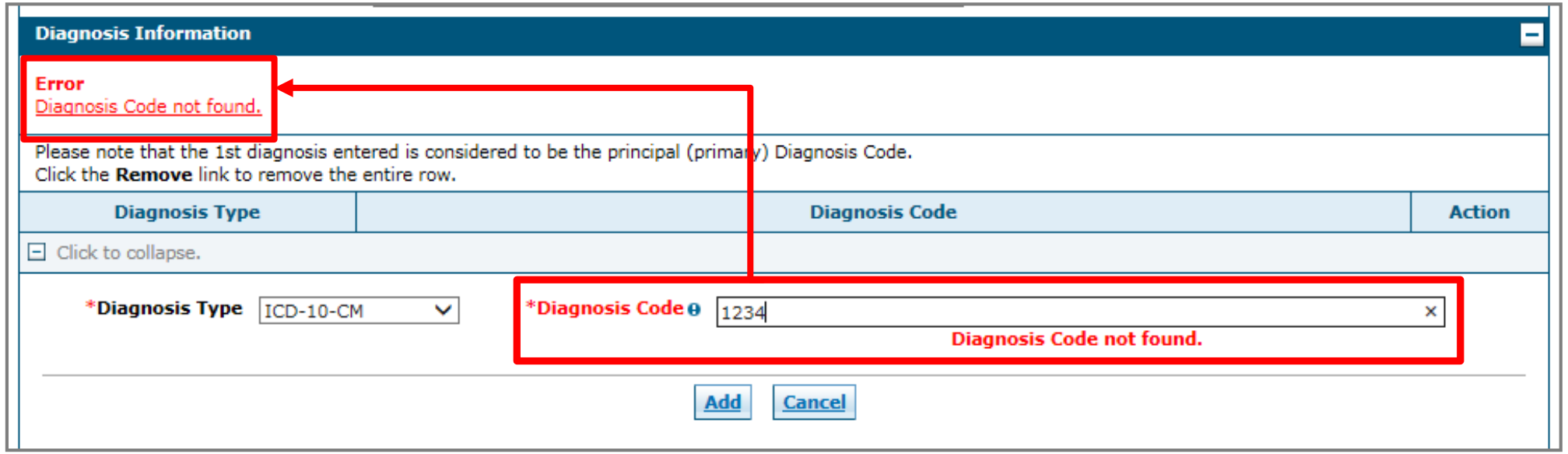
Submitting a PA Request, continued



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.

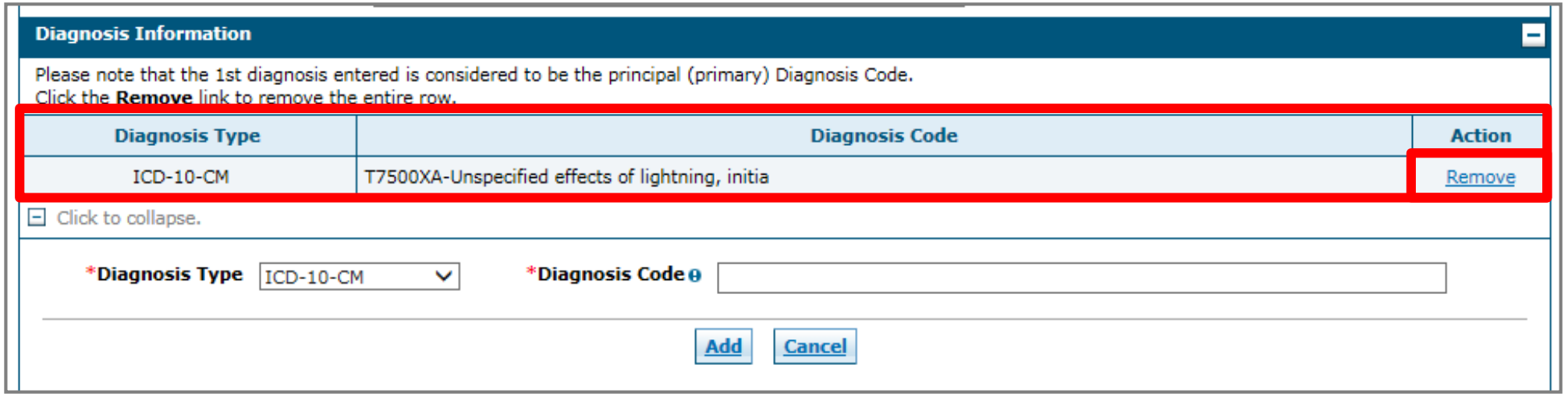
NOTE: Repeat steps 9-11 to enter up to nine codes. The first code entered will be considered the primary.

Submitting a PA Request, continued



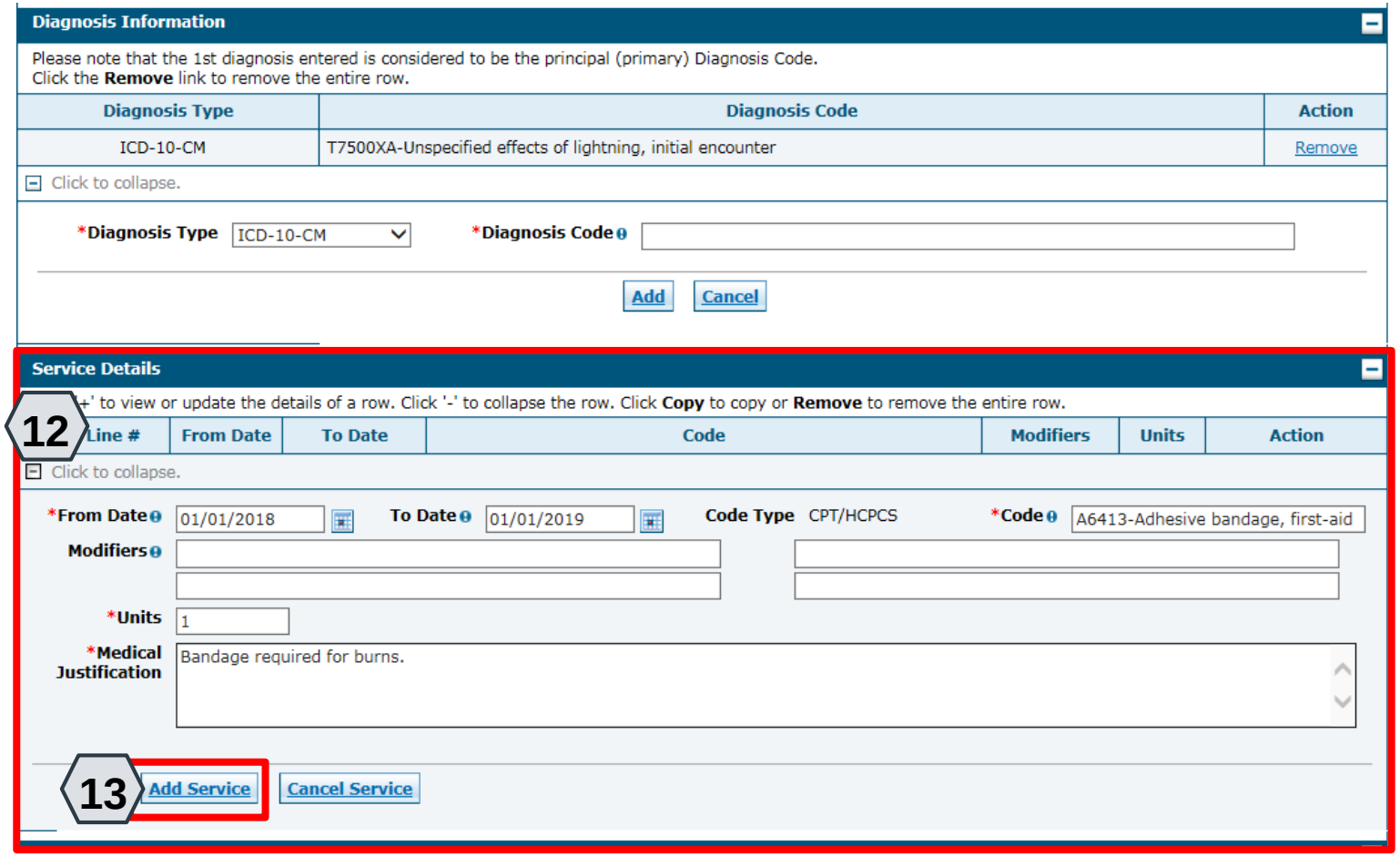
- If you click the Add button with an invalid diagnosis code, an error will display. Ensure the diagnosis code is correct, up-to-date with the selected Diagnosis Type, and does not include decimals.

Submitting a PA Request, continued



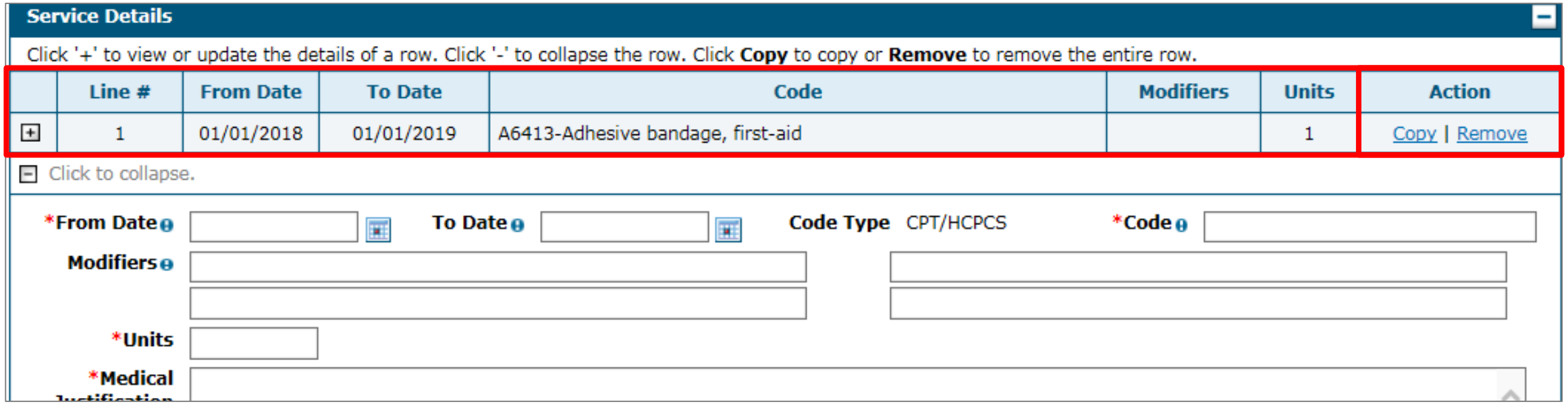
- Once a diagnosis code has been entered accurately, and the Add button has been clicked, the diagnosis code will display under the Diagnosis Information section. If a code needs to be removed from the PA request, click Remove located in the Action column.

Submitting a PA Request, continued



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

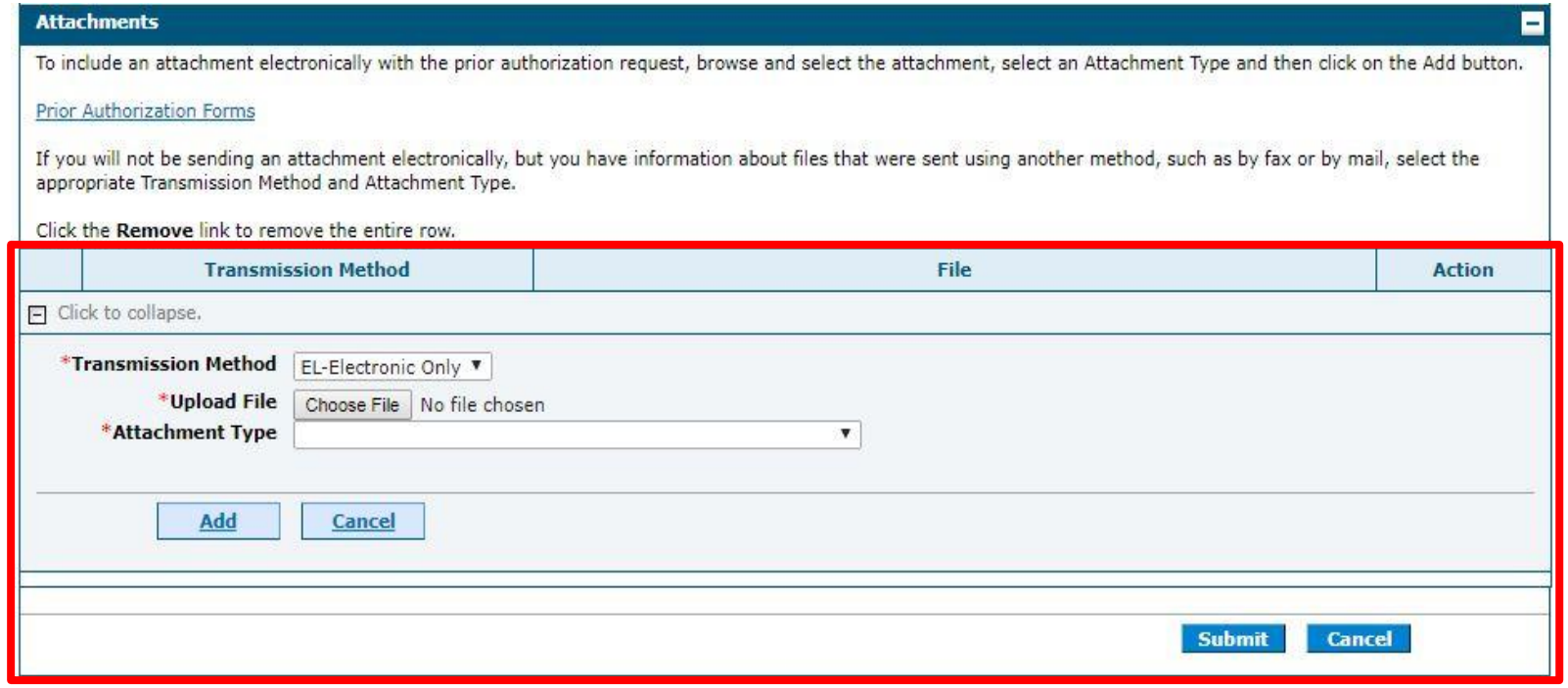
Submitting a PA Request, continued



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

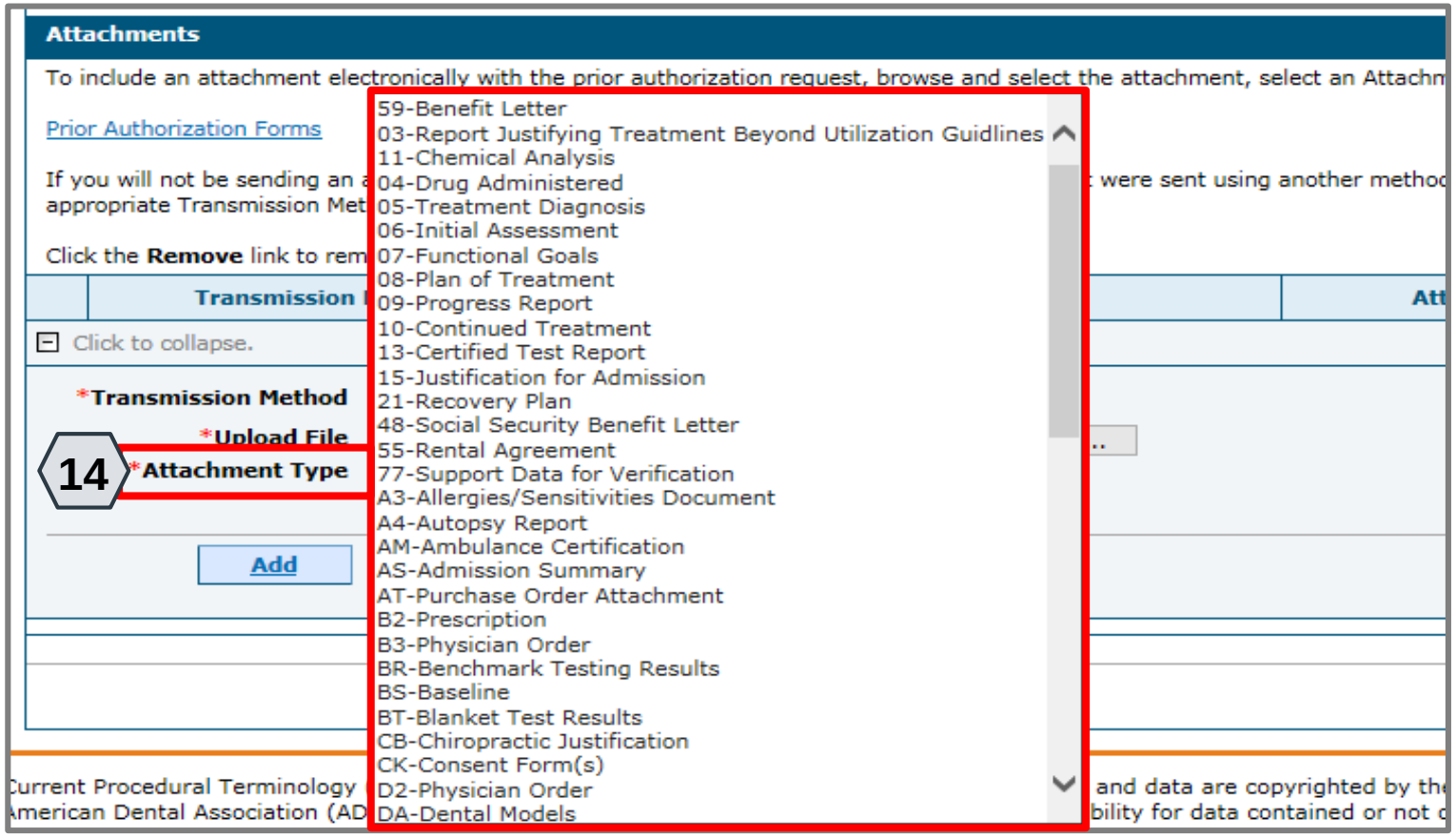
NOTE: Manage additional details as needed. If a user wishes to copy a service detail, click Copy located in the Action column. To remove the detail, click Remove.

Submitting a PA Request, continued



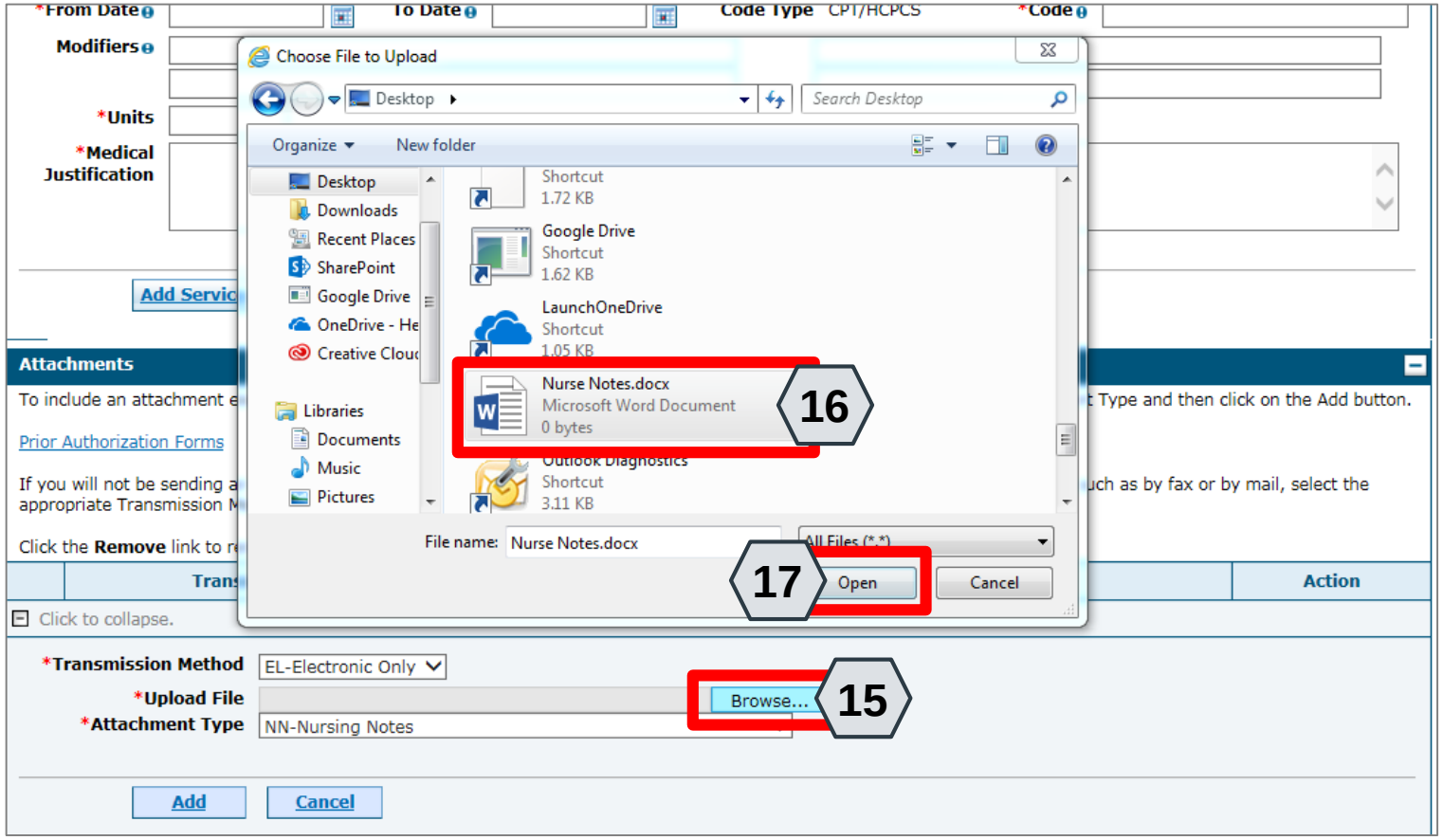
- The Transmission Method will default to EL-Electronic Only as attachments must be sent via the Provider Web Portal.

Submitting a PA Request, continued



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

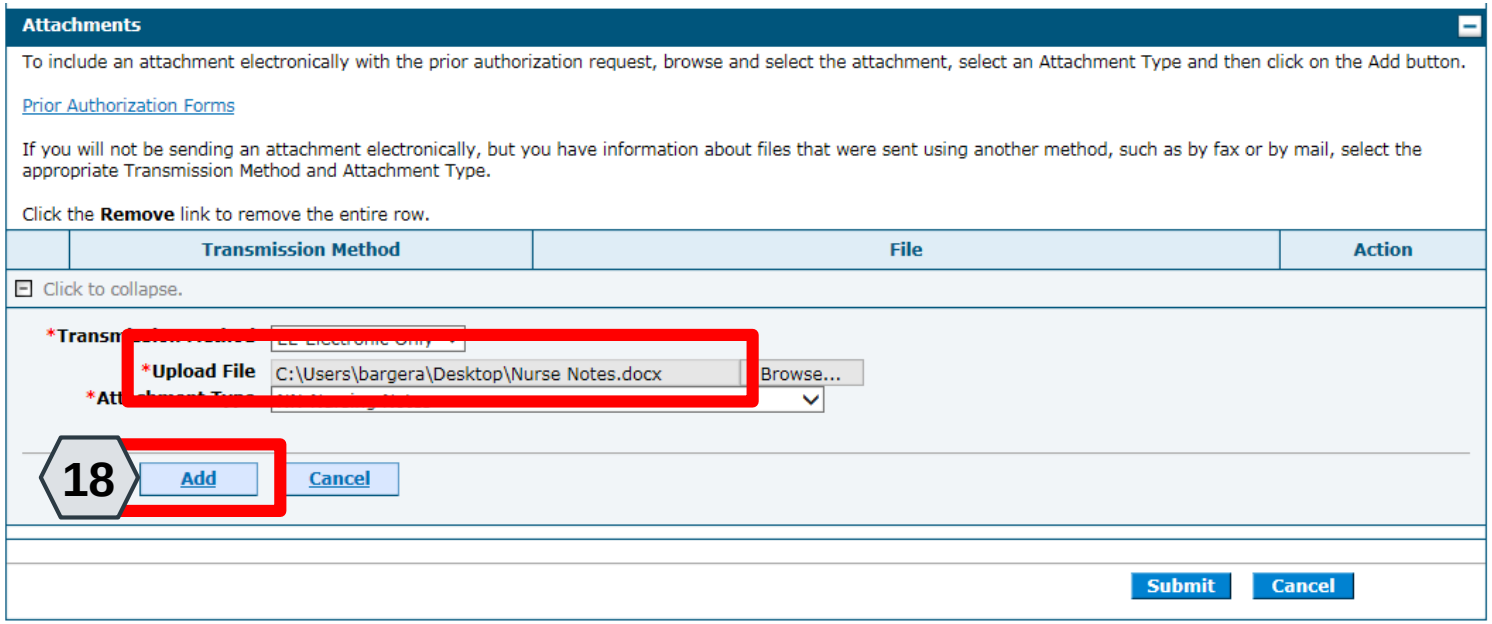
Submitting a PA Request, continued



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

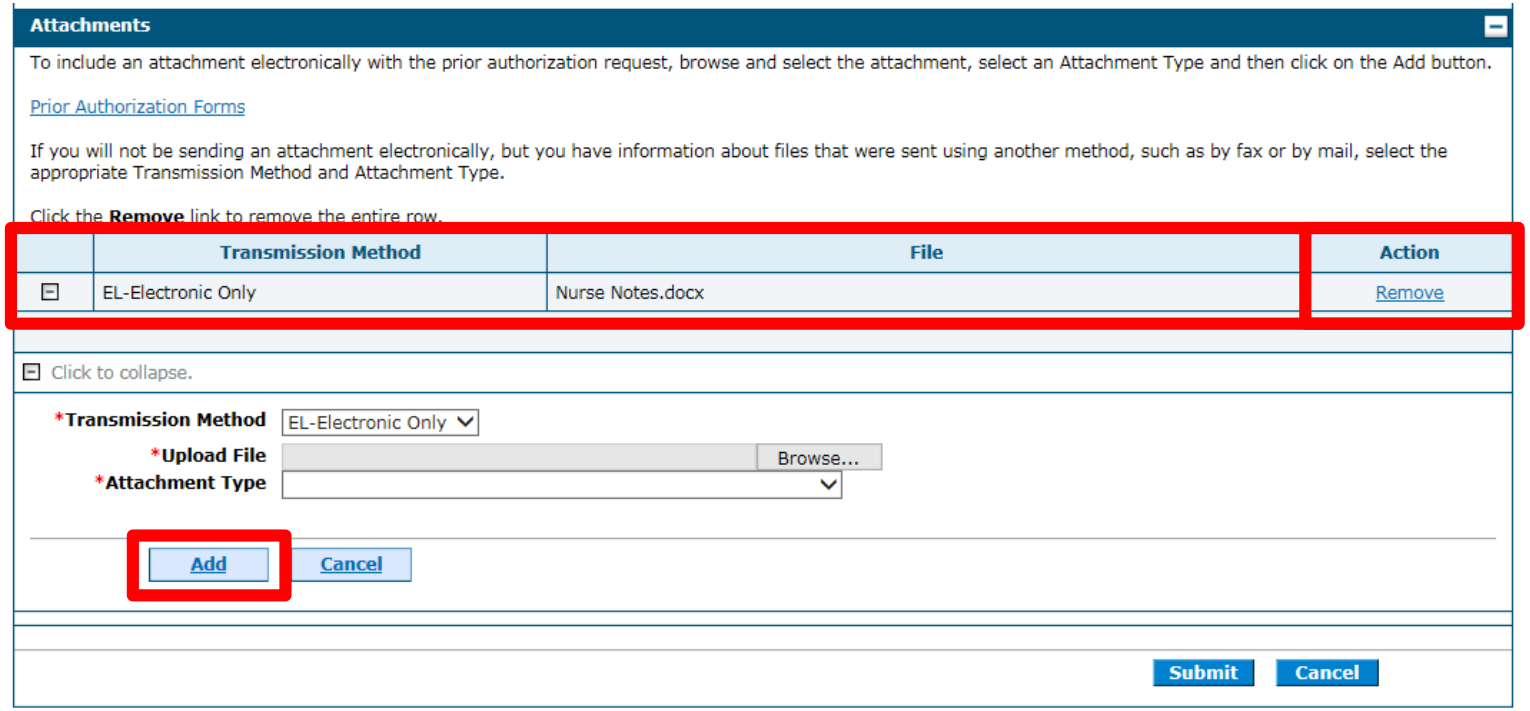
- Allowable file types include: .doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.

