

# Psychiatric Hospital, Inpatient - Provider Type 13



Nevada Medicaid Provider Training

2020

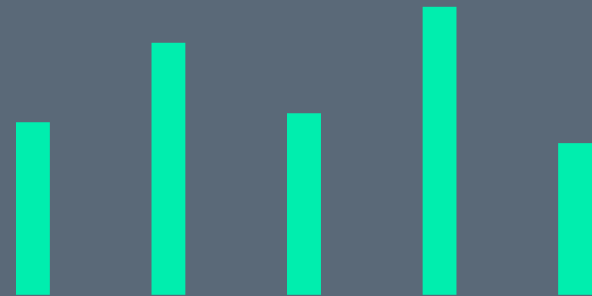
# Objectives



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- Coverage and Limitations
- Submit a Claim to Nevada Medicaid via Direct Data Entry (DDE)
- Resources
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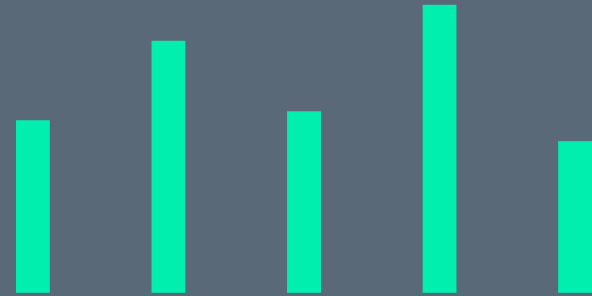
# Recipient Eligibility



# 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)



**Nevada Department of  
Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

Home

Home

**Login** ?

\*User ID  
hospizona1 1

Log In 2

[Forgot User ID?](#)

[Register Now](#)

**Broadcast Messages**


**Hours of Availability**  
The Nevada Provider Web Portal is unavailable between 12:25 AM PST on Sunday.

**What can you do in the Provider Portal?**  
Through this secure and easy to use internet portal, health care providers can...

- 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

 **Computer and Challenge Question**

**Site Key**

The HealthCare Portal uses a personalized site key to protect your privacy online. To use a site key, you are asked to respond to your Challenge question the first time you use a personal computer, or every time you use a public computer. When you type the correct answer to the Challenge question, your site key token displays which ensures that you have been correctly identified. Similarly, by displaying your personalized site key token, you can be sure that this is the actual HealthCare Portal and not an unauthorized site.

If this is your personal computer, you can register it now by selecting: **This is a personal computer. Register it now.**

**Answer the challenge question to verify your identity.**

**Challenge Question** In what city were you born?

3 **\*Your Answer**

[Forgot answer to challenge question?](#)

4 **Select** ☐ This is a personal computer. Register it now.  
☒ This is a public computer. Do not register it.

5 **Continue**


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

[Home](#) > [Challenge Question](#) > Site Token Password

**Confirm Site Key Token and Passphrase**


Confirm that your site key token and passphrase are correct.

If you recognize your site key token and passphrase, you can be more comfortable that you are at the valid HealthCare Portal site and therefore is safe to enter your password.

**Make sure your site key token and passphrase are correct.**

If the site key token and passphrase are correct, type your password and click **Sign In**.  
If this is not your site key token or passphrase, do not type your password.  
Call the [customer help desk](#) to report the incident.

6

Site Key: 

7

Passphrase Answer  
\*Password

8

**Sign In**  
[Forgot Password?](#)

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

Nevada Department of Health and Human Services  
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) | [Logout](#)

My Home

**Provider**

Name  
Provider ID  
Location ID

**Broadcast Messages**

[Contact Us](#)

[Secure Correspondence](#)

**Provider Services**

- [Member Focused Viewing](#)
- [Search Payment History](#)
- [Revalidate-Update Provider](#)
- [Pharmacy PA](#)
- [PASRR](#)
- [EHR Incentive Program](#)
- [EPSDT](#)
- [Presumptive Eligibility](#)

**Welcome Health Care Professional!**

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and search for claims, payment information, and access Remittance Advices, our secure site provides access to eligibility, answers to frequently asked questions, and the ability to process authorizations.

Prior Authorization Quick Reference Guide [\[Review\]](#)  
Provider Web Portal Quick Reference Guide [\[Review\]](#)

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

The screenshot displays the Nevada Department of Health and Human Services Provider Web Portal. The header includes the department's logo and name, along with links for 'Contact Us' and 'Logout'. A navigation bar at the top contains tabs for 'My Home', 'Eligibility', 'Claims', 'Care Management', 'File Exchange', and 'Resources', with 'My Home' highlighted. Below this, the 'My Home' section features a 'Provider' profile area on the left with fields for 'Name', 'Provider ID', and 'Location ID', and links for 'My Profile' and 'Manage Accounts'. To the right of the profile is a 'Broadcast Messages' section containing 'Hours of Availability' information and links for 'Contact Us' and 'Secure Correspondence'. Below the broadcast messages is a 'Welcome Health Care Professional!' message with a photo of healthcare workers and a paragraph of text. At the bottom, there is a 'Provider Services' section with a list of links: 'Member Focused Viewing', 'Search Payment History', 'Revalidate-Update Provider', 'Pharmacy PA', 'PASRR', 'EHR Incentive Program', 'EPSDT', and 'Presumptive Eligibility'. Finally, at the very bottom, there are links for 'Prior Authorization Quick Reference Guide' and 'Provider Web Portal Quick Reference Guide'.

**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.

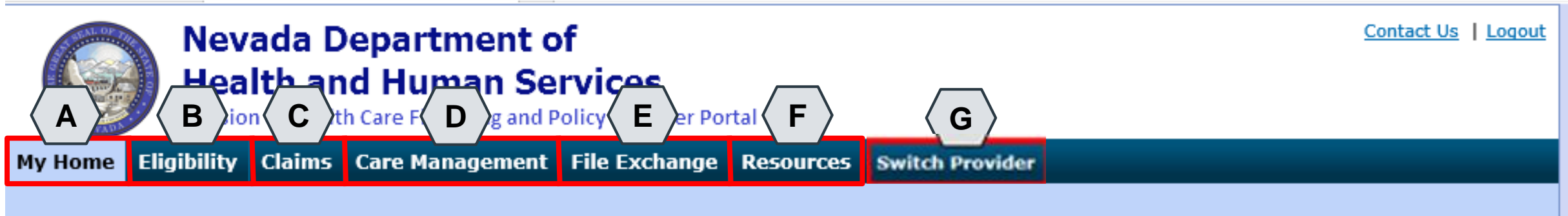
**E** Links to additional information regarding Medicaid programs and services.

**F** Links to additional PWP resources.

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

The screenshot shows the 'Eligibility Verification Request' form. It includes a header with a question mark icon. Below the header, there is a note: '\* 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.' The form fields are: Recipient ID (48317469498), Last Name, First Name, SSN, Birth Date, \*Effective From (12/05/2018), and Effective To (12/31/2018). Below these is the 'Service Type Code Search' section with a dropdown menu showing '30-Health Benefit Plan Coverage'. At the bottom are 'Submit' and 'Reset' buttons. Numbered callouts are: 3 (red box around Recipient ID, Last Name, First Name, SSN, Birth Date), 4 (red box around \*Effective From and Effective To), 5 (red box around Service Type Code dropdown), and 6 (red box around Submit button).

**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 48317469498 Last Name First Name  
SSN Birth Date  
\*Effective From 12/05/2018 Effective To 12/31/2018  
Service Type Code Search  
Service Type Code 30-Health Benefit Plan Coverage  
Submit Reset

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	<input type="text"/>	Last Name	<input type="text"/>	First Name	<input type="text"/>
SSN	<input type="text"/>	Birth Date	<input type="text"/>		
*Effective From	<input type="text"/>	Effective To	<input type="text"/>		

Service Type Code Search

Service Type Code

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
<a href="#">Medicaid Fee For Service</a>	02/01/2019	02/28/2019	0000000000	07/31/2018
<a href="#">Managed Care Organization</a>	02/01/2019	02/28/2019	ANTHEM BLUE CROSS AND BLUE SHIELD	
<a href="#">Dental Benefit Administrator</a>	02/01/2019	02/28/2019	LIBERTY DENTAL PLAN OF NEVADA INC (1013434810)	
<a href="#">Non Emergency Transportation</a>	02/01/2019	02/28/2019	MEDICAL TRANSPORTATION MANAGEMENT INC (1134260078)	
<a href="#">Other Insurance Detail Information</a>				

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

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 From02/01/2019

Effective To02/28/2019

Service Type Code Search

Service Type Code30-Health Benefit Plan Coverage

SubmitReset

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
<a href="#">Medicaid Fee For Service</a>	02/01/2019	02/28/2019	0000000000	07/31/2018
<a href="#">Managed Care Organization</a>	02/01/2019	02/28/2019	ANTHEM BLUE CROSS AND BLUE SHIELD	
<a href="#">Dental Benefit Administrator</a>	02/01/2019	02/28/2019	LIBERTY DENTAL PLAN OF NEVADA INC (1013434810)	
<a href="#">Non Emergency Transportation</a>	02/01/2019	02/28/2019	MEDICAL TRANSPORTATION MANAGEMENT INC (1134260078)	

[Other Insurance Detail Information](#)

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.

Nevada Medicaid – Provider Type 13 (Psychiatric Hospital, Inpatient)

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## Viewing a Member's Benefit Details, continued

Print Preview

Coverage Details

Back to Eligibility Verification Request

?

Coverage Details for

from 02/01/2019 to 02/28/2019

Verification Response ID

Expand All

Collapse All

Benefit Details				
Coverage	Description	Effective Date	End Date	Date of Decision
Medicaid Fee For Service	The Medicaid Program is a State administered, federal grant-in-aid program. Its purpose is to help meet the cost of medical services of those individuals receiving public assistance payments, and those individuals and families with low income. The program objective is to provide a broad range of medical and related services to assist individuals to attain or retain an optimal level of health care. Medicaid is jointly funded by the federal and state governments and is administered by the State.	02/01/2019	02/28/2019	07/31/2018

Copayment Details

Coinurance Details

Deductible Details

Managed Care Assignment Details

Living Arrangement Details

Demographic Details

After clicking any of the coverage links, the “Coverage Details” page displays, listing details about each coverage benefit in sections.

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

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

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

# Viewing a Member's Benefit Details, continued

[Print Preview](#)

[Back to Eligibility Verification Request](#) ?

**Coverage Details**

Coverage Details for JOHN A SMITH from 02/01/2019 to 02/28/2019

Verification Response ID 1912600009

[Expand All](#) | [Collapse All](#)

**Benefit Details** -

Coverage	Description	Effective Date	End Date	Date of Decision
Medicaid Fee For Service	The Medicaid Program is a State administered, federal grant-in-aid program. Its purpose is to help meet the cost of medical services of those individuals receiving public assistance payments, and those individuals and families with low income. The program objective is to provide a broad range of medical and related services to assist individuals to attain or retain an optimal level of health care. Medicaid is jointly funded by the federal and state governments and is administered by the State.	02/01/2019	02/28/2019	07/31/2018

**Copayment Details** +

**Coinsurance Details** +

**Deductible Details** +

**Managed Care Assignment Details** +

**Living Arrangement Details** +

**Demographic Details** +

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

**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 note that this information is currently used during search.

Recipient ID	<input type="text" value="48317469498"/>	Last Name	<input type="text"/>	First Name	<input type="text"/>
SSN	<input type="text"/>	Birth Date	<input type="text"/>		
*Effective From	<input type="text" value="12/05/2018"/>	Effective To	<input type="text" value="12/31/2018"/>		

**Service Type Code Search**

Service Type Code	<input type="text" value="30-Health Benefit Plan Coverage"/>
-------------------	--

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

Eligibility Verification Information for NYEPCPPY KRXOXE from 12/05/2018 to 12/31/2018			
Recipient ID 48317469498		Birth Date 03/06/1939	
Coverage	Effective Date	End Date	
<a href="#">Medicaid Fee For Service</a>	12/05/2018	12/31/2018	0000000000
<a href="#">Qualified Medicare Beneficiaries</a>	12/05/2018	12/31/2018	0000000000
<a href="#">Special Low Income Medicare Beneficiaries</a>	12/05/2018	12/31/2018	0000000000
<a href="#">Other Insurance Detail Information</a>			

# Viewing a Member's Third-Party Coverage, continued

Other Insurance Information for HVXQOSDCN I IRAPSEU						<a href="#">Back to Eligibility Verification Request</a> ?		
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

[Print Preview](#)

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.

Print Preview

Other Insurance Information for NYEPCPPY KRXOXE

[Back to Eligibility Verification Request](#)

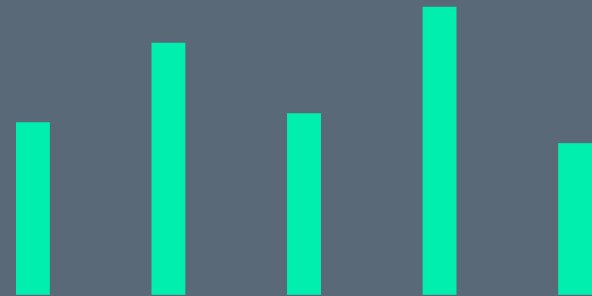
There is no information available for the Other Insurance. Contact Us for more information.

[Print Preview](#)

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

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.

