PROVIDER QUICK TIP GUIDE:
Submitting INPATIENT PSYCHIATRIC AND RTC Prior Authorization Requests

INTRODUCTION

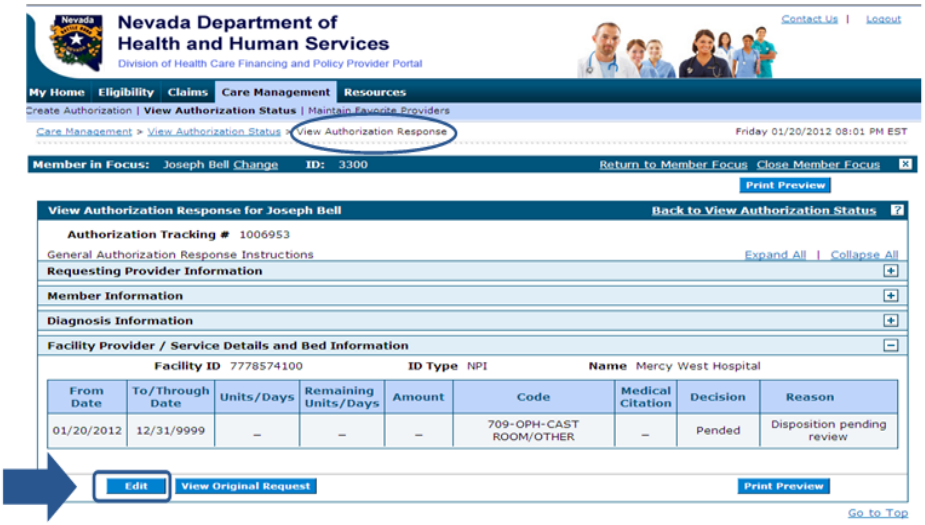
This document provides tips for submitting an **inpatient psychiatric or residential treatment center (RTC)** prior authorization (PA) request to assist in reducing the need for PA requests to be pended for additional information and to assist in a quick turnaround of provider requests.

PROVIDER WEB PORTAL SUBMISSION OF A CONTINUED STAY REQUEST:

- When submitting a request for a continued stay for a recipient, providers should use the edit button on the existing request located in the Provider Web Portal.
- Continued stay requests should not be submitted as a new request for authorization.
- If the original result was denied, then the edit button will not display and the provider will need to submit the request via the Provider Web Portal.

Prior authorization – initiate update to a PA:

Click the Edit button on the View Authorization Response page.



TIP: If the authorization is ineligible for an update, no Edit button displays.

DOCUMENTATION NEEDS:

Documentation submitted should be legible, accurate, sufficient and appropriate:

- Illegible handwritten notes will not be reviewed. Please type the notes.
- If there is information that needs to be brought to the reviewer's attention, such as the request is retro, this information must be attached to your submission.

MAXIMUM NUMBER OF DAYS PER NON-RETRO REQUEST:

When submitting a request always request the appropriate number of days based on the clinical presentations. Below are the maximum number of days that can be considered:

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- RTC maximum number of days per request is 90.
- Inpatient maximum number of days per request is 7.

SUBMISSION OF FORM FA-29 FOR DATA CORRECTIONS:

- These are to be submitted via the Provider Web Portal.
- Always include the contact name and direct phone number of a person at your facility who can answer questions regarding the submission.
- When submitting form FA-29 (Prior Authorization Data Correction Form), provide a detailed explanation of the exact problem with the data that was previously submitted and what you expect the outcome of the data correction to accomplish.
- RTC providers: Submit an FA-29 if the date of admission differs from the date of admission on the prior authorization. Please note that the prior authorization end date will remain the same.
- Inpatient Psychiatric and RTC providers: Submit an FA-29 if the recipient is discharged on or before the last authorized date of service.

PRIOR AUTHORIZATION SUBMISSIONS:

When submitting a request for a review, please provide the following:

- Contact name and direct phone number of a person at your facility who can answer questions regarding the submission.
- Initial Request: Completed FA form (FA-12 for Inpatient, FA-15 for RTC).
- Concurrent Request: Completed FA form (FA-14 for Inpatient, FA-13 for RTC).
- Certificate of Need (C.O.N.) is to be signed. RTC C.O.N. is signed by the physician at the receiving facility.

