Residential Treatment Center (RTC)
Provider Type 63
Training
Objectives
Objectives:

- Residential Treatment Center (RTC)
- Recipient Eligibility
- Prior Authorization: Initial & Concurrent Review
- Submit a Prior Authorization via the Electronic Verification System (EVS)
- Appeals: Peer-to-Peer and Reconsideration
- All-inclusive Rates
- Therapeutic Home Passes
- Quarterly Family Visits
- Acute Care
- Critical Interaction or Events
- Provider Discharge Planning
- Nevada Medicaid Website
- Billing Guideline
- Submit a Claim via Direct Data Entry (DDE) through EVS
- References
- Questions
Residential Treatment Center (RTC)
RTC requirements:
- Are delivered in multiple facility types, also known as Psychiatric Residential Treatment Facility (PRTF) (42 CFR 441.151(a)(2), Subpart D).
- Are for recipients under age 22 and must be being provided before the individual reaches age 21 (42 CFR 441.151(a)(3), Subpart D).

If the individual was receiving services in an RTC immediately before reaching age 21, these services must be:
- Provided before the date the individual no longer requires the services; or
- Provided before the date the individual reaches 22; and
- Certified in writing to be necessary in the setting in which it will be provided.

RTC must also meet the requirements and submit a self attestation letter for Conditions of Participation for the use of restraint and seclusion (42 CFR 483.352, Subpart G).
Recipient Eligibility
Recipient Eligibility: Verification

- Verify recipient eligibility monthly. Eligibility is determined on a monthly basis and may change.

- Options for verifying eligibility are:
  - Electronic Verification System (EVS): To access EVS, visit www.medicaid.nv.gov. Select the “EVS” tab to review the User Manual and to register or login to EVS. EVS is available 24 hours a day, 7 days a week.
  - Automated Response System (ARS): To access ARS, call (800) 942-6511.
Recipient Eligibility: Retrospective Authorization

- If the recipient loses eligibility during the stay, request a Retrospective Authorization using form FA-15 or form FA-13 found at https://www.medicaid.nv.gov/providers/forms/forms.aspx. Check “Retrospective Authorization” at the top of the form.

- If the recipient is currently a patient at the RTC, the provider has 10 business days from the date of decision of recipient eligibility to submit their retrospective review.
Prior Authorization: Initial Review
Prior Authorization: Initial Review

- All RTC initial admission requests must be submitted using form FA-15, which should be submitted via the Provider Web Portal no less than five business days prior to the recipient’s admission or transfer. (MSM Chapter 400, Section 403.8C.1)

- The FA-15 can be found on the Providers Forms webpage at https://www.medicaid.nv.gov/providers/forms/forms.aspx.

- The QIO-like vendor will notify the provider of the outcome within 5 business days of receipt. (If sent to physician for review, allow an additional 2 business days.)
Prior Authorization: Initial Review, continued

Prior authorization (PA) may be requested for up to 90 days and must include:

- Certificate of Need (CON) signed by the RTC physician; the CON is included within the FA-15 form
- A current psychiatric evaluation (Current within 6 months of the admission date)
- A CASII/LOCUS acuity level of at least 6 is required for RTC admission
- Initial individualized Treatment Plan
- Proposed Discharge Plan

Note: Based on the clinical assessment and the comprehensive psychiatric evaluation, no child or youth placed in an RTC should have an unspecified primary diagnosis.
Prior Authorization: Initial Review, continued

Nevada Medicaid must verify the medical necessity for all RTC services and verify:

- The ability for the recipient to benefit rehabilitatively from RTC services; this may include the recipient’s IQ level if there are any questions regarding developmental delays.

- The Treatment Plan, which must include active participation by the recipient and their family (when applicable); and

- The Discharge Plan, which must be viable and includes coordinated case management services.

- The clinical documentation should include all specific outpatient services (and in-state services if out-of-state RTC) that have been attempted prior to RTC admission.
Change in Admission Date

Should there be a change in the admission date, notify Nevada Medicaid with the following:

- A data correction form (FA-29) must be submitted to Nevada Medicaid when the date of admission to the RTC changes.

- Submit the FA-29 via the Provider Portal, which can be found at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and reference the prior authorization number. If the admission date changes to an earlier date than anticipated, then the end date will be changed by Nevada Medicaid to reflect the number of units/days originally approved.

- If the admission date changes to a later date than anticipated, then the end date will remain the same as medical necessity was only determined through that specific date; this includes initial requests that were approved/modified by the physician.
Criteria for Exclusion from RTC Admission

- Psychiatric symptoms requiring acute hospitalization.
- Physical disability that cannot be accommodated by the RTC.
- Impaired Learning Capacity.
- Traumatic Brain Injury (TBI).
- Organic Brain Syndromes.
- Pregnancy, unless the RTC can meet the needs of the adolescent.
- Chronic unmanageable violent behavior posing unsafe risks to other clients or staff.
- A medical illness which limits the recipient’s ability to fully participate in RTC services.
- Drug and/or alcohol detoxification.
- A diagnosis of Oppositional Defiant Disorder and/or Conduct Disorder alone.
Prior Authorization: Concurrent Review
Prior Authorization: Concurrent Review

- Requests for concurrent review must be submitted using form FA-13, which must be submitted online through the Provider Web Portal using the same prior authorization number. The FA-13 can be found on the Providers Forms webpage at: https://www.medicaid.nv.gov/providers/forms/forms.aspx. RTC dates of service are a “through date” so the start date on a concurrent review is the next day after the last authorized date.