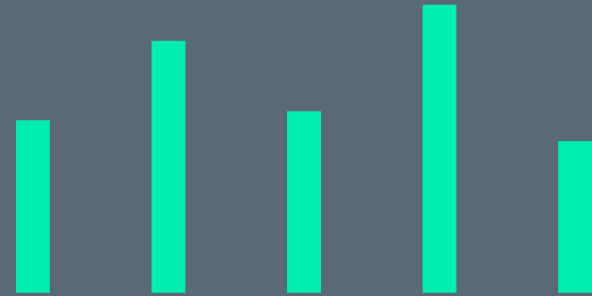
# Medicare Eligibility



# 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

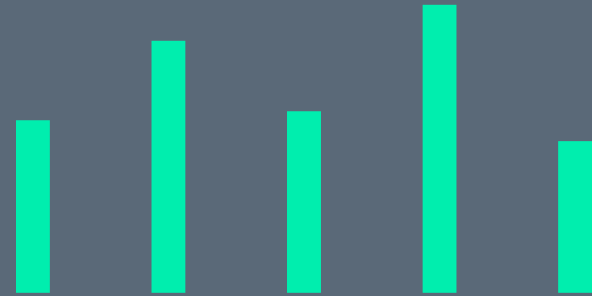


# Prior Authorization Submission Guidelines

- 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:

# 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: _____			
<b>VII.REQUESTED TREATMENT</b>			
Requested Treatment: <input type="checkbox"/> SA Rehabilitation <input type="checkbox"/> Detoxification <input type="checkbox"/> Inpatient Psychiatric			
Are you requesting EPSDT referral/services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Admission Status: <input type="checkbox"/> Elective <input type="checkbox"/> Emergency <input type="checkbox"/> 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:          			

# 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: <input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.*

# 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 \_\_\_\_\_

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

# 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 <b>Inpatient Mental Health Concurrent Review</b>	
Describe recipient's participation in groups and activities:	
Describe recipient's current individualized treatment plan and goals <i>(please update as appropriate)</i> :	
Discuss justification for continued services at this level of care <i>(evaluation of risk and level of acuity to demonstrate medical necessity for number of days being requested for review)</i> :	
Recipient's Estimated Date of Discharge:	
Describe the discharge plan and discharge criteria for this recipient <i>(note placement options and efforts to discharge)</i> :	
<b>V. REQUESTED TREATMENT</b>	
Requested Treatment: <input type="checkbox"/> SA Rehabilitation <input type="checkbox"/> Detoxification <input type="checkbox"/> Inpatient Psychiatric	
Are you requesting EPSDT referral/services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Admission Status: <input type="checkbox"/> Elective <input type="checkbox"/> Emergency <input type="checkbox"/> Court-Ordered	
Admission Date:	Number of days requested:

# Prior Authorization Information, FA-14, continued

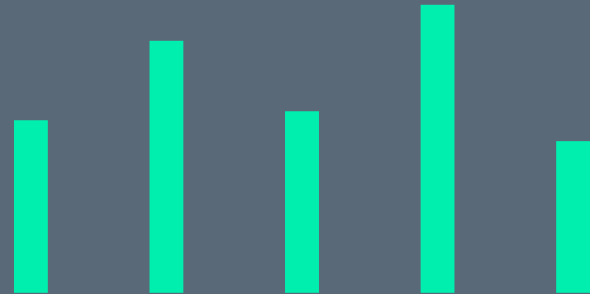
- Section V, continued
  - List/describe the inpatient services that you are requesting for the recipient.

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.*

# 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.

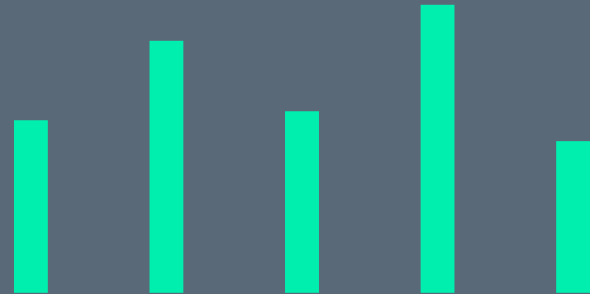
# Clinical Documentation, continued

- 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	<a href="#">Hide</a>	Not Certified 02/21/2013	–
<b>Medical Citation</b> 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid. <b>Notes To Provider</b> 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	<a href="#">View</a>	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





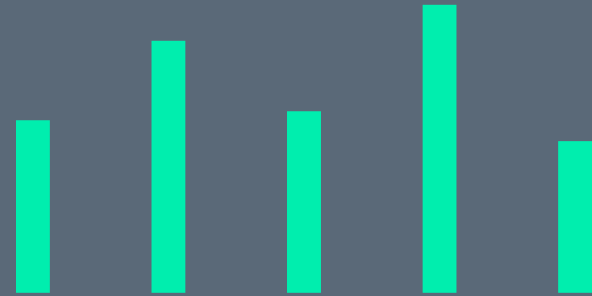
# Skilled Days

- 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.

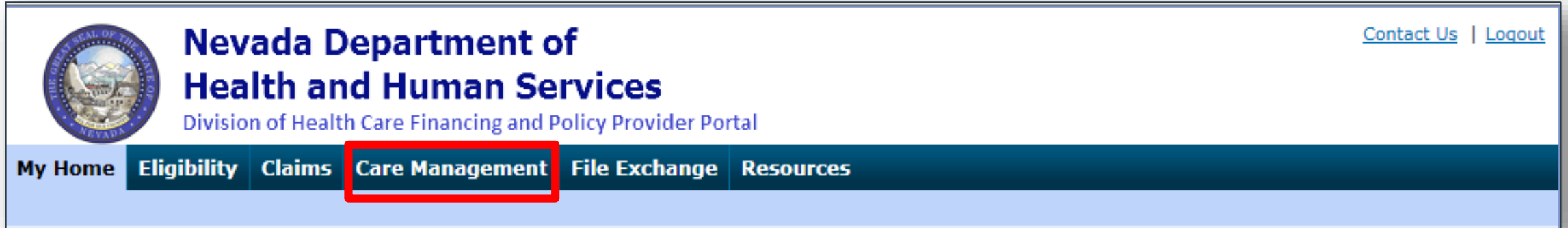
# Skilled Days, continued

- 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

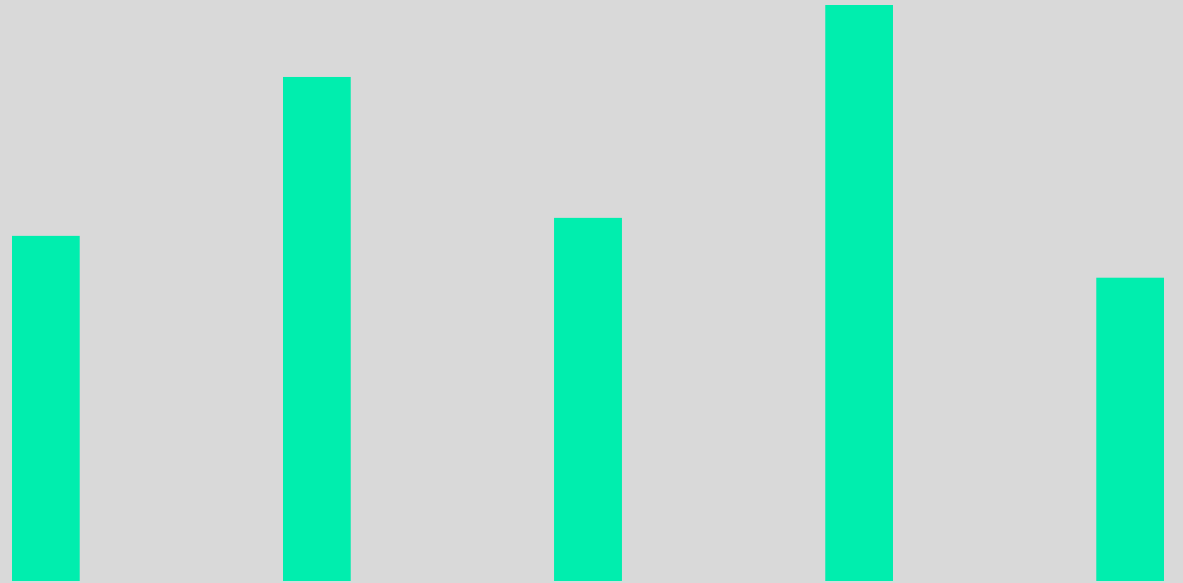
## View Authorization Status

- 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

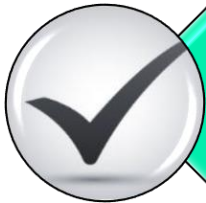
# Before Creating an Authorization Request



# 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.

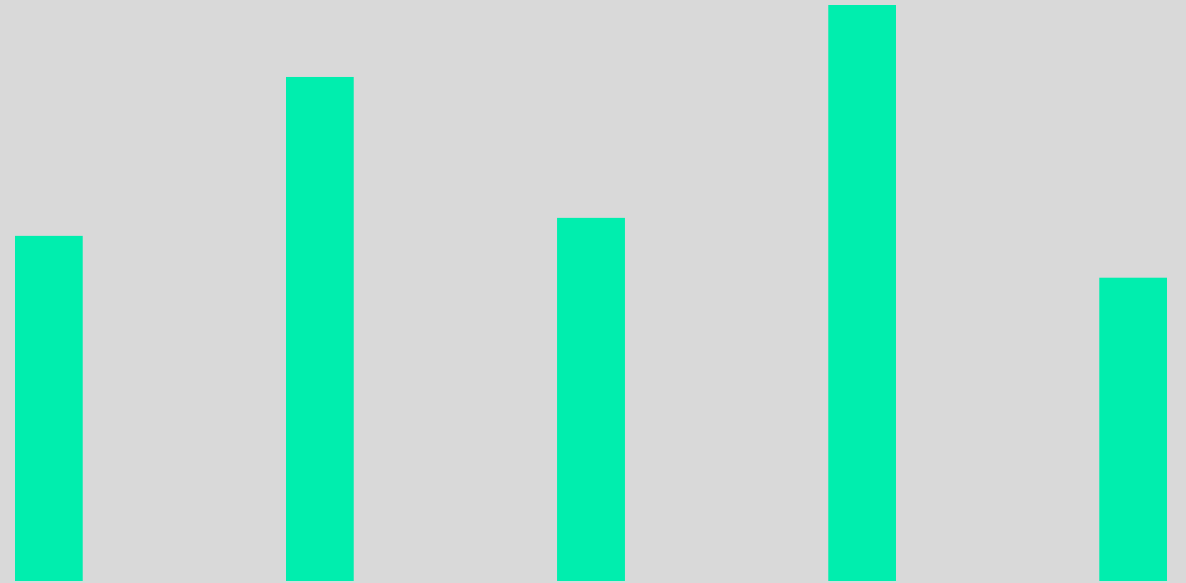


Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.

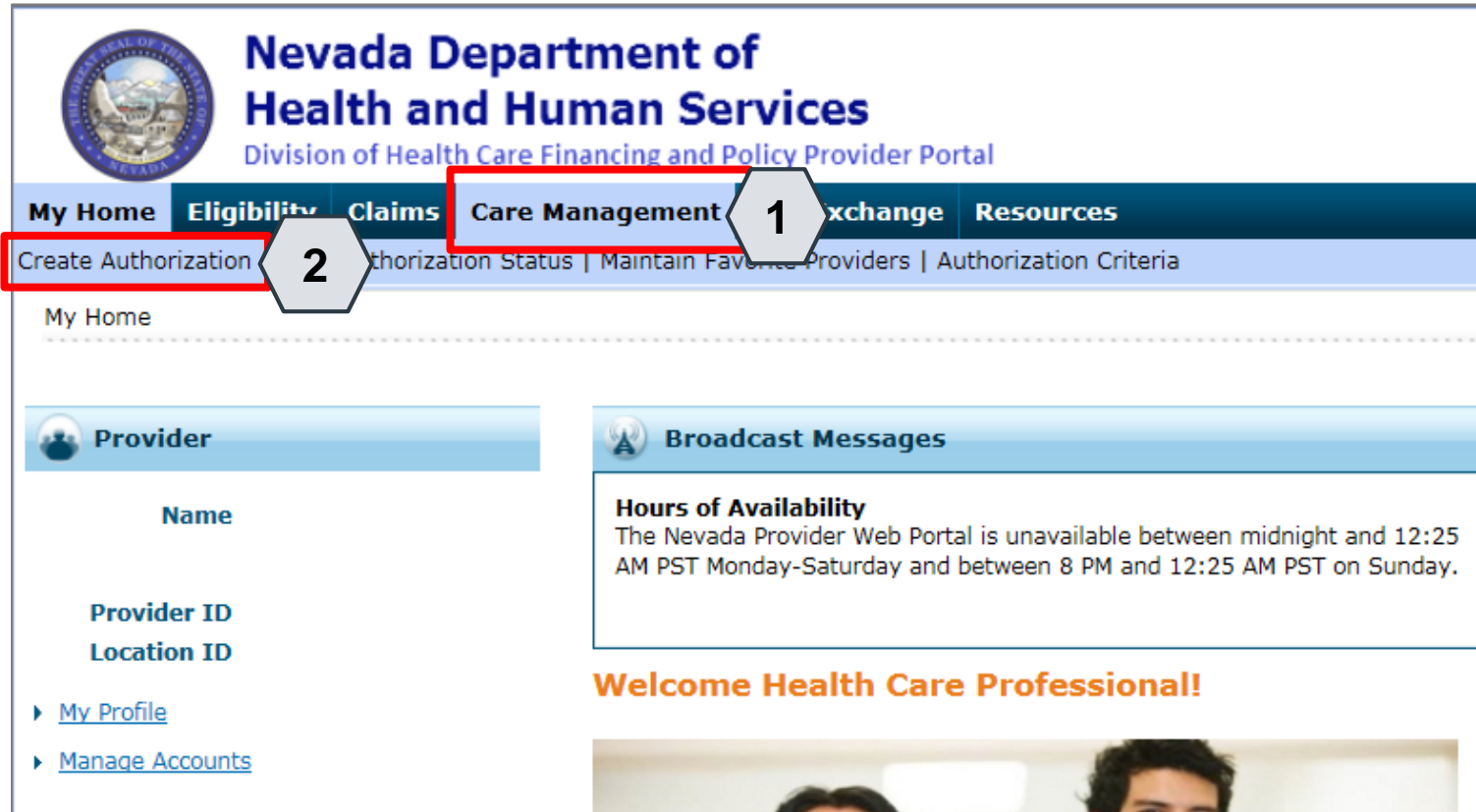


Use the Provider Web Portal to check PAs in pending status for additional information.

# 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

**Create Authorization** ?

\* Indicates a required field.

