

Provider Type 63 – Residential Treatment Center (RTC) Training



Nevada Medicaid Provider Training

2020

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)



Residential Treatment Centers (RTC)

RTC requirements:

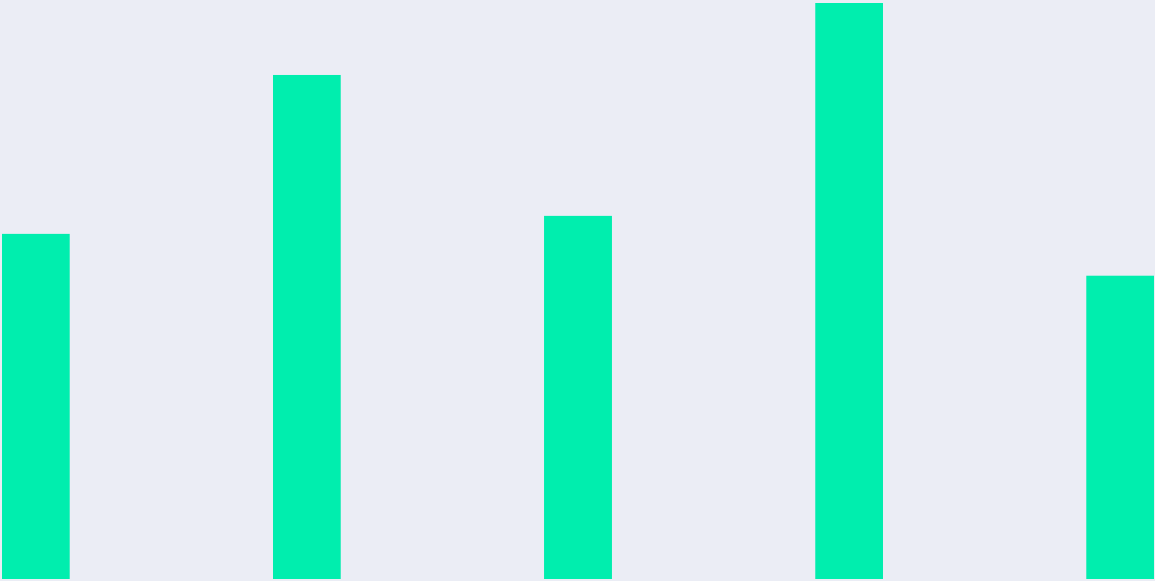
- Are delivered in multiple facility types, also known as Psychiatric Residential Treatment Facility (PRTF) (42 CFR 441.151(a)(2), Subpart D).
- Are for recipients under age 22 and must be being provided before the individual reaches age 21 (42 CFR 441.151(a)(3), Subpart D).

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.

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

Eligibility Monday 10/28/2013 10:51 AM PST

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" value="XXXXXXXXXX"/>	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="10/28/2013"/>	Effective To	<input type="text" value="10/28/2013"/>		

Service Type Code Search

Eligibility Verification Information for		from 10/28/2013 to 10/28/2013		
Recipient ID	Birth Date			
Coverage	Effective Date	End Date	Primary Care Provider	
MEDICAID FFS	10/28/2013	10/31/2013	0000000000	
XIX EMERGENCY	10/28/2013	10/31/2013	0000000000	
Other Insurance Detail Information				

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 Request
Nevada Medicaid and Nevada Check Up

Residential Treatment Center Concurrent Review

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

REQUEST DATE: / /

REQUEST TYPE: ☐ Concurrent Review

☒ Retrospective Authorization – Date of Eligibility Decision

NOTES:

I. RECIPIENT INFORMATION

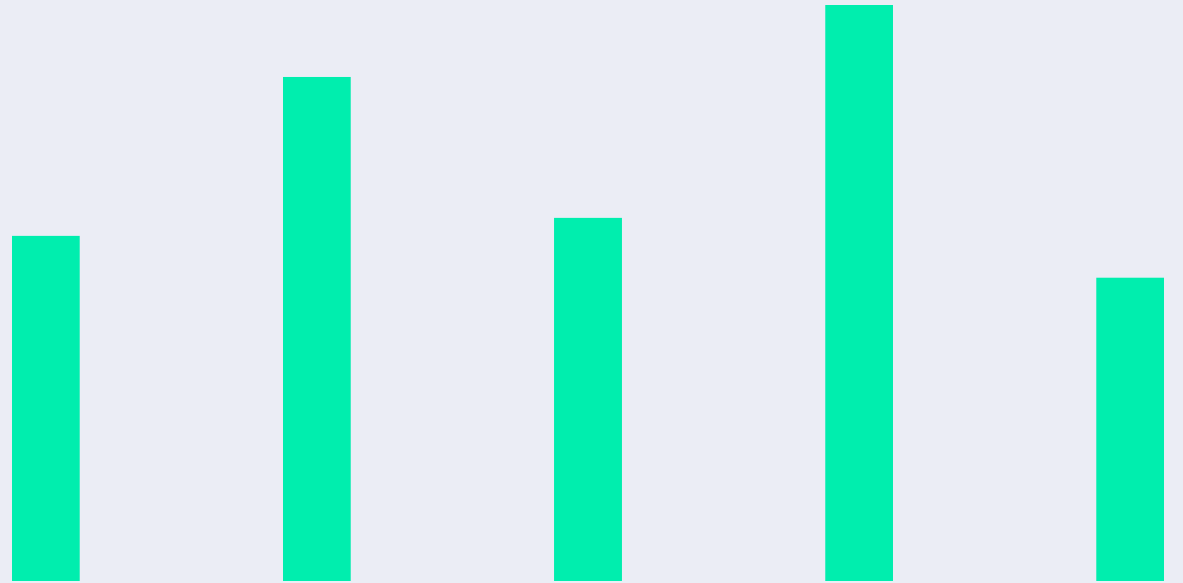
Is the recipient in state custody? ☐ Yes ☐ No

Recipient Name:

Recipient Medicaid ID:

DOB:

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 Request Form
Nevada Medicaid and Nevada Check Up
Residential Treatment Center

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

REQUEST DATE: ____/____/____

REQUEST TYPE: ☐ Initial Review
☐ Retrospective Authorization – Date of Eligibility Decision: ____

NOTES:

I. RECIPIENT INFORMATION

Recipient Name (Last, First, MI): _____
Recipient Medicaid ID: _____ DOB: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Recipient's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Where does recipient reside? ☐ Group Home ☐ Parents ☐ Relatives ☐ Foster Care ☐ Other: _____
Is the recipient currently in state custody? ☐ Yes ☐ No

II. RESPONSIBLE PARTY INFORMATION

Name: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Relationship to recipient: ☐ Parents ☐ Other relative ☐ Government agency ☐ Other: _____

III. ADMITTING FACILITY INFORMATION

Facility Name: _____ NPI: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

IV. ICD-10 DIAGNOSIS

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

V. CLINICAL INFORMATION

Admission Status: ☐ Elective ☐ Involuntary ☐ Voluntary ☐ Court Committed ☐ Other: _____
Recipient Transferred From: _____
Is this request for Healthy Kids (EPSDT) services? ☐ Yes ☐ No
Special precautions for this recipient: ☐ SP ☐ Aggression ☐ Elopement ☐ Other: _____
Intervals: ☐ q15 ☐ q30 ☐ q 1 hour ☐ Routine ☐ Other: _____

Recipient's Current Medication(s)	Dosage	Frequency	Start Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FA-15
Updated 09/25/2019 (pv01/30/2019)

Page 1 of 4

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 Request Form Nevada Medicaid and Nevada Check Up Residential Treatment Center	
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):	SSN:
Recipient ID Number:	DOB:
CASE MANAGER / REFERRING PROVIDER 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:
Referring Provider Name:	Referring Provider NPI:
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: 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.

Prior Authorization Request Form Nevada Medicaid and Nevada Check Up Residential Treatment Center	
Describe outcome of previous outpatient treatment.	
Previous Inpatient Treatment:	
Where was treatment provided?	
Admit Date:	Discharge Date:
Describe outcome of previous inpatient treatment.	
VI. REQUESTED DATES AND SERVICES	
Requested Admission Date:	Number of Days Requested:
The recipient's treatment plan includes: <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Psychotherapy <input type="checkbox"/> Family Therapy	
Does the recipient have an Individualized Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "No," does the treatment plan include a referral for an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If this is an out-of-state placement, are you prepared to produce written verification of unavailability of appropriate in-state services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the proposed treatment for this recipient?	
Describe the recipient's discharge plan:	

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.

Nevada Medicaid and Nevada Check Up
Prior Authorization Data Correction Form

Purpose: Use this form to correct or modify non-clinical, administrative data on a previously submitted prior authorization request. This form cannot be used to request re-determination of medical necessity, nor does it take the place of a prior authorization request. Please allow up to 30 days for processing.

Attachments: Attachments are not required with this form. Documentation to fully support medical necessity must be submitted with the prior authorization request and be available in the recipient's medical record.