- For Medicaid recipients to remain in RTCs longer than 90 days, the RTC must, prior to the expiration of each authorization, submit a Continued Stay Request to the QIO-like vendor for authorization. (MSM 403.8C.7)

- Recommend submitting no more than 15 business days prior to end date on PA and not less than 5 business days.

- The provider portal will be updated with the status of the PA as it changes. It may take 5 to 7 business days to get a final status on the PA once all required information is received.
Prior Authorization: Concurrent Review, continued

- A comprehensive psychiatric evaluation should be completed every 6 months by the Medical Director of the RTC starting from the date of admission.

- Please be sure to submit using the current prior authorization number for all documentation as there should never be more than one PA number for an RTC stay.

- Requests for continued stay should not include diagnoses that have yet to be ruled out. Whether these diagnoses are contributing factors to the recipient’s current cognitive, emotional and behavioral symptoms should have been determined within 90 days of admission to the RTC.

- Each prior authorization request must stand on its own. Therefore, do not refer to trauma or incidents of aggression/assault without providing specific information. If the recipient has been transferred from a hospital or from juvenile detention, please explain why they were placed there initially.
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 (hand-written) forms will not be processed.

- All significant/pertinent clinical documentation should be included on the FA-15 or FA-13 in summary format or specific information when indicated. Additional attachments are considered unnecessary as the FA-form should include all of the documentation needed to determine medical necessity.

- While viewing a prior authorization in the Provider Web Portal, review the Medical Citation field as additional information may be requested from Nevada Medicaid.

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

Hover over “Care Management” and select “Create Authorization” to begin.
Submitting a Prior Authorization, continued

From the “Create Authorization” section, select Medical.

RTC’s should either select BH RTC or RETRO BH RTC from the drop-down menu next to Process Type.
The “Requesting Provider Information” should be populated with the provider information, based on the login credentials used. The user must also select the appropriate “Service Location” from the drop-down.

Users will then need to input a valid Recipient ID under the section titled “Recipient Information” and once the recipient ID is populated, click outside of the field and the Last Name, First Name and Birth Date will autopopulate based on the recipient ID populated.
If the referring provider is the same as the requesting provider, select the checkbox.

If the referring provider is different from the requesting provider, select the appropriate provider from the drop-down menu if that provider has been saved as a favorite.

If the referring provider is different from the requesting provider and the referring provider has not been saved as a favorite, input the National Provider Identifier (NPI) into the Provider ID field, and select NPI from the ID Type drop-down. If this provider will be used in the future, it is recommended that the user select Add to Favorites for future use.
Submitting a Prior Authorization, continued

If the service provider is the same as the requesting provider, select the checkbox.

If the service provider is different from the requesting provider, select the appropriate provider from the drop-down menu if that provider has been saved as a favorite.

If the service provider is different from the requesting provider and the referring provider has not been saved as a favorite, input the NPI into the Provider ID field, and select NPI from the ID Type drop-down. If this provider will be used in the future, it is recommended that the user select Add to Favorites for future use.

Users will also need to indicate the Service Location from the drop-down menu. This will be populated once an active service provider is selected. The Location may be required dependent upon the services being requested.
Users must input an active International Classification of Diseases (ICD) code. Select the Diagnosis Type from the drop-down menu and input the Diagnosis (DX) Code. When inputting the DX Code, the field will be predictive and if a user cannot remember the code, the user can also type the description of the code.

Once the user locates the appropriate DX Code, they must select Add to save it to the request.

The first DX Code input will be considered the primary diagnosis.
Users must input the following criteria:
- From Date
- Code (This will be the Revenue Code being used to bill a claim)
- # of Days
- Medical Justification (this information must be detailed as to why the prior authorization is being requested)

Once all fields are completed, select Add Service.
All prior authorization requests require attachments. Users should locate the appropriate attachment by selecting “Choose File” and locate the attachment. Once the attachment has been added, select the appropriate description from the Attachment Type drop-down and select Add.

Once all attachments are added, select Submit. Once the user selects Submit, the next page will allow them to review their information. If all information is correct, the user will then select Confirm to have their Authorization Tracking Number generated. If there are any errors, use the blue Back button to make changes.
Viewing Status of a Prior Authorization
View status of a PA

In order to view the status of a PA, hover over the Care Management tab.