☒ **Medical** ☐ Dental 3

4 **\*Process Type** [Expand All](#) | [Collapse All](#)

<b>Requester Information</b>			
<b>Provider ID</b>	<b>ID Type</b> NPI	<b>Name</b> HOSPITALIST SERVICES OF NEVADA-MANDAVIA	
<b>Recipient Information</b>			
<b>*Recipient ID</b>			
<b>Last Name</b>	<b>First Name</b>		
<b>Birth Date</b>			
<b>Referring Provider Information</b>			
<b>Referring Provider same as Requesting Provider</b>			
<b>Select from Favorites</b>			
<b>Provider ID</b>	<b>ID Type</b> <input type="text"/>	<b>Name</b> <input type="text"/>	<b>Add to Favorites</b> <input type="checkbox"/>
<b>Service Provider Information</b>			
<b>Service Provider same as</b>			

ABA  
ADHC  
Audiology  
BH Inpt  
BH Outpt  
BH PHP/IOP  
BH Rehab  
BH RTC  
DME  
Home Health  
Hospice  
Inpt M/S  
Ocular  
Outpt M/S  
PCS Annual Update  
PCS One-Time  
PCS SDS  
PCS Significant Change  
PCS Temporary Auth  
PCS Transfer  
Retro ABA  
Retro ADHC  
Retro Audiology  
Retro BH Inpt  
Retro BH Outpt  
Retro BH PHP/IOP  
Retro BH Rehab  
Retro BH RTC  
Retro DME

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

# Submitting a PA Request, continued

**Create Authorization** ?

\* Indicates a required field.

☒ **Medical** ☐ **Dental**

\*Process Type Home Health Expand All | Collapse All

**Requesting Provider Information** -

Provider ID	ID Type	NPI	Name
-------------	---------	-----	------

**Recipient Information** -

\*Recipient ID 43827875678

Last Name ABIEGUT First Name ABYNNRYP

Birth Date 04/10/1928

**Referring Provider Information** -


Referring Provider same as Requesting Provider ☐

Select from Favorites No favorite providers available.

Provider ID	ID Type	Name	Add to Favorites
-------------	---------	------	------------------

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

**Create Authorization** 


\* Indicates a required field.


☒ **Medical** ☐ **Dental**

**\*Process Type** Home Health [Expand All](#) | [Collapse All](#)


**Requesting Provider Information** 

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

**Recipient Information** 


 **6**

**\*Recipient ID** 43827875678  
**Last Name** ABIEGUT **First Name** ABYNNRYP  
**Birth Date** 04/10/1928

**Referring Provider Information** 

**Referring Provider same as Requesting Provider** ☐

**Select from Favorites** No favorite providers available.

**Provider ID**   **ID Type**  **Name**  **Add to Favorites** ☐

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

# Submitting a PA Request, continued

**Create Authorization** ?

\* Indicates a required field.

☒ Medical ☐ Dental

\*Process Type  [Expand All](#) | [Collapse All](#)

**Requesting Provider Information** [-]

Provider ID  ID Type  Name

\*Service Location

**Recipient Information** [-]

\*Recipient ID

Last Name  First Name

Birth Date

**Referring Provider Information** [-]

Referring Provider same as Requesting Provider ☐

Select from Favorites

Provider ID   ID Type  Name

**Service Provider Information** [-]

Service Provider same as Requesting Provider ☐

Select from Favorites

\*Provider ID   \*ID Type  Name

\*Service Location

Location

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

7

# Submitting a PA Request, continued

The screenshot shows a web form titled "Referring Provider Information". It contains several fields and a checkbox. Annotations A, B, C, and D are placed over specific elements:

- A** points to the checkbox labeled "Referring Provider same as Requesting Provider".
- B** points to the "Select from Favorites" drop-down menu.
- C** points to the "Provider ID" text input field and the "ID Type" drop-down menu.
- D** points to the "Add to Favorites" checkbox.

Red boxes and lines highlight the areas indicated by the annotations.

- 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

**Referring Provider Information**

Referring Provider same as Requesting Provider ☐

Select from Favorites

Provider ID   ID Type  Name

**Service Provider Information**

Service Provider same as Requesting Provider ☐

Select from Favorites

\*Provider ID   \*ID Type  Name

\*Service Location

Location

8. Enter Service Provider Information.

8

# Submitting a PA Request, continued

**Service Provider Information**

Service Provider same as Requesting Provider ☐

Select from Favorites: No favorite providers available.

\*Provider ID:  \*ID Type:  Name:  Add to Favorites: ☐

\*Service Location:  Location:

**Diagnosis Information**

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
*Diagnosis Type: ICD-10-CM ICD-9-CM	*Diagnosis Code: <input type="text"/>	<input type="button" value="Add"/> <input type="button" value="Cancel"/>

**Service Details**

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

Diagnosis Information

Error

Diagnosis Code not found.

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.  
Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
Click to collapse.		
*Diagnosis Type	ICD-10-CM	
*Diagnosis Code	1234	

Diagnosis Code not found.

Add

Cancel

- 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

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.  
Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initia	<a href="#">Remove</a>

☐ Click to collapse.

\*Diagnosis Type ICD-10-CM

\*Diagnosis Code

Add

Cancel

- 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

**Diagnosis Information**

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter	<a href="#">Remove</a>

☐ Click to collapse.

\*Diagnosis Type  \*Diagnosis Code

**Service Details**

+ to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

Line #	From Date	To Date	Code	Modifiers	Units	Action
<input type="checkbox"/> Click to collapse.						
	*From Date <input type="text" value="01/01/2018"/>	To Date <input type="text" value="01/01/2019"/>	Code Type <input type="text" value="CPT/HCPCS"/>	*Code <input type="text" value="A6413-Adhesive bandage, first-aid"/>		
	Modifiers <input type="text"/>		<input type="text"/>			
	<input type="text"/>		<input type="text"/>			
	*Units <input type="text" value="1"/>					
	*Medical Justification <div>Bandage required for burns.</div>					
<div><div>13</div><input type="button" value="Add Service"/> <input type="button" value="Cancel Service"/></div>						

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

## Submitting a PA Request, continued

Service Details

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

	Line #	From Date	To Date	Code	Modifiers	Units	Action
+	1	01/01/2018	01/01/2019	A6413-Adhesive bandage, first-aid		1	<a href="#">Copy</a>   <a href="#">Remove</a>

Click to collapse.

\*From Date

To Date

Code Type

CPT/HCPCS

\*Code

Modifiers

\*Units

\*Medical

- 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

**Attachments**

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

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

Transmission Method	File	Action
Click to collapse.		
*Transmission Method	EL-Electronic Only	
*Upload File	Choose File No file chosen	
*Attachment Type		
<div>AddCancel</div>		
<div>SubmitCancel</div>		

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

## Submitting a PA Request, continued

**Attachments**

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type, and click the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, please contact your provider or submit the documents were sent using another method.

Click the **Remove** link to remove attachments from the request.

Attachment Type	Transmission Method
<div> <input type="checkbox"/> Click to collapse.           </div> <div> <b>*Transmission Method</b>  <b>*Upload File</b>  <b>*Attachment Type</b> </div> <div> <input type="button" value="Add"/> </div>	<ul style="list-style-type: none"> <li>59-Benefit Letter</li> <li>03-Report Justifying Treatment Beyond Utilization Guidelines</li> <li>11-Chemical Analysis</li> <li>04-Drug Administered</li> <li>05-Treatment Diagnosis</li> <li>06-Initial Assessment</li> <li>07-Functional Goals</li> <li>08-Plan of Treatment</li> <li>09-Progress Report</li> <li>10-Continued Treatment</li> <li>13-Certified Test Report</li> <li>15-Justification for Admission</li> <li>21-Recovery Plan</li> <li>48-Social Security Benefit Letter</li> <li>55-Rental Agreement</li> <li>77-Support Data for Verification</li> <li>A3-Allergies/Sensitivities Document</li> <li>A4-Autopsy Report</li> <li>AM-Ambulance Certification</li> <li>AS-Admission Summary</li> <li>AT-Purchase Order Attachment</li> <li>B2-Prescription</li> <li>B3-Physician Order</li> <li>BR-Benchmark Testing Results</li> <li>BS-Baseline</li> <li>BT-Blanket Test Results</li> <li>CB-Chiropractic Justification</li> <li>CK-Consent Form(s)</li> <li>D2-Physician Order</li> <li>DA-Dental Models</li> </ul>

Current Procedural Terminology  
American Dental Association (ADA)

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

# Submitting a PA Request, continued

The screenshot displays a web application interface for submitting a PA Request. A 'Choose File to Upload' dialog box is open, showing the 'Desktop' folder. The file 'Nurse Notes.docx' (Microsoft Word Document, 0 bytes) is selected and highlighted with a red box and a callout labeled '16'. The 'Open' button in the dialog is also highlighted with a red box and a callout labeled '17'. In the background, the main form is visible. The 'Transmission Method' is set to 'EL-Electronic Only'. The 'Upload File' section has a 'Browse...' button highlighted with a red box and a callout labeled '15'. The 'Attachment Type' is set to 'NN-Nursing Notes'. The 'Add' and 'Cancel' buttons are at the bottom of the form.

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.

**Attachments**

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

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

Transmission Method	File	Action
Click to collapse.		
*Transmission Method [EE - Electronic Only]	*Upload File C:\Users\bargera\Desktop\Nurse Notes.docx Browse...	*Attachment Type [v]

18

Add

Cancel

Submit

Cancel

# Submitting a PA Request, continued

**Attachments**

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

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

	Transmission Method	File	Action
<input type="checkbox"/>	EL-Electronic Only	Nurse Notes.docx	<a href="#">Remove</a>

☐ Click to collapse.

\*Transmission Method

\*Upload File

\*Attachment Type

- 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.

Justification

Add Service

Cancel Service

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

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

	Transmission Method	File	Action
<input type="checkbox"/>	EL-Electronic Only	Nurse Notes.docx	<a href="#">Remove</a>

☐ Click to collapse.

\*Transmission Method

EL-Electronic Only

\*Upload File

Browse...

\*Attachment Type

Add

Cancel

19

Submit

Cancel

# Submitting a PA Request, continued

20

**Confirm Authorization** [Expand All](#) | [Collapse All](#)

**Requesting Provider Information**

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

**Recipient Information and Process Type**

**Recipient ID** 43827875678  
**Recipient** ABYNNRYP ABIEGUT **Gender** Female  
**Birth Date** 04/10/1928  
**Process Type** Home Health

**Referring Provider Information**

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

**Service Provider Information**

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

[Expand All](#) | [Collapse All](#)

**Diagnosis Information**

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Diagnosis Type	Diagnosis Code
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter

**Service Details**

Line #	From Date	To Date	Code	Modifiers	Units
1	01/01/2018	01/01/2019	CPT/HCPCS A6413-Adhesive bandage, first-aid		1

**Attachments**

Transmission Method	File	Attachment Type
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes

[Back](#) **21** [Confirm](#) [Cancel](#)

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

**My Home** **Eligibility** **Claims** **Care Management** **File Exchange** **Resources**

Create Authorization | View Authorization Status | Maintain Favorite Providers | Authorization Criteria

[Care Management](#) > Authorization Receipt

---

**Authorization Receipt** ?

Your Authorization Tracking Number **45180650011** was successfully submitted.

Click **Print Preview** to view authorization details and receipt.  
Click **Copy** to copy member data or authorization data.  
Click **New** to create a new authorization for a different member.  
General Authorization Receipt Instructions

[Print Preview](#) [Copy](#) [New](#)

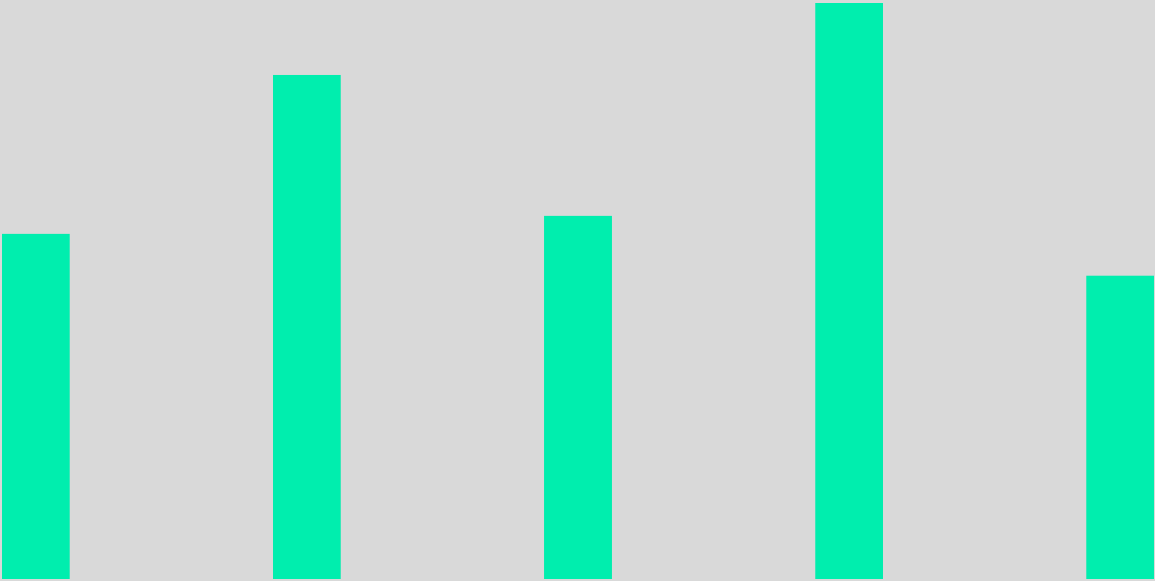
- After the Confirm button has been clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.