Upload this form through the Provider Web Portal.

Questions: If you have any questions, please call Nevada Medicaid at (800) 525-2395.

NOTES:	
Submission Date of This Form:	Date(s) of Service:
Are you an out of state provider? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does TPL exist? <input type="checkbox"/> No <input type="checkbox"/> Yes
SERVICE TYPE <i>Indicate the type of service for which you are requesting a data correction.</i>	
<input type="checkbox"/> ADHC/PCS <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Inpatient Medical/Surgical <input type="checkbox"/> Inpatient LTAC <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Outpatient Medical/Surgical <input type="checkbox"/> Outpatient Rehab <input type="checkbox"/> Outpatient Therapy <input type="checkbox"/> RTC	
AUTHORIZATION NUMBER	
11-digit Authorization Number assigned to your original request:	
BILLING PROVIDER INFORMATION	
Provider Name:	NPI:
Contact Name:	
Phone:	Fax:
INFORMATION TO MODIFY	
What non-clinical data on your original request should be modified?	
Why should this data be modified?	
RECIPIENT INFORMATION	
Recipient Name:	
Date of Birth:	Recipient ID:
Admission Date or Begin Date of Service:	Discharge Date:

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 Request
Nevada Medicaid and Nevada Check Up
Residential Treatment Center Concurrent Review
Upload this request through the Provider Web Portal. Questions? Call: (800) 525-2395

REQUEST DATE: / /
REQUEST TYPE: ☐ Concurrent Review
☐ Retrospective Authorization – Date of Eligibility Decision

NOTES:

I. RECIPIENT INFORMATION
Is the recipient in state custody? ☐ Yes ☐ No
Recipient Name:
Recipient Medicaid ID: DOB:

II. FACILITY INFORMATION
Facility Name: NPI:
Address:
City: State: Zip Code:
Phone: Fax:

III. PROVIDER INFORMATION
Provider Name: NPI:
Phone: Fax:

IV. CASE MANAGEMENT INFORMATION
Does the recipient have a case manager? ☐ Yes ☐ No Case Manager Name:
Case Management Organization: Phone:

V. ICD-10 DIAGNOSIS
Primary Code: Disorder:
Secondary Code: Disorder:
Tertiary Code: Disorder:

VI. CLINICAL INFORMATION
Date of Admission: Number of RTC days requested: Requested Start Date:
Are you requesting EPSDT referral/services? ☐ Yes ☐ No
Date of physician's initial admission assessment:
Special precautions for this recipient: ☐ Suicide ☐ Aggression ☐ Elopement ☐ Other:
Intervals: ☐ q15 ☐ q30 ☐ q1 hour ☐ Routine ☐ Other:

List of Current Medication(s)	Dosage	Start Date
1. <input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>	<input type="text"/>
4. <input type="text"/>	<input type="text"/>	<input type="text"/>

FA-13
Updated 09/25/2019 (pv01/30/2019)

Page 1 of 3

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

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**

Create Authorization | [View Authorization Status](#) | [Maintain Favorite Providers](#) | [Authorization Criteria](#)

My Home

Delegate for: FieldTeam | Role IDs | Location

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](#)
► [Presumptive Eligibility](#)

Welcome Health Care Professional!



[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

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 [\[Review\]](#)

Hover over “Care Management” and select “Create Authorization” to begin

Submitting a Prior Authorization, continued



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](#)

[Create Authorization](#) | [View Authorization Status](#) | [Maintain Favorite Providers](#) | [Authorization Criteria](#)

[Care Management](#) > Create Authorization

Delegate forFieldTeam

Role IDs

Location

Create Authorization

* Indicates a required field.

☒ Medical

☐ Dental

*Process Type

BH RTC

OCULAR

AUDIOLOGY

ADHC

ABA

BH PHP/IOP

PCS SDS

PCS SIGNIFICANT CHANGE

PCS ONE TIME

PCS TRANSFER

PCS ANNUAL UPDATE

RETRO ABA

RETRO AUDIOLOGY

RETRO BH INPT

RETRO BH OUTPT

RETRO BH PHP/IOP

RETRO BH RTC

RETRO DME

RETRO HOME HEALTH

Expand All

Collapse All

Requesting Provider Information

Provider ID

*Service Location

ID Type

NPI

Name

Recipient Information

*Recipient ID

Last Name

Birth Date

First Name

Referring Provider Information

Referring Provider same as

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.

Submitting a Prior Authorization, continued

Requesting Provider Information		
Provider ID	ID Type	NPI
Name		
*Service Location		
Recipient Information		
*Recipient ID		
Last Name	First Name	
Birth Date		

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.

Submitting a Prior Authorization, continued

Referring Provider Information

Referring Provider same as Requesting Provider

Select from Favorites

No favorite providers available.

Provider ID

ID Type

Name

Add to Favorites

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

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

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.

Submitting a Prior Authorization, 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
<div><div><div>Click to collapse.</div></div></div>		
<div><div>*Diagnosis Type</div><div>ICD-10-CM</div></div>	<div><div>*Diagnosis Code</div><div></div></div>	
<div><div>Add</div><div>Cancel</div></div>		

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.

Submitting a Prior Authorization, 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	Through Date	Code	# of Days	Action
Click to collapse.					
	*From Date 	Code Type Revenue	*Code 		
	*# of Days				
	*Medical Justification				
<div>Add ServiceCancel Service</div>					

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.

Submitting a Prior Authorization, 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"/> Click to collapse.		
*Transmission Method	EL-Electronic Only	
*Upload File	Choose File No file chosen	
*Attachment Type		

Add

Cancel

Submit

Cancel

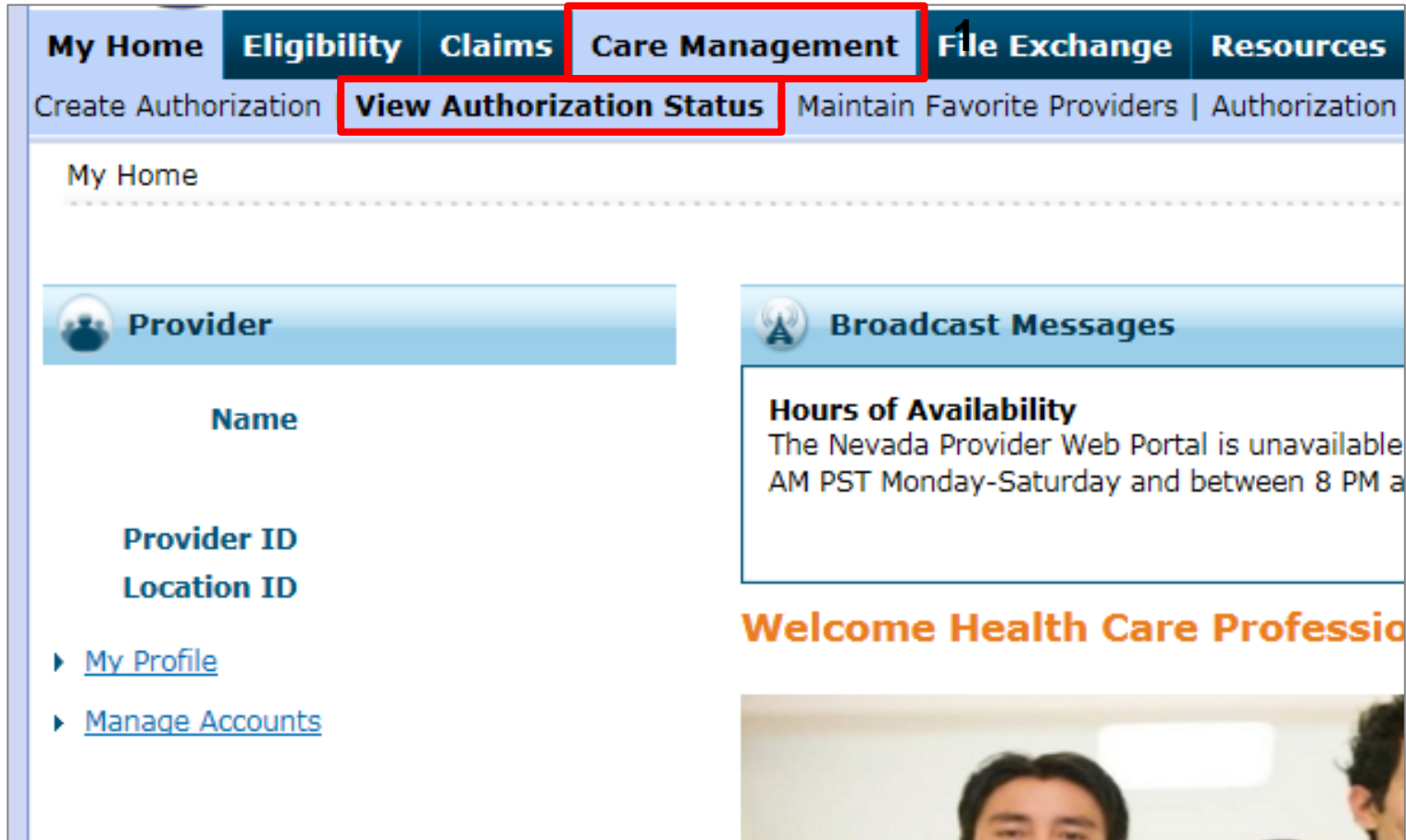
All prior authorization requests require attachments. Users should locate the appropriate attachment by selecting “Choose File” and locate the attachment. Once the attachment has been added, select the appropriate description from the Attachment Type drop-down and select Add.

