Adult Day Health Care
Provider Type 39 Training

Nevada Medicaid Provider Training

2018
Objectives
Objectives

- Locate Medicaid Policy
- Locate CMS-1500 Claim Form Instructions, Billing Manual and Billing Guidelines
- Utilize the Search Fee Schedule
- Locate Prior Authorization Forms
- Login to the Electronic Verification System (EVS) Secure Web Portal
- Review Delegate Access
- Successfully submit a Prior Authorization
- View Prior Authorizations
- Learn about benefits of Electronic Data Interchange (EDI)
- Locate the EDI Companion Guide
- Navigate to Web Announcements:
  - Review Web Announcement 1104
  - Review Web Announcement 1323
Provider Web Portal
EVS

EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period, Monday through Friday 12:00–12:30 a.m. Pacific Time (PT) and Sunday 8:00 p.m.–12:30 a.m. PT

System Requirements

To access EVS, you must have internet access and a computer with a web browser (Microsoft Internet Explorer 9.0 or higher, Mozilla Firefox, or Google Chrome recommended)
Medicaid Services Manual (MSM)
Chapter 1800
Locating MSM Chapter 1800

- Step 1: Highlight Quick Links from top blue tool bar
- Step 2: Select Medicaid Services Manual from the drop-down menu
- Note: MSM Chapters will open in new web page through the DHCFP website
Locating MSM Chapter 1800, continued

- Select “1800 Adult Day Health Care”
- From the next page, always make sure that you select the “Current” policy
Medicaid Billing Information
Locating Medicaid Billing Information

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

Paper Claim Form Instructions

<table>
<thead>
<tr>
<th>Title</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA (Version 2012) Claim Form Instructions</td>
<td>01/28/16</td>
</tr>
<tr>
<td>CMS-1500 (02-12) Claim Form Instructions</td>
<td>07/27/17</td>
</tr>
<tr>
<td>UB Claim Form Instructions</td>
<td>05/30/17</td>
</tr>
</tbody>
</table>

Utilize the CMS-1500 Claim Form Instructions to properly submit claims.

Billing Manual

For Archives Click here

<table>
<thead>
<tr>
<th>Title</th>
<th>File Size</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Manual</td>
<td>2 MB</td>
<td>09/01/2017</td>
</tr>
</tbody>
</table>

Utilize the Billing Manual for general billing information.

Billing Guidelines (by Provider Type)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Center</td>
<td>07/24/17</td>
</tr>
</tbody>
</table>

Utilize the Billing Guidelines for specific information for PT 39, including prior authorization information, covered and non-covered services.
Fee Schedule and Rates Unit
Utilize the Search Fee Schedule to determine the rate of reimbursement for a procedure code.
Fee Schedule, continued

Step 1: Click “I Accept”

Step 2: Click “Submit”
Fee Schedule, continued

- Step 1: Select Code Type from drop-down menu
- Step 2: Input Procedure Code of Description (see Billing Guide for codes)
- Step 3: Input appropriate Provider Type
- Step 4: Click “Search” to populate results
Fee Schedule, continued

Note: Make sure that the Effective Date ends in 9999 for current rates of reimbursement.
Rates Unit

Quick Links
- Change Provider Information
- PASRR
- Medicaid Services Manual
- Rates Unit
- Get Adobe Reader

- Step 1: Highlight Quick Links from tool bar
- Step 2: Select “Rates Unit”
- Step 3: From new window, select “Accept”
Rates Unit, continued

REIMBURSEMENT, ANALYSIS AND DEVELOPMENT

Rates Unit - Nevada Medicaid

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

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

New Codes for 2017

- Status Update
- Annual New Code Update Process
- 2017 New Codes
- 2017 New Codes PT 10 & 46

Fee Schedule Search

Nevada Medicaid has a new feature on the Medicaid.gov website under the Provider “Home” page (EV5). The new feature will allow Providers to not only view fee schedules, but also the ability to verify member eligibility, search for claims, payment information, and Remittance Adjudications. For modifier or anesthesia base units, see the appropriate links below. Please refer to the appropriate Medicaid policy to fully determine coverage as well as any coverage limitations. Medicaid policy takes precedence over any code and rate listed here for a particular provider type.