# Submitting a PA Request, continued

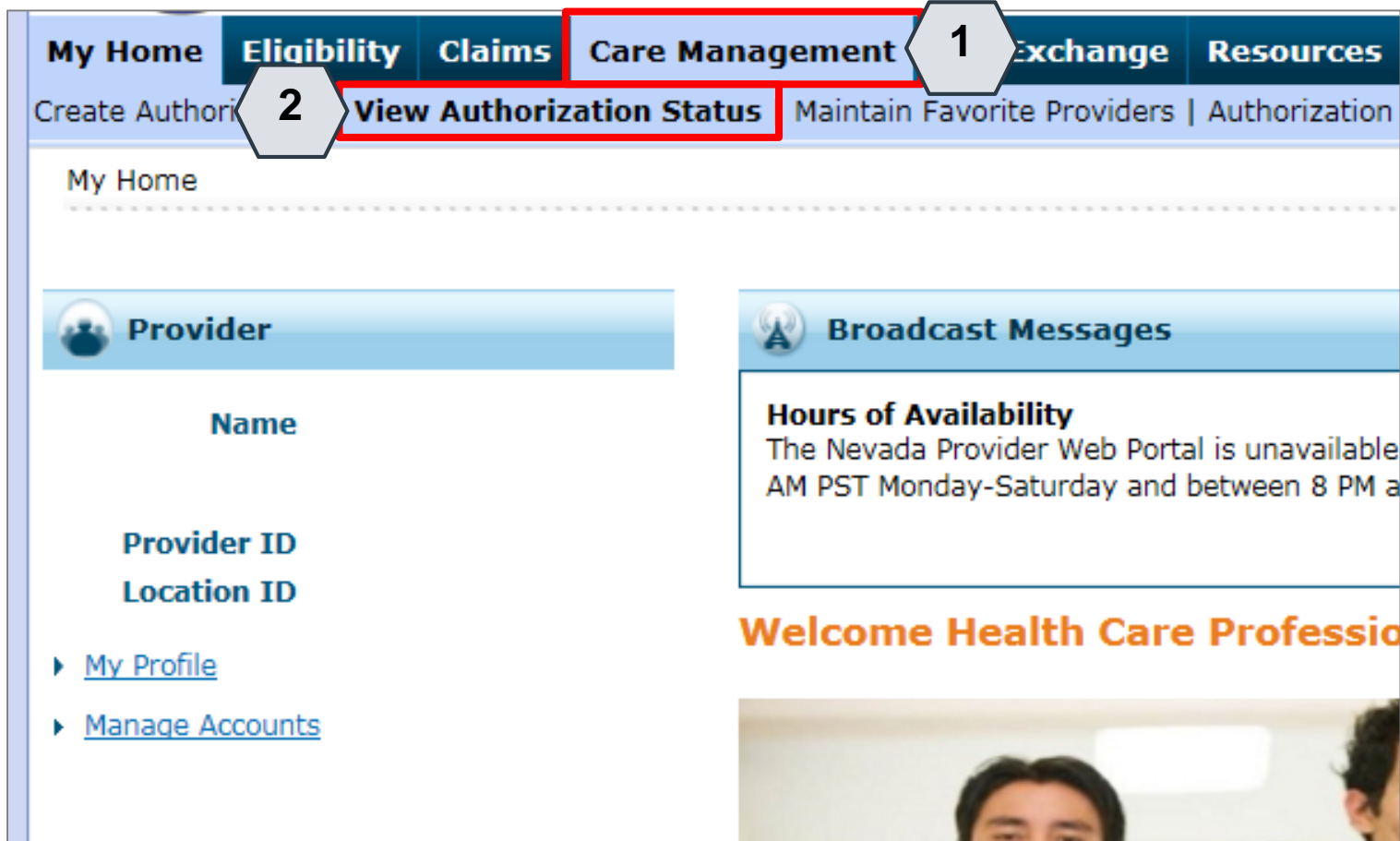
The screenshot displays a web application interface for managing authorizations. At the top, a navigation bar includes links for 'My Home', 'Eligibility', 'Claims', 'Care Management', 'File Exchange', and 'Resources'. Below this, a secondary bar lists actions: 'Create Authorization', 'View Authorization Status', 'Maintain Favorite Providers', and 'Authorization Criteria'. The main content area is titled 'Care Management > Authorization Receipt'. A dark blue header for the 'Authorization Receipt' section contains a help icon. The body of the section displays a confirmation message: 'Your Authorization Tracking Number 45180650011 was successfully submitted.' Below this, instructions are provided: 'Click **Print Preview** to view authorization details and receipt.', 'Click **Copy** to copy member data or authorization data.', and 'Click **New** to create a new authorization for a different member.' A link for 'General Authorization Receipt Instructions' is also present. At the bottom, three buttons are shown: 'Print Preview' (labeled A), 'Copy' (labeled B), and 'New' (labeled C). These buttons are highlighted with a red rectangular border.

- 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

**My Home** **Eligibility** **Claims** **Care Management** **File Exchange** **Resources**

Create Authorization | **View Authorization Status** | Maintain Favorite Providers | Authorization Criteria

[Care Management](#) > View Authorization Status

**View Authorization Status**

Prospective Authorizations

Prospective authorizations identifying you as the Requesting or Servicing Provider are listed below. These results include beginning Services Date of today or greater. Click the Authorization Tracking Number to view the authorization response or search for a different authorization.

**Prospective Authorizations**

<a href="#">Authorization Tracking Number</a>	<a href="#">Service Date</a> ▲	<a href="#">Recipient Name</a>	<a href="#">Recipient ID</a>	<a href="#">Process Type</a>	<a href="#">Requesting Provider</a>
<a href="#">45181270003</a>	01/01/2018 - 01/01/2019	ABIEGUT, ABYNNRYP	43827875678	Home Health	HOSPITALIST SERVICES NEVADA-MANDAVIA
<a href="#">43180110001</a>	01/11/2018 - 01/11/2019	QROTB, FENKTPVI	54409179444	Outpt M/S	HOSPITALIST SERVICES NEVADA-MANDAVIA
<a href="#">41180120002</a>	01/12/2018 - 01/12/2019	KWLVDTYRXW, AOWPEW H	80335695037	Outpt M/S	HOSPITALIST SERVICES NEVADA-MANDAVIA


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


3


# Viewing the Status of PAs, continued


**View Authorization Response for AOWPEW KWLVDTYRXW** [Back to View Authorization Status](#) ?


**Authorization Tracking #** 41180120002 **Process Type** Outpt M/S [Expand All](#) | [Collapse All](#)

**Requesting Provider Information** 

**Recipient Information** 

**Referring Provider Information** 


**Diagnosis Information** 

**Service Provider / Service Details Information** 

**5** **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	—

[Edit](#) [View Provider Request](#) [Print Preview](#)

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

**View Authorization Response for AOWPEW KWLVDTYRXW** [Back to View Authorization Status](#) ?

**Authorization Tracking #** 41180120002 **Process Type** Outpt M/S [Expand All](#) | [Collapse All](#)

**Requesting Provider Information** +

**Recipient Information** +

**Referring Provider Information** +

**Diagnosis Information** +

**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	6	Certified In Total 01/12/2018	-

[Edit](#) [View Provider Request](#) [Print Preview](#)

- 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	<a href="#">View</a>	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	<a href="#">View</a>	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

Service Provider / Service Details Information								
<b>Provider</b> <b>C</b> 1573690 <b>D</b>		<b>ID Type</b> NPI <b>E</b>		<b>Name</b> HOSPITAL SERVICES OF NEVADA- <b>F</b> MANDALAY <b>G</b>				
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	—

- 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	<a href="#">Hide</a>	Not Certified 02/21/2013	—
<b>Medical Citation</b> 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid. <b>Notes To Provider</b> 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	<a href="#">View</a>	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

**Print Preview**

**View Authorization Response for AOWPEW KWLVDYRXW** [Back to View Authorization Status](#) ?

**Authorization Tracking #** 41180120002 **Process Type** Outpt M/S [Expand All](#) | [Collapse All](#)

**Requesting Provider Information** +

**Recipient Information** +

**Referring Provider Information** +

**Diagnosis Information** +

**Service Provider / Service Details Information** -

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

**J**

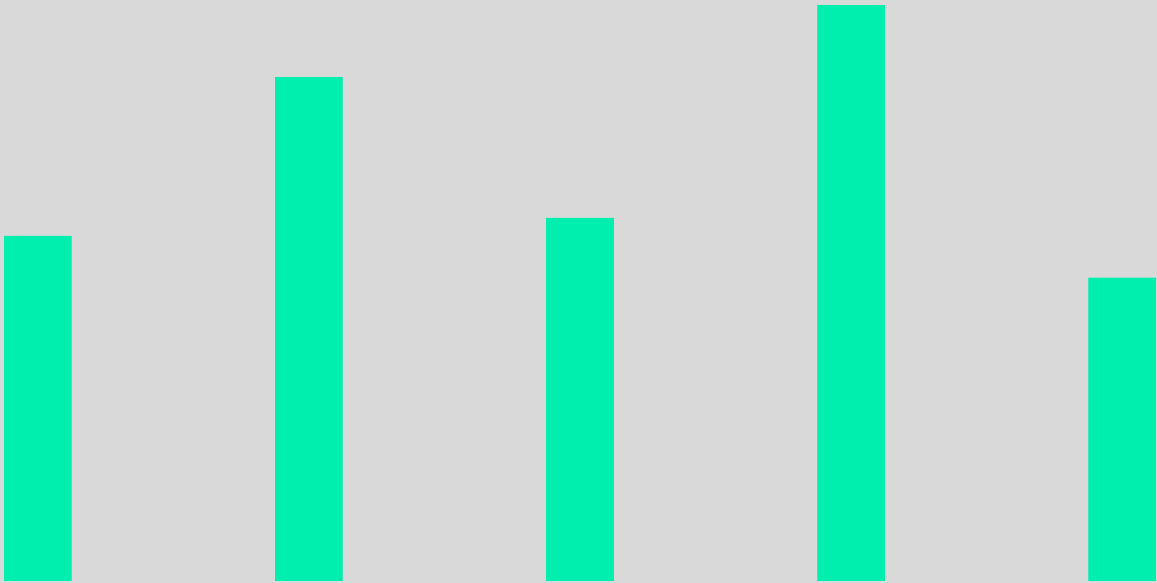
From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	-	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	-	Certified In Total 01/12/2018	-

**H** **I**

**Edit** **View Provider Request** **Print Preview**

- 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

The screenshot shows a web form titled "Prospective Authorizations" with a "Search Options" tab highlighted by a red box and a callout labeled "1". Below the tab, a red box outlines the main search criteria section, with a callout labeled "2" pointing to the "Authorization Tracking Number" field. The form includes several sections: "Authorization Information" with a text input for "Authorization Tracking Number" (containing "43180110001") and a "Day Range" dropdown; "Status Information" with a "Status" dropdown; "Recipient Information" with fields for "Recipient ID", "Last Name", "Birth Date", and "First Name"; and "Provider Information" with a "Provider ID" field, an "ID Type" dropdown, and radio buttons for "Servicing Provider on the Authorization" (selected) and "Requesting Provider on the Authorization". At the bottom are "Search" and "Reset" buttons.

Prospective Authorizations Search Options 1

Enter at least one of the following fields to search for an authorization.

**Authorization Information**

Authorization Tracking Number 43180110001

Select a Day Range or specify a Service Date

Day Range OR Service Date

**Status Information**

Select status to return authorization service lines with the chosen status.

Status

**Recipient Information**

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

Recipient ID Birth Date

Last Name First Name

**Provider Information**

Provider ID ID Type

This Provider is the

☒ Servicing Provider on the Authorization

☐ Requesting Provider on the Authorization

Search Reset

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



# Searching for PAs, continued

Authorization Information	
<b>A</b>	<b>Authorization Tracking Number</b> <input type="text"/>
Select a Day Range or specify a Service Date	
<b>B</b>	<b>Day Range</b> <input type="text" value="Last 30 days"/> <input type="button" value="v"/>
OR	<b>C</b>
	<b>Service Date</b> <input type="text"/> <input type="button" value="Calendar"/>

- 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

Status Information	
Select status to return authorization service lines with the chosen status.	
<div>D</div>	<div>Status<ul style="list-style-type: none"><li>Cancel</li><li>Certified In Total</li><li>Certified Partial</li><li>Not Certified</li><li>Pended</li></ul></div>
Recipient Information	
Recipient information is not mandatory. You can either enter the Recipient ID; or the Last Name, First Name, and Birth Date.	

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

# Searching for PAs, continued

Recipient Information			
Member information is not mandatory. You can either enter the Member ID; or the Last Name, First Name, and Birth Date.			
E	Recipient ID	<input type="text"/>	F Birth Date 
G	Last Name	<input type="text"/>	First Name <input type="text"/>

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

**Provider Information**

**H** **Provider ID**  

**I** **ID Type**

**J** **This Provider is the** ☒ Servicing Provider on the Authorization  
☐ Referring Provider on the Authorization

**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

Recipient Information

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

Recipient ID

Birth Date

Last Name

First Name

Provider Information

Provider ID

ID Type

This Provider is the

☒ Servicing Provider on the Authorization

☐ Requesting Provider on the Authorization

3

Search

Reset

Search Results

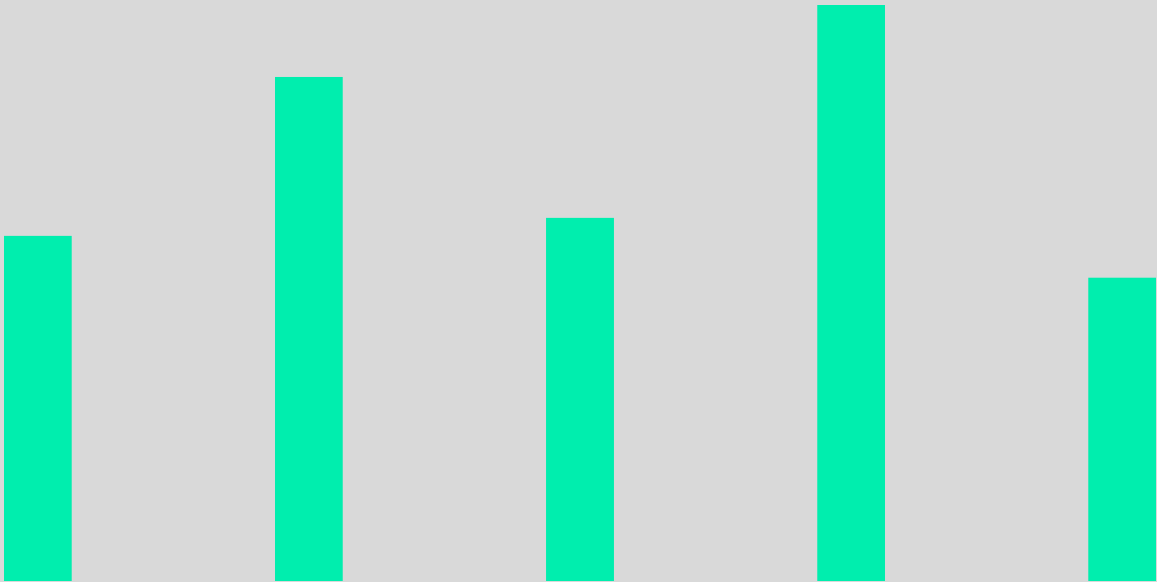
Authorization Tracking Number	Service Date	Recipient Name	Recipient ID	Process Type	Requesting Provider
43180110001	01/11/2018 - 01/11/2019	QROTB, FENKTPVI	54409179444	Outpt M/S	HOSPITALIST SERVICES NEVADA-MANDAVIA

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

Nevada Medicaid – Provider Type 13 (Psychiatric Hospital, Inpatient)

93


# 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


**View Authorization Response for ABYNNRYP ABIEGUT** [Back to View Authorization Status](#) 


**Authorization Tracking #** 45181270003 **Process Type** Home Health [Expand All](#) | [Collapse All](#)

**Requesting Provider Information** 

**Recipient Information** 



**Referring Provider Information** 

**Diagnosis Information** 

**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
01/01/2018	01/01/2019	1	0	—	CPT/HCPCS A6413-Adhesive bandage, first-aid	—	Pended —	—

  **Edit** **Provider Request** **Print Preview**

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**

**Diagnosis Information**  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Insert decimals as needed.  
Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter	

Click to collapse.