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

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

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

Locate and select the appropriate ATN to view.

View status of a PA, 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

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

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

Review the information as needed.

View status of a PA, continued

Service Provider / Service Details Information								
Provider ID			ID Type NPI		Name			
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	—

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

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

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

View status of a PA, continued

Service Provider / Service Details Information

C

Provider

D

1573690

E

ID Type

NPI

F

Name

HOSPITAL SERVICES OF NEVADA-
MANDA

G

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 Current Procedural Terminology / Healthcare Common Procedure Coding System (CPT/HCPCS) code on the PA.
- G. Medical Citation: Indicates when additional information is needed for authorizations (including denied).

View status of a PA, continued

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

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

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

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.

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Prior Authorization Reconsideration Request

Purpose: Request a reconsideration on any denied services on an authorization request.
Required Attachments: Documentation you would like considered under this reconsideration request.
Notes: - Services are dependent on medical necessity.
- Please review the Billing Guidelines for the appropriate provider type available on the [Providers Billing Information](#) webpage.

Upload this form and required attachments through the Provider Web Portal.
Questions? Call: (800) 525-2395

DATE OF REQUEST: ____ / ____ / ____

Prior Authorization Number pertaining to services to be reconsidered: _____

SECTION I: RECIPIENT INFORMATION	
Recipient Name: _____	Date of Birth: _____
Recipient Medicaid ID: _____	Phone: _____
Recipient Mailing Address: _____	
SECTION II: FACILITY/PROVIDER INFORMATION	
Name: _____	NPI: _____
Phone: _____	Fax: _____
Physical Address: _____	
Name of Person Completing This Form: _____	
Professional Title of Person Completing This Form: _____	
Contact Phone: _____	Contact Email Address: _____
SECTION III: DENIED SERVICES/DATES/UNITS TO BE RECONSIDERED	
HCPCS/CPT/CDT/Rev Code: _____	
Dates of Service to be Reconsidered: Begin Date: _____	End Date: _____
Number of Denied Days or Units: _____	
SECTION IV: ADDITIONAL INFORMATION Additional information is required to process your request. Please include additional information (including documentation) that supports your original prior authorization request, but that was NOT submitted with the original request.*	

* Give a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered. Include only the medical records that support the medical necessity issues identified in the synopsis. Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

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.

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>

<div style="display: flex; justify-content: space-between; font-size: 0.8em; margin-bottom: 5px;"> Prior Authorization Request Nevada Medicaid and Nevada Check Up </div> <h2 style="margin: 0;">Prior Authorization Reconsideration Request</h2>	
Purpose: Request a reconsideration on any denied services on an authorization request.	
Required Attachments: Documentation you would like considered under this reconsideration request.	
Notes: <ul style="list-style-type: none"> - Services are dependent on medical necessity. - Please review the Billing Guidelines for the appropriate provider type available on the Providers Billing Information webpage. 	
Upload this form and required attachments through the Provider Web Portal.	
Questions? Call: (800) 525-2395	
DATE OF REQUEST: / / 	
Prior Authorization Number pertaining to services to be reconsidered: 	
SECTION I: RECIPIENT INFORMATION	
Recipient Name: 	Date of Birth:
Recipient Medicaid ID: 	Phone:
Recipient Mailing Address: 	
SECTION II: FACILITY/PROVIDER INFORMATION	
Name: 	NPI:
Phone: 	Fax:
Physical Address: 	
Name of Person Completing This Form: 	
Professional Title of Person Completing This Form: 	
Contact Phone: 	Contact Email Address:
SECTION III: DENIED SERVICES/DATES/UNITS TO BE RECONSIDERED	
HCP/CS/CPT/CDT/Rev Code: 	
Dates of Service to be Reconsidered: Begin Date: End Date: 	
Number of Denied Days or Units: 	
SECTION IV: ADDITIONAL INFORMATION Additional information is required to process your request. Please include additional information (including documentation) that supports your original prior authorization request, but that was NOT submitted with the original request.*	

* Give a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered. Include only the medical records that support the medical necessity issues identified in the synopsis. Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

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

FA-29B
01/29/2019 (pv03/20/2017)

Page 1 of 1

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

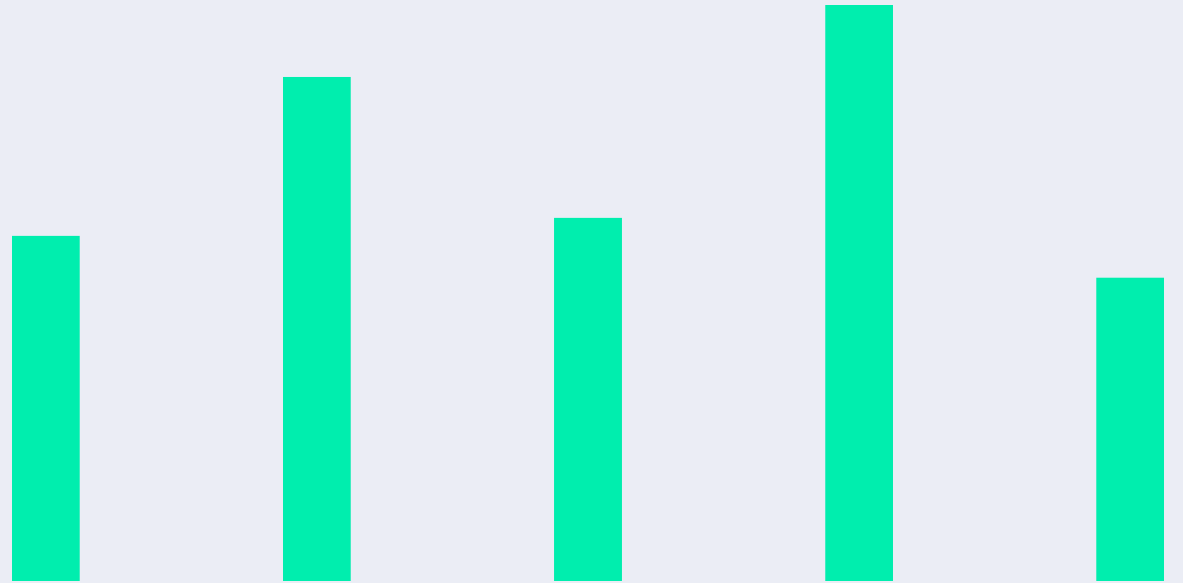
NOTE: The above services are ***not*** to be billed separately and doing so may result in the RTC claim being denied.

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>

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.

Therapeutic Home Passes, continued

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.

Nevada Medicaid and Nevada Check Up
RTC Absence Form

Purpose: To notify Nevada Medicaid of an absence from a Residential Treatment Center (RTC) . This form is not to be used for an elopement. The Prior Authorization Data Correction Form (FA-29) is to be used to report an elopement.

Policy for therapeutic pass: A therapeutic home pass must be used 1) to facilitate a recipient's discharge back to their home or less restrictive setting, 2) within 90 days of the recipient's planned discharge and 3) in coordination with their discharge plan. The recipient must 1) have demonstrated a series of successful incremental day passes first and 2) be in the final phase of treatment in the RTC program (*MSM 403.8A.6a.2*).

Limitations: Three therapeutic home passes are allowed per calendar year (*MSM 403.8A.6*).

Notification/Request Timeline:

- This form must be received at least 14 days prior to the pass being issued to the recipient if related to a therapeutic pass.
- This form must be submitted the day of the absence for any other type of absence.

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

Request Type (please check one): <input type="checkbox"/> Notification of a recipient's 72-hour or less therapeutic home pass <input type="checkbox"/> Prior authorization request for a therapeutic home pass longer than 72 hours <input type="checkbox"/> Other type of absence, provide details in "Notes" field below			
NOTES:			
RECIPIENT INFORMATION			
Recipient Name:			Recipient ID:
FACILITY INFORMATION			
Facility Name:			
Facility Address:			
NPI:			
ABSENCE INFORMATION			
Dates of Leave – From:		Time:	To: Time:
Explain the goals and objectives for a therapeutic home pass and identify how they pertain to the recipient's discharge plan or details related to the reason for any other type of leave.			
PHYSICIAN'S ORDER			
Is it clinically appropriate for the recipient to travel alone? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is there an escort? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I certify that the individual indicated above meets the requirements for therapeutic home leave if applicable.			
Physician Signature:			Date:
Physician Name (print/type):			
Professional Title:			

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.