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

Fee Schedules

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

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

- Managed Care Capitation Rates
- Fee-for-Service PDF Fee Schedules

Locate the “Fee-for-Service PDF Fee Schedules” from the Fee Schedules Section
Rates Unit, continued

Select appropriate title to open the PDF pertaining to the Reimbursement Schedule you would like to review.
Prior Authorization Form
Locating Prior Authorization Form (FA-17)

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

Note: All ADHC services require a prior Authorization.
Prior Authorization Form (FA-17), continued

While on the Forms page, locate form FA-17

Make sure that you follow the instructions on the form

All active forms are fillable forms for easy uploading and online PA submission

Any form that is not legible will not be accepted

To avoid delays in processing your request, use the most current version of form FA-17
Prior Authorization Form (FA-17), Page 1

- Fill out all fields on the form
- Section I: Recipient Information
- Section II: ADHC Facility Information
- Section III: Requested Services
  - Begin Date must be on or after the date services are being requested. It cannot be backdated or PA request will be denied.
  - End Date: If the request has a start date of the 1st through the 15th of the month, the latest end date that may be requested is one year from the end of the previous month. If the request has a start date of the 16th through the 31st of the month, the latest end date that may be requested is one year from the end of the current month.
  - The dates and services must match what is entered in the Provider Web Portal.
- Section IV: Recipient Verification
Section V: Universal Needs Assessment
- Tuberculosis Screening: TB Test must be current within a year
- The initial TB test must be 2-step or the 1-step Quantiferon Gold
- TB Testing is required annually
- TB Screening must come back negative. If TB test is positive, provider must completely fill out TB Screening along with the Signs and Symptoms Checklist.
- Do not leave any blanks. Check Yes or No and all appropriate boxes.
Prior Authorization Form (FA-17), Page 3

- Page 3 must be filled out completely

- Page 3 must be signed and dated by the Physician, Advanced Practice Registered Nurse or Physicians Assistant

- Double check to confirm all pages of the form are complete and be sure the information on the form matches the request on the Provider Web Portal
EVS Secure Provider Web Portal
The EVS/Provider Web Portal can be accessed by highlighting EVS from the top tool and select “Provider Login” or select “Provider Login (EVS)” from the Featured Links section.
EVS Secure Provider Web Portal, continued

- Step 1: Input User ID
- Step 2: Select “Log In”

If there is not an account created, select “Register Now” to begin creating a web portal account. See Chapter 1: Getting Started of the EVS User Manual for reference.
EVS Secure Provider Web Portal, continued

- Answer the challenge question to verify your identity the first time you log in from a personal computer or every time you use a public computer.
- Select personal computer or a public computer.
- Click Continue.
Confirm that your site key token and passphrase are correct. If you recognize your site key token and passphrase, you can be assured that you are at the valid Provider Web Portal website and it is safe to enter your password.

- Enter your **Password**
- Select **Forgot Password** to start the reset process
EVS Secure Provider Web Portal, continued

- Verify all Provider Information
- Utilize Provider Services
- Use the “Contact Us” or “Secure Correspondence” links to contact Nevada Medicaid
EVS Secure Provider Web Portal, continued

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

My Home
Confirm provider information and contact information and check messages.

Eligibility
Search recipient eligibility information.

Claims
Search claims and payment history.

Care Management
Create authorizations, view authorization status, and maintain favorite providers.

File Exchange
Upload forms online.

Resources
Download forms and documents.
Role-Based Security and Delegate Access
Granting Access to a Delegate

- A new delegate is a person who does not currently have a delegate code, including a code that was created by someone else.

- An existing delegate is a person who was previously provided with a delegate code and is registered for a portal account.

- Each delegate should only have one delegate code, which is created by the first provider to add them as a delegate.