Click View Authorization Status.
View status of a PA, continued

<table>
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<tr>
<th>Authorization Tracking Number</th>
<th>Service Date</th>
<th>Recipient Name</th>
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</table>

Locate and select the appropriate ATN to view.
View status of a PA, continued

Click the plus symbol to the right of a section to display its information.

Review the information as needed.
Review the details listed in the Decision / Date and Reason columns. In the Decision / Date column, users may see one of the following decisions:

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

When the Decision / Date column is not “Certified in Total”, information will be provided in the Reason column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).
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.
G. Medical Citation: Indicates when additional information is needed for authorizations (including denied).
### View status of a PA, continued

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.

<table>
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<th>From Date</th>
<th>To Date</th>
<th>Units</th>
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<th>Amount</th>
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**Medical Citation**

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

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

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<tr>
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<td>Certified In Total 02/24/2013</td>
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</table>
Appeals: Peer-to-Peer and Reconsideration
Appeals

- Dates of service not authorized by Nevada Medicaid will not be reimbursed by Medicaid.
- Dates of service originally denied cannot be requested as a concurrent review. Denied dates of service may only be appealed.
  - If a request for 90 days has been modified to approve 60 days, then the last 30 days were denied. Those dates cannot be requested on a new PA request; those dates must be appealed to be considered again.
- The provider may not appeal dates of service that were not originally requested on the PA.
- The appeals process applies to initial and concurrent prior authorization requests.
- Providers may appeal with either a Peer-to-Peer Review or a request for Reconsideration.
  - A Peer-to-Peer Review must occur first, if desired, as this gives the provider a chance to hear from the reviewing physician why the prior authorization request was denied/reduced.
Peer-to-Peer Review

- A Peer-to-Peer Review is to provide clarification as to why the decision was made to deny or modify the PA request. A physician level provider can participate in the Peer-to-Peer Review or a clinician that is designated by the physician. No new information is accepted in a Peer-to-Peer level review.
- The provider may request a Peer-to-Peer Review by:
  - Emailing: nvpeer_to_peer@dxc.com
- The provider must request the Peer-to-Peer Review within 10 business days of the date on the Notice of Decision (NOD) letter. A Peer-to-Peer Review does not extend the 90-day deadline for requesting a Reconsideration Review.
- If there is new information introduced at the Peer-to-Peer Review, the session will be terminated and the provider will be advised to submit a Reconsideration Review.
Peer-to-Peer Review, continued

Please provide the following information when requesting a Peer-to-Peer Review:

- Prior authorization number and type of service that was denied;
- Recipient ID;
- Recipient name;
- Date(s) of service;
- Name and contact information (telephone number) of the physician requesting the Peer-to-Peer Review; and
- Available days and times.

- Please be advised that the physician reviewers may make recommendations for alternate types of placement when providing their clinical rationale. However, they are unable to provide directives regarding specific placement options. That is the role of the facility’s discharge planning team.
Reconsideration Review

- A Reconsideration Review is a one-time review of denied services. Once the review has been completed, no further documentation will be accepted. A Reconsideration may be used to request all the days denied or fewer days. If you choose to request fewer days than were originally denied you may not request another reconsideration for review of any additional days that had been denied.

- Use form FA-29B to request Reconsideration Reviews. Please identify the revenue code you are requesting, which would be 0100. Change the start date and number of days requested to reflect the initial date that was denied and the number of days you would like reconsidered.

- Then, clearly designate where the new clinical information is documented. Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider’s responsibility to identify the pertinent/additional information in a synopsis and document it on the FA-29B. If necessary, an additional document may be attached to the FA-29B.
Reconsideration Review, continued

- A Reconsideration for RTC services must be requested in writing within 90 calendar days of the denial date on the original Notice Of Decision (NOD) letter.

- An alternate physician consultant, when possible, will base the Reconsideration determination on the clinical documentation previously submitted and the additional/new information provided in the request for Reconsideration.

- Nevada Medicaid will notify the provider of the outcome within 30 calendar days of receipt.

- **Note**: The 90-day provider deadline for Reconsiderations is independent of the 10-day deadline for Peer-to-Peer Reviews. If requesting a Reconsideration Review, it is recommended that the provider not wait until the 90-day time frame is near.

- Forms are available at: [https://www.medicaid.nv.gov/providers/forms/forms.aspx](https://www.medicaid.nv.gov/providers/forms/forms.aspx)
All-inclusive Rates
All-inclusive Rates

Nevada Medicaid’s all-inclusive daily RTC rate includes: Refer to Medicaid Services Manual (MSM) Chapter 400, Section 403.8A.1 along with WA 1852:

- Room and board
- Active treatment
- Psychiatric and psychological services
- Therapeutic and behavioral modification services
- Individual, group, family, recreation and milieu therapies
- Nursing services
- All medications
- Quarterly RTC-sponsored family visits
- Psycho-educational services and supervised work projects

**NOTE:** The above services are **not** to be billed separately and doing so may result in the RTC claim being denied.
Non-covered Services