Nevada Medicaid and Nevada Check Up

RTC Absence Form

Purpose: To notify Nevada Medicaid of an absence from a Residential Treatment Center (RTC). This form is not to be used for an elopement. The Prior Authorization Data Correction Form (FA-29) is to be used to report an elopement.

Policy for therapeutic pass: A therapeutic home pass must be used 1) to facilitate a recipient's discharge back to their home or less restrictive setting, 2) within 90 days of the recipient's planned discharge and 3) in coordination with their discharge plan. The recipient must 1) have demonstrated a series of successful incremental day passes first and 2) be in the final phase of treatment in the RTC program (*MSM 403.8A.6a.2*).

Limitations: Three therapeutic home passes are allowed per calendar year (*MSM 403.8A.6*).

Notification/Request Timeline:

- This form must be received at least 14 days prior to the pass being issued to the recipient if related to a therapeutic pass.
- This form must be submitted the day of the absence for any other type of absence.

Upload this request through the Provider Web Portal.

Questions? Call: (800) 525-2395

Request Type (please check one):			
<input type="checkbox"/> Notification of a recipient's 72-hour or less therapeutic home pass			
<input type="checkbox"/> Prior authorization request for a therapeutic home pass longer than 72 hours			
<input type="checkbox"/> Other type of absence, provide details in "Notes" field below			
NOTES:			
RECIPIENT INFORMATION			
Recipient Name:			Recipient ID:
FACILITY INFORMATION			
Facility Name:			
Facility Address:			
NPI:			
ABSENCE INFORMATION			
Dates of Leave – From:		Time:	To: Time:
Explain the goals and objectives for a therapeutic home pass and identify how they pertain to the recipient's discharge plan or details related to the reason for any other type of leave.			
PHYSICIAN'S ORDER			
Is it clinically appropriate for the recipient to travel alone? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is there an escort? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I certify that the individual indicated above meets the requirements for therapeutic home leave if applicable.			
Physician Signature:		Date:	
Physician Name (print/type):			
Professional Title:			

RTC Absence for Less Than 24 Hours

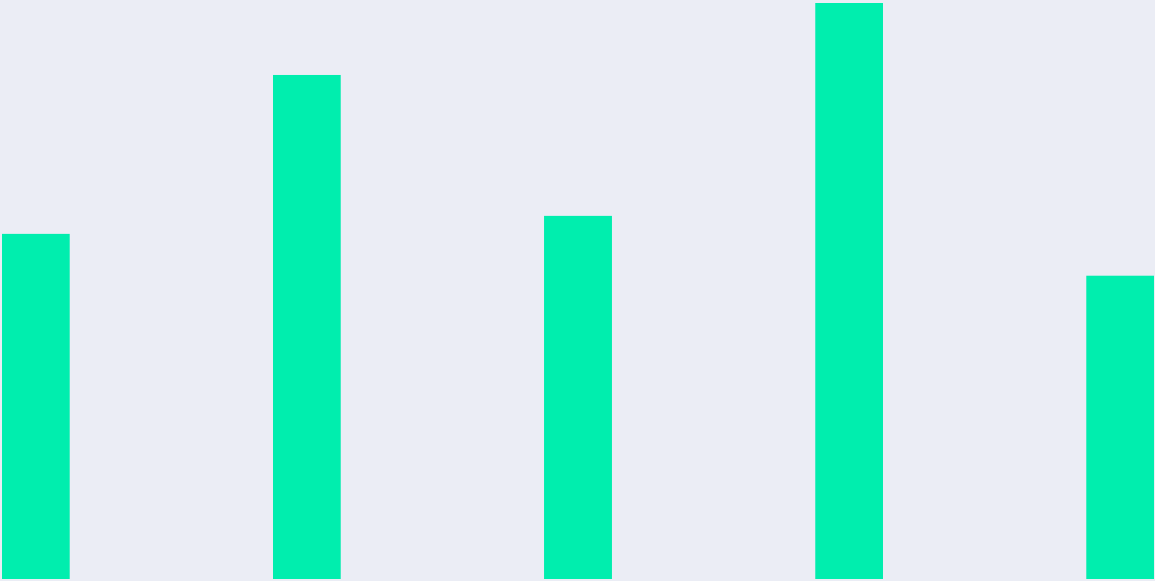
- If the recipient is gone from the RTC less than 24 hours, but had been admitted as an inpatient, then they would be considered discharged from the RTC and an FA-29 would need to be submitted. When re-admitting to the RTC after a discharge, submit a new PA (FA-15), including reason for going to acute, 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 or directly at the following: <https://medicaid.nv.gov/providers/forms/forms.aspx>

FA-13	Residential Treatment Center Concurrent Review
FA-13A	RTC Absence Form
FA-14	Inpatient Mental Health Services Concurrent Review Request
FA-15	Residential Treatment Center Prior Authorization
FA-16A	Home Health Agency – Intermittent Services Prior Authorization Request
FA-16A Instructions	Home Health Agency – Intermittent Services Prior Authorization Request Instructions
FA-16B	Home Health Agency – Private Duty Nursing (PDN) Services Only Prior Authorization Request
FA-16B Instructions	Home Health Agency – Private Duty Nursing (PDN) Services Only Prior Authorization Request Instructions
FA-17	Adult Day Health Care Services Prior Authorization Request
FA-18	Level 1 Identification Screening for PASRR
FA-19	Level of Care Assessment for Nursing Facilities
FA-19 Instructions	Level of Care Assessment for Nursing Facilities Instructions
FA-20	PASRR and LOC Copy Request
FA-21	PASRR and LOC Data Correction Form
FA-22	Screening Request for Pediatric Specialty Care Services
FA-24	Personal Care Services (PCS) Prior Authorization PCS Assessment Forms
FA-24 Instructions	Personal Care Services (PCS) Prior Authorization Instructions
FA-24A	Coordination of Hospice and Waiver or Personal Care Services (PCS)
FA-24A Instructions	Coordination of Hospice and Waiver or Personal Care Services (PCS) Instructions
FA-24B	Legally Responsible Individual (LRI) Availability Determination for the Personal Care Services Program
FA-24C	Authorization Request for Self-Directed Skilled Services
FA-24C Instructions	Authorization Request for Self-Directed Skilled Services Instructions
FA-24T	Personal Care Services Recipient Request for Provider Transfer
FA-25	Orthodontic Medical Necessity (OMN) Form
FA-26	Client Treatment History Form (For Medicaid Orthodontic Treatment)
FA-29	Prior Authorization Data Correction Form
FA-29A	Request for Termination of Service
FA-29B	Prior Authorization Reconsideration Request

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@dncfp.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.”**

RTCs are responsible for:

- 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.

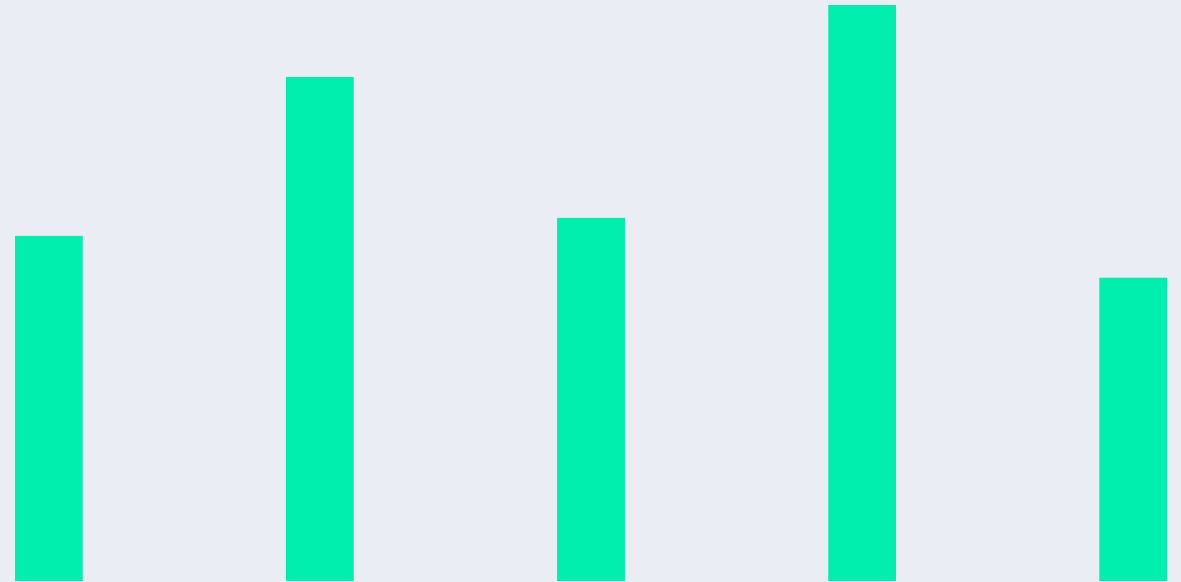
Critical Events or Interactions, continued

- 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**
https://medicaid.nv.gov/Downloads/provider/web_announcement_1315_20170227.pdf
 - 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