Submitting a PA Request, continued



18. Click the Add button.

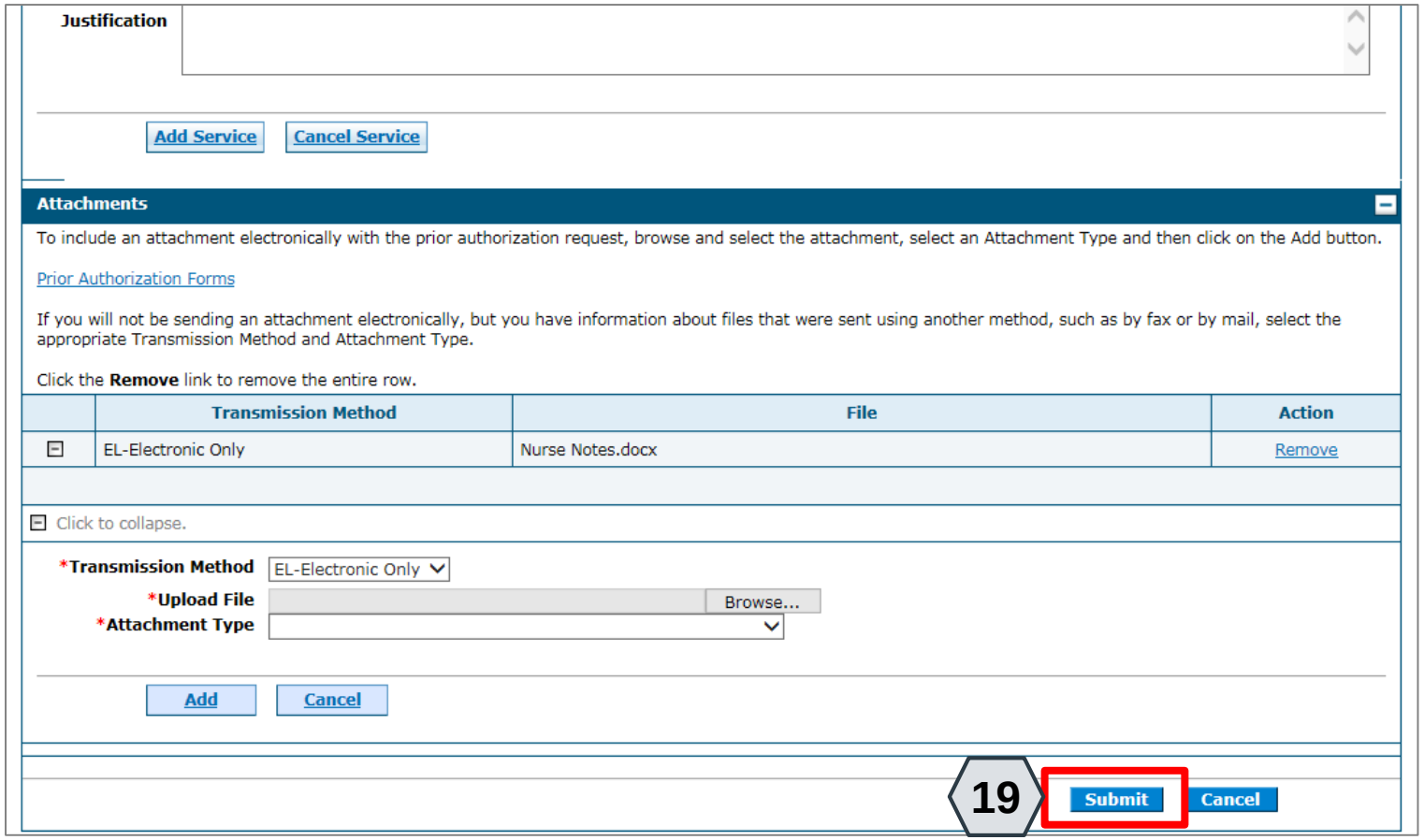
Submitting a PA Request, continued



- The added attachment displays in the list.
- To remove the attachment, click Remove in the Action column.
- Add additional attachments by repeating steps 14-18.

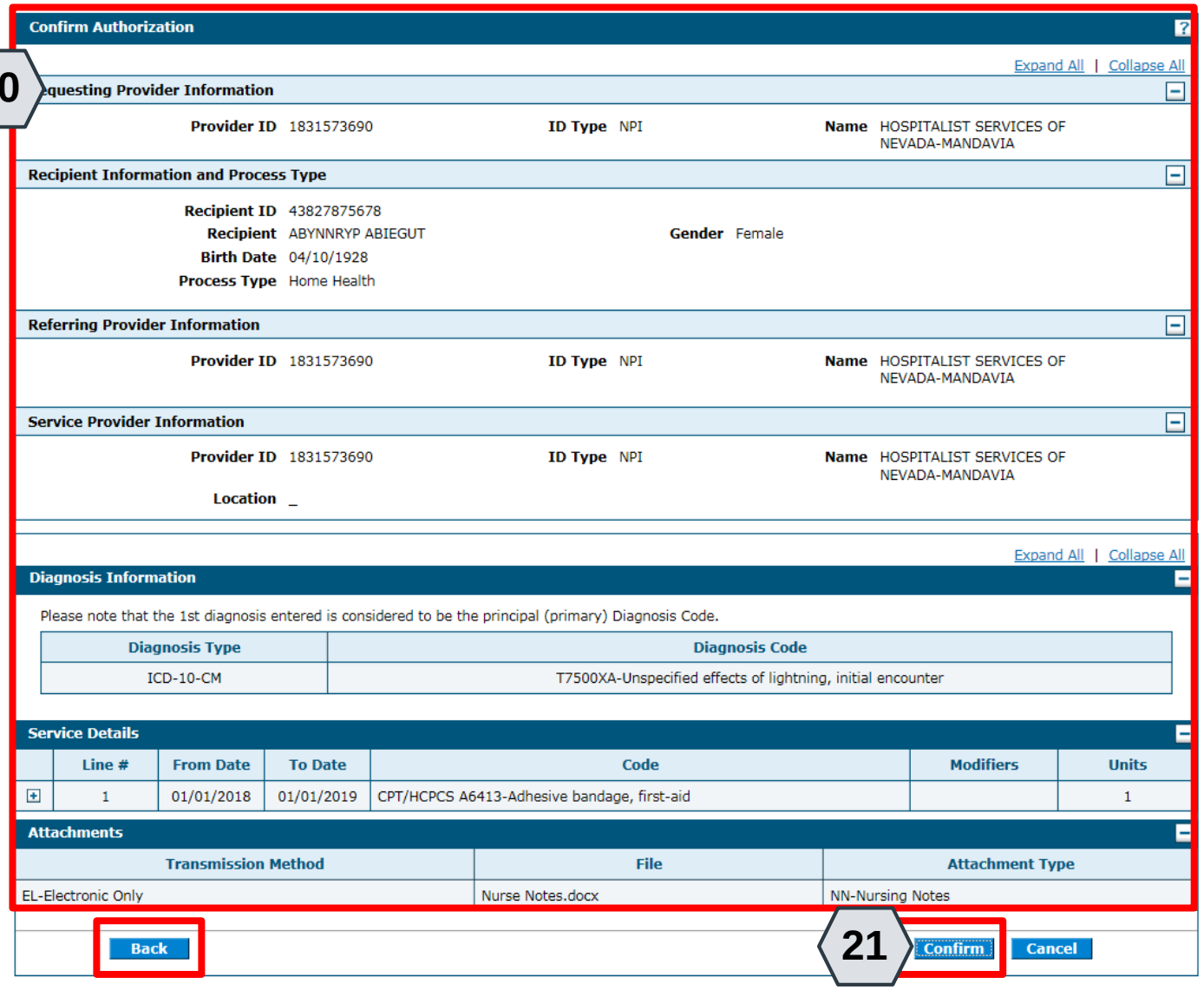
NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards, go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.

Submitting a PA Request, continued



19. Click the Submit button.

Submitting a PA Request, continued

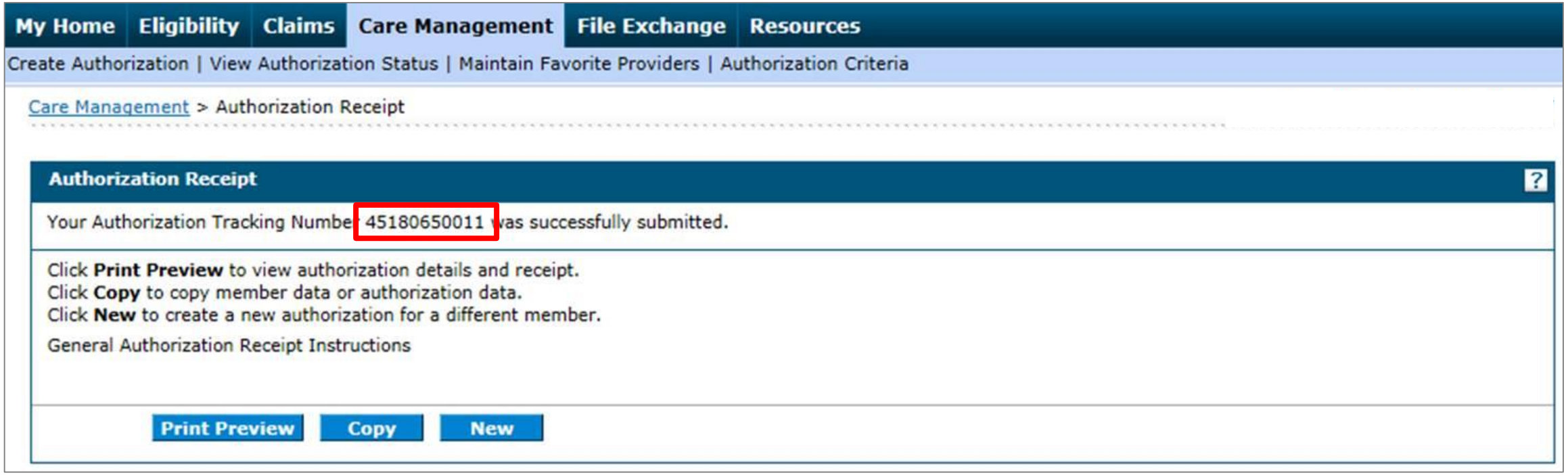


20. Review the information on the PA request.

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

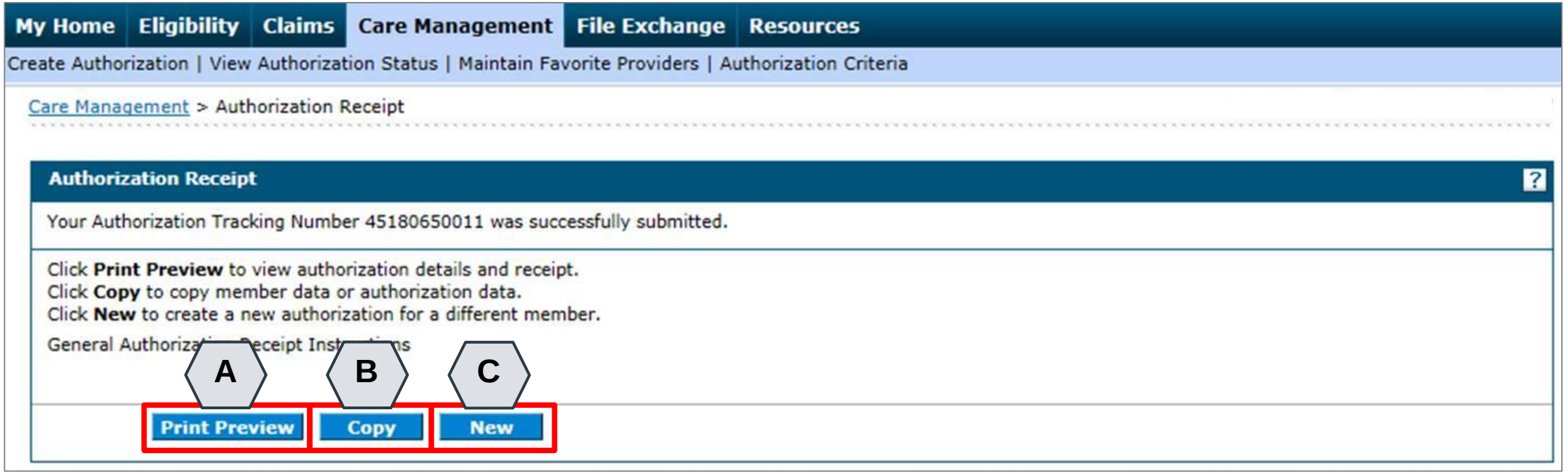
- NOTE: If updates are needed prior to clicking the Confirm button, click the Back button to return to the “Create Authorization” page.

Submitting a PA Request, continued



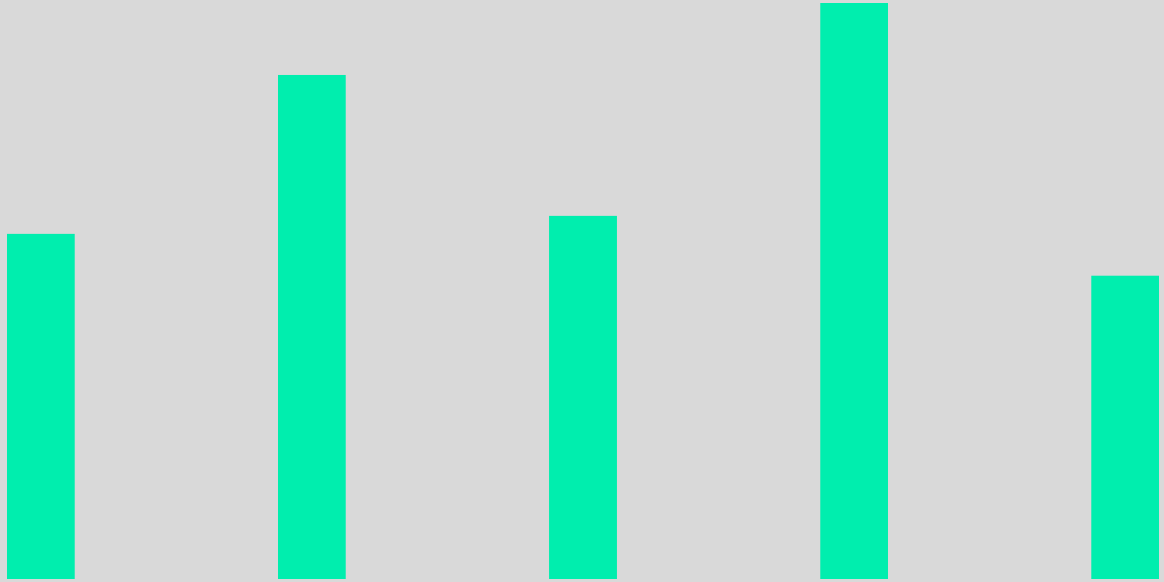
- After the Confirm button has been clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.

Submitting a PA Request, continued

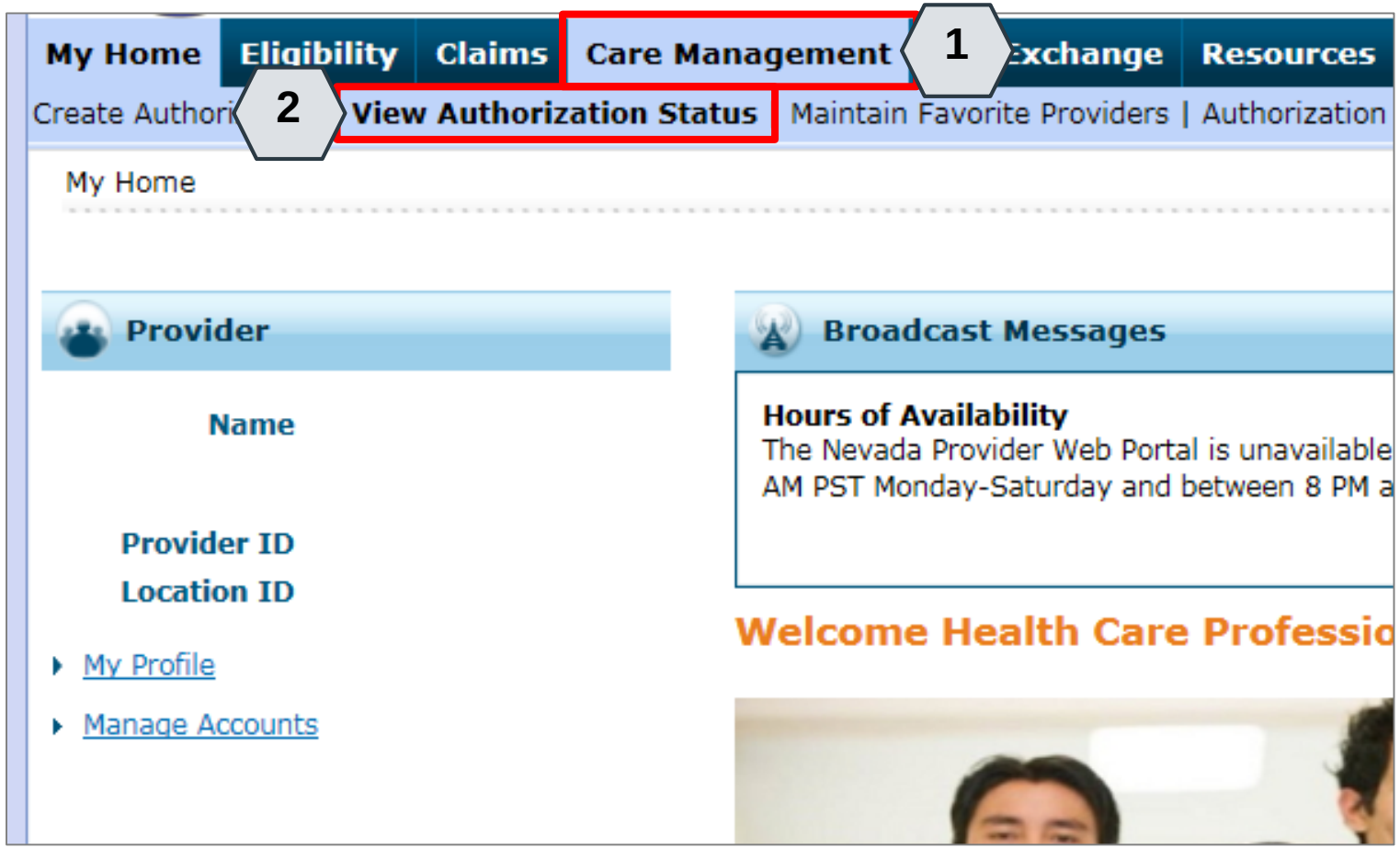


- A. Print Preview: Allows a user to view the PA details and receipt for printing.
- B. Copy: Allows a user to copy member or authorization data for another authorization.
- C. New: Allows a user to begin a new PA request for a different member.

Viewing Status

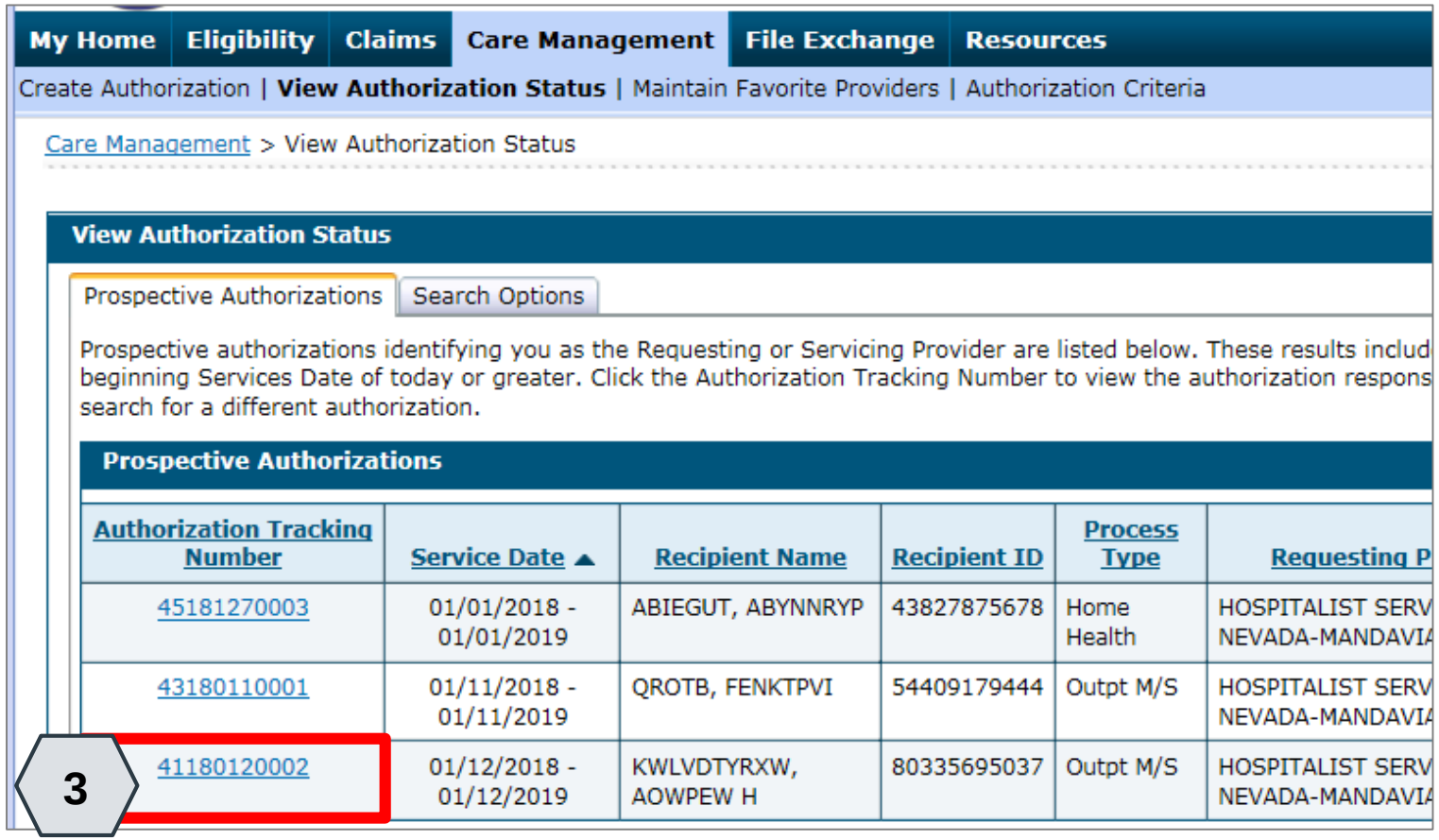


Viewing the Status of PAs



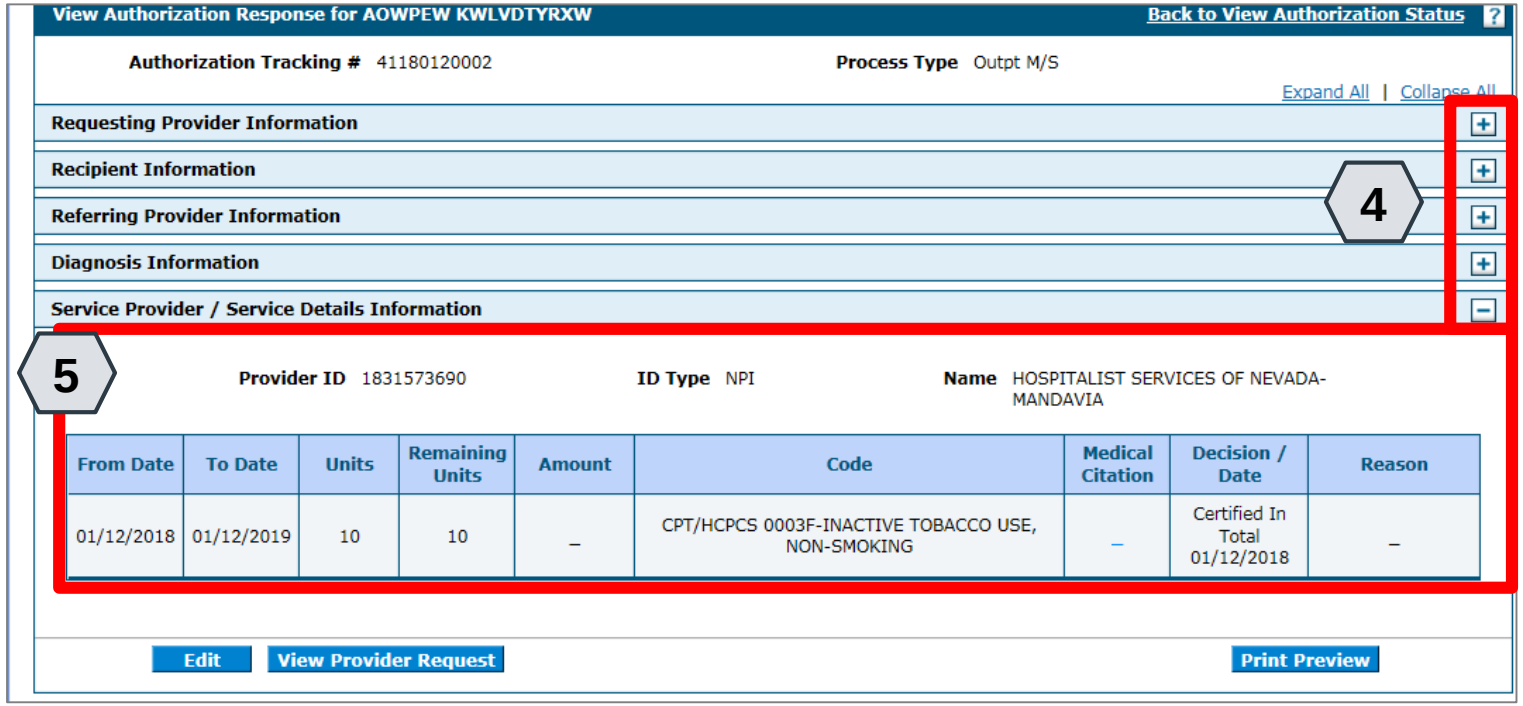
1. Hover over the Care Management tab.
2. Click View Authorization Status.

Viewing the Status of PAs, continued



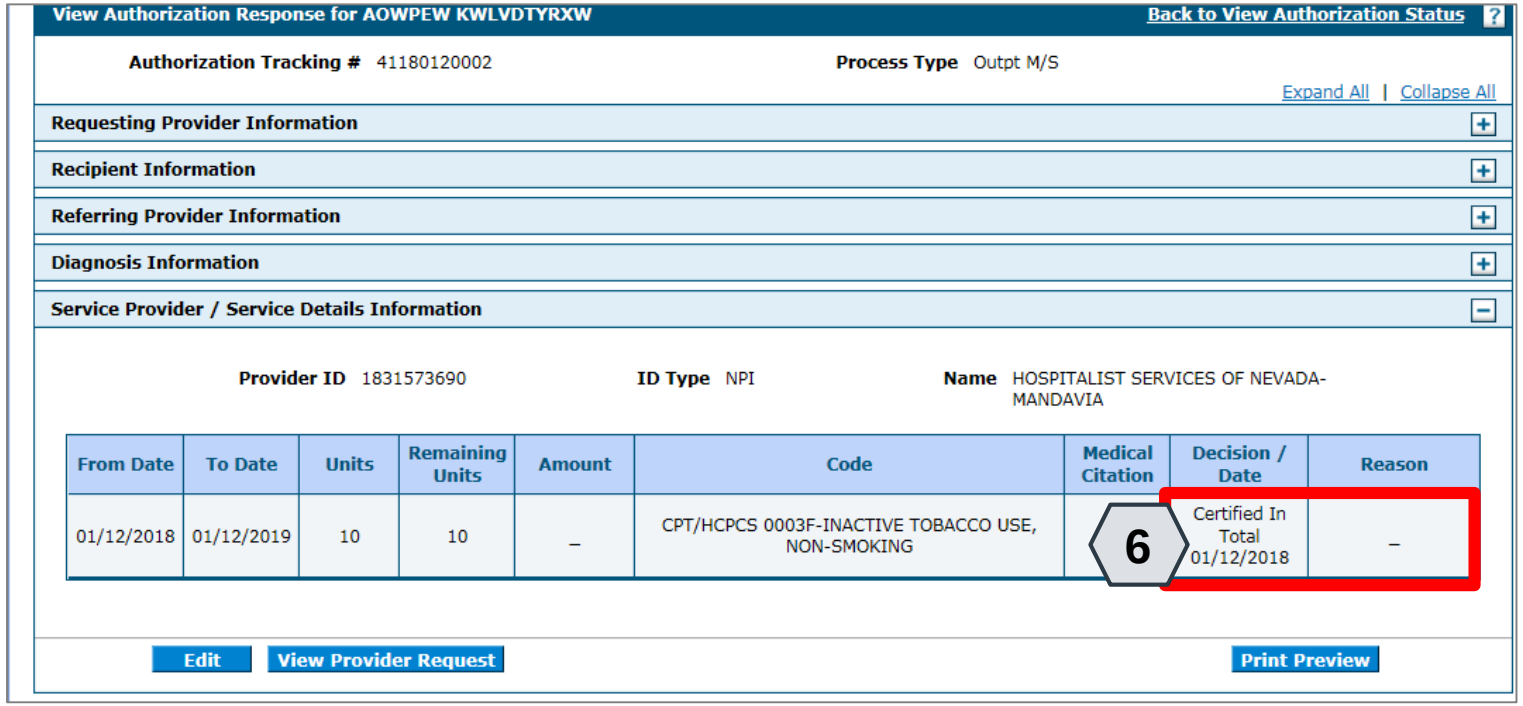
3. Click the ATN hyperlink of the PA to be viewed.

Viewing the Status of PAs, continued



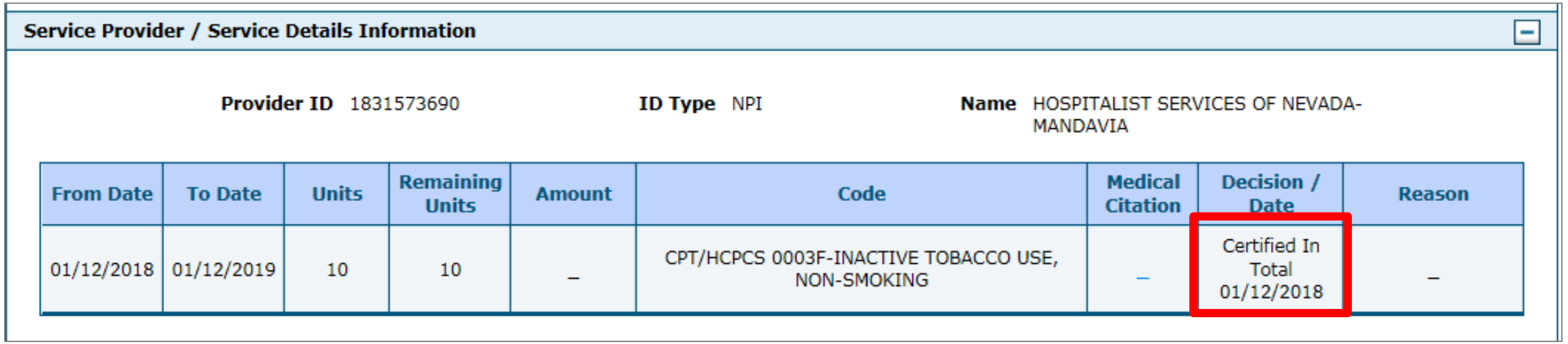
4. Click the plus ⊞ symbol to the right of a section to display its information.
5. Review the information as needed.