The all-inclusive daily rate does **not** include services such as (Refer to Medicaid Services Manual (MSM) Chapter 400, Section 403.8A.2 along with Web Announcement 1852):

- General physician (non-psychiatrist) services
- Neuropsychological services
- Dental or Optometry services
- Durable Medical Equipment (DME)
- Radiology or lab services
- Therapies (physical, speech and occupational)
- Formal educational services

- Services that are Medicaid benefits must be billed separately by the particular servicing provider and may require prior authorization.
- Services considered duplicative in nature billed from another provider type may cause a denial of a PT 63 claim.
Therapeutic Home Passes
Therapeutic Home Passes

Home Passes are to be utilized to facilitate a recipient’s discharge back to their home or to a less restrictive setting. The following guidelines must be met for reimbursement:

1. A physician’s order.
2. In coordination with discharge plan, the recipient must have demonstrated a series of successful incremental day passes first.
3. Must be documented in the recipient’s case file.
4. The RTC must track the number of Therapeutic Home Passes used.
5. If the recipient leaves without issuance of a Therapeutic Home Pass, the recipient will be considered discharged — Nevada Medicaid must be notified of this. Form FA-29 must be submitted to correct the end date to reflect this discharge date.

- Note: Reference MSM Chapter 400, Section 403.8A.6.a for further information
Therapeutic Home Passes, continued

Use Form FA-13A: Can be found on the Providers Forms webpage at [https://www.medicaid.nv.gov/providers/forms/forms.aspx](https://www.medicaid.nv.gov/providers/forms/forms.aspx)

Notification Purposes: The QIO-like vendor must be notified by the RTC of all therapeutic home passes at least 14 days prior to the pass being issued to the recipient. (Reference Chapter 400, Section 403.8A.6)

- There is a limit of three (3) home passes per calendar year; calendar year begins on January 1
- Recipient must be able to benefit from the home pass experience
- Duration limits of 72 hours or less per home pass

Prior Authorization: All home passes which exceed 72 hours must be prior authorized by Nevada Medicaid.

- Clinical review -- Duration per pass is no greater than 72 hours, unless there is a documented medically necessary reason for a longer-term pass
- When recipient has used the benefit of 3 passes

- Anytime a recipient is out of the facility overnight and is not accompanied by staff would be considered a therapeutic home pass, including overnight stays in a hotel/motel by the recipient and their family.
All fields of the RTC Absence Form must be completed and the form should be uploaded through the Provider Web Portal to the active PA for the recipient.
Therapeutic Home Passes, continued

- If a recipient doesn’t return to the RTC from a Therapeutic Home Pass, and this absence has been properly documented by the RTC, the RTC may utilize the day the recipient was expected to return as the discharge date.
  - In the case of a family emergency or an extended pass greater than 72 hours, which had been approved by the QIO-like vendor, this period cannot extend 120 hours.
- Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility.
  - Prior authorization utilizing form FA-15 and a Certificate of Need (CON) signed by a physician are required for payment.
Acute Care
RTC Absence for Less Than 24 Hours

Use Form FA-13A:
- Can be found on the Providers Forms webpage at https://www.medicaid.nv.gov/providers/forms/forms.aspx

- To be utilized in the event of a recipient’s absence for less than 24 hours. An example would be recipient going to emergency care without an admission to inpatient (Reference Web Announcement 1885).

- Submit an FA-13A indicating the date/time the recipient left the RTC and the date/time the recipient returned to the RTC. These must be uploaded via the Provider Web Portal and attached to the current PA within 48 hours of their return to the RTC.

- If the recipient returns to the RTC in less than 24 hours, for emergency/outpatient services, submit the FA-13A including dates/times of the recipient’s absence. The recipient’s current stay will continue without interruption of RTC services.
RTC Absence for Less Than 24 Hours

- If the recipient is gone from the RTC less than 24 hours, but had been admitted as an inpatient, then they would be considered discharged from the RTC and an FA-29 would need to be submitted. When re-admitting to the RTC after a discharge, submit a new PA (FA-15), including reason for going to acute, and including the comprehensive psychiatric evaluation that was most recently completed by the medical director (this should have been completed within the past 6 months or less).

- If recipient has been gone greater than 24 hours, this will be considered a discharge as well and will require submission of an FA-29.
Discharge from RTC for Acute Care Greater Than 24 Hours

- RTCs must notify Nevada Medicaid within 24 hours if a recipient is admitted for inpatient acute care by submitting an FA-29 with the date of discharge. **Discharge of the recipient would begin on the date of their transfer to acute which would be documented as the date of discharge on the submitted FA-29.**

- As the recipient is considered discharged from the RTC, a new/initial request (FA-15) is required to be submitted for review to readmit the recipient to the RTC (along with a current psychiatric evaluation — from the hospital if admitted for Behavioral Health reasons and from the facility’s medical director if admitted for Med/Surg reasons).