1. Log in to Provider Web Portal.
2. Click Manage Accounts.
Delegate Assignment Tabs

- Add New Delegate
- Add Registered Delegate

Required fields are marked with a red asterisk (*).
Delegate Assignment

Add New Delegate

Enter the delegate's:
- First Name, Last Name, Date of Birth and Last four digits of the delegate's Driver’s License Number
- Click Submit

Add Registered Delegate

Enter the delegate's:
- Last Name and previously provided Delegate Code
Delegate Assignment, continued

- Choose the Functions you want the delegate to be able to perform
- Click Confirm

Edit Delegate
- Make the appropriate changes to the functionality for the delegate.
- To remove the delegate’s ability to have access to your Portal, chose “Inactive”
- When changes are complete, click “Submit”
Delegate Assignment, continued

New Delegate

- The delegate needs a code to register for their own Provider Web Portal account. Once registered, they can access and switch between all providers who have assigned them as a delegate.

Registered Delegate

- A Delegate Assignment box will be displayed to confirm that the delegate was added to the provider’s delegate list.
Before You Create a Prior Authorization
Before Creating a Prior Authorization

- 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 exist 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.
- An authorization request is not complete until Nevada Medicaid receives all pertinent information.
Create a Prior Authorization Request
Key Information

Recipient Demographics

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

Diagnosis Codes

‒ All PAs will require at least one valid diagnosis code

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

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

PA Attachments

‒ Attachments are required with all PA requests

‒ Attachments can be submitted electronically, by mail or by fax

‒ PA requests received without an attachment will remain in pended status for 30 days

‒ If no attachment is received within 30 days, the PA request will automatically be cancelled
Create Authorization

– Hover over the Care Management tab or select Care Management from the top tool bar, then click “Create Authorization” from the sub-menu
One Page Process for Prior Authorization Requests

− Step 1: Select the radio button next to “Medical”

− Step 2: Select either “ADHC” or “Retro ADHC”
Create Medical Prior Authorization
Provider, Recipient, Referring and Servicing Provider Information

### Requesting Provider Information
The information in this section is automatically populated.

### Recipient Information
Enter the Recipient ID.

### Referring Provider Information
If there is a referring provider, complete one of the following options:
- Check the **Referring Provider same as Requesting Provider** box.
- Use the **Select from Favorites** drop-down list to select a provider from your favorites list.
- Enter the **Provider ID** and select the **ID Type** from the drop-down list.

### Service Provider Information
- Check the **Service Provider same as Requesting Provider** box.
- Use the **Select from Favorites** drop-down list to select a provider from your favorites list.
- Enter the **Provider ID** and select the **ID Type** from the drop-down list.
- Select service **Location** (optional).

The Last Name, First Name and Birth Date will be automatically populated based on the Recipient ID that is entered.
Diagnosis Information

- The first diagnosis code entered is considered to be the principal or primary diagnosis code
- The Provider Web Portal allows up to nine diagnosis codes
- Click **Add** to add each diagnosis code

Do **not** key any decimals into the diagnosis code fields.
**Diagnosis Information, continued**

**Invalid diagnosis code.**

```plaintext
<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM</td>
<td>T1019</td>
<td>Add</td>
</tr>
</tbody>
</table>
```

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.

**Valid diagnosis code.**

```plaintext
<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM</td>
<td>R69-Illness, unspecified</td>
<td>Remove</td>
</tr>
</tbody>
</table>
```

Add  Cancel
Service Details

- Indicate a **From Date**, i.e., start date
- Select a **Code Type** from the drop-down menu
- Input Code.
- Input amounts of units being requested
- In the Medical Justification field, indicate “See attached form”
- Select “Add Service”
Unsaved Data Warning

If you have entered information on the prior authorization and have not clicked the “Add” button, you will get the message below when you click the “Submit” button.

![Unsaved Data Warning Message]

The prior page contained unsaved Service Detail changes. If changes needed to be saved, navigate back to the page, reapply the changes to the table, and save.