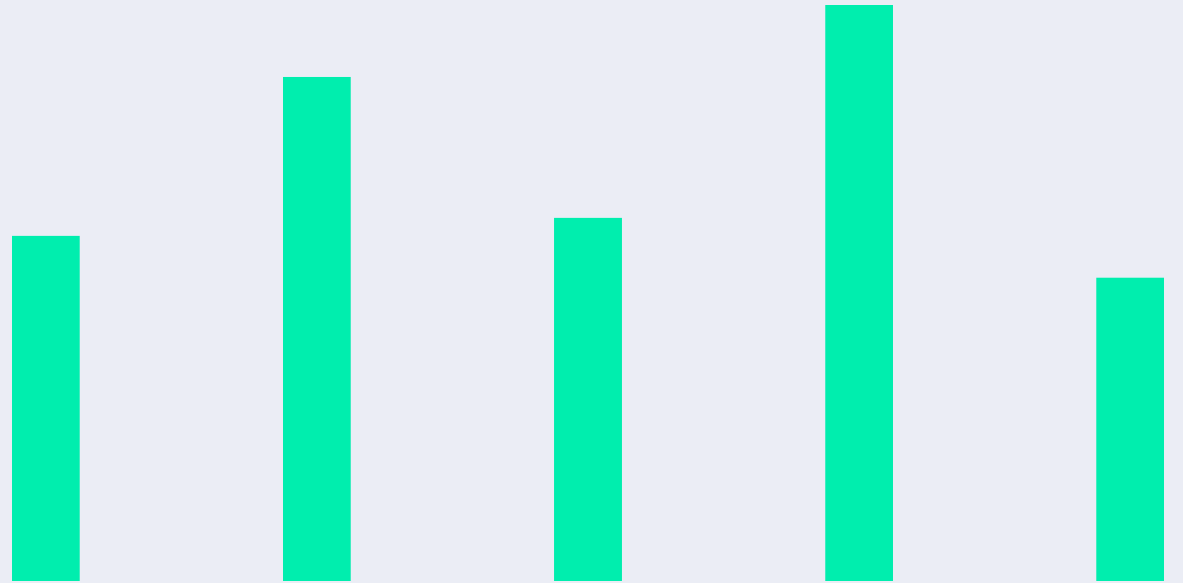
Provider Discharge Planning

- 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

Nevada Medicaid Website



Nevada Medicaid Website: <https://www.medicaid.nv.gov>



Nevada Department of
Health and Human Services

Division of Health Care Financing and Policy Provider Portal

Contact Us



DHCFP Home

Search



Home Providers EVS Pharmacy Prior Authorization Claims Quick Links Calendar

Announcements Latest News

[Web Announcement 2054](#)

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims

[Web Announcement 2053](#)

New Professional Anesthesia Services Claims Error Code

[Web Announcement 2052](#)

Update for Provider Types 14 (Behavioral Health Outpatient Treatment) and 17 (Special Clinics) Specialty 215 (Substance Abuse Agency Model [SAAM]) Regarding Claims for Procedure Code H0035

[Web Announcement 2051](#)

Attention Provider Types 23 (Hearing Aid Dispenser & Related Supplies) and 76 (Audiologist): Update Regarding 2019 Hearing Aid Procedure Codes

[Web Announcement 2050](#)

Medicaid Services Manual Update Effective December 2, 2019

[View All Web Announcements](#)

Welcome

Provider Enrollment and Revalidation Instructions

See the Provider Enrollment and Provider Training webpages for training materials

See [Web Announcement 1963](#) for Revalidation Training Opportunities

Nevada Medicaid



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.

Notifications

Urgent Notification:

The Reno office of DXC Technology and the Nevada Medicaid Customer Service Call Centers will be closed for an internal meeting on Friday, December 20, 2019, from 10:15 to 11:15 a.m. Pacific Time. Please make arrangements to contact DXC staff and Call Center Agents outside of this time period.


Known Modernization System Issues-Click [HERE](#)

Paper claims are no longer accepted by Nevada Medicaid. Please refer to [Web Announcement 1733](#) and [Web Announcement 1829](#) for additional information.



Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims. See [Web Announcement 2054](#).


Nevada Medicaid Website: Announcements

Click on “View All Web Announcements”:



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

Contact Us   DHCFP Home

Search 

Providers EVS Pharmacy Prior Authorization Claims Quick Links Calendar

Announcements Latest News

[Web Announcement 2054](#)
Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims

[Web Announcement 2053](#)
New Professional Anesthesia Services Claims Error Code

[Web Announcement 2052](#)
Update for Provider Types 14 (Behavioral Health Outpatient Treatment) and 17 (Special Clinics) Specialty 215 (Substance Abuse Agency Model [SAAM]) Regarding Claims for Procedure Code H0035

[Web Announcement 2051](#)
Attention Provider Types 23 (Hearing Aid Dispenser & Related Supplies) and 76 (Audiologist): Update Regarding 2019 Hearing Aid Procedure Codes

[Web Announcement 2050](#)
Medicaid Services Manual Update Effective December 2, 2019

[View All Web Announcements](#)

Announcements & Newsletters

Search by Category: All Announcements 

Date	Announcement Number	Topic
Dec 19, 2019	2054	Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims
Dec 19, 2019	2053	New Professional Anesthesia Services Claims Error Code
Dec 18, 2019	2052	Update for Provider Types 14 (Behavioral Health Outpatient Treatment) and 17 (Special Clinics) Specialty 215 (Substance Abuse Agency Model [SAAM]) Regarding Claims for Procedure Code H0035
Dec 17, 2019	2051	Attention Provider Types 23 (Hearing Aid Dispenser & Related Supplies) and 76 (Audiologist): Update Regarding 2019 Hearing Aid Procedure Codes
Dec 17, 2019	2050	Medicaid Services Manual Update Effective December 2, 2019
Dec 16, 2019	2049	Attention Provider Type 33 (Durable Medical Equipment, Prosthetics, Orthotics and Supplies): Claims that Processed Incorrectly with Authorization on File Have Been Reprocessed
Dec 16, 2019	2048	Attention Provider Types 25 (Optometrist), 41 (Optician, Optical Business) and 60 (School Based): Assembly Bill 108 Provider Survey Announcement
Dec 13, 2019	2047	Wage and Benefit Survey Open for Home and Community Based Waiver for the Frail Elderly Providers
Dec 13, 2019	2046	Attention Provider Type 22 (Dentist): Fluoride Toothpaste Coverage

Notifications

Urgent Notification:
The Reno office of DXC Technology and the Nevada Medicaid Customer Service Call Centers will be closed for an internal meeting on Friday, December 20, 2019, from 10:15 to 11:15 a.m. Pacific Time. Please make arrangements to contact DXC staff and Call Center Agents outside of this time period.

Known Modernization System Issues-Click HERE

Paper claims are no longer accepted by Nevada Medicaid. Please refer to [Web Announcement 1733](#) and [Web Announcement 1829](#) for additional information.

Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims. See [Web Announcement 2054](#).

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 11, 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 10, 2019
 - On the fifth claim: April 11, 2019 through April 30, 2019
 - On the sixth claim: May 1, 2019 through May 31, 2019

From Date	To Date	Units	Remaining Units	Amount	Code
01/11/2019	04/10/2019	90	0	–	Revenue 0100-All Inclusive Rate (R&B + Ancillary)
04/11/2019	07/09/2019	90	0	–	Revenue 0100-All Inclusive Rate (R&B + Ancillary)
07/10/2019	10/07/2019	90	0	–	Revenue 0100-All Inclusive Rate (R&B + Ancillary)
10/08/2019	01/05/2020	90	0	–	Revenue 0100-All Inclusive Rate (R&B + Ancillary)

- Wait 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.



October 12, 2018
Announcement 1711

Requirements Regarding National Provider Identifier of Attending and Ordering, Prescribing or Referring Provider on Claims

If the service you are billing was ordered, prescribed or referred by another physician or other eligible professional, you must enter that Ordering, Prescribing or Referring (OPR) provider's National Provider Identifier (NPI) on the claim form.

The following table shows the provider types that are required to include the NPI of the attending and OPR provider effective on claims processed on or after October 15, 2018. Effective with claims processed on or after October 15, 2018, if the OPR provider is the same as the attending provider, the OPR provider is not required on UB-04 and institutional claims.