- Needed forms (FA-13A, FA-15, and FA-29) can be found on the Providers Forms webpage at [www.medicaid.nv.gov](https://www.medicaid.nv.gov) or directly at the following: [https://medicaid.nv.gov/providers/forms/forms.aspx](https://medicaid.nv.gov/providers/forms/forms.aspx)
Elopements
Elopements from an RTC

- An RTC is considered a "secure" facility meaning a facility which provides residential treatment for mental illness that has the capability of being locked to prevent a child with an emotional disturbance from leaving the facility without an escort.

- Refer to MSM Chapter 400, Section 403.8A.6.a and 403.8A.6.a.7:
  - If the recipient leaves without issuance of a Therapeutic Home Pass, the recipient will be considered discharged and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.
  - Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility. Prior authorization and a Certificate of Need (CON) signed by a physician are required for payment.
  - An FA-29 needs to be submitted via uploading through the Provider Portal in addition to notifying Nevada Medicaid via the Behavioral Health Email at BehavioralHealth@dhcfp.nv.gov.
  - Discharge of the recipient would begin on the date of their elopement, which would be documented as the date of discharge on the submitted FA-29, and should be submitted to the QIO-like vendor within 24 hours.

- Elopement time frames are not specifically addressed per policy. Anytime a child/youth leaves the RTC’s campus and is not accompanied by a staff member or another approved person, such as family, or is not within their line of sight, would be considered an elopement.

- If the recipient is readmitted to the facility, then a new/initial PA (FA-15), including what occurred before, during and after the elopement, must be submitted along with the comprehensive psychiatric evaluation most recently completed by the medical director (should have occurred within the past 6 months).
Admission to Another RTC
Admission to Another RTC

- A prior authorization request is required to admit the recipient to another RTC if the needs of the recipient are better met at another facility. There is no transfer and this practice is discouraged unless the admitting RTC has a specialty unit.
Quarterly Family Visits
Quarterly Family Visits

Quarterly family visits are based on clinical appropriateness and are utilized to support person- and family-centered treatment planning. See MSM Chapter 400, Section 403.8B.6 “Provider Responsibilities.”

RTC responsibilities:

- Bringing two family members per quarter when the family resides 200 miles or more from the RTC.
- Providing travel, lodging, and meals to the family.
- If a Medicaid-eligible recipient is in the custody of a public child welfare agency, the RTC, prior to the visit, must consult and obtain approval from the agency’s clinical representative pertaining to the appropriateness of such a visit.
Quarterly Family Visits, continued

The all-inclusive daily rate includes expenses for quarterly family visits.

- As specified in federal regulations and the terms of all provider agreements, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. (Reference Chapter 100, Section 105.1).
- The provider (RTC) is responsible for these expenses.
- The provider may not bill the legal guardian or the recipient for any costs related to the quarterly family visits or require a legal guardian/recipient to pay expenses and then reimburse.

* Please note that any services billed to and paid by a recipient parent/guardian or State or County agency that should be billed to Nevada Medicaid can be recouped from the RTC provider.
Critical Events or Interactions
Critical Events or Interactions

- RTCs are required to notify Nevada Medicaid and the State-designated Protection and Advocacy system of any critical events or interactions involving any Nevada RTC recipient by the close of business the next business day following the incident. (Refer to 42 CFR 483.374 and Chapter 400, Section 403.8B).

- Information that must be reported includes, but is not limited to:
  - Death
  - Serious injuries: defined in CFR as:
    - any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and any injuries to internal organs, whether self-inflicted or inflicted by someone else
  - Assaults
  - Suicide attempts
  - Police or sheriff’s investigations
  - Physical, sexual or emotional abuse allegations
Critical Events or Interactions, continued

- In the case of a minor, the facility must notify the resident’s parent(s) or legal guardian(s) as soon as possible — in no case later than 24 hours after the serious occurrence.

- Staff must document in the resident’s record that the serious occurrence was reported to both the State Medicaid agency and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported.

- A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.
Critical Events or Interactions, continued

- The report must include:
  - The name of the resident involved in the serious occurrence
  - A description of the occurrence
  - The name, street address and telephone number of the facility

- Reporting of deaths — In addition to the reporting requirements required for serious occurrences, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office:
  - By no later than the close of business the next business day
  - Documentation in the resident’s record must show that the death was reported to the CMS regional office
Critical Events or Interactions, continued

- Refer to the MSM 403.8B.2 and Web Announcement 1315 for steps to report
  
  - Faxes are no longer accepted by Nevada Medicaid.

- All critical incidents that have occurred during the past review period, and reported as required, must be included on the subsequent FA-13, included in the section labeled critical incidents.

- Each critical incident that has occurred and been reported should be dated and described with detailed information including any injuries and/or medical intervention that was required as a result of the incident.
Provider Discharge Planning
Provider Discharge Planning

- Discharge planning and step-down placement begin at admission.

- Discharge planner should check if a case manager is assigned to the recipient (Foster Care, State Custody, parental placement, etc.) who should be included in discharge planning.