**\*Diagnosis Type** ICD-10-CM **\*Diagnosis Code**

Add Cancel

**Service Details**  
Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

	Line #	From Date	To Date	Decision	Code	Modifiers	Units	Action
+	1	01/01/2018	01/01/2019	Pended	A6413-Adhesive bandage, first-aid		1	<a href="#">Copy</a>

Click to collapse.

**Attachments**  
To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.  
[Prior Authorization Forms](#)  
If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.  
Click the **Remove** link to remove the entire row.

Transmission Method	File	Attachment Type	Action
---------------------	------	-----------------	--------

Click to collapse.

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

# Submitting Additional Information, continued

**Attachments**

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

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

Transmission Method	File	Attachment Type	Action
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes	<a href="#">Remove</a>
EL-Electronic Only	Benefit Letter.docx	59-Benefit Letter	<a href="#">Remove</a>

☐ Click to collapse.

**\*Transmission Method** EL-Electronic Only ▾

**\*Upload File**  [Browse...](#)

**\*Attachment Type**  ▾

[Add](#) [Cancel](#)

3

[Resubmit](#) [Cancel](#)

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

# Submitting Additional Information, continued

4

Referring Provider Information

Provider ID

1831573690

ID Type

NPI

Name

Service Provider Information

Provider ID

1831573690

ID Type

NPI

Name

DF

Location

\_

Expand All

Collapse All

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Diagnosis Type	Diagnosis Code
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter

Service Details

	Line #	From Date	To Date	Code	Modifiers	Units
+	1	01/01/2018	01/01/2019	CPT/HCPCS A6413-Adhesive bandage, first-aid		1

Attachments

Transmission Method	File	Attachment Type
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes
EL-Electronic Only	Benefit Letter.docx	59-Benefit Letter

Back

5

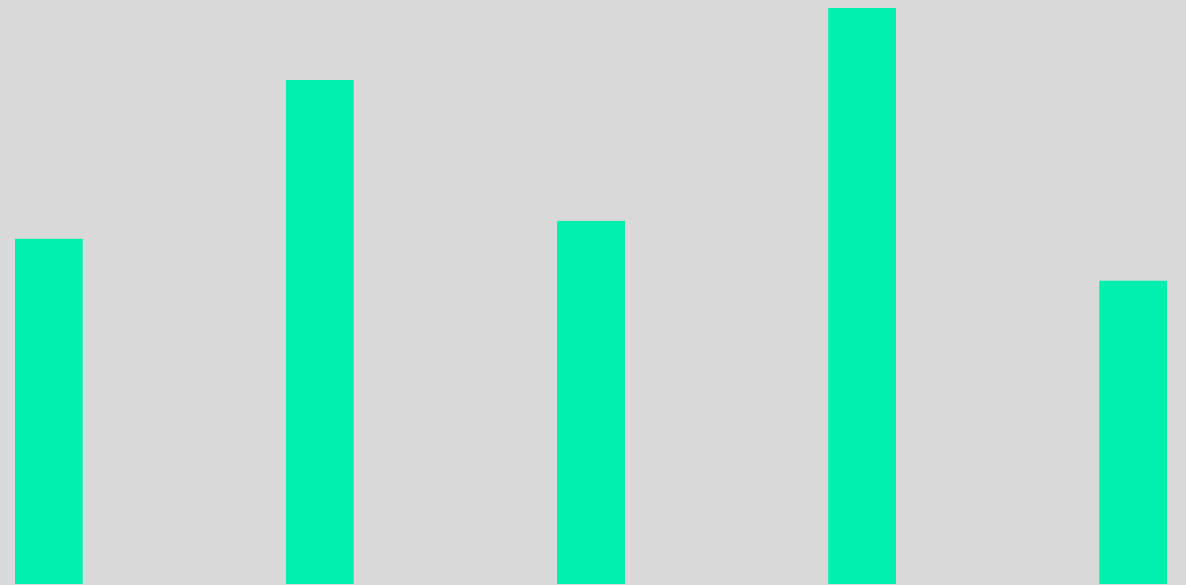
Confirm

Cancel

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@dx.com](mailto:nvpeer_to_peer@dx.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.

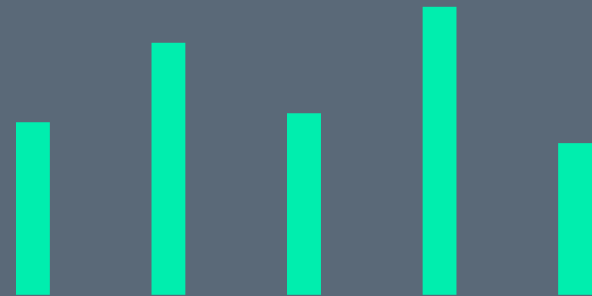
# Discharge Planning



# 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](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**

<b>SECTION I.</b> Information in this section <b>MUST MATCH</b> 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. <i>(This section must be completed for all submissions.)</i>				
Type of Medicaid Eligibility: <i>(Please check one)</i>		<input type="checkbox"/> MAABD	<input type="checkbox"/> Child Welfare	<input type="checkbox"/> TANF
CURRENT STATUS:		<input type="checkbox"/> Medicaid Eligible	<input type="checkbox"/> Medicaid Pending	
Facility Submitting Form: <i>(Please do not use initials)</i>		Medicaid Provider Number:	Attending Physician:	
Medicaid Billing No. (11 digits): <i>(Please complete, even if pending)</i>	*Aid Code:	Social Security No.:	Date of Birth: MO DY YR ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient's/Resident's Last Name:		Patient's/Resident's First Name:		M.I.:
<i>*Aid Code to be completed if known by accessing one of the above three sources. <b>DO NOT</b> contact eligibility hot lines to obtain. If above information is for a newborn, complete the following:</i>				
Newborn's Mother's Last Name:		First Name:	Medicaid Billing No. (11 digits):	Social Security No.:

<b>SECTION II.</b> Complete either Section A. or B.	
<b>A. ADMISSION INFORMATION:</b> <i>(Complete this information only if being sent as an Admit Notice)</i>	
ADMIT DATE TO THIS LEVEL OF CARE <i>(Regardless of Payment Source)</i> MO DY YR ____/____/____	
* ADM CODE: <i>(See below)</i>	Patient/Resident Admitted From: <i>(Include name. Do not use initials.)</i>
<b>B. DISCHARGE/DEATH INFORMATION:</b> <i>(Complete this area only if being sent as a Discharge/Death Notice)</i>	
DISCHARGE OR DEATH DATE: MO DY YR ____/____/____	
WAS THIS STAY PRIMARY MEDICARE? <i>(for nursing facility discharges only)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	
**DIS CODE: <i>(See below)</i>	Patient/Resident Discharged To: <i>(Include name)</i>
Notice Completed by: _____ Telephone: _____	
<b>*ADM(ission) Code:</b> B from ACUTE Level C from SKILLED NURSING Level D from INTERMEDIATE CARE Level E from INDEPENDENT LIVING	
<b>**DIS(charge) Code:</b> 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



 **Nevada Department of Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

**My Home** **Eligibility** **Claims** **Care Management** **File Exchange** **Resources**

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#)

Claims

 **Claims**

- ▶ [Search Claims](#)
- ▶ [Submit Claim Dental](#)
- ▶ [Submit Claim Inst](#)
- ▶ [Submit Claim Prof](#)
- ▶ [Search Payment History](#)
- ▶ [Treatment History](#)

Hover over the **Claims** tab.

Select **Submit Claim Inst.**

# Submitting a Claim, continued



**Nevada Department of Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

**My Home** | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources**

[Search Claims](#) | [Submit Claim Dental](#) | **[Submit Claim Inst](#)** | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

[Claims](#) > [Submit Claim Inst](#)

---

**Submit Institutional Claim: Step 1**

\* Indicates a required field.

Claim Type

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an O

Billing Provider ID: 1016162705

**Claim Type Options:**

- Inpatient
- Inpatient**
- Crossover Inpatient
- Outpatient
- Crossover Outpatient
- Long Term Care

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



# Submitting a Claim, continued

**Submit Institutional Claim: Step 1**

\* Indicates a required field.

**Claim Type** Inpatient

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

**Billing Provider ID** 1255360160 **ID Type** NPI

**\*Billing Provider Service Location** 10-CARSON TAHOE HOSPITAL-1600 MEDICAL PARKWAY,CARSON CITY,NEVADA,897034625

**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**

**Last Name**  **First Name**

**Birth Date**

**Claim Information**

**\*Covered Dates**  -

**\*Admission Date/Hour**  (hh:mm) **Discharge Hour**  (hh:mm)

**\*Admission Type**  **\*Admission Source**

**\*Admitting Diagnosis Type** ICD-10-CM **\*Admitting Diagnosis**

**\*Patient Status**  **\*Facility Type Code**

**\*Patient Number**  **Authorization Number**

**Include Other Insurance** ☐ **Total Charged Amount** \$0.00

**Continue** **Cancel**

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

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	POA	Action
<a href="#">1</a>	ICD-10-CM	B088-Oth viral infections with skin and mucous membrane lesions	Yes	<a href="#">Remove</a>
<a href="#">2</a>	ICD-10-CM	B012-Varicella pneumonia	Yes	<a href="#">Remove</a>
<a href="#">3</a>				

3

\*Diagnosis Type

ICD-10-CM

\*Diagnosis Code

B01

Present on Admission

No

Add

Reset

B01

B010-Varicella meningitis

B0111-Varicella encephalitis and encephalomyelitis

B0112-Varicella myelitis

B012-Varicella pneumonia

B0181-Varicella keratitis

B0189-Other varicella complications

B019-Varicella without complication

External Cause of Injury Diagnosis Codes

Other Insurance Details

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 <b>Remove</b> 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	<a href="#">Remove</a>
2	0250-Pharmacy (Drugs)-General				1.000 Unit	\$500.25	<a href="#">Remove</a>
3	0320-Dx X-Ray-General				1.000 Unit	\$1,500.31	<a href="#">Remove</a>
4	0300-Laboratory (Lab)-General				1.000 Unit	\$621.52	<a href="#">Remove</a>
5					0.000		

5 \*Revenue Code  HCPCS/Proc Code

Modifiers

From Date  To Date  \*Units  \*Unit Type

\*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	HCP/CS/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

[Claims](#) > Claim Receipt

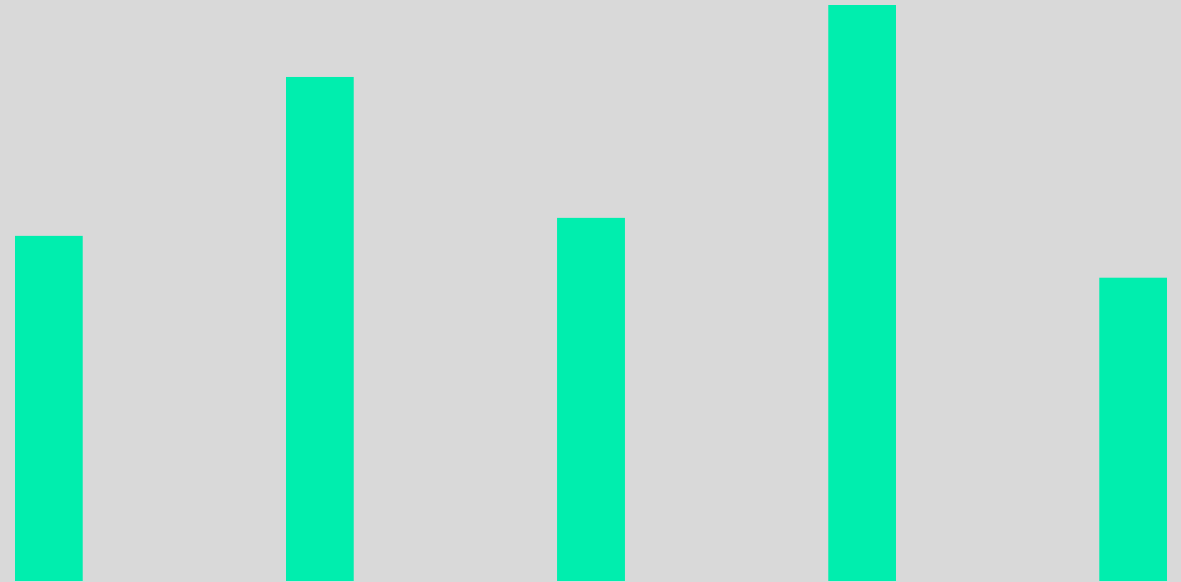
Submit Inpatient Claim: Confirmation
Inpatient Claim Receipt
Your Inpatient Claim was successfully submitted. The claim status is Finalized Payment. The Claim ID is <b>2218269000008</b> .
Click <b>Print Preview</b> to view the claim details as they have been saved on the payer's system. Click <b>Copy</b> to copy member or claim data. Click <b>Adjust</b> to resubmit the claim. Click <b>New</b> to submit a new claim. Click <b>View</b> to view the details of the submitted claim.
<a href="#">Print Preview</a> <a href="#">Copy</a> <a href="#">Adjust</a> <a href="#">New</a> <a href="#">View</a>

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

**Submit Professional Claim: Step 1**

\* Indicates a required field.