Viewing the Status of PAs, continued



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

Viewing the Status of PAs, continued



Service Provider / Service Details Information

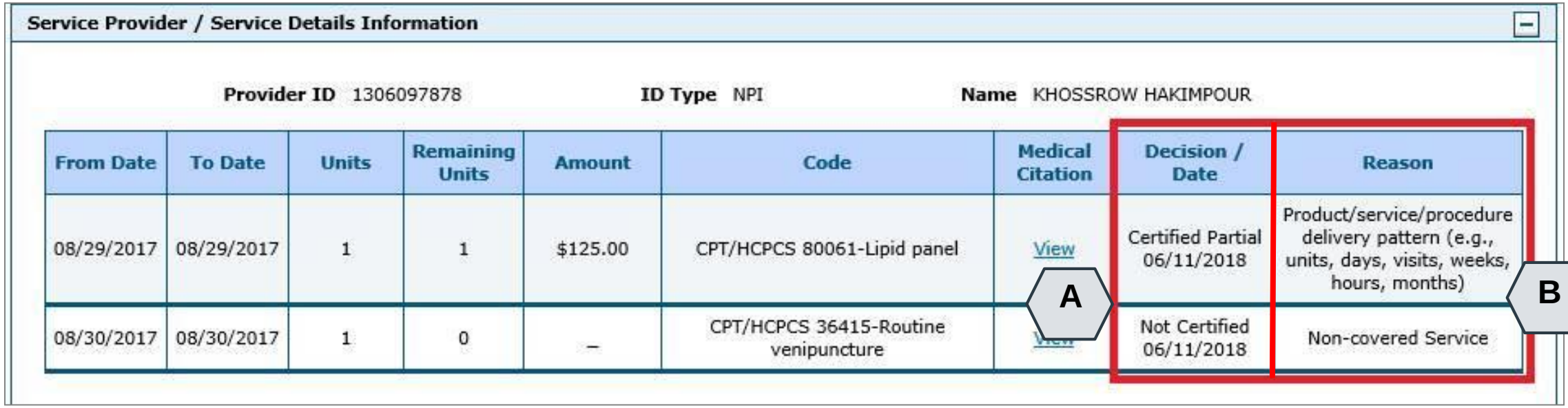
Provider ID 1831573690 **ID Type** NPI **Name** HOSPITALIST SERVICES OF NEVADA-MANDAVIA

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

In the Decision / Date column, 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.

Viewing the Status of PAs, continued



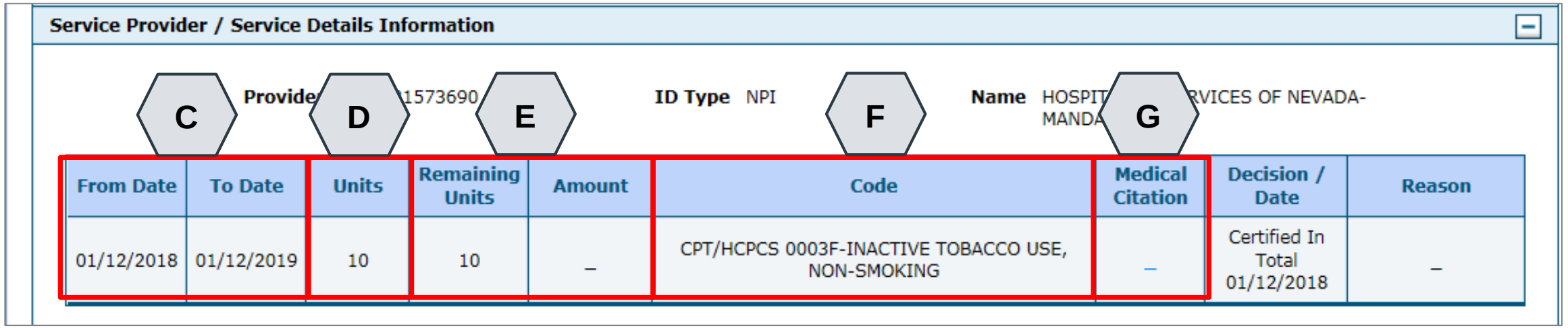
Service Provider / Service Details Information

Provider ID 1306097878 **ID Type** NPI **Name** KHOSSROW HAKIMPOUR

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

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

Viewing the Status of PAs, continued



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

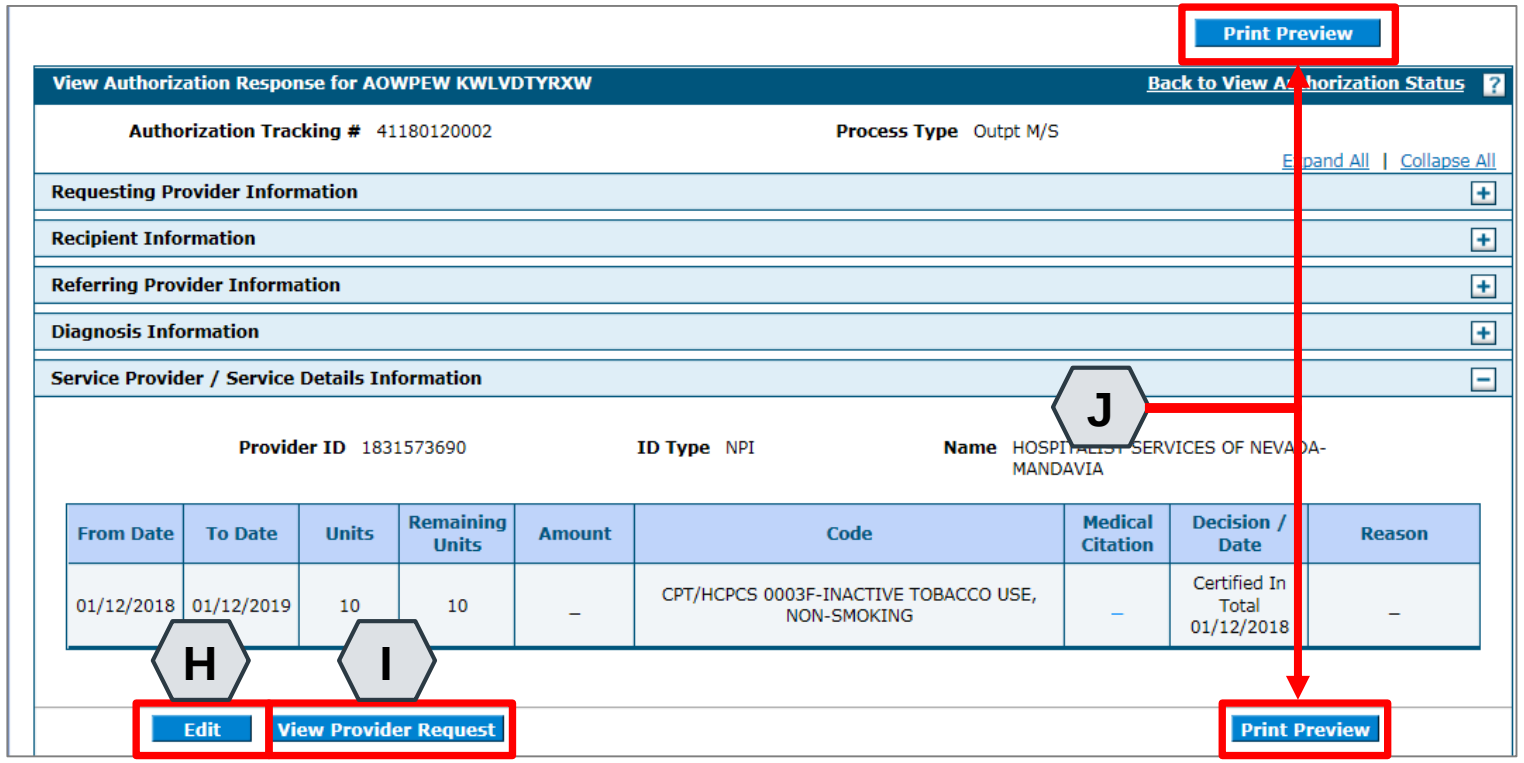
Viewing the Status of PAs, continued

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

Edit | View Provider Request | Print Preview

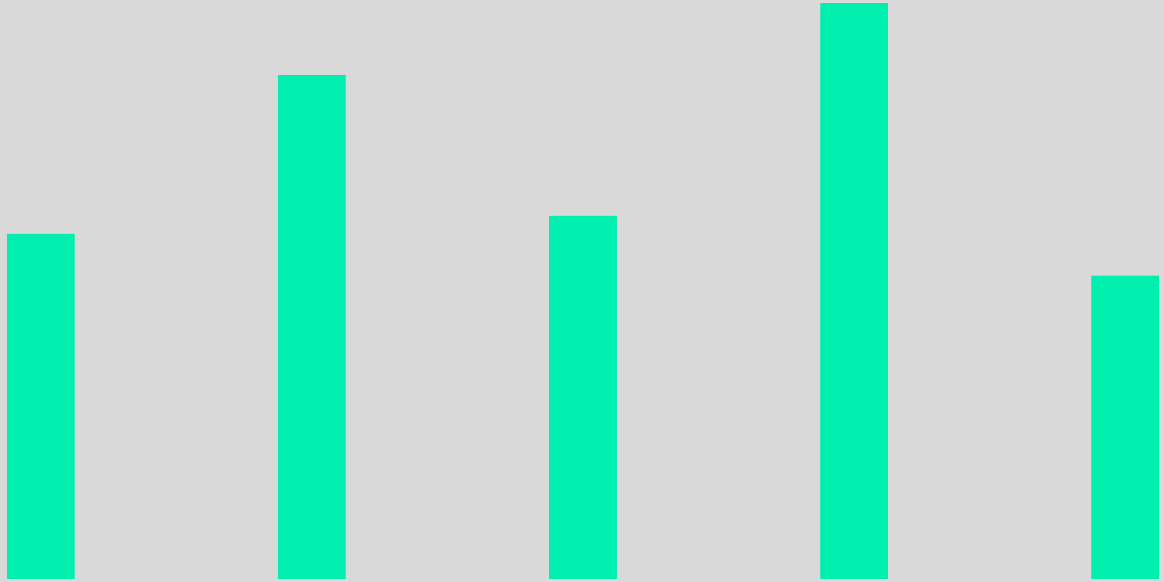
The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.

Viewing the Status of PAs, continued

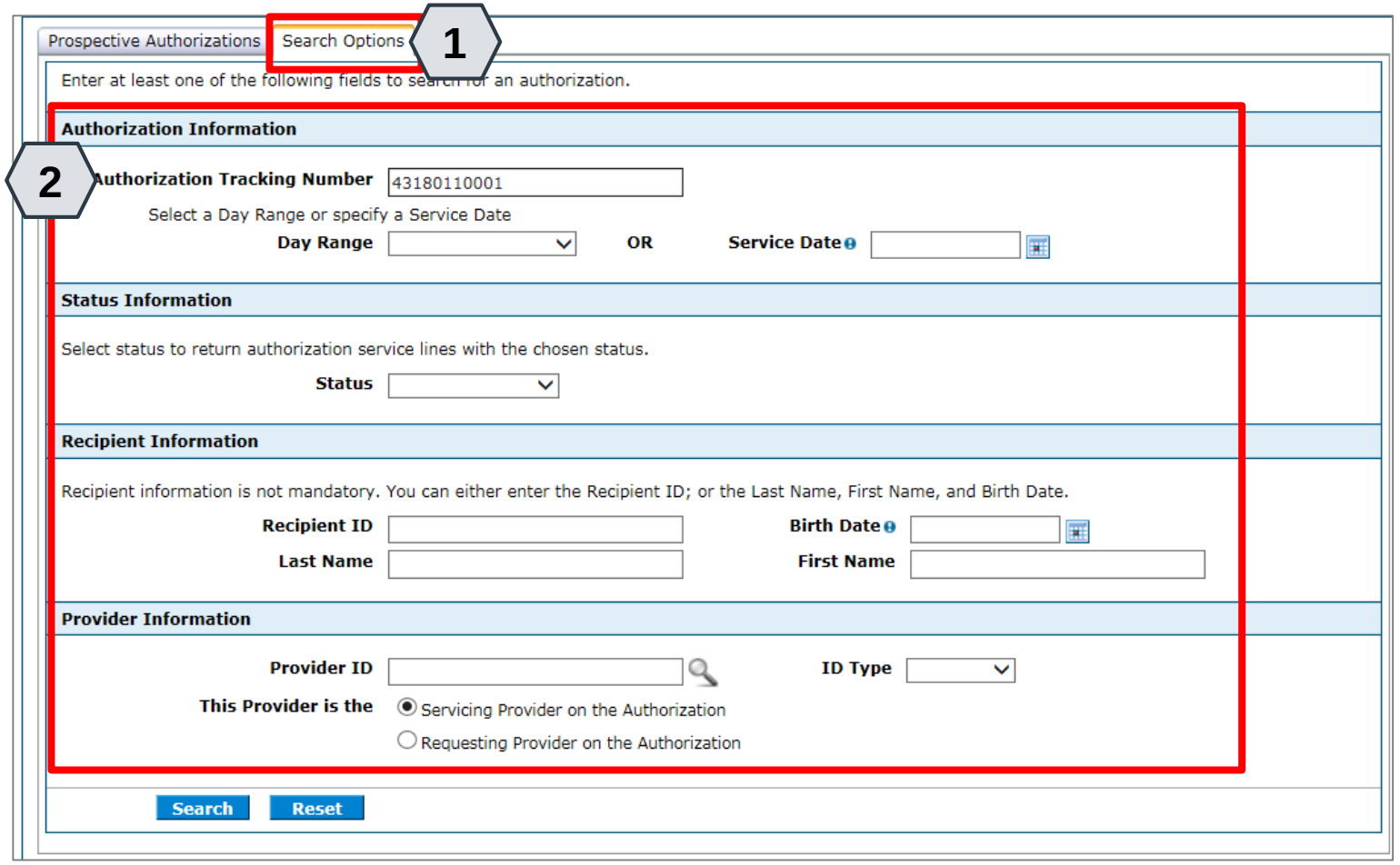


- H. Edit: Edit the PA.
- I. View Provider Request: Expand all sections to view the information.
- J. Print Preview: Display a printable version of the PA with options to print.

Searching for PAs

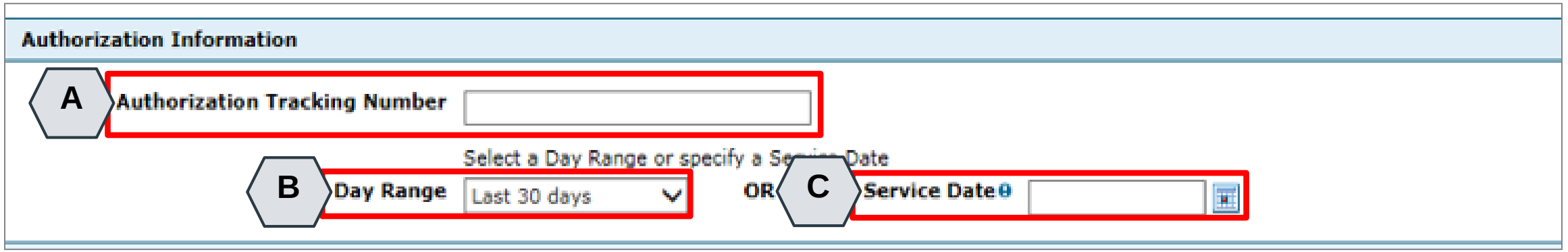


Searching for PAs



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

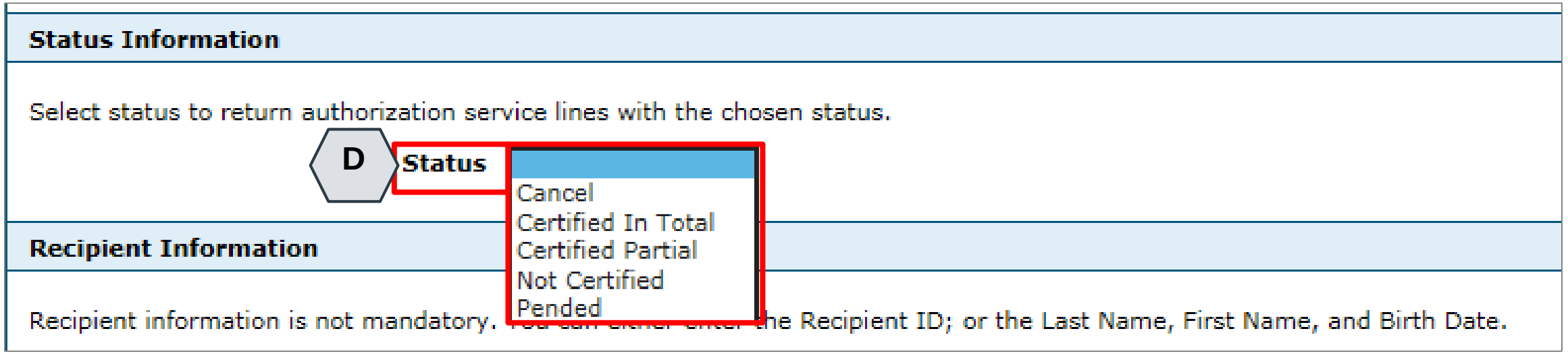
Searching for PAs, continued



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

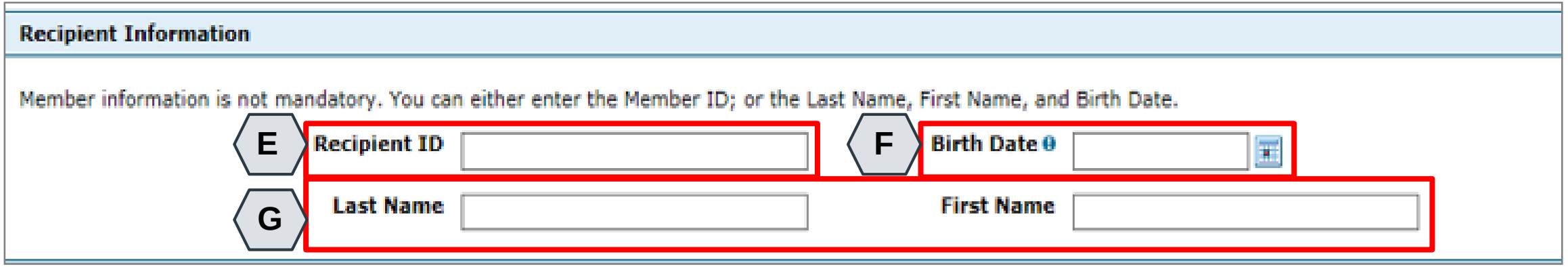
NOTE: Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.

Searching for PAs, continued



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

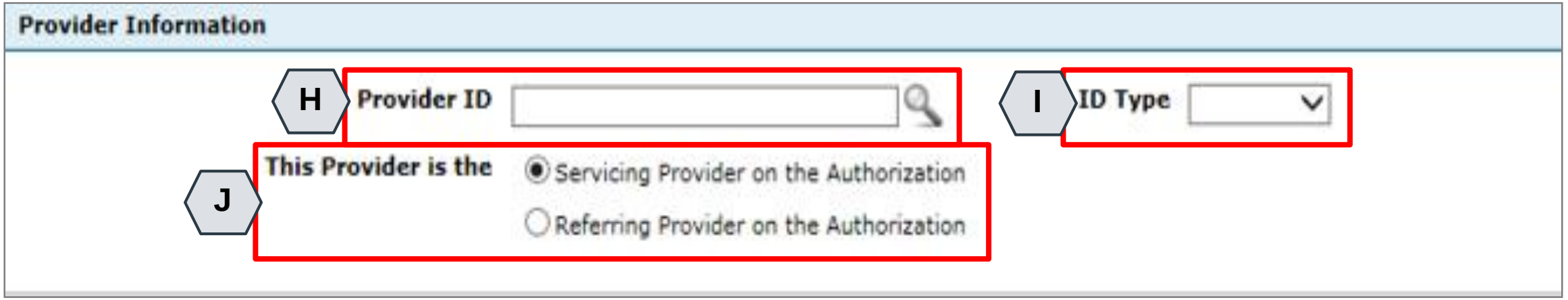
Searching for PAs, continued



E. **Recipient ID:** Enter the unique Medicaid ID of the client.
F. **Birth Date:** Enter the date of birth for the client.
G. **Last Name** and **First Name:** Enter the client's first and last name.

NOTE: Enter only the **Recipient ID or** the client's last name, first name and date of birth.

Searching for PAs, continued

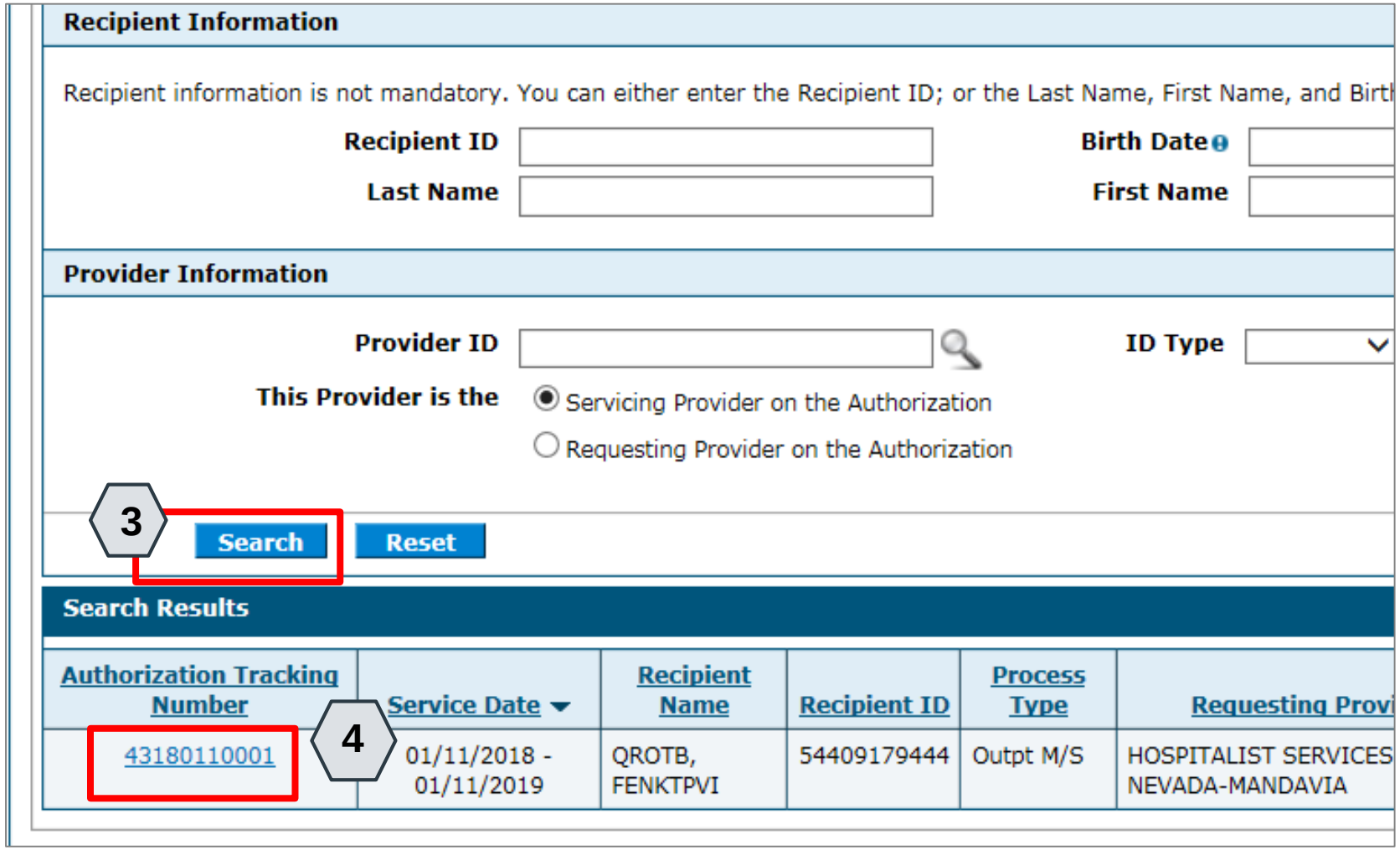


H. **Provider ID:** Enter the provider's unique National Provider Identifier (NPI).

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

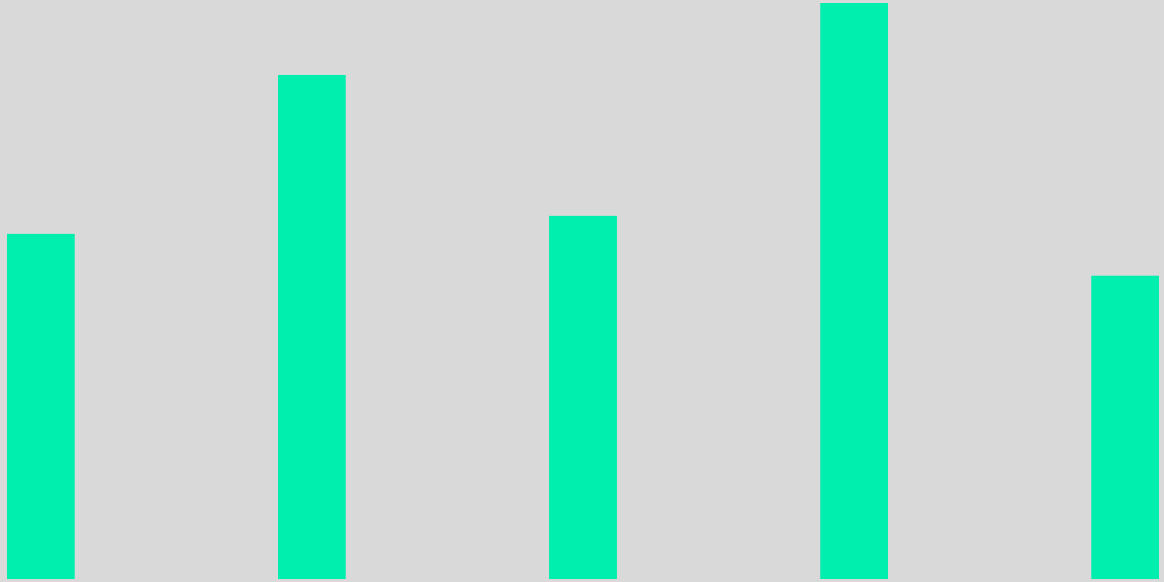
J. **This Provider is the:** Select whether the provider is the servicing or referring provider on the PA request.

Searching for PAs, continued



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

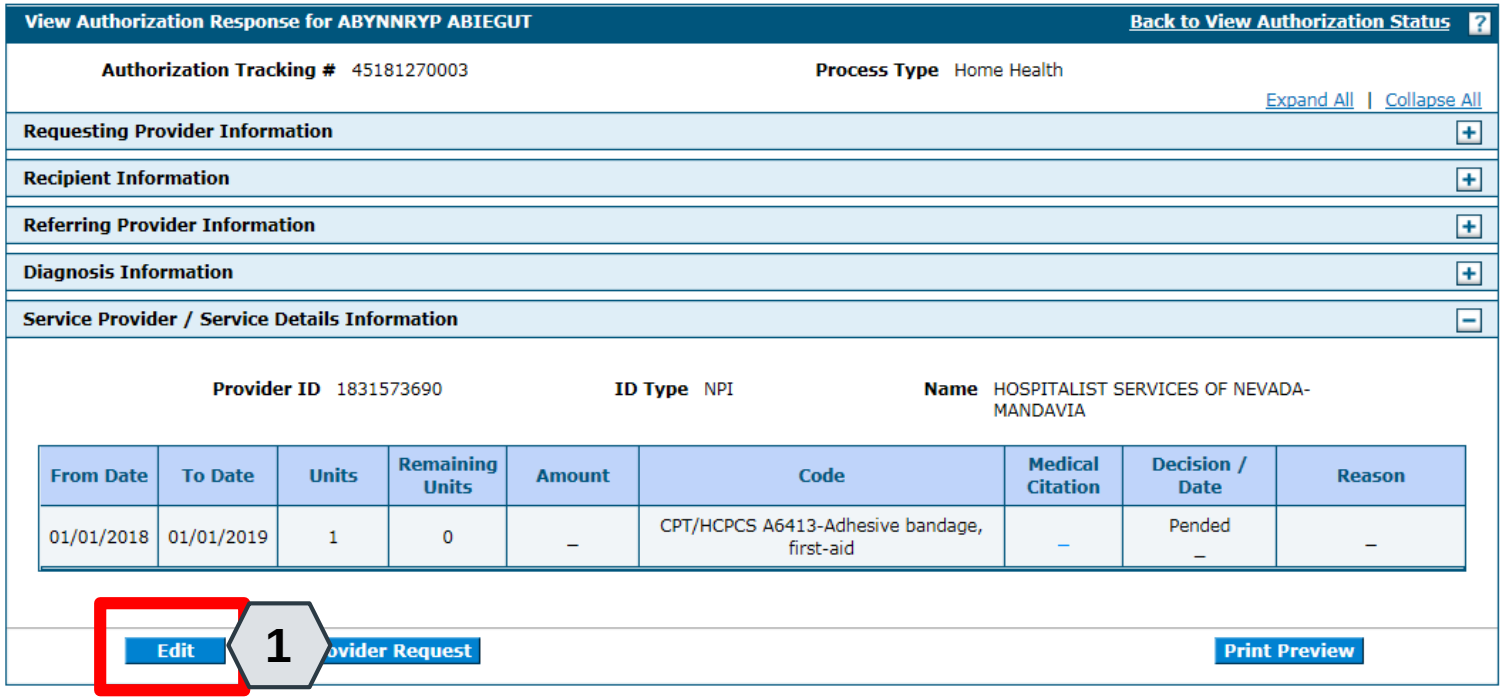
Submitting Additional Information



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

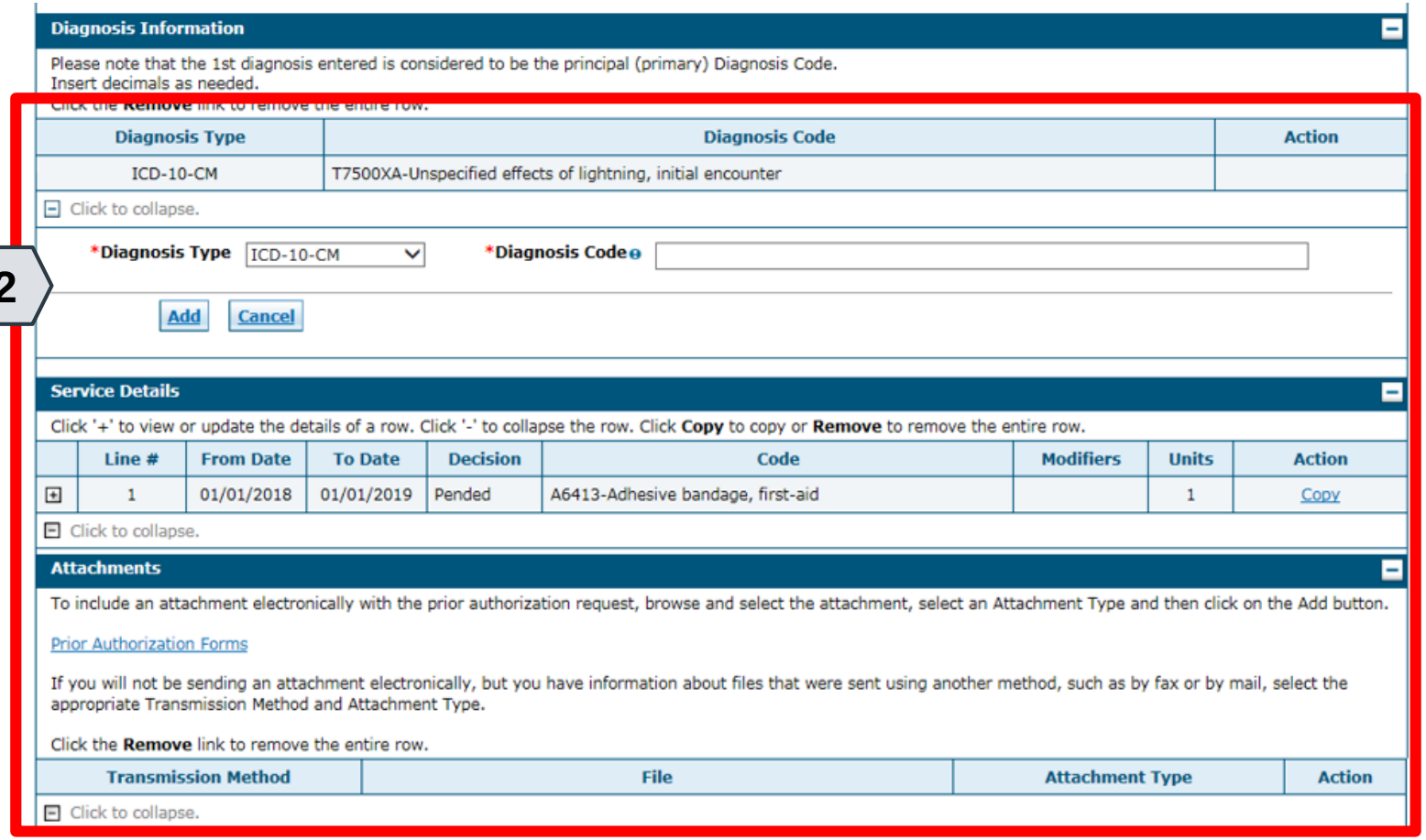


1. Click the **Edit** button to edit a submitted PA request.

Additional information may include:

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

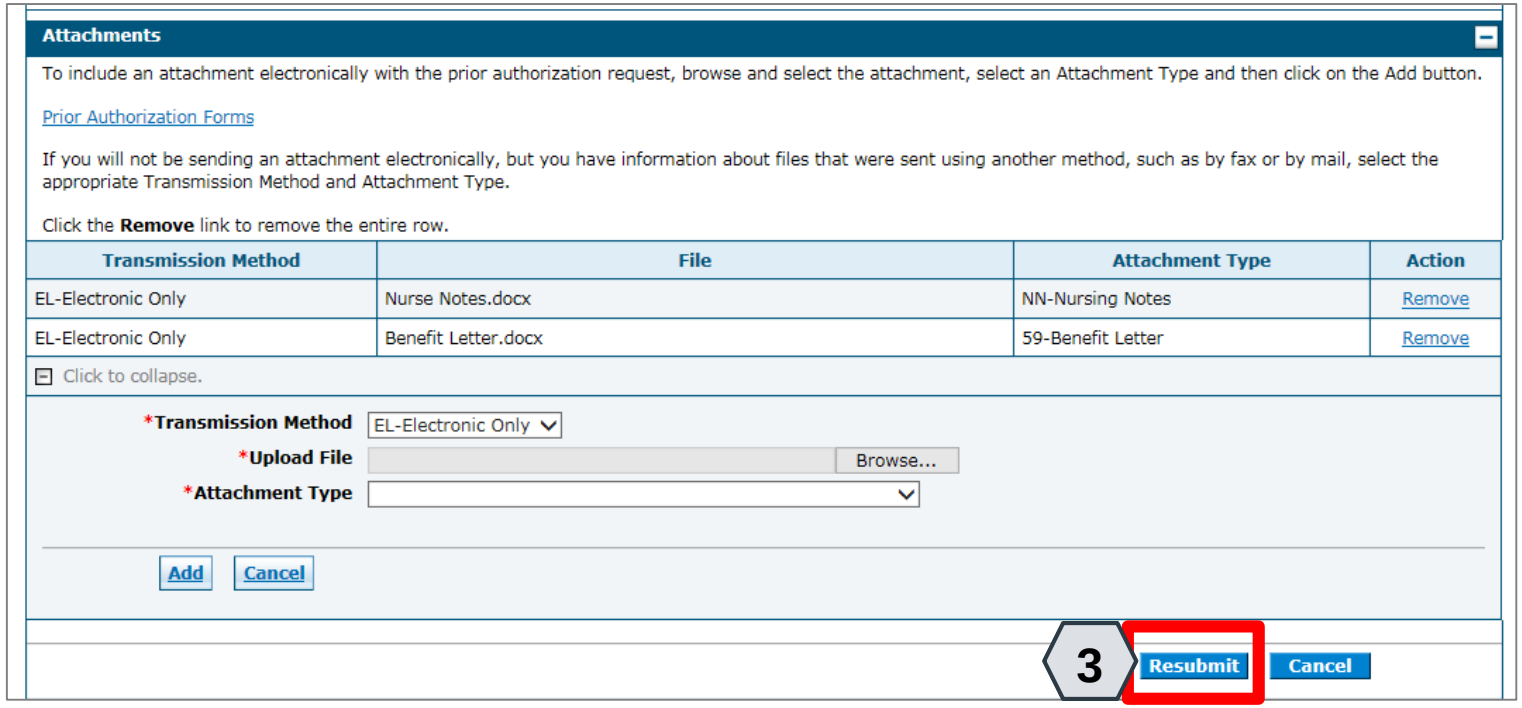
Submitting Additional Information, continued



2

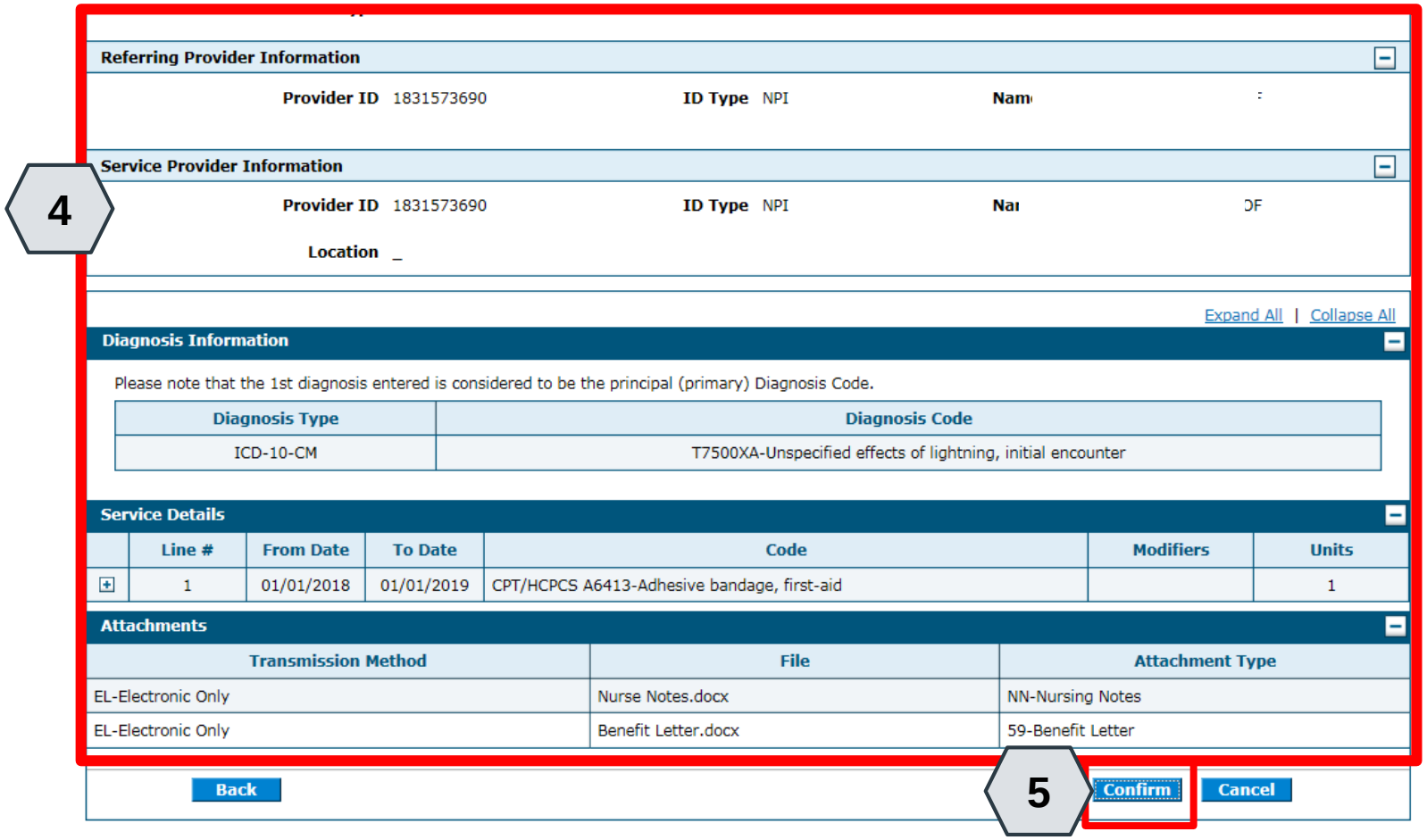
2. Add additional diagnosis codes, service details and/or attachments.

Submitting Additional Information, continued



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

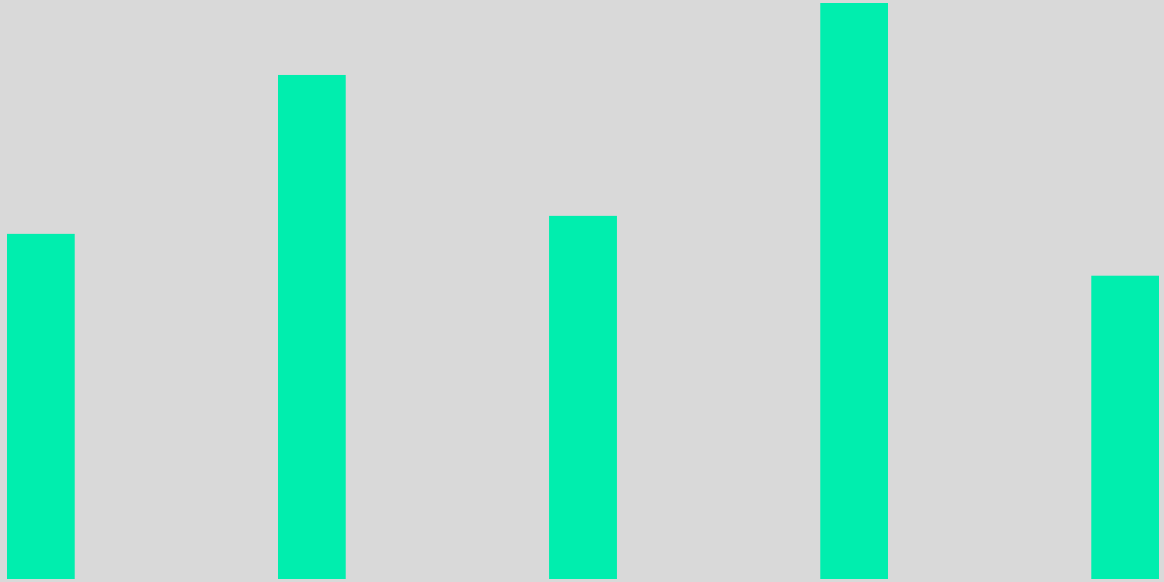
Submitting Additional Information, continued



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

NOTE: The PA number remains the same as the original PA request when resubmitting the PA request.

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. The provider must exhaust any internal grievance process, such as the reconsideration, available through the QIO-like vendor/fiscal agent prior to submitting a DHCFP Fair Hearing request.

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.

Reconsideration Request, continued

- A reconsideration must be requested within 30 calendar days from the date of the denial, except for Residential Treatment Center (RTC) services, which must be requested within 90 calendar days.
- The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review.
- Give a synopsis of the medical necessity not presented previously. Include only the medical records that support the issues identified in the synopsis. Voluminous documentation will not be reviewed. It is the provider's responsibility to identify the pertinent information in the synopsis.
- Only available for denials related to the medical necessity of the service.

Medicaid Provider Hearing

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

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.

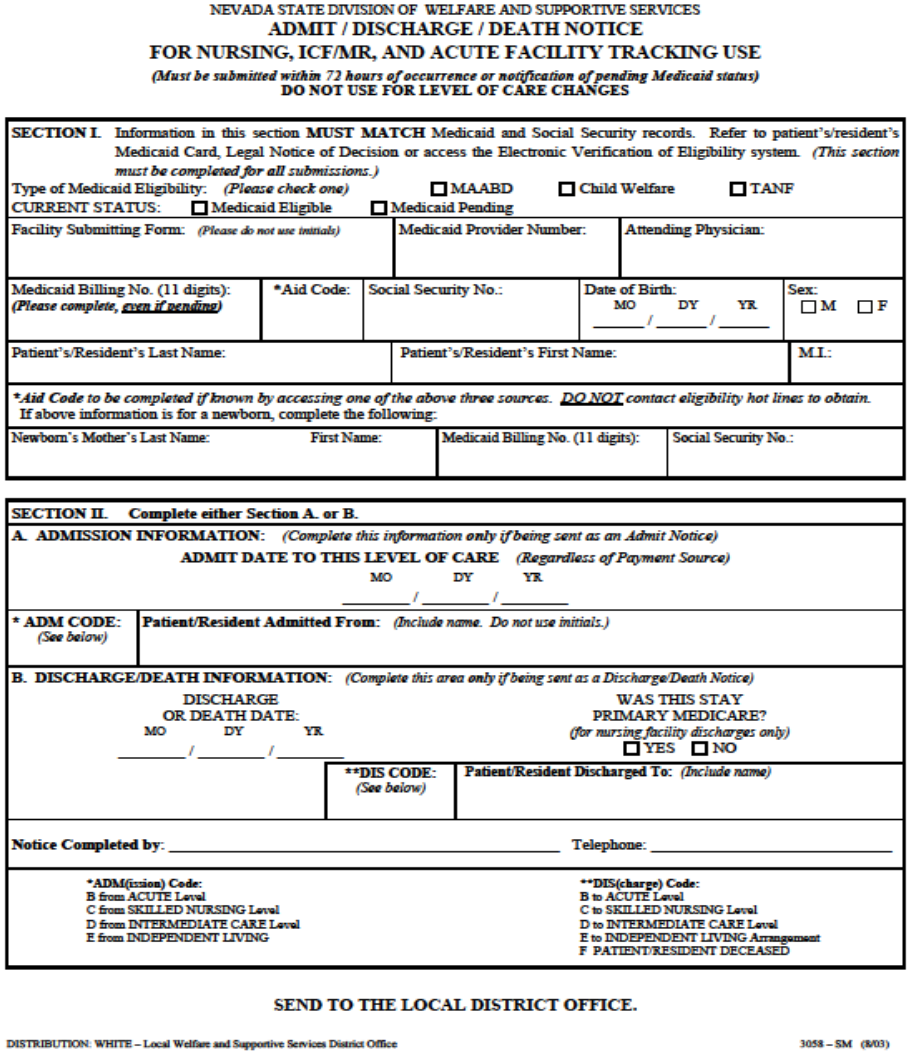
Provider Responsibilities

- 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/dwssnvgov/content/Home/Features/Forms_3058-SM.pdf



NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES
ADMIT / DISCHARGE / DEATH NOTICE
FOR NURSING, ICF/MR, AND ACUTE FACILITY TRACKING USE
(Must be submitted within 72 hours of occurrence or notification of pending Medicaid status)
DO NOT USE FOR LEVEL OF CARE CHANGES

SECTION I. Information in this section **MUST MATCH** Medicaid and Social Security records. Refer to patient's/resident's Medicaid Card, Legal Notice of Decision or access the Electronic Verification of Eligibility system. *(This section must be completed for all submissions.)*

Type of Medicaid Eligibility: *(Please check one)* ☐ MAABD ☐ Child Welfare ☐ TANF
CURRENT STATUS: ☐ Medicaid Eligible ☐ Medicaid Pending

Facility Submitting Form: *(Please do not use initials)*	Medicaid Provider Number:	Attending Physician:

Medicaid Billing No. (11 digits): *(Please complete, even if pending)*	*Aid Code:	Social Security No.:	Date of Birth: MO DY YR	Sex: ☐ M ☐ F
			____ / ____ / ____	

Patient's/Resident's Last Name:	Patient's/Resident's First Name:	M.I.:

**Aid Code to be completed if known by accessing one of the above three sources. DO NOT contact eligibility hot lines to obtain.*
If above information is for a newborn, complete the following:

Newborn's Mother's Last Name:	First Name:	Medicaid Billing No. (11 digits):	Social Security No.:

SECTION II. Complete either Section A. or B.

A. ADMISSION INFORMATION: *(Complete this information only if being sent as an Admit Notice)*
ADMIT DATE TO THIS LEVEL OF CARE *(Regardless of Payment Source)*
MO DY YR
_____ / _____ / _____

* ADM CODE: *(See below)*	Patient/Resident Admitted From: *(Include name. Do not use initials.)*

B. DISCHARGE/DEATH INFORMATION: *(Complete this area only if being sent as a Discharge/Death Notice)*

DISCHARGE OR DEATH DATE: MO DY YR _____ / _____ / _____

WAS THIS STAY PRIMARY MEDICARE? *(for nursing facility discharges only)* ☐ YES ☐ NO

**DIS CODE: *(See below)*	Patient/Resident Discharged To: *(Include name)*

Notice Completed by: _____ Telephone: _____

***ADM(ission) Code:**
B from ACUTE Level
C from SKILLED NURSING Level
D from INTERMEDIATE CARE Level
E from INDEPENDENT LIVING

****DIS(charge) Code:**
B to ACUTE Level
C to SKILLED NURSING Level
D to INTERMEDIATE CARE Level
E to INDEPENDENT LIVING Arrangement
F PATIENT/RESIDENT DECEASED

SEND TO THE LOCAL DISTRICT OFFICE.

DISTRIBUTION: WHITE – Local Welfare and Supportive Services District Office 3058 – SM (8/03)

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 Qualified Medicare Beneficiary (QMB) — in these instances Medicaid may reimburse for copays and/or deductibles for QMB recipients 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

Submit a Claim to Nevada Medicaid via Direct Data Entry (DDE)

Submitting a Claim

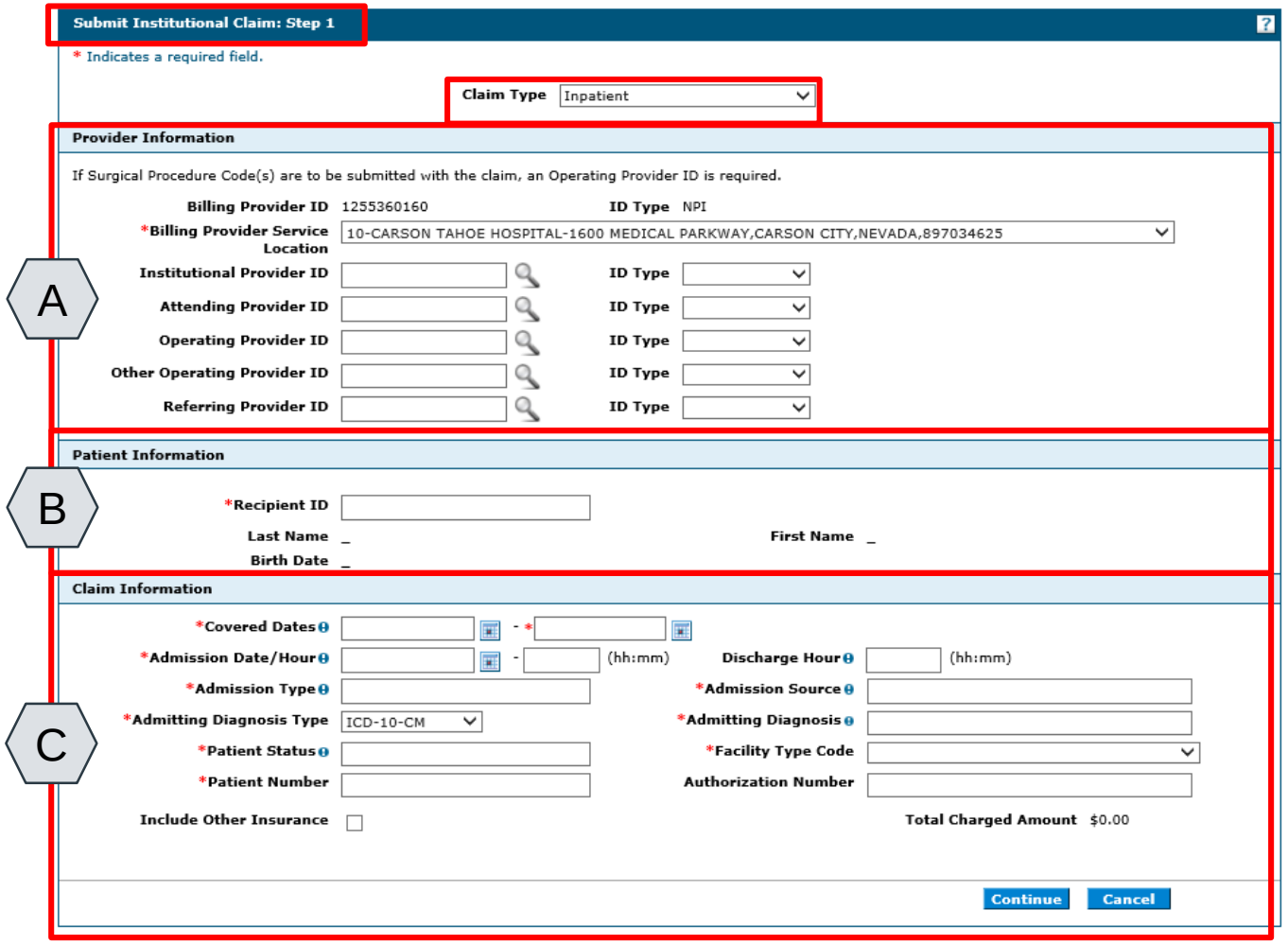
Hover over the **Claims** tab.

Select **Submit Claim Inst.**

Submitting a Claim, continued

RTC providers should select “Inpatient” from the Claim Type drop-down menu.

Submitting a Claim, continued



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

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

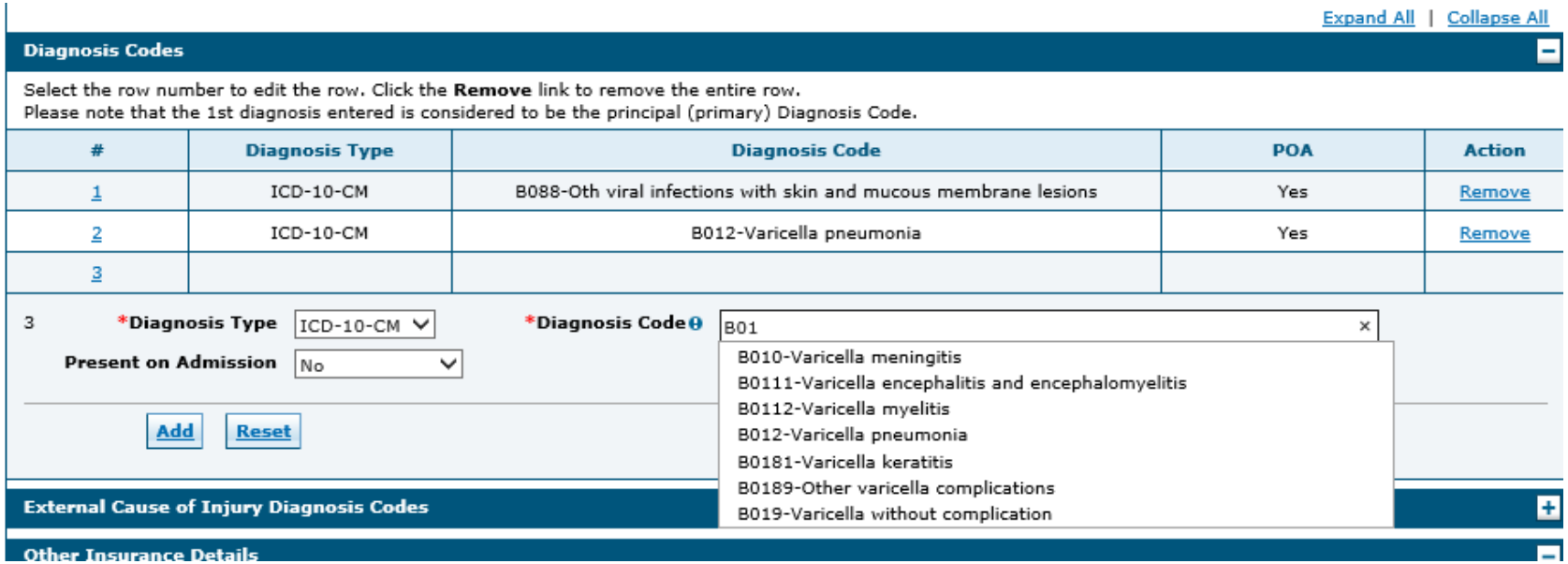
If the recipient has other insurance, the user should select **Include Other Insurance**.

Once all fields are appropriately completed, select **Continue**.

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

Submitting a Claim, continued

Diagnosis Codes

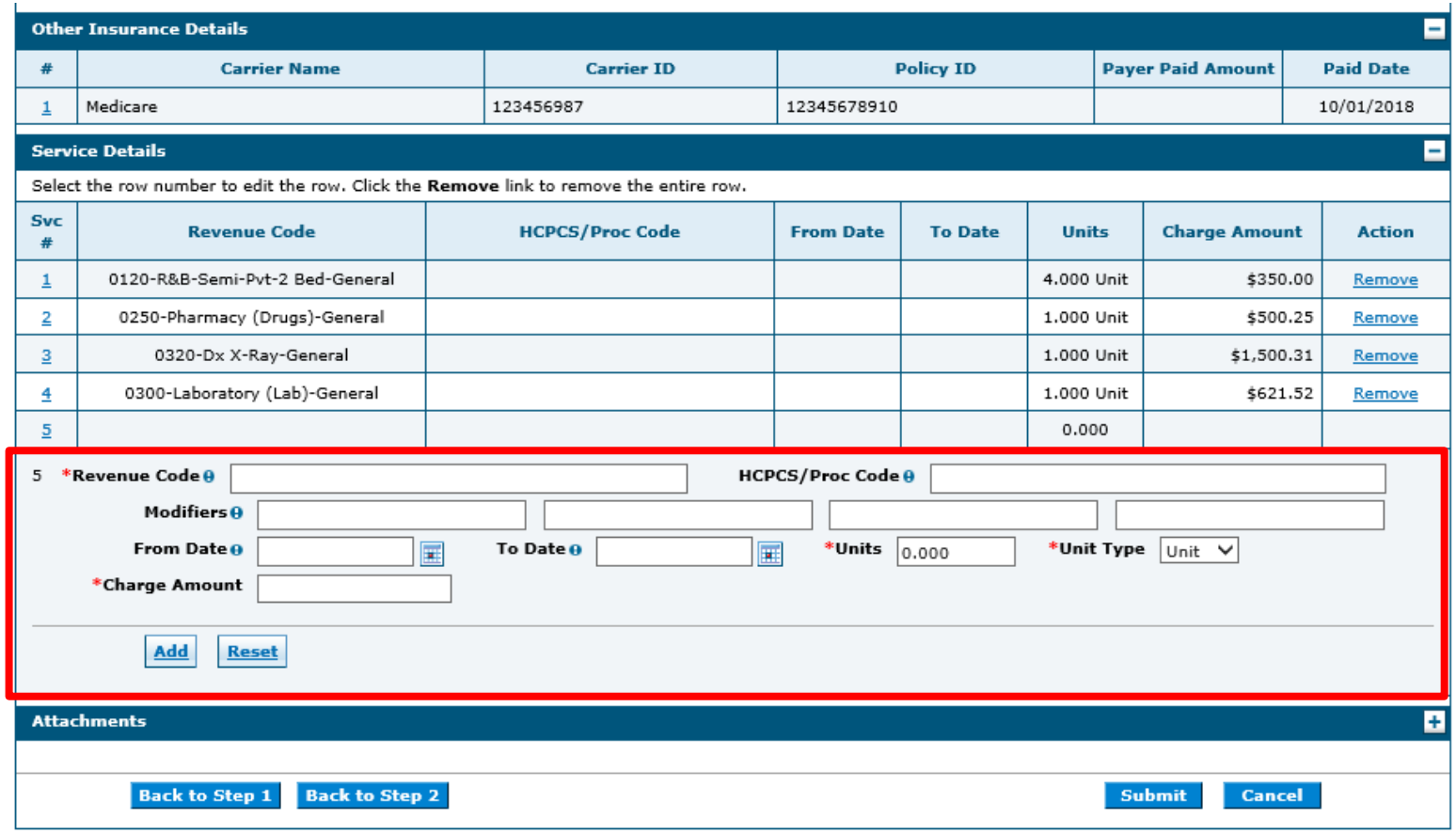


Choose a **Diagnosis Type** (Auto-populates as “ICD-10-CM” but “ICD-9-CM” is also available), enter the **Diagnosis Code** and click the **Add** button**.**

If there is no other insurance on file, user will then select **Continue** from the bottom of the page.