CONCURRENT REQUESTS:

When submitting a concurrent request:

- Count the actual number of calendar days on your existing request.
- RTC: Please be aware that 90 days is the maximum number of days that can be considered for a single RTC request. The PA is through the last authorized date on the PA and therefore the next date would be the start date on a request for continued stay/concurrent review.
- INPATIENT: Please be aware that seven (7) days is the maximum number of days that can be considered for a single Inpatient request. The last day on the PA is considered the last authorized date and therefore the first date for a concurrent review would be the anticipated date of discharge after the previous authorized treatment period.

RETROSPECTIVE SUBMISSIONS:

When submitting a request for a retrospective review, **please provide the following**:

- Provider is to complete the appropriate form and is asked to provide only pertinent clinical information. This information would substantiate the medical necessity for inpatient care. Providing voluminous clinical data slows the review process.

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- Please do not submit an entire medical record. If this occurs, it will delay the review process. A summary of 10 pages or less is suggested.
- Provider may request a combination of acute and skilled days. It is essential that the level of care and requested dates/days be clearly documented.
- Contact name and direct phone number of a person at your facility who can answer questions regarding the submission.
- The Date of Decision (Eligibility).
- Document that a request is being made for a retrospective review.
- Sufficient clinical documentation to support medical necessity for the entire stay (some are very long stays).
- Summary physician notes for the entire stay.
- Admit and Discharge Summaries.
- Providers are advised that when the patient is inpatient and determined eligible *during their inpatient stay,* the provider must request prior authorization within 10 business days of the date of eligibility decision (refer to the Prior and Retrospective Authorization chapter in the Billing Manual).
- If a recipient is determined eligible for Medicaid benefits *after* service is provided (or after discharge), a retrospective authorization may be requested within 90 calendar days from the date of eligibility decision (refer to the Prior and Retrospective Authorization chapter in the Billing Manual).

RETRO REQUESTS When MEDICARE is exhausted:

When submitting:

- Submit within 30 calendar days of receipt of Medicare notification that Medicare payments are exhausted.
- Mark the submission as Retro for this reason.
- Include a copy of the Medicare Catastrophic Coverage Act (MECCA) form printout or other qualifying documentation that shows Medicare is exhausted.

ADVERSE DECISIONS:

When a request has been modified (partially approved) by the physician:

- You may request a peer-to-peer within 10 business days of the notice of decision date.
- A provider may request a Peer-to-Peer Review by emailing nvpeer_to_peer@dxc.com within 10 business days of the adverse determination.
- You may request a reconsideration within 30 calendar days of the notice of decision date (90 calendar days for RTC).
- You may not request a concurrent review for denied dates of service. Those dates of service may be appealed.

When a request has been denied by the physician:

- You may request a peer-to-peer review within 10 business days of the physician's decision.

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- You may request a reconsideration within 30 calendar days of the physician's decision (90 calendar days for RTC).
- Inpatient providers may request denied dates of service at a lower level of care. The dates of service requested at the skilled level of care do not need to be denied first at the acute level of care.
- Should the provider choose to not appeal they may request these dates of service at a lower level of care.

Skilled Days

Skilled Days do not need to be denied first at the acute level of care, but can be submitted as concurrent days. If the provider does not appeal an adverse decision, a request can be made for the denied dates of service at a lower level of care. When submitting a reconsideration review, additional days cannot be added at a lower level of care as they were not part of the original denial. Requests for additional days must be submitted separately. Skilled Days will be denied if the recipient was not at an acute inpatient level of care facility at least one day immediately preceding the request for skilled days.

Skilled Days will be denied if a recipient, family member or physician refuse to cooperate with the discharge plan or refuse appropriate placement. Skilled Days will be denied if the provider fails to submit evidence of comprehensive discharge planning.

CHECK THE FORM FOR ACCURACY AND COMPLETENESS:

When submitting:

- Is there a start date and is it correct?
- Is there a number of days requested?
- Does the portal entry match the attachment?
- If the request is concurrent, is your start date correct?
- Did you include the signed C.O.N. for initial request?
- RTC Initial request – did you include comprehensive psychiatric assessment current within 6 months and a signed C.O.N.?

Notes:

This Provider Quick Tip Guide is meant to be used as a reference in conjunction with the Billing Manual for Nevada Medicaid and Nevada Check Up.

For more information regarding PA submissions, forms and/or billing information, please refer to the Billing Manual on the Providers Billing Information webpage at www.medicaid.nv.gov. Forms can be found on the Providers Forms webpage at www.medicaid.nv.gov.

Training information is available on the Provider Training webpage.