OK
Attachments
All PA requests require an attachment and any PA request that does not have an attachment submitted within 30 days will be automatically cancelled.
Attachment Requirements, continued

- Choose the type of attachment being submitted from the drop-down list
Uploading Attachments, continued
File Upload Naming Convention Guidelines

- Forms being uploaded must be in an approved format
- Files should be saved using the form name as the prefix
- Non-compliant files may cause a delay in processing the request

File Upload Naming Convention Examples

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Correct</th>
<th>Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-17_MaryPoppins.pdf</td>
<td>MaryPoppins_FA17.pdf</td>
<td></td>
</tr>
</tbody>
</table>

Nevada Medicaid Adult Day Health Care Provider Training
Submitting a Prior Authorization

- Once all of the required information, service details lines and attachment information has been added, click “Submit” to go to the Confirm Authorization page.
Finalizing a Prior Authorization

Review the information for accuracy:

- If errors are present, click “Back” to return to the Create Authorization page
- After all of the information has been reviewed, click “Confirm” to submit the PA for processing
- When confirming the PA, only click on Confirm once and wait for the confirmation page to load. Clicking multiple times will create multiple PAs in the system.
Authorization Successfully Submitted

- An authorization tracking number (ATN) receipt is generated upon successfully submitting the PA request
- Click “Print Preview” to view the PA details and receipt
- Click “Copy” to copy member data or authorization data
- Click “New” to create a new PA request for a different recipient
Example of an Unsuccessful Authorization

- Duplicate service lines that already exist on another PA for the same recipient
Copying an Authorization
Copying an Authorization

A PA request can be copied, either for the same recipient or the same service, from the Authorization Receipt screen once the original PA request has been successfully submitted.
Copying an Authorization, continued
Member or Authorization Data

- Copy a PA request for an existing recipient when requesting a new service
- Only the recipient data is copied

- Copy a PA request by service in order to submit a PA request for similar services but for a different recipient
Viewing Authorizations
View Status of Authorization

- Hover over the Care Management tab from the top tool bar and select “View Authorization Status” from the sub-menu or select Care Management from the top tool bar and click “View Status of Authorizations” from the Authorizations menu.
Viewing Authorizations, continued

- Prospective Authorizations and Search Options tabs will be displayed
- Prospective Authorizations displays PAs by either the requesting or servicing provider
- Search Options allows a search by either recipient or provider information
- To view the details of an authorization, click the blue, underlined “ATN” link
- The ATN is the same as the PA number
- If a claim is submitted before the PA is approved, the claim will deny
- The PA status always defaults to “Pended” until a determination is complete
### Viewing Authorizations, continued

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/17/2013</td>
<td>02/17/2013</td>
<td>3</td>
<td>0</td>
<td></td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified 02/21/2013</td>
<td>--</td>
</tr>
<tr>
<td>02/20/2013</td>
<td>02/20/2013</td>
<td>2</td>
<td>0</td>
<td></td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified 02/22/2013</td>
<td>--</td>
</tr>
<tr>
<td>02/17/2013</td>
<td>02/20/2013</td>
<td>3</td>
<td>3</td>
<td></td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>--</td>
<td>Certified In Total 02/24/2013</td>
<td>--</td>
</tr>
</tbody>
</table>

- **Under the Decision/Date field:**
  - Certified in Total – The PA request was approved.
  - Not Certified – The PA was not approved.
  - Certified in Partial – The PA was approved but only for a specific amount that is different than what was requested.

- **Under the Reason field:**
  - Disposition pending review – The PA request is still in process, which appears when the PA request is in “Pended” status.
Viewing Authorizations, continued

- Remaining Units/Days — The amount counts down as claims are processed. A dash indicates that a claim is not processed for the authorization.
- 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.
- PA requests submitted through the Provider Web Portal are viewable. Faxed authorizations may limit the amount of information that is viewable (summary, status of request).