Submitting a Claim, continued

Service Details



Other Insurance Details

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date
1	Medicare	123456987	12345678910		10/01/2018

Service Details

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

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0120-R&B-Semi-Pvt-2 Bed-General				4.000 Unit	$350.00	Remove
2	0250-Pharmacy (Drugs)-General				1.000 Unit	$500.25	Remove
3	0320-Dx X-Ray-General				1.000 Unit	$1,500.31	Remove
4	0300-Laboratory (Lab)-General				1.000 Unit	$621.52	Remove
5					0.000		

5 *Revenue Code HCPCS/Proc Code

Modifiers

From Date To Date *Units 0.000 *Unit Type Unit

*Charge Amount

Add Reset

Attachments

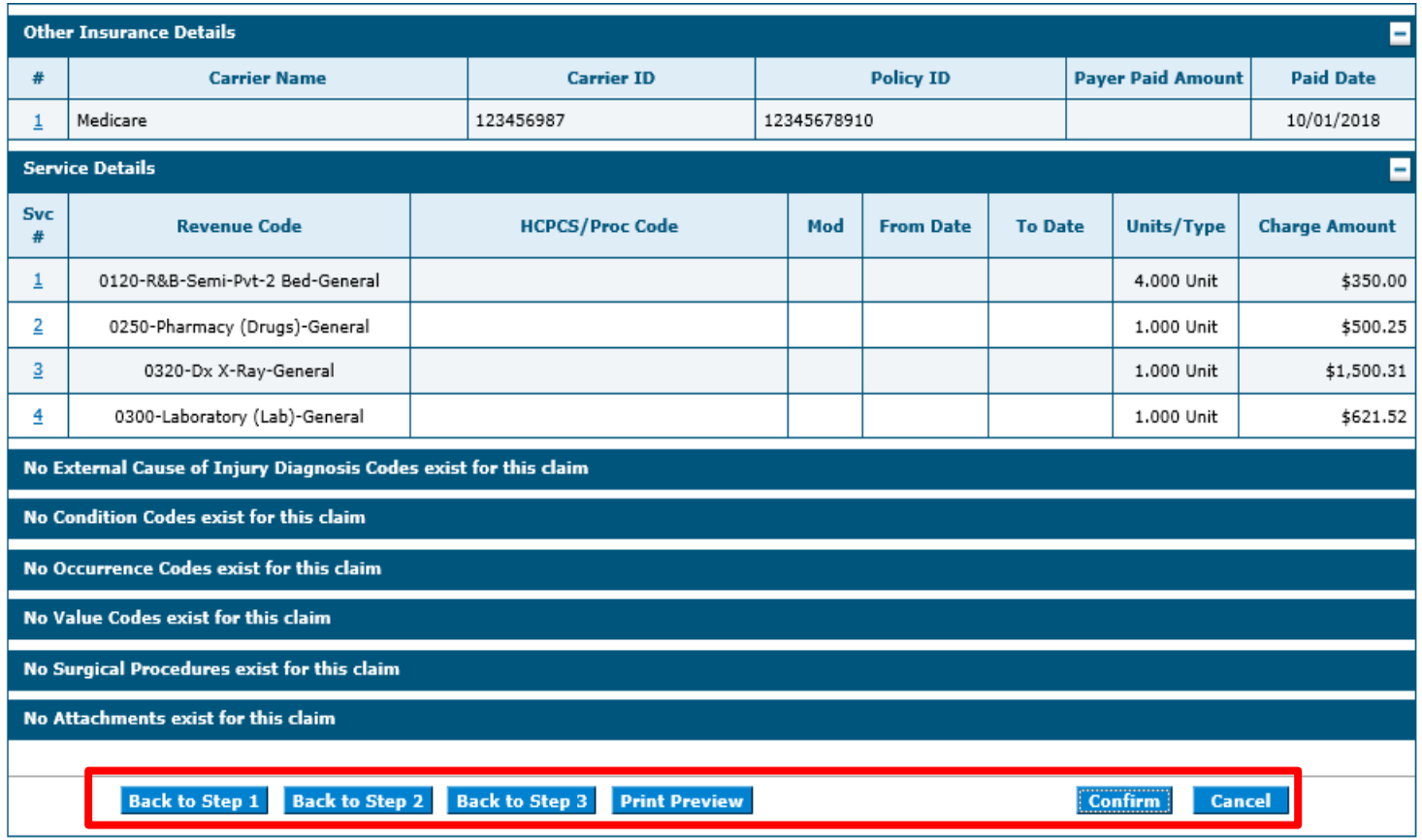
Back to Step 1 Back to Step 2 Submit Cancel

Enter the required fields.

Click the **Add** button.

Click the **Submit** button.

Submitting a Claim, continued



Other Insurance Details

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date
1	Medicare	123456987	12345678910		10/01/2018

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount
1	0120-R&B-Semi-Pvt-2 Bed-General					4.000 Unit	$350.00
2	0250-Pharmacy (Drugs)-General					1.000 Unit	$500.25
3	0320-Dx X-Ray-General					1.000 Unit	$1,500.31
4	0300-Laboratory (Lab)-General					1.000 Unit	$621.52

No External Cause of Injury Diagnosis Codes exist for this claim

No Condition Codes exist for this claim

No Occurrence Codes exist for this claim

No Value Codes exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

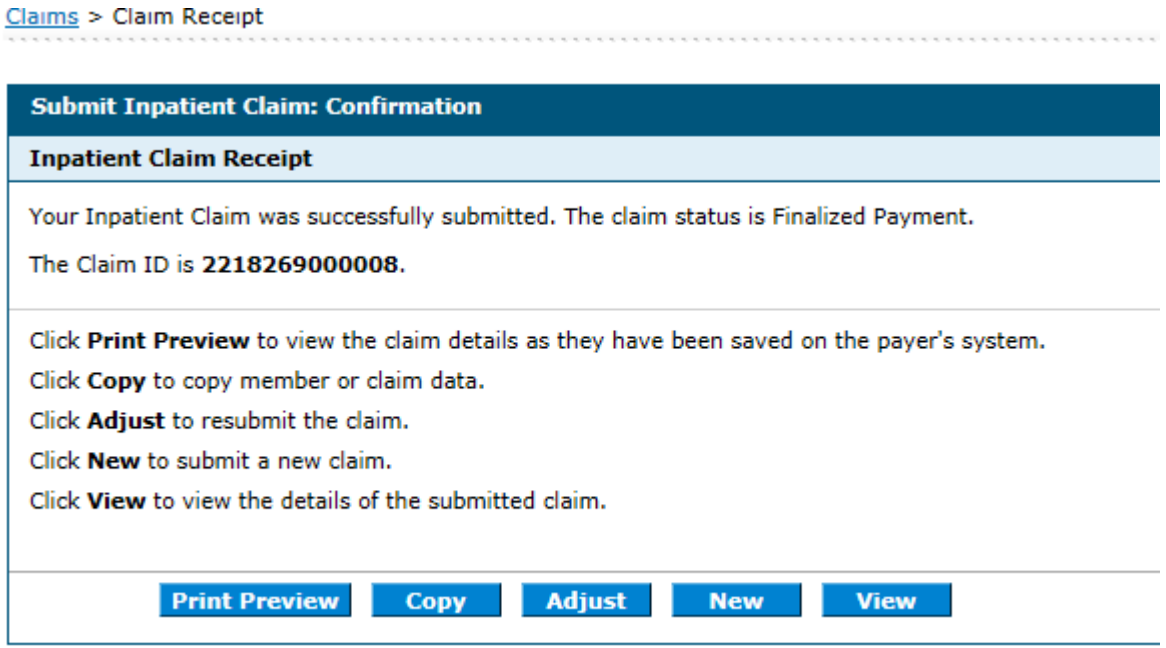
Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | Confirm | Cancel

At this point, the user has the option to:

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

To continue, the user must click the **Confirm** button.

Submitting a Claim, continued

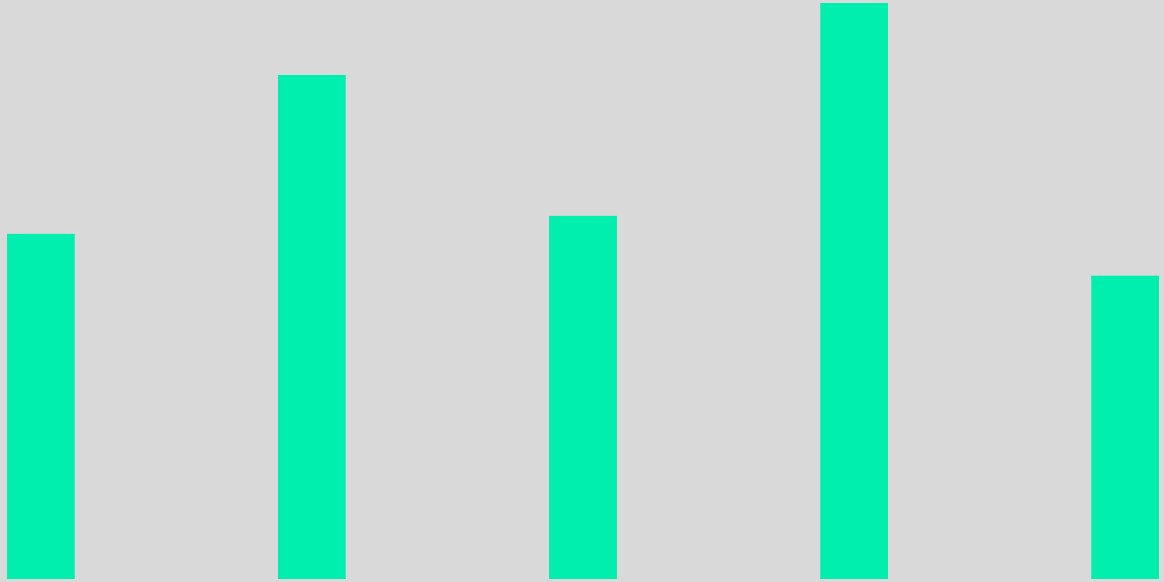


The **Submit Inpatient Claim: Confirmation** will appear after the claim has been submitted. It will display the claim status and Claim ID.

The user may then:

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

Submitting a Claim with Third Party Liability (TPL)



Claim Submission: TPL

This section will cover the submission of claims in EVS where there is Other Healthcare Coverage. ***Failure to submit claims properly may result in denial***, so please be aware of the following rules prior to submission.

In the case of Professional or Dental Third Party Liability (TPL) claims:

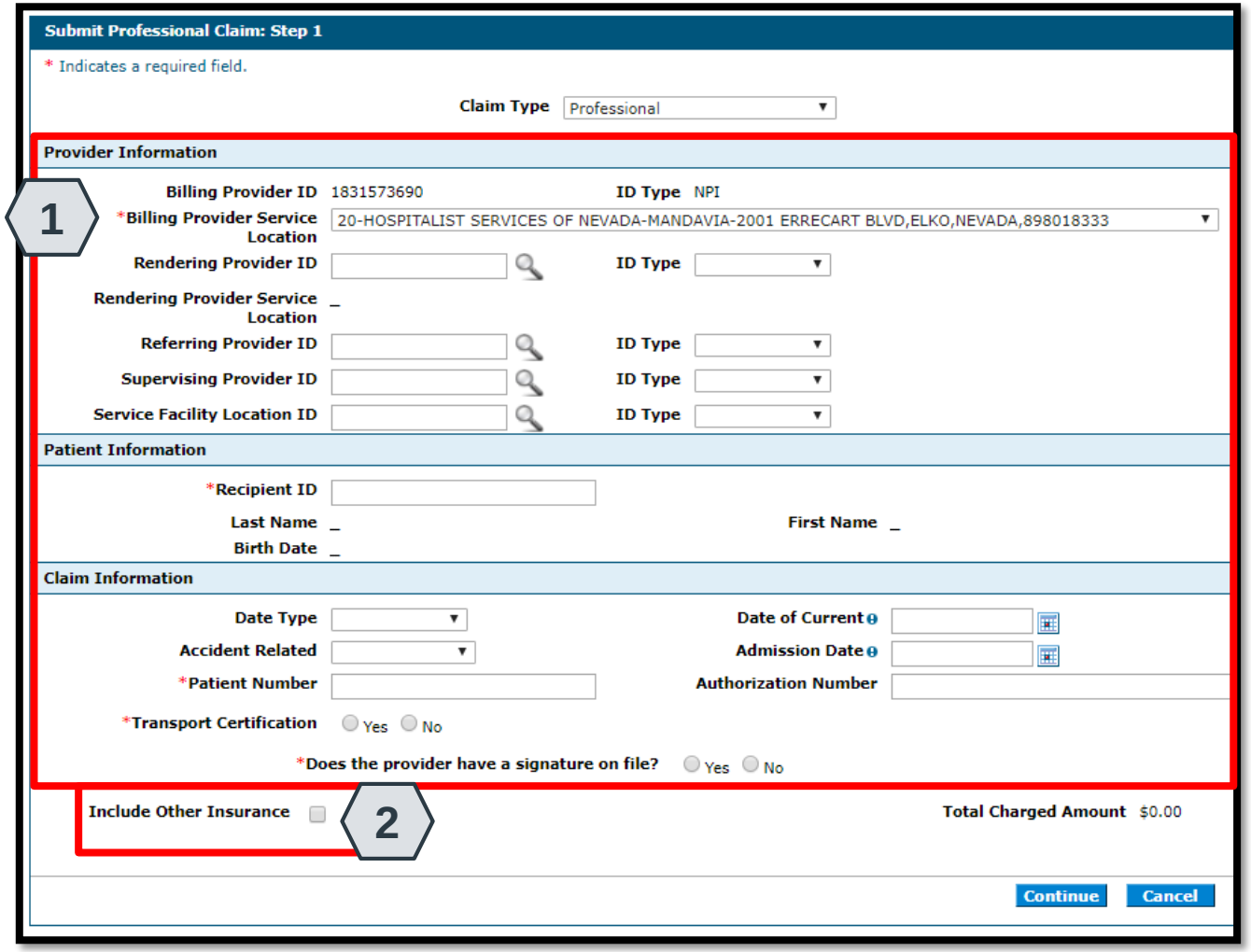
A. Claim must be submitted as “Professional” or “Dental” appropriately (*not Crossover*):
    a. “Include Other Insurance” box in Step 1 of claim must be checked
B. In Step 2, the applicable TPL carrier should be selected from the list:
    a. Remove any carriers that are not applicable to the claim
    b. If the carrier is not on the list, click to add new other insurance
    c. Input payment information, but *do not* include Adjustment Reason codes
C. In Step 3, input service details:
    a. Enter TPL carrier/payment information
    b. Claim Adjustment Detail *must* be entered for each service detail
    c. Do Enter adjustments details in this step
    d. No EOB attachment is needed

Claim Submission: TPL, continued

In the case of Institutional TPL claims:

A. Claim must be submitted as “Inpatient” or “Outpatient” appropriately (*not Crossover*)
B. “Include Other Insurance” box in Step 1 of claim must be checked
C. In Step 2, the applicable TPL carrier should be selected from the list:
    a. Remove any carriers that are not applicable to the claim
    b. If the carrier is not on the list, click to add new other insurance
    c. Input carrier/payment information
    d. Do Enter Claim Adjustment Details in this step
D. In Step 3, input service details:
    a. Do not include Adjustment Reason codes
    b. No EOB attachment is needed

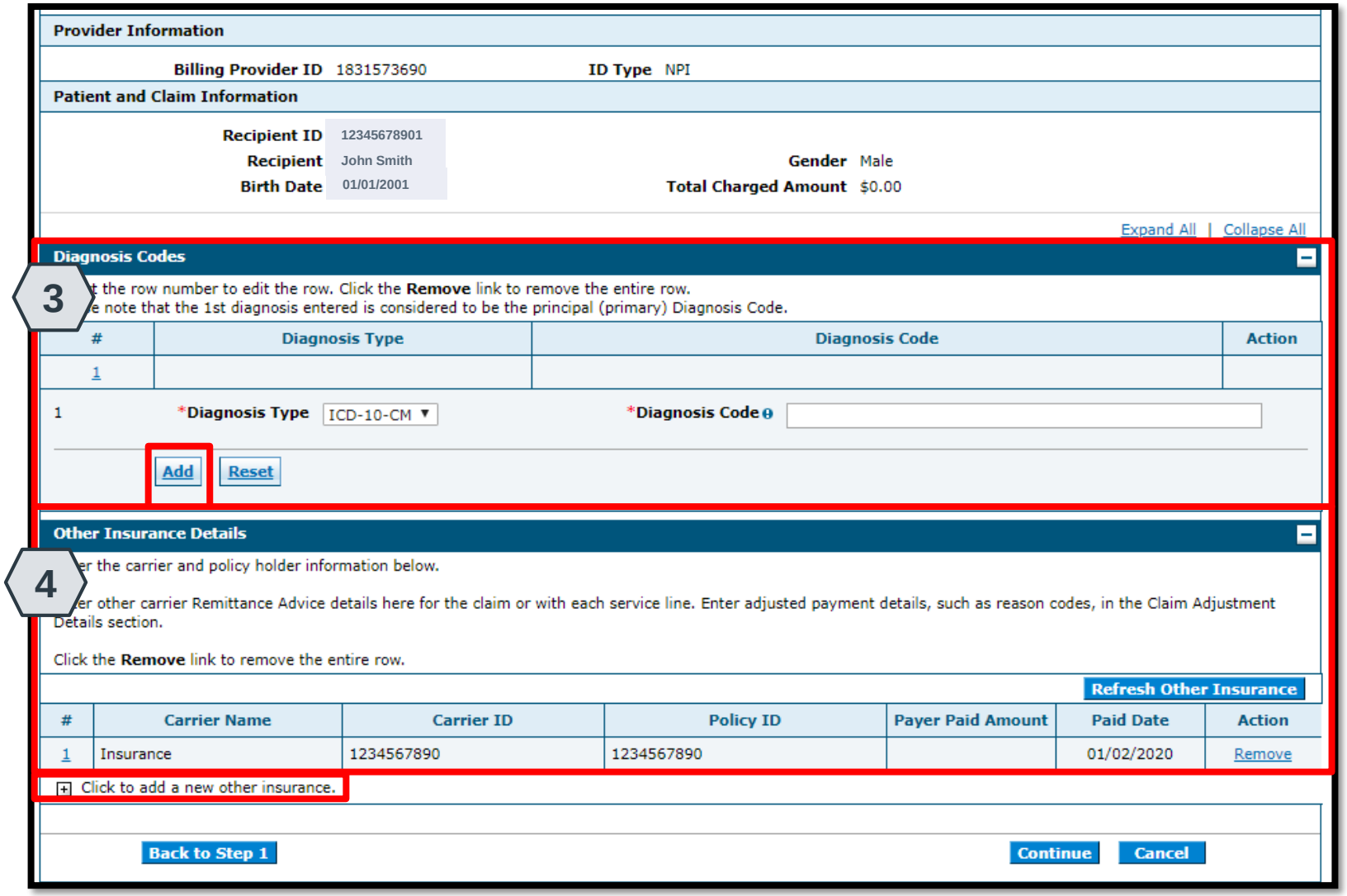
Claim Submission: TPL, continued



In Step 1, after selecting the appropriate claim type, the user will:

1. Fill out the provider, patient and claim information
2. Select the “Include Other Insurance” checkbox to indicate that there is Other Healthcare Coverage to be included on the claim

Claim Submission: TPL, continued

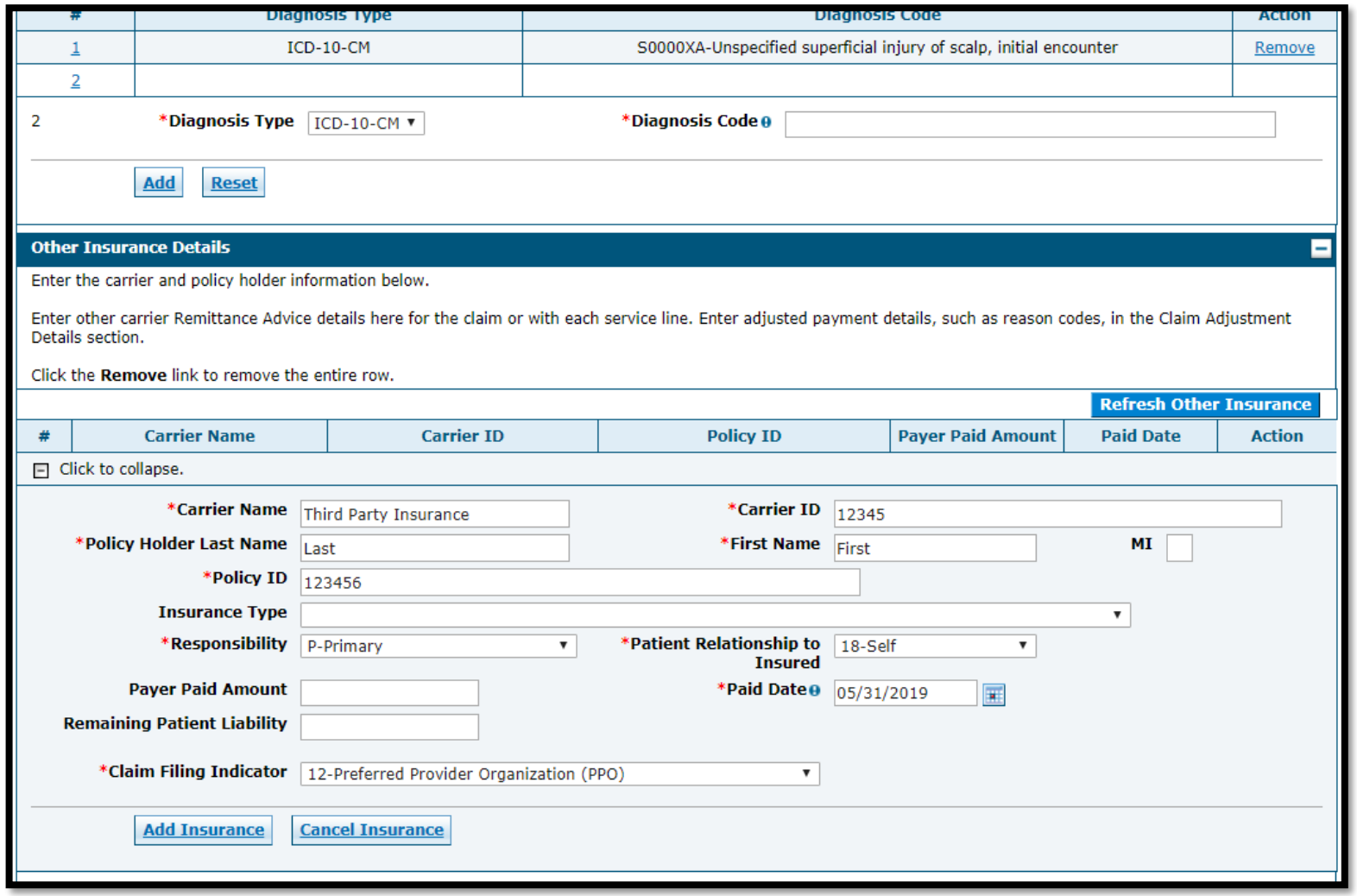


In Step 2, the user will:

3. Enter all applicable diagnosis codes and click **Add** for each one
4. Complete the section titled **Other Insurance Details** with any applicable carrier or payment information

TPL details already on file with Nevada Medicaid will populate carrier information automatically. If no recipient TPL information is automatically populated, select “+ Click to add a new other insurance” to add the information.

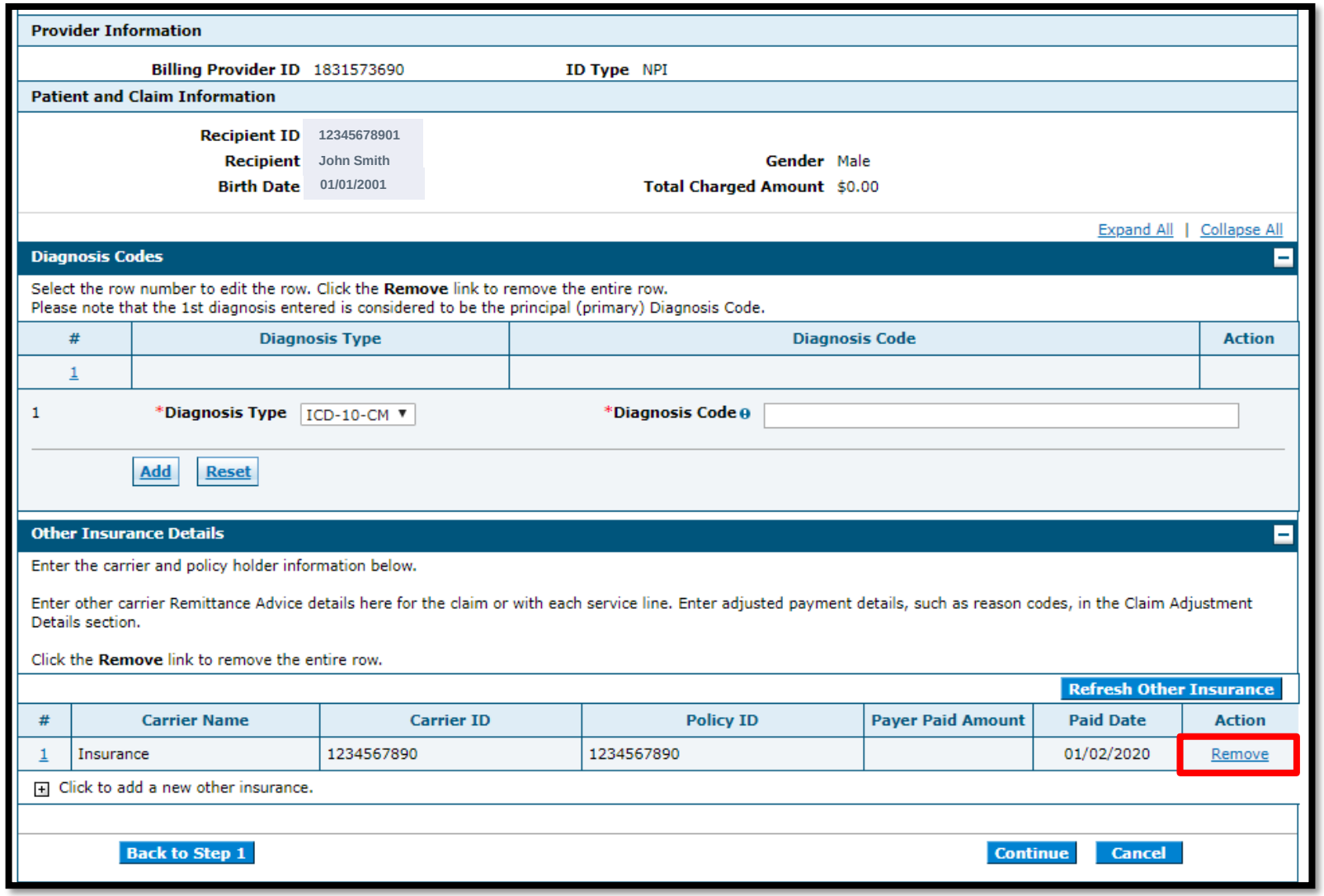
Claim Submission: TPL, continued



After clicking the (+), the user must complete all required fields (*) and select the **Add Insurance** button to add the Other Insurance details to the claim.

NOTE: The **Carrier ID** is information that is listed on the recipient's ID card and should be five digits. This is also known as the Electronic Payer ID.

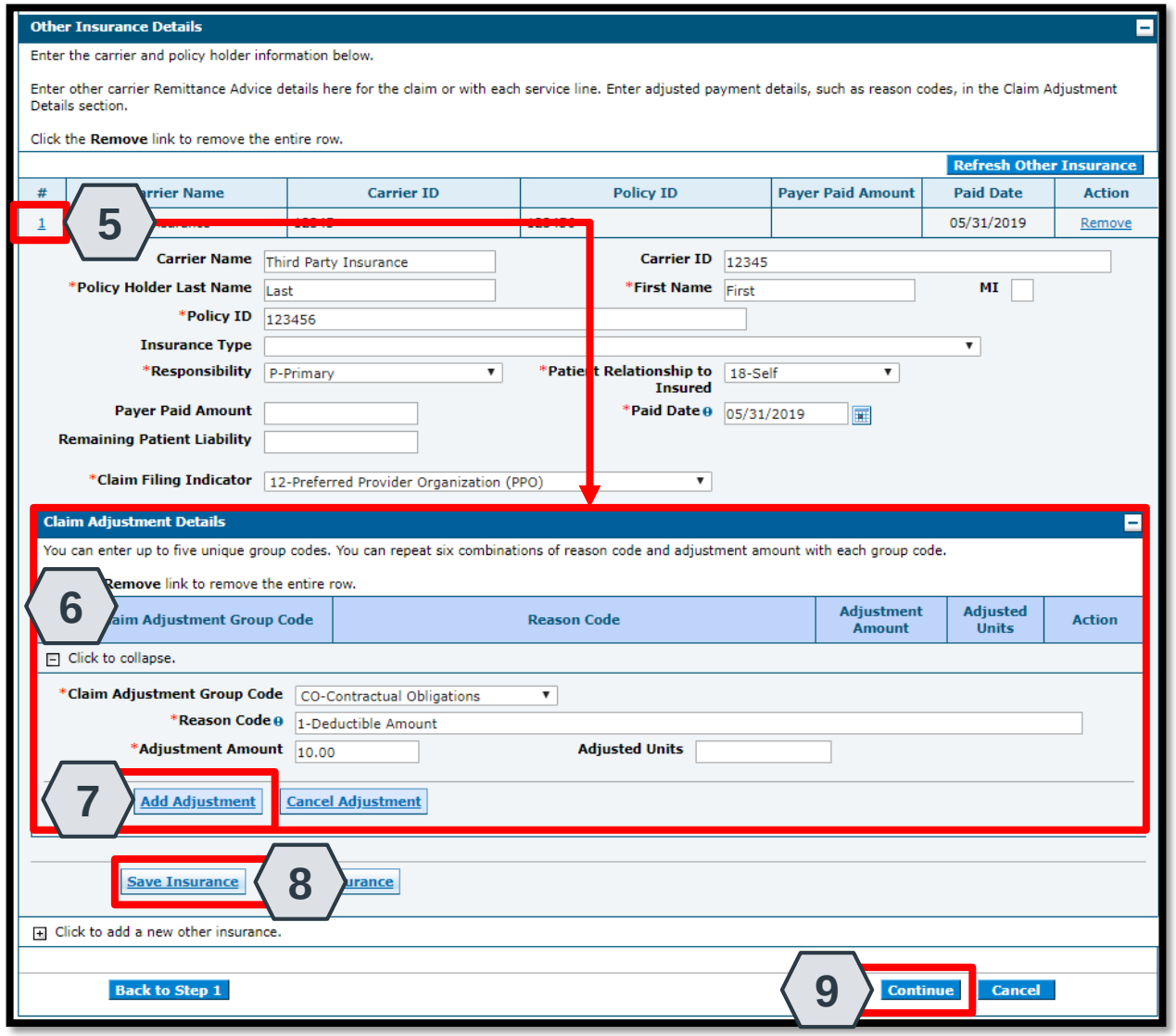
Claim Submission: TPL, continued



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

NOTE: Do not enter more than ten (10) Other Insurance details.