Claim Type Professional

---

**Provider Information**

**1**

Billing Provider ID 1831573690 ID Type NPI

\*Billing Provider Service Location 20-HOSPITALIST SERVICES OF NEVADA-MANDAVIA-2001 ERRECART BLVD, ELKO, NEVADA, 898018333

Rendering Provider ID  ID Type

Rendering Provider Service Location -

Referring Provider ID  ID Type

Supervising Provider ID  ID Type

Service Facility Location ID  ID Type

---

**Patient Information**

\*Recipient ID

Last Name - First Name -

Birth Date -

---

**Claim Information**

Date Type  Date of Current

Accident Related  Admission Date

\*Patient Number  Authorization Number

\*Transport Certification ☐ Yes ☐ No

\*Does the provider have a signature on file? ☐ Yes ☐ No

---

Include Other Insurance ☐ **2** Total Charged Amount \$0.00

Continue Cancel

# Claim Submission: TPL, continued

3

Click the row number to edit the row. Click the **Remove** link to remove the entire row. Note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1			

1      \*Diagnosis Type    ICD-10-CM      \*Diagnosis Code   

Add

Reset

4

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

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

Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	Insurance	1234567890	1234567890		01/02/2020	<a href="#">Remove</a>

+ Click to add a new other insurance.

Back to Step 1

Continue

Cancel

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

#	Diagnosis Type	Diagnosis Code	Action
<a href="#">1</a>	ICD-10-CM	S0000XA-Unspecified superficial injury of scalp, initial encounter	<a href="#">Remove</a>
<a href="#">2</a>			

2	<b>*Diagnosis Type</b> ICD-10-CM ▼	<b>*Diagnosis Code</b> <input type="text"/>
---	------------------------------------	---

[Add](#) [Reset](#)

**Other Insurance Details**

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

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

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.						

<b>*Carrier Name</b>	<input type="text" value="Third Party Insurance"/>	<b>*Carrier ID</b>	<input type="text" value="12345"/>
<b>*Policy Holder Last Name</b>	<input type="text" value="Last"/>	<b>*First Name</b>	<input type="text" value="First"/> <b>MI</b> <input type="text"/>
<b>*Policy ID</b>	<input type="text" value="123456"/>		
<b>Insurance Type</b>	<input type="text"/>		
<b>*Responsibility</b>	<input type="text" value="P-Primary"/>	<b>*Patient Relationship to Insured</b>	<input type="text" value="18-Self"/>
<b>Payer Paid Amount</b>	<input type="text"/>	<b>*Paid Date</b>	<input type="text" value="05/31/2019"/>
<b>Remaining Patient Liability</b>	<input type="text"/>		
<b>*Claim Filing Indicator</b>	<input type="text" value="12-Preferred Provider Organization (PPO)"/>		

[Add Insurance](#) [Cancel Insurance](#)

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

Provider Information

Billing Provider ID

1831573690

ID Type

NPI

Patient and Claim Information

Recipient ID

12345678901

Recipient

John Smith

Birth Date

01/01/2001

Gender

Male

Total Charged Amount

\$0.00

Expand All

Collapse All

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	*Diagnosis Type ICD-10-CM ▼	*Diagnosis Code <input type="text"/>	

Add

Reset

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

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

Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	Insurance	1234567890	1234567890		01/02/2020	<a href="#">Remove</a>

+

 Click to add a new other insurance.

Back to Step 1

Continue

Cancel

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

**Other Insurance Details**

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

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

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	5	12345	123456		05/31/2019	<a href="#">Remove</a>

**Carrier Name** Third Party Insurance **Carrier ID** 12345

**\*Policy Holder Last Name** Last **\*First Name** First **MI** ☐

**\*Policy ID** 123456

**Insurance Type**

**\*Responsibility** P-Primary **\*Patient Relationship to Insured** 18-Self

**Payer Paid Amount**  **\*Paid Date** 05/31/2019

**Remaining Patient Liability**

**\*Claim Filing Indicator** 12-Preferred Provider Organization (PPO)

**Claim Adjustment Details**

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click to collapse.

Claim Adjustment Group Code	Reason Code	Adjustment Amount	Adjusted Units	Action
*Claim Adjustment Group Code	CO-Contractual Obligations			
*Reason Code	1-Deductible Amount			
*Adjustment Amount	10.00			

**7** [Add Adjustment](#) [Cancel Adjustment](#)

**8** [Save Insurance](#) [Insurance](#)

Click to add a new other insurance.

**9** [Continue](#) [Cancel](#)

[Back to Step 1](#)

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).

#	Carrier Name	Carrier ID	Policy ID	Payer Paid Amount	Paid Date	Action
1	Third Party Insurance	12345	123456		05/31/2019	<a href="#">Remove</a>

Carrier Name	<input type="text" value="Third Party Insurance"/>	Carrier ID	<input type="text" value="12345"/>
*Policy Holder Last Name	<input type="text" value="Last"/>	*First Name	<input type="text" value="First"/> MI <input type="checkbox"/>
*Policy ID	<input type="text" value="123456"/>		
Insurance Type	<input type="text"/>		
*Responsibility	<input type="text" value="P-Primary"/>	*Patient Relationship to Insured	<input type="text" value="18-Self"/>
Payer Paid Amount	<input type="text"/>	*Paid Date	<input type="text" value="05/31/2019"/>
Remaining Patient Liability	<input type="text"/>		
*Claim Filing Indicator	<input type="text" value="12-Preferred Provider Organization (PPO)"/>		

**Claim Adjustment Details**

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

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

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Adjusted Units	Action
<input type="checkbox"/> Click to collapse.					
*Claim Adjustment Group Code	<input type="text" value="CO-Contractual Obligations"/>	*Reason Code	<input type="text" value="1-Deductible Amount"/>	*Adjustment Amount	<input type="text" value="10.00"/> Adjusted Units <input type="text"/>

[Add Adjustment](#) [Cancel Adjustment](#)

[Save Insurance](#) [Cancel Insurance](#)

☐ Click to add a new other insurance.

[Back to Step 1](#) [Continue](#) [Cancel](#)

# 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 Adjustment Details

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Adjusted Units
1	CO-Contractual Obligations	1-Deductible Amount	\$10.00	

Service Details

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

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1						0.000	

1

\*From Date

05/30/2019

To Date

\*Place of Service

11-Office

EMG

\*Procedure Code

01953-ANESTH BUR

Modifiers

\*Diagnosis Pointers

1

\*Charge Amount

10.00

\*Units

10.000

\*Unit Type

Unit

EPSDT

Family Plan

Clia Number

Rendering Provider ID

Rendering Provider Service Location

Referring / Ordering Provider ID

ID Type

Ordering Provider

Yes

No

NDCs for Svc. # 1

Add

Nevada Medicaid – Provider Type 13 (Psychiatric Hospital, Inpatient)

135

# Claim Submission: TPL, continued

**Service Details**

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

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	05/30/2019	05/30/2019	11-Office	01953-Anesth burn each 9 percent	\$10.00	1.000 Unit	<a href="#">Remove</a>

1 \*From Date 05/30/2019 To Date 05/30/2019 \*Place of Service 11-Office EMG

\*Procedure Code 01953-Anesth burn Modifiers \*Diagnosis Pointers 1

\*Charge Amount 10.00 \*Units 1.000 \*Unit Type Unit EPSDT Family Plan

Clia Number Rendering Provider ID ID Type Referring Provider ID ID Type

**NDCs for Svc. # 1**

**Other Insurance for Service Detail**

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

#	Carrier ID	Procedure Code	Modifiers	Payer Paid Amount	Paid Date	Paid Units	Remaining Patient Liability	Action
---	------------	----------------	-----------	-------------------	-----------	------------	-----------------------------	--------

Click to collapse.

\*Other Carrier \*Procedure Code Modifiers

Payer Paid Amount \*Paid Date Paid Units 0.00

Remaining Patient Liability

[Add Insurance](#) [Insurance](#)

[Save](#) [Reset](#) [Cancel](#)

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

**NDCs for Svc. # 1**

**Other Insurance for Service Detail**

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

#	Carrier ID	Procedure Code	Modifiers	Payer Paid Amount	Paid Date	Paid Units	Remaining Patient Liability	Action
<b>15</b>		01953-ANESTH BURN EACH 9 PERCENT			05/31/2019	0.00		<a href="#">Remove</a>

**Other Carrier** 12345-Third Party Insurance

**\*Procedure Code** 01953-ANESTH BURN EACH 9 PERCENT

**Modifiers**

**Payer Paid Amount**

**\*Paid Date** 05/31/2019

**Paid Units** 0.00

**Remaining Patient Liability**

**Claim Adjustment Details**

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

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

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Adjusted Units	Action
---	-----------------------------	-------------	-------------------	----------------	--------

☐ Click to collapse.

**\*Claim Adjustment Group Code**

**\*Reason Code**

**\*Adjustment Amount**

**Adjusted Units**

**17** [Add Adjustment](#) [Add Adjustment](#)

**18** [Save Insurance](#) [Cancel Insurance](#)

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

Code

\*Charge Amount

Units

\*Units

Unit Type

\*Unit Type

EPSDT

Family Plan

Clia Number

Rendering Provider ID

Rendering Provider Service Location

ID Type

ID Type

Referring Provider ID

ID Type

NDCs for Svc. # 2

Add

Reset

Attachments

Click the Remove link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FT-File Transfer			
	*Upload File	Choose File No file chosen			
	*Attachment Type				
	Description				
<div> <div>Add</div> <div>Cancel</div> </div>					

Back to Step 1

Back to Step 2

20

Submit

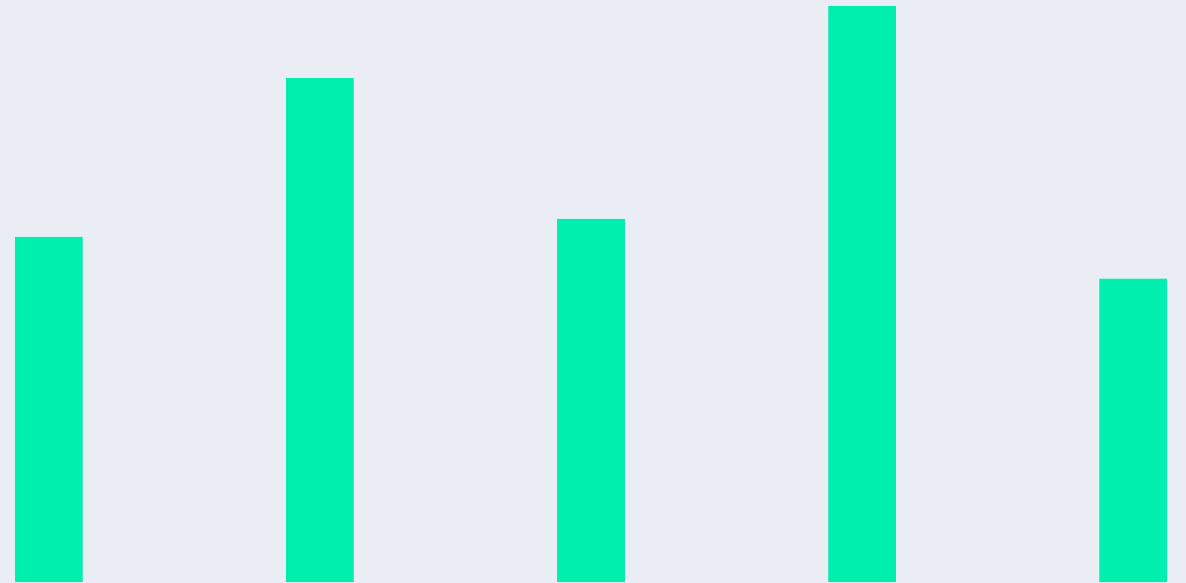
Cancel

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:

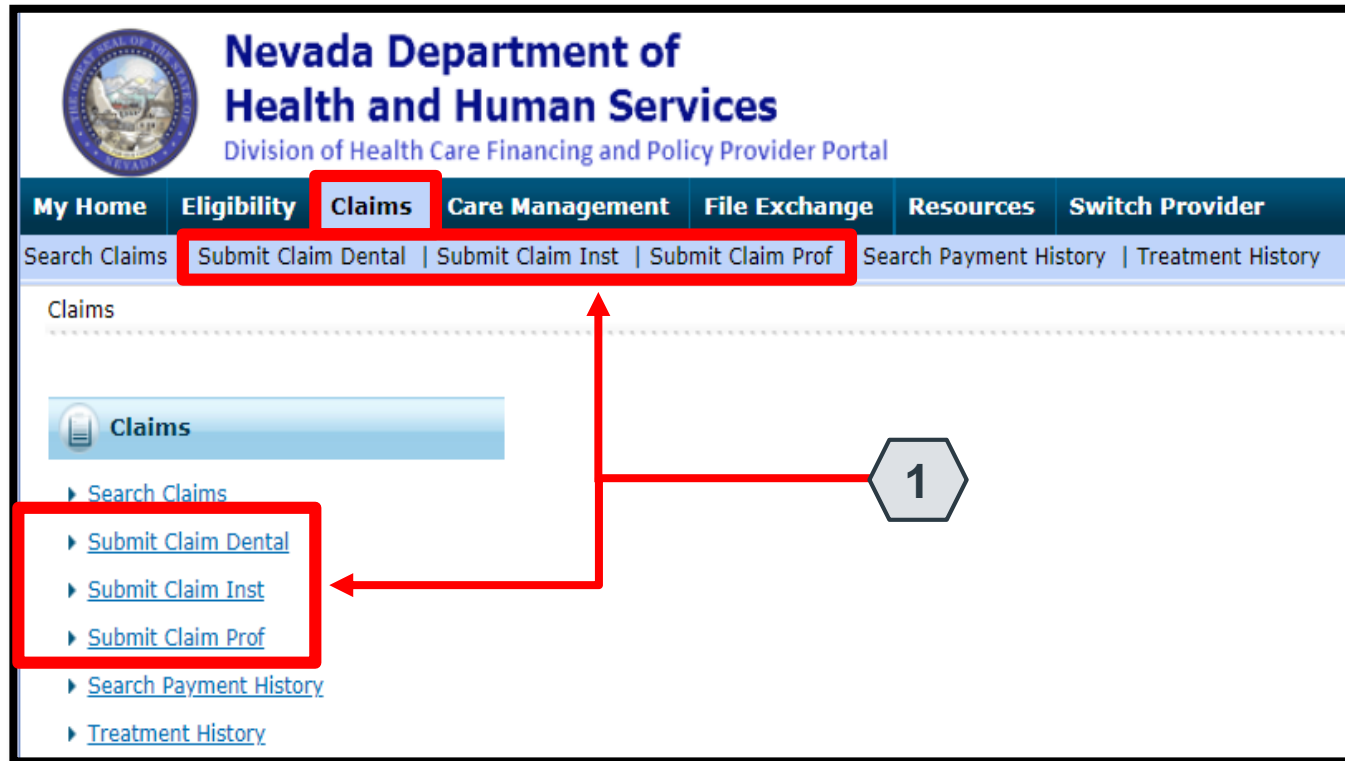
- A. When Medicare has made a payment on the claim, or has left an amount to patient responsibility (i.e., coinsurance, copay, deductible):
  - a. Claim must be submitted as “Crossover Professional”
  - b. Crossover details must be filled out
  - c. No Explanation of Benefits (EOB) attachment needed
- 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

**Submit Professional Claim: Step 1** ?

\* Indicates a required field.