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/17/2013</td>
<td>02/17/2013</td>
<td>3</td>
<td>0</td>
<td>_</td>
<td>Revenue 0121-R88-2 BED-MED-SURG-GYN</td>
<td>Hide</td>
<td>Not Certified 02/22/2013</td>
<td>_</td>
</tr>
<tr>
<td>02/20/2031</td>
<td>02/20/2031</td>
<td>2</td>
<td>0</td>
<td>_</td>
<td>Revenue 0121-R88-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified 02/22/2013</td>
<td>_</td>
</tr>
<tr>
<td>02/17/2013</td>
<td>02/20/2013</td>
<td>3</td>
<td>3</td>
<td>_</td>
<td>Revenue 0121-R88-2 BED-MED-SURG-GYN</td>
<td></td>
<td>Certified In Total 02/24/2013</td>
<td>_</td>
</tr>
</tbody>
</table>
Searching Authorization Status
To search for a PA, enter at least one of the following:

- Enter the Authorization Tracking Number
- Select the Day Range from the drop-down list
- Enter the Service Date
  Or
- Recipient’s ID number or the recipient’s Last name, First name and Date of Birth
  Or
- Provider’s NPI and ID Type
- Indicate Servicing or Referring Provider

Click “Search”
- Search results will display at the bottom of the screen
Submitting Additional Information
How to Submit Additional Information

If you have submitted a PA request via the Provider Web Portal but need to submit additional information such as:

- A corrected FA-17
- Request for Termination of Service

Use the approved naming convention when uploading attachments; for instance, use “Form Name” as the prefix FA-XX.
How to Submit Additional Information, continued

- Locate necessary forms on the Forms Page after the completion of a PA
- On the FA-29A, if the recipient is terminating service with another ADHC Provider, the FA-29A Request for Termination of Service must be submitted

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

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

Changes cannot be made to previously submitted information. If you need to update previously submitted information, attach the FA-29 Prior Authorization Data Correction Form to the PA request that needs to be updated.
How to Submit Additional Information, continued

Resubmission Process:
1. Search for the PA using the View Authorization Status search page
2. Click the ATN for the PA in the Search Results grid to get to the View Authorization Response page
3. Click the “View” hyperlink to view notes to provider.
How to Submit Additional Information, continued

4. Click “Edit” on the View Authorization Response page to open the PA to resubmit with attachments in the attachment panel.
5. The PA is re-opened and new diagnosis codes, service details and/or attachments can be added

6. Once the new information has been added to the PA request, click “Resubmit” to review the PA information

7. Click “Confirm” to resubmit the PA

Note: The ATN will remain the same
EDI Information
Locating the EDI Companion Guides

- Step 1: Highlight “Providers” from top blue tool bar
- Step 2: Select “Electronic Claims/EDI” from the drop-down menu
EDI Enrollment Forms

EDI enrollment forms are for completion and submission by active or enrolling Nevada Medicaid and Nevada Check Up providers only.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-35</td>
<td>Electronic Transaction Agreement for Service Centers</td>
</tr>
<tr>
<td>FA-36</td>
<td>Service Center Operational Information</td>
</tr>
<tr>
<td>FA-37</td>
<td>Service Center Authorization</td>
</tr>
<tr>
<td>FA-39</td>
<td>Payerpath Enrollment</td>
</tr>
</tbody>
</table>

- Fill out necessary forms completely:
  - The Allscripts-Payerpath program is a free program for all Nevada Medicaid providers
- Send completed enrollment forms to Nevada Medicaid:
  - By uploading into the Provider Web Portal
  - Mail to the address listed on the form
  - E-mail to: NVMMISEDISupport@dxc.com
- Training opportunities are hosted every month for Payerpath Trainings. Please review EDI Announcements on the EDI webpage for training sessions.
Locating the EDI Companion Guides

- Step 1: Highlight Providers from top blue tool bar
- Step 2: Select “Electronic Claims/EDI” from the drop-down menu
Locating the EDI Companion Guides, continued

EDI Companion Guides

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction 270/271 - Health Care Eligibility Inquiry and Response</td>
<td>February 2015</td>
</tr>
<tr>
<td>Transaction 271U - Unsolicited Transaction - HIPAA Version 5010</td>
<td>February 2013</td>
</tr>
<tr>
<td>Transaction 277U - Unsolicited 277 Claims Status Response - HIPAA Version 5010</td>
<td>October 2012</td>
</tr>
<tr>
<td>Transaction 820 - Health Care Premium Payment - HIPAA Version 5010</td>
<td>October 2012</td>
</tr>
<tr>
<td>Transaction 834 - Benefit Enrollment and Maintenance - HIPAA Version 5010</td>
<td>October 2012</td>
</tr>
<tr>
<td>Transaction 835 - Health Care Payment/Advice</td>
<td>February 2015</td>
</tr>
<tr>
<td>Transaction 837D - Dental Health Care Claim - HIPAA Version 5010</td>
<td>October 2015</td>
</tr>
<tr>
<td>Transaction 837P - Professional Health Care Claim - HIPAA Version 5010</td>
<td>October 2015</td>
</tr>
</tbody>
</table>

The Companion Guides contain our HIPAA-compliant technical specifications for each transaction.