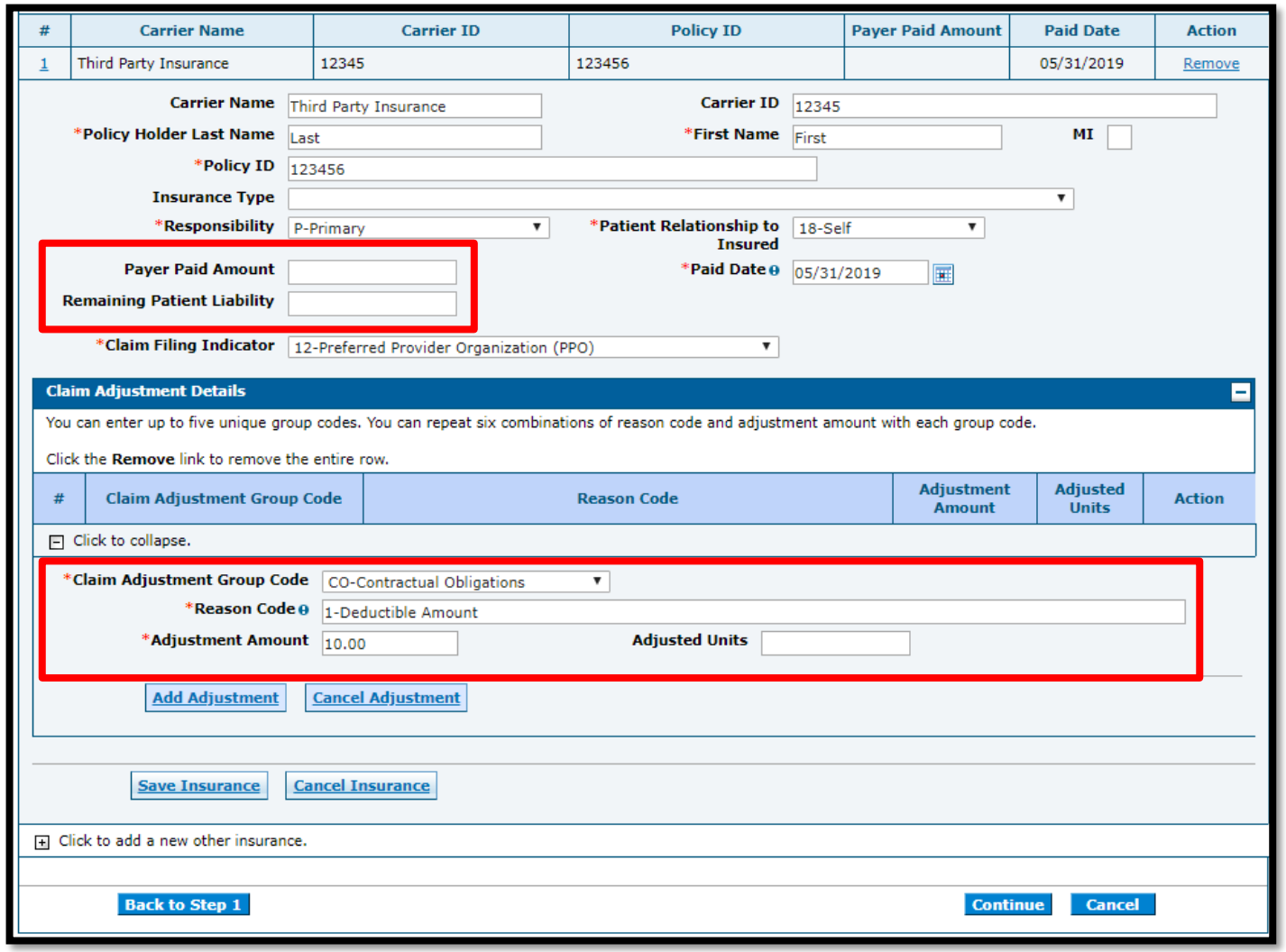
Claim Submission: TPL, continued



If submitting an Institutional claim, the user must complete any Claim Adjustment Details. If the user is submitting a Professional claim, do not include Adjustment Details in this step and skip to slide 135.

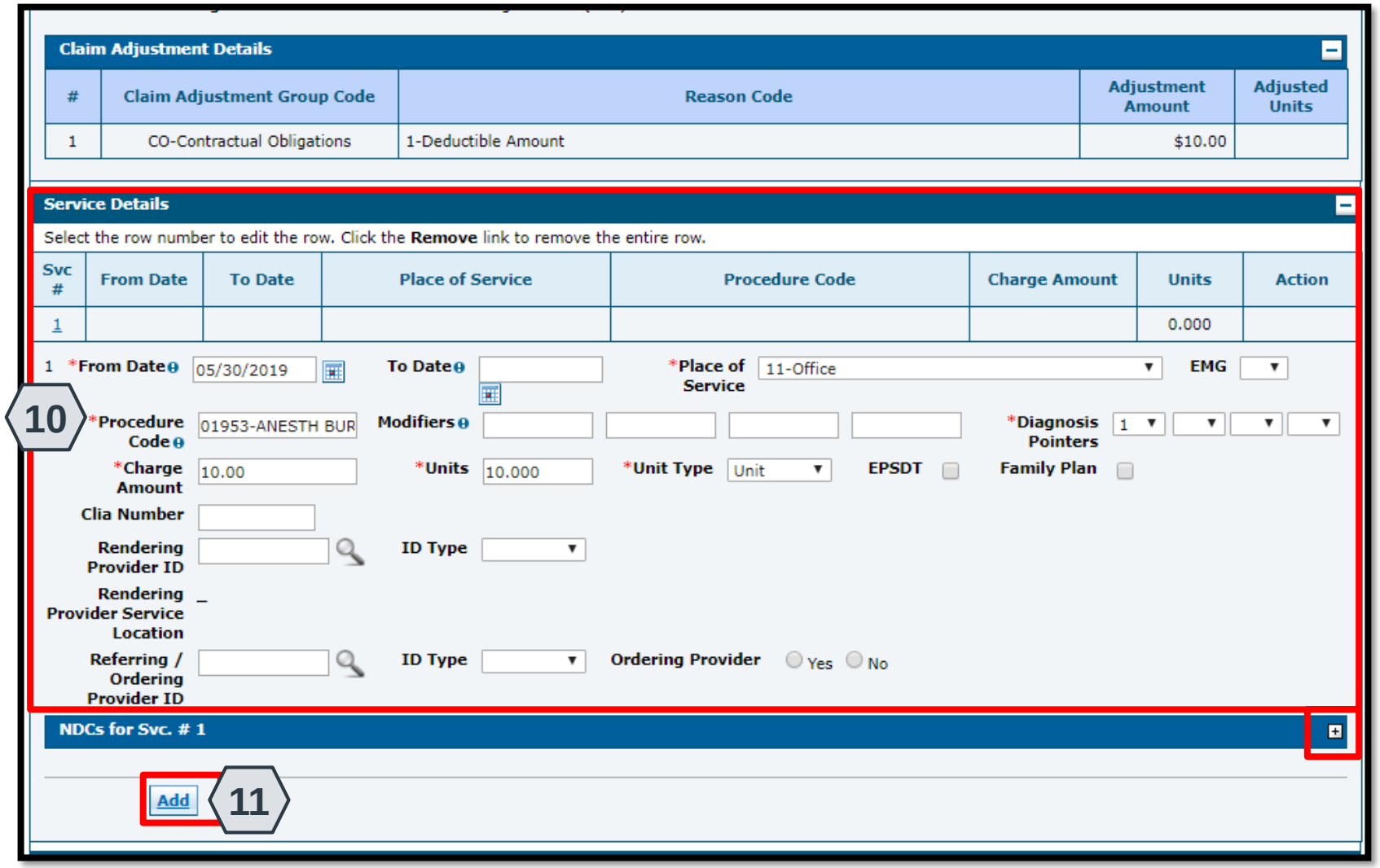
5. Select the sequence number adjacent to the relevant carrier (#)
6. Enter the **Claim Adjustment Details**
7. Click **Add Adjustment** to ensure that the adjustment details are added to the carrier details
8. Click **Save Insurance** to save updates
9. Click **Continue** to go to Step 3

Claim Submission: TPL, continued



NOTE: Information for the **Payer Paid Amount**, **Remaining Patient Liability** and **Claim Adjustment Details** must match the Explanation of Benefits (EOB).

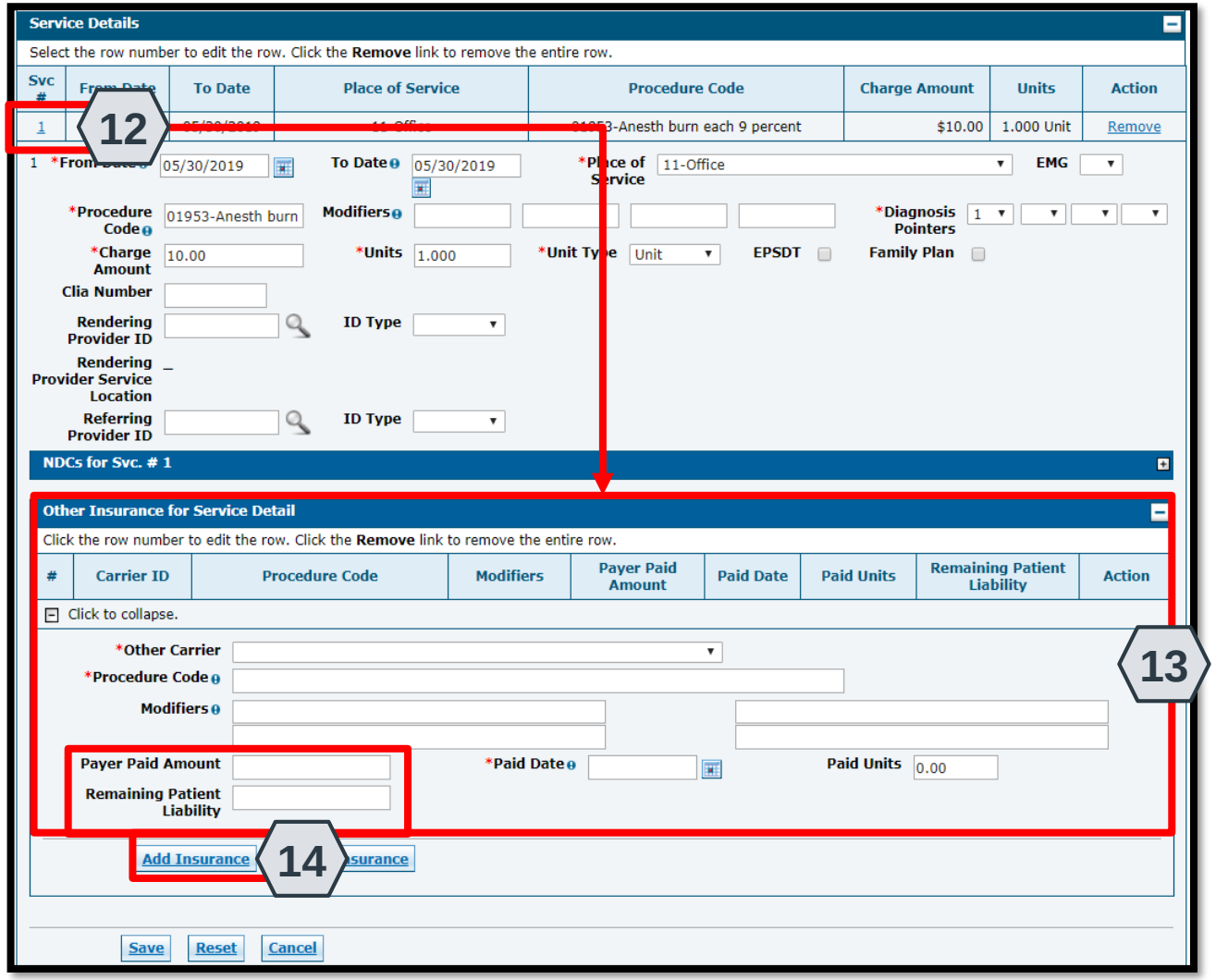
Claim Submission: TPL, continued



In Step 3, the user must:

10. Enter all applicable Service Detail information
11. Click **Add** to add each service detail to the claim

Claim Submission: TPL, continued

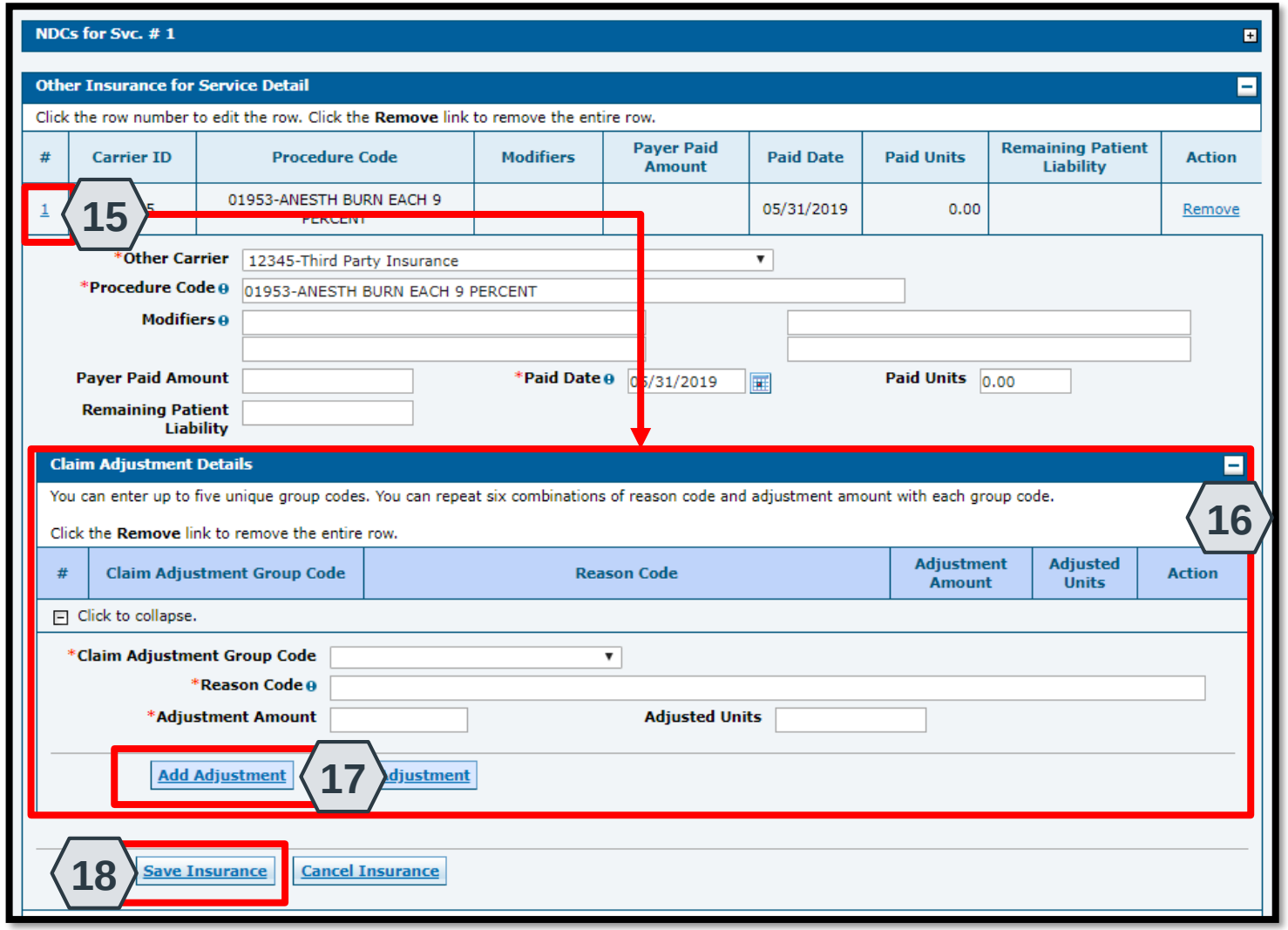


For Professional claims, Other Insurance information is required for each service detail entered. If submitting an Institutional claim, skip this slide.

12. Select the appropriate Service Line Detail **(Svc)**
13. Enter **Other Insurance for Service Detail** information
14. Click **Add Insurance** to add insurance information to the service detail

NOTE: The amounts in **Payer Paid Amount** and **Remaining Patient Liability** are specific to the service rendered. The total paid amounts for all service details are reflected in Step 2.

Claim Submission: TPL, continued

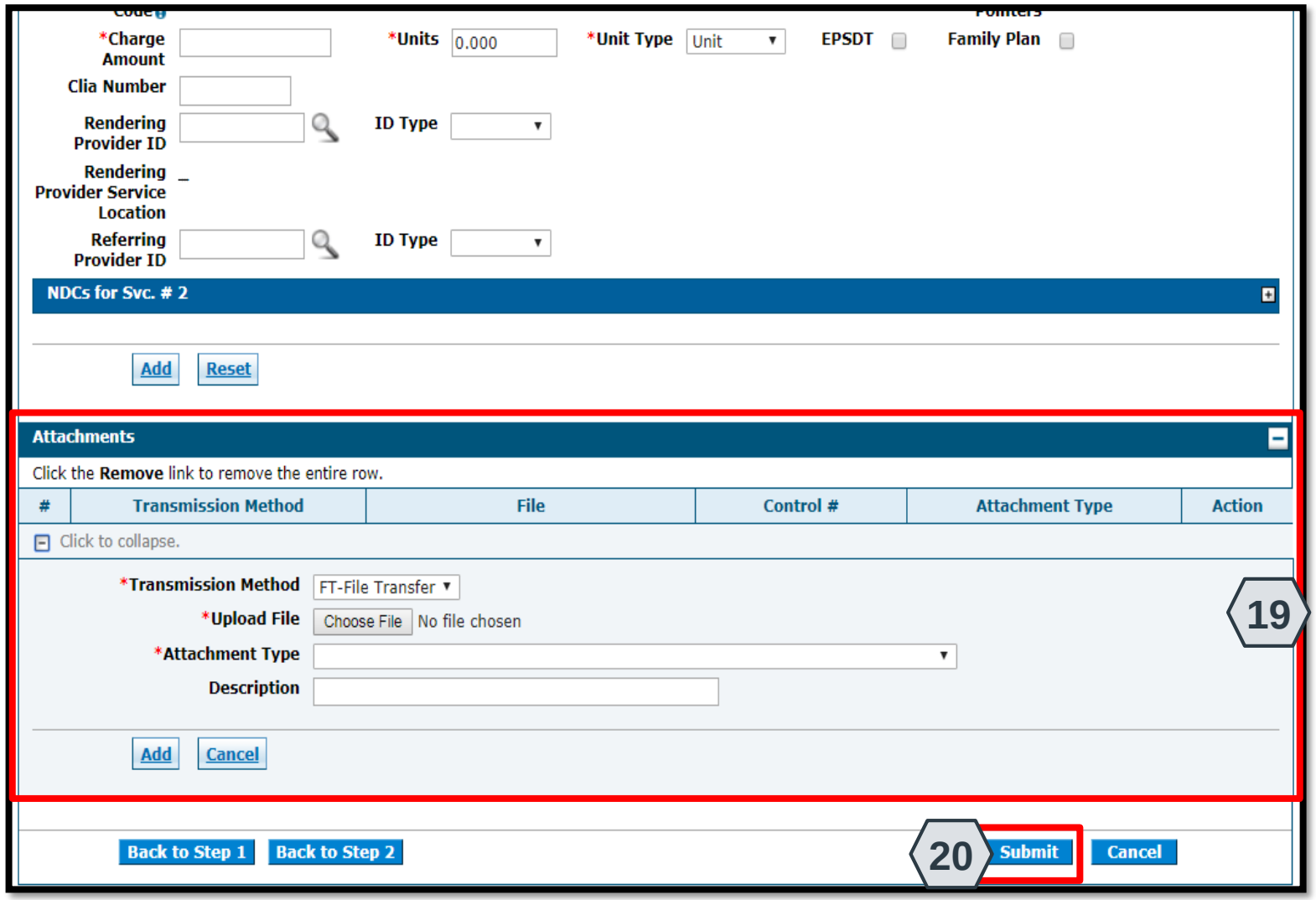


For Professional claims, Adjustment Details must be entered for each service line. For Institutional claims, skip this slide.

15. Select the sequence number adjacent to the relevant procedure code
16. Complete the **Claim Adjustment Details** panel
17. Click **Add Adjustment** to add the adjustment details
18. Click **Save Insurance** to save all insurance details to the claim line

NOTE: Do not enter more than ten (10) Claim Adjustment Details.

Claim Submission: TPL, continued

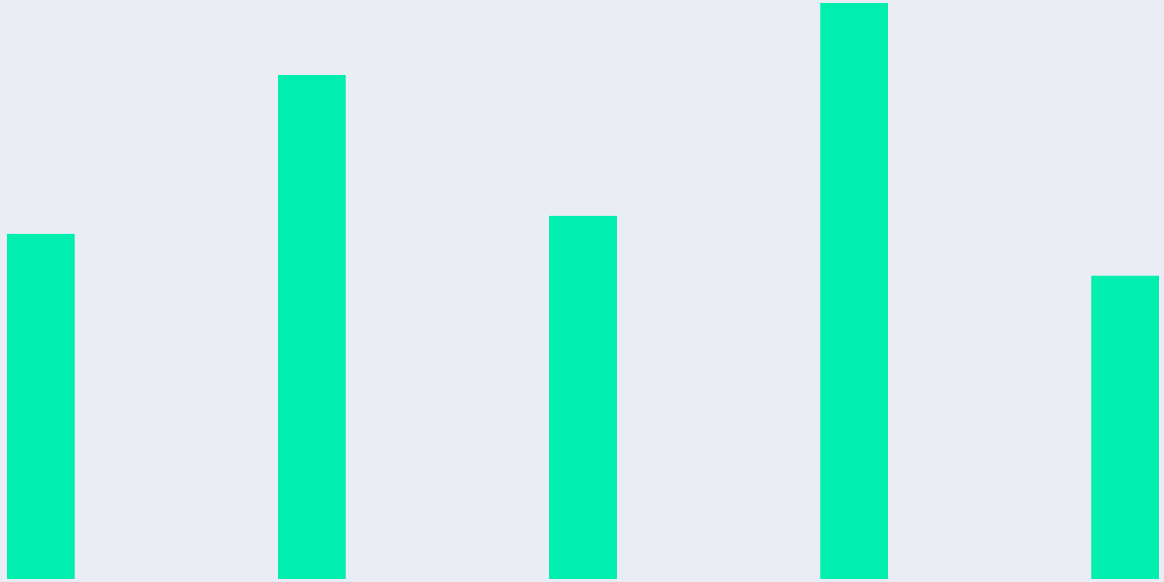


19. Add any necessary attachments
20. Click **Submit**

After clicking **Submit**, the user will be provided a final opportunity to review the claim before final submission and adjudication.

NOTE: It is not necessary to upload the EOB.

Claim Submission: Medicare Crossover



Claim Submission: Medicare Crossover

This section will cover the submission of Medicare Crossover claims in EVS where Medicare is the primary payer. ***Failure to submit claims properly may result in denial***, so please be aware of the following rules prior to submission.

In the case of Professional Crossover claims:

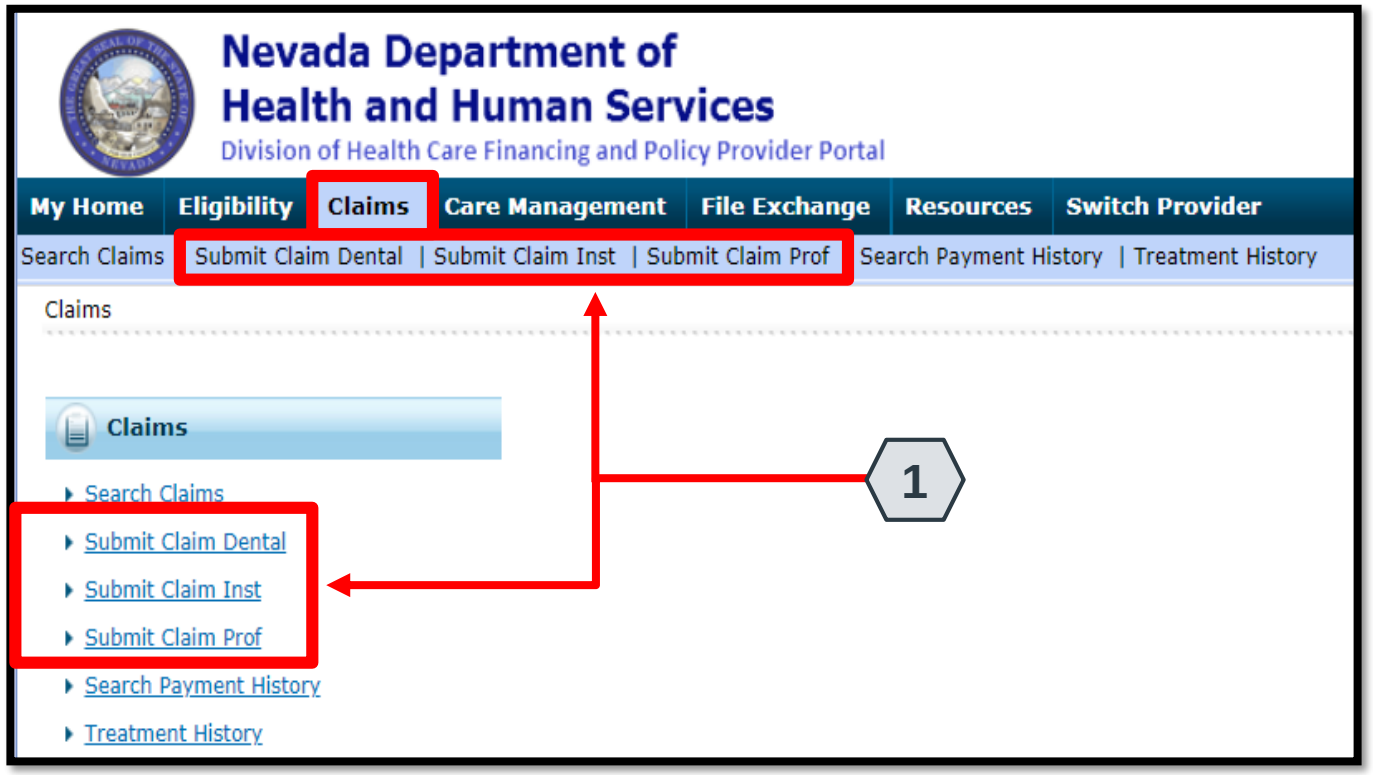
A. When Medicare has made a payment on the claim, or has left an amount to patient responsibility (i.e., coinsurance, copay, deductible):
    a. Claim must be submitted as “Crossover Professional”
    b. Crossover details must be filled out
    c. No Explanation of Benefits (EOB) attachment needed
B. If Medicare denies the claim, the “Other Insurance” rules must be followed:
    a. Medicare will need to be added as an Other Insurance carrier
    b. Carrier/payment information must be listed at the header
    c. Claim Adjustment Reason Code (CARC) details must be submitted with each detail level
    d. No EOB attachment needed

Claim Submission: Medicare Crossover, continued

In the case of Institutional Crossover claims:

A. When Medicare has made a payment or has left an amount to patient responsibility (i.e., coinsurance, copay, deductible):
    a. Claim must be submitted as “Crossover Inpatient” or “Crossover Outpatient”
    b. Crossover details must be filled out
    c. No EOB attachment needed
B. If Medicare denies the claim, the “Other Insurance” rules must be followed:
    a. Medicare will need to be added as an Other Insurance carrier
    b. Carrier/payment information must be listed at the header
    c. CARC details must be submitted at the header
    d. No EOB attachment needed

Claim Submission: Medicare Crossover, continued

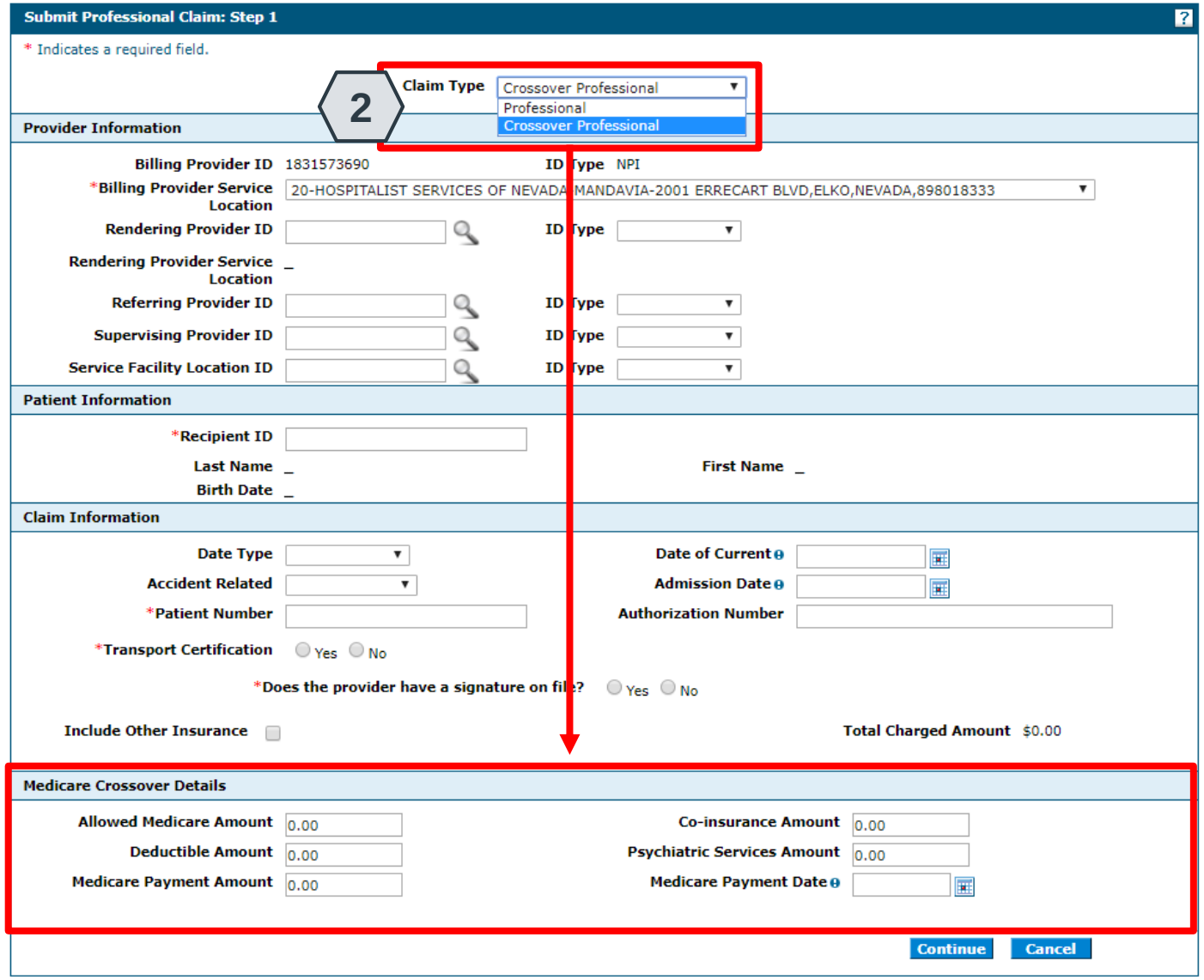


Crossover claims may be submitted in EVS by first changing the claim type to indicate a crossover.