Provider Type	Provider Type Description	NPI of Attending Provider Required	NPI of OPR Provider Required
10	Outpatient Surgery, Hospital Based	Yes	*
11	Hospital, Inpatient	Yes	*
12	Hospital, Outpatient	Yes	*
13	Psychiatric Hospital, Inpatient	Yes	*
15	Registered Dietitian		Yes
16	Intermediate Care Facilities for Individuals with Intellectual Disabilities / Public	Yes	*
17 (specialties 167 and 196)	Special Clinics (Genetics and Special Children's Clinic)		Yes
19	Nursing Facility	Yes	*
23	Hearing Aid Dispenser & Related Supplies		Yes
27	Radiology and Non-invasive Diagnostic Centers		Yes
28	Pharmacy		Yes
29	Home Health Agency	Yes	*
33	Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS)		Yes
34	Therapy		Yes

Provider Type	Provider Type Description	NPI of Attending Provider Required	NPI of OPR Provider Required
43	Laboratory, Pathology Clinical		Yes
44	Swing-bed, Acute Hospital	Yes	*
45	End Stage Renal Disease (ESRD) Facility	Yes	*
46	Ambulatory Surgical Centers		Yes
51	Indian Health Service Hospital, Inpatient (Tribal)	Yes	*
52	Indian Health Service Hospital, Outpatient (Tribal)	Yes	*
55	Home Based Habilitation Services	Yes	*
56	Inpatient Rehabilitation and Long Term Acute Care (LTAC) Specialty Hospitals	Yes	*
60	School Based		Yes
63	Residential Treatment Centers (RTC)	Yes	*
64	Hospice	Yes	*
65	Hospice, Long Term Care	Yes	*
68	Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private	Yes	*
75	Critical Access Hospital (CAH), Inpatient	Yes	*
78	Indian Health Service Hospital, Inpatient (Non-Tribal)	Yes	*
79	Indian Health Service Hospital, Outpatient (Non-Tribal)	Yes	*
81	Hospital Based ESRD Provider	Yes	*
85	Applied Behavior Analysis (ABA)		Yes

*Required unless the same as Attending Provider.

Claims processed on or after October 15, 2018, and before December 15, 2018, that do not have the NPI of the attending and OPR provider will receive a soft edit, which is an informative message regarding the requirement, but will not cause the claim to deny. Claims processed on or after December 15, 2018, that do not have the NPI of the attending and OPR provider will deny.

[Electronic Verification System \(EVS\) User Manual Chapter 7 \(Search Provider\)](#) provides instructions on how to search the Provider Web Portal for OPR providers.

It is the responsibility of the billing provider to ensure that the NPI which they enter on a claim belongs to an **individual provider** (not an organization or group): who ordered, prescribed or referred the service being billed; is authorized to do so; and is an active Nevada Medicaid provider on the date of service. Any claims which do not conform to these requirements may deny, and if they pay in error, they are subject to recoupment.

If an OPR provider's NPI is submitted on the claim when it is not mandatory, the NPI will still be validated by the system and the claim will deny if the OPR provider's NPI is not valid or the OPR provider is not enrolled in Nevada Medicaid.

Nevada Medicaid Website: Billing Information

Click on “Billing Information” under the Providers tab.



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

Contact Us   DHCFP Home

Search 

[Home](#) [Providers](#) [EVS](#) [Pharmacy](#) [Prior Authorization](#) [Claims](#) [Quick Links](#) [Calendar](#)

Announcements/Newsletters

Billing Information

Electronic Claims/EDI

E-Prescribing

Forms

NDC

Provider Enrollment

Provider Training

[Web Announcement 2052](#)
Update for Provider Types 14 (Behavioral Health Outpatient Treatment) and 17 (Special Clinics) Specialty 215 (Substance Abuse Agency Model [SAAM]) Regarding Claims for Procedure Code H0035

[Web Announcement 2051](#)
Attention Provider Types 23 (Hearing Aid Dispenser & Related Supplies) and 76 (Audiologist): Update Regarding 2019 Hearing Aid Procedure Codes

[Web Announcement 2050](#)
Medicaid Services Manual Update Effective December 2, 2019

[View All Web Announcements](#)

Billing Information

Effective February 1, 2019, all providers will be required to submit their claims electronically (using Trading Partners or Direct Data Entry [DDE]), as paper claims submission will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at <https://www.medicaid.nv.gov/providers/Modernization.aspx> for further details.

Attention All Providers: Requirements on When to Use the National Provider Identifier (NPI) of an Ordering, Prescribing or Referring (OPR) Provider on Claims [[Web Announcement 1711](#)]

FAQs: National Correct Coding Initiative (NCCI) Claim Review Edits [[Review Now](#)]
Clinical Claim Editor FAQs Updated December 5, 2011 [[Review Now](#)]
Third Party Liability Frequently Asked Questions [[Review Now](#)]

Billing Manual

For Archives [Click here](#)

Title	File Size	Last Update
Billing Manual	2 MB	11/21/2019

Billing Guidelines (by Provider Type)

Notifications

Urgent Notification:
The Reno office of DXC Technology and the Nevada Medicaid Customer Service Call Centers will be closed for an internal meeting on Friday, December 20, 2019, from 10:15 to 11:15 a.m. Pacific Time. Please make arrangements to contact DXC staff and Call Center Agents outside of this time period.

Known Modernization System Issues-Click HERE

Paper claims are no longer accepted by Nevada Medicaid. Please refer to [Web Announcement 1733](#) and [Web Announcement 1829](#) for additional information.

Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims. See [Web Announcement 2054](#).

<https://www.medicaid.nv.gov/providers/BillingInfo.aspx#>

PT 63 Billing Guide



PT 63 Billing Guide

- Available at the www.medicaid.nv.gov webpage or directly at:
https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT63.pdf
- Updated on 4/29/19 (Refer to WA 1885) to provide information regarding notification for RTC absences via the FA-13A and Billing.



Provider Type 63 Billing Guide

Residential Treatment Center

Residential Treatment Centers (RTCs) are facilities capable of being locked, and providing 24-hour structured inpatient care, treatment and supervision for children and adolescents under age 21 with an Intensity of Needs Level 6 (see [Medicaid Services Manual \(MSM\) Chapter 400](#), Section 403.8).

RTCs are designed as a medical model of therapeutic care to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders who have not benefited from, or who are not appropriate for, a higher or lower level of care.

Covered Services

Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications (for Axis I, II and III diagnoses), quarterly RTC-sponsored family visits, psycho-educational services and supervised work projects (MSM Chapter 400, Section 403.8A.1).

The RTC per diem rate is covered by Fee for Service (FFS) Medicaid.

If the recipient is enrolled in a Managed Care Organization (MCO), the MCO is responsible for reimbursement of the first month of admission. Recipients will be disenrolled from the MCO on the first day of the next administratively possible month following the RTC admission.

If the recipient is enrolled in Nevada Check Up, it is the MCO's responsibility to reimburse for any ancillary services and the daily bed rate is covered by FFS Medicaid.

Note: It is the provider's responsibility to contract with the MCOs to become one of their participating providers. If a recipient has an MCO plan and you are not contracted with that MCO, refer the recipient to the MCO and instruct them to ask for assistance in finding an in-network provider who is currently accepting new patients.

The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, dental, optometry, durable medical equipment, radiology, lab, and therapies (physical, speech and occupational). All of these services are benefits that must be billed separately by the particular service provider (MSM Chapter 400, Section 403.8A.2).

Prior Authorization

Prior authorization is required:

- For all RTC admissions
- For therapeutic home passes longer than 72 hours
- If more than 3 passes will be requested within 1 calendar year

Nevada Medicaid does not generate a separate authorization number for RTC days and therapeutic home pass days; therefore, RTC days and therapeutic home pass days should be billed on the same claim form. See the Billing section below for details.

The QIO-like vendor (DXC Technology) is the QIO-like vendor and is referred to as Nevada Medicaid) must authorize all RTC stays for both FFS and MCO Medicaid.

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

- Please review the Billing Manual at <https://www.medicaid.nv.gov/home.aspx> on the Provider Billing Information webpage. Review Chapter 8 Claims processing and beyond, Claims Appeals.
- 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



 **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

Billable 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
1	ICD-10-CM	B088-Oth viral infections with skin and mucous membrane lesions	Yes	Remove
2	ICD-10-CM	B012-Varicella pneumonia	Yes	Remove
3				

3

***Diagnosis Type**

ICD-10-CM 

***Diagnosis Code** 

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


Present on Admission

No 

[Add](#)

[Reset](#)

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

5 *Revenue Code HCPCS/Proc Code

Modifiers

From Date To Date *Units *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 1Back to Step 2Back to Step 3Print Preview