EDI Companion Guides are located at the bottom of the webpage.
Viewing Web Announcements
Web Announcements

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

- Select “View All Web Announcements” to view Web Announcements
Results can be narrowed selecting a category from the drop down menu or utilizing the “Ctrl F” to bring up a Search Box.
Web Announcements, continued

Web Announcement 1104:
Prior Authorization Requirements for ADHC Services

Attention Provider Type 39: Prior Authorization Reminders for Adult Day Health Care Services

Adult Day Health Care (ADHC) providers (provider type 39) are required to do the following when submitting requests for prior authorization.

1. Do not return your request for review unless specifically asked to do so. Your request for review should appear in the Provider Web Portal within five (5) business days from the date of receipt. Be advised that the data the request is received is not calculated as the first day.
   a. Providers should use the Provider Web Portal to check the status of a request.
   b. If the provider is not yet registered to use the Provider Web Portal, please go to the login page (https://www.medicaid.nv.gov/Provider/MyAdh/135/Default.aspx) at www.medicaid.nv.gov and register.
   c. If there is still a question, providers may call Prior Authorization Customer Service at (800) 525-2395.

2. Use the current prior authorization request form FA 17, dated 03/25/2016 or later. Use of any other form will delay the completion of the requested review.

3. Requests for ADHC are based on a monthly frequency, so the end date indicated must be the last day of a month.
   a. If the request has a start date of the 1st through the 15th of the month, the latest end date that may be requested is one year from the end of the previous month.
   b. If the request has a start date of the 16th through the 31st of the month, the latest end date that may be requested is one year from the end of the current month.

Examples:
- A start date of 03/15/2016 may have an end date as late as 02/28/2017.
- A start date of 03/16/2016 may have an end date as late as 03/31/2017.

4. The requested authorization begins date cannot precede Hewlett Packard Enterprise’s receipt date of a completed request. Be sure to include the requested number of days per week.

5. Do not fax a copy of the Tuberculosis (TB) testing or other medical records. Please maintain this information in the recipient’s file. Include only the following with your submission:
   a. FA 17 including signature that the recipient is aware they can select the ADHC provider of choice
   b. Universal Needs Assessment
   c. Care Plan
   d. Physician Evaluation and order of ADHC services

6. A current ICD-10 diagnosis is required.
Web Announcements, continued

Web Announcement 1323:
Changes to the FA-17 Prior Authorization request form

Attention Provider Type 39:

Use Updated Form FA-17 (Adult Day Health Care Services Prior Authorization Request)

Adult Day Health Care Providers (provider type 39) are informed that form FA-17 (Adult Day Health Care Services Prior Authorization Request) has been updated. The new form is posted on the Providers Forms webpage. The Physician Evaluation for Adult Day Health Care Services form (NMO-7060) and the Universal Needs Assessment for 1915(c) Services form (NMO-3543) have been incorporated into the FA-17 and are no longer required for review for these services. NMO-7060 and NMO-3543 have been removed from the Providers Forms webpage. All requests for review for ADHC services must be submitted on the updated FA-17 beginning April 1, 2017. Providers should therefore begin using the form immediately as requests for review submitted April 1, 2017, and forward on the previous forms will be denied.
Resources
Additional Resources

- Forms: https://www.medicaid.nv.gov/providers/forms/forms.aspx
- EVS General Information: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

DHCFP Contact Information:
Contact Form: http://dhcfp.nv.gov/Contact/ContactUsForm/
Contact Nevada Medicaid
Contact Us — Nevada Medicaid Customer Service

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

Prior Authorization Department: 800-525-2395

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