Once the user has logged into the EVS secure Provider Web Portal, the user will:

1. Select the appropriate claim type to submit from the **Claims** sub-menu

Claim Submission: Medicare Crossover, continued

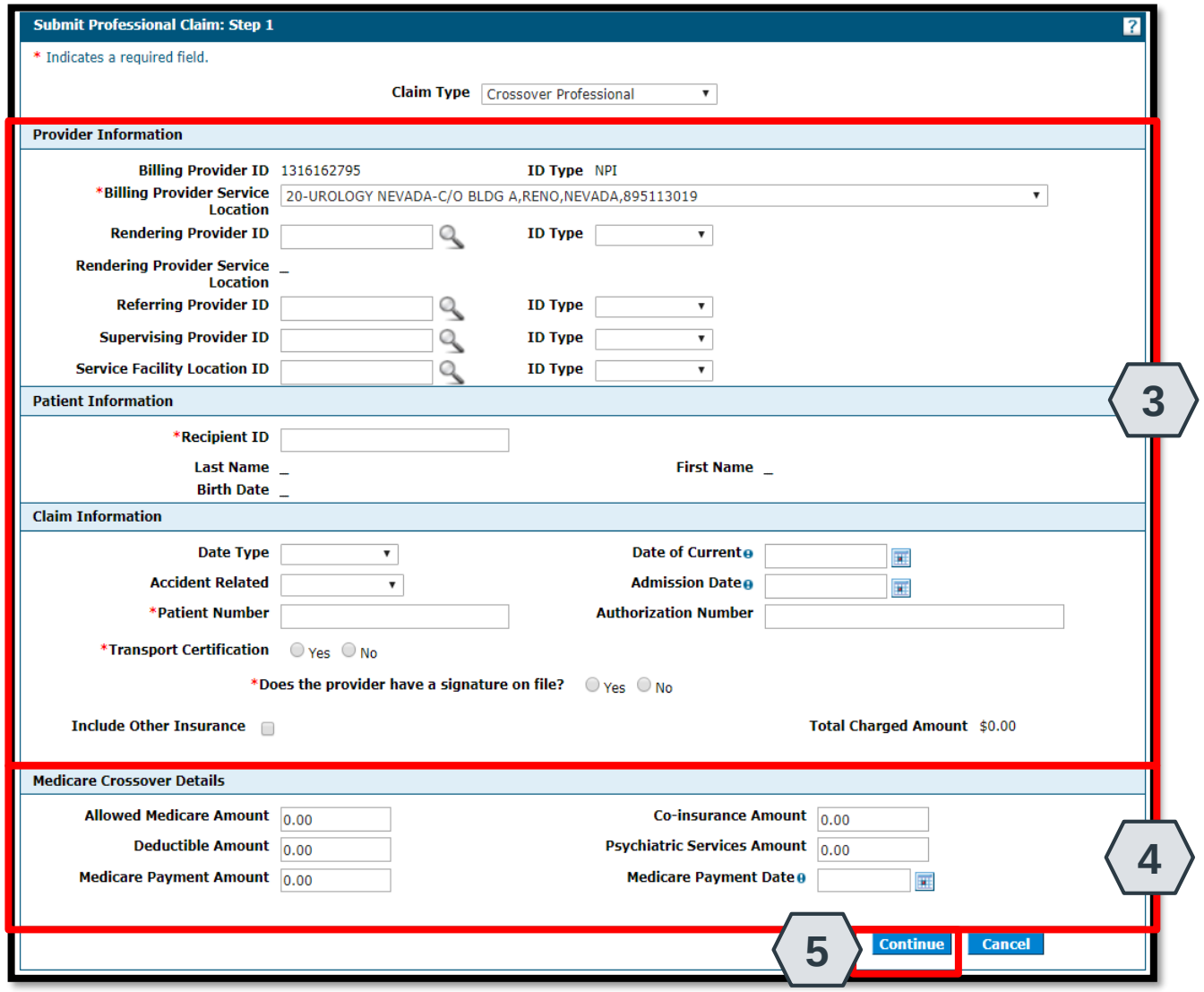


After selecting either a Professional or Institutional claim type, the user will:

2. Select a “Crossover” option from the **Claim Type** drop-down menu

Once crossover is selected, the page will refresh and a new panel, **Medicare Crossover Details**, will appear at the bottom.

Claim Submission: Medicare Crossover, continued

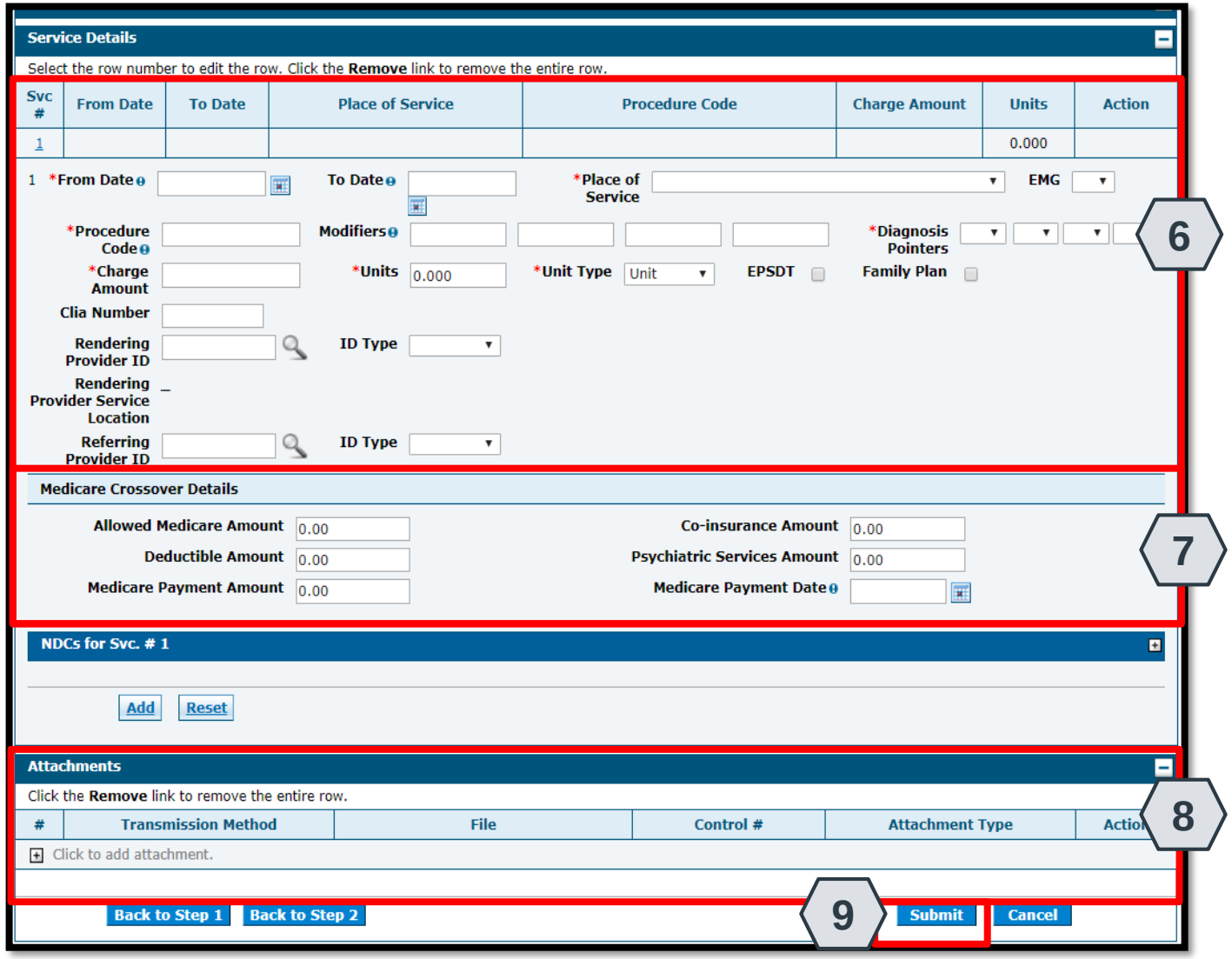


In Step 1, after selecting the appropriate claim type, the user will:

3. Fill out the provider, patient and claim information
4. Complete the new section, **Medicare Crossover** details
5. Click **Continue**

The **Medicare Crossover Details** panel will populate with information at the header level that will encompass the entire claim and at least one (1) of the fields must be completed.

Claim Submission: Medicare Crossover, continued



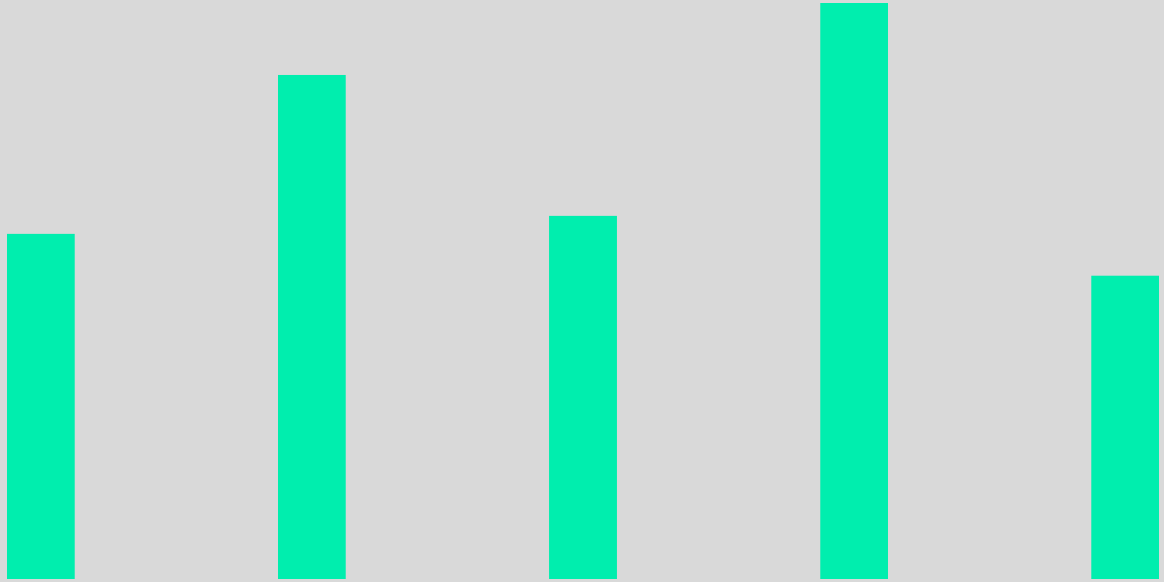
After Step 1 is completed, the user will enter claim information in Step 2. Once all applicable information is added, the user will continue to Step 3.

In Step 3, the user will:

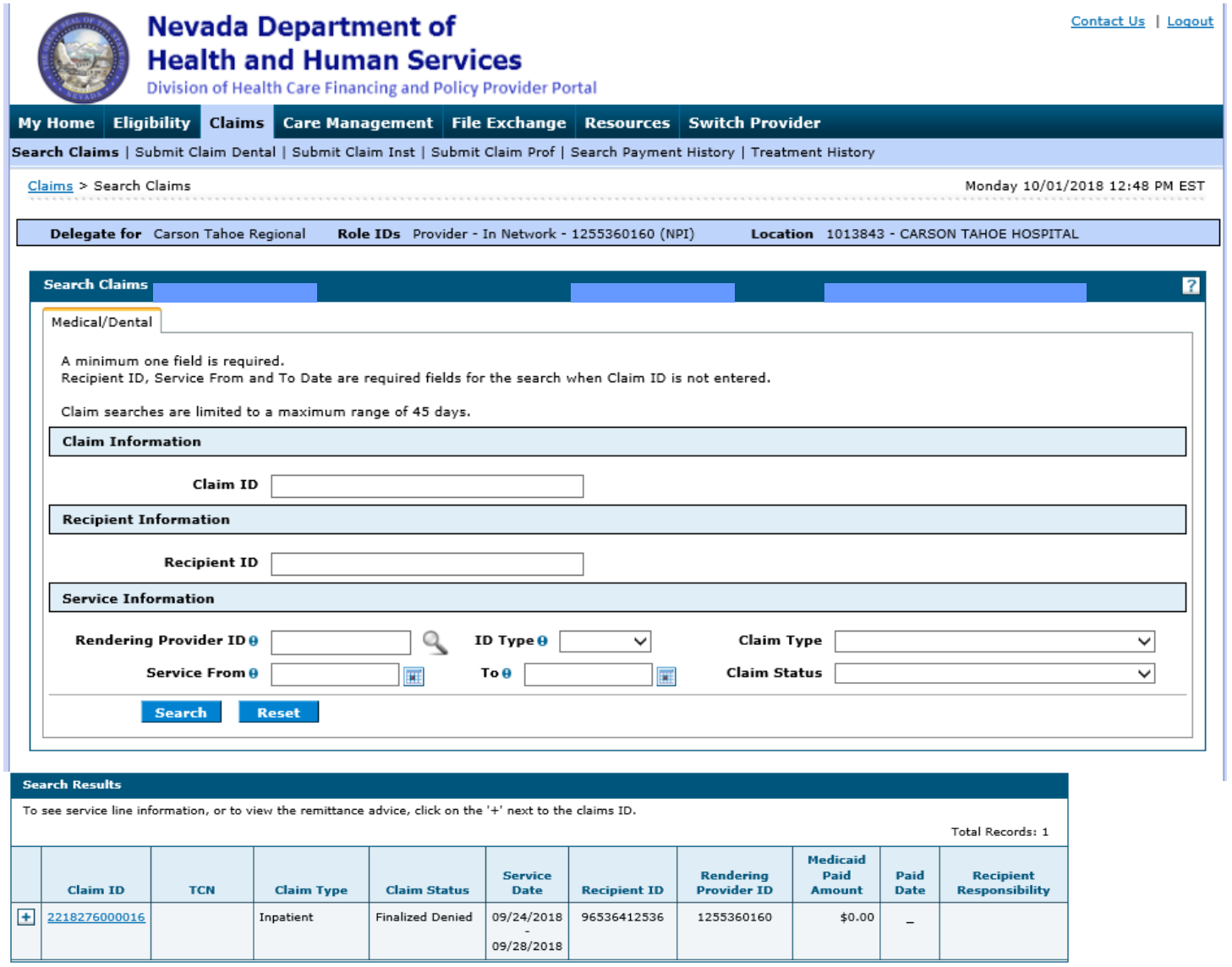
6. Input all applicable Procedure Codes
7. Complete the **Medicare Crossover Details** for each individual Service Line (This information is specific to that Service Line (**Svc** #) and must match the EOB)
8. Add any attachments that are necessary
9. Click **Submit**

NOTE: It is not necessary to upload the EOB.

Searching for Claims



Search for Claims



To search for a claim,
Hover over **Claims** and select **Search Claims**

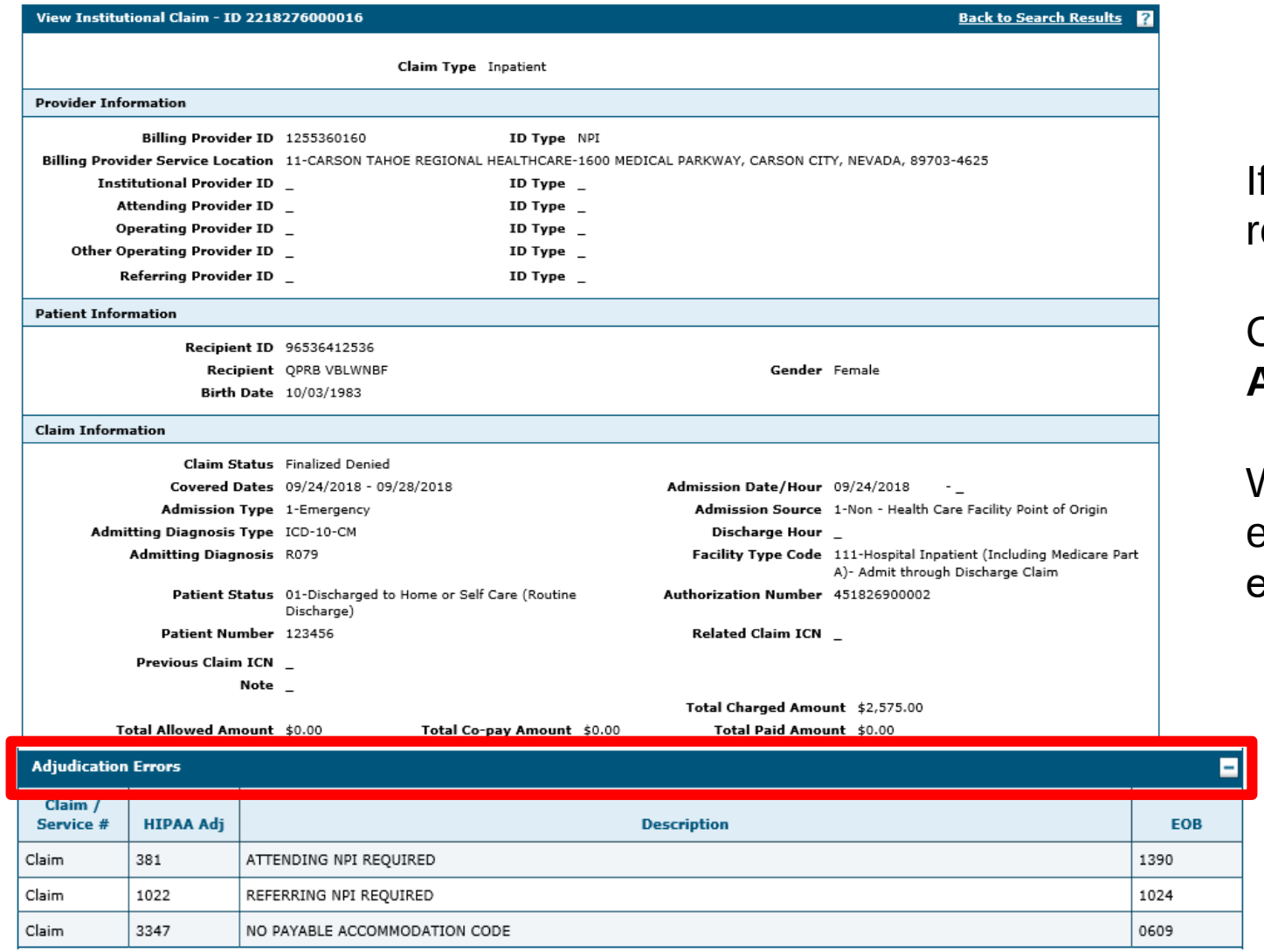
The fastest way to locate a claim is by entering the **Claim ID.**

To search without using the Claim ID:

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

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

Search for Claims, continued



View Institutional Claim - ID 2218276000016 — Back to Search Results

Claim Type Inpatient

Provider Information

Billing Provider ID	1255360160	**ID Type**	NPI
Billing Provider Service Location	11-CARSON TAHOE REGIONAL HEALTHCARE-1600 MEDICAL PARKWAY, CARSON CITY, NEVADA, 89703-4625		
Institutional Provider ID	_	**ID Type**	_
Attending Provider ID	_	**ID Type**	_
Operating Provider ID	_	**ID Type**	_
Other Operating Provider ID	_	**ID Type**	_
Referring Provider ID	_	**ID Type**	_

Patient Information

Recipient ID	96536412536		
Recipient	QPRB VBLWNBF	**Gender**	Female
Birth Date	10/03/1983		

Claim Information

Claim Status	Finalized Denied		
Covered Dates	09/24/2018 - 09/28/2018	**Admission Date/Hour**	09/24/2018 - _
Admission Type	1-Emergency	**Admission Source**	1-Non - Health Care Facility Point of Origin
Admitting Diagnosis Type	ICD-10-CM	**Discharge Hour**	_
Admitting Diagnosis	R079	**Facility Type Code**	111-Hospital Inpatient (Including Medicare Part A)- Admit through Discharge Claim
Patient Status	01-Discharged to Home or Self Care (Routine Discharge)	**Authorization Number**	451826900002
Patient Number	123456	**Related Claim ICN**	_
Previous Claim ICN	_		
Note	_		
		Total Charged Amount	$2,575.00
Total Allowed Amount	$0.00	**Total Co-pay Amount** $0.00	**Total Paid Amount** $0.00

Adjudication Errors

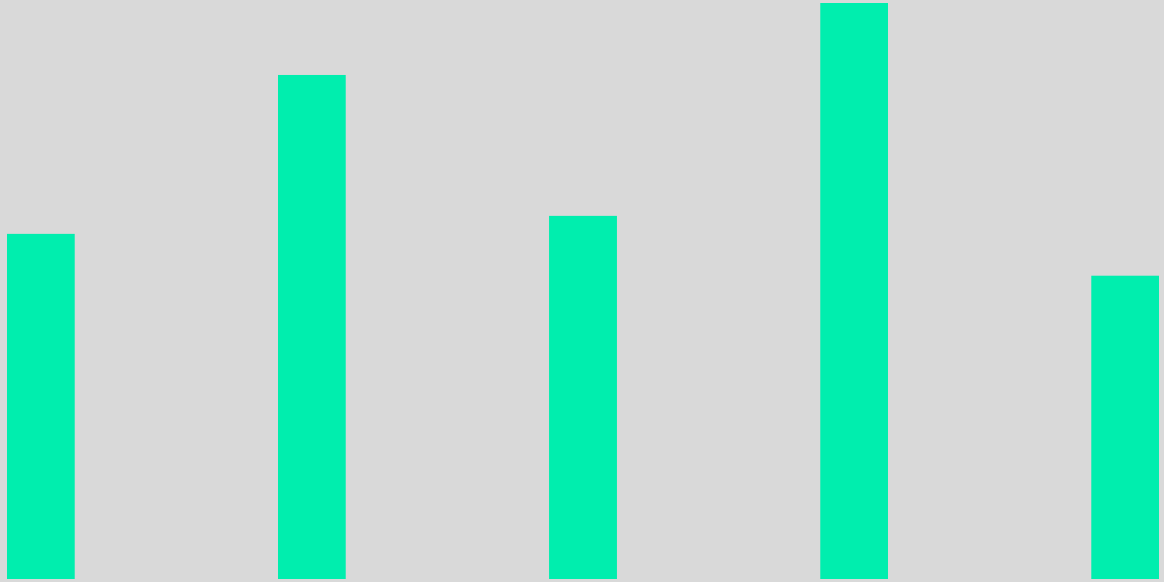
Claim / Service #	HIPAA Adj	Description	EOB
Claim	381	ATTENDING NPI REQUIRED	1390
Claim	1022	REFERRING NPI REQUIRED	1024
Claim	3347	NO PAYABLE ACCOMMODATION CODE	0609

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

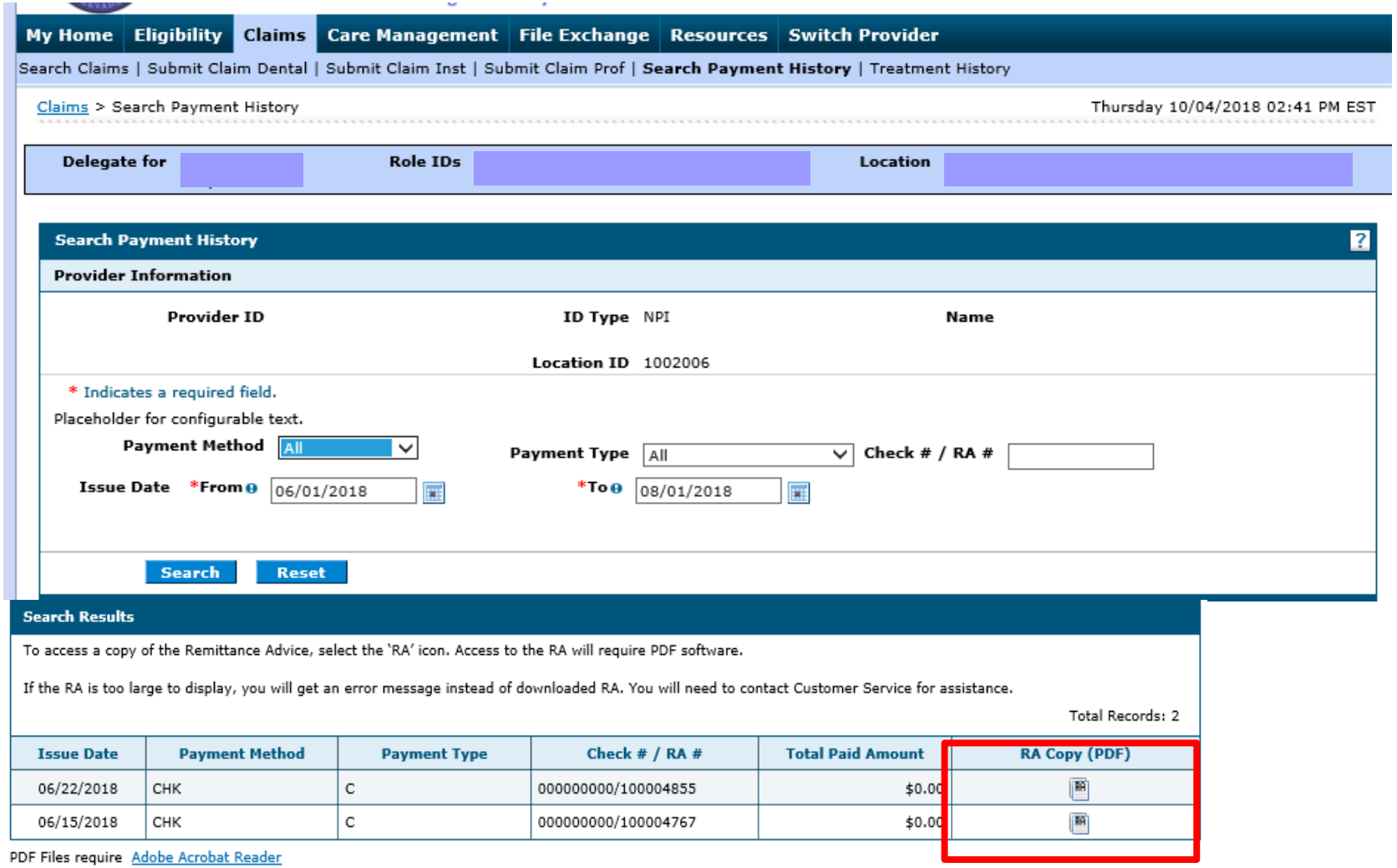
Click the **(+)** symbol adjacent to the **Adjudication Errors** panel.