ConfirmCancel

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

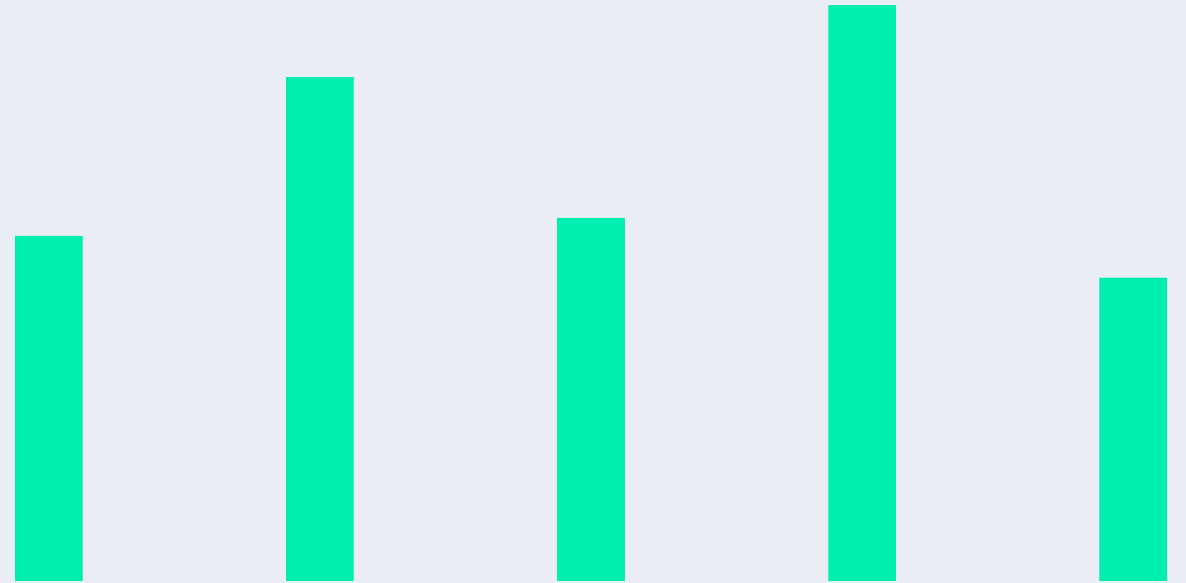
Submit Inpatient Claim: Confirmation
Inpatient Claim Receipt
Your Inpatient Claim was successfully submitted. The claim status is Finalized Payment. The Claim ID is 2218269000008 .
Click Print Preview to view the claim details as they have been saved on the payer's system. Click Copy to copy member or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

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

Claim Information	
*Covered Dates ⓘ	09/17/2018 - * 09/21/2018 ⓘ
*Admission Date/Hour ⓘ	09/17/2018 ⓘ - (hh:mm) Discharge Hour ⓘ (hh:mm)
*Admission Type ⓘ	1-Emergency
*Admitting Diagnosis Type	ICD-10-CM ▼
*Patient Status ⓘ	01-Discharged to Home or Self Ca
*Patient Number	123456789
*Admission Source ⓘ	1-Non - Health Care Facility Point of Origin
*Admitting Diagnosis ⓘ	G40111-Local-rel symptc epi w simple part s
*Facility Type Code	111-Hospital Inpatient (Including Medicare ▼
Authorization Number	
Include Other Insurance <input checked="" type="checkbox"/>	Total Charged Amount \$2,972.08

[Continue](#) [Cancel](#)

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

Click the **Continue** button.

Submitting a Claim with TPL, continued

#	Diagnosis Type	Diagnosis Code
1	ICD-10-CM	G041-Tropical spastic paraplegia
2		

2

*Diagnosis Type

ICD-10-CM

*Diagnosis Code

Present on Admission

No

Add

Reset

External Cause of Injury Diagnosis Codes

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 Details section.

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

#	Carrier Name	Carrier ID	Policy ID	Payer Paid A
+ Click to add a new other insurance.				

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

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	Medicare	123456789	12365478910		10/01/2018	Remove

Carrier Name: Carrier ID:

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

*Policy ID:

*Responsibility: *Patient Relationship to Insured:

Payer Paid Amount: *Paid Date:

Remaining Patient Liability:

*Claim Filing Indicator:

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

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

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.

Submitting a Claim with 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	Medicare	123456789	12365478910		10/01/2018	Remove

[+](#) Click to add a new other insurance.

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	Medicare	123456789	12365478910		10/01/2018	Remove

[+](#) Click to add a new other insurance.

Condition Codes [+](#)

Occurrence Codes [+](#)

Value Codes [+](#)

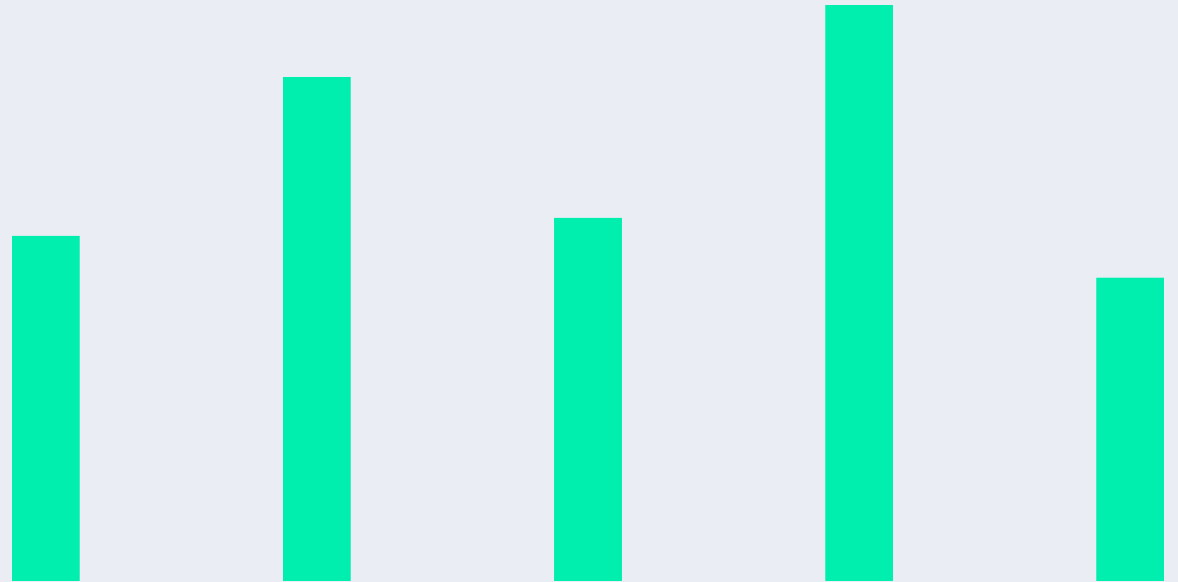
Surgical Procedures [+](#)

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


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



Search for Claims



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 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

Service From

ID Type

To

Claim Type

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
+	2218276000016		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

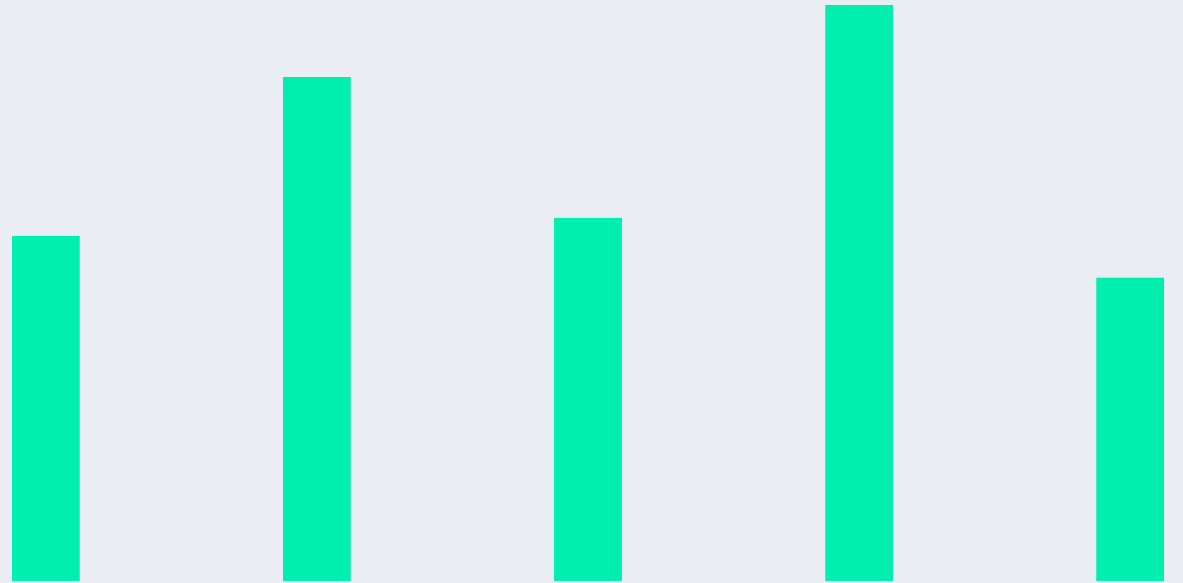
Claim / Service #	HIPAA Adj	Description	EOB
Claim	381	ATTENDING NPI REQUIRED	1390
Claim	1022	REFERRING NPI REQUIRED	1024
Claim	3347	NO PAYABLE ACCOMMODATION CODE	0609

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 *From 06/01/2018

To 08/01/2018



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	

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.

PDF Files require [Adobe Acrobat Reader](#)

Copying a Claim



Copy 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
+	2218276000016		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.

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"/> Recipient Information	<input type="radio"/> Service Information	<input type="radio"/> Recipient and Service Information	<input checked="" type="radio"/> Entire Claim
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)		

Copy **Cancel**


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
+	2218276000016		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
Adjust Copy Void Print Preview

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 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, 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" section with a "Browse..." button, an "Attachment Type" dropdown menu, and a "Description" text input 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: [Browse...]