**2** **Claim Type** Crossover Professional  
Professional  
Crossover Professional

**Provider Information**

Billing Provider ID 1831573690 ID Type NPI  
\*Billing Provider Service Location 20-HOSPITALIST SERVICES OF NEVADA MANDAVIA-2001 ERRECART BLVD, ELKO, NEVADA, 898018333  
Rendering Provider ID  ID Type   
Rendering Provider Service Location   
Referring Provider ID  ID Type   
Supervising Provider ID  ID Type   
Service Facility Location ID  ID Type

**Patient Information**

\*Recipient ID   
Last Name  First Name   
Birth Date

**Claim Information**

Date Type   
Accident Related   
\*Patient Number   
\*Transport Certification ☐ Yes ☐ No  
\*Does the provider have a signature on file? ☐ Yes ☐ No  
Include Other Insurance ☐  
Date of Current   
Admission Date   
Authorization Number   
Total Charged Amount \$0.00

**Medicare Crossover Details**

Allowed Medicare Amount  0.00  
Deductible Amount  0.00  
Medicare Payment Amount  0.00  
Co-insurance Amount  0.00  
Psychiatric Services Amount  0.00  
Medicare Payment Date

**Continue** **Cancel**

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

**Submit Professional Claim: Step 1** ?

\* Indicates a required field.

Claim Type Crossover Professional

---

**Provider Information**

Billing Provider ID 1316162795 ID Type NPI

\*Billing Provider Service Location 20-UROLOGY NEVADA-C/O BLDG A,RENO,NEVADA,895113019

Rendering Provider ID  ID Type

Rendering Provider Service Location -

Referring Provider ID  ID Type

Supervising Provider ID  ID Type

Service Facility Location ID  ID Type

---

**Patient Information**

\*Recipient ID

Last Name - First Name -

Birth Date -

---

**Claim Information**

Date Type  Date of Current

Accident Related  Admission Date

\*Patient Number  Authorization Number

\*Transport Certification ☐ Yes ☐ No

\*Does the provider have a signature on file? ☐ Yes ☐ No

Include Other Insurance ☐ Total Charged Amount \$0.00

---

**Medicare Crossover Details**

Allowed Medicare Amount 0.00 Co-insurance Amount 0.00

Deductible Amount 0.00 Psychiatric Services Amount 0.00

Medicare Payment Amount 0.00 Medicare Payment Date

---

**5** Continue Cancel

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

Service Details

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

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1						0.000	

1

\*From Date

To Date

\*Place of Service

EMG

\*Procedure Code

Modifiers

\*Diagnosis Pointers

\*Charge Amount

\*Units

\*Unit Type

EPSDT

Family Plan

Clin Number

Rendering Provider ID

ID Type

Rendering Provider Service Location

Referring Provider ID

ID Type

Medicare Crossover Details

Allowed Medicare Amount

Deductible Amount

Medicare Payment Amount

Co-insurance Amount

Psychiatric Services Amount

Medicare Payment Date

NDCs for Svc. # 1

Add

Reset

Attachments

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

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

Back to Step 1

Back to Step 2

Submit

Cancel

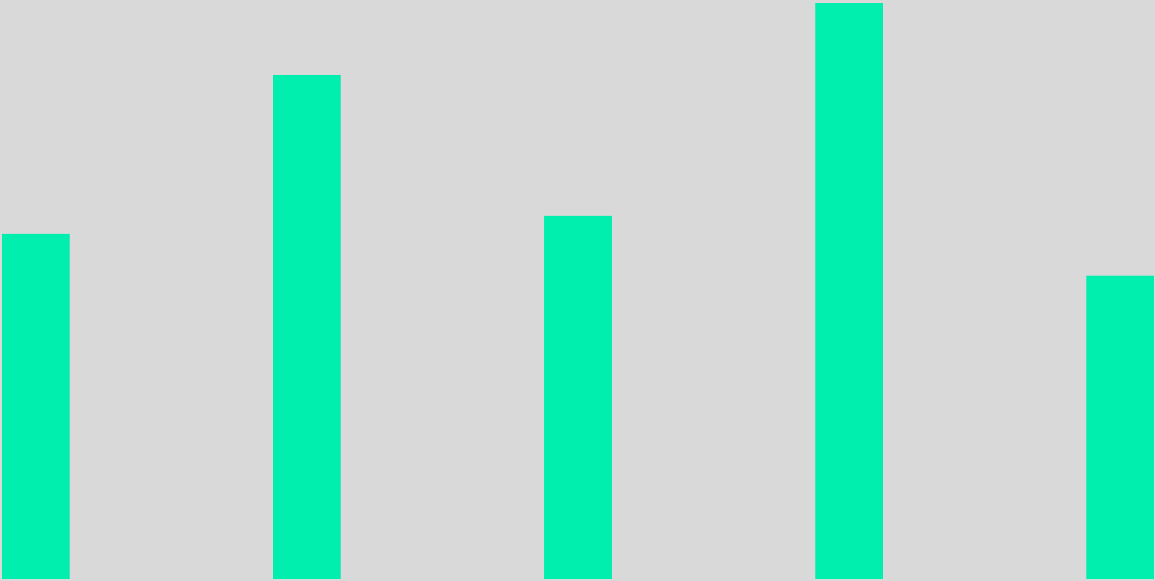
After Step 1 is completed, the user will enter claim information in Step 2. Once all applicable information is added, the user will continue to Step 3.

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



**Nevada Department of  
Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

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[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

[Claims](#) > Search Claims

Monday 10/01/2018 12:48 PM EST

**Delegate for** Carson Tahoe Regional | **Role IDs** Provider - In Network - 1255360160 (NPI) | **Location** 1013843 - CARSON TAHOE HOSPITAL

**Search Claims**

Medical/Dental

A minimum one field is required.  
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.  
  
Claim searches are limited to a maximum range of 45 days.


**Claim Information**



Claim ID

**Recipient Information**

Recipient ID

**Service Information**

Rendering Provider ID   ID Type  Claim Type

Service From   To   Claim Status


Search

Reset

**Search Results**

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

Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
	<a href="#">2218276000016</a>		Inpatient	Finalized Denied	09/24/2018 - 09/28/2018	96536412536	1255360160	\$0.00	-	

- 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 Type

1-Emergency

Admitting Diagnosis Type

ICD-10-CM

Admitting Diagnosis

R079

Patient Status

01-Discharged to Home or Self Care (Routine Discharge)

Patient Number

123456

Previous Claim ICN

\_

Note

\_

Admission Date/Hour

09/24/2018 - \_

Admission Source

1-Non - Health Care Facility Point of Origin

Discharge Hour

\_

Facility Type Code

111-Hospital Inpatient (Including Medicare Part A)- Admit through Discharge Claim

Authorization Number

451826900002

Related Claim ICN

\_

Total Charged Amount

\$2,575.00

Total Allowed Amount

\$0.00

Total Co-pay Amount

\$0.00

Total Paid Amount

\$0.00

Adjudication Errors

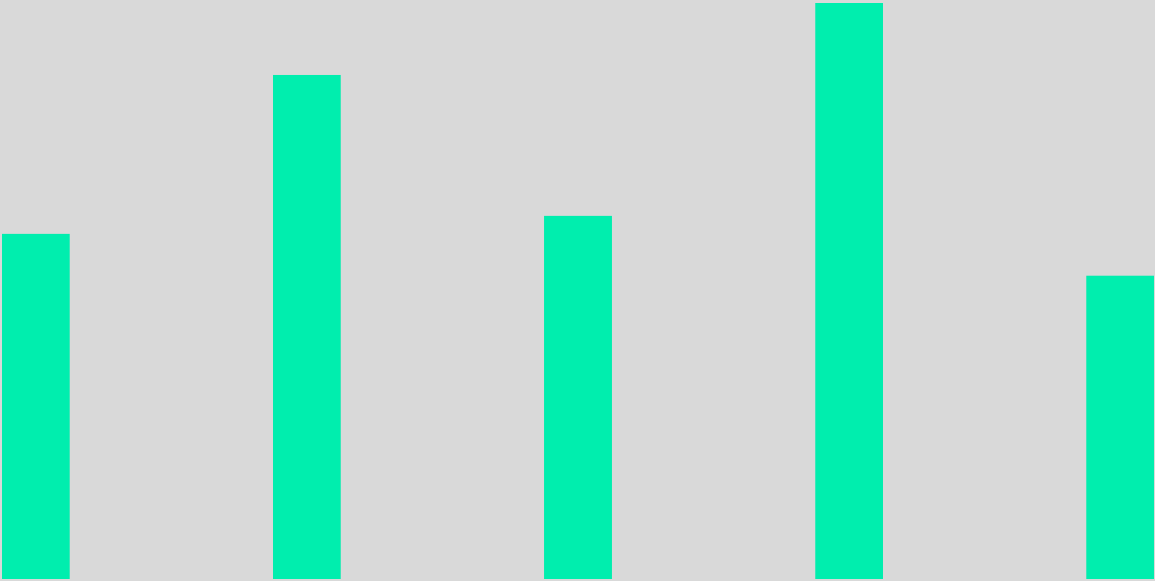
Claim / Service #	HIPAA Adj	Description	EOB
Claim	381	ATTENDING NPI REQUIRED	1390
Claim	1022	REFERRING NPI REQUIRED	1024
Claim	3347	NO PAYABLE ACCOMMODATION CODE	0609

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

My HomeEligibilityClaimsCare ManagementFile ExchangeResourcesSwitch Provider

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

Claims > Search Payment HistoryThursday 10/04/2018 02:41 PM EST

Delegate forRole IDsLocation

Search Payment History

Provider Information

Provider ID	ID Type	NPI	Name
Location ID		1002006	

\* Indicates a required field.

Placeholder for configurable text.

Payment MethodAll

Payment TypeAll

Check # / RA #

Issue Date

\*From06/01/2018

\*To08/01/2018

SearchReset

Search Results

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

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

Total Records: 2

Issue Date	Payment Method	Payment Type	Check # / RA #	Total Paid Amount	RA Copy (PDF)
06/22/2018	CHK	C	000000000/100004855	\$0.00	
06/15/2018	CHK	C	000000000/100004767	\$0.00	

PDF Files require [Adobe Acrobat Reader](#)

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

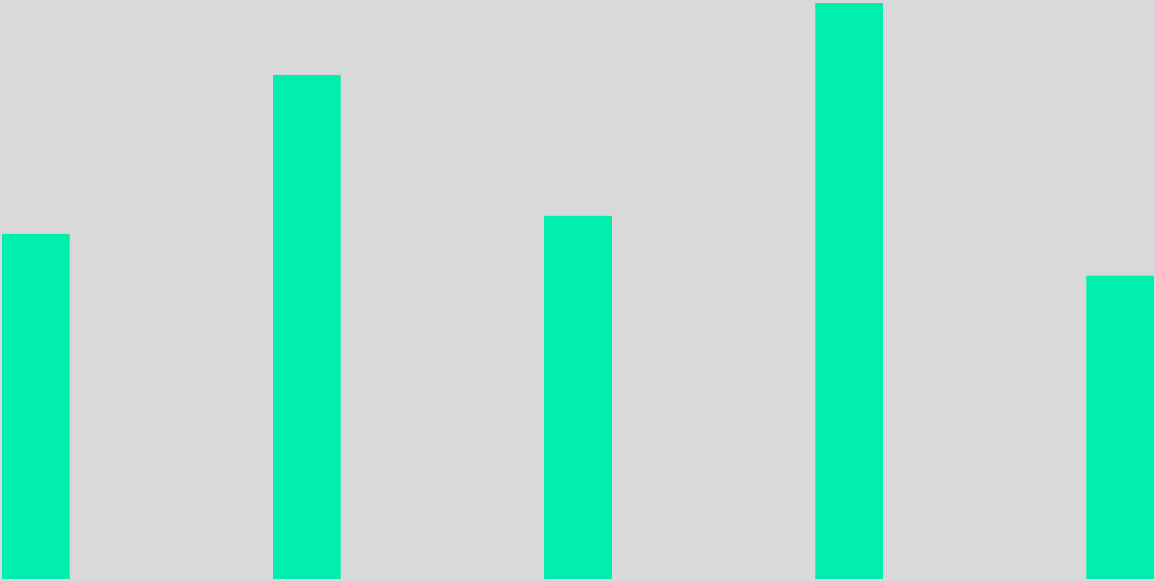
Enter search criteria to refine the search results.

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


Nevada Medicaid – Provider Type 13 (Psychiatric Hospital, Inpatient)

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# Copying a Claim



# Copy a Claim



Nevada Department of  
Health and Human Services

Division of Health Care Financing and Policy Provider Portal

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[Claims](#) > Search Claims

Monday 10/01/2018 12:48 PM EST

Delegate for

Role IDs

Provider - In Network -

Location

Search Claims

Medical/Dental

A minimum one field is required.  
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.

Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID

ID Type

Claim Type

Service From

To

Claim Status

Search

Reset

Search Results

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

Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
+	<a href="#">2218276000016</a>		Inpatient	Finalized Denied	09/24/2018 - 09/28/2018	96536412536	1255360160	\$0.00	-	

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

Claim Information

Claim Status

Finalized Denied

Covered Dates

09/17/2018 - 09/21/2018

Admission Type

1-Emergency

Admitting Diagnosis Type

ICD-10-CM

Admitting Diagnosis

G40111

Patient Status

01-Discharged to Home or Self Care (Routine Discharge)

Patient Number

123456789

Previous Claim ICN

\_

Note

\_

Admission Date/Hour

09/17/2018 - \_

Admission Source

1-Non - Health Care Facility Point of Origin

Discharge Hour

\_

Facility Type Code

111-Hospital Inpatient (Including Medicare Part A)- Admit through Discharge Claim

Authorization Number

\_

Related Claim ICN

\_

Total Charged Amount

\$2,972.08

Total Allowed Amount

\$0.00

Total Co-pay Amount

\$0.00

Total Paid Amount

\$0.00

Expand All

Collapse All

Adjudication Errors

Diagnosis Codes

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	0120-R&B-Semi-Pvt-2 Bed-General			09/17/2018	09/21/2018	4.000 Unit	\$350.00	\$0.00	\$0.00	\$0.00
2	0250-Pharmacy (Drugs) -General			09/17/2018	09/21/2018	1.000 Unit	\$500.25	\$0.00	\$0.00	\$0.00
3	0320-Dx X-Ray-General			09/17/2018	09/21/2018	1.000 Unit	\$1,500.31	\$0.00	\$0.00	\$0.00
4	0300-Laboratory (Lab) -General			09/17/2018	09/21/2018	1.000 Unit	\$621.52	\$0.00	\$0.00	\$0.00

No External Cause of Injury Diagnosis Codes exist for this claim

No Other Insurance Details 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

Copy

Print Preview

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.

Nevada Medicaid – Provider Type 13 (Psychiatric Hospital, Inpatient)

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# Copy a Claim, continued

Delegate for	Role IDs	Provider - In Network	Location
--------------	----------	-----------------------	----------

### Copy Inpatient Claim

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

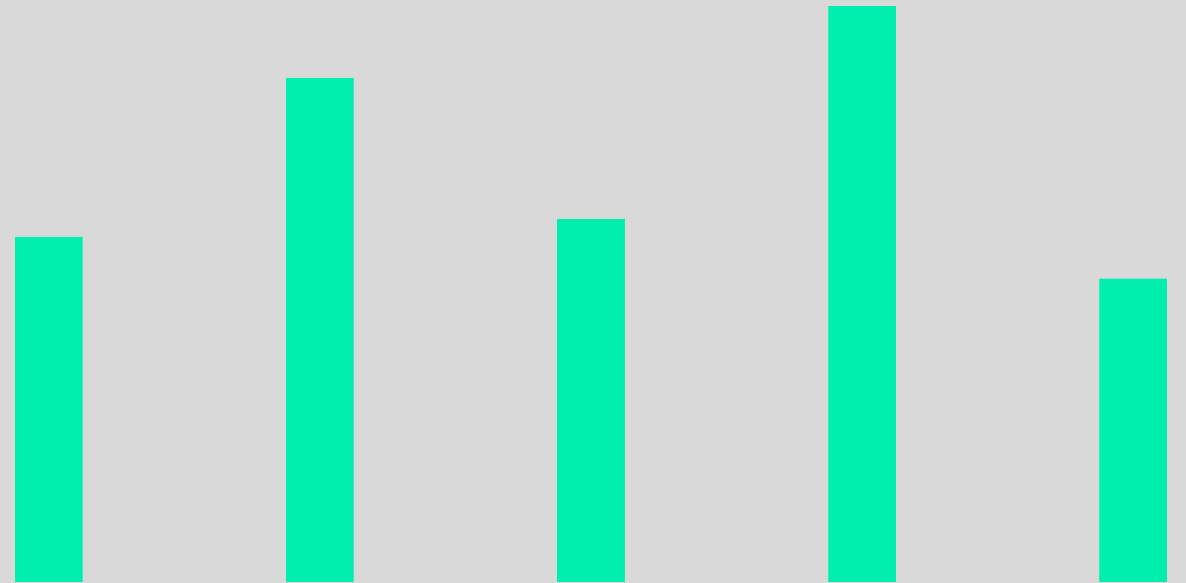
<input type="radio"/> <b>Recipient Information</b>	<input type="radio"/> <b>Service Information</b>	<input type="radio"/> <b>Recipient and Service Information</b>	<input checked="" type="radio"/> <b>Entire Claim</b>
Recipient ID	Inpatient/Outpatient Ind.	Copies data listed in previous 2 columns.	Copies data listed in columns 1 and 2 PLUS:
Last Name	Admission Source		All Providers
First Name	Admission Type		Admission Date/Hour
Birth Date	Admitting Diagnosis		Discharge Hour
Condition Codes(s)	Place of Service		Patient Status
	Diagnosis Code(s)		Authorization Number
	Revenue Code(s)		Occurrence Code(s)
	HCPCS/Proc Code(s)		Value Code(s)
	Modifier(s)		Surgical Procedure Code(s)
	Detail Charge Amount(s)		NDC Prescription #(s)
	Units		NDC Prescription Type(s)
	Unit Type(s)		Other Insurance Details
	NDC Code Type(s)		All Dates
	NDC Code(s)		All Amounts
	NDC Quantity(s)		
	NDC Unit of Measure(s)		

CopyCancel


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



**Nevada Department of  
Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) | [Logout](#)

[My Home](#) | [Eligibility](#) | [Claims](#) | [Care Management](#) | [File Exchange](#) | [Resources](#) | [Switch Provider](#)

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

[Claims](#) > Search ClaimsMonday 10/01/2018 12:48 PM EST

[Delegate for](#)

[Role IDs](#)

[Provider - In Network -](#)

[Location](#)

**Search Claims**

Medical/Dental

A minimum one field is required.  
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.  
  
Claim searches are limited to a maximum range of 45 days.


**Claim Information**



Claim ID

**Recipient Information**

Recipient ID

**Service Information**

Rendering Provider ID   ID Type  Claim Type

Service From   To   Claim Status

[Search](#) [Reset](#)

**Search Results**

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

Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
<a href="#">+</a>	<a href="#">2218276000016</a>		Inpatient	Finalized Denied	09/24/2018 - 09/28/2018	96536412536	1255360160	\$0.00	-	

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

No Surgical Procedures exist for this claim			
No Attachments exist for this claim			
Adjust	Copy	Void	Print Preview

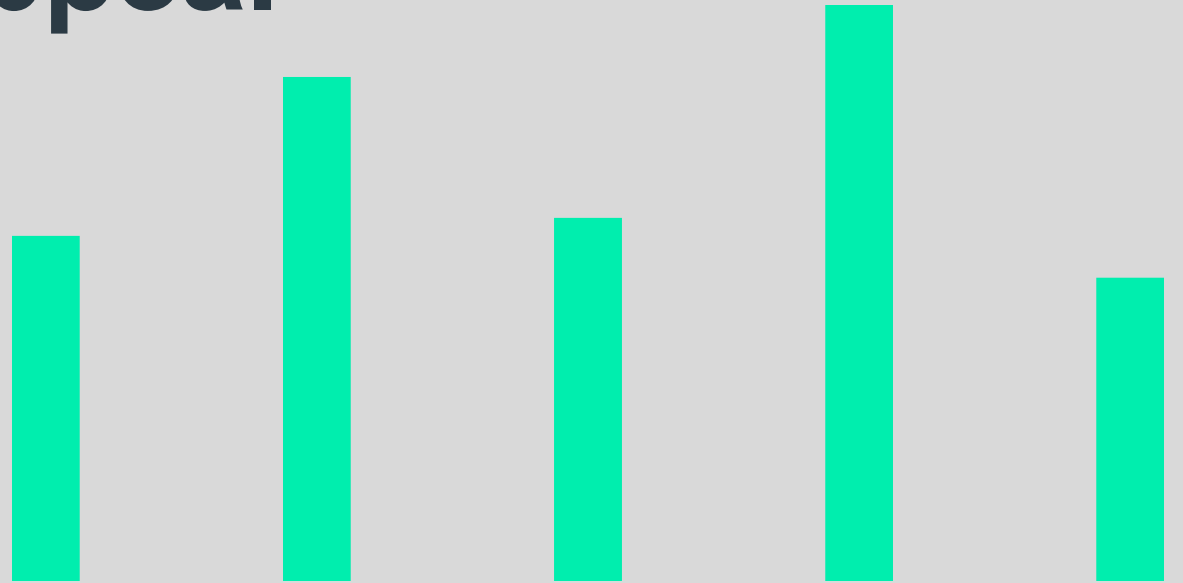
Locate the **Adjust** button from the bottom of the page. Once **Adjust** is selected, the user will be able to make any changes as necessary and then follow all steps previously outlined to submit the adjusted claim.

# Void a Claim

No Surgical Procedures exist for this claim
No Attachments exist for this claim
<div>AdjustCopyVoidPrint Preview</div>

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

**Provider**

Welcome  
Name

Provider ID  
Location ID

► [My Profile](#)

► [Switch Provider](#)

**Provider Services**

► [Member Focused Viewing](#)

► [Search Payment History](#)

► [Revalidate-Update Provider](#)

► [Pharmacy PA](#)

► [PASRR](#)

► [EHR Incentive Program](#)

► [EPSDT](#)

► [Presumptive Eligibility](#)

**Broadcast Messages**

**Hours of Availability**  
The Nevada Provider Web Portal is unavailable between midnight and 12:25 AM PST Monday-Saturday and between 8 PM and 12:25 AM PST on Sunday.

**Welcome Health Care Professional!**



We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and search for claims, payment information, and access Remittance Advices, our secure site provides access to eligibility, answers to frequently asked questions, and the ability to process authorizations.

Prior Authorization Quick Reference Guide [\[Review\]](#)

Provider Web Portal Quick Reference Guide [\[Review\]](#)

**Contact Us**

**Secure Correspondence**

All Claim Inquiries should be submitted to the following Address:

Nevada Medicaid Administration  
P.O.Box 30042  
Reno, NV 89520-3042

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



# Appealing a Claim, continued

The screenshot shows the 'Secure Correspondence - Create Message' form in the Nevada Department of Health and Human Services Provider Portal. The form is titled 'Secure Correspondence - Create Message' and includes a 'Back to Message Box' link. It contains the following fields and instructions:

- Subject:** Appeal of a denied claim
- Message Category:** Claims - Appeals (selected from a dropdown menu)
- Email:** john.doe@myhealth.com
- Confirm Email:** john.doe@myhealth.com
- Phone Number:** (empty field)
- Preferred Method of Communication:** Email (selected from a dropdown menu)
- Service Provider ID:** 1234567890
- Provider Type:** 20 - Physician
- Denial Reason:** Denied with EOB 0245.
- Message:** Claim was Denied. Please review additional documentation.

Technical Support will accept Provider Web Portal usage issues submitted through this page except for those relating to prior authorization. For pharmacy prior authorization questions call 855-455-3311. For non-pharmacy prior authorization questions, call 800-525-2395. For non-technical support related issues, please go to [www.medicaid.nv.gov](http://www.medicaid.nv.gov) or call 1-877-638-3472.

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

The screenshot shows a web application window titled "Attachments". Inside the window, there is a table with the following columns: #, Transmission Method, File, Control #, Attachment Type, and Action. Below the table, there is a section for adding attachments. This section includes a "Click to collapse" link, a "Transmission Method" dropdown menu (currently set to "EL-Electronic Only"), an "Upload File" field with a "Browse..." button, an "Attachment Type" dropdown menu, and a "Description" text field. At the bottom of this section are "Add" and "Cancel" buttons. At the very bottom of the window are "Send" and "Cancel" buttons.

#	Transmission Method	File	Control #	Attachment Type	Action
---	---------------------	------	-----------	-----------------	--------

Click to collapse.

\*Transmission Method: EL-Electronic Only ▼

\*Upload File: [Text Field] Browse...

\*Attachment Type: [Dropdown Menu]

Description: [Text Field]

Add Cancel

Send Cancel

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.

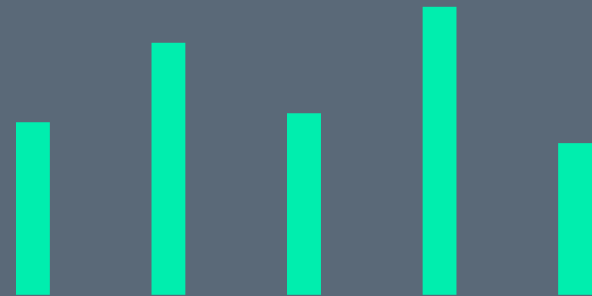
# Appealing a Claim, continued

Secure Correspondence - Message Box					<a href="#">Back to My Home</a> ?
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.					
<a href="#">Create New Message</a>					
					Total Records: 13
Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4256	<a href="#">Appeal of a denied claim</a>	Claims - Appeals	10/02/2018	10/02/2018
Open	4255	<a href="#">testing</a>	Claims - Appeals	09/27/2018	09/27/2018
Open	4253	<a href="#">Testing from MO</a>	Level 2 Support - Account Issues	09/19/2018	09/19/2018
Open	4252	<a href="#">Testing 6268 in MO</a>	Level 2 Support - Account Issues	09/18/2018	09/18/2018
Open	4251	<a href="#">Testing 6268</a>	Claims - Appeals	09/06/2018	09/06/2018
Open	4227	<a href="#">Testing sample for 5916</a>	Level 2 Support - Account Issues	08/14/2018	08/14/2018
Closed	4217	<a href="#">Help</a>	Other	07/08/2018	08/03/2018
Open	4218	<a href="#">Testing Help</a>	Other	07/08/2018	07/08/2018
Open	4219	<a href="#">Testing help..</a>	Other	07/08/2018	07/08/2018
Open	4188	<a href="#">Testing in Model</a>	Level 2 Support - Account Issues	04/09/2018	04/09/2018
					1 2

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

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@dxcc.com

**Thank you**