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

Viewing a Remittance Advice (RA)



Viewing an RA

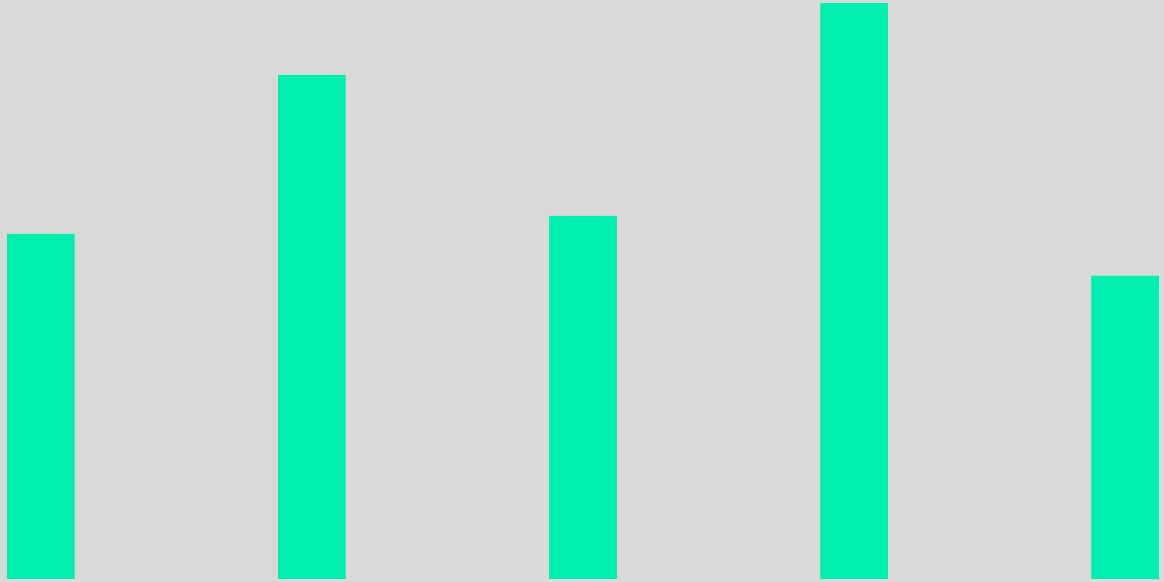


To begin locating an RA, hover over **Claims a**nd select **Search Payment History.**

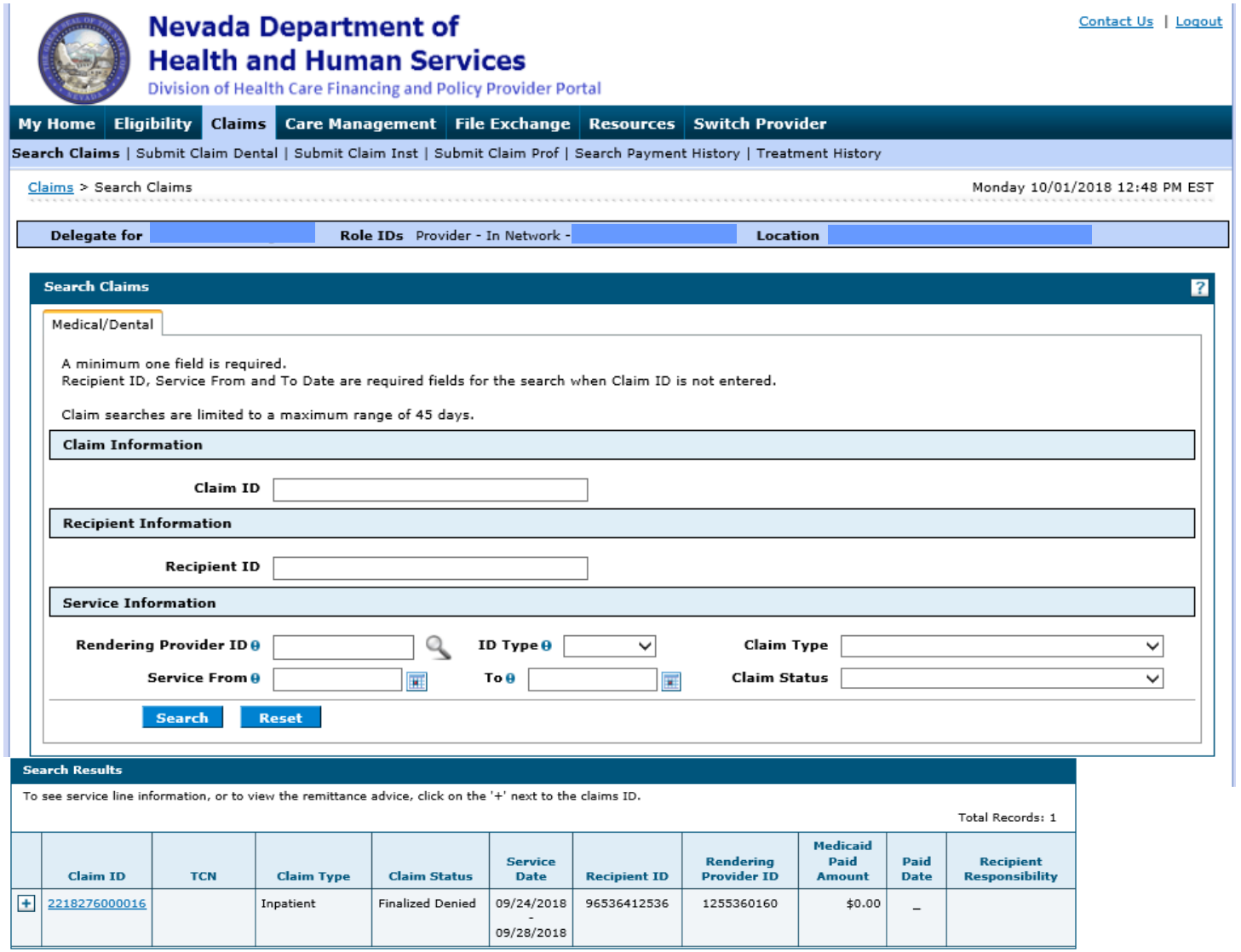
Enter search criteria to refine the search results.

Click the **Search** button. Click on the image in the **RA Copy** column to view the RA.

Copying a Claim



Copy a Claim

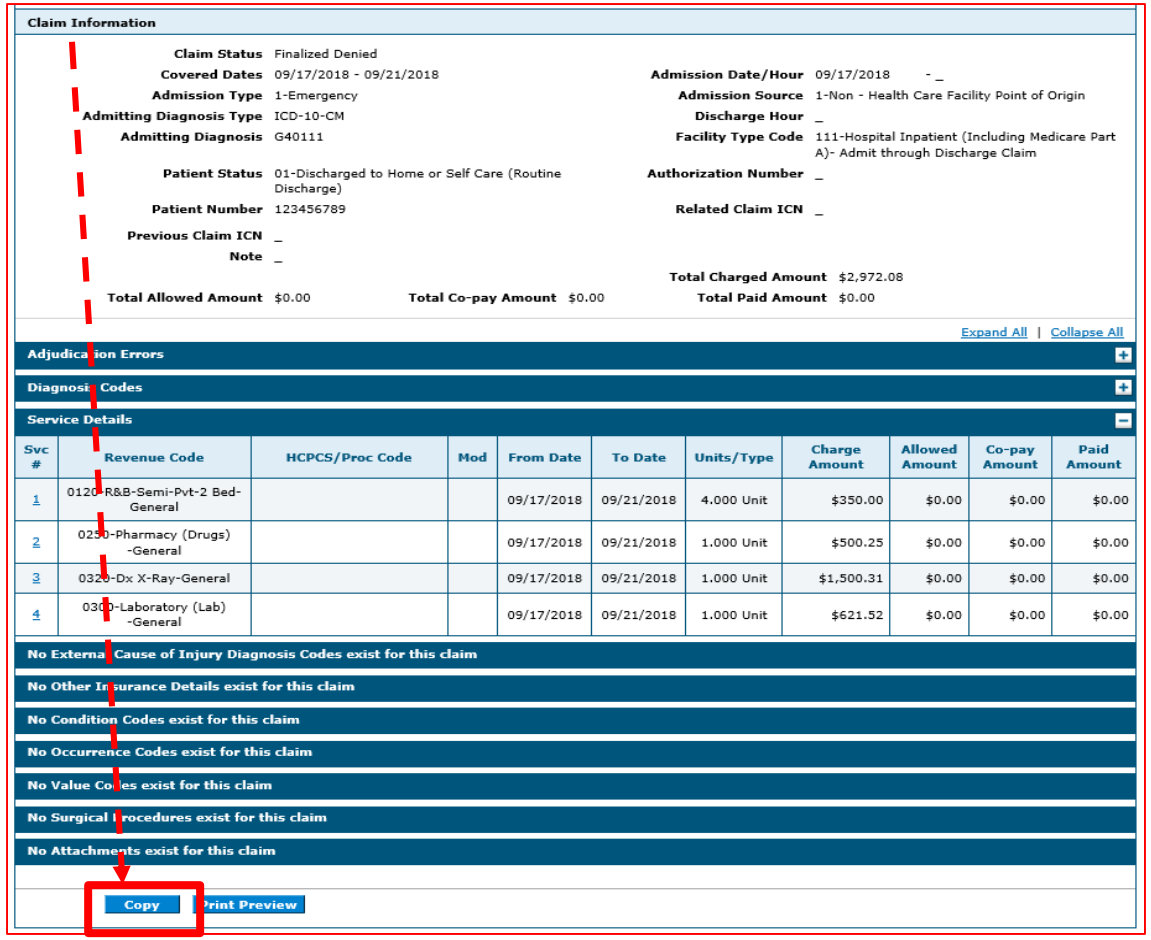


To copy a claim

Return to the “Search Claims” page.
Enter the search criteria and click the **Search** button.

From the search results:
Click the **Claim ID** link.

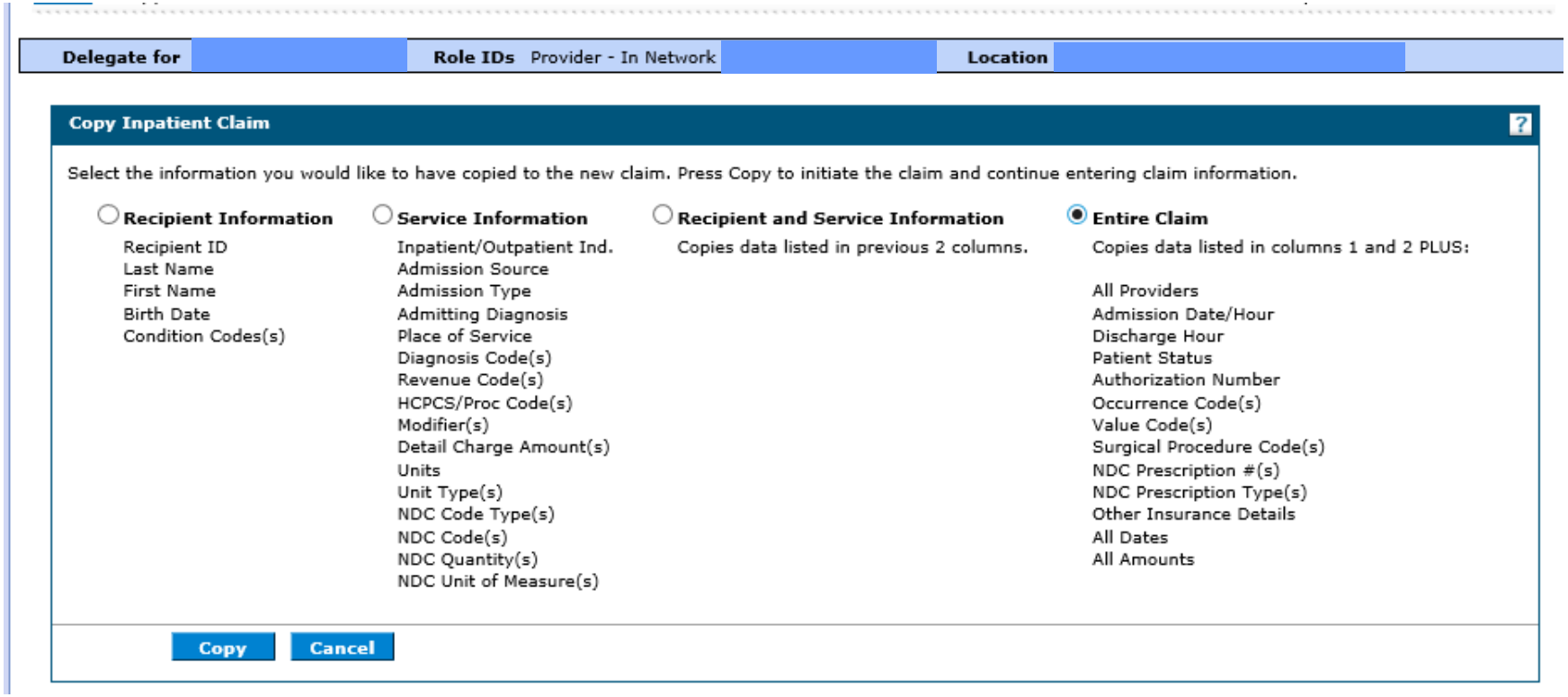
Copy a Claim, continued



After the user has viewed the claim scroll down to the bottom of the page.

Click the **Copy** button, which will open the copied claim.

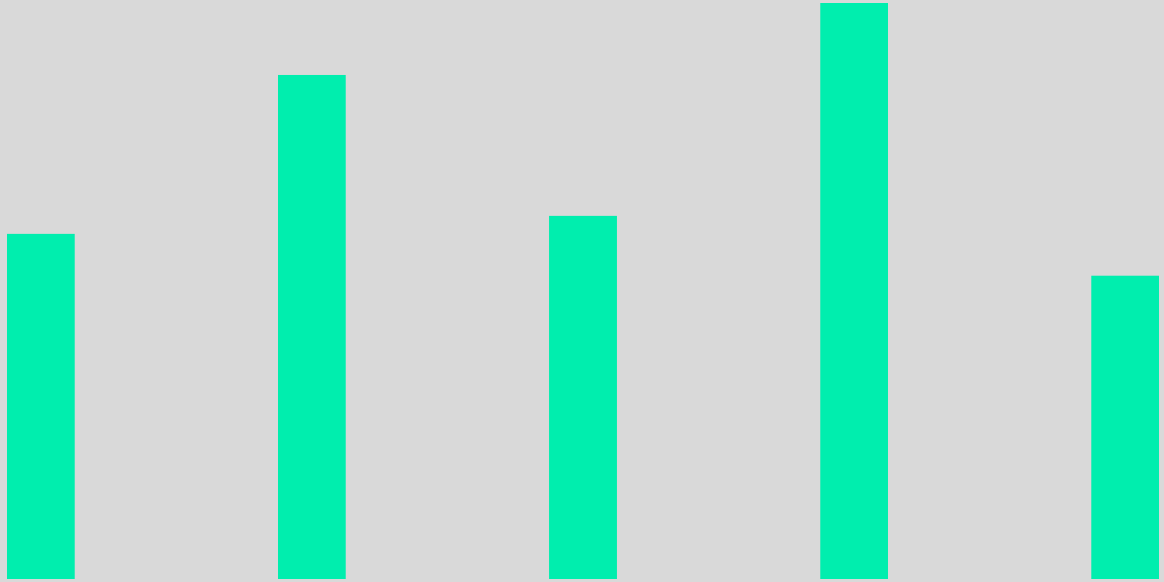
Copy a Claim, continued



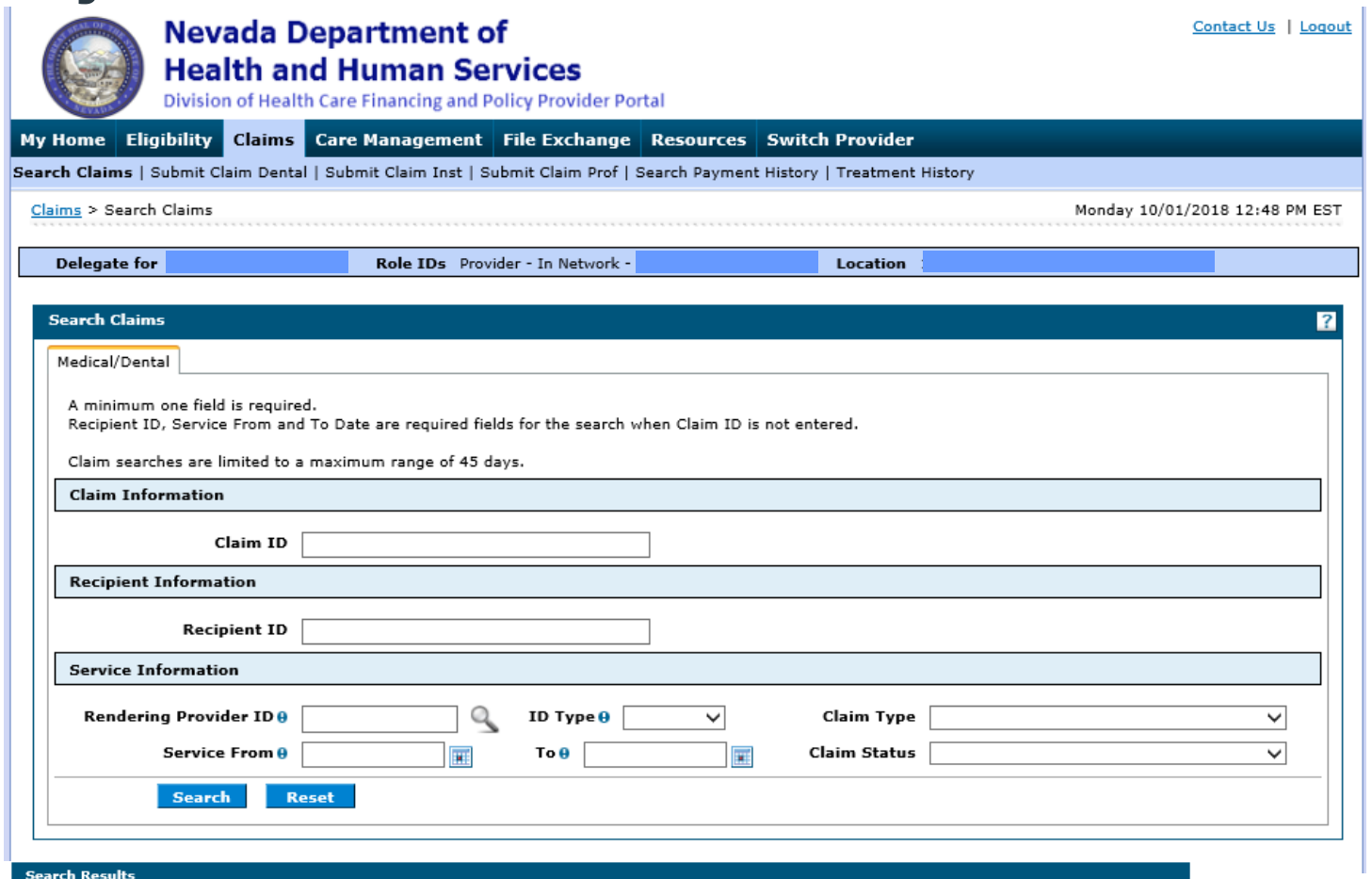
Select what portion of the claim to copy (for this example, the user has selected **Entire Claim**)

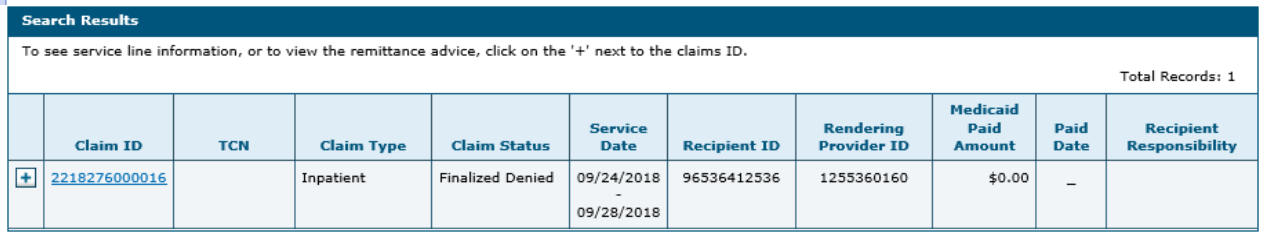
Click the **Copy** button

Adjusting or Voiding a Claim



Adjust or Void a Claim





To begin the claim adjustment process:

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

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

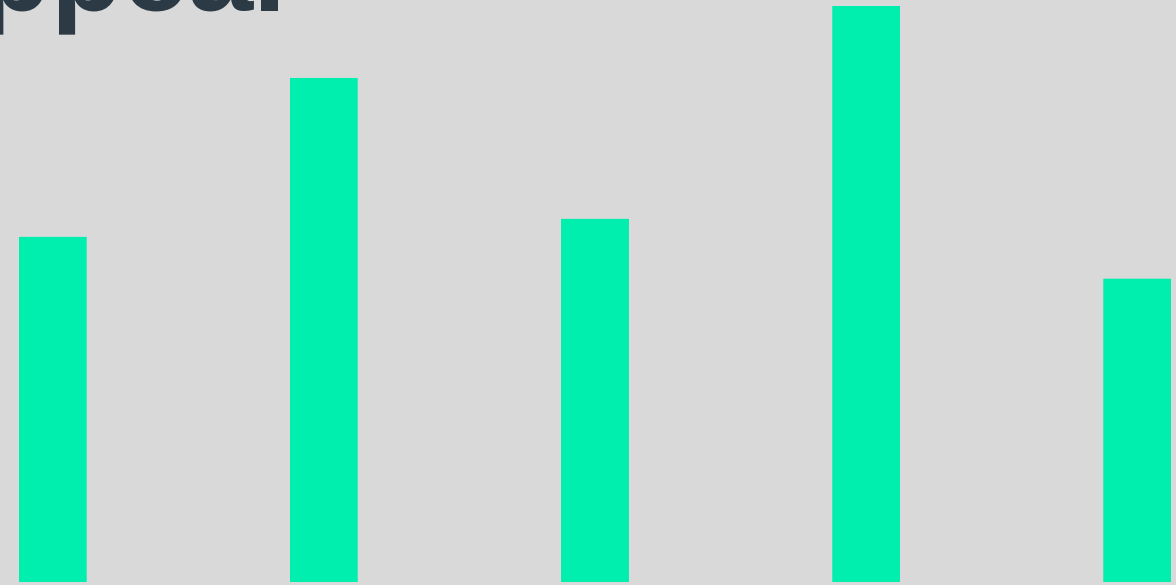
Adjust a Claim, continued

Locate the **Adjust** button from the bottom of the page. Once **Adjust** is selected, the user will be able to make any changes as necessary and then follow all steps previously outlined to submit the adjusted claim.

Void a Claim

Locate the Void button from the bottom of the page. Once Void is selected, the user will be asked to confirm their choice and once OK is selected, the user will receive a message indicating the claim has been voided.

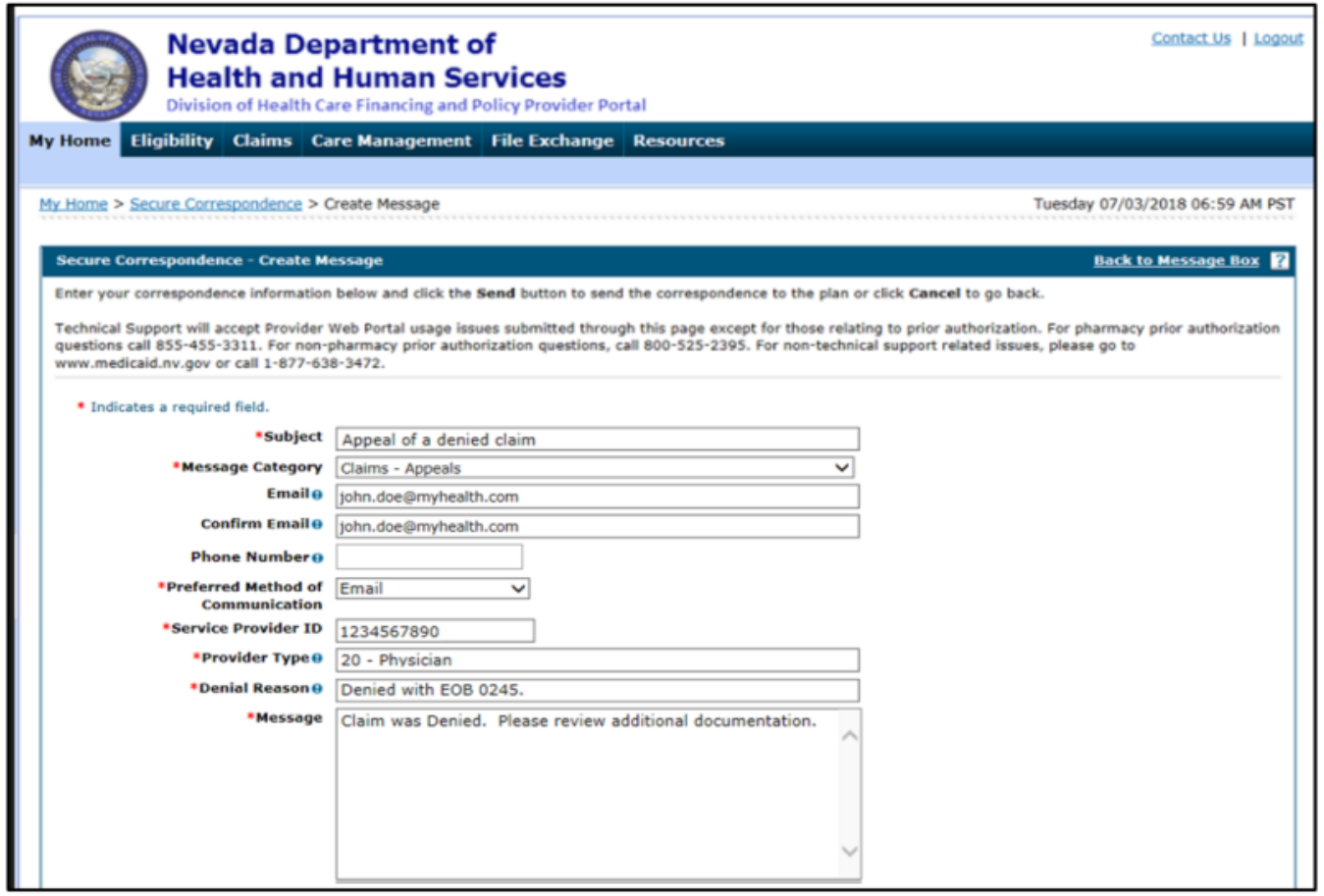
Submitting a Claim Appeal



Appealing a Claim

To submit an appeal for a denied claim, select **Secure Correspondence** from the home page.

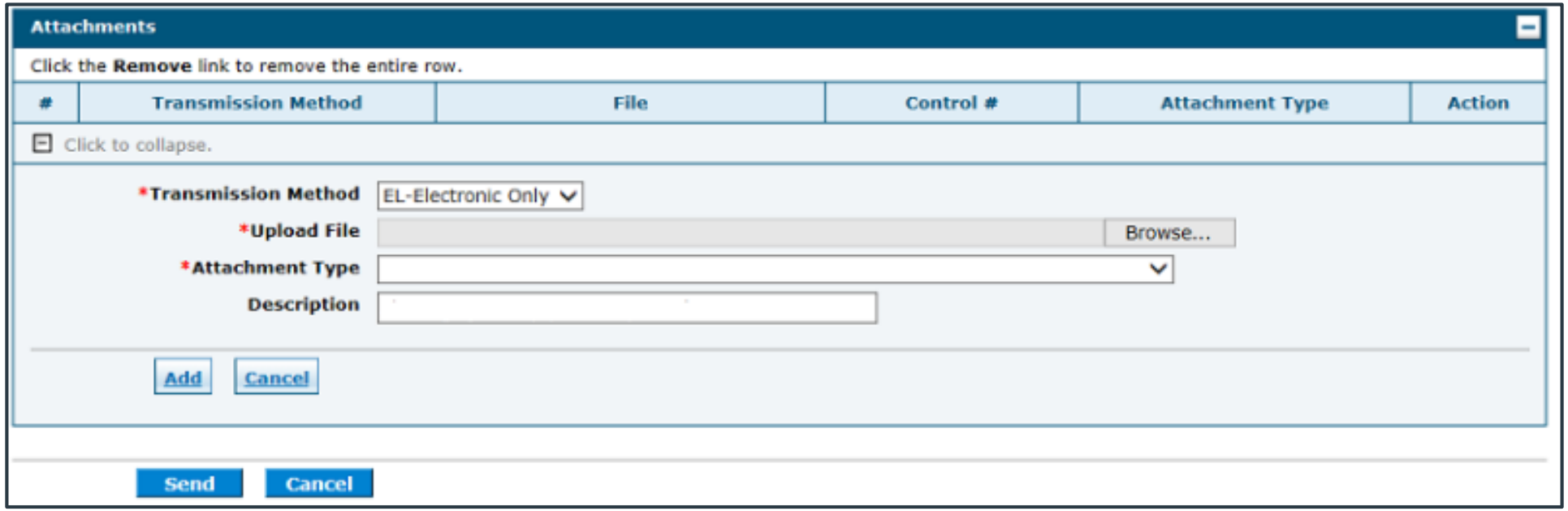
Appealing a Claim, continued



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

NOTE: If a different Message Category is selected, the appeal will not be reviewed.

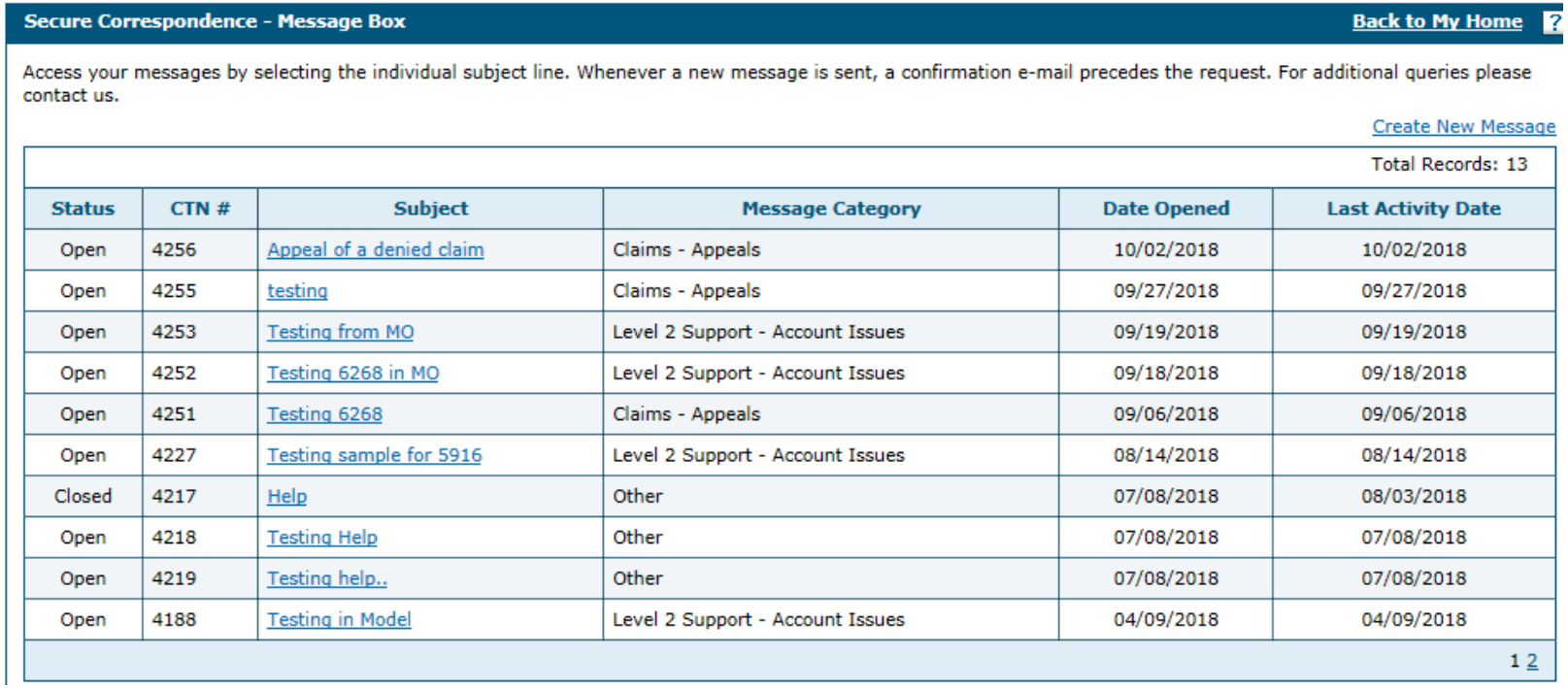
Appealing a Claim, continued



Upload any attachments and select **Add**. After the attachments have been added, select **Send**.

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.

Appealing a Claim, continued



Secure Correspondence - Message Box Back to My Home ?

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

Create New Message

Total Records: 13

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

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

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

Resources

Additional Resources

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

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