- **If the recipient is discharged before the last authorized date, the provider is to submit, via the Provider Web Portal, the Prior Authorization Data Correction Form (FA-29) with the corrected discharge date. This is crucial so that any outpatient services can be approved.**

- Within 90 days a specific discharge plan should be in place, including the name of any outpatient provider that will be servicing the recipient, to include which specific services or which step-down facility the recipient may be admitted to after discharge and the date of their bed availability.

- Within 180 days a specific back-up discharge plan should be in place in the event that the original discharge plan cannot be implemented.
Provider Discharge Planning: Prescriptions

- RTCs must ensure upon discharge that the legal representative of the Medicaid-eligible recipient be given an adequate supply or access to current prescribed medications.

- RTCs must ensure that prescriptions are written by an enrolled Nevada Medicaid provider. See Web Announcement 1017 posted at: https://medicaid.nv.gov/Downloads/provider/web_announcement_1017_20151123.pdf

- Please see Web Announcement 1711 regarding using the National Provider Identifier (NPI) of the Ordering, Prescribing or Referring (OPR) provider on claims: https://medicaid.nv.gov/Downloads/provider/web_announcement_1711_20181012.pdf

- The OPR application is located on the Provider Enrollment webpage: https://www.medicaid.nv.gov/Downloads/provider/NV_OPR_Enrollment_Application.pdf
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.
Nevada Medicaid Website: Announcements

Click on “View All Web Announcements”:
Nevada Medicaid Website: Announcements
Web Announcements 1947 and 1711

August 14, 2019
Web Announcement 1947

Attention Provider Type 63 (Residential Treatment Centers):
Submission Requirements for Claims with Prior Authorizations

To prevent potential underpayment issues, provider type 63 (Residential Treatment Centers, RTC) providers are urged to be aware of the following claim submission requirements:

- Claims with a prior authorization (PA) must be billed in chronological order.
- Each claim with a PA must be billed for dates from only one PA line detail and within one calendar month as illustrated in the example below:
  - On the first claim: January 1, 2019 through January 31, 2019
  - On the second claim: February 1, 2019 through February 28, 2019
  - On the third claim: March 1, 2019 through March 31, 2019
  - On the fourth claim: April 1, 2019 through April 30, 2019
  - On the fifth claim: April 1, 2019 through May 30, 2019
  - On the sixth claim: May 1, 2019 through May 31, 2019

- For successful processing of each claim prior to submitting the next chronological claim to allow claims to continue processing in date order.

The Provider Type 63 billing guidelines will be updated to include this information.

Nevada Medicaid Residential Treatment Center Training
Click on “Billing Information” under the Providers tab.
PT 63 Billing Guide
PT 63 Billing Guide

- Available at the www.medicaid.nv.gov webpage or directly at:

- Updated on 4/29/19 (Refer to WA 1885) to provide information regarding notification for RTC absences via the FA-13A and Billing.
Billing Time Frames (Stale Dates)

- Providers must bill Medicaid for all claims within the specific time frame set by Medicaid. (Reference Medicaid Services Manual Chapter 100, Section 105.2B)

- To be considered timely, claims must be received by Nevada Medicaid within:
  - 180 days from the date of service or the date of eligibility decision, whichever is later, for in-state providers.
  - For out-of-state providers, or when a third-party resource exists, the timely filing period is 365 days.
Disputed Payment


- Requests for adjustments to paid claims, including zero-paid claims, must be received by Nevada Medicaid no later than the Medicaid stale date period. (Reference Chapter 100, Section 105.2C).

- Providers can request an appeal of denied claims through Nevada Medicaid. All requests shall be submitted electronically through the Provider Web Portal.

- Claim appeals must be requested no later than 30 days from the date of the initial Remittance Advice (RA) listing the claim as denied. An additional 30 days to appeal a denied claim will not be allowed when an identical claim has been subsequently submitted.
Disputed Payment, continued

- Providers who request an appeal must follow the claim appeal process outlined in the Billing Manual.

- A NOD will be sent by Nevada Medicaid to the provider advising them of the appeal decision.

- Claims appealed due to a provider’s dissatisfaction with reimbursement for specific procedure codes are first researched by Nevada Medicaid. If there is a need for policy clarification or a question of policy change, Nevada Medicaid will send the appeal, along with the full documentation of research, to Medicaid’s Chief of Compliance.

- Providers must exhaust Nevada Medicaid’s claim appeal process prior to pursuing a Fair Hearing with the Division of Health Care Financing and Policy.
Submit a Claim to Nevada Medicaid via DDE
Submitting a Claim

Hover over the **Claims** tab.

Select **Submit Claim Inst.**
RTC providers should select “Inpatient” from the Claim Type drop-down menu.
Submitting a Claim, continued

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

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

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

Once all fields are appropriately completed, select Continue.