*Attachment Type: ▼

Description: []

[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.

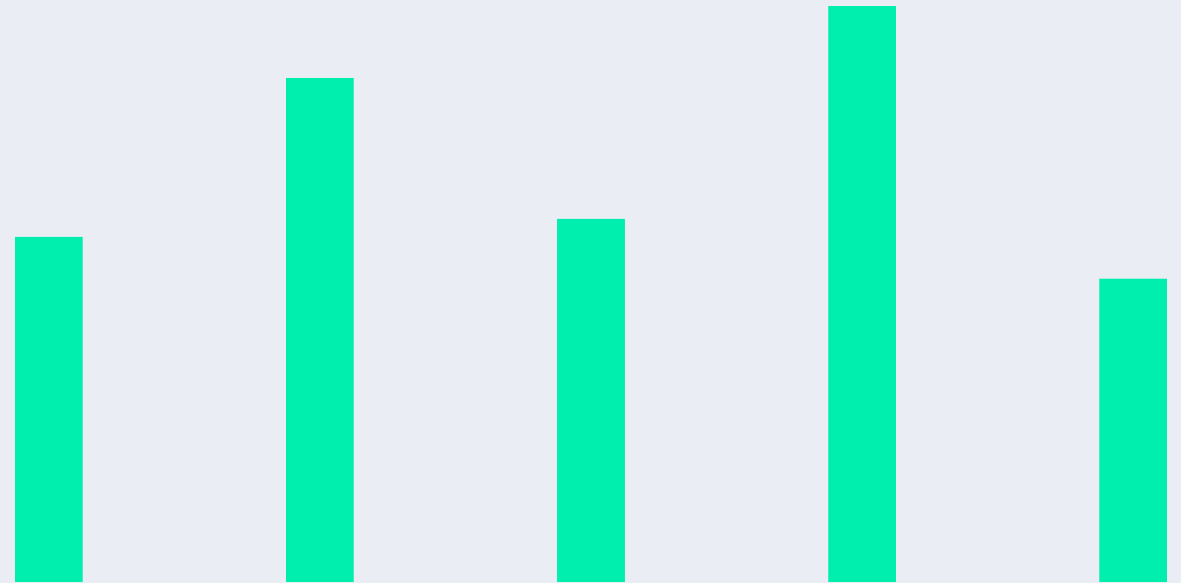
Appealing a Claim, continued

Secure Correspondence - Message Box					Back to My Home ?
Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional queries please contact us.					
Create New Message					
					Total Records: 13
Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4256	Appeal of a denied claim	Claims - Appeals	10/02/2018	10/02/2018
Open	4255	testing	Claims - Appeals	09/27/2018	09/27/2018
Open	4253	Testing from MO	Level 2 Support - Account Issues	09/19/2018	09/19/2018
Open	4252	Testing 6268 in MO	Level 2 Support - Account Issues	09/18/2018	09/18/2018
Open	4251	Testing 6268	Claims - Appeals	09/06/2018	09/06/2018
Open	4227	Testing sample for 5916	Level 2 Support - Account Issues	08/14/2018	08/14/2018
Closed	4217	Help	Other	07/08/2018	08/03/2018
Open	4218	Testing Help	Other	07/08/2018	07/08/2018
Open	4219	Testing help..	Other	07/08/2018	07/08/2018
Open	4188	Testing in Model	Level 2 Support - Account Issues	04/09/2018	04/09/2018
					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.

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](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.

TPL/OHC, continued

- **State Medicaid Manual (SMM) 3900 (In Chapter 3 — Eligibility):** <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
 - 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

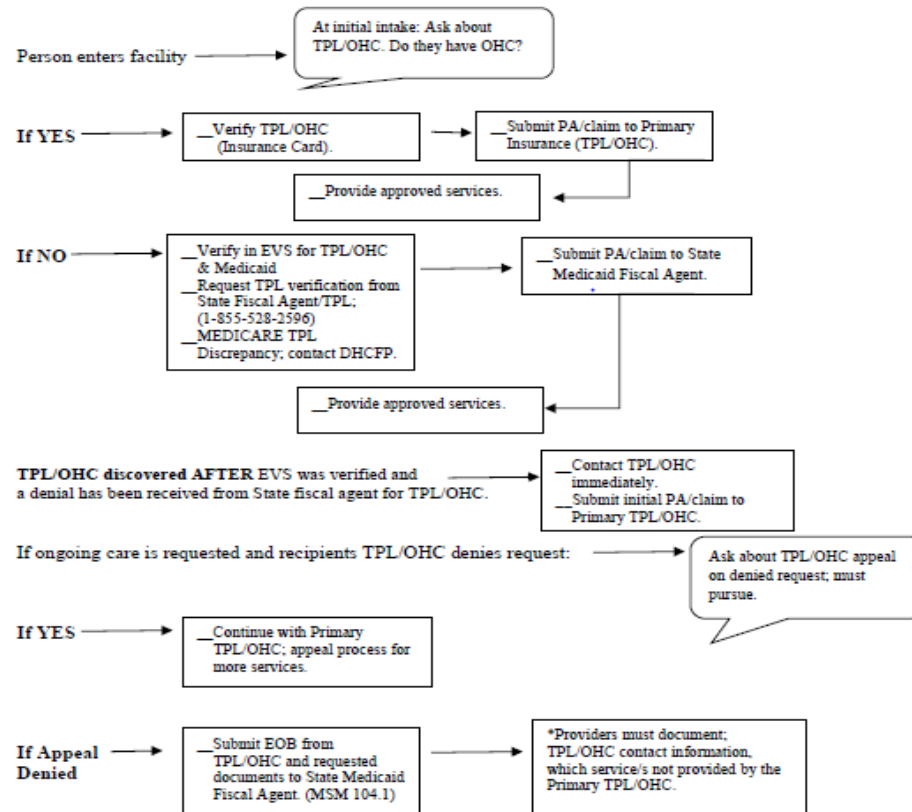
- The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in **42 CFR 447.20** - Provider restrictions: State plan requirements
- Another important CFR addressing TPL is: **42 CFR 433.139** - Payment of Claims
- Medicaid 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

Third party Liability (TPL) Insurance / Other Health Care Coverage (OHC) Guide



*State of Nevada does not automatically cover services approved or denied by Other Health Care Coverage; Third Party Liability Insurance.

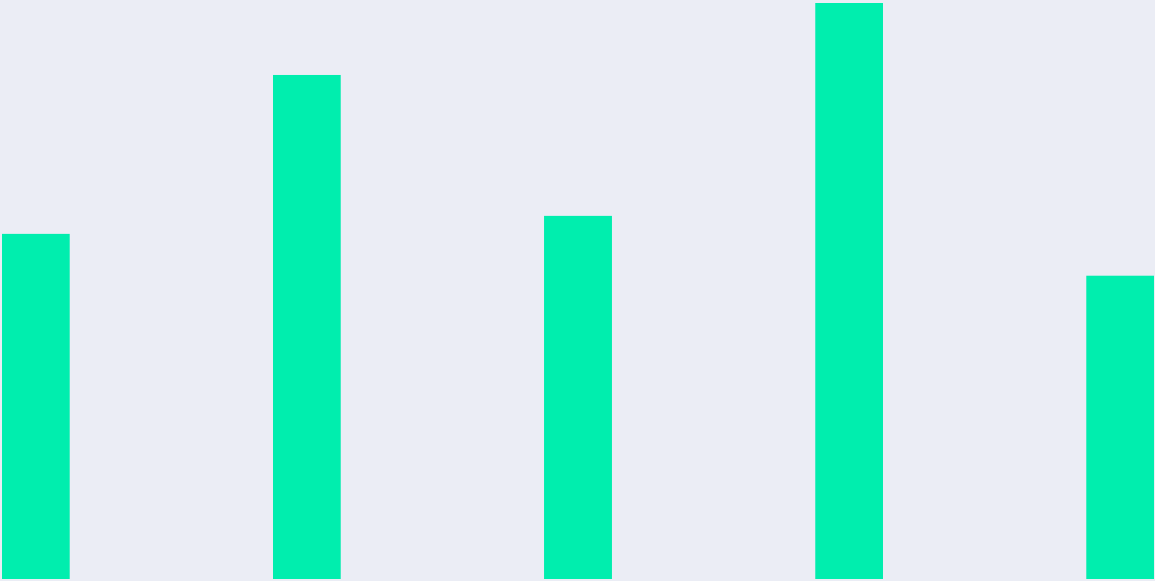
SEE BACK SIDE FOR EXCEPTIONS TO THIRD PARTY BILLING.

*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
- Parts B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Women, Infants, and Children Program
- 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
- Grantees under Title V of the Social Security Act (Maternal and Child Health Service Block Grant)

Contacts



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 nvpeer_to_peer@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/nvmedicaid

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