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

Diagnosis Codes

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

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

Service Details

Enter the required fields.
Click the Add button.
Click the Submit button.
At this point, the user has the option to:

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

To continue, the user must click the **Confirm** button.
Submitting a Claim, continued

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

The user may then:

- Click the **Print Preview** button to view the claim details.
- Click the **Copy** button to copy claim data and start a new claim using identical details.
- Click the **Adjust** button to adjust a submitted claim.
- Click the **New** button to submit a new claim.
- Click the **View** button to view the details of the submitted claim, including adjudication errors.
Submitting a Claim with Third Party Liability (TPL)
Submitting a Claim with TPL

Check the **Include Other Insurance** checkbox located at the bottom of the page.

Click the **Continue** button.
To add a policy or new other insurance, the user will:

Click the (+) in the **Other Insurance Details** panel at the bottom of the page.

**NOTE:** If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto-populate in the **Other Insurance Details** panel. If not, no policy information will display.
Submitting a Claim with TPL, continued

After clicking the (+)

Complete all required fields (*).

Click the Add Insurance button to add the Other Insurance details to the claim.

NOTE: Click the Cancel Insurance button to cancel addition of a new other health insurance detail.
After the user clicks the **Add Insurance** button, the new insurance will populate.

Click Continue and follow the steps outlined in the previous section.
Searching for Claims
To search for a claim, Hover over **Claims** and select **Search Claims**.

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

To search without using the Claim ID:

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

Click the (+) symbol to expand the claim details.
Search for Claims, continued

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

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

With the **Adjudication Errors** panel expanded, the user may review the errors associated with the claim’s denial.
Viewing a Remittance Advice (RA)
Viewing an RA

To begin locating an RA, hover over **Claims** 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.
Copying a Claim
Copy a Claim

To copy a claim

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

From the search results:
Click the Claim ID link.
After the user has viewed the claim scroll down to the bottom of the page.

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

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

Click the Copy button
Adjusting or Voiding a Claim
Adjust or Void a Claim

To begin the claim adjustment process:

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

NOTE: Denied Claims cannot be adjusted. The Claim Status column will indicate Finalized Payment if a claim is paid.
Locate the **Adjust** button from the bottom of the page. Once **Adjust** is selected, the user will be able to make any changes as necessary and then follow all steps previously outlined to submit the adjusted claim.
Void a Claim

Locate the Void button from the bottom of the page. Once Void is selected, the user will be asked to confirm their choice and once OK is selected, the user will receive a message indicating the claim has been voided.
Submitting a Claim Appeal
To submit an appeal for a denied claim, select Secure Correspondence from the home page.
Appealing a Claim, continued

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

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

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

NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.
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.
Managed Care Organizations
Managed Care Organizations

- All prior authorization requests must be submitted through the Quality Improvement Organization (QIO)-like vendor for approval, even if the recipient is a member of a Managed Care Organization (MCO).

- The QIO-like vendor will notify the State of Nevada, who will then dis-enroll the recipient from the MCO.

- * The MCO will be responsible for room & board and all associated services per the all-inclusive rate through the initial administrative month and will also be responsible for all ancillary services.

- Nevada Medicaid will then be responsible for room & board and all associated services per the all-inclusive rate at the start of the next administrative month going forward and Nevada Medicaid will be responsible for all ancillary services.

- An exception is made for recipients with Nevada Check Up Fee-For-Service (FFS). Nevada Medicaid will be responsible for room & board and all associated services per the all-inclusive rate while the MCO will remain responsible for all ancillary services.

- Please note that Nevada Check Up FFS recipients are not eligible for retrospective reviews per the Billing Manual.

- Refer to: MSM Chapter 3600, Section 3603.4, g. EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS, Residential Treatment Center (RTC) Limitations at the following link: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C3600/MSM_3600_14_11_03(1).pdf
Third Party Liability/Other Healthcare Coverage (TPL/OHC)
Third Party Liability/Other Healthcare Coverage (TPL/OHC)

- Medicaid is the payer of last resort whenever TPL/OHC is involved, with the exception of certain cases noted in Chapter 100 and the Billing Manual Chapter 5.

- Medicaid authorization requirements apply to recipients enrolled in the FFS plan (regardless of Third Party Liability coverage), with the exception of recipients also covered by Medicare, unless the recipient has exhausted their Medicare benefits. (Reference the Billing Manual Chapter 4 — Special authorization requirements based on recipient eligibility).

- The TPL must be billed first, before a claim can be sent to Nevada Medicaid for payment.
Third parties are entities or individuals who are legally responsible for paying the medical claims of Medicaid recipients. Federal law and regulations require States to assure that Medicaid recipients utilize all other resources available to them to pay for all or part of their medical care needs before turning to Medicaid. This may involve health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more recipients. **Medicaid pays only after the third party has met its legal obligation to pay; i.e., Medicaid is payer of last resort.**

- **SMM 3902:** Take reasonable measures to determine the legal liability of third parties to pay for services furnished under the Medicaid State plan (herein referred to as the State plan). At a minimum:

  - Collect health insurance information during the initial eligibility interview process and the redetermination process. (See §3903.1.)
TPL/OHC, continued

- The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in **42 CFR 447.20** - Provider restrictions: State plan requirements

- Another important CFR addressing TPL is: **42 CFR 433.139** - Payment of Claims

- Medicaid Services Manual (MSM) Chapter 100 Section 104.B:
  - *Providers are required to bill a recipient’s OHC prior to billing Medicaid.*

- If a provider or the agency (such as the Division of Child and Family Services, DCFS) knows through initial intake that the beneficiary has OHC, they must seek liable third party resources. When they become a Nevada Medicaid or any state Medicaid provider, they agreed to these terms.
TPL/OHC, continued

- Per MSM Chapter 100 Section 104.1, it is not necessary to bill the OHC if it is known the specific service provided is not a covered benefit under the OHC policy.

- Providers billing for services that are not billed to the OHC, as it is known the service is non-covered, should be billing the services as follows to Nevada Medicaid:
  
  • For Institutional claims where the primary carrier is a commercial insurance: Include the claim adjustment reason code OA 204 to indicate non-covered services, carrier information, payment information and payment date at the header level.

  • For Institutional claims where the primary carrier is Medicare: Submit the claim as a Fee-for-Service claim and include the claim adjustment reason code OA 204 to indicate non-covered services, carrier information, payment information and payment date at the header level.

- The information concerning the non-coverage received from the OHC should be maintained in the recipient’s records to support the non-coverage for documentation purposes.
Third Party Liability Guide

*EXCEPTIONS to TPL: There are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federal administered health programs.

The federal statutes creating the following programs expressly state that they pay for a service after Medicaid (and thus are exceptions to the payer of last resort rule):

- Crime Victims Compensation Fund
- Part B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Women, Infants, and Children Programs
- Veteran’s benefits, for emergency treatment provided to certain veterans in a non-VA facility
- Veteran’s benefits for state nursing home per diem payments
- State health agencies
- State vocational rehabilitation agencies
- Grants under Title V of the Social Security Act (Maternal and Child Health Service Block Grant)

See back side for exceptions to third party billing.
Contacts

- For Prior Authorization questions: (800) 525-2395
- For Provider Enrollment questions: (877) 638-3472
- For Prior Authorization Appeals Peer-to-Peer contact: email at NVPeertoPeer@dxc.com
- For Critical Events/Interactions contact: BehavioralHealth@dhcfp.nv.gov
- Customer Service Center: Claim inquiries and general information: (877) 638-3472
- Provider Training: NevadaProviderTraining@DXC.com
- Policy Questions: Division of Health Care Financing and Policy (DHCFP): BehavioralHealth@dhcfp.nv.gov or (775) 684-3733
- To reach RTC PA staff: (800) 525-2395 - ask for RTC Behavioral Health
- From the https://www.medicaid.nv.gov/ webpage, located in the top right-hand corner, click the “Contact Us” button which will take you to: https://www.medicaid.nv.gov/contactinfo.aspx
- Third Party Liability (TPL) Unit: Email: NVTPL@HMS.com
MCO Contacts

- Anthem Blue Cross & Blue Shield: Phone: (702) 228-1308; Fax: (866) 495-8711; Email: nv1-providerservices@anthem.com
  - Provider Customer Service (for eligibility, claims and pre-certification): Phone: (844) 495-8711 (except re-certification)
  - Pre-certification:
    - Fax: (800) 694-3627 (for all other pre-certification requests, including ALL elective inpatient or outpatient service)
    - Fax: (866) 920-8362 (for durable medical equipment (DME), outpatient rehabilitation (PT/OT/ST), pain management, home care, home infusion, hyperbaric treatment and wound care)
- Provider Self-Service Website: https://mediproviders.anthem.com/nv
- Anthem Nevada Member Services: Phone: (844) 396-2329 Website: www.anthem.com/nvm edicaid
MCO Contacts, continued

- Health Plan of Nevada (HPN): Phone: (800) 962-8074; Fax: (702) 242-9124
  - Claims Address:
    - Health Plan of Nevada; P.O. Box 15645; Las Vegas, NV 89114
- SilverSummit HealthPlan (Centene): Phone: (844) 366-2880; Email: NetworkManagement@SilverSummitHealthPlan.com
  - Provider Inquiry Line (for eligibility, claims and pre-certifications):
    - Phone: Medical/Behavioral Health: (844) 366-2880
    - Pharmacy: (844) 366-2880
    - Pharmacy (Prior Authorization): (855) 565-9520
    - Vision: (855) 896-8572
  - Claims Address:
    - Medical/Behavioral Health; P. O. Box 5090; Farmington, MO 63640
    - Pharmacy; 5 River Park Place E. Suite 210; Fresno, CA 93720
    - Vision: Attn: Claims Processing; P.O. Box 7548; Rocky Mount, NC 27804